Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

March 21, 2024 BCC Agenda Date/Item: _____

Board of County Commissioners
Clackamas County

Approval of a Subrecipient Agreement with the Clackamas County Children's Commission for Healthy Families of Oregon Programming. Agreement value is $1,792,274.92 for 1 year and 8 months. Funding is through the Oregon Department of Early Learning and Care. No County General Funds are involved.

Previous Board Action/Review	BCC Issues: 3/19/2024		
Performance Clackamas	1. Ensure safe, healthy and secure communities.		
Counsel Review	Yes	**Procurement Review**	No
Contact Person	Jessica Duke	**Contact Phone**	971-291-8569

EXECUTIVE SUMMARY: The Children, Family & Community Connections (CFCC) Division of the Health, Housing and Human Services Department requests approval of a Subrecipient Grant Agreement with Clackamas County Children's Commission (CCCC) for the continuation of Healthy Families programming in Clackamas County. Healthy Families Oregon (HFO) is an evidence-based, voluntary, home visiting program that contributes to the economic prosperity of Oregon by preventing child abuse and neglect, promoting healthy child development, improving family self-sufficiency, and helping parents prepare their children for kindergarten.

In 2022, 112 families in Clackamas County receives Healthy Families Oregon services. On average 480 home visits are completed each quarter.

Of families who received Healthy Families Services –

- 100% of children have a primary care provider
- 89% of children are up-to-date on their immunizations
- 74% of parents report reading to their children at least 3 times per week.
- 90% of parents report positive parent child interactions.

Agreement value is $1,792,274.92 for 1 year and 8 months for services from October 1, 2023 through June 30, 2025.

RECOMMENDATION: Staff recommends Board approve this agreement and authorizes Tootie Smith, Chair, to sign it on behalf of Clackamas County.

Respectfully submitted,
Rodney A. Cook
Rodney A. Cook, Director
Health, Housing and Human Services

For Filing Use Only

CLACKAMAS COUNTY, OREGON
SUBRECIPIENT GRANT AGREEMENT 24-023

Project Name: ***Healthy Families of Oregon***
Project Number: **400324480/400324481/400324482/400324485**

This Agreement is between **Clackamas County**, Oregon, acting by and through its Health, Housing and Human Services Children, Family and Community Connections Division ("COUNTY"), and Clackamas County Children's Commission ("SUBRECIPIENT"), an Oregon Nonprofit Corporation.

Clackamas County Data	
Grant Accountant: ***Lorrie Biggs***	Program Manager: ***Dani Stamm Thomas***
Clackamas County – Finance 2051 Kaen Road Oregon City, OR 97045 503-742-5429 *lbiggs@clackamas.us*	Children, Family and Community Connections 112 11th Street Oregon City, OR 97045 971-288-8264 *dstammthomas@clackamas.us*
Subrecipient Data	
Finance/Fiscal Representative: ***Carlos Valles***	Program Representative: ***Darcee Kilsdonk***
Clackamas County Children's Commission 16518 SE River Road Milwaukie, OR 97297 541-314-3624 carlosv@clackcokids.org	Clackamas County Children's Commission 16518 SE River Road Milwaukie, OR 97297 541-314-3624 darceek@clackcokids.org
UEI: V1CETLLGDUC6	

RECITALS

1. Healthy Families Oregon (HFO) is an evidence-based, voluntary, home visiting program nationally accredited by Healthy Families America. HFO contributes to the economic prosperity of Oregon by preventing child abuse and neglect, promoting healthy child development, improving family self-sufficiency, and helping parents prepare their children for kindergarten.

2. SUBRECIPIENT is currently the only certified provider of Healthy Family services in Clackamas County. The Healthy Family program promotes the development of healthy, thriving children, and strong, nurturing families, typically initiated prenatally and at the time of birth with high risk families, and following the Healthy Families America program model.

3. SUBRECIPIENT will provide community-based services to increase the strength and stability of high risk families, prenatally through their child's third birthday, and in some cases include a transition period following the child's birthday. Services range from universal basic short-term services to long-term intensive home visitation for high risk families.

NOW THEREFORE, according to the terms of this Subrecipient Grant Agreement (this "Agreement") the COUNTY and SUBRECIPIENT agree as follows:

AGREEMENT

1. **Term and Effective Date.** This Agreement shall become effective on the date it is fully executed and will terminate on **June 30, 2025**, unless sooner terminated or extended pursuant to the terms hereof. Eligible expenses for this Agreement may be charged during the period beginning **October 1, 2023,** and expiring **June 30, 2025**, subject to additional restrictions set forth below and to the exhibits attached hereto, and unless this Agreement is sooner terminated or extended pursuant to the terms hereof. No grant funds are available for expenditures after the expiration date of this Agreement.

2. **Program.** The Program is described in the attached Exhibit A: Subrecipient Program Activities & Project Reporting. SUBRECIPIENT agrees to carry out the Program in accordance with the terms and conditions of this Agreement and according to SUBRECIPIENT Program Activities & Project Reporting set forth in Exhibit A.

3. **Standards of Performance.** SUBRECIPIENT shall perform all activities and programs in accordance with the requirements set forth in this Agreement and all applicable laws and regulations. Furthermore, SUBRECIPIENT shall perform all activities and programs in compliance with the requirements of the **Oregon Department of Early Learning and Care Healthy Families Grant** that is the source of the grant funding, which is attached hereto as Exhibit M and made a part of this Agreement by this reference. SUBRECIPIENT shall further comply with any and all terms, conditions, and other obligations as may be required by the applicable local, State or Federal agencies providing funding for performance under this Agreement, whether or not specifically referenced herein. SUBRECIPIENT agrees to take all necessary steps and execute and deliver any and all necessary written instruments, to perform under this Agreement including, but not limited to, executing all additional documentation necessary to comply with applicable State and Federal funding requirements.

4. **Grant Funds**. COUNTY's funding for this Agreement is as follows:

    - State of Oregon, Department of Early Learning and Care :
        - Oregon State General Fund: **$1,298,240.62**
        - Federal Title IV-B2 for Family Support, ALN #93.556: **$148,715**
        - Medicaid funding through Oregon Health Authority: **$125,441**
        - State of Oregon Student Success Act: **$219,878.30**

    The maximum, not to exceed, grant amount COUNTY will pay is **$1,792,274.92.** This is a cost reimbursement grant, the award is conditional, and disbursements will be made in accordance with the schedule and requirements contained in Exhibit D: Required Financial Reporting and Payment Request. Failure to comply with the terms of this Agreement may result in withholding of payment or COUNTY pursuing any other rights or remedies available to it under this Agreement, at law, or in equity. Funds advanced and unspent must be returned to COUNTY within 30 days of the end of termination period in Section 1 if award conditions are not met.

5. **Amendments.** The terms of this Agreement shall not be waived, altered, modified, supplemented, or amended, in any manner whatsoever, except by written instrument signed by both parties. **SUBRECIPIENT must submit a written request including a justification for any amendment to COUNTY in writing at least forty-five (45) calendar days before this Agreement expires.** No payment will be made for any services performed before the beginning date or after the expiration date of this Agreement. If the maximum compensation amount is increased by amendment, the amendment must be fully executed before SUBRECIPIENT performs work subject to the amendment.

6. **Termination.** This Agreement may be suspended or terminated prior to the expiration of its term as follows:

    a. At COUNTY's discretion, upon thirty (30) days' advance written notice to SUBRECIPIENT;
    b. Upon SUBRECIPIENT's default under this Agreement, following thirty (30) days' written notice with an opportunity to cure;
    c. Upon mutual agreement by COUNTY and SUBRECIPIENT;

d. Immediately upon written notice provided by COUNTY that funds are no longer available for this purpose; and/or
e. Immediately upon written notice provided by COUNTY that it lacks sufficient funds, as determined by COUNTY in its sole discretion, to continue to perform under this Agreement.

Upon completion of improvements or upon termination of this Agreement, any unexpended balances shall remain with COUNTY.

7. **Effect of Termination**. The expiration or termination of this Agreement, for any reason, shall not release SUBRECIPIENT from any obligation or liability to COUNTY, or any requirement or obligation that:

a. Has already accrued hereunder;
b. Comes into effect due to the expiration or termination of the Agreement; or
c. Otherwise survives the expiration or termination of this Agreement.

Following the termination of this Agreement, SUBRECIPIENT shall promptly identify all unexpended funds and return all unexpended funds to COUNTY. Unexpended funds are those funds received by SUBRECIPIENT under this Agreement that (i) have not been spent or expended in accordance with the terms of this Agreement; and (ii) are not required to pay allowable costs or expenses that will become due and payable as a result of the termination of this Agreement.

8. **Funds Available and Authorized.** COUNTY certifies that it has received an award sufficient to fund this Agreement. SUBRECIPIENT understands and agrees that payment of amounts under this Agreement is contingent on COUNTY receiving appropriations or other expenditure authority sufficient to allow COUNTY, in the exercise of its sole administrative discretion, to continue to make payments under this Agreement.

9. **Future Support.** COUNTY makes no commitment of future support and assumes no obligation for future support for the activity contracted herein except as set forth in Section 8.

10. **Federal and State Procurement Standards**

a) All procurement transactions, whether negotiated or competitively bid and without regard to dollar value, shall be conducted in a manner so as to provide maximum open and free competition. All sole-source procurements must receive prior written approval from COUNTY in addition to any other approvals required by law applicable to SUBRECIPIENT. Justification for sole-source procurement should include a description of the project and what is being contracted for, an explanation of why it is necessary to contract noncompetitively, time constraints and any other pertinent information. Interagency agreements between units of government are excluded from this provision.

b) COUNTY's performance under the Agreement is conditioned upon SUBRECIPIENT's compliance with, and SUBRECIPIENT shall comply with, the obligations applicable to public contracts under the Oregon Public Contracting Code and applicable Local Contract Review Board rules, which are incorporated by reference herein.

c) SUBRECIPIENT must maintain written standards of conduct covering conflicts of interest and governing the performance of its employees engaged in the selection, award and administration of contracts. If SUBRECIPIENT has a parent, affiliate, or subsidiary organization that is not a state, local government, or Indian tribe, SUBRECIPIENT must also maintain written standards of conduct covering organizational conflicts of interest. SUBRECIPIENT shall be alert to organizational conflicts of interest or non-competitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade. Contractors that develop or draft specifications, requirements, statements of work, and/or Requests for Proposals ("RFP") for a proposed procurement must be excluded by SUBRECIPIENT from bidding or submitting a proposal to compete for the award of such procurement. Any request for exemption must be submitted in writing to COUNTY.

d) **Contracting with Small and Minority Businesses, Women's Business Enterprises, and Labor Surplus Area Firms**. SUBRECIPIENT shall take all necessary affirmative steps to assure that small & minority businesses, women's business enterprises, and labor surplus area firms are used when possible when contracting for services or soliciting for potential resources, per 2 CFR 200.321.

11. **General Agreement Provisions**.

a) **Non-appropriation Clause.** If payment for activities and programs under this Agreement extends into COUNTY's next fiscal year, COUNTY's obligation to pay for such work is subject to approval of future appropriations to fund the Agreement by the Board of County Commissioners.

b) **Indemnification.**

a. **Indemnification of County.** SUBRECIPIENT agrees to indemnify, defend, and hold COUNTY, and its elected officials, officers, employees, and agents, harmless with respect to any claim, cause, damage, action, penalty or other cost (including attorney's and expert fees) arising from or related to (1) SUBRECIPIENT's negligent or willful acts or those of its employees, agents, or those under SUBRECIPIENT's control; or (2) SUBRECIPIENT's acts or omissions in performing under this Agreement including, but not limited to, any claim by State or Federal funding sources that SUBRECIPIENT used funds for an ineligible purpose. SUBRECIPIENT is responsible for the actions of its own agents and employees, and COUNTY assumes no liability or responsibility with respect to SUBRECIPIENT's actions, employees, agents or otherwise with respect to those under its control.

Neither SUBRECIPIENT, nor any attorney engaged by SUBRECIPIENT, shall defend any claim in the name of COUNTY, nor purport to act as legal representative of the COUNTY or any of its departments, without the prior written consent of the Office of Clackamas County Counsel. The COUNTY may, at any time at its election, assume its own defense and settlement in the event that it determines that SUBRECIPIENT is prohibited from defending the COUNTY, or that SUBRECIPIENT is not adequately defending the COUNTY's interests, or that an important governmental principle is at issue or that it is in the best interests of the COUNTY to do so. The COUNTY reserves all rights to pursue claims it may have against SUBRECIPIENT if the COUNTY elects to assume its own defense.

b. **Indemnification of State.** SUBRECIPIENT shall indemnify, defend, save and hold harmless State of Oregon, the Department of Early Learning and Care, and their officers, agents and employees(collectively the "State") from and against any and all claims, actions, liabilities, damages, losses, or expenses, including attorneys' fees, arising from a tort, as now or hereafter defined in ORS 30.260, caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of SUBRECIPIENT or SUBRECIPIENT's officers, agents, employees or subcontractors ("Claims"). Neither SUBRECIPIENT, nor any attorney engaged by SUBRECIPIENT, shall defend any claim in the name of State or any agency of the State of Oregon, nor purport to act as legal representative of the State or any of its agencies, without the prior written consent of the Oregon Attorney General. The State may, at any time at its election, assume its own defense and settlement in the event that it determines that SUBRECIPIENT is prohibited from defending the State, or that SUBRECIPIENT is not adequately defending the State's interests, or that an important governmental principle is at issue or that it is in the best interests of the State to do so. The State reserves all rights to pursue claims it may have against SUBRECIPIENT if the State of Oregon elects to assume its own defense.

c) **Assignment.** This Agreement may not be assigned in whole or in part without the prior express written approval of COUNTY.

d) **Independent Status.** SUBRECIPIENT is independent of COUNTY and will be responsible for any federal, state, or local taxes and fees applicable to payments hereunder. SUBRECIPIENT is not an agent of COUNTY and undertakes this work independent from the control and direction of COUNTY excepting as set forth herein. SUBRECIPIENT shall not seek or have the power to bind COUNTY in any transaction or activity.

e) **Notices.** This Agreement, and all rights, obligations, and disputes arising out of it, shall be governed and construed in accordance with the laws of the State of Oregon and the ordinances of Clackamas County without regard to principles of conflicts of law. Any claim, action, or suit between COUNTY and SUBRECIPIENT that arises out of or relates to the performance of this Agreement shall be brought and conducted solely and exclusively within the Circuit Court for Clackamas County, for the State of Oregon. Provided, however, that if any such claim, action, or suit may be brought in a federal forum, it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the COUNTY of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise, from any claim or from the jurisdiction of any court. SUBRECIPIENT, by execution of this Agreement, hereby consents to the personal jurisdiction of the courts referenced in this section.

f) **Governing Law.** This Agreement, and all rights, obligations, and disputes arising out of it, shall be governed and construed in accordance with the laws of the State of Oregon and the ordinances of Clackamas County without regard to principles of conflicts of law. Any claim, action, or suit between COUNTY and SUBRECIPIENT that arises out of or relates to the performance of this Agreement shall be brought and conducted solely and exclusively within the Circuit Court for Clackamas County, for the State of Oregon. Provided, however, that if any such claim, action, or suit may be brought in a federal forum, it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the COUNTY of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise, from any claim or from the jurisdiction of any court. SUBRECIPIENT, by execution of this Agreement, hereby consents to the personal jurisdiction of the courts referenced in this section.

g) **Severability**. If any provision of this Agreement is found to be illegal or unenforceable, this Agreement nevertheless shall remain in full force and effect and the provision shall be stricken.

h) **Counterparts.** This Agreement may be executed in any number of counterparts, all of which together will constitute one and the same Agreement. Facsimile copy or electronic signatures shall be valid as original signatures.

i) **Third Party Beneficiaries**. Except as expressly provided in this Agreement, there are no third party beneficiaries to this Agreement. The terms and conditions of this Agreement may only be enforced by the parties.

j) **Binding Effect.** This Agreement shall be binding on all parties hereto, their heirs, administrators, executors, successors and assigns.

k) **Integration**. This Agreement contains the entire Agreement between COUNTY and SUBRECIPIENT and supersedes all prior written or oral discussions or Agreements.

l) **No Attorney Fees**. In the event any arbitration, action or proceeding, including any bankruptcy proceeding, is instituted to enforce any term of this Agreement, each party shall be responsible for its own attorneys' fees and expenses.

m) **Debt Limitation**. This Agreement is expressly subject to the limitations of the Oregon Constitution and Oregon Tort Claims Act and is contingent upon appropriation of funds. Any provisions herein that conflict with the above referenced laws are deemed inoperative to that extent.

n) **Survival**. All rights and obligations shall cease upon termination or expiration of this Agreement, except for the rights and obligations set forth in Sections 3,7,11 (a), (b), (f), (g), (i), (j) ,(k) ,(l) and (m), and all other rights and obligations which by their context are intended to survive.

12. **Exhibits and Attachments**.

This document is comprised of the following exhibits and attachments:

- Exhibit A: SUBRECIPIENT Program Activities and Program Reporting
- Exhibit B: SUBRECIPIENT Program Budget
- Exhibit C: Lobbying Certificate
- Exhibit D: Required Financial Reporting and Payment Request
- Exhibit E: General Administrative and Federal Terms and Conditions
- Exhibit F: Insurance Requirements
- Exhibit G: Specific Federal Program Requirements
- Exhibit H: Final Financial Report
- Exhibit I: 2 CFR 200.332(a) Required Information
- Exhibit M: State of Oregon Department of Early Learning and Care ("DELC") - Healthy Families Oregon Service Provider Grant Agreement #23020

If a conflict exists between the main body of this Agreement and the Exhibits, the Exhibits shall control.

(Signature Page Follows)

SIGNATURE PAGE TO SUBRECIPIENT GRANT AGREEMENT

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers.

Clackamas County
Tootie Smith

By: _____

Its: Board Chair

Dated: _____

Clackamas County Children's Commission
Darcee Kilsdonk

By: Darcee Kilsdonk

Its: Executive Director

Dated: 3.4.2024

Approved to Form

By: _____
County Counsel

Dated: 03/05/2024

EXHIBIT A
SUBRECIPIENT PROGRAM ACTIVITIES AND PROJECT REPORTING

PROGRAM NAME: Healthy Families of Oregon	**AGREEMENT No. 24-023**
SUBRECIPIENT: Clackamas County Children's Commission	

Program Objectives

Background And Goals
Healthy Families Oregon ("HFO") is an evidence-based, voluntary, home visiting program nationally accredited by Healthy Families America ("HFA"). HFO contributes to the economic prosperity of Oregon by preventing child abuse and neglect, promoting healthy child development, improving family self-sufficiency, and helping parents prepare their children for kindergarten.

HFO's aims to:

- Prevent the incidence of child abuse and neglect;
- Increase school readiness;
- Improve health outcomes for children and families;
- Build trusting, nurturing relationships with parents;
- Teach parents to identify strengths and utilize problem-solving skills; and
- Improve families' support systems through linkages and appropriate referrals to community services.

HFO services begin early, during pregnancy or shortly after the birth of a baby, and can last up to 3 years. Parents are voluntarily assessed by HFO Eligibility Screeners to determine eligibility for the program. Parents having factors that place their children at risk of abuse and neglect, and who live in SUBRECIPIENT's Service Delivery Area, as defined in Exhibit M, are invited to participate in the program. The families who volunteer to participate are connected with a trained, SUBRECIPIENT-provided home visitor, as defined in Exhibit M, eligible families who do not volunteer cannot be offered services due to full caseloads, and families who are not eligible will be offered referrals to community resources as needed. Families who participate receive weekly home visits, as defined in Exhibit M, that decrease in frequency as families increase protective factors and make progress toward providing a safe, healthy, and stable environment for their children.

Strong community partnerships are necessary to provide families with additional services such as child care, mental health counseling, substance abuse treatment, domestic violence intervention and access to basic needs such as food, housing and clothing.

PROGRAM ACTIVITES
COUNTY will disburse award funds only for the costs of Program activities that occur, including expenses incurred, during the term of this Agreement.

1. **EQUITY REQUIREMENT**. SUBRECIPIENT must meet the following equity objectives and complete the following equity activities:

    - SUBRECIPIENT's entire organization works to build a climate that promotes acceptance, inclusion and respect of all individuals;
    - SUBRECIPIENT's staff understands the communities they serve, in a non-static manner, including the communities' cultures, values, norms, histories, customs, and particularly types of discrimination, marginalization and exclusion they face in this country;

- SUBRECIPIENT must apply that knowledge to services they provide under this Agreement in a responsive, non-limiting and non-stereotyping manner;
- Whenever possible, SUBRECIPIENT must interact with service users according to their preferred cultural norms including social greetings, family conventions, dietary preferences, welcoming culture, healing beliefs and spiritual needs;
- SUBRECIPIENT's staff engage in continuous learning about their own biases, assumptions and stereotypes that limit their ability to be culturally-responsive, and to understand how these biases affect their work with service users; and
- SUBRECIPIENT uses data concerning needs, demographics and risks of the community in the determination of which populations to target and prioritize for services.

2. PROGRAM STANDARDS.

a. Guidelines. SUBRECIPIENT shall implement the HFO program and provide services according to the Guidelines set forth in Exhibit M. SUBRECIPIENT must meet the statewide performance and outcome indicators outlined in the HFO Program Policies and Procedures Manual (PPPM) and implement the HFO program in accordance with the PPPM and Healthy Families America Best Practices set forth in Exhibit M.

b. Background Checks. SUBRECIPIENT will conduct appropriate, legally permissible and mandated inquiries of state or provincial criminal history records on all prospective employees and volunteers who will have direct contact with children and/or access to data involving children, i.e., assessment staff, Home Visitors, supervisors and program managers.

c. Mandatory Reporting. All SUBRECIPIENT staff involved with the Program are mandatory reporters, and must report any suspected abuse or neglect of a minor, following applicable law, their local policy, and Oregon DHS guidelines (the "Guidelines"): http://www.oregon.gov/DHS/ABUSE/Pages/mandatory_report.aspx.

3. HFO SPECIFIC ACTIVITIES.

SUBRECIPIENT must undertake the specific Program activities described in the Guidelines, HFO Best Practice Standards ("BPSs"), Program, Policy, and Procedure Manual ("PPPM") and the specific program activities described below. SUBRECIPIENT is expected to be familiar with the requirements of the Guidelines, BPSs and PPPM, and to fulfill those obligations, whether or not they are specifically set forth below. SUBRECIPIENT must:

- Assure each staff member who serves as a home visitor achieves caseload capacity. Caseload size is based upon staff member's tenure. Notwithstanding the foregoing, a full time home visitor shall carry no more than a maximum total weighted caseload of 30 points and full time home visitors who have been employed more than one year shall carry no less than 18 points at any one time.

  The following are minimum requirements for the first year of hire for a full time Home Visitor:

  - At 3 months, a home visitor must have a minimum of 4 points.
  - At 6 months, a home visitor must have a minimum of 10 points.
  - At 12 months, a home visitor must have a full caseload (18-30 points).

  Caseload capacity is defined as follows:

  - Full-time home visitors in the first or second year of working in the role, typically have a caseload range at any given time of approximately 10-12 families; or

  - Full-time home visitors in the role for three years or more typically have a

caseload range at any given time of approximately 15-20 families.

- The caseload for full time home visitors shall not exceed thirty (30) case weight points.

- Collaborate with other home visit providers in the Service Delivery Area, as defined in Exhibit M, by:
    - Identifying and building upon existing services for families in the Service Delivery Area and prioritizing additional services if needed (e.g., mental health, addiction, intimate partner violence, and early intervention). If necessary, and to the extent resources are available, Agency may provide technical assistance to promote improved collaboration. SUBRECIPIENT must document any referrals provided to a client in a Home Visit;
    - Participating in local Early Learning Hub and other community efforts to implement supports and services towards the achievement of desired outcomes, working to maximize the effective use of available resources and to avoid duplication of services in the Service Delivery Area;
    - Participating in an independent statewide program evaluation by submitting an evaluation form to the statewide evaluation team and entering data identified by DELC, as defined in Exhibit M, into the HFO data system;
    - Requiring SUBRECIPIENT's program managers (supervisors and appropriate staff when resources allow) to attend statewide trainings for Healthy Families Services at annual meeting;
    - Requiring SUBRECIPIENT's program managers (and supervisors when requested by DELC) to attend all monthly HFO virtual meetings scheduled by COUNTY.
    - Developing a site specific procedure manual, based off of the HFO PPPM, to further specify local service delivery procedures.
- SUBRECIPIENT must participate in the Medicaid Administrative Claiming ("MAC") program, which includes:
    - Attending DELC-coordinated training prior to completing any Random Time Study ("RTS") (see information below on participating in required RTS);
    - Each of SUBRECIPIENT's staff person completing the MAC training, each year; and
    - Participating in required RTS during the four dates randomly selected by the State of Oregon, through the Oregon Health Authority ("OHA") each quarter. DELCwill notify Grantee within 5 working days of when each RTS day will be. Typical activities that will be recorded include, but are not limited to:
        - Outreach activities to inform families about health services and benefits;
        - Referral, coordination, monitoring and training of Medicaid/OHP covered services;
        - Medicaid/OHP transportation and translation services;
        - Program planning, policy development, and interagency coordination related to Medicaid/OHP services; and
        - Counseling Medicaid/OHP eligible families that they are free to accept or reject Medicaid/OHP services and to receive such service from an

enrolled provider of their choice unless otherwise restricted by OHA to an OHP provider.

- Utilizing the activity codes for identifying MAC activities performed and using the time study methodology to document the time spent on all activities performed during the randomly selected dates for each quarter period. The Activity Codes are available from Agency upon request.

- Complying with all requirements of 42 CFR 434.6, as applicable, which are hereby incorporated by this reference herein.

4. **FAMILY SUPPORT SPECIFIC SERVICES.**

Federal Family Support Funds under Title IV-B(2), must be used by SUBRECIPIENT to provide HFO services, as described in this Agreement, to eligible families in the Service Delivery Area, as follows:

- To provide community-based services that promote the well-being of children and families and are designed to increase the strength and stability of families (including adoptive, foster, and extended families), to increase parents' confidence and competence in their parenting abilities, to afford children a safe, stable and supportive family environment, to strengthen parental relationships and promote healthy marriages, and otherwise to enhance child development;

- To provide services that are (1) family-focused and targeted to the family and not only the child or other individual family member(s); (2) focused on at-risk families so that the services will have an impact on the population that would otherwise require services from DHS; and (3) focus on child welfare (not educational needs or other services which are the responsibility of other agencies);

- To provide services that are NOT family preservation or family reunification services, as these are services provided by DHS; and

- To comply with the additional federal requirements applicable to Title IV-B2 Family Support Services funds pursuant to 42 USC 629 et seq., including but not limited to: maintaining and providing to Agency such documentation as Agency will require to comply with federal reporting requirements, 45 CFR Part 92, and the limitations on the use of Title IV-B2 funds in 42 USC 629d.

PERFORMANCE REPORTING REQUIREMENTS AND SCHEDULE

1. SUBRECIPIENT must submit a monthly Performance Report (*to be provided by Oregon Department of Early Learning and Care (DELC)*, no later than the 15th day of the following month. It should accompany the Fiscal Report and Reimbursement Request.

2. SUBRECIPIENT must submit a quarterly Performance Report each calendar quarter that includes, at a minimum, caseload points for each Home Visitor, number of families served, number of new families enrolled, number of families referred, number of screens completed, number of families eligible based upon screening, and staff Home Visit completion percentages. The quarterly outcome report must be submitted through Smartsheets before any request for funds is approved. Oregon Department of Early Learning and Care will provide SUBRECIPIENT with a site specific link for reporting. The Final Performance Report should be submitted no later than, no later the 15th day of the month following the end of the calendar quarter. Quarterly reports must be submitted electronically on the Healthy Families Work Plan Quarterly Reporting document template (*to be provided by DELC*). The Final Performance Report should be submitted no later than August 15, 2025.

In addition to the Quarterly Performance Reports, SUBRECIPIENT must notify COUNTY Program Manager of developments that have a significant impact on the grant supported activities. SUBRECIPIENT must inform COUNTY Program Manager as soon as problems, delays or adverse conditions become known which will materially impair the ability to meet the outputs/outcomes specified above. This notification shall include a statement of the action taken or contemplated and any assistance needed to resolve the situation.

EXHIBIT B
SUBRECIPIENT Program Budget

PROGRAM NAME: Healthy Families of Oregon	**AGREEMENT No. 24-023**
SUBRECIPIENT: Clackamas County Children's Commission	

EXHIBIT B: PROGRAM BUDGET						
Organization:	*Clackamas County Children's Commission*					
Funded Program Nam	*Healthy Families*					
Program Contact:						
Agreement Term:	***Oct 1, 2023-June 30, 2025***					
Approved Award Budget Categories		***Approved ODE Early Learning Division***	***Approved Title IV B-2***	***Medicaid***	***SSA***	***Total Approved Budget***
Personnel (List salary, FTE & Fringe costs for each position)						
Healthy Families GF Staff (4.43 fte)		$ 1,148,259.75				$ 1,148,259.75
Healthy Families Title IV B-2 Staff (1 fte)			$ 148,715.00			$ 148,715.00
Healthy Families Medicaid Staff (.57 fte)				$ 70,233.54		$ 70,233.54
Health Families SSA Home Visitors (1 fte)					$ 219,878.30	$ 219,878.30
Total Personnel Services		**$ 1,148,259.75**	**$ 148,715.00**	**$ 70,233.54**	**$ 219,878.30**	**$ 1,587,086.59**
Administration						
Administrative Overhead (ELD general fund $130,561.93)		$ 26,200.33				$ 26,200.33
						$ -
Total Adminstration		**$ 26,200.33**	**$ -**	**$ -**	**$ -**	**$ 26,200.33**
Supplies						
Materials and supplies, family support meetings, phone, copies, advisory, etc.		$ 58,752.75				$ 58,752.75
Office space, office supplies, maintenance, insurance		$ 28,092.54		$ 29,107.46		$ 57,200.00
Translation				$ 8,190.00		$ 8,190.00
						$ -
Travel and Training						$ -
Mileage		$ 25,835.25				$ 25,835.25
Professional Development		$ 11,100.00		$ 9,200.00		$ 20,300.00
Conference/Training						$ -
Additional (please specify)						$ -
Welcome Baby Packets				$ 2,310.00		$ 2,310.00
Ancillary supplies (diapers, books, safety supplies, gas cards, bus tickets)				$ 6,400.00		$ 6,400.00
Total Programmatic Costs		**$ 123,780.54**	**$ -**	**$ 55,207.46**		**$ 178,988.00**
Total Budget		**$ 1,298,240.62**	**$ 148,715.00**	**$ 125,441.00**	**$ 219,878.30**	**$ 1,792,274.92**

EXHIBIT C
LOBBYING CERTIFICATE

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on the behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, contribution, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Title 31 U.S.C. §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Please do not alter this form; any questions regarding the form should be directed to EFSP staff.

Clackamas County Children's Commission

Darcee Kilsdonk, Executive Director
Representative Name

Darcee Kilsdonk — 3.4.2024

Representative Signature **Date (month/day/year)**

EXHIBIT D
REQUIRED FINANCIAL REPORTING AND PAYMENT REQUEST

PROGRAM NAME: Healthy Families of Oregon	**AGREEMENT No. 24-023**
SUBRECIPIENT: Clackamas County Children's Commission	

EXHIBIT D Fiscal Report and Reimbursement Request

Organization: *Clackamas County Children's Commission*
unded Program Name: *Healthy Families* — ***Claim Period***
Program Contact:
Agreement Term: *October 1, 2023 - June 30, 2025*

Requests for reimbursement and supporting documentation are due monthly by the 15th of the month, including:
1. Request for Reimbursement with an authorized signature
2. General Ledger backup to support the requested amount

Approved Award Budget Categories	*Approved ODE Early Learning Division*	*Approved Title IV B-2*	*Approved Medicaid (MAC earnings)*	*SSA Funds*	*Total Approved Budget*	*Current Expenditure State GF*	*Current Expenditure Title IV B-2*	*Current Expenditure Medicaid*	*Current Expenditure SSA*	*Previously Requested*	*Balance Remaining*
Personnel (List salary, FTE & Fringe costs for											
Healthy Families GF Staff (4.43 fte)	$ 1,148,259.75				$ 1,148,259.75					$ -	$ 1,148,259.75
Healthy Families Title VI B-2 Staff (1 fte)		$ 148,715.00			$ 148,715.00					$ -	$ 148,715.00
Healthy Families Medicaid Staff (.57 fte)			$ 70,233.54		$ 70,233.54					$ -	$ 70,233.54
Health Families SSA Home Visitors (1 fte)				$ 219,878.30	$ 219,878.30					$ -	$ 219,878.30
Total Personnel Services	**$ 1,148,259.75**	**$ 148,715.00**	**$ 70,233.54**	**$ 219,878.30**	**$ 1,587,086.59**	$ -	$ -	$ -	$ -	$ -	**$ 1,587,086.59**
Administration											
Administrative Overhead (ELD general fund)	$ 26,200.33				$ 26,200.33					$ -	$ 26,200.33
Total Adminstration	**$26,200.33**	**$0.00**	**$0.00**	**$0.00**	**$26,200.33**	$ -	$ -	$ -	$ -	$ -	**$ 26,200.33**
Supplies											
Materials and supplies, family support meetings, phone, copies, advisory meetings, etc.	$ 58,752.75		$ -		$ 58,752.75					$ -	**$ 58,752.75**
Office space, supplies, maintenance, insurance	$ 28,092.54		$ 29,107.46		$ 57,200.00					$ -	**$ 57,200.00**
Translation			$ 8,190.00		$ 8,190.00					$ -	**$ 8,190.00**
					$ -					$ -	**$ -**
Travel and Training					$ -					$ -	**$ -**
Mileage	$ 25,835.25		$ -		$ 25,835.25					$ -	**$ 25,835.25**
Professional Development	$ 11,100.00		$ 9,200.00		$ 20,300.00					$ -	**$ 20,300.00**
Conference/Training					$ -					$ -	**$ -**
Additional (please specify)					$ -					$ -	**$ -**
Welcome Baby Packets			$ 2,310.00		$ 2,310.00					$ -	**$ 2,310.00**
Ancillary supplies (diapers, books, safety,			$ 6,400.00		$ 6,400.00					$ -	**$ 6,400.00**
Total Programmatic Costs	**$ 123,780.54**	**$ -**	**$ 55,207.46**	**$ -**	**$ 178,988.00**	$ -	$ -	$ -	$ -	$ -	**$ 178,988.00**
Total Grant Costs	**$ 1,298,240.62**	**$ 148,715.00**	**$ 125,441.00**	**$ 219,878.30**	**$ 1,792,274.92**	$ -	$ -	$ -	$ -	$ -	**$ 1,792,274.92**

Clackamas County retains the right to inspect all financial records and other books, documents, papers, plans, records of shipments and payments and writings of the Subrecipient that are pertinent to this Agreement.

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Healthy Families Agency Services Contract. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).

EXHIBIT E
GENERAL ADMINISTRATIVE AND FEDERAL REQUIREMENTS

1. Federal Funds

a) This Agreement is funded in part by federal funds. By signing this Agreement, SUBRECIPIENT certifies neither it nor its employees, contractors, subcontractors, or subrecipients who will perform the Program activities described herein are currently employed by an agency or department of the federal government.

b) COUNTY has determined:

☒ Entity is a subrecipient ☐ Entity is a contractor ☐ Not applicable

c) Assistance Listing Number (ALN) of federal funds paid through this Agreement: 93.556

Medicaid funds (ALN 93.778 – Medical Assistance Program) payable through this agreement are not considered subrecipient funding subject to federal Single Audit requirements.

2. Administrative Requirements. SUBRECIPIENT agrees to its status as a subrecipient, and accepts among its duties and responsibilities the following:

a) **Financial Management.** SUBRECIPIENT shall comply with 2 CFR Part 200, Subpart D—*Post Federal Award Requirements*, and agrees to adhere to the accounting principles and procedures required therein, use adequate internal controls, and maintain necessary sources documentation for all costs incurred.

b) **Revenue Accounting**. Grant revenue and expenses generated under this Agreement should be recorded in compliance with generally accepted accounting principles and/or governmental accounting standards. This requires that the revenues are treated as unearned income or "deferred" until the compliance requirements and objectives of the grant have been met. Revenue may be recognized throughout the life cycle of the grant as the funds are "earned." All grant revenues not fully earned and expended in compliance with the requirements and objectives at the end of the period of performance must be returned to COUNTY within 15 days.

c) **Change in Key Personnel**. SUBRECIPIENT is required to notify COUNTY, in writing, whenever there is a change in SUBRECIPIENT key administrative or programmatic personnel and the reason for the change. Key personnel include but are not limited to: Executive Director, Finance Director, Program Manager, Bookkeeper, or any equivalent to these positions within the organization.

d) **Cost Principles**. SUBRECIPIENT shall administer the award in conformity with 2 CFR 200, Subpart E. These cost principles must be applied for all costs incurred whether charged on a direct or indirect basis. Costs disallowed by the Federal government shall be the liability of the SUBRECIPIENT.

e) **Period of Availability**. SUBRECIPIENT may charge to the award only allowable costs resulting from obligations incurred during the funding period.

f) **Match**. Matching funds are not required for this Agreement.

g) **Budget**. SUBRECIPIENT use of funds may not exceed the amounts specified in the Exhibit B: Subrecipient Program Budget. At no time may budget modification change the scope of the original grant application or Agreement.

h) **Payment**. SUBRECIPIENT must submit a final request for payment no later than fifteen (15) days after the end date of this Agreement. Routine requests for reimbursement should be submitted as specified in Exhibit D: Reimbursement Request.

i) **Performance Reporting**. SUBRECIPIENT shall comply with reporting requirements as specified in Exhibit A.

j) **Financial Reporting**. Methods and procedures for payment shall minimize the time elapsing between the transfer of funds and disbursement by the grantee or SUBRECIPIENT, in accordance with Treasurer regulations at 31 CFR Part 205. Therefore, upon execution of this Agreement, SUBRECIPIENT will submit completed Exhibit D: Reimbursement Request on a monthly basis.

k) **Closeout**. COUNTY will closeout this award when COUNTY determines that all applicable administrative actions and all required work have been completed by SUBRECIPIENT, pursuant to 2 CFR 200.344—Closeout. SUBRECIPIENT must liquidate all obligations incurred under this award and must submit all financial, performance, and other reports as required by the terms and conditions of the Federal award and/or COUNTY, no later than 90 calendar days after the end date of this Agreement.

l) **Unique Entity Identifier and Contractor Status**. SUBRECIPIENT shall register and maintain an active registration in the Central Contractor Registration database using its Unique Entity Identifier ("UEI"), located at http://www.sam.gov.

m) **Suspension and Debarment**. SUBRECIPIENT shall comply with 2 CFR Part 180. These rules restrict subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal assistance programs or activities. SUBRECIPIENT is responsible for further requiring the inclusion of a similar term or condition in any subsequent lower tier covered transactions. SUBRECIPIENT may access the Excluded Parties List System at http://www.sam.gov. The Excluded Parties List System contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Orders 12549 and 12689. Awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

n) **Lobbying**. SUBRECIPIENT certifies (Exhibit C: Lobbying) that no portion of the Federal grant funds will be used to engage in lobbying of the Federal Government or in litigation against the United States unless authorized under existing law and shall abide by 2 CFR 200.450 and the Byrd Anti-Lobbying Amendment 31 U.S.C. 1352. In addition, the SUBRECIPIENT certifies that it is a nonprofit organization described in Section 501(c) (3) of the Code, but does not and will not engage in lobbying activities as defined in Section 3 of the Lobbying Disclosure Act.

o) **Audit**. SUBRECIPIENT shall comply with the audit requirements prescribed in the Single Audit Act Amendments and the new Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, located in 2 CFR 200.501. SUBRECIPIENT expenditures of $750,000 or more in Federal funds require an annual Single Audit. SUBRECIPIENT is required to hire an independent auditor qualified to perform a Single Audit. Subrecipients of Federal awards are required under the Uniform Guidance to submit their audits to the Federal Audit Clearinghouse ("FAC") within 9 months from SUBRECIPIENT's fiscal year end or 30 days after issuance of the reports, whichever is sooner. The website for submissions to the FAC is https://www.fac.gov/. At the time of submission to the FAC, SUBRECIPIENT will also submit a copy of the audit to COUNTY. If requested and if SUBRECIPIENT does not meet the threshold for the Single Audit requirement, SUBRECIPIENT shall submit to COUNTY a financial audit or independent review of financial statements within 9 months from SUBRECIPIENT's fiscal year end or 30 days after issuance of the reports, whichever is sooner.

p) **Monitoring**. SUBRECIPIENT agrees to allow COUNTY access to conduct site visits and inspections of financial records for the purpose of monitoring in accordance with 2 CFR 200.332.

COUNTY, the Federal government, and their duly authorized representatives shall have access to such financial records and other books, documents, papers, plans, records of shipments and payments and writings of SUBRECIPIENT that are pertinent to this Agreement, whether in paper, electronic or other form, to perform examinations and audits and make excerpts and transcripts. Monitoring may be performed onsite or offsite, at COUNTY's discretion. Depending on the outcomes of the financial monitoring processes, this Agreement shall either a) continue pursuant to the original terms, b) continue pursuant to the original terms and any additional conditions or remediation deemed appropriate by COUNTY, or c) be de-obligated and terminated.

q) **Record Retention**. SUBRECIPIENT will retain and keep accessible all such financial records, books, documents, papers, plans, records of shipments and payments and writings for a minimum of six (6) years from the end of program date, or such longer period as may be required by the Federal agency or applicable state law, following final payment and termination of this Agreement, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever date is later, according to 2 CFR 200.334-338.

r) **Certification of Compliance with Grant Documents**. SUBRECIPIENT acknowledges that it has read the award conditions and certifications for Healthy Families Oregon and the Federal Title IV-B2 for Family Support Program, that it understands and accepts those conditions and certifications, and that it agrees to comply with all the obligations, and be bound by any limitations applicable to the Clackamas County, as COUNTY, under those grant documents.

s) **Compliance with Confidentiality Laws.** SUBRECIPIENT may, in the course of the Program, be exposed to or acquire information that is protected under applicable law, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"), the regulations governing disclosure of substance use disorder information under 42 C.F.R. Part 2, and state law regarding the protection of personal information, as defined by ORS 646A.602. SUBRECIPIENT shall comply with all applicable local, state, or federal laws regarding the confidentiality of protected information.

3. Default

a) **Subrecipient's Default**. SUBRECIPIENT will be in default under this Agreement upon the occurrence of the following:
   a. SUBRECIPIENT fails to use the grant funds for eligible purposes described in Exhibit A;
   b. Any representation, warranty or statement made by SUBRECIPIENT in this Agreement or in any documents or reports relied upon by COUNTY to measure the Program, the expenditure of grant funds or the performance by SUBRECIPIENT is untrue in any material respect when made;
   c. After thirty (30) days' written notice with an opportunity to cure, SUBRECIPIENT fails to comply with any term or condition set forth in this Agreement;
   d. A petition, proceeding, or case is filed by or against SUBRECIPIENT under federal or state bankruptcy, insolvency, receivership, or other law.

b) **County's Default**. COUNTY will be in default under this Agreement if, after thirty (30) days' notice and opportunity to cure, COUNTY fails to perform a material obligation under this Agreement provided, however, that failure to disburse grant funds due to lack of appropriation shall not constitute a default of COUNTY.

4. Remedies

a) **County's Remedies.** In the event of SUBRECIPIENT's default, COUNTY may, at is option, pursue any or all remedies available to it under this Agreement, at law, or in equity including, but not limited to: (1) withholding SUBRECIPIENT grant funds until compliance is met; (2) reclaiming grant funds in the case of omissions or misrepresentations in financial or programmatic reporting; (3) requiring repayment of any funds used by SUBRECIPIENT in violation of this Agreement; (4) termination of this Agreement; (5) declaring SUBRECIPIENT ineligible for receipt of future awards

from COUNTY; (6) initiation of an action or proceeding for damages, declaratory, or injunctive relief.

b) **Subrecipient's Remedies**: In the event COUNTY is in default, and whether or not SUBRECIPIENT elects to terminate this Agreement, SUBRECIPIENT's sole remedy for COUNTY's default, subject to the limits of applicable law or in this Agreement, is reimbursement for eligible costs incurred in accordance with this Agreement, less any claims COUNTY may have against SUBRECIPIENT. In no event will COUNTY be liable to SUBRECIPIENT for expenses related to termination of this Agreement or for any indirect, incidental, consequential or special damages.

5. Compliance with Applicable Laws

a) **Public Policy.** SUBRECIPIENT expressly agrees to comply with all public policy requirements, laws, regulations, and executive orders issued by the Federal government, to the extent they are applicable to the Agreement: (i) Titles VI and VII of the Civil Rights Act of 1964, as amended; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended; (iii) the Americans with Disabilities Act of 1990, as amended; (iv) Executive Order 11246, "Equal Employment Opportunity" as amended; (v) the Health Insurance Portability and Accountability Act of 1996; (vi) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended; (vii) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; (viii) all regulations and administrative rules established pursuant to the foregoing laws; and (ix) all other applicable requirements of federal and state civil rights and rehabilitation statutes, rules and regulations; and 2 CFR Part 200 as applicable to SUBRECIPIENT.

b) **Rights to Inventions Made Under a Contract or Agreement.** SUBRECIPIENT agrees that contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention in accordance with 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any further implementing regulations issued by the U.S. Treasury Department.

c) **Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.).** SUBRECIPIENT agrees that if this Agreement is in excess of $150,000, the recipient agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended 33 U.S.C. 1251 et seq. Violations shall be reported to the awarding Federal Department and the appropriate Regional Office of the Environmental Protection Agency.

d) **State Statutes**. SUBRECIPIENT expressly agrees to comply with all statutory requirements, laws, rules, and regulations issued by the State of Oregon, to the extent they are applicable to this Agreement.

e) **Conflict Resolution.** If potential, actual or perceived conflicts are discovered among federal, state and local statutes, regulations, administrative rules, executive orders, ordinances or other laws applicable to the Services under the Agreement, SUBRECIPIENT may in writing request COUNTY to resolve the conflict. SUBRECIPIENT shall specify if the conflict(s) create a problem for the design or other Services required under the Agreement. COUNTY shall undertake reasonable efforts to resolve the issue but is not required to deliver any specific answer or product. SUBRECIPIENT shall remain obligated to independently comply with all applicable laws and no action by COUNTY shall be deemed a guarantee, waiver, or indemnity for non-compliance with any law.

f) **Disclosure of Information.** Any confidential or personally identifiable information (2 CFR 200.1) acquired by SUBRECIPIENT during the execution of the project should not be disclosed during or upon termination or expiration of this Agreement for any reason or purpose without the prior written consent of COUNTY. SUBRECIPIENT further agrees to take reasonable measures to

safeguard such information (including those set forth in 2 CFR 200.303(e)) and to follow all applicable federal, state and local regulations regarding privacy and obligations of confidentiality.

g) **Mileage reimbursement.** If mileage reimbursement is authorized in SUBRECIPIENT budget or by the written approval of COUNTY, mileage must be paid at the rate established by SUBRECIPIENT's written policies covering all organizational mileage reimbursement or at the IRS mileage rate at the time of travel, whichever is lowest.

h) **Human Trafficking**. In accordance with 2 CFR Part 175, SUBRECIPIENT, its employees, contractors and subrecipients under this Agreement and their respective employees may not:

- Engage in severe forms of trafficking in persons during the period of the time the award is in effect;
- Procure a commercial sex act during the period of time the award is in effect; or
- Used forced labor in the performance of the Agreement or subaward under this Agreement.

SUBRECIPIENT must inform COUNTY immediately of any information SUBRECIPIENT receives from any source alleging a violation of any of the above prohibitions in the terms of this Agreement. COUNTY may terminate this Agreement, without penalty, for violation of these provisions. COUNTY's right to terminate this Agreement unilaterally, without penalty, is in addition to all other remedies under this Agreement. SUBRECIPIENT must include these requirements in any subaward made to public or private entities under this Agreement.

EXHIBIT F
INSURANCE REQUIREMENTS

During the term of this Agreement, SUBRECIPIENT shall maintain in force, at its own expense, each insurance noted below:

1) **Workers' Compensation.** Insurance in compliance with ORS 656.017, which requires all employers that employ subject workers, as defined in ORS 656.027, to provide workers' compensation coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). If contractor is a subject employer, as defined in ORS 656.023, contractor shall obtain employers' liability insurance coverage limits of not less than $1,000,000.

2) **Commercial General Liability**.

   ☒ Required by COUNTY ☐ NOT Required by COUNTY

   SUBRECIPIENT shall obtain, at SUBRECIPIENT's expense, and keep in effect during the term of this Agreement, Commercial General Liability Insurance covering bodily injury and property damage on an "occurrence" form in the amount of not less than $1,000,000 per occurrence/ $2,000,000 general aggregate for the protection of COUNTY, its officers, elected officials, and employees. This coverage shall include Contractual Liability insurance for the indemnity provided under this Agreement. This policy(s) shall be primary insurance as respects to the COUNTY. Any insurance or self-insurance maintained by COUNTY shall be excess and shall not contribute to it.

3) **Commercial Automobile Liability**.

   ☒ Required by COUNTY ☐ NOT Required by COUNTY

   SUBRECIPIENT shall obtain at SUBRECIPIENT expense and keep in effect during the term of this Agreement, Commercial Automobile Liability coverage including coverage for all owned, hired, and non-owned vehicles. The combined single limit per occurrence shall not be less than $1,000,000, or SUBRECIPIENT shall obtain at SUBRECIPIENT expense, and keep in effect during the term of the agreement, Personal auto coverage. The limits shall be no less than $250,000/occurrence, $500,000/aggregate, and $100,000 property damage.

4) **Professional Liability**.

   ☒ Required by COUNTY ☐ NOT Required by COUNTY

   SUBRECIPIENT shall obtain and furnish COUNTY evidence of Professional Liability Insurance in the amount of not less than $1,000,000 combined single limit per occurrence/$2,000,000 general annual aggregate for malpractice or errors and omissions coverage for the protection of COUNTY, its officers, elected officials and employees against liability for damages because of personal injury, bodily injury, death, or damage to property, including loss of use thereof, and damages because of negligent acts, errors and omissions in any way related to this Agreement. COUNTY, at its option, may require a complete copy of the above policy.

5) **Abuse and Molestation Clause**.

   ☒ Required by COUNTY ☐ NOT Required by COUNTY

   As part of the Commercial General Liability policy, SUBRECIPIENT shall obtain Abuse and Molestation coverage in a form and with coverage satisfactory to COUNTY covering damages arising out of actual or threatened physical abuse, mental injury, sexual molestation, negligent hiring, employment, supervision, investigation, reporting to proper authorities, and retention of any person for whom SUBRECIPIENT is responsible including but not limited to SUBRECIPIENT and SUBRECIPIENT's employees and volunteers. Policy endorsement's definition of an insured shall

include SUBRECIPIENT, and SUBRECIPENT's employees and volunteer. Coverage shall be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Any annual aggregate limit shall not be less than $3,000,000.

6) **Directors, Officers and Organization Liability**.

☒ Required by COUNTY ☐ NOT Required by COUNTY

Directors, officers and organization liability insurance covering the Grantee's organization, directors, officers, and trustees actual or alleged errors, omissions, negligent, or wrongful acts, including improper governance, employment practices and financial oversight – including improper oversight and / or use of Grant Funds and donor contributions – with a combined single limit of no less than $1,000,000 per claim.

7) **Additional Insured Provisions**. All required insurance, other than Professional Liability, Workers' Compensation, and Personal Automobile Liability and Pollution Liability Insurance, shall include "Clackamas County, its agents, elected officials, officers, and employees".

8) **Notice of Cancellation.** There shall be no cancellation, material change, exhaustion of aggregate limits or intent not to renew insurance coverage without 60 days written notice to COUNTY. Any failure to comply with this provision will not affect the insurance coverage provided to COUNTY. The 60 days' notice of cancellation provision shall be physically endorsed on to the policy.

9) **Insurance Carrier Rating**. Coverage provided by SUBRECIPIENT must be underwritten by an insurance company deemed acceptable by COUNTY. Insurance coverage shall be provided by companies admitted to do business in Oregon or, in the alternative, rated A- or better by Best's Insurance Rating. COUNTY reserves the right to reject all or any insurance carrier(s) with an unacceptable financial rating.

10) **Certificates of Insurance.** As evidence of the insurance coverage required by this Agreement, SUBRECIPIENT shall furnish a Certificate of Insurance to COUNTY. The COUNTY and its elected officials, employees and officers must be named as an additional insured on the Certificate of Insurance. No Agreement shall be in effect until the required certificates have been received, approved, and accepted by COUNTY. A renewal certificate will be sent to COUNTY 10 days prior to coverage expiration.

11) **Primary Coverage Clarification**. SUBRECIPIENT coverage will be primary in the event of a loss and will not seek contribution from any insurance or self-insurance maintained by, or provided to, the additional insureds listed above.

12) **Cross-Liability Clause**. A cross-liability clause or separation of insured's condition will be included in all general liability, professional liability, and errors and omissions policies required by the Agreement.

13) **Waiver of Subrogation**. SUBRECIPIENT agrees to waive their rights of subrogation arising from the work performed under this Agreement.

EXHIBIT G
SPECIFIC FEDERAL PROGRAM REQUIREMENTS

FAMILY SUPPORT SPECIFIC SERVICE. Funds derived from federal Family Support Funds under Title IV-B(2) must be used by SUBRECIPIENT to provide HFO services, as described in this Agreement, to eligible families in the service delivery Area, that:

a. Provide community-based services that promote the well-being of children and families and are designed to increase the strength and stability of families (including adoptive, foster, and extended families), to increase parents' confidence and competence in their parenting abilities, to afford children a safe, stable and supportive family environment, to strengthen parental relationships and promote healthy marriages, and otherwise to enhance child development; and

b. Are (1) family-focused and targeted to the family and not only the child or other individual family member(s); (2) focused on at-risk families so that the services will have an impact on the population that would otherwise require services from DHS; and (3) focus on child welfare (not educational needs or other services which are the responsibility of other agencies); and

c. Are NOT used for family preservation or family reunification services, as these are services provided by DHS.

d. Comply with the additional federal requirements applicable to Title IV-B2 Family Support Services funds pursuant to 42 USC 629 et seq., including but not limited to: maintaining and providing to Agency such documentation as Agency will require to comply with federal reporting requirements, 45 CFR Part 92, and the limitations on the use of Title IV-B2 funds in 42 USC 629d.

EXHIBIT H
FINAL FINANCIAL REPORT

Program Name: Healthy Families of Oregon	***Agreement #: 24-023***
Federal Award #:	***Date of Submission: XX/XX/XX***
Subrecipient: Clackamas County Children's Commission	
Has Subrecipient submitted all requests for reimbursement? Y/N	
Has Subrecipient met all programmatic closeout requirements? Y/N	

Exhibit H: Final Financial Report

Report of Funds received, expended, and reported as match (if applicable) under this Agreement

Total Federal Funds authorized on this agreement:	
Total Federal Funds requested for reimbursement on this agreement:	
Total Federal Funds received on this agreement:	
Total non-Federal Funds authorized on this agreement:	
Agreement-to-Date non-Federal Funds requested for reimbursement on this agreement:	
Total non-Federal Funds received on this agreement:	
Balance of unexpended Federal Funds (Line 1 minus Line 3):	
Balance of unexpended non-Federal Funds (Line 4 minus Line 6):	

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).

Subrecipient's Certifying Official (printed): _____

Subrecipient's Certifying Official (signature): _____

Subrecipient's Certifying Official's title: _____

EXHIBIT I
2 CFR 200.332(a) REQUIRED INFORMATION

Federal award identification	
SUBRECIPIENT Name:	**Clackamas County Children's Commission**
SUBRECIPIENT Unique Entity Identifier:	**V1CETLLGDUC6**
Federal Award Identification Number (FAIN):	2303ORFPSS
Federal award date:	**August 25, 2023**
Period of Performance (This Agreement):	**October 1, 2023 - June 30, 2025**
Budget Period (This Agreement):	**October 1, 2023 - June 30, 2025**
Amount of federal funds obligated by this action to SUBRECIPIENT:	**$148,715.00**
Total amount of all federal funds obligated to SUBRECIPIENT including the current financial obligation:	**$148,715.00**
Total amount of federal award committed to SUBRECIPIENT:	**$148,715.00**
Federal award project description:	**Family preservation and family support**
Federal awarding agency:	**Department of Health and Human Services**
Name of pass-through entity:	**Clackamas County**
Pass-through entity award identifying number to SUBRECIPIENT:	**24-023**
Contact information for awarding official of the pass-through entity:	**Jessica Duke** **jduke@clackamas.us**
Assistance Listing Number (ALN) & Title:	**93.556 MaryLee Allen Promoting Safe and Stable Families Program**
Is Award for Research and Development?	**No**
SUBRECIPIENT indirect cost rate on this Agreement:	**No indirect cost claimed on federal award by SUBRECIPIENT**

EXHIBIT M

State of Oregon Department of Early Learning and Care ("DELC") - Healthy Families Oregon Service Provider Grant Agreement #23020

(The remainder of this page has been left intentionally blank. The Healthy Families Oregon Service Provider Grant Agreement is included as an attachment.)

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

January 4, 2024

BCC Agenda Date/Item: 20240104 III.E.6

Board of County Commissioners
Clackamas County

Approval of a Revenue Grant Agreement from Oregon Department of Early Learning and Care for Healthy Families of Oregon programming. Agreement value is $1,867,774.92 for 1 year and 8 months. Funding through the State of Oregon. No County General Funds are involved.

Previous Board Action/Review	BCC Issues: 1/3/2024		
Performance Clackamas	1. Ensure safe, healthy and secure communities.		
Counsel Review	Yes	**Procurement Review**	No
Contact Person	Jessica Duke	**Contact Phone**	971-291-8569

EXECUTIVE SUMMARY: The Children, Family & Community Connections (CFCC) Division of the Health, Housing and Human Services Department requests approval of a Revenue Grant Agreement from Oregon Department of Early Learning and Care (DELC) for the continuation of Healthy Families of Oregon (HFO) programming. HFO is an evidence-based, voluntary, home visiting program that contributes to the economic prosperity of Oregon by preventing child abuse and neglect, promoting healthy child development, improving family self-sufficiency, and helping parents prepare their children for kindergarten.

In 2022, 112 families in Clackamas County received Healthy Families Oregon services. On average 480 home visits are completed each quarter.

Agreement value is $1,867,774.92 for 1 year and 8 months for services from October 1, 2023 through June 30, 2025.

RECOMMENDATION: Staff recommend that the Board approve this agreement and authorize Tootie Smith, Chair, to sign it on behalf of Clackamas County.

Respectfully submitted,

Rodney A. Cook

Rodney A. Cook, Director
Health, Housing and Human Services

For Filing Use Only

STATE OF OREGON
GRANT AGREEMENT

Grant No. 23020

This Grant Agreement ("Grant") is between the State of Oregon acting by and through its Department of Early Learning and Care("Agency") and Clackamas County ("Grantee"), each a "Party" and, together, the "Parties".

SECTION 1: AUTHORITY

Pursuant to ORS 417.723 and 417.795, Agency is authorized to enter into a grant agreement and provide funding for the purposes described in this Grant.

SECTION 2: PURPOSE

The mission of Early Learning and Care Agency ("DELC") is to support all of Oregon's young children and families to learn and thrive. DELC values equity, making a positive impact for children and families, dedication, integrity, and collective wisdom to benefit Oregon children and families.

Healthy Families Oregon ("HFO") is an evidence-based, voluntary, home visiting program nationally accredited by Healthy Families America ("HFA"). HFO contributes to the economic prosperity of Oregon by preventing child abuse and neglect, promoting healthy child development, improving family self-sufficiency, and helping parents prepare their children for kindergarten.

The purpose of this Grant is to engage Grantee to implement the HFO program according to the most current versions of HFA Best Practice Standards ("BPSs") and DELC's HFO Program, Policy, and Procedure Manual ("PPPM"), as well as the legal standards set forth in ORS 417.795 and OAR 414-525-0005 through 0015 (collectively, the "Guidelines"). The current version of the BPSs is attached as Exhibit F. The PPPM is attached as Exhibit G.

SECTION 3: EFFECTIVE DATE AND DURATION

When all Parties have executed this Grant, and all necessary approvals have been obtained ("Execution Date"), this Grant is effective and has a Grant funding start date as of October 1, 2023 ("Effective Date"), and, unless extended or terminated earlier in accordance with its terms, will expire on June 30, 2025 ("Expiration Date").

SECTION 4: GRANT MANAGERS

4.1 Agency's Grant Manager is:

Heidi Grogger
700 Summer Street NE, Suite 350, Salem, OR 97301
Phone: 971-345-1306
Heidi.grogger@delc.oregon.gov

4.2 Grantee's Grant Manager is:

Adam Freer
Clackamas County
2051 Kaen Road Oregon City,OR 97045
971-288-8264
afreer@clackamas.us

4.3 A Party may designate a new Grant Manager by written notice to the other Party.

SECTION 5: PROJECT ACTIVITIES

Grantee must perform the project activities set forth on Exhibit A (the "Project"), attached hereto and incorporated in this Grant by this reference, for the period beginning on the Effective Date and ending on the Expiration Date (the "Performance Period").

SECTION 6: GRANT FUNDS

In accordance with the terms and conditions of this Grant, Agency will provide Grantee up to $1,867,774.92 ("Grant Funds") for the Project. Agency will pay the Grant Funds from monies available through its General Fund and Other Funds appropriations and with federal funds provided to Agency under the Title IV-B2 of the federal Social Security Act for promoting safe and stable families, as set forth below ("Funding Source"). The funds available under this Grant are subject to reduction for reasons that include those described in Exhibit A, Section IV, paragraph (e).

Source	**10/1/2023 –6/30/2025**
General Funds	$1,373,740.62
Other Funds (Student Success Act's Early Learning Account)	$219,878.30
Federal Title IV-B2 for Family Support	$148,715.00
Medicaid Earnings	$125,441.00
Grand Total	**$1,867,774.92**

SECTION 7: DISBURSEMENT GENERALLY

7.1 Disbursement.

7.1.1 Subject to the availability of sufficient moneys in and from the Funding Source, Agency will disburse Grant Funds to Grantee for the allowable Project activities described in Exhibit A that are undertaken during the Performance Period.

7.1.2 Grantee must provide to Agency any information or detail regarding the expenditure of Grant Funds required under Exhibit A prior to disbursement or as Agency may request.

7.1.3 Agency will only disburse Grant Funds to Grantee for activities completed or materials produced, that, if required by Exhibit A, are approved by Agency. If Agency determines any completed Project activities or materials produced are not acceptable and any deficiencies are the responsibility of Grantee, Agency will prepare a detailed written description of the deficiencies within 15 days of receipt of the materials or performance of the activity, and will deliver such notice to Grantee. Grantee must correct any deficiencies at no additional cost to Agency within 15 days. Grantee may resubmit a request for disbursement that includes evidence satisfactory to Agency demonstrating deficiencies were corrected.

7.2 Conditions Precedent to Disbursement. Agency's obligation to disburse Grant Funds to Grantee under this Grant is subject to satisfaction of each of the following conditions precedent:

7.2.1 Agency has received sufficient funding, appropriations, expenditure limitation, allotments or other necessary expenditure authorizations to allow Agency, in the exercise of its reasonable administrative discretion, to make the disbursement from the Funding Source;

7.2.2 No default as described in Section 15 has occurred; and

7.2.3 Grantee's representations and warranties set forth in Section 8 are true and correct on the date of disbursement(s) with the same effect as though made on the date of disbursement.

7.3 No Duplicate Payment. Grantee may use other funds in addition to the Grant Funds to complete the Project; provided, however, the Grantee may not credit or pay any Grant Funds for Project costs that are paid for with other funds and would result in duplicate funding.

SECTION 8: REPRESENTATIONS AND WARRANTIES

8.1 Organization/Authority. Grantee represents and warrants to Agency that:

8.1.1 Grantee is a Governmental Entity duly organized and validly existing;

8.1.2 Grantee has all necessary rights, powers and authority under any organizational documents and under Oregon Law to (a) execute this Grant, (b) incur and perform its obligations under this Grant, and (c) receive financing, including the Grant Funds, for the Project;

8.1.3 This Grant has been duly executed by Grantee and when executed by Agency, constitutes a legal, valid and binding obligation of Grantee enforceable in accordance with its terms;

8.1.4 If applicable and necessary, the execution and delivery of this Grant by Grantee has been authorized by an ordinance, order or resolution of its governing body, or voter approval, that was adopted in accordance with applicable law and requirements for filing public notices and holding public meetings; and

8.1.5 There is no proceeding pending or threatened against Grantee before any court or governmental authority that if adversely determined would materially or adversely affect the Project or the ability of Grantee to carry out the Project.

8.2 False Claims Act. Grantee acknowledges the Oregon False Claims Act, ORS 180.750 to 180.785, applies to any "claim" (as defined by ORS 180.750) made by (or caused by) Grantee that pertains to this Grant or to the Project. Grantee certifies that no claim described in the previous sentence is or will be a "false claim" (as defined by ORS 180.750) or an act prohibited by ORS 180.755. Grantee further acknowledges in addition to the remedies under Section 16, if it makes (or causes to be made) a false claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against the Grantee.

8.3 No limitation. The representations and warranties set forth in this Section are in addition to, and not in lieu of, any other representations or warranties provided by Grantee.

SECTION 9: OWNERSHIP

9.1 Intellectual Property Definitions. As used in this Section and elsewhere in this Grant, the following terms have the meanings set forth below:

"Grantee Intellectual Property" means any intellectual property owned by Grantee and developed independently from the Project.

"Third Party Intellectual Property" means any intellectual property owned by parties other than Grantee or Agency.

"Work Product" means every invention, discovery, work of authorship, trade secret or other tangible or intangible item Grantee is required to create or deliver as part of the Project, and all intellectual property rights therein.

9.2 Grantee Ownership. Grantee must deliver copies of all Work Product as directed in Exhibit A. Grantee retains ownership of all Work Product, and grants Agency an irrevocable, non-exclusive, perpetual, royalty-free license to use, to reproduce, to prepare derivative works based upon, to distribute, to perform and to display the Work Product, to authorize others to do the same on Agency's behalf, and to sublicense the Work Product to other entities without restriction.

9.3 Third Party Ownership. If the Work Product created by Grantee under this Grant is a derivative work based on Third Party Intellectual Property, or is a compilation that includes Third Party Intellectual Property, Grantee must secure an irrevocable, non-exclusive, perpetual, royalty-free license allowing Agency and other entities the same rights listed above for the pre-existing element of the Third party Intellectual Property employed in the Work Product. If state or federal law

requires that Agency or Grantee grant to the United States a license to any intellectual property in the Work Product, or if state or federal law requires Agency or the United States to own the intellectual property in the Work Product, then Grantee must execute such further documents and instruments as Agency may reasonably request in order to make any such grant or to assign ownership in such intellectual property to the United States or Agency.

SECTION 10: CONFIDENTIAL INFORMATION

10.1 Confidential Information Definition. Grantee acknowledges it and its employees or agents may, in the course of performing its responsibilities, be exposed to or acquire information that is: (i) confidential to Agency or Project participants or (ii) the disclosure of which is restricted under federal or state law, including without limitation: (a) personal information, as that term is used in ORS 646A.602, (b) social security numbers, and (c) information protected by the federal Family Educational Rights and Privacy Act under 20 USC § 1232g (items (i) and (ii) separately and collectively "Confidential Information").

10.2 Nondisclosure. Grantee agrees to hold Confidential Information as required by any applicable law and in all cases in strict confidence, using at least the same degree of care Grantee uses in maintaining the confidentiality of its own confidential information. Grantee may not copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give, or disclose Confidential Information to third parties, or use Confidential Information except as is allowed by law and for the Project activities and Grantee must advise each of its employees and agents of these restrictions. Grantee must assist Agency in identifying and preventing any unauthorized use or disclosure of Confidential Information. Grantee must advise Agency immediately if Grantee learns or has reason to believe any Confidential Information has been, or may be, used or disclosed in violation of the restrictions in this Section. Grantee must, at its expense, cooperate with Agency in seeking injunctive or other equitable relief, in the name of Agency or Grantee, to stop or prevent any use or disclosure of Confidential Information. At Agency's request, Grantee must return or destroy any Confidential Information, If Agency requests Grantee to destroy any Confidential Information, Grantee must provide Agency with written assurance indicating how, when and what information was destroyed.

10.3 Identity Protection Law. Grantee must have and maintain a formal written information security program that provides safeguards to protect Confidential Information from loss, theft, and disclosure to unauthorized persons, as required by the Oregon Consumer Identity Theft Protection Act, ORS 646A.600-646A.628. If Grantee or its agents discover or are notified of a potential or actual "Breach of Security", as defined by ORS 646A.602(1)(a), or a failure to comply with the requirements of ORS 646A.600 – 646A.628, (collectively, "Breach") with respect to Confidential Information, Grantee must promptly but in any event within one calendar day (i) notify the Agency Grant Manager of such Breach and (ii) if the applicable Confidential Information was in the possession of Grantee or its agents at the time of such Breach, Grantee must (a) investigate and remedy the technical causes and technical effects of the Breach and (b) provide Agency with a written root cause analysis of the Breach and the specific steps Grantee will take to prevent the recurrence of the Breach or to ensure the potential Breach will not recur. For the avoidance of doubt, if Agency determines notice required of any such Breach to any individual(s) or entity(ies), Agency will have

sole control over the timing, content, and method of such notice, subject to Grantee's obligations under applicable law.

10.4 Subgrants/Contracts. Grantee must require any subgrantees, contractors or subcontractors under this Grant who are exposed to or acquire Confidential Information to treat and maintain such information in the same manner as is required of Grantee under subsections 10.1 and 10.2 of this Section.

10.5 Background Check. If requested by Agency and permitted by law, Grantee's employees, agents, contractors, subcontractors, and volunteers that perform Project activities must agree to submit to a criminal background check prior to performance of any Project activities or receipt of Confidential Information. Background checks will be performed at Grantee's expense. Based on the results of the background check, Grantee or Agency may refuse or limit (i) the participation of any Grantee employee, agent, contractor, subgrantee, or volunteer, in Project activities or (ii) access to Agency Personal Information or Grantee premises.

SECTION 11: CONTRIBUTION/INDEMNITY/LIABILITY

11.1 Contribution.

If any third party makes any claim or brings any action, suit or proceeding alleging a tort as now or hereafter defined in ORS 30.260 (a "Third Party Claim") against a Party (the "Notified Party") with respect to which the other Party (the "Other Party") may have liability, the Notified Party shall promptly notify the Other Party in writing of the Third Party Claim and deliver to the Other Party, along with the written notice, a copy of the claim, process and all legal pleadings with respect to the Third Party Claim that have been received by the Notified Party. Each Party is entitled to participate in the defense of a Third Party Claim, and to defend a Third Party Claim with counsel of its own choosing. Receipt by the Other Party of the notice and copies required in this Section and a meaningful opportunity for the Other Party to participate in the investigation, defense and settlement of the Third Party Claim with counsel of its own choosing are conditions precedent to the Other Party's contribution obligation under this Section 11 with respect to the Third Party Claim.

With respect to a Third Party Claim for which Agency is jointly liable with Grantee (or would be if joined in the Third Party Claim), Agency shall contribute to the amount of expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred and paid or payable by Grantee in such proportion as is appropriate to reflect the relative fault of Agency on the one hand and of Grantee on the other hand in connection with the events that resulted in such expenses, judgments, fines or settlement amounts, as well as any other relevant equitable considerations. The relative fault of Agency on the one hand and of Grantee on the other hand shall be determined by reference to, among other things, the Parties' relative intent, knowledge, access to information and opportunity to correct or prevent the circumstances resulting in such expenses, judgments, fines or settlement amounts. Agency's contribution amount in any instance is capped to the same extent it would have been capped under Oregon law if the State had sole liability in the proceeding.

With respect to a Third Party Claim for which Grantee is jointly liable with Agency (or would be if joined in the Third Party Claim), Grantee shall contribute to the amount of expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and

reasonably incurred and paid or payable by Agency in such proportion as is appropriate to reflect the relative fault of County on the one hand and of Agency on the other hand in connection with the events that resulted in such expenses, judgments, fines or settlement amounts, as well as any other relevant equitable considerations. The relative fault of Grantee on the one hand and of Agency on the other hand shall be determined by reference to, among other things, the Parties' relative intent, knowledge, access to information and opportunity to correct or prevent the circumstances resulting in such expenses, judgments, fines or settlement amounts. Grantee's contribution amount in any instance is capped to the same extent it would have been capped under Oregon law if it had sole liability in the proceeding. Grantee may not use any Grant Funds to reimburse itself for the defense of or settlement of any Third Party Claim.

11.2 Subagreement Indemnity.

Grantee's subagreement(s) shall require the other party to such subagreements(s) that is not a unit of local government as defined in ORS 190.003, if any, to indemnify, defend, save and hold harmless State of Oregon, the Department of Early Learning and Care, and their officers, agents and employees from and against any and all claims, actions, liabilities, damages, losses, or expenses, including attorneys' fees, arising from a tort, as now or hereafter defined in ORS 30.260, caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of the other party to Grantee's subagreement or any of such party's officers, agents, employees or subcontractors ("Claims"). It is the specific intention of the Parties that Agency shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of Agency, be indemnified by the other party to Grantee's subagreement(s) from and against any and all Claims.

Any such indemnification shall also provide that neither Grantee's subrecipient(s), contractor(s) nor subcontractor(s), nor any attorney engaged by Grantee's subrecipient(s), contractor(s) nor subcontractor(s) shall defend any claim in the name of Agency or any agency of the State of Oregon, nor purport to act as legal representative of the State of Oregon or any of its agencies, without the prior written consent of the Oregon Attorney General. The State may, at any time at its election, assume its own defense and settlement in the event that it determines that Grantee's subrecipient is prohibited from defending the State, or that Grantee's subrecipient is not adequately defending the State's interests, or that an important governmental principle is at issue or that it is in the best interests of the State to do so. The State reserves all rights to pursue claims it may have against Grantee's subrecipient if the State of Oregon elects to assume its own defense.

11.3 Limitation. Except as provided in this Section, neither Party will be liable for incidental, consequential, or other indirect damages arising out of or related to this Grant, regardless of whether the damages or other liability is based in contract, tort (including negligence), strict liability, product liability or otherwise. Neither Party will be liable for any damages of any sort arising solely from the termination of this Grant in accordance with its terms.

SECTION 12: INSURANCE

12.1 Workers' Compensation. If Grantee employs subject workers, as defined in ORS 656.027, Grantee must comply with ORS 656.017 and provide workers' compensation insurance coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). Grantee must require and ensure each of its subgrantees, contractors and subcontractors complies with these requirements. If Grantee is a subject employer, as defined in ORS 656.023, Grantee must also obtain employers' liability insurance coverage with limits not less than $500,000 each accident. If Grantee is an employer subject to any other state's workers' compensation law, Grantee must provide workers' compensation insurance coverage for its employees as required by applicable workers' compensation laws including employers' liability insurance coverage with limits not less than $500,000 and must require and ensure each of its out-of-state subgrantees, contractors and subcontractors complies with these requirements.

12.2 Private Insurance. If Grantee is a private entity, or if any contractors, subcontractors, or subgrantees used to carry out the Project are private entities, Grantee and any private contractors, subcontractors or subgrantees must obtain and maintain insurance covering Agency in the types and amounts indicated in Exhibit B.

12.3 Public Body Insurance. If Grantee is a "public body" as defined in ORS 30.260, Grantee agrees to insure any obligations that may arise for Grantee under this Grant, including any indemnity obligations, through (i) the purchase of insurance as indicated in Exhibit B or (ii) the use of self-insurance or assessments paid under ORS 30.282 that is substantially similar to the types and amounts of insurance coverage indicated on Exhibit B, or (iii) a combination of any or all of the foregoing.

SECTION 13: GOVERNING LAW, JURISDICTION

This Grant is governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding (collectively "Claim") between Agency or any other agency or department of the State of Oregon, or both, and Grantee that arises from or relates to this Grant must be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; provided, however, if a Claim must be brought in a federal forum, then it will be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event may this Section be construed as a waiver by the State of Oregon of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the eleventh amendment to the Constitution of the United States or otherwise, to or from any Claim or from the jurisdiction of any court. GRANTEE, BY EXECUTION OF THIS GRANT, HEREBY CONSENTS TO THE PERSONAL JURISDICTION OF SUCH COURTS.

SECTION 14: ALTERNATIVE DISPUTE RESOLUTION

The Parties should attempt in good faith to resolve any dispute arising out of this Grant. This may be done at any management level, including at a level higher than persons directly responsible for

administration of the Grant. In addition, the Parties may agree to utilize a jointly selected mediator to resolve the dispute short of litigation. Each Party will bear its own costs incurred for any mediation.

SECTION 15: DEFAULT

15.1 **Grantee.** Grantee will be in default under this Grant upon the occurrence of any of the following events:

15.1.1 Grantee fails to use the Grant Funds for the intended purpose described in Exhibit A or otherwise fails to perform, observe or discharge any of its covenants, agreements or obligations under this Grant;

15.1.2 Any representation, warranty or statement made by Grantee in this Grant or in any documents or reports relied upon by Agency to measure the Project, the expenditure of Grant Funds or the performance by Grantee is untrue in any material respect when made; or

15.1.3 A petition, proceeding or case is filed by or against Grantee under any federal or state bankruptcy, insolvency, receivership or other law relating to reorganization, liquidation, dissolution, winding-up or adjustment of debts; in the case of a petition filed against Grantee, Grantee acquiesces to such petition or such petition is not dismissed within 20 calendar days after such filing, or such dismissal is not final or is subject to appeal; or Grantee becomes insolvent or admits its inability to pay its debts as they become due, or Grantee makes an assignment for the benefit of its creditors.

15.2 **Agency.** Agency will be in default under this Grant if, after 15 days written notice specifying the nature of the default, Agency fails to perform, observe or discharge any of its covenants, agreements, or obligations under this Grant; provided, however, Agency will not be in default if Agency fails to disburse Grant Funds because there is insufficient expenditure authority for, or moneys available from, the Funding Source.

SECTION 16: REMEDIES

16.1 **Agency Remedies.** In the event Grantee is in default under Section 15.1, Agency may, at its option, pursue any or all of the remedies available to it under this Grant and at law or in equity, including, but not limited to: (a) termination of this Grant under Section 18.2, (b) reducing or withholding payment for Project activities or materials that are deficient or Grantee has failed to complete by any scheduled deadlines, (c) requiring Grantee to complete, at Grantee's expense, additional activities necessary to satisfy its obligations or meet performance standards under this Grant, (d) initiation of an action or proceeding for damages, or declaratory or injunctive relief, (e) exercise of its right of recovery of overpayments under Section 17 of this Grant or setoff, or both, or (f) declaring Grantee ineligible for the receipt of future awards from Agency. These remedies are cumulative to the extent the remedies are not inconsistent, and Agency may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever.

16.2 Grantee Remedies. In the event Agency is in default under Section 15.2 and whether or not Grantee elects to terminate this Grant, Grantee's sole monetary remedy will be, within any limits set forth in this Grant, reimbursement of Project activities completed and accepted by Agency and authorized expenses incurred, less any claims Agency has against Grantee. In no event will Agency be liable to Grantee for any expenses related to termination of this Grant or for anticipated profits.

SECTION 17: WITHHOLDING FUNDS, RECOVERY

Agency may withhold from disbursements of Grant Funds due to Grantee, or Grantee must return to Agency within 30 days of Agency's written demand:

17.1 Any Grant Funds paid to Grantee under this Grant, or payments made under any other agreement between Agency and Grantee, that exceed the amount to which Grantee is entitled;

17.2 Any Grant Funds received by Grantee that remain unexpended or contractually committed for payment of the Project at the end of the Performance Period;

17.3 Any Grant Funds determined by Agency to be spent for purposes other than allowable Project activities; or

17.4 Any Grant Funds requested by Grantee as payment for deficient activities or materials.

SECTION 18: TERMINATION

18.1 Mutual. This Grant may be terminated at any time by mutual written consent of the Parties.

18.2 By Agency. Agency may terminate this Grant as follows:

18.2.1 At Agency's discretion, upon 30 days advance written notice to Grantee;

18.2.2 Immediately upon written notice to Grantee, if Agency fails to receive funding, or appropriations, limitations or other expenditure authority at levels sufficient in Agency's reasonable administrative discretion, to perform its obligations under this Grant;

18.2.3 Immediately upon written notice to Grantee, if federal or state laws, rules, regulations or guidelines are modified or interpreted in such a way that Agency's performance under this Grant is prohibited or Agency is prohibited from funding the Grant from the Funding Source; or

18.2.4 Immediately upon written notice to Grantee, if Grantee is in default under this Grant and such default remains uncured 15 days after written notice thereof to Grantee.

18.3 By Grantee. Grantee may terminate this Grant as follows:

18.3.1 If Grantee is a governmental entity, immediately upon written notice to Agency, if Grantee fails to receive funding, or appropriations, limitations or other expenditure authority at levels sufficient to perform its obligations under this Grant.

18.3.2 If Grantee is a governmental entity, immediately upon written notice to Agency, if applicable laws, rules, regulations or guidelines are modified or interpreted in such a way that the Project activities contemplated under this Grant are prohibited by law or Grantee is prohibited from paying for the Project from the Grant Funds or other planned Project funding; or

18.3.3 Immediately upon written notice to Agency, if Agency is in default under this Grant and such default remains uncured 15 days after written notice thereof to Agency.

18.4 Cease Activities. Upon receiving a notice of termination of this Grant, Grantee must immediately cease all activities under this Grant, unless Agency expressly directs otherwise in such notice. Upon termination, Grantee must deliver to Agency all materials or other property that are or would be required to be provided to Agency under this Grant or that are needed to complete the Project activities that would have been performed by Grantee.

SECTION 19: MISCELLANEOUS

19.1 Conflict of Interest. Grantee by signature to this Grant declares and certifies the award of this Grant and the Project activities to be funded by this Grant, create no potential or actual conflict of interest, as defined by ORS Chapter 244, for a director, officer or employee of Grantee.

19.2 Nonappropriation. Agency's obligation to pay any amounts and otherwise perform its duties under this Grant is conditioned upon Agency receiving funding, appropriations, limitations, allotments, or other expenditure authority sufficient to allow Agency, in the exercise of its reasonable administrative discretion, to meet its obligations under this Grant. Nothing in this Grant may be construed as permitting any violation of Article XI, Section 7 of the Oregon Constitution or any other law limiting the activities, liabilities or monetary obligations of Agency.

19.3 Amendments. The terms of this Grant may not be altered, modified, supplemented or otherwise amended, except by written agreement of the Parties.

19.4 Notice. Except as otherwise expressly provided in this Grant, any notices to be given under this Grant must be given in writing by email, personal delivery, or postage prepaid mail, to a Party's Grant Manager at the physical address or email address set forth in this Grant, or to such other addresses as either Party may indicate pursuant to this Section. Any notice so addressed and mailed becomes effective five (5) days after mailing. Any notice given by personal delivery becomes effective when actually delivered. Any notice given by email becomes effective upon the sender's receipt of confirmation generated by the recipient's email system that the notice has been received by the recipient's email system.

19.5 Survival. All rights and obligations of the Parties under this Grant will cease upon termination of this Grant, other than the rights and obligations arising under Sections 8, 9, 10, 11, 13, 14, 16, 17 and subsections 19.2, 19.5 and 19.13 hereof and those rights and obligations that by their express terms survive termination of this Grant; provided, however, termination of this Grant will not prejudice any rights or obligations accrued to the Parties under this Grant prior to termination.

19.6 Severability. The Parties agree if any term or provision of this Grant is declared by a court of

competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions will not be affected, and the rights and obligations of the Parties will be construed and enforced as if the Grant did not contain the particular term or provision held to be invalid.

19.7 Counterparts. This Grant may be executed in several counterparts, all of which when taken together constitute one agreement, notwithstanding that all Parties are not signatories to the same counterpart. Each copy of the Grant so executed constitutes an original.

19.8 Compliance with Law. In connection with their activities under this Grant, the Parties must comply with all applicable federal, state and local laws.

19.9 Intended Beneficiaries. Agency and Grantee are the only parties to this Grant and are the only parties entitled to enforce its terms. Nothing in this Grant provides, is intended to provide, or may be construed to provide any direct or indirect benefit or right to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of this Grant.

19.10 Assignment and Successors. Grantee may not assign or transfer its interest in this Grant without the prior written consent of Agency and any attempt by Grantee to assign or transfer its interest in this Grant without such consent will be void and of no force or effect. Agency's consent to Grantee's assignment or transfer of its interest in this Grant will not relieve Grantee of any of its duties or obligations under this Grant. The provisions of this Grant will be binding upon and inure to the benefit of the Parties hereto, and their respective successors and permitted assigns.

19.11 Contracts and Subgrants. Grantee may not, without Agency's prior written consent, enter into any contracts or subgrants for any of the Project activities required of Grantee under this Grant. Agency's consent to any contract or subgrant will not relieve Grantee of any of its duties or obligations under this Grant.

19.12 Time of the Essence. Time is of the essence in Grantee's performance of the Project activities under this Grant.

19.13 Records Maintenance and Access. Grantee must maintain all financial records relating to this Grant in accordance with generally accepted accounting principles. In addition, Grantee must maintain any other records, whether in paper, electronic or other form, pertinent to this Grant in such a manner as to clearly document Grantee's performance. All financial records and other records, whether in paper, electronic or other form, that are pertinent to this Grant, are collectively referred to as "Records." Grantee acknowledges and agrees Agency and the Oregon Secretary of State's Office and the federal government and their duly authorized representatives will have access to all Records to perform examinations and audits and make excerpts and transcripts. Grantee must retain and keep accessible all Records for a minimum of six (6) years, or such longer period as may be required by applicable law, BPSs or PPPM, following termination of this Grant, or until the conclusion of any audit, controversy or litigation arising out of or related to this Grant, whichever date is later.

19.14 Headings. The headings and captions to sections of this Grant have been inserted for identification and reference purposes only and may not be used to construe the meaning or to interpret this Grant.

19.15 Grant Documents. This Grant consists of the following documents, which are incorporated by this reference and listed in descending order of precedence:

- This Grant less all exhibits
- Exhibit D (Federal Terms and Conditions)
- Exhibit A (the "Project")
- Exhibit C (Equity Objectives and Results Expectations)
- Exhibit B (Insurance)
- Exhibit E (Federal Award Identification)
- Exhibit F (HFA Best Practice Standards)
- Exhibit G (HFO Program, Policy, and Procedure Manual)

19.16 Merger, Waiver. This Grant and all exhibits and attachments, if any, constitute the entire agreement between the Parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Grant. No waiver or consent under this Grant binds either Party unless in writing and signed by both Parties. Such waiver or consent, if made, is effective only in the specific instance and for the specific purpose given.

SECTION 20: SIGNATURES

EACH PARTY, BY SIGNATURE OF ITS AUTHORIZED REPRESENTATIVE, HEREBY ACKNOWLEDGES IT HAS READ THIS GRANT, UNDERSTANDS IT, AND AGREES TO BE BOUND BY ITS TERMS AND CONDITIONS.

IN WITNESS WHEREOF, the Parties have executed this Grant as of the dates set forth below.

STATE OF OREGON acting by and through its Department of Early Learning and Care

By: Lori Nordlien — 1/19/2024

Lori Nordlien, Procurement Director — Date

Clackamas County

By: [signature] — 01/04/2024

Authorized Signature — Date

Tootie Smith — Chair

Printed Name — Title

93-6002286

Federal Tax ID Number

Approved for Legal Sufficiency in accordance with ORS 291.047

By: Attorney, Kevin Gleim 10/4/23 via e-mail

Approved to Form: Clackamas County

[signature] Date: 12/18/2023

EXHIBIT A
THE PROJECT

SECTION I. BACKGROUND AND GOALS

HFO is an evidence-based, voluntary, home visiting program nationally accredited by HFA. HFO contributes to the economic prosperity of Oregon by preventing child abuse and neglect, promoting healthy child development, improving family self-sufficiency, and helping parents prepare their children for kindergarten.

HFO's aims to:

- Prevent the incidence of child abuse and neglect;
- Increase school readiness;
- Improve health outcomes for children and families;
- Build trusting, nurturing relationships with parents;
- Teach parents to identify strengths and utilize problem-solving skills; and
- Improve families' support systems through linkages and appropriate referrals to community services.

HFO services begin early, during pregnancy or shortly after the birth of a baby, and can last at minimum for 3 years. Parents are voluntarily assessed via an evidence-based screening tool to determine eligibility for the program. Parents having factors that place their children at risk of abuse and neglect, and who live in Grantee's Service Delivery Area are invited to participate in the program. The families who volunteer to participate are connected with a trained, Grantee-provided Home Visitor. Eligible families who do not volunteer cannot be offered services due to full caseloads, and families who are not eligible will be offered referrals to community resources as needed. Families who participate receive weekly Home Visits that decrease in frequency as families increase protective factors and make progress toward providing a safe, healthy, and stable environment for their children.

Strong community partnerships are necessary to provide families with additional services such as child care, mental health counseling, substance abuse treatment, domestic violence intervention and access to basic needs such as food, housing and clothing.

SECTION II. DEFINITION OF TERMS

Healthy Families America ("HFA"): The signature program of Prevent Child Abuse America, HFA is theoretically rooted in the belief that early, nurturing relationships are the foundation for life-long, healthy development. Interactions between direct service providers and families are relationship-based, designed to promote positive parent-child relationships and healthy attachment that is strength-based, family centered, culturally sensitive, and reflective. HFA is the Home Visiting model by which all HFO sites are accredited.

HFO Eligibility Screeners: Grantee's staff for HFO who administer the New Baby Questionnaire (NBQ) eligibility tool with pregnant mothers and with parents soon after the birth of their babies.

Healthy Families Oregon ("HFO"): An accredited multi-site state system with HFA and Oregon's largest child abuse prevention program that empowers parents to be their child's best teacher from the very start.

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.

Home Visitors: Grantee staff who provide parent education and support to parents, in the parents' homes. HFA calls these direct service staff, "Family Support Specialists."

Program Participant: An individual who voluntarily participates in HFO services after having been assessed as eligible for HFO services using the validated NBQ.

Service Delivery Area: The defined geographic area in which Grantee will provide HFO services in alignment with Early Learning Hubs.

SECTION III. PROJECT ACTIVITIES

Agency will disburse Grant Funds only for the costs of Project activities that occur, including expenses incurred, during the Performance Period.

1. EQUITY.

Grantee must meet the Equity Objectives and complete the Equity Activities described in Exhibit C.. Notwithstanding the due dates in the above link, the due dates identified in this Grant Agreement control.

2. PROGRAM STANDARDS.

a. Guidelines. Grantee shall implement the HFO program and provide services according to the Guidelines. Grantee must meet the statewide performance and outcome indicators outlined in the Healthy Families PPPM and implement the HFO program in accordance with the PPPM and Healthy Families America BPSs. Any new subcontracted providers of Healthy Families Services (providers that have not previously provided such services) must make progress toward full compliance with ORS 417.795 as operationalized by the PPPM.

b. Background Checks. The Agency conducts appropriate, legally permissible and mandated inquiries of state or provincial criminal history records on all prospective employees and volunteers who will have direct contact with children and/or access to data involving children, e.g., assessment staff, Home Visitors, supervisors and program managers. Grantee shall provide Agency with any information necessary to comply with this paragraph.

c. Mandatory Reporting. All Grantee staff involved with the Project are mandatory reporters, and must report any suspected abuse or neglect of a minor, following their local policy and Oregon DHS direction: http://www.oregon.gov/DHS/ABUSE/Pages/mandatory_report.aspx.

3. HFO SPECIFIC ACTIVITIES.

Grantee must undertake the specific Project activities described in the Guidelines, BPSs, PPPM and the specific Project Activities described below. Grantee is expected to be familiar with the requirements of the Guidelines, BPSs and PPPM, and to fulfill those obligations, whether or not they are specifically set forth below. Grantee must:

a. Assure each staff member who serves as a Home Visitor achieves caseload capacity. Caseload size is based upon staff member's tenure. Notwithstanding the foregoing, a full time Home Visitor shall carry no more than a maximum total weighted caseload of 30 points and full time Home Visitors who have been employed more than one year shall carry no less than 18 points at any one time.

The following are minimum requirements for the first year of hire for a full time Home Visitor:

- At 3 months, a Home Visitor must have a minimum of 4 points.
- At 6 months, a Home Visitor must have a minimum of 10 points.
- At 12 months, a Home Visitor must have a full caseload (18-30 points).

Caseload capacity is defined as follows:

(i) Full-time Home Visitors in the first or second year of working in the role, typically have a caseload range at any given time of approximately 10-12 families; or

(ii) Full-time Home Visitors in the role for three years or more typically have a caseload range at any given time of approximately 15-20 families.

(iii) The caseload for full time Home Visitors shall not exceed thirty (30) case weight points.

b. Collaborate with other home visit providers in the Service Delivery Area by:

(i) Identifying and building upon existing services for families in the Service Delivery Area and prioritizing additional services if needed (e.g., mental health, addiction, intimate partner violence, and early intervention). If necessary, and to the extent resources are available, Agency may provide technical assistance to promote improved collaboration. Grantee must document any referrals provided to a client in a Home Visit;

(ii) Participating in local Early Learning Hub and other community efforts to implement supports and services towards the achievement of desired outcomes, working to maximize the effective use of available resources and to avoid duplication of services in the Service Delivery Area;

(iii) Participating in an independent statewide program evaluation by submitting an evaluation form to the statewide evaluation team and entering data identified by DELC into the HFO data system;

(iv) Program managers (supervisors and appropriate staff when resources allow) attending statewide trainings for Healthy Families Services at annual meeting;

(v) Program managers (and supervisors when requested by DELC) attending all monthly HFO virtual meetings scheduled by Agency.

(vi) Developing a site specific procedure manual, based off of the HFO PPPM, to further specify local service delivery procedures.

c. All Grantee and subcontracted providers' HFO staff that perform Medicaid administrative activities must participate in the Medicaid Administrative Claiming ("MAC") program, which includes:

(i) Attending Agency-coordinated training prior to completing any Random Time Study ("RTS") (see (iii) below);

(ii) Each staff person completing the MAC training, each year; and

(iii) Participating in required RTS during the four dates randomly selected by OHA each quarter. Agency will notify Grantee within 5 working days of when each RTS day will be. Typical activities that will be recorded include, but are not limited to:

A. Outreach activities to inform families about health services and benefits;

B. Referral, coordination, monitoring and training of Medicaid/OHP covered services;

C. Medicaid/OHP transportation and translation services;

D. Program planning, policy development, and interagency coordination related to Medicaid/OHP services; and

E. Counseling Medicaid/OHP eligible families that they are free to accept or reject Medicaid/OHP services and to receive such service from an enrolled provider of their choice unless otherwise restricted by OHA to an OHP provider.

d. Utilizing the Activity Codes for identifying MAC activities performed and using the time study methodology to document the time spent on all activities performed during the randomly selected dates for each quarter period. The Activity Codes are available from Agency upon request.

e. Complying with all requirements of 42 CFR 434.6, as applicable.

4. FAMILY SUPPORT SPECIFIC SERVICES[2]. If Grantee's Grant Funds include moneys that are derived from federal Family Support Funds under Title IV-B(2), such moneys must be used by Grantee to provide HFO services, as described in this Grant, to eligible families in the Service Delivery Area, as follows:

a. To provide community-based services that promote the well-being of children and families and are designed to increase the strength and stability of families (including adoptive, foster, and extended families), to increase parents' confidence and competence in their parenting abilities, to afford children a safe, stable and supportive family environment, to strengthen

[2] Section 4 applies only to Grantees that receive federal Family Support Funds under Title IV-B(2) as part of their Grant Funds (see table in Section IV).

parental relationships and promote healthy marriages, and otherwise to enhance child development;

b. To provide services that are (1) family-focused and targeted to the family and not only the child or other individual family member(s); (2) focused on at-risk families so that the services will have an impact on the population that would otherwise require services from DHS; and (3) focus on child welfare (not educational needs or other services which are the responsibility of other agencies);

c. To provide services that are NOT family preservation or family reunification services, as these are services provided by DHS; and

d. To comply with the additional federal requirements applicable to Title IV-B2 Family Support Services funds pursuant to 42 USC 629 et seq., including but not limited to: maintaining and providing to Agency such documentation as Agency will require to comply with federal reporting requirements, 45 CFR Part 92, and the limitations on the use of Title IV-B2 funds in 42 USC 629d.

5. BUDGET DEVELOPMENT. Grantee must include the HFO program manager in the development and monitoring of Grantee's Healthy Families Services budget as well as any subcontracted budgets, even if the program manager is employed by a subcontracted agency.

a. Administrative Costs. Agency will identify what amounts of the total Grant Funds are derived from Agency's General Fund, Other Funds, and federal funds. Agency guidelines must be followed for expenditure of the Grant Funds derived from Agency's General Fund and Other Funds. This may result in different limits on administrative costs. Grantee must follow the fiscal guidelines (outlined in the PPPM) in spending Grant Funds. Grantee's total administrative and indirect costs (including any administrative and indirect costs for the Grantee and any subcontracts) for the Grant Funds provided under Agency's General Fund or Other Funds are limited to 15% of that portion of the Grant Funds derived from those funding sources. If any of the Grant Funds are derived from Title IV-B2 federal funds, no more than 10% of the Grant Funds derived from that funding source may be expended on administrative overhead.

b. Agency Approval. Grantee must submit a budget for Agency approval within 30 days of the Execution Date, using the template provided by the Agency, for the period beginning July 1, 2023 through June 30, 2025 (which must include all funds supporting the HFO program). The budget must include the expenses of all subcontracted providers, and the budget must be approved by Agency before Agency will disburse Grant Funds.

c. Updates. Grantee must submit a budget update to the Agency by December 31, 2024 that includes a narrative explaining how Grantee plans to spend the remaining Grant Funds before the end of the biennium. The Agency will provide a template for this narrative.

SECTION IV. BUDGET AND DISBURSEMENT

a. Agency will disburse the Grant Funds using its Awards Management System ("AMS"), on a cost incurred basis upon monthly or quarterly receipt of Grantee's request(s) for reimbursement. With each request for reimbursement, Grantee must submit an expenditure report via Smartsheet (or such other method as may be provided by notice from Agency) to Agency's Grant Manager identified in Section 4. The Agency's Grant Manager will provide the Grantee with an agency specific link to Smartsheet reporting. Grantee must inform Agency within 14 days of the Effective Date of this Agreement, as to whether Grantee will submit its expenditure reports (and draw funds) each month or quarter.

Source	**10/1/2023 –6/30/2025**
General Funds	$1,373,740.62
Other Funds (Student Success Act's Early Learning Account)	$219,878.30
Federal Title IV-B2 for Family Support	$148,715.00
Medicaid Earnings	$125,441.00
Grand Total	**$1,867,774.92**

b. Other than Medicaid Earnings (which will be paid as described below), payments will be made after the end of each calendar month or quarter on an expense reimbursement basis for expenses actually incurred during the prior month or quarter, within the budget line items included in Grantee's approved budget, for the delivery of HFO services under this Grant. Title IV-B2 federal funds, if provided, will only be paid on reimbursement basis for actual expenses incurred during that period and in accordance with the Family Support Specific Services set forth above in Section III.4 of this Exhibit A.

c. Grantee may, upon written notice to the Agency, move up to 10% of the funds in any one category of Grantee's approved budget (Salary/Benefits, Materials & Supplies, Indirect/Administration) (other than the Medicaid Earnings line item) to any other budget category (other than the Medicaid Earnings line item). Any other budget modifications are subject to and conditioned on Agency's prior written approval.

d. Payments under this Grant are further conditioned on (1) no default by Grantee under this agreement, (2) Grantee providing Agency with all service outcome data for the prior quarter in the form identified by Agency, and (3) Agency's receipt and approval of Grantee's expenditure report through Smartsheet.

e. Agency will use expense request reports throughout the performance period to determine if the Grantee is on track to spend all General Fund, Other Funds, and Title IV-B2 funds, if allocated, before June 30, 2025. If by June 30, 2024 the Grantee has not expended a minimum of 45% of the Grant Funds, Agency will further review to determine if an amendment to this Grant to reduce funding is necessary. If Agency determines an amendment to reduce funding

is necessary, Grantee must execute the amendment. This allows the Agency time to reallocate any unspent funds so that the most possible families benefit from HFO services.

f. Agency will not reimburse Grantee for any travel expenses outside of the expenses outlined and approved within Grantee's approved budget. Acceptable travel expenses include (but are not limited to): staff travel to Home Visits, hospitals, community partners, trainings, conferences, out of state conferences, or committee meetings. Reimbursable travel expenses must not exceed the U.S. General Services Administration ("GSA") rates published at the time of travel.

SECTION V. PROJECT EVALUATION AND REPORTING REQUIREMENTS

Grantee must:

a. Ensure all tasks outlined in the Aligned Quality Assurance (QA) Calendar are completed on time.

b. Report to Agency yearly on the use of Medicaid funds disbursed to Grantee. This will be done through the Medicaid Reinvestment form, provided by Agency.

c. Submit a program outcome report to Agency each calendar quarter that includes at a minimum, caseload points for each Home Visitor, number of families served, number of new families enrolled, number of families referred, number of screens completed, number of families eligible based upon screening, and staff Home Visit completion percentages. The quarterly outcome report must be submitted through Smartsheet before any request for funds is approved. Agency's Grant Manager will provide the Grantee with a site specific link for reporting.

d. Submit an expenditure report before Agency will release any Grant Funds.

e. In addition, Grantee must submit the following items by the due dates listed in the table below:

HFO SCOPE OF WORK

2023-2025

Activities and Budget

Grantee will provide Healthy Families Services in accordance with the Healthy Families America model, the Healthy Families Oregon Program Policy and Procedure Manual and minimum standards set forth in ORS 417.795 and OAR 414-525-0005 through 414-525-0015.

Required Activities	Deliverables	Due Dates
1) **Maintain home visitor expected level of caseload points.**	Minimum of 95% of the daily number of expected caseload points	Quarterly
2) **Collaborate with other home visiting Providers in the Service Delivery Area** a) **Identify and build upon existing services for families and to prioritize additional services if needed (i.e.: mental health, addiction, intimate partner violence, and early intervention). As necessary, and to the extent resources are available, Agency may provide technical assistance to promote improved collaboration;** b) **Participate in local Early Learning Hub and other community efforts to implement supports and services towards the achievement of desired outcomes, working to maximize the effective use of available resources and to avoid duplication of services;** **3) Participate in the independent statewide program evaluation;** **4) Participate in statewide trainings for Healthy Families Services program managers, supervisors, home visitors and screening staff;** **5) Participate in annual meetings and/or trainings for Healthy Families Services program managers and Supervisors;** **6) Meet statewide performance and outcome indicators outlined in the Healthy Families Program Policy and Procedure Manual;** **7) Participate in the Healthy Families America (HFA) Site Self-Assessment, as part of ongoing quality improvement and HFA**	Referrals provided on behalf of a client are documents on the Home Visit Record Provide narrative of how this local HFO site is participating in other community efforts as described Submit evaluation forms, enter data into HFO data system All staff complete and attend all required trainings as outlined in the PPPM. Program Managers and Supervisors attend annual meetings and trainings Annual Status Report Attends webinars, conference calls and trainings/meetings in preparation for reaccreditation. Submits Site	On-going Quarterly On-going Annually at CQI visit As Offered As needed As needed

Required Activities	Deliverables	Due Dates
accreditation as required a minimum of every 5 years; **8) Develop site specific procedure manual, based on the Healthy Families Oregon State Policy and Procedure Manual, to further specify local service delivery procedures;** **9) Implement the HFO program in accordance with the State Policy and Procedure Manual and Healthy Families America Best Practice Standards.**	Self-Assessment. Submits updated local PPPM to HFO QA/TA Specialist Submit all requests pre-site visit information as requested by HFO QA/TA Specialist	Annually, and as needed On-going and Annual CQI Visit
10) All Grantee and subcontracted providers' HFO staff that perform Medicaid Administrative activities will participate in the Medicaid Administrative Claiming program and procedures. **Participation includes the following requirements:** a) **Attend training prior to completing any Random Time Study (see b below) in accordance with Oregon Health Authority (OHA) policies or coordinated through the Agency;** b) **Each staff person must complete an annual MAC training, each year.** c) **Participate in required Random Time Studies (RTS) during the four dates randomly selected as required by OHA each quarter. Agency will notify Grantee within 5 working days of when the RTS day will be. Typical activities that will be recorded include, but are not limited to:** a. **Outreach activities to inform families about health services and benefits;** b. **Referral, coordination, monitoring and training of Medicaid OHP covered services;**	Follow Medicaid Administrative Claiming requirements	Ongoing

Required Activities	Deliverables	Due Dates
c. **Medicaid OHP Transportation and Translation services;** d. **Program planning, policy development/Interagency Coordination related to Medicaid/OHP services.** e. **Counsel Medicaid eligible families that they are free to accept or reject Medicaid services and to receive such service from an enrolled provider of their choice unless otherwise restricted to a provider of the Oregon Health Plan by OHA.** d) **Utilize the Activity Codes provided by Agency for identifying MAC activities performed and using the time study methodology to document the time spent on all activities performed during the randomly selected dates for each quarter period.** e) **Comply with all requirements of 42 CFR 434.6 as applicable.** f) **Conduct quality assurance checks of Time Study documentation in accordance with Oregon Health Authority (OHA) or coordinated through the Agency;**	Completion reviewed by Agency at the end of each Time Study.	
11) Background Checks. The grantee conducts appropriate, legally permissible and mandated inquiries of state or provincial criminal history records on all prospective employees and volunteers who will have direct contact with children and/or access to data involving children, i.e., assessment staff, home visitors, supervisors and program managers. Agency will be notified upon completion of each background check.	Background Check completion is noted in the program staffing smartsheet within one week of hire date.	Ongoing
12) Mandatory Reporting. All HFO staff are mandatory reporters, and must report any	Grantees document all staff participation in annual CAN	Ongoing

Required Activities	Deliverables	Due Dates
suspected abuse or neglect of a minor, following their local policy and Oregon DHS direction: http://www.oregon.gov/DHS/ABUSE/Pages/mandatory_report.aspx	training. Reviewed by Agency at annual CQI visits.	
13) Participates in All Reporting Requirements to Agency a) **Ensure all Quality Assurance (QA) reports are completed on time in accordance to Central Administration guidelines.** b) **Report to the Agency yearly on the use of Medicaid Administrative Claiming (Title XIX) funds disbursed to Grantee. This will be done through the Medicaid Reinvestment form, provided by the Agency and through the biennial budget. Grantee must follow the fiscal guidelines in spending MAC reimbursement funding.** c) **Grantee will submit a quarterly program outcome report. This report will be provided to the Agency and will include at a minimum, caseload points for each home visitor, number of families served, number of new families enrolled, and staff Home Visit Completion percentages. This report will be due to the Agency by the 30th day of the month following the end of each quarter. The quarterly outcome report must be submitted before any request for funds is approved** d) **Grantee will submit an expenditure report either monthly or quarterly by the 30th day of the following month. An expenditure report must be submitted before funding can be released. Grantee will communicate with the Agency within 14 days of agreement start date, if they will be submitting expenditure reports (and drawing funds) either monthly or quarterly**	Submit reports to the Agency	Reports are due to the Agency in accordance with the Quality Assurance (QA) Calendar.

Required Activities	Deliverables	Due Dates
14) Budget **The HFO program manager will be included in the development and monitoring of Grantee's Healthy Families Services budget as well as any subcontracted budgets, even if the Program Manager is employed by a subcontracted agency.** **The total program's administrative and indirect costs (this includes any administrative and indirect costs for the Grantee and any subcontracts) for the General Fund portion of this agreement are limited to 15 percent of the current biennium's award. If there is a mix of federal, general and other funds in the NTE, federal guidelines should be used for Federal Funds and Agency guidelines for General and Other Funds. This may result in different limits on administrative costs.** **a) Grantee will submit a final budget (template provided by the Agency) for the period beginning October 1, 2023 through June 30, 2025 (which must include all funds supporting the HFO program), to the Agency for review and final approval. The budgets must include the expenses of all subcontracted Providers.** **b) Grantee will submit a budget update to the Agency. This budget update will include a narrative that explains how the Grantee plans to spend all remaining funds before the end of the biennium. The Agency will provide a template for this narrative.**	Submit final budget Submit budget update and narrative	October 31, 2023 August 31, 2024
c) New subcontracted Providers of Healthy Families Services (Providers that have not previously provided such services) will make progress toward full compliance with ORS 417.795 as operationalized by the PPPM.	All subcontracted Providers of Healthy Families services will be in full compliance	Within twelve months of initial services delivery.

Required Activities	Deliverables	Due Dates
d) Grantees receiving Family Support Services (Title IV-(B)(2)) **1. Grantee will utilize Family Support Funds to provide Healthy Families Oregon Services, as described in this agreement, to eligible families in the Coverage Area in accordance with and subject to the requirements of this Exhibit D** **2. Family Support Funds must be used to provide community-based services to promote the well-being of children and families designed to increase the strength and stability of families (including adoptive, foster, and extended families), to increase parents' confidence and competence in their parenting abilities, to afford children a safe, stable and supportive family environment, to strengthen parental relationships and promote healthy marriages, and otherwise to enhance child development. US Department of Health and Human Services, Administration for Children and Families.** **3. Family Support Funded Services must (1) be family-focused and targeted to the family and not only the child or other individual family member(s); (2) be focused on at-risk families so that the services will have an impact on the population that would otherwise require services from DHS; and (3) focus on child welfare (not educational needs or other services which are the responsibility of other agencies). Family Support Services funds allocated may not be used for family preservation or family reunification services as these are services provided by DHS.** **4. Family Support Services funds are federal Title IV-B(2). Use and expenditure of these funds must meet all federal requirements.**		Ongoing

Required Activities	Deliverables	Due Dates
5. When utilizing Family Support Services funds, Grantee will comply and require all Providers to comply with the additional federal requirements applicable to Title IV-B2 Family Support Services funds in 42 USC 629 et seq., including but not limited to: maintaining and providing to Agency such documentation as Agency will require to comply with federal reporting requirements, 45 CFR Part 92, and the limitations on the use of Title IV-B2 funds in 42 USC 629d. **6. No more than 10% of the Federal Title IV-B2 Family Support Services Funds provided to Grantee under this agreement may be expended on administrative overhead.**		

Disbursement Provisions

Agency will disburse the Grant Funds using its Awards Management System ("AMS") , on a cost incurred basis upon monthly or quarterly receipt of Grantee's request for reimbursement.

a. Other than Medicaid earnings interim payments will be made after the end of each calendar month or quarter on an expense reimbursement basis for expenses actually incurred during the prior month or quarter, within the Budget line items, for the delivery of Healthy Families Oregon services under this agreement. Family Support (Title IV-B2) funds, if allocated, will only be made on reimbursement basis for actual expenses incurred during that period and in accordance with the Family Support Services Funding Requirements set forth in Exhibit A, Section 3.

b. Grantee may, upon written notice to the Agency, move up to 10% of the funds in any one Budget category (Salary/Benefits, Materials & Supplies, Indirect/Administration) (other than the Medicaid Earnings line item) to any other Budget category (other than the Medicaid Earnings line item). Any other Budget modifications are subject to and conditioned on Agency's prior written approval.

c. Payments under this agreement are further conditioned on (1) no default by Grantee under this agreement, (2) entry of all service outcome data for the prior quarter, and (3) Agency's receipt and approval of Grantee's report as specified in this EXHIBIT A.

d. Agency will use expense request reports from October 1, 2023 – June 30, 2025 to determine if the Agency is on track to spend all general fund, and Title IV-B2 funds if allocated, before June 30, 2025. If by June 30, 2024 the Agency has not expended a minimum of 45% of general funds (and Title IV-B2 funds if allocated),

Agency will further review to determine if an amendment to reduce funding is necessary. This allows the Agency time to reallocate any unspent funds so that the most possible families benefit from HFO services.

e. Agency will not reimburse Grantee for any travel expenses outside of the expenses outlined and approved within Grantee's approved budget. Acceptable travel expenses include (but is not limited to): staff travel to home visits, hospitals, community partners, trainings, conferences, out of state conferences or trainings, committee meetings. Travel expenses, per Grantee's budget, will be reimbursed at the Grantee's per diem/mileage rates.

Healthy Families Oregon Implementation Reports	**Due Dates**
1. Quality Assurance report: Including a description of the tasks outlined in the QA Calendar that were completed.	Reports are due to the Agency in accordance with the QA Calendar. The QA Calendar is available from the Agency upon request.
2. Quarterly Program Outcomes report: Including at a minimum caseload points for each Home Visitor, number of families served, number of new families enrolled, number of families referred, number of screens completed, number of families eligible based upon screening, and staff Home Visit completion percentages. The Quarterly Program Outcomes report must be submitted before the final request for reimbursement will be approved.	30th day of the month following the end of each quarter
3. Program Expenditure report: Includes a breakdown of expenditures for the reporting time period.	Either monthly or quarterly by the 30th day of the following month

Budgets	**Due Dates**
4. Final budget for approval by Agency	Within 30 days of Execution Date
5. Budget update and narrative on Agency template.	August 31, 2024

Medicaid Administrative Claiming (MAC)	**Due Dates**
1. Report on the use of Medicaid funds disbursed to Grantee using Medicaid Reinvestment form, provided by Agency. Grantee must follow the fiscal guidelines (outlined in the PPPM) in spending MAC reimbursement funding.	Within 30 days of Execution Date

If the Performance Period begins prior to the Executed Date of this Grant, any reports for Project activities shown above as due prior to the Executed Date must be provided to Agency within 30 days

of the Executed Date, if not already provided to Agency despite the lack of an executed Grant. Grantee will not be in default for failure to perform any reporting requirements prior to the Executed Date.

EXHIBIT B
INSURANCE

INSURANCE REQUIREMENTS

Grantee must obtain at Grantee's expense, and require its first tier contractors and subgrantees, if any, to obtain the insurance specified in this exhibit prior to performing under this Grant, and must maintain it in full force and at its own expense throughout the duration of this Grant, as required by any extended reporting period or tail coverage requirements, and all warranty periods that apply. Grantee must obtain and require its first tier contractors and subgrantees, if any, to obtain the following insurance from insurance companies or entities acceptable to Agency and authorized to transact the business of insurance and issue coverage in Oregon. Coverage must be primary and non-contributory with any other insurance and self-insurance, with the exception of professional liability and workers' compensation. Grantee must pay and require its first tier contractors and subgrantees to pay, if any, for all deductibles, self-insured retention and self-insurance, if any.

COMMERCIAL GENERAL LIABILITY

☒ **Required** ☐ **Not required**

Commercial general liability insurance covering bodily injury and property damage in a form and with coverage that are satisfactory to Agency. This insurance must include personal and advertising injury liability, products and completed operations, contractual liability coverage for the indemnity provided under this Grant, and have no limitation of coverage to designated premises, project or operation. Coverage must be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Annual aggregate limit may not be less than $2,000,000.

AUTOMOBILE LIABILITY INSURANCE

☒ **Required** ☐ **Not required**

Automobile liability insurance covering Grantee's business use including coverage for all owned, non-owned, or hired vehicles with a combined single limit of not less than $1,000,000 for bodily injury and property damage. This coverage may be written in combination with the commercial general liability insurance (with separate limits for commercial general liability and automobile liability). Use of personal automobile liability insurance coverage may be acceptable if evidence that the policy includes a business use endorsement is provided.

DIRECTORS, OFFICERS AND ORGANIZATION LIABILITY (for non-profit entities only)

☒ **Required** ☐ **Not required**

Directors, officers and organization liability insurance covering the Grantee's organization, directors, officers, and trustees actual or alleged errors, omissions, negligent, or wrongful acts, including improper governance, employment practices and financial oversight - including improper oversight and/or use of Grant Funds and donor contributions - with a combined single limit of no less than $1,000,000 per claim.**PHYSICAL ABUSE AND MOLESTATION INSURANCE COVERAGE**

☒ **Required** ☐ **Not required**

Abuse and molestation insurance in a form and with coverage satisfactory to the State covering damages arising out of actual or threatened physical abuse, mental injury, sexual molestation, negligent: hiring, employment, supervision, investigation, reporting to proper authorities, and retention of any person for whom the Grantee, its contractors, subcontractors or subgrantees ("Covered Entity") is responsible including but not limited to any Covered Entity's employees and volunteers. Policy endorsement's definition of an insured must include the Covered Entity and its employees and volunteers. Coverage must be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Any annual aggregate limit may not be less than $3,000,000. Coverage can be provided by a separate policy or as an endorsement to the commercial general liability or professional liability policies. The limits must be exclusive to this required coverage. Incidents related to or arising out of physical abuse, mental injury, or sexual molestation, whether committed by one or more individuals, and irrespective of the number of incidents or injuries or the time period or area over which the incidents or injuries occur, must be treated as a separate occurrence for each victim. Coverage must include the cost of defense and the cost of defense must be provided outside the coverage limit.

EXCESS/UMBRELLA INSURANCE

A combination of primary and excess/ umbrella insurance may be used to meet the required limits of insurance.

ADDITIONAL INSURED

All liability insurance, except for workers' compensation, professional liability, and network security and privacy liability (if applicable), required under this Grant must include an additional insured endorsement specifying the State of Oregon, its officers, employees and agents as Additional Insureds, including additional insured status with respect to liability arising out of ongoing operations and completed operations, but only with respect to Grantee's activities to be performed under this Grant. Coverage must be primary and non-contributory with any other insurance and self-insurance. The Additional Insured endorsement with respect to liability arising out of Grantee's ongoing operations must be on ISO Form CG 20 10 07 04 or equivalent and the Additional Insured endorsement with respect to completed operations must be on ISO form CG 20 37 04 13 or equivalent.

WAIVER OF SUBROGATION

Grantee waives, and must require its first tier contractors and subgrantees waive, rights of subrogation which Grantee, Grantee's first tier contractors and subgrantees, if any, or any insurer of Grantee may acquire against the Agency or State of Oregon by virtue of the payment of any loss. Grantee must obtain, and require its first tier contractors and subgrantees to obtain, any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the Agency has received a waiver of subrogation endorsement from the Grantee or the Grantee's insurer(s).

TAIL COVERAGE

If any of the required insurance is on a claims made basis and does not include an extended reporting period of at least 24 months, Grantee must maintain, and require its first tier contractors and subgrantees, if any, maintain, either tail coverage or continuous claims made liability coverage, provided the effective date of the continuous claims made coverage is on or before the Effective Date of this Grant, for a minimum of 24 months following the later of (i) Grantee's completion and Agency's

acceptance of all Project activities required under this Grant, or, (ii) Agency or Grantee termination of Grant, or, iii) the expiration of all warranty periods provided under this Grant.

CERTIFICATE(S) AND PROOF OF INSURANCE

Grantee must provide to Agency's Grant Manager Certificate(s) of Insurance for all required insurance before performing any Project activities required under this Grant. The Certificate(s) must list the State of Oregon, its officers, employees and agents as a Certificate holder and as an endorsed Additional Insured. The Certificate(s) must also include all required endorsements or copies of the applicable policy language effecting coverage required by this Grant. If excess/ umbrella insurance is used to meet the minimum insurance requirement, the Certificate of Insurance must include a list of all policies that fall under the excess/ umbrella insurance. As proof of insurance, Agency has the right to request copies of insurance policies and endorsements relating to the insurance requirements in this Grant. Grantee must furnish acceptable insurance certificates to: delc.insurance@delc.state.or.us or by mail to: Attention Procurement Services, Oregon Department of Education, 255 Capitol St NE, Salem OR, 97310 prior to commencing the work.

NOTICE OF CHANGE OR CANCELLATION

Grantee or its insurer must provide at least 30 days' written notice to Agency before cancellation of, material change to, potential exhaustion of aggregate limits of, or non-renewal of the required insurance coverage(s).

INSURANCE REQUIREMENT REVIEW

Grantee agrees to periodic review of insurance requirements by Agency under this Grant, and to provide updated requirements as mutually agreed upon by Grantee and Agency.

STATE ACCEPTANCE

All insurance providers are subject to Agency acceptance. If requested by Agency, Grantee must provide complete copies of insurance policies, endorsements, self-insurance documents and related insurance documents to Agency's representatives responsible for verification of the insurance coverages required under this exhibit.

EXHIBIT C
EQUITY

EQUITY OBJECTIVES AND RESULTS EXPECTATIONS

The Department of Early Learning and Care's (DELC) work is in service to children, families, staff, and communities to support all of Oregon's young children and families to learn and thrive. DELC recognizes that families and children must have access to family-centered resources and supports to address their unique needs.

DELC applies an asset-based mindset and strength-based approach to operationalize equity. An *asset-based mindset* focuses on seeing potential rather than deficits and draws upon the strengths of children, families, and communities to develop and enhance grantees' services. A *strengths-based approach* uses policies, practice methods and strategies to identify and draw upon the strengths of children, families, and communities to develop and enhance grantees' services.

DELC supports culturally responsive services that are respectful of, and relevant to, the beliefs, practices, culture, and linguistic needs of diverse communities. Cultural responsiveness refers to the capacity to respond to the issues of diverse communities. It requires knowledge and capacity at distinct levels of intervention: structural, organizational, interpersonal, and individual.

Program Expectations and Commitment to Children and Families

To the extent permitted by law, Grantee's staff shall:

a) Work to build a climate that promotes acceptance, inclusion, and respect of all individuals;
b) Understand the communities they serve, in a non-static manner, including the communities' culture, values, norms, history, customs, and particular types of discrimination, marginalization, and exclusion they face in this country. Grantee's staff shall apply that knowledge to services it provides under this Grant in a responsive, non-limiting, and non-stereotyping manner;
c) Whenever possible, interact with children and families according to their preferred language and cultural norms including social greetings, family conventions, dietary preferences, welcoming culture, healing beliefs, and spiritual needs; and
d) Engage in continuous learning about their own biases, assumptions, and stereotypes that limit their ability to be culturally responsive and to understand how these biases affect their work with children and families.

To the extent permitted by law, Grantee's leadership shall:

a) Ensure that applicants and employees are not subjected to unlawful discrimination in hiring, compensation, or the terms, conditions or privileges of employment because of race, color, religion, sex, sexual orientation, national origin, marital status, age, political affiliation, or disability; and

b) Ensure that any subcontract, purchase, or other agreement used to carry out the Project expressly prohibits the performing entity from subjecting employees or applicants to

discrimination in hiring, compensation or the terms, conditions or privileges of employment because of race, color, religion, sex, sexual orientation, national origin, marital status, age, political affiliation, or disability.

Agency Expectations and Commitment to Grantees

DELC has identified four priority areas this biennium to partner with grantees in achieving equitable results: collaboration and cocreation with working partners, communities and families, supporting partners' and families' involvement in strategic planning, improving workplace workforce equity. Each of these four areas is described in more detail in the table below. **Grantee shall collaborate with DELC to submit an Equity Plan annually that supports equity objective(s) and addresses how Grantee is achieving equitable results within the four Equitable Results Areas described below**. Some objectives and equitable results described below may not apply to Grantee. The Equity Plan will identify, track, and report the activities and metrics, including areas of disparate impact on communities. Grantee may request an Equity Plan template from the Agency for guidance.

Equitable Results Area	**Description**
Working Partners and Community Collaborators Engagement	– Grantee collaborates and cocreates with working partners and community collaborators. – Grantee engages with working partners and community collaborators, including families, administrators, teachers, and Department of Early Learning and Care (DELC), to discuss the issues and obtain insights.
Working Partners and Community Collaborators Empowerment	– Grantee supports working partners and community collaborators. – Grantee provides opportunities for staff, families, and communities to be involved in training, strategic planning and support their involvement.
Workforce Equity	– Grantee improves workforce equity. – Grantee progressively ensures that the identities of staff reflect the changing population of children and families served by the organizations in their geographical areas.
Workplace Equity	– Grantee improves workplace equity. – Grantee builds/improves an environment that promotes acceptance, inclusion and respect of all individuals.

EXHIBIT D
FEDERAL TERMS AND CONDITIONS

1. FEDERAL FUNDS

1.1. If specified below, Agency's payments to Grantee under this Grant will be paid in whole or in part by funds received by Agency from the United States Federal Government. If so specified then Grantee, by signing this Grant, certifies neither it nor its employees, contractors, subcontractors or subgrantees who will perform the Project activities are currently employed by an agency or department of the federal government.

Payments ☒ will ☐ will not be made in whole or in part with federal funds.

1.2. In accordance with the State Controller's Oregon Accounting Manual, policy 30.40.00.102, Agency has determined:

☒ Grantee is a subrecipient ☐ Grantee is a contractor ☐ Not applicable

1.3. Catalog of Federal Domestic Assistance (CFDA) #(s) of federal funds to be paid through this Grant: 93.556 and 93.778

2. FEDERAL PROVISIONS

2.1. The use of all federal funds paid under this Grant are subject to all applicable federal regulations, including the provisions described below.

2.2. Grantee must ensure that any further distribution or payment of the federal funds paid under this Grant by means of any contract, subgrant, or other agreement between Grantee and another party for the performance of any of the activities of this Grant, includes the requirement that such funds may be used solely in a manner that complies with the provisions of this Grant.

2.3. Grantee must include and incorporate the provisions described below in all contracts and subgrants that may use, in whole or in part, the funds provided by this Grant.

In accordance with Appendix II to 2 CFR Part 200 – Contract Provisions for Non-Federal Entity Contracts Under Federal Awards, the following provisions apply to this Grant, as applicable.

For purposes of these provisions, the following definitions apply:

"Contract" means this Grant or any contract or subgrant funded by this Grant.

"Contractor" and **"Subrecipient"** and **"Non-Federal entity"** mean Grantee or Grantee's contractors or subgrantees, if any.

(A) Contracts for more than the simplified acquisition threshold currently set at $150,000, which is the inflation adjusted amount determined by the Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council (Councils) as authorized by 41 U.S.C. 1908, must address administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provide for such sanctions and penalties as appropriate.

(B) All contracts in excess of $10,000 must address termination for cause and for convenience by the non-Federal entity including the manner by which it will be effected and the basis for settlement.

(C) Equal Employment Opportunity. Except as otherwise provided under 41 CFR Part 60, all contracts that meet the definition of "federally assisted construction contract" in 41 CFR Part 60-1.3 must include the equal opportunity clause provided under 41 CFR 60-1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964-1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and implementing regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(D) Davis-Bacon Act, as amended (40 U.S.C. 3141-3148). When required by Federal program legislation, all prime construction contracts in excess of $2,000 awarded by non-Federal entities must include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 3141-3144, and 3146-3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction"). In accordance with the statute, contractors must be required to pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor. In addition, contractors must be required to pay wages not less than once a week. The non-Federal entity must place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation. The decision to award a contract or subcontract must be conditioned upon the acceptance of the wage determination. The non-Federal entity must report all suspected or reported violations to the Federal awarding agency. The contracts must also include a provision for compliance with the Copeland "Anti-Kickback" Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). The Act provides that each contractor or subrecipient must be prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The non-Federal entity must report all suspected or reported violations to the Federal awarding agency.

(E) Contract Work Hours and Safety Standards Act (40 U.S.C. 3701-3708). Where applicable, all contracts awarded by the non-Federal entity in excess of $100,000 that involve the employment of mechanics or laborers must include a provision for compliance with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5). Under 40 U.S.C. 3702 of the Act, each contractor must be required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

(F) Rights to Inventions Made Under a Contract or Agreement. If the Federal award meets the definition of "funding agreement" under 37 CFR §401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under

Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

(G) Clean Air Act (42 U.S.C. 7401-7671q.) and the Federal Water Pollution Control Act (33 U.S.C. 1251-1387), as amended—Contracts and subgrants of amounts in excess of $150,000 must contain a provision that requires the non-Federal award to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401-7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

(H) Debarment and Suspension (Executive Orders 12549 and 12689)—A contract award (see 2 CFR 180.220) must not be made to parties listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

(I) Byrd Anti-Lobbying Amendment (31 U.S.C. 1352)—Contractors that apply or bid for an award exceeding $100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non-Federal award.

(J) See §200.322 Procurement of recovered materials: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=92b159d8a4db712007ed9d36214ee0ec&mc=true&n=pt2.1.200&r=PART&ty=HTML#se2.1.200_1322.

(K) Audits.

i. Contractor must comply, and require any subcontractor to comply, with applicable audit requirements and responsibilities set forth in this Contract and applicable state or federal law.

ii. If Contractor receives federal awards in excess of $750,000 in a fiscal year, Contractor is subject to audit conducted in accordance with the provisions of 2 CFR part 200, subpart F. Copies of all audits must be submitted to Agency within 30 days of completion.

iii. Contractor must save, protect and hold harmless Agency from the cost of any audits or special investigations performed by the Secretary of State with respect to the funds expended under this Contract. Contractor acknowledges and agrees that any audit costs incurred by Contractor as a result of allegations of fraud, waste or abuse are ineligible for reimbursement under this or any other agreement between Contractor and State.

(L) Whistleblower. Grantee must comply, and ensure the compliance by subcontractors or subgrantees, with 41 U.S.C. 4712, Program for Enhancement of Employee Whistleblower Protection. Grantee must inform subrecipients, contractors and employees, in writing, in the predominant

language of the workforce, of the employee whistleblower rights and protections under 41 USC § 4712.

(M) System for Award Management. Grantee must comply with applicable requirements regarding the System for Award Management (SAM), currently accessible at https://www.sam.gov, and used to complete Exhibit E. This includes applicable requirements regarding registration with SAM, as well as maintaining current information in SAM. The Grantee also must comply with applicable restrictions on subawards ("subgrants") to first-tier subrecipients (first-tier "subgrantees"), including restrictions on subawards to entities that do not acquire and provide (to the Grantee) the unique entity identifier required for SAM registration.

3. ADDITIONAL FEDERAL REQUIREMENTS

45 CFR Part 75

45 CFR Part 96

42 CFR Subchapter C

EXHIBIT E
FEDERAL AWARD IDENTIFICATION
(Required by 2 CFR 200.332(a)(1))

Federal Title IV-B2 for Family Support

(i) Grantee name: *(must match name associated with UEI)*	Clackamas County
(ii) Grantee's Unique Entity Identifier (UEI):	DUNS: SAM:
(iii) Federal Award Identification Number (FAIN):	2102ORFPSS
(iv) Federal award date: *(date of award to state by federal agency)*	7/1/2021
(v) Grant period of performance start and end dates:	Start:10/01/2023 End: 06/30/2025
(vi) Grant budget period start and end dates:	Start: 10/1/2023 End:06/30/2025
(vii) Amount of federal funds obligated by this Grant:	$148,715.00
(viii) Total* amount of federal funds obligated to Grantee by pass-through entity**, including this Grant:	Unavailable
(ix) Total* amount of the federal award committed to Grantee by pass-through entity: *(amount of federal funds from this FAIN committed to Grantee)*	Unavailable
(x) Federal award project description:	Family preservation and family support
(xi) a. Federal awarding agency:	Department of Health and Human Services
b. Name of pass-through entity:	Oregon Department of Early Learning and Care
c. Contact information for awarding official of pass-through entity:	Name: Dawn Baker Dawn.baker@delc.oregon.gov
(xii) Assistance listings number, title, and amount:	Number: Title: Amount: $
(xiii) Is federal award research and development:	Yes ☐ No ☒
(xiv) a. Indirect cost rate for the federal award:	
b. Is the de minimis rate being used per §200.414?	Yes ☐ No ☒

Medicaid Earnings

(i) Grantee name: *(must match name associated with UEI)*	Clackamas County
(ii) Grantee's Unique Entity Identifier (UEI):	
(iii) Federal Award Identification Number (FAIN):	2205OR5ADM
(iv) Federal award date: *(date of award to state by federal agency)*	10/1/2021
(v) Grant period of performance start and end dates:	Start:10/1/2023 End:6/30/2025
(vi) Grant budget period start and end dates:	Start:10/1/2023 End: 6/30/2025
(vii) Amount of federal funds obligated by this Grant:	$125,441.00
(viii) Total* amount of federal funds obligated to Grantee by pass-through entity**, including this Grant:	Unavailable
(ix) Total* amount of the federal award committed to Grantee by pass-through entity: *(amount of federal funds from this FAIN committed to Grantee)*	Unavailable
(x) Federal award project description:	Medicaid
(xi) a. Federal awarding agency:	Department of Health and Human Services
b. Name of pass-through entity:	Oregon Department of Education
c. Contact information for awarding official of pass-through entity:	Name: Heidi Grogger Email: Heidi.grogger@delc.oregon.gov
(xii) Assistance listings number, title, and amount:	Number: 93.778 Title: Medical Assistance Program Amount: $82,703,000.00
(xiii) Is federal award research and development:	Yes ☐ No ☒
(xiv) a. Indirect cost rate for the federal award:	15%
b. Is the de minimis rate being used per §200.414?	Yes ☐ No ☒

*The total amount is limited to the current state fiscal year (July 1 to June 30).

**The term "pass-through entity" refers to the State of Oregon, acting through its Department of Education.

EXHIBIT F
HFA BEST PRACTICE STANDARDS

(The remainder of this page has been left intentionally blank. The HFA Best Practice Standards is included as an attachment.)

8TH EDITION

HEALTHY FAMILIES AMERICA

BEST PRACTICE STANDARDS

Healthy Families America®

Digital version 8.3 released December 2022. To make sure you have the right version, please login to healthyfamiliesamerica.org

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GA. Governance and Administration

National Office Requirements

INTRODUCTION & GLOSSARY

HFA BEST PRACTICE STANDARDS:

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

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

The policies, procedures and practices within each critical element are defined specifically so that HFA sites have clear direction on how to implement the HFA model. Sites utilize the Standards to engage in a process of continuous quality improvement while striving to meet model fidelity expectations. In order to ensure that all families being served through the HFA model receive high quality services, all HFA sites regularly participate in HFA's Accreditation process, which evaluates the site's current degree of model implementation and fidelity.

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

QUALITY ASSURANCE AND ACCREDITATION:

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

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

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

Step 1 - The Self-Study

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

Step 2 - The Site Visit

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

Step 3 - Response Period

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

THE STRUCTURE OF THE HFA BEST PRACTICE STANDARDS:

The Standards:

The HFA Best Practice Standards contain a series of inter-related standards. A standard establishes the expectation for policy or practice that has been determined either through research or consensus from the field, as a demonstration of quality. The *Standards* are broadly organized by the first order standards (the critical elements) and a section on governance and administration. The first order standard (e.g., Standard 1, Standard 2, Standard 3, etc.) states the overall purpose or aim of the practice within each section. Each first order standard is supported by a series of second order standards (e.g., within Standard 1 are second order standards 1-1, 1-2, 1-3 and 1-4). While the second order standards provide more detail and specificity than the first order standards, their main purpose is to provide further context to guide implementation. Some second order standards are unsupported or stand-alone, meaning they are not broken down any further into third order standards. These include 9-2, 9-4, 10-1, 10-5 and GA-6. However, most second order standards are further broken down into a series of third order standards (e.g., within second order 1-1, are third order standards 1-1.A, 1-1.B, and 1-1.C). The third order standards and the stand-alone second order standards allow for the formation of strong programmatic practice and are the most specific standards with which the site needs to show documentation of implementation.

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

Rating Indicators:

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

ALL RATING INDICATORS ARE IN TEAL WITH A TEAL GRADIENT SCALE.

Standards that are specific to policy expectations are rated as a 2 or 1 rating only, owing to the fact that policy is either in adherence or not. However, there are a few exceptions to this rule. For standard 2-1.A regarding a site's policy on the administration of the FROG scale sites will be acknowledged with a 3 rating if their policy states that the tool will be completed on or before the second home visit, or a 2 rating if the policy states that the tool will be completed on or before the fourth home visit with a family. This also applies to supervision policy standards 12-1.A and 12-3.A, where sites can receive a 3 rating if they have established policy that meets the added expectation about supervision duration for direct service staff (12-1.A) and frequency of reflective supervision for supervisors (12-3.A).

It is also important to note that while most practice related standards will hold the site accountable to the standard, there are some standards that will hold the site to their policy, even if the site's policy expectation is more rigorous than the standard. It is useful for sites to keep this in mind when establishing policy for standards 2-1.B, 2-1.C, and GA-3.D.

1st Order Intent:

The 12 Critical Elements and Governance and Administration (GA) are represented in the first order standards 1-12 and GA and are found at the beginning of each section. Immediately following each of the 1st order standards is the overall intent of the critical element. The intent provides the context or foundation for the critical element. The HFA Literature Review can also be utilized to provide greater understanding of the critical elements.

ALL 1ST ORDER INTENT STATEMENTS ARE BOLD IN BLUE.

2nd Order and 3rd Order Standards Intent

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

ALL 2ND AND 3RD ORDER INTENTS ARE BLUE

Tips:

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

TIPS CAN BE FOUND IN BLUE BOXES MARKED WITH A GREEN ICON

Safety Standards:

These are standards that **must be met** in order to be accredited as they impact the safety of the children and families being served and the staff serving them. Safety standards include personnel background checks (9-3.B), orienting staff on child abuse and neglect indicators, role as a mandated reporter, and reporting requirements (10-2.D), supervision of direct service staff (12-1.B), site practices related to informed consent when sharing family information (GA-3.C) and child abuse and neglect policy and procedures that include reporting criteria, definitions and practice (GA-4.A, GA-4.B). Each of these standards is identified as a safety standard in its respective rating indicator box.

Essential Standards:

Essential Standards are standards determined to be especially significant to the HFA model, as they embody the essence of what it means to implement HFA. The existence of Essential Standards within the BPS is not to suggest that the other standards are non-essential, but to bring additional emphasis to this set of standards as a representation of what it means to embrace the HFA Advantage. HFA's Essential Standards set HFA sites and systems apart from other family support or case management approaches and they stand out as essential in helping direct service staff meet the goals of Healthy Families America.

The Essential Standards are:

- 2-1.B: The administration of the FROG scale to learn about family strengths and challenges.
- 3-3.B: The use of Creative Outreach as a trauma-informed strategy to build trust and re-engage families who have missed visits.
- 4-2.C: The use of HFA Level Change Forms to review family progress and decrease the frequency of home visits.
- 5-4.B: The development of an Equity Plan to support the site in achieving greater equity in all facets of its work.
- 6-1.C: The implementation of the Service Plan, the intentional work of the FSS to respond to concerns that families have shared.
- 6-2.B: The supports that FSSs provide around setting and achieving goals with families.
- 6-3.B, C, and E: The use of CHEERS to observe, partner with and support families in developing nurturing parent child relationships, and the supervisor support to staff around this important aspect of their work.
- 9-1.D: The processes for hiring HFA direct service staff.
- 10-4.A,B,C: The Core trainings required of staff within certain timeframes.
- 12-2.B: The provision of weekly reflective supervision to all direct service staff.
- GA-3.A: Policies and forms related to family rights and confidentiality.
- GA-3.B: The practice of informing families of their rights and about the processes around confidentiality at the start of HFA services.

While adherence to each of these standards is not required in order to receive HFA accreditation, a site with any of these standards rated out of adherence will be required to prepare and submit an improvement plan that clearly indicates the site's efforts to bring the standard into compliance, coupled with documentation of implementation.

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

National Office Requirements:

In order to be accredited, sites must also demonstrate that they are in good standing and upholding responsibilities as an HFA affiliate pursuant to the HFA Affiliation and Licensing agreement. These are described in GA-7 and include providing HFA required data, having HFA fees paid and up-to-date, using the HFA logo, name and graphics appropriately, following the HFA Site Research Policy, and reporting any critical incidents to the National Office.

Tables of Documentation:

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

Use of HFA Tools and Spreadsheets:

For certain standards, forms and spreadsheets have been created to support sites in measuring data consistent with HFA expectations and presenting documentation in a concise and manageable format. These forms should be used if the site does not have a current data system to present the information, or if the data system does not provide reports on any of these standards. If sites provide their own tracking reports they should ensure they include the same fields of information outlined in the HFA tools.

All tracking forms can be found here.

When using the HFA spreadsheets be sure to look carefully at all worksheets contained within (tabs at the bottom of each spreadsheet). This includes reading the tabbed worksheet that gives instructions on the correct use of the spreadsheet. Sites should ensure that in addition to entering data that data is also analyzed and interpreted with narrative in the space provided, along with a plan for improvement. Additionally, be sure that all data is compiled for the entire time period and use all tabs on the analyses spreadsheets. If the site works across multiple counties or with multiple partner agencies in the delivery of HFA services, the data from all counties or all partner agencies must be combined and reported collectively as one site.

ADAPTATIONS AND ENHANCEMENTS TO THE HFA MODEL:

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

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

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

ACCELERATED:

An option for HFA service delivery available to sites that serve families identified at low risk (less than 10) on the FROG Scale. Families remaining at low-risk generally move through the various levels of service at a more rapid pace and may complete services in less than three years when criteria for successful completion of program (see HFA Level Change forms) have been met. Families who do not remain at low-risk, i.e., when additional family concerns and stresses are shared subsequent to administration of the FROG Scale that would have resulted in the family scoring 10 or higher.

ASSESS, ADDRESS, PROMOTE:

The complete process of identifying and utilizing CHEERS to support nurturing Parent-Child Interactions during visits with families. **Assess** refers to the factual parent-child interactions that are seen or heard during visits and documented on the visit record by the Family Support Specialist (FSS). Once the FSS has an opportunity to assess the parent-child interactions for CHEERS, this information is used to identify what to address and what to promote during the current visit or during future visits. **Address** refers to any CHEERS domains identified as opportunities for improvement or concerns that are addressed with the parent by the FSS through the use of HFA Reflective Strategies, visit activities, and/or parenting materials. **Promote** refers to any CHEERS domains identified as strengths, skills, or emerging strengths and skills that are promoted with the parent by the FSS using Accentuate the Positive, Strategic Accentuate the Positive, other affirmations, and celebratory visit activities.

CASELOAD:

The total number of families assigned to a direct service staff person, and not to exceed the maximum case weight of 30 points.

CENTRALIZED or COORDINATED INTAKE SYSTEMS:

Sites can choose to use a centralized intake system for referrals into their program. This system needs to have a solid understanding of the site's eligibility criteria so the site receives referrals from the intake system that reflect the families the site intends to serve.

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

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

Safety guidelines often need to be adapted or expanded to address the specific concerns of each location or situation. Supervision sessions provide an appropriate venue for discussion of specific safety concerns and fine-tuning of safety procedures. The supervisor should be available and immediately informed if the direct service staff fears for their safety. The safety of staff is of utmost importance.

CHEERS:
An acronym to support Family Support Specialists and parents in understanding and observing the different dimensions of parent-child interaction that ultimately result in attachment over time. The elements of the acronym include Cues, Holding, Expression, Empathy, Rhythmicity/Reciprocity, and Smiles. These observations are expected to be made during each home visit as specified in the standard and intent. Training on CHEERS is also a significant part of HFA Core (Foundations for Family Support) training.

CHEERS CHECK-IN:
The CHEERS Check-In is a validated measurement tool developed by HFA and used to assess parent-child interaction at least twice annually and up to quarterly. Web-based training (required) and support on the use of this tool is provided by HFA.

CHILD WELFARE PROTOCOLS:
An option for HFA service delivery available to support sites with maintaining model fidelity while working with child welfare referred families. Affiliated sites seeking to implement CWP will submit a written implementation plan. Sites will establish relationships with their local child welfare office before seeking approval for implementation. Families enrolled through CWP must be referred by an agency within the child welfare system and the first home visit must be completed within 24 months of birth (see Standard 1-3). Sites implementing CWP are expected to establish a formal Memorandum of Agreement with the local child welfare office (see Standard 1-1.B) and code family data in a way that allows it to be analyzed and reported separately from families enrolled through traditional HFA protocols. Families are offered voluntary services for three years from the date of enrollment regardless of age at intake.

COMMENSURATE HFA EXPERIENCE:
During the new hire recruitment process, applicants for HFA site level positions are screened based on a variety of factors. Individuals who themselves participated in HFA services and/or worked in other HFA roles (e.g. an FSS, FRS or team lead now applying for a supervisor position) bring highly valuable attributes from their HFA experience and lived expertise. When considering whether the level of HFA experience is commensurate with an educational degree, this will be decided on a case-by-case basis by the hiring team, factoring the length of their previous experience (though there is not an automatic 1:1 ratio where for example a 4-year degree is met by having 4 years HFA experience), and more importantly how the individual themselves describes the impact of HFA involvement on their readiness to take on a new role.

COMMUNITY ADVISORY BOARD:
An organized voluntary group with responsibilities to advise on the planning, implementation, and evaluation of the HFA site operations. The functions and responsibilities of this group may include making recommendations to the HFA site and the organization's governing group regarding site policy, operations, fiscal needs, community needs, etc. Community Advisory Board members are a diverse group of individuals who represent the interests of the community as guided by the critical elements.

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

CONTEXTUAL DECISION-MAKING:

On a site visit, the peer reviewers may see mixed information pertaining to a standard (e.g., an FSS has a first home visit with a prenatal family, and the Focus Child is born before the second visit. Because of this, the family is no longer prenatal, and the FSS was unable to complete a prenatal depression screen). In situations like this, where there may be extenuating circumstances, peer reviewers are trained to use contextual decision making to rate a standard, which means they must ensure the site is operating from best practice. For example, in the situation above, if the missed prenatal depression screen was because the baby was born shortly after the first home visit, the site could be rated in adherence even though not all prenatal families received a prenatal depression screen. Or, in another example, if the site had a new staff signed up for Core training, however she missed it because she was out unexpectedly for 3 months on FMLA, but as soon as she returned from FMLA she went to Core, the site was operating from best practice so therefore this would be taken into account to rate the standard in adherence vs out of adherence. This means sites should document the reasons for variances when they arise, which allows peers to have the information they need to use contextual decision making.

CORE TRAINING:

Intensive model-specific training that addresses some or all of the core components of the model, including FROG Scale, Foundations, Supervision and Implementation training.

CULTURAL CHARACTERISTICS:

Distinguishing features and attributes such as ethnic heritage, race, age, customs, values, language, gender, religion, sexual orientation, social class, and geographic origin, disability, among others, that combine to create a unique cultural identity for families, based on both experience and history.

CULTURAL HUMILITY:

Originating in the health care field, the concept of "cultural humility" was developed as an alternative to the idea that we can become "competent" in the cultures of others. Cultural humility is a lifelong commitment to self-awareness, to addressing power imbalances and to developing partnerships with people and groups who advocate for others.[2] In HFA, we embrace cultural humility in our approach to working with families from a place of self-awareness, understanding that each family has a unique culture and that our own culture and values can impact our interactions with families. It is our responsibility to continuously evaluate our interactions, interpretations and assumptions and to be committed to lifelong learning about ourselves and others. We reflect on our interactions with others and seek to understand how real or perceived power imbalances can influence our effectiveness. We align ourselves with other people or groups that advocate for others as we build authentic relationships with the families we serve. A culturally humble approach to our work ensures that we are successful in creating healthy relationships across the parallel process in alignment with the HFA Advantage.

CRITERIA:

Rules upon which judgment or decisions are based.

DEPRESSION SCREENING TOOL:

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

DIRECT SERVICE STAFF:

Staff at an HFA site who carry a caseload of enrolled families to whom they provide HFA home visits and/or staff who administer the FROG scale with families.

EARLY COMPLETION:

A family enrolled and remaining as HFA Accelerated is eligible for early completion when able to sustain Level 3 accomplishments to move to Level 4 for a minimum of 6 months (or 180 days). Families enrolled in traditional HFA services, who choose to discontinue service early may potentially be regarded as early completers when they also meet and sustain for a minimum of six months accomplishments associated with moving from Level 3 to Level 4. In both cases, the Level 3-4 Completion form must be completed and signed.

ELIGIBILITY FOR SERVICES:

The process utilized to determine potential families who may be most in need of or could benefit from intensive home visiting services. Sites will determine the best way to identify eligible families, based on funder guidance, community need, and their own description of the families they intend to serve. HFA recognizes that in most situations, a well-developed screen will meet site needs for eligibility determination. Some sites may choose to use the FROG Scale to determine eligibility for service.

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[2] *Tervalon & Murray-Garcia (1998)*

ELIGIBILITY 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. In most cases, sites determine eligibility for services using a screening tool. In some cases, sites may use the FROG Scale to determine eligibility.

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

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

EQUITY PLAN:
An Equity Plan results from the site's intentional, honest, critical and reflective look inward (site self-assessment) that also integrates feedback received from families and staff. This level of exploration allows sites to assess their capacity to 1) provide families with equitable access to culturally respectful and responsive services, 2) create a diverse, inclusive and supportive work culture for staff, and 3) operate within the context of the community and in partnership with parents and other providers to strengthen services. Based on what the site learns, activities are applied to promote equity and advance the current level of cultural humility at the family, staff and/or community level. The Equity Plan also includes recommendations/suggestions from its community advisory board.

EVIDENCE-INFORMED PARENTING MATERIALS:
The information that sites staff share with families must be evidence-informed, meaning that the information is based on scientific knowledge or research. Strategies employed may also be grounded in scientific research (e.g., strive to strengthen the parent-child relationship, which research has shown to be a key factor in healthy development). The reason there is a focus on the use of evidence-informed materials is to ensure that families are receiving well-founded, factual, relevant, and credible information versus materials that are opinion-based or outdated and no longer accurate. Sites may choose to use a formal parenting curriculum that is designed for home visiting or parent support, or sites may identify other evidence-based sources of parenting materials.

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

FAMILY RESOURCE SPECIALIST (FRS):
Typically, HFA sites use the title Family Resource Specialist to represent a direct service staff member with responsibilities related to the engagement and enrollment of new families. This role may include activities such as managing referrals, outreach to families referred, determining eligibility for services, offering HFA services, connecting families to additional resources in the community, and maintaining relationships with referral sources. Because of the variability in how this role is defined across sites, and because some sites divide these responsibilities across all direct service staff, HFA does not provide a role-specific training for the FRS. Find information about the role of direct service staff on Network Resources.

FAMILY SUPPORT SPECIALIST (FSS):
HFA home visitors are referred to in HFA training materials, the BPS, and other HFA produced documents as Family Support Specialists. This title conveys to families the purpose of the role in a way that families can relate to. FSS are responsible for building and maintaining an ongoing supportive relationship with families enrolled in home visiting services. Sites are welcome use this title or to continue titling this role in a way that best fits within their organization. Find information about the role of direct service staff on Network Resources.

FIDELITY ASSESSMENT:
A process to affirm model fidelity and support CQI activities at sites. HFA National Office staff conduct Fidelity Assessments with new provisional (not yet accredited) sites and, in very limited situations, as an alternative to a full reaccreditation site visit, including when conditions are such that site visits cannot be safely conducted. A Fidelity Assessment includes the review of site documentation related to all Essential and Safety Standards, the development of a Self-Study by the site, and a 6-month response period for sites to demonstrate improved practice. Sites successfully completing a Fidelity Assessment will have their accreditation expiration date extended for up to 3 years from the date of the Fidelity Assessment.

FIRST HOME VISIT:
The first visit completed by the assigned Family Support Specialist after eligibility has been determined, where rights and confidentiality forms are signed (unless already signed), where CHEERS is typically observed, and at least one focus area (see glossary for home visit definition) occurs.

FOCUS CHILD:

Eligibility is determined early for HFA families, ideally during the prenatal period. Healthy Families services are centered on the focus child (or children in the case of multiples), who is the prenatal child at enrollment, or child most recently born to a newly enrolled family.

FOUNDATIONS TRAINING:

Foundations training is an in-depth, formalized training required for all direct service staff, supervisors, and program managers. The training outlines the duties of the direct service staff in their role within HFA. Topics include but are not limited to: trauma-informed practice; communication skills; assessing, addressing, and promoting nurturing and sensitive parent-child relationships; creating a trusting partnership with families; goal setting; and strategies to enhance family functioning, address challenging situations, ensure healthy childhood development, and support healthy relationships. The training is facilitated by a trainer who has completed an extensive training program and is certified by the HFA National Office.

FROG SCALE:

The FROG (Family Resilience and Opportunities for Growth) Scale is the psychosocial assessment tool used by HFA sites at the onset of services to gather information about each family's unique strengths (protective factors) and challenges (risks for child maltreatment). HFA sites use the FROG Scale as the foundation for the family's Service Plan which guides ongoing services. Some sites use the FROG Scale to determine eligibility for HFA. The FROG Scale is administered with families in conversational style, respectful of what families feel comfortable sharing. While staff will continue to learn about families throughout the course of services, early completion of the FROG Scale supports relationship building by:

- immediately offering services that are responsive to the concerns and interests of each family
- building on family strengths to address concerns or challenges
- sending a clear message that this is a safe place to share difficult experiences

Each of the protective factors and potential risks identified below are measured on a continuum from strength to risk, with low scores in each area reflecting significant strengths and high scores reflecting significant risk.

- parent's childhood experiences
- experiences with substances or other potentially addictive behaviors
- mental illness
- experience with child welfare
- coping skills and supports
- stressors (housing, finances, childcare, employment, etc.)
- relationship with partner (including level of support and history or current intimate partner violence)
- knowledge of child development
- plans for discipline methods
- perception of baby/child
- physical and emotional availability of parent

FROG TRAINING:

FROG Scale training is an in-depth, formalized training for all direct service staff who will use the FROG Scale with families and their supervisors. The training includes but is not limited to: understanding the importance of telling one's story; using the framework of the FROG Scale to identify families' strengths and concerns; engaging families through conversation; documenting in narrative form; and using the FROG Scale scoring guide. The training is facilitated by a trainer who has completed an extensive training program and is certified by the HFA National Office.

FULL TIME EQUIVALENCY (FTE):

The calculation of full-time equivalent (FTE) is an employee's scheduled hours divided by the employer's hours for a full-time workweek. When an employer has a 40-hour workweek, employees who are scheduled to work 40 hours per week are 1.0 FTEs. Employees scheduled to work 20 hours per week are 0.5 FTEs. Family Support Specialists caseload maximums are determined by their FTE. This caseload expectation needs to be adjusted if the Family Support Specialist is less than 1 FTE. For example, sites will prorate a .5 FTE (1/2-time employee) so that their caseload does not exceed 15 points and that staff have an adequate amount of time to work with each family. Learn more about calculating FTE.

GRADUATE:

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

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

HOME VISIT:
A face-to-face interaction that occurs between the family and the Family Support Specialist. The goal of the home visit is to promote nurturing parent-child interaction, support healthy childhood growth and development, and enhance family functioning. Typically, home visits occur in the home, last a minimum of an hour and the child is present. Circumstances may occur where visits take place outside the home, are of slightly shorter duration than an hour, or occur with the child not present. These may be counted as a home visit if the overall goals of a home visit and some of the focus areas (listed below) have been addressed.

Also, when engagement challenges are present or special situations such as severe weather, natural disaster or community safety advisory impedes the ability to conduct an in-person visit with a family, a virtual home visit (via phone or preferably video platform), can be counted when documented on a home visit record and the goals of a home visit are met, including some of the focus areas (below).

Sites are permitted to count one group meeting per month as a home visit while families are on Level 1 or 1P; however, to do so requires that a Family Support Specialist be present during the group meeting and that the group meeting be documented on a home visit note, including some aspects of CHEERS for that particular family (when the group includes parent-child interaction time). The site may also count one visit per month conducted by a multi-disciplinary team member (if with documentation to demonstrate the staff person received HFA Foundations for Family Support training and receives supervision consistent with 12-1 and 12-2 standards. The focus areas during home visits may include, but are not limited to:

Promotion of nurturing parent-child interaction/attachment:

- development of healthy relationships with parent(s)
- support of parental attachment to child(ren)
- support of parent-child attachment
- social-emotional relationship
- support for parent role in promoting and guiding child development
- parent-child play activities
- support for parent-child goals, etc.
- PCI screening and assessment

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
- health and development screening

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
- family functioning screening and assessment
- coping & problem-solving skills
- stress management & self-care
- home management & life skills
- linkage to appropriate community resources (e.g., food stamps, employment, education)
- access to health care
- reduction of challenging issues (e.g., substance abuse, domestic violence)
- reduction of social isolation
- crisis management
- advocacy

IMMUNIZATION SCHEDULE:

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

IMPLEMENTATION TRAINING:

In-depth, formalized training designed to prepare Program Managers and other Healthy Families America leaders for their important work. Implementation Training is an opportunity to become intensely immersed in HFA, the expectations of the model, and the responsibilities of HFA leaders, all while developing relationships with National Office staff and a network of support from other HFA colleagues throughout the country. Learners receive resources aimed at making implementation of the HFA model easier, gain familiarity with the HFA Best Practice Standards and have opportunities to consider the implementation of these standards within local sites or systems. This training is provided online by HFA National Office Staff.

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"[3].

LEVEL CHANGE FORMS:

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

LIVED EXPERTISE:

HFA staff are often more effective in supporting families and achieving program outcomes if they have experience within the community, apart from the formal educational attainment that is commonly included in hiring standards. Staff with knowledge of the culture of the people that the site intends to serve, and self-awareness around their own place within the community will be more successful in building trusting working relationships with the families that come into contact with the HFA site. Focusing on lived expertise also increases opportunities for diverse representation, equitable access to positions, and elevation of family voice within the services the program provides.

MEDICAL/HEALTH CARE PROVIDER:

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

MONITOR:

To keep track of through the ongoing collection of available information. The extent of the information collected for tracking and monitoring purposes will vary and is a less rigorous process than compiling data for an analysis.

Monitoring is not limited to review of data and reporting. Sites may find that they are able to learn more about the processes and outcomes that they are monitoring through the review of notes in family files, individual screening tool results or survey responses. For example, in monitoring well-child visit completion, sites may find that they are able to identify trends by reviewing a report of all families and the dates of their well child visits, but that they may learn more about site performance in this area through conversations in team meetings. For monitoring the systems related to referral relationships, sites may combine data related to the number and success of referrals from specific partners with informal information about provider relationships from direct service staff.

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[3] *World Assn. IMH*

MOTIVATIONAL INTERVIEWING (M.I.):
A collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a change goal by eliciting and exploring an individual's own arguments for change.[4] The spirit of Motivational Interviewing is a significant part of *HFA Advanced Family Support: Facilitating Change* training.

MULTI-DISCIPLINARY TEAM MEMBER(S):
An employed or contracted member of the local HFA site providing supplemental support to HFA staff and/or families (e.g., doulas, therapists, child development specialists, etc.). When providing services to families, these staff work in conjunction with the assigned FSS, and therefore are not considered to carry an HFA caseload. If the site chooses to have a visit from a multi-disciplinary team member count as an HFA home visit, the multi-disciplinary team member must 1) have received HFA Foundations training, 2) document the visit, including CHEERS observations, on an HFA home visit record and 3) receive supervision consistent with HFA standards for direct service staff. If the site is not counting visits from multi-disciplinary members as an HFA home visit, items 1-3 above are not required.

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.

PARALLEL PROCESS:
A key component of reflective practice, the parallel process encompasses all the relationships within the delivery of the HFA Services and focuses each person's ability to develop and promote a nurturing relationship. This includes an awareness of how focusing on the ways in which we are present and emotionally available for another creates a nurturing environment within all other relationships within the parallel process: Parent and Baby, Direct Service Staff and Parent, Supervisor and Direct Service Staff, and Program Manager and Supervisor. This is summed up in the Platinum Rule: "Do unto others as you would have others do unto others." Jeree Pawl.

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 focus child.

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

PARTNERING WITH PARENTS AROUND CHEERS:
HFA Family Support Specialists support families and promote nurturing parent-child relationships using CHEERS observations. In addition to the documentation of CHEERS to assess, address and promote attachment, FSSs support the parent-child relationship by discussing the domains of CHEERS with families through the use of reflective strategies, visit activities, and parenting materials. The more that parents become familiar with and reflect on concepts related to secure attachment, the more that they are able to make parenting choices that align with their family culture and build healthy relationships with their children. CHEERS is not something that is "done to" families, but an opportunity to come alongside families and create a shared language to talk about attachment and parent-child interaction.

PLANNING, IMPLEMENTATION, AND CONTINUOUS QUALITY IMPROVEMENT (ADVISORY GROUP ROLE):
Planning refers to the planning of events, additional referral sources, and integration of services between agencies serving families, etc. Implementation applies to supporting any implementation challenges the site faces, such as striving for early enrollment, engaging fathers, etc. Continuous quality improvement relates to feedback from the group related to the analyses and strategies aimed at strengthening site services.

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

[4] *William Miller, Steve Rollnick, 2012*

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

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

PROGRAM MANAGER:
Each site has a designated Program Manager (PM) that is responsible for the day-to-day, hands-on management of the site, and is involved in planning, budgeting, staffing, training, quality assurance, and evaluation. PMs are also responsible for ongoing collaboration with community/state partners, public relations, and 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 direct service staff in a dual role as Supervisor (see Supervisor definition). Find information about the role of program manager on Network Resources.

PROTECTIVE FACTORS:
- parental resilience
- social connections
- concrete supports in times of need
- knowledge of parenting and child development
- social and emotional competence

Additional information and training can be found online. Learn more.

QUALITY ASSURANCE PLAN:
A plan to monitor and track quality and implementation to model fidelity that includes all aspects of the service delivery system, i.e., initial engagement, home visiting, supervision and management. Quality assurance can be monitored via satisfaction surveys, case file reviews, shadowing, quality assurance phone calls, supervision rates, etc. A sample Quality Assurance Plan is available.

QUALITY IMPROVEMENT PLAN:
A plan that incorporates specific, measurable, attainable, realistic, and time-oriented improvement goals carried out by the entire team with an intent to test small changes and their impact on process and/or outcomes. Download sample Quality Improvement Plan.

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

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

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

REFLECTIVE CAPACITY:

The capacity to exercise introspection and the willingness to learn more about the fundamental nature, purpose, and essence of how humans experience this world and how our own world-view is impacted by that experience. HFA staff with reflective capacity are able to consider multiple points of view, have awareness of their own biases and feelings, can tolerate ambiguity and are able to recognize their own dysregulation. It is important 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 CONSULTATION GROUPS:

Sessions generally last 1.5-2 or more hours and are conducted by an individual with advanced training or credential in the area of reflective practice and professional group facilitation. Reflective consultation groups include but are not limited to:

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

REFLECTIVE STRATEGIES:

The HFA Reflective Strategies are specifically designed intervention tools that create an environment of increased self-awareness and self-efficacy sustained within healthy helping relationships. The reflective strategies are in alignment with the trauma-informed approach and utilized by all HFA staff regardless of role. Each strategy has a unique purpose as follows:

- Mindful Self-Regulation encourages self-awareness and promotes self-regulatory, self-care practices.
- Accentuate the Positive builds self-esteem and confidence by promoting specific skills and strengths along with the impacts and benefits of the identified skills and strengths.
- Strategic Accentuate the Positive increases the frequency of healthy, safe, and nurturing behaviors that also builds self-esteem and confidence.
- Feel, Name, & Tame supports a persons' capacity to recognize and regulate their feelings.
- Explore & Wonder builds awareness, empathy, and sensitive responses to missed cues and the feelings of others.
- Problem Talk encourages creative thinking and problem solving by clarifying and learning more about a concern, problem, or situation.
- Normalizing addresses concerns related to dangerous or harmful beliefs, behaviors, and practices while offering alternative healthy and safe options for consideration and further exploration.

The HFA Foundations for Family Support Core and Supervisor Core training include detailed descriptions, discussions, examples, handouts, and practice opportunities on all the HFA Reflective Strategies.

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:

A systematic examination of information to answer a question and advance knowledge and any activity, including program evaluation and/or quality improvement activities, (i) that would, according to Federal regulations, require review by an Institutional Review Board, or (ii) that could be expected to yield generalizable knowledge that could be shared publicly with the professional, academic and/or lay communities. 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 or quality improvement is not considered Research.

SAFER SLEEP:

HFA sites share information with families about infant sleep to reduce the risk of sleep related infant death. Sites provide information about evidence-based safe sleep practices and engage in conversations with families related to things that parents and caregivers can do to keep babies safe. For families whose choices around infant sleep may include co-sleeping or other culturally specific sleep practices, HFA staff may choose to take a harm reduction approach and share information with families about how to increase the safety of these practices.

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

SERVICE PLAN:
HFA requires sites to develop a Service Plan for each family. The Service Plan is a Supervisor's tool that brings collaboration and intentionality to the forefront of our work. A well-constructed Service Plan is the cornerstone of services that are effectively organized, coordinated, and based on each family's unique strengths and areas of concerns. A Service Plan operationalizes the family story into a road map that supports Family Support Specialists in their ongoing and long-term work with the family and is the mechanism by which Supervisors document their clinical support to staff that is specific to each family.

Sites may adapt or develop their own Service Plan document if it meets the expectation of the 6-1 standard. The HFA National Office is happy to review and advise on any modified forms. Download HFA Service Plan Materials.

SERVICE POPULATION:
The individuals currently enrolled and receiving services.

SERVICES:
When referenced in the Standards, services include the activities offered to families by Healthy Families direct service staff at enrollment and during home visits and does not include Healthy Families service enhancements (e.g., groups, augmented support from clinicians, or other programs housed at the agency).

SITE:
The term used to describe an HFA affiliate. Additional information about defining an HFA Site can be found in HFA Site Definition documents.

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

Download Sample Staff Development Plan for Program Managers, Supervisors, and Direct Service Staff.

SUPERVISION TRAINING:
In-depth, formalized training that outlines the specific duties of the supervisor's role within Healthy Families and covers topics including, but not limited to: the role of direct service staff, the importance of reflective supervision, supervision session structure and content for all staff, reflective strategies for supervisors, supervision of staff using the FROG Scale, sample tools and forms to use for continuous quality improvement, etc. The trainer is certified by the HFA National Office.

SUPERVISOR:
Supervisors provide weekly individualized supervision to the direct service staff within a Healthy Families site. The supervisor ensures quality of service provision. The supervisor protects the integrity of the program and demonstrates respect for the parallel process by supporting, guiding, and building on the strengths of staff so that they may best support, guide, and build on the strengths of the families served. Find information about the role of supervisor on Network Resources.

TRANSFER FAMILIES:

When families move from one location to another, HFA encourages sites to ask families if they would be interested in continuing with HFA home visiting services in their new location. The HFA website has a Site Finder feature that sites can use to locate an HFA site close to where the family is relocating and to determine if the site can provide services for this transitioning family. In addition, new HFA affiliates who are transitioning from a previous home visiting model to HFA will transfer families from previous services to HFA when possible.

When families transfer from one HFA site to a new HFA site, we recommend the Family Support Specialist at the original site review with the family what information would be helpful to share with the new site so that families can make an informed decision about their consent to share this information. For continuity of service, the new site my find the following information helpful:

- Initial FROG scale
- Current Service Plan (including documentation of any additional concerns identified by the site over the course of services, including potential developmental delays, parental depression or concerns related to the parent-child relationship)
- Current Family Goal
- Family Transition Plan (if developed by the original site ahead of the close of services)
- Current family Level of Service
- Signed release of information from the family

Sites must follow all HFA policies related to informed consent when transferring families. Families transferred into an HFA site should be tracked in the same way as other referrals and included in acceptance and retention data tracking.

If the initial FROG scale completed with the family at the original site has not been shared with the new HFA site, the new FSS should complete the FROG scale early in services with transfer families to begin the process of learning more about their strengths and opportunities for growth.

Families transferring into an HFA site will be offered weekly visits at the onset of services, until progress criteria is met for moving to less frequent visits. While families may have been receiving less frequent visits at their previous site, all families benefit from increased frequency of initial visits after a transfer, allowing for staff and families to learn more about each other and to begin the process of trust-building. The life transitions and circumstances related to a move to a new community may have created additional stress in the family and weekly visits ensure families receive adequate support during this time. Sites will assess the progress of transfer families using HFA Level Change forms and will reduce frequency of visits as progress criteria are met.

Transfer families are included in HFA data collection, though they may be excluded from some calculations.

- Sites do not have to include transfer families in the calculation of families' receipt of the initial home visit before three months of age. (1-3.B)
- Transfer families are exempt from the requirement to be offered three years of service from the date of enrollment, but sites should plan to serve transfer families until the focus child reaches three years of age at a minimum. (4-3.B)
- For standards related to completion of screening tools with children and families, (6-3.D, 6-5.B, 6-5.C,) sites should note transfer status of families in data reporting in cases where the timing of the transfer to the new HFA site precludes the ability of the site to complete screenings as described in the standards. This information can be used for contextual decision-making by peer reviewers or the Panel.
- Sites will follow their policies related to depression screening, administering screens to primary caregivers within 3 months of enrollment, including transfer families.

TRAUMA-INFORMED:

One component of the HFA Advantage is HFA's trauma-informed approach. Being trauma-informed requires an awareness of the impact that trauma has had on the lives of families, an awareness of behaviors and responses that might trigger re-traumatization, and an openness to understanding how current behaviors are often adaptations to past abuses. Trauma-informed support includes ensuring safety, emphasizing autonomy and a collaborative strength-based approach. The trauma-informed approach applies to all families, and across the parallel process to include site staff, and does not rely on specific knowledge of anyone's trauma experiences or require disclosure on the part of any individuals. Because trauma is a common experience, being trauma-informed does not mean that we treat certain individuals differently based on their trauma history, but instead we provide trauma-informed support to everyone. HFA sites and systems build successful working relationships with all families and staff that provide safety, predictability, comfort and joy and result in improved outcomes for all families.

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).

WAITLIST:

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

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

HFA ACCEPTANCE RATE:

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

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

Measuring Acceptance Rates:

HFA methodology for calculating a site's acceptance rate is:

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

The HFA National Office has a spreadsheet available that will calculate acceptance rates using HFA methodology.

HFA RETENTION RATE:

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

Measuring Retention Rates:

HFA methodology for calculating a site's retention rate is:

1. Select a specified time period, e.g., January 1, 2019, to December 31, 2019 (can be a calendar year or fiscal year).
2. Count the number of families who received a first home visit during this time period.
3. Count the number of families in this group that remained in services over specified periods of time (six months, 12 months, two years or more, etc.).
4. Divide this number by the total number of families defined in step 2 (that received a first home visit during the time period).
5. For accuracy, a time period must be selected that ended at least one year ago for one year retention rate, two years ago for two-year retention rate, three years ago for three-year retention rate, and so on. This is to ensure that all families beginning services during the specified time period have had the opportunity to stay for the full retention period being measured. For example, a family enrolled in December 2019 could not be counted as retained for one year until December 2020.

The HFA National Office has a spreadsheet available that will calculate retention rates using HFA methodology.

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

ANALYSIS:

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

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

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

Please note: Not all factors listed below are required to be analyzed, however sites should review as many as possible in order to isolate those that may be impacting acceptance and retention rates most.

Sites are strongly encouraged to choose factors that will allow them to uncover potential equity issues related to acceptance and retention in the program. In addition, the inclusion of at least one factor related to how the program operates allows the site to learn more about how adjustments to policies and practices may improve family experiences.

PROGRAMMATIC FACTORS:

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

Programmatic Factors to consider for Acceptance Analysis

- relationships with partner agencies or other community providers
- referral sources
- staffing issues (patterns & trends among direct service staff)
- number of days between referral and assessment
- screening or assessment timeframe (e.g., prenatal, at birth within two weeks, more than two weeks)
- if a re-enrolled or transferred family
- training of staff

Programmatic Factors to consider for Retention Analysis

- enrollment timeframe (e.g., enrolled prenatally, at birth, or at a later period)
- if a re-enrolled of transfer family
- staffing issues (patterns and trends among direct service staff--depending on site size, staffing trends can be evaluated by individual, by team, and by satellite
- current service level
- length of time in services
- age of focus child(ren) at enrollment
- how policies impact what happens with families and site outcomes
- relationships with partner agencies or other community providers
- training of staff

PARENT AND FAMILY FACTORS:

- gender identity
- age
- race & ethnicity
- marital status
- education level (last grade completed)
- primary language
- sexual orientation
- employment Status (not employed, employed part-time, full-time, or seasonally)
- socioeconomic status
- location: urban, suburban, rural
- families experiencing systematic oppression
- city/zip code
- FROG Scale score
- work or school issues (barriers to engaging or retaining due to HS or college schedule, work hours, significant commute, works night shift, etc.)
- family or friend support
- teen parent(s) living independently or with parents
- grandparents raising focus child
- linkages to other community resources
- religious affiliation
- domestic/family violence
- families with disabled parents or children
- families impacted by substance use
- families impacted by mental health
- families impacted by violence or over-policing

INFORMATION USED IN ANALYSES:

Sites are required to consider formal data and other information related to analysis factors to identify patterns or trends in family acceptance or retention. Formal data refers to information that can be numerically recorded, often regarded as "hard data," or quantitative data. Factors related to program processes and activities, and factors related to family or individual parent characteristics can all be reported as formal data using both numbers and percentages. Anecdotal information, often regarded as qualitative data, gathered from site staff, advisory board members and parents related to the analysis factors helps complete the story of what is impacting family acceptance or retention. Anecdotal information may be collected in staff meetings, individual supervision, parent focus groups or community advisory board meetings.

REASONS WHY:

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

COMPREHENSIVE ANALYSIS:

A comprehensive analysis is a thoughtful and intentional selection and examination of key programmatic, and Parent and Family factors that includes a combination of raw (numeric) and aggregate (percentage) formal data as well as informal (anecdotal) data, and how various factors may relate to and influence other factors. A comprehensive analysis also includes a narrative that summarizes the findings, including any patterns or trends. Data and conclusions from the analysis are used to develop and apply strategies aimed at improving site services in the site's Comprehensive Quality Improvement Plan.

Summary and Guidance for Data Collection Timeframes

The Tables of Documentation provide a complete list of data requirements in the HFA Best Practice Standards (BPS). Also included is a column with recommended timeframes for ongoing monitoring and adherence to the standards, as it is helpful to have routine monitoring, measurement, and documentation of these activities support your site's Quality Assurance Plan (GA-2.A). These recommended timeframes may also be helpful as you develop and follow-up on your site's Quality Improvement Plan (Standard GA-2.B). When a site finds that any of these QA activities are following below expectations stated in the standards the site is also encouraged to include these items on their site Quality Improvement Plan for ongoing monitoring and improvement.

Measuring/Monitoring/Reporting Timeframes

- Annual - Site selects the most recent 12 months, most recent calendar year, or most recent fiscal year

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

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
1-1.C Tracking Referrals and Site Capacity	Quarterly	Submit report reflecting all families referred to your site in the most recent quarter: 1. Number of families referred by each referral source 2. Their eligibility status Include most recent plan with strategies to fill available slots or reduce gaps in service availability. Indicate which have been applied.	HFA Spreadsheet or local data report and strategies.	Update Monthly
1-2.B Initial Engagement Process	Annual	Submit a narrative about how the site monitors its initial engagement process and activities reflecting all families referred in the most recent year. A data report may be submitted in combination with a narrative regarding engagement activities. HFA's spreadsheet includes: 1. The length of time from referral to initial contact 2. The length of time from initial contact to offer of services 3. Whether able to establish initial contact or not. 4. Whether services were offered or not. Reasons why if services not offered.	HFA Spreadsheet or local data report and strategies.	Update Quarterly or more frequently, depending on number of referrals received
1-3.B Initial Engagement Process	Annual	Submit a report reflecting all families who received a first home visit in the most recent year. 1. Count number with a first home visit 2. Count number with first home visit either prenatally or within 3 months of birth 3. Calculate: #2 (number with first home visit prenatally or within 3 months) divided by #1 (number who had a first home visit) For sites enrolling families through Child Welfare Protocols (CWP), remove CWP families from the calculation above to calculate CWP families separately, 1. Count CWP number with a first home visit 2. Count CWP number with first home visit within 24 months of birth 3. Calculate: 2. (number with first home visit within 24 months) divided by 1. (number with a first home visit) Sites will include the signed MOU with CWP partners in their accreditation self-study.	HFA Spreadsheet or local data report. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
1-4.A Measure Acceptance	Annual	Submit a narrative describing the site's definition of acceptance rate and method for calculation (unless using HFA spreadsheet) and the current acceptance rate for all families offered services in the most recent year. Also describe the site's process (how and when) acceptance rate is reviewed or reference the site's current QA Plan if the site has included a review of its acceptance rate there. 1. Count number offered HFA home visiting services 2. Count number with a first home visit 3. Calculate: #2 (number with a first home visit) divided by #1 (number offered services).	HFA Spreadsheet or Acceptance Rate and description of methodology, if not using HFA spreadsheets.	Update Every Six Months
1-4.B Acceptance Analysis	Every other year	Analyze the data from all families who were offered services during at least the most recent year. Analyze both formally and informally: 1. Families who refused services in comparison to families who accept services. 2. Includes at least one analysis factor 3. The reasons why families decline. For smaller sites with less than 50 families offered services over a two-year period, the site is required at a minimum to submit a narrative including: 1. The number of families offered services within the two-year period. 2. Informal data about families who refuse services or accepts services 3. Reasons why families are not accepting services If at least ninety percent (90%) of families offered services over a two-year timeframe accepted services by receiving a first home visit, an analysis is not required. New sites not yet in operation for two full years with an acceptance rate of 90% during the first year are also exempt from completing an analysis.	HFA Spreadsheet or Acceptance Analysis for at least one cohort year. For sites not required to complete Acceptance Analysis, submit a narrative defining reason for exemption. Please see glossary for more information on analysis.	Update Annually

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
3-4.A Measure Retention	Annual	Submit the site's definition of family retention and method for calculating (unless using HFA spreadsheet) and retention calculation for families enrolled within at least one cohort year. HFA methodology for calculating a site's retention rate is: 1. Select a specified time frame (i.e., January 1, 2020 to December 31, 2020). This can be a 12-month period, a calendar year, or fiscal year. 2. Count the number of families who received a first home visit during this time frame. 3. Count the number of families in this group who remained in services at specified intervals (i.e., the number from this group remaining in services 6 months or longer, 12 months or longer, two years or more, etc.); 4. Divide #3 (totals remaining for 6 months, 12 months, etc.) by the number of families in step #2 (that received a first home visit during the time frame. 5. When selecting a time frame, it helps keep in mind the last day of your time frame will determine which intervals you can measure. A family who might have enrolled on the last day of that time frame could only be counted as retained or not for 6 months if at least 6 months have passed since they enrolled. Example: I have selected 1/1/2020-12/31/2020 and today is 1/1/2022, so any family that might have enrolled on the last day of that year has had the opportunity to be in the program for 1year and 1 day. For all the families who enrolled during that year, I can measure how many were still enrolled at the 6-month interval and the 12-month interval. I can't measure the 2-year interval yet because not all families who enrolled in that year (specifically, a family that might have enrolled on the last day) have had the opportunity to make it to the 2-year mark.	HFA Spreadsheet or Retention Rate and description of methodology, if not using HFA spreadsheets.	Update Every Six Months
3-4.B Retention Analysis	Every other year	For all families who enrolled within at least one cohort year, analyze both formally (numbers and percentages) and informally (anecdotal information from staff and advisory members) 1. Families who remain in services in comparison to families who leave. 2. Includes at least one analysis factor 3. The reason why families leave. For sites with less than 50 enrolled families at any one time over a two-year period, submit a narrative including: 1. The maximum number of families that were enrolled at any one time. 2. Informal data about families who leave service or are retained 3. Reasons why families are leaving services If at least ninety percent (90%) of families enrolled in services over a two-year timeframe remained in services, an analysis is not required. New sites not yet in operation for two full years with a retention rate of 90% during the first year are also exempt from completing an analysis.	HFA Spreadsheet or Retention Analysis for at least one cohort year. For sites not required to complete Retention Analysis, submit a narrative describing the reason for exemption. Please see glossary for more information on analysis.	Update Annually

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
4-2.B Home Visit Completion	Quarterly	Submit home visit completion report for the most recent quarter which includes: All active families by FSS including level of service, level changes that quarter, number of expected home visits that quarter and number of completed home visits that quarter. To calculate home visit completion: 1. Determine for each family over the course of a quarter the expected number of home visits (based on level of service alone). 2. Count the number of completed visits (while family is on active service level) for each family during the quarter. 3. For each family calculate: #2 (completed visits) divided by #1 (expected visits). 4. Count the total number of active families. 5. Subtract from #4 (total active families) the number of families who were on creative outreach for the entire quarter. 6. Count the number of active families who received at least 75% of expected home visits. 7. Program HVC rate is calculated by taking #6 (number of active families who received at least 75% of visits) divided by #5 (active families - minus CO entire quarter).	HFA Spreadsheet or local Home Visit completion reports by FSS and rolled-up by site for the most recent quarter *Note: The overall site level HVC is determined by taking the total number of families who completed at least 75% of the expected home visits based on their level of service, divided by the total number of families on active caseloads for the site (exclude families who were on creative outreach the entire quarter). It is NOT calculated by averaging the HVC for all FSSs.* This is a threshold standard, meaning to be in adherence a minimum threshold has been established (75% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Quarterly
4-3.B Services minimum of three years	Annual	Local data.	Report indicating current number of families who have been enrolled for 3 or more years. If families graduate after three years of service, provide a report indicating all families who have graduated within the last year.	Update Annually
5-4.A Staff & Family Input	Every Year	Narrative Summary	Submit a narrative summary of most recent efforts to obtain meaningful feedback from parents/caregivers and staff (current and former). Include a summary of findings: summarize patterns and trends, strengths and challenges.	Update Annually
5-4.B Equity Plan **Essential Standard**	Every Year	Submit site's Equity Plan	Please submit the most recent site equity plan. Please note: Sample of organizational self-assessments available	Update Annually

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
6-3.D CHEERS Check-In	Annual	Submit a report of all enrolled focus children (including multiples) that includes: 1. Child's date of birth 2. CCI administration dates 3. Documentation of declined screening by primary caregiver Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children.	HFA Spreadsheet or CHEERS Check-In tracking report. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Annually
6-5.B ASQ Development Screening	Ongoing- All Active Focus Children	Submit a report of all enrolled focus children that includes: 1. Child's date of birth 2. Enrollment date 3. ASQ-3 administration dates 4. Documentation of a. Indication of delay and if a referral was made b. Not screened due to involvement of early intervention services c. Revised screening schedule (prematurity or other reason) d. If the timing of re-enrolling, transferring into services, or Child Welfare Protocol enrollment precludes availability of 2 remaining intervals in a given year for contextual decision-making by Peer Reviewers or Panel. Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children.	HFA Spreadsheet or ASQ-3 Tracking Report including explanation of any missed screens. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly
6-5.C ASQ:SE Social Emotional Screening	Ongoing- All Active Focus Children	Submit a report of all enrolled focus children that includes: 1. Child's date of birth 2. Enrollment date 3. ASQ:SE administration dates since 1/1/2018 4. Documentation of a. Indication of delay b. Not screened when developmentally inappropriate Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children.	HFA Spreadsheet or ASQ-SE-2 Tracking Report including explanation of any missed screens. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly
7-1.B Medical/ Health Care Provider	Ongoing- All Active Focus Children	Submit a report reflecting: 1. List and count all active focus children 2. List and count all active focus children w/medical provider, include provider Calculate: #2 (focus children w/medical provider) divided by #1 (total number of focus children)	HFA Spreadsheet or report detailing all active focus children and their current medical/health care provider, including percent of children with a provider. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recs
7-2.B Measure Immunization Rates at 1 yr	Ongoing-All Active Focus Children	Please submit the site's immunization schedule. Also submit a report reflecting immunization rates for all enrolled focus children ages 12-23 months (including those on Creative Outreach). 1. Count number of focus children currently between 12-23 months 2. Subtract from #1 (focus children between 12-23 months) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step #2), count how many are fully up to date with all immunizations expected through 6 months 4. Report number and calculate: #3 (those up to date) divided by #2 (number between 12-23 months minus those excluded from count) Children served through CWP who are enrolled between 6-12 months of age may be excluded from the Standard 7-2.B measurement if not up to date with immunizations at one year of age. Children served through CWP who are enrolled before 6 months of age will be included in all immunization data cohorts as described in the standard (see Standard 7-2).	HFA Spreadsheet or local data report and site's immunization schedule, including immunization rate. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Every 6 Months
7-2.C Measure Immunization Rates at 2yr	Ongoing-All Active Focus Children	Submit a report reflecting immunization rates for all active focus children 24 months and older (including those on creative outreach). 1. Count number of focus children currently older than 24 months 2. Subtract from #1 (focus children 24 months and older) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step #2), count how many are fully up to date with all immunizations expected through 18 months 4. Report number and calculate: #3 (those up to date) divided by #2 (number 24 months and older minus those excluded from count) Children served through CWP who are enrolled between 18-24 months of age may be excluded from the Standard 7-C.B measurement if not up to date with immunizations at two years of age. Children served through CWP who are enrolled before 6 months of age will be included in all immunization data cohorts as described in the standard (see Standard 7-2).* Sites will include the signed MOU with CWP partners in their accreditation self-study.	HFA Spreadsheet or local data report, including immunization rate. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Every 6 Months
7-4.B Prenatal Screening Primary Care Giver for Depression	Ongoing-All Active Focus Families	Submit a report of all current primary caregivers enrolled prenatally in the past 12 months. Include: 1. enrollment date 2. date of birth of focus child 3. Prenatal screening date(s) 4. Provide an explanation of any missed screens To calculate percent screened prenatally: 1. Count number enrolled prenatally 2. Count number screened prenatally Divide #3 (screened prenatally) by #2 (enrolled prenatally).	HFA Spreadsheet or local data report, including percent screened prenatally. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
7-4.C Postnatal Screening Primary Care Giver for Depression	Ongoing-All Active Families	Submit a report of all current primary caregivers enrolled in the past 12 months. Include: 1. Enrollment date 2. Date of birth of focus child 3. Postnatal screening date(s) 4. Provide an explanation of any missed screens To calculate percent of primary caregivers screened within 3 months: 1. Count number enrolled 2. Count number screened a. For prenatal enrollments, count if received within 3 months of the child's birth b. For postnatal enrollments, count if received within 3 months of enrollment c. Add these counts together (a + b) 3. Divide #2 (screened) by #1 (enrolled) for percent screened To calculate percent of primary caregivers screened within 6 months: 1. Count number enrolled 2. Count number screened: a. For prenatal enrollments, count if received within 6 months of the child's birth b. For postnatal enrollments, count if received within 6 months of enrollment c. Add these counts together (a + b). 3. Divide #2 (screened) by #1 (enrolled) for percent screened	HFA Spreadsheet or local data report, including percent of primary caregivers screened within 3 months and within 6 months. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly
7-4.D Subsequent Birth Depression Screen	Ongoing-All Active Families	Submit a report of all current primary caregivers with a subsequent birth in the most recent 12 months. Include: 1. date of birth of subsequent child 2. Postnatal screening date(s) 3. Provide an explanation of any missed screens To calculate percent of primary caregivers screened: 1. Count number who had a subsequent birth 2. Count number screened within 3 months of the subsequent birth 3. Divide #2 (screened) by #1 (number with a subsequent birth) for percent screened	HFA Spreadsheet or local data report, including percent of subsequent births screened within 3 months. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	
8-1.B Caseload monitoring	Ongoing-All Active Families	Report indicating the active caseload for all current FSS over the past 12 months. Include each FSS's full time equivalency, the number of families assigned to them, and the level/intensity of service each family is receiving.	HFA Spreadsheet or local data report.	Update Monthly

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
9-4. Staff Satisfaction and Retention	Every other year	Submit: 1. For staff retention Include staff (by position title) who left during the timeframe (12 months for new sites, 24 months for all others), their hire date, termination date, reason why they left; and any other pertinent characteristics. 2. For staff satisfaction include a summary of staff satisfaction input in regard to work conditions that contribute both negatively and positively to job satisfaction (typically aggregated survey results) for those currently employed with the HFA site. Agency-wide staff satisfaction surveys, if used, must be filtered and reported for HFA staff only. Include strategies developed for staff retention based on what was learned from retention and satisfaction data.	Narrative reflecting factors associated with staff turnover along with satisfaction feedback from existing HFA staff utilized to develop staff retention strategies, improve diversity and inclusion, and promote equity. Include which strategies have been implemented. Please note: Sample Surveys available	Update Annually
10-2. Orientation Training	Ongoing-All Current Staff	Training Logs indicate the date of hire and the date staff person began providing direct service or supervision, along with the date each staff person (direct service staff, supervisors, and program managers) completed each of the orientation topics (10-2.A-H). Also include the date the program manager's supervisor completed 10-2.A.	HFA Training Log or local training report.	Update Monthly
10-3. Stop-Gap Training	Ongoing-All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (direct service staff, supervisors, and program managers).	HFA Training Log or local training report.	Update Monthly
10-4. HFA Core Training **Essential Standards**	Ongoing-All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (direct service staff, supervisors, and program managers).	HFA Training Log or local training report.	Update Monthly
10-5. Implementation Training	Ongoing-All Current Staff	Training Logs including hire date and date of all training topics received for program manager.	HFA Training Log or local training report.	
10-6. Screening Tools Training	Ongoing-All Current Staff	Training Logs including hire date, date of all trainings received, and date of first tool administration (or tool supervision) for all current HFA staff and supervisors who are responsible for the administration of the screening tools or supervising the use of the screening tools.	HFA Training Log or local training report.	

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
11-1. through 11.3 Wrap Around Training	Ongoing- All Current Staff	Training Logs including hire date and date of training topics received for current HFA supervisors & direct service staff. All staff at affiliated HFA sites may use the online trainings developed by HFA (or other training resources provided by the National Office) to complete the 11-1, 11-2, and 11-3 training topics. If sites use something other than HFA's recommended online wraparound training, the training will comprehensively address each of the overall topics with a variety of relevant subtopics critical for preparing staff to do this work. Program Managers will have documentation of training topics related to diversity and equity (11-1.D,11-2.G,11-3.E).	HFA Training Log or local training report.	Update Monthly
11-4. Ongoing Training	Ongoing- All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (direct service staff, supervisors, and program managers).	HFA Training Log or local training report.	Update Monthly
12-1.B Frequency and Duration of Supervision	Quarterly	Please submit a report indicating the frequency and duration of supervision sessions for the most recent quarter. 1. Determine needed frequency and duration of supervision per FTE guidelines within BPS for each direct service staff 2. Determine number of expected supervision sessions for each staff member for one quarter 3. Subtract from #2 (expected sessions) any excused sessions per guidelines provided by BPS 4. Count number of supervision sessions that occurred within proper timeframes and for expected duration 5. Divide #4 (number of supervision sessions at required duration) by #3 (expected sessions minus those excused) 6. Create report to communicate findings for each staff member	HFA Spreadsheet or local data report.	Update Monthly

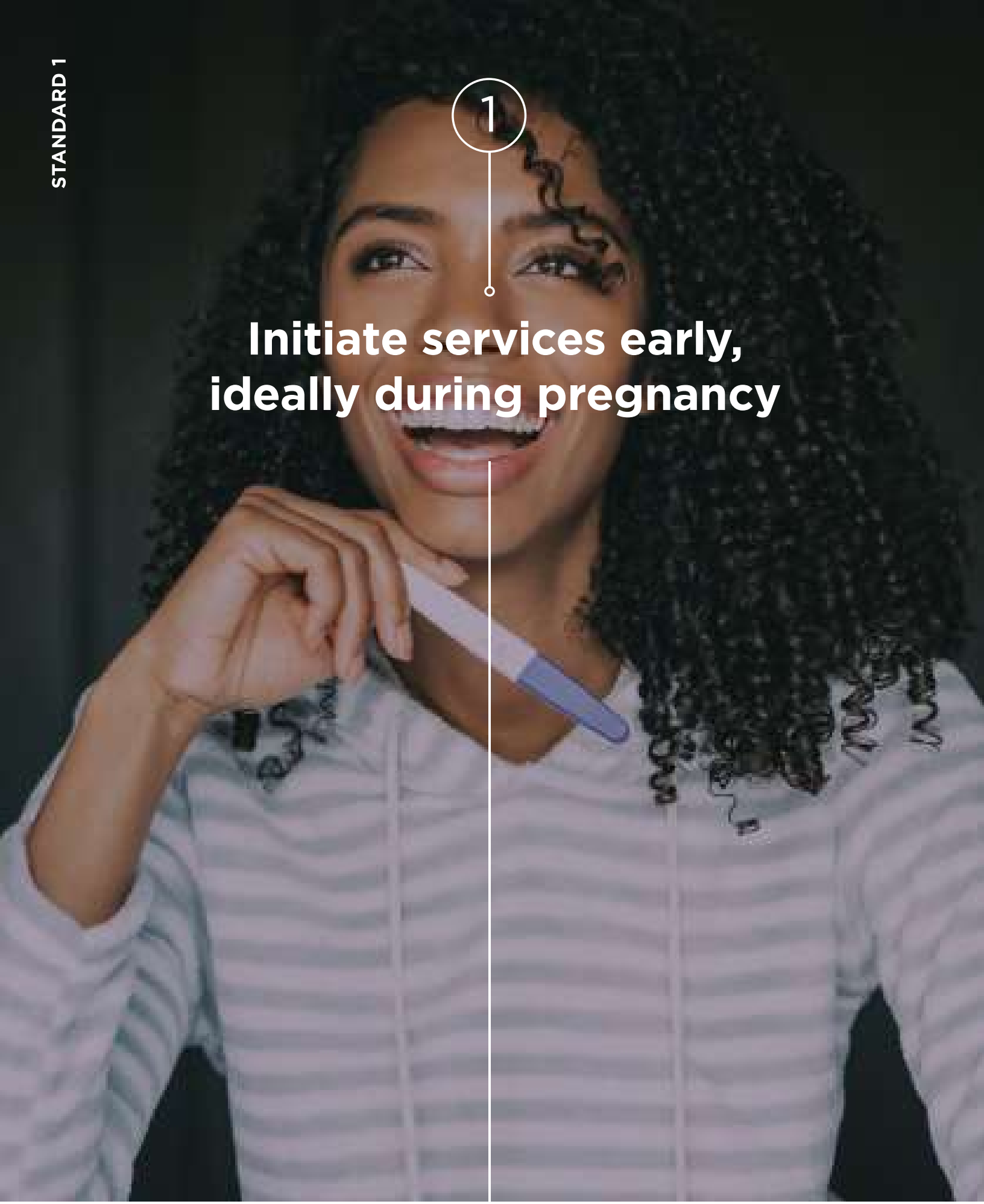
Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
GA-2.A Quality Assurance Plan	Annually	Site's Quality Assurance Plan	Please submit the site's Quality Assurance Plan including QA activities related to all aspects of site implementation (initial engagement, home visiting, supervision and management). Indicate how these activities have been implemented and follow-up mechanisms developed and implemented to address areas of improvement. Sample Quality Assurance Plan Template Available.	Update Quarterly
GA-2.B Quality Improvement Plan	Annually	Site's Quality Improvement Plan	Please submit site Quality Improvement Plan including improvement goals, improvement strategies and annual progress review. Sample Quality Improvement Plan Template Available	Update Quarterly

STANDARD 1

1

Initiate services early, ideally during pregnancy



Standard 1 Intent is to ensure the site has a well-thought out mechanism for the early identification and engagement of families who could benefit from services. The earlier families are enrolled during pregnancy the greater the opportunity to support healthy practices during pregnancy which can lead to improved birth outcomes (Lee, E., et al, 2009) and longer term parent and infant health.

When enrolled in the newborn period (0-3 months), parents can be supported with consistent, responsive, nurturing caregiving practices early in the infant's development, helping to ensure a secure attachment relationship. This timing is pivotal and research demonstrates it can increase resilience and buffer the child from later adversity (Hambrick, Brawn & Perry, 2017). Children who are securely attached as infants tend to develop stronger self-esteem and better self-reliance as they grow older and also tend to be more independent, perform better in school, have successful social relationships, and experience less depression and anxiety (Young, Simpson, Griskevicius, Huelsnitz, & Fleck, 2019).

1-1. The site has a description of its eligibility criteria and the community relationships in place to identify and initiate services during pregnancy or within three months of birth. *Please Note*: See glossary for limited exception and approval process related to HFA's Child Welfare Protocols.

1-1.A The site has a description of: 1) its eligibility criteria 2) how these criteria were selected, 3) the defined service area, and 4) the number of families the site has capacity to serve. Eligibility criteria are determined based on data collected from one or more sources, e.g., a community needs assessment, kidscount.org, state rankings, vital records, census.gov, etc., and are reviewed by the site's community advisory board at least once every four years.

Intent: Communities choose to implement the HFA model as a mechanism to improve family and child outcomes and do so because there is local, state, and/or federal interest in providing supportive home visiting services in partnership with parents of infants and young children. It is important for the site to focus on creating equitable access to services for families experiencing barriers to resources and to base its eligibility criteria on community data, ensuring a systematic process for identifying families is in place.

The site's eligibility criteria are reviewed at least once every four years and updated as changes in funding, site infrastructure, or community demographics warrant. When the site is approved to implement HFA's Child Welfare protocols for families referred from child welfare, this must be referenced in the site's eligibility criteria description.

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For example, I work with my community advisory board and we determine teen parents are the eligibility criteria we will use, because teen parents are an underserved demographic in our area and there are very few existing services in our community to support them. We know from the Kids Count Data Center (kidscount.org), in the most recent year data is available, a total of 1,000 women under the age of 20 gave birth in our area. We also know 780 women under the age of 20 gave birth in our city's largest birthing hospital last year. We therefore define our eligibility criteria as pregnant or parenting teens (with an infant less than 3 months old), who reside in Babyville County. We have ten full-time Family Support Specialists able to serve a total of 200 families each year.

1-1.A RATING INDICATORS

3 The site has a description of 1) its eligibility criteria 2) community data (include source and year) used in deciding on these criteria, 3) the geographic service area, and 4) the total number of families projected annually to be served based on site capacity. The description and data utilized have been reviewed by the site's community advisory board **within the last two years,** and adjusted as needed based on changing community demographics or program infrastructure.

2 The site has a description of 1) its eligibility criteria 2) community data (include source and year) used in deciding on these criteria, 3) the geographic service area, and 4) the total number of families projected annually to be served based on site capacity. Both the description and data utilized have been reviewed by the site's community advisory board **within the last four years** and adjusted as needed based on changing community demographics or program infrastructure.

1 The site does not yet have a description of its eligibility criteria; or any of the following are not yet included: community data (source and year), service area, or total number of families projected annually to be served; or it has been four years or more since the community advisory board last reviewed.

TIP: Sites are encouraged to be realistic when identifying eligibility criteria. For example, while it is commendable to want to reach all families giving birth, fiscal capacity or limited staffing may make this goal unrealistic.

TIP: Eligibility criteria may include factors such as: parent age, Medicaid eligibility, geographical area, first time pregnancy, a particular number of positive screen factors, a certain score or higher on the Family Resilience and Opportunities for Growth (FROG) Scale, etc.

1-1.B The site establishes organizational relationships with community providers for purposes of identifying families and receiving referrals (e.g., local hospitals, prenatal clinics, high schools, centralized intake systems, etc.). Please Note: for sites approved to use HFA's Child Welfare Protocols, a formal Memorandum of Understanding (MOU) between the HFA site and local child welfare office is required. HFA has a sample MOU.

Intent: In addition to the site's description of its eligibility criteria and process for determining eligibility, the site will indicate the community providers who identify and refer families to HFA services. In order for sites to engage families, it is essential to create relationships with community entities who come into contact with families. In some cases these community partnerships may require formal Memorandums of Understanding/Agreement (MOU/MOA), and in other cases these relationships may be verbal agreements or informal in nature. In either case, it is important these relationships allow site staff to initially engage with families. The site will decide if a formal agreement would be beneficial with some of its referral sources. Some sites may have only formal agreements in place, while others will have only informal (verbal) agreements in place, and others still may have a mix of both formal and informal.

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

1-1.B RATING INDICATORS

3 No 3 rating indicator for 1-1.B.

2 The site identifies organizations within the community where families can be referred from, and agreements (either formal or informal) are in place. Sites approved by the National Office to implement HFA's Child Welfare Protocols have an MOU established with the local child welfare office.

1 The site does not yet identify organizations within the community where families can be referred from, or the site has not yet initiated relationships with identified referral organizations; or if approved to use HFA's Child Welfare Protocols, does not have an MOU established with the local child welfare office.

1-1.C The site tracks the number of families identified or referred by referral source, and their eligibility status. The site implements strategies to help maximize existing program capacity and support family needs in the community. *Please Note:* An HFA Spreadsheet is available for this standard.

Intent: Tracking the number of families identified or referred allows the site to utilize data effectively to advocate for families in the community whose needs may go unmet. For example, there may be many more potential families than can be served owing to the site's current capacity. This data provides the site with valuable information to maximize existing staff capacity, allowing the site to determine what dynamics might be getting in the way of engaging families in services.

Monitoring the system of organizational relationships is a key component to understanding how families are identified or referred. The site will use this data to develop strategies to improve its identification and referral processes (e.g., form new community provider relationships, strengthen existing provider relationships, provide in-service training for referral agencies including how to describe services in ways that may be more appealing to families, create more effective ways to identify families in the service area, etc.).

For example, over the past four quarters, the Babyville HFA site received a total of 350 referrals, with 210 referrals from the birthing hospital, 90 from WIC, 46 from a local food pantry, and 4 self-referrals; however, 100 of these referrals were duplicates or did not meet eligibility criteria because they either resided outside the county or were not teens. As a result 250 referrals received in the past year met eligibility criteria. With ten full-time Family Support Specialists, we have capacity to serve 200 families at any given time, and have remained at capacity each of the last four quarters. One hundred twenty (120) of the 250 referrals could not be served given current capacity limitations. Since we have seen similar trends over the past two years, Babyville's community advisory board has helped identify potential funding sources to support an additional 1-2 Family Support Specialists. We are in the process of applying for these funds.

1-1.C RATING INDICATORS

3 The site tracks at least quarterly all families identified or referred to Healthy Families services, indicating whether the family was eligible or not, and the source of each referral. The site, in conjunction with its community advisory board, uses this data to monitor program capacity and apply strategies to fill available slots when not yet at full capacity, and, when at capacity, to reduce gaps in service availability. The site discusses with its community advisory board opportunities for improvement at least once annually.

2 The site tracks at least quarterly all families identified or referred to Healthy Families services, indicating whether the family was eligible or not, and the source of each referral. Past instances may have occurred when the site did not track data quarterly or use this data to apply strategies to fill available slots or reduce gaps in service availability, however **recent practice** indicates this is now occurring. The site discusses with its community advisory board opportunities for improvement at least once annually.

1 Any of the following: the site has not yet tracked at least quarterly all families identified or referred; or does not yet identify the referral source; or has not yet applied strategies to increase capacity, or in conjunction with its community advisory board, discussed opportunities for improvement at least once annually.

TIP: When working in partnership with an external entity providing centralized intake, it will be important to have a formal agreement in place allowing reciprocal sharing of aggregate data. This includes how many families are being identified and referred to HFA by centralized intake and how many of these referrals are engaging in services. When partnering with centralized intake entities, it is important to periodically review criteria prompting referral to Healthy Families to ensure it is neither too broad nor too restrictive.

1-2. The site ensures all referrals into the HFA site are tracked and monitored from receipt of referral to the offer of services.

1-2.A The site has policy and procedures regarding initial engagement processes and mechanisms (from referral to offer of services) to ensure timely determination of eligibility and offer of service. Policy and procedures include each step of the process for all referrals, from receipt of referral to offer of service, the site's tracking and monitoring requirements, and documentation of reasons why when families are not offered services.

1-2.A RATING INDICATORS

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

2 The site's policy and procedures include the following information:

- Activities and expected timeframe between receipt of referral and initial contact with family
- Activities and expected timeframe between initial contact with family and offer of services
- How and when eligibility is determined
- Mechanisms to track and monitor each step of the initial engagement process, whether able to establish initial contact or not, whether services were offered or not, and the timeliness of these activities
- Documentation of reasons why if families are not offered services

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

TIP: Things to consider 1) how do you receive referrals? 2) what eligibility criteria do you use? 3) what happens if a family does not meet these criteria?

TIP: Throughout the process, what are the points of contact with families? Which staff are responsible for these points of contact, and what is the goal for each step in the process? How quickly should this process move?

What is documented along the way (and where)? Is follow-up with the referral sources expected?

Are the policies and procedures detailed enough so someone unfamiliar with your site's process can carry out initial engagement by reading the policy?

TIP: It is recommended sites utilize the following timeframes, which help demonstrate to the family the site's responsiveness and the site's genuine care and concern for the family. A shorter window between referral and contact with the family has been demonstrated to increase the likelihood of successful engagement in services (unless site is at full capacity):

- Ideally less than five business days between receipt of referral and initial (actual or attempted) contact with family
- Ideally less than five additional business days between initial contact (actual) and offer of services

1-2.B The site monitors its initial engagement process, tracking the timeliness from receipt of referral to offer of service, whether able to establish initial contact or not, whether services are offered or not, and reasons why if families were not offered services.

Intent: Many families miss the opportunity to participate in services because site staff is unable, for a variety of reasons, to establish or maintain contact with them subsequent to the initial referral. Therefore, sites monitor closely the initial engagement process.

Please Note: For sites working with a centralized intake system that offers HFA services to families, the site will consider the offer of services to occur after the site receives the referral and contacts the family themselves to offer services.

Please Note: During times when HFA caseloads are at capacity, sites are discouraged from maintaining families on a waitlist. Telling eligible families they are on a waitlist conveys a promise of eventual enrollment, which may not be possible. It may be several months before an opening occurs and urgent or immediate needs the family has would go unattended, potentially at dire consequence to the family or child, bringing a liability risk to the HFA host agency. In such situations, a referral to other community services is preferred to wait-listing the family (unless a known opening is about to occur). Most often, the reason sites use a waitlist is to ensure caseload capacity can be maintained should a family leave services early. While this may be in service to the agency to demonstrate consistent capacity levels, it is not in service to the family. It also undermines the ability to initiate services as early as possible.

1-2.B RATING INDICATORS

3 The site monitors its initial engagement process. For each family referred, the site tracks the length of time from referral to offer of services, whether able to establish initial contact or not, whether services were offered or not, and when services are not offered to the family, reasons why are documented.

2 The site monitors its initial engagement process. Past instances may have occurred when the site did not track each family referred, including the length of time from referral to offer of service, whether able to establish initial contact or not, whether services were offered or not, and when services were not offered to the family, reasons why were not documented, however **recent practice** indicates this is now occurring.

1 The site does not yet monitor its initial engagement process; or track the timeliness of its initial engagement process from referral to offer of service; or, when services are not offered, the reasons why are not yet being documented.

1-2.C The site develops strategies, based on its data from 1-2.B, to strengthen its initial engagement process with families, aiming to reduce barriers and provide equitable access to HFA services.

Intent: The intention behind all data collection should be the opportunity to monitor quality and to guide continuous quality improvement efforts. With data the site collects for standard 1-2.B, it will develop strategies for increasing the capacity of the site to connect with families and improve initial engagement.

1-2.C RATING INDICATORS

3 The site has **applied strategies** to improve the initial engagement process or 90% of families referred received initial contact and were offered services, in which case strategies do not need to be applied.

2 The site has **developed strategies** to improve the initial engagement process.

1 The site has not yet developed strategies to improve the initial engagement process.

TIP: Sites are encouraged to follow-up with referring entities (assuming referring organization has a signed consent in place for information sharing) to provide information regarding the outcome of their referral(s), including when the initial contact with the family is not completed.

1-3. The first home visit occurs within three months after the birth of the baby for at least 80% of families; for sites approved to use HFA's Child Welfare Protocols, the first home visit occurs within twenty-four months for at least 80% of families referred from child welfare.

See glossary for limited exception and approval process related to HFA's Child Welfare Protocols.

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

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

The earlier the alliance between Family Support Specialist and parent is formed, the greater the likelihood of increased family engagement and retention, and improved outcomes.

1-3.A The site has policy and procedures describing activities to ensure at least 80% of families receive a first home visit prenatally or within the first three months after the birth of the baby (i.e., up until the baby turns 3 months of age), or within 24 months for families referred from child welfare (when approved by the National Office to use HFA's Child Welfare Protocols).

1-3.A RATING INDICATORS

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

2 The site's policy and procedures describe the site's activities to ensure: the first home visit occurs prenatally or within the first three months after the birth of the baby for at least 80% of families; or for sites approved to use HFA's Child Welfare Protocols, within twenty-four months for at least 80% of families referred from child welfare.

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

1-3.B The site's practices ensure, for families who accept services, the first home visit occurs prenatally or within the first three months of the birth of the baby, or within 24 months of birth for sites approved to use HFA's Child Welfare Protocols, for at least 80% of families initiating services in a given year.

Please Note: When infants begin life with an extended hospital stay in the NICU, it may not be possible to begin home visits until after 3 months. These situations must be documented and will be exempted from the requirements of this standard.

Please Note: Sites approved to implement HFA's Child Welfare Protocols will calculate separately the percentage of families referred from child welfare with at least 80% or more of first home visits by 24 months of age.

Please Note: Sites are encouraged to accept transfers from other sites whenever appropriate and to re-enroll families with the same focus child when previously closed from services. Any transfers or re-enrollments when the child is already 3 months old or older will be exempted from this calculation. Re-enrollment of graduate or soon-to-graduate families (on Level 3) with a new focus child (based on a subsequent pregnancy) is discouraged, given the progress the family has already demonstrated, and to ensure space is available to enroll brand new families.

1-3.B RATING INDICATORS

3 Ninety-five percent (95%) through one hundred percent (100%) of first home visits occur prenatally or within the first three months after the birth of the baby, and within twenty-four months after the birth of the baby for families referred from child welfare (when site has been approved to use HFA's Child Welfare Protocols).

2 **Eighty percent (80%) through ninety-four percent (94%)** of first home visits occur within the timeframes described in the 3 rating.

1 Less than eighty percent (80%) of first home visits occur within the timeframes described in the 3 rating.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% threshold, and supervision time is used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

1-4. The site measures the acceptance rate of families offered services on an annual basis and in a consistent manner and, at least once every two years, analyzes its data associated with family acceptance to better understand the underlying issues associated with families choosing to accept services or not.

1-4.A The site measures annually (12 consecutive months of data whether calendar or fiscal year) the acceptance rate of families offered services, using HFA methodology (based on receipt of first home visit and using both numbers and percentages). When measuring and analyzing, sites can use the An HFA Spreadsheet is available for this standard.

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

1-4.A RATING INDICATORS

3 The site measures its acceptance rate of families (using HFA methodology) into services and acceptance rates are being **measured more than once a year.**

2 The site measures its acceptance rate of families (using HFA methodology) into services and acceptance rates are being **measured annually.**

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

1-4.B For sites with 50 or more families offered Healthy Families services over a two-year period, the site analyzes its data, to identify to identify possible reasons for changes in the site's acceptance rate, comparing data for families who accept services to those who decline services (including the reasons why families decline services). Please see glossary for common terms associated with analyses. An HFA Spreadsheet is available for this standard.

For smaller sites with less than 50 families offered services over a two-year period, the site will at a minimum review anecdotal information from staff about any patterns associated with acceptance and reasons why families are not accepting services, at least once every two years. The site will do a more thorough analysis when the sample size over a two-year period is 50 or more.

Intent: Sites conduct a thorough acceptance analysis at least once every two years to determine possible reasons for changes in the site's acceptance rate. The analysis examines various factors of those who accept services (demonstrated by completion of a first home visit) compared with those, during the same time period, who were offered services yet never received a first home visit. The site will determine which factors it analyzes based on trends or patterns it has observed. The intent is to ensure the analysis can yield meaningful results that lead to activities to address underlying causes and increase acceptance as a result (see GA-2.B) *Please Note*: Sites can analyze data more frequently than every other year if beneficial to the site. *Please Note*: Brand new sites will complete a first analysis with one year of data instead of two. If the site is both new and small (fewer than 25 families offered services over one year; or less than 50 over two years), they will report on informal information and reasons why for families who declined services.

1-4.B RATING INDICATORS

3 The site uses formal data (numbers and percentages) and anecdotal information from staff to analyze, at least once every two years, families who declined services and why. The analysis examines data to identify and better understand possible reasons for changes in the site's acceptance rates. The analysis **includes at least three (3)** factors in its comparison of those who accepted and those who declined during the same time period

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

2 The site uses formal (numbers and percentages) and anecdotal information from staff to analyze, at least once every two years, families who declined services and why. The analysis examines data to better understand possible reasons for changes in the site's acceptance rates. The analysis **includes one or two factors** in its comparison of those who accepted and those who declined during the same time period.

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

1 Any one of the following:

1) the site does not yet have an analysis of who declined services and why

2) the analysis does not yet include both formal data and anecdotal information

3) the analysis does not yet include a comparison of any factors of those who accepted and those who declined during the same time period

4) the analysis is not yet conducted at least once every two years

5) if a smaller site, the site has not yet, at a minimum, collected informal data and reasons why families are not accepting

NA The site did not offer HFA services to any families in the last two years, or there were less than 10 families who declined service during the two-year period to determine any patterns.

TIP: While sites choose which factors to include in their acceptance analysis it is recommended sites consider the role race and ethnicity may have on acceptance. In addition it is recommended that sites consider the impact of factors related to the program (such as staffing issues, or policy issues) may have on family acceptance. Sites are encouraged to reflect on any trends observed from the last acceptance analysis to the present one, and any lessons to be learned.

Tables of Documentation

*Note: Submit Self Study Face Sheet with Self Study

1. Initiate services early, ideally during pregnancy.

Standard	Pre-Site Documentation to include in Self Study
1-1.A | Eligibility Criteria	Submit a narrative description of: 1) Site eligibility criteria 2) how these criteria were selected, 3) the defined service area, and 4) the number of families the site has capacity to serve. Eligibility criteria are determined based on data collected from one or more sources and reviewed at least once every four years.
1-1.B | Referring Organizations	Submit a narrative identifying organizations within the community where families can be referred from, and the formal/informal agreements in place. Sites approved by the national office to implement HFA's Child Welfare Protocols have an MOU established with the local child welfare office. Sample MOU available.
1-1.C | Tracking Referrals and Site Capacity	Submit report reflecting all families referred in the most recent quarter: 1. Number of families referred by each referral source 2. Their eligibility status 3. Include most recent plan with strategies to fill available slots or reduce gaps in service availability and indicate which have been applied Please note: An HFA Spreadsheet is available for data elements of this standard
1-2.A | Policy – Initial Engagement Process	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
1-2.B | Initial Engagement Process	Submit a narrative about how the site monitors its initial engagement process and activities reflecting all families referred in the most recent year. A data report may be submitted in combination with a narrative regarding engagement activities. HFA's spreadsheet includes: 1. The length of time from referral to initial contact 2. The length of time from initial contact to offer of services 3. Whether able to establish initial contact or not 4. Whether services were offered or not 5. Reasons why if services not offered Please note: An HFA Spreadsheet is available for this standard.
1-2.C | Initial Engagement Process - Developed Strategies	Submit a narrative of developed strategies (based on data from 1-2.B) to improve the initial engagement process with families reducing barriers to ensure equitable access to HFA services.
1-3.A | Policy - First Home Visit Within 3 Months or Within 24 Months if Approved To Use CWP	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available

Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
1-3.B | First Home Visit Within 3 Months	Submit a report reflecting all families who received a first home visit in the most recent year. 1. Count number with a first home visit 2. Count number with first home visit either prenatally or within 3 months of birth 3. Calculate: #2 (number with first home visit prenatally or within 3 months) divided by #1 (number who had a first home visit) For sites enrolling families through Child Welfare Protocols (CWP), remove CWP families from the calculation above to calculate CWP families separately, 1. Count CWP number with a first home visit 2. Count CWP number with first home visit within 24 months of birth 3. Calculate: 2. (number with first home visit within 24 months) divided by 1. (number with a first home visit) Please note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
1-4.A | Measure Acceptance Rate	Submit a narrative describing the site's definition of acceptance rate and method for calculation (unless using HFA spreadsheet) and the current acceptance rate for all families offered services in the most recent year. 1. Count number offered HFA home visiting services 2. Count number with a first home visit 3. Calculate: #2 (number with a first home visit) divided by #1 (number offered services) Please note: An HFA Spreadsheet is available for this standard.
1-4.B | Acceptance Analysis	Analyze the data from all families who were offered services during at least the most recent year. Analyze both formally and informally: 1. Families who refused services in comparison to families who accept services 2. Includes at least one analysis factor 3. The reasons why families decline Please note: An HFA Spreadsheet is available for formal analysis. Please see glossary for more information on analysis. For smaller sites with less than 50 families offered services over a two-year period, the site is required at a minimum to submit a narrative including: 1. The number of families offered services within the two-year period 2. Informal data about families who refuse services or accepts services 3. Reasons why families are not accepting services For sites not required to complete Acceptance Analysis, submit a narrative describing the reason for exemption: If at least ninety percent (90%) of families offered services over a two-year timeframe accepted services by receiving a first home visit, an analysis is not required. New sites not yet in operation for two full years with an acceptance rate of 90% during the first year are also exempt from completing an analysis.

2

Sites use the validated Family Resilience and Opportunities for Growth (FROG) Scale to identify family strengths and concerns at the start of services.

Standard 2 Intent is to ensure the site has an objective process for learning about each family's strengths and concerns at the start of services. The FROG Scale is a family-centered tool used to identify the presence of both protective factors that promote resilience and factors associated with increased risk for child maltreatment or other adverse childhood experiences. It is used at the start of services to guide initial service planning and ongoing support services for the family throughout the course of services based on their identified strengths and needs.

2-1. The site is required to use the FROG Scale at the start of services to provide the family an opportunity to tell their story, to identify the presence of protective factors as well as factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences, and to support the development of a service plan to support the unique needs of each family.

Intent: Parents/caregivers represent a broad variety of backgrounds, experiences, values, and cultural norms, and these are combined in unique ways in each individual family. What may appear as a risk factor in one family may be mediated by nurturing relationships and/or significant protective factors in another. By completing the Family Resilience and Opportunities for Growth (FROG) Scale, staff learn about each family's strengths and concerns and are better able to plan services and resources that will be of most interest and benefit to the family.

2-1.A The site has policy and procedures requiring the FROG Scale be administered to identify risk and protective factors that could contribute to or mediate the risk for child maltreatment or other adverse childhood experiences. The policy and procedures also require documentation of these risk and protective factors be completed in narrative format that fully describes the concerns/needs and strengths expressed by the parent(s) during the FROG Scale conversation, and all items are scored in accordance with the guidelines of the tool. The policy and procedures identify who is responsible for administering the tool and the timeframe for completing the narrative, including supervisor review.

Intent: Site policy and procedures ensure the FROG Scale is administered objectively and reliably, and in a relationship-building, conversational style. Using a conversational style allows parents to share their story in a way that makes sense to them and enables staff to follow up for greater understanding of the family's experiences. When parents are able to tell their story at the onset of service (or as soon as possible thereafter), the parent feels heard and valued. The intent with the FROG Scale is for staff to explore all areas while understanding parents are only expected to share as much as they are comfortable sharing. Doing so conveys the respect all families deserve, and sets the stage for a genuinely attentive and responsive relationship.

Site policy also includes expectations for the documentation of the FROG Scale narrative to ensure it conveys accurately what each family shared in regard to strengths, risk factors, questions, and concerns. Consistent documentation in this way ensures accurate scoring of the tool and provides Family Support Specialists with an understanding of each family and an opportunity to provide individualized service planning based upon each family's unique strengths and concerns.

The FROG Scale is completed in as timely a way possible, i.e., no later than the fourth home visit (ideally within 30 days of enrollment though the fourth home visit may extend beyond 30 days if parents are not immediately receptive to weekly home visits).

Please Note: Some sites choose to use the FROG Scale to determine eligibility, in which case it will be completed prior to the first home visit.

2-1.A RATING INDICATORS

3 The site policy and procedures require:

1) The FROG Scale is completed **on or before the first or second home visit (ideally within a single visit and no later than within 15 days from enrollment).**
2) The FROG Scale is documented in narrative format detailing the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences. Any area not yet documented is identified for later conversation and inclusion in the service plan when needs warrant (the same is true for any updated information a family shares at a later time).
3) Responses from parents (or partner/significant other) present at the FROG visit are scored (0-4 or UR) in all domains the parent shared information for. When staff do not explore a particular area of the FROG, the reason is documented.
4) The timeframe for completing the narrative documentation and scoring is identified.
5) The process and timeframe for supervisor review and feedback are identified.

2 The site policy and procedures require:

1) The FROG Scale is completed **by the third or fourth home visit (ideally within a single visit and no later than 30 days from enrollment).**
2) The FROG Scale is documented in narrative format detailing the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences. Any area not yet documented is identified for later conversation and inclusion in the service plan when needs warrant (the same is true for any updated information a family shares at a later time).
3) Responses from parents (or partner/significant other) present at the FROG visit are scored (as 0-4 or UR) in all domains the parent shared information. When staff do not explore a particular area of the FROG, the reason is documented.
4) The timeframe for completing the narrative documentation and scoring is identified.
5) The process and timeframe for supervisor review and feedback are identified.

1 The site does not yet have policy and procedures including the detail listed in the 2 rating.

2-1.B The FROG Scale is administered and documented uniformly and in accordance with site policy and procedures.

2-1.B RATING INDICATORS

3 The FROG Scale is administered and documented in accordance with site policy and procedures.

2 Past instances may have occurred when the site did not administer and document the FROG Scale in accordance with site policy and procedures; however, **recent practice** indicates this is now occurring.

1 The site does not yet administer and document the FROG Scale in accordance with site policy and procedures.

Note: This is an Essential Standard.

TIP: Sites are encouraged to highlight/document specific conversations indicating a parent(s) motivation for change (e.g., statements such as, "I don't want to parent the same way as my parents," "I really want to finish school," "I want to learn everything I can to meet my baby's needs," "I want to stay clean for my baby," or "I am not going to use a belt to discipline my baby"). Statements like these assist FSSs in identifying potential starting points for home visit activities and can facilitate connections with families.

TIP: Information gathered on the FROG Scale is used throughout the time a family is enrolled in HFA for ongoing service planning and is the basis for standards 6-1.A, 6-1.B, and 6-1.C.

2-1.C The FROG Scale is administered within the timeframe identified in the site's policy and procedures.

2-1.C RATING INDICATORS

3 The FROG Scale is administered within the timeframe identified in the site's policy and procedures (by the 2nd visit or the 4th visit).

2 Past instances may have occurred when the site did not administer the FROG Scale within the timeframe identified in the site's policy and procedures (by the 2nd visit or the 4th visit); however, **recent practice** indicates this is now occurring.

1 The site does not yet administer the FROG Scale within the timeframe identified in its policy and procedures.

2-1.D Supervisors provide support and skill building to staff such that FROG conversations are done in a manner that is respectful, culturally responsive, and strength-based. Supervisors review and provide feedback to staff who administer the FROG Scale to ensure consistent quality of scoring and documentation.

2-1.D RATING INDICATORS

3 Supervisors review and provide feedback to staff each time the tool is administered to ensure documentation is complete, scoring is accurate, and staff are supported over time in the way they engage families in the FROG Scale conversation.

2 Past instances may have occurred when the supervisor did not review and provide feedback to staff each time the tool is administered or support staff over time in the way they engage families in the FROG Scale conversation; however, **recent practice** indicates this is now occurring.

1 Supervisors do not yet review, provide feedback, and support staff each time the FROG Scale is administered.

TIP: When supervisors attend FROG Scale training, they are encouraged to complete post-training feedback activities with their trainer. Doing so helps to develop a process supervisors can use with their staff for ongoing review and feedback.

TIP: At the time of a site visit, a supervisor's initials or signature on the FROG Scale, along with notes in the staff Supervision binder can be used to indicate the review and feedback process and demonstrate that staff are receiving support and skill building over time in the way they engage families in the FROG conversation. Supervisors may choose to save the initial draft of the FROG Scale narrative, with comments they provided or suggestions for alternate scoring, though that is not required.

TIP: Supervisors are strongly encouraged to review the FROG Scale within five business days of administration (allowing staff 1-3 business days to complete documentation and the supervisor an additional 1-2 business days to review after receiving it from staff). This helps ensure the family's immediate concerns can be addressed promptly and service planning can begin in as timely a way as possible.

Tables of Documentation

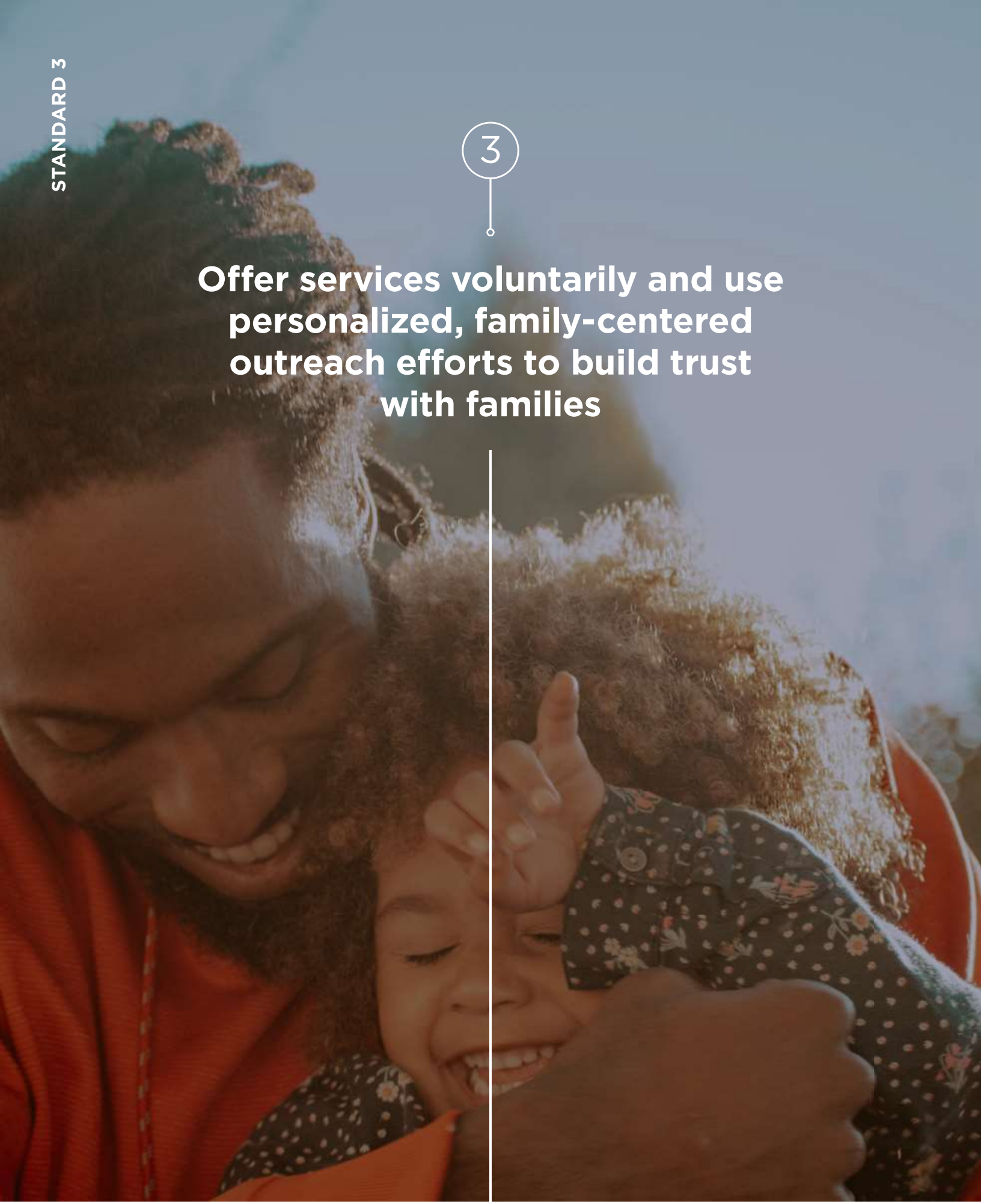
2. Sites use the validated Family Resilience and Opportunities for Growth (FROG) Scale to identify family strengths and concerns at the start of services.

Standard	Pre-Site Documentation to include in Self Study
2-1.A | Policy - FROG Scale	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
2-1.B | FROG Scale Uniformity **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
2-1.C | FROG Scale Timeframes	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
2-1.D | FROG Scale Supervision	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

STANDARD 3

3

Offer services voluntarily and use personalized, family-centered outreach efforts to build trust with families



Standard 3 Intent is to ensure the site has an equitable process for reaching out to and engaging families initially as well as throughout the time families choose to remain enrolled. HFA's emphasis on trust-building informs the HFA Advantage–a relationship-focused and trauma-informed approach to working with families. Staff interact with families utilizing the components of secure attachment–safety, predictability, comfort, and pleasure–to develop trust. Providing outreach in this way reflects our commitment to families and demonstrates our understanding of the impact that institutional and generational mistrust and misuse of power have created. The HFA approach to outreach seeks to address some of the power imbalances that can be found in helping relationships by putting parents in control and engaging with them in partnership.

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

Intent: Offering services voluntarily (allowing families to choose to participate) increases trust and receptivity. Research suggests an important reason for voluntary services is 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).

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

3-1.A RATING INDICATORS

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

2 The site has policy and procedures regarding the voluntary nature of site services, including how this information is shared with families.

1 The site does not yet have policy and procedures regarding the voluntary nature of services, including how this information is shared with families.

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

Intent: HFA is very clear about services to families being offered voluntarily; however, there may be some external agencies who require HFA as part of mandated treatment (e.g., child welfare, court systems, substance abuse treatment facilities, etc.). HFA does not have authority to prevent this type of referral: however, sites should remind referral entities of such and clarify with families that regardless of the intent of the referral entity, HFA services are voluntary and families may end services at any time. Doing so helps to reduce stigma and fear, and establishes for parents a greater sense of personal power and control.

Additionally, when the site enrolls families already open and active with child welfare (CPS), whether referred directly from CPS or not, and whether the site is approved to implement HFA's Child Welfare Protocols or not, HFA staff are not to monitor family's progress on behalf of CPS or the court. Sharing of family service information with child welfare or the court system is bound by HFA's confidentiality requirements and informed consent process (GA-3) (unless subpoenaed or directed by statute) which is authorized by the parent and indicates precisely what information is to be shared. Additionally, it may be important to inform families that sharing such information may not always be helpful to the family's situation.

3-1.B RATING INDICATORS

3 The site practice clearly indicates services are offered to all families solely on a voluntary basis.

2 Past instances may have occurred when services were not provided voluntarily to all families; however, **recent practice** indicates services are now offered to families solely on a voluntary basis.

1 There are instances in which services are not yet provided voluntarily.

3-2. Staff utilizes positive pre-enrollment outreach methods to build family trust and engage new families.

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

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

3-2.A RATING INDICATORS

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

2 The site has policy and procedures specifying a variety of positive methods to build family trust when engaging new families to enroll in services.

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

TIP: Pre-enrollment outreach methods are best when personalized and may include:

- warm telephone calls focused on the family's well being
- creative and upbeat notes which encourage parents to want to participate
- drop-by visits (exercising safety) and leaving a card when families are not home
- texting brief messages to let a parent know you are thinking about them
- anchoring conversations based on family's interests
- encouraging self-care practices

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

3-2.B Staff utilize positive methods to build family trust when engaging them to enroll in services.

Intent: Staff utilize a variety of strategies to engage and enroll families in services. Research indicates families who have experienced generational abuse are at greater risk for difficulty in developing healthy relationships with others and are often reluctant to accept a partnership with direct service staff (Fraiberg, 1975). Staff will develop unique ways to connect with families.

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

3-2.B RATING INDICATORS

3 Site staff use positive methods to build family trust when enrolling families in services.

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

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

3-3. For families that have had at least one home visit, the site offers post-enrollment outreach (level CO) for a minimum of three months before discontinuing services (or for a cumulative three-month period over six consecutive months). Families remain at the case weight of the level they were on prior to moving to CO.

3-3.A The site policy and procedures specify when families are placed on a post-enrollment outreach level and the activities to be carried out (and documented) while the family is on outreach. The site maintains the case weight at the level prior to CO and all post-enrollment outreach levels are continued for three months (or for a cumulative three-month period over six consecutive months). Creative Outreach is only concluded prior to three months when families have engaged in services, declined services, moved from the area, or closed due to other allowable reasons (bolded below in the intent).

Families who are assigned a permanent worker from Level TR or returned to the service area from Level TO, but who are unable to be engaged on an active service level, will be moved to Level CO. In these situations, the cumulative time on TR or TO plus CO will be for a minimum of 90 days.

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

Creative outreach activities are uniquely tailored to the individual family and are focused on demonstrating to the family that the Family Support Specialist is genuinely interested in them and wanting to continue to offer services. Creative outreach activities occur consistently and at the frequency associated with their previous level throughout the three-month time period. Sites are advised to avoid correspondence demanding the family contact the site or threatening termination from services. While services may end up being terminated after the three-month timeframe, correspondence indicating such will likely add to the feelings of alienation and lack of trust families have. Repeated, positive attempts at interaction through personalized notes and texts may be more effective in establishing a trusting relationship.

Site policy will include criteria for closing prior to three months only if the family re-engages in service, declines services, moves out of the service area, or other allowable reasons for ending services **(parent no longer has custody, pregnancy terminated or ended in miscarriage, focus child or primary care provider is deceased, significant staff safety issues, or transferred to another program).**

Please Note: Use of outreach level change forms can be helpful to keep track of dates when changes in service level occurred but are not required if start and end dates of outreach are maintained in a data system. Only levels that require progress criteria be met for movement to less frequent visits are required to be maintained in the family record.

3-3.A RATING INDICATORS

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

2 The policy and procedures specify:

- when families will be placed on a post-enrollment outreach level (CO)
- the activities to be carried out and documented during the course of outreach
- outreach is continued for 3 months and the case weight from the family's previous level is maintained during this time
- CO is only concluded prior to 3 months (whether 3 consecutive months or 3 cumulative months during a consecutive 6-month period) when families have engaged in services, declined services, moved from the service area, other allowable reasons (parent no longer has custody, pregnancy is terminated or ends in miscarriage, focus child or primary care provider is deceased, significant staff safety issues, or transferred to another program), or permanent staff assignment has been reestablished.

1 The site does not yet have policy and procedures; or the policy and procedures do not yet address all points required in the 2 rating.

TIP: Post-enrollment outreach methods are best when personalized and may include:

- warm telephone calls focused on the family's well being
- creative and upbeat notes which encourage parents to want to participate
- drop-by visits (exercising safety) and leaving a card when families are not home
- texting brief messages to let a parent know you are thinking about them
- anchoring conversations based on family's interests
- encouraging self-care practices

TIP: It is common for families to go on and off creative outreach several times, particularly when the parent has a history of past relationships that have been unsafe, unstable, or unpredictable. Reluctance to engage may be a form of self- and family protection to avoid repeating a pattern of being hurt or victimized by others. Reluctance to engage might be one of few mechanisms a parent feels able to use in order to establish some amount of control over their lives. When the Family Support Specialist offers positive, attentive creative outreach activities, it demonstrates to the parent our genuine caring for the family.

TIP: Some of the most poignant and powerful stories of family outcomes are with families who were initially very hard to engage and were on and off creative outreach. Some sites have reported as many as 40-60% of families engage from creative outreach, which is tremendous. When considering the high-risk circumstances of families' lives and the vulnerability of babies, re-engaging just one family is a huge success.

TIP: It is recommended the Family Support Specialist check in with families regularly to obtain new or additional emergency contacts. Having updated secondary contact information, and consent from the parent to use if unable to locate, can make a significant difference in maintaining connections with families over the course of service delivery.

3-3.B Families disengaging from services are placed on post-enrollment outreach (level CO) and outreach activities are continued for at least three months (or for a cumulative three month period over six consecutive months), only concluding outreach prior to three months when families have engaged in services, declined services, moved from the area, or other allowable reasons as stated in the 3-3.A intent.

3-3.B RATING INDICATORS

3 The site places families disengaging from services on outreach appropriately, conducts activities while on outreach to engage the family, and continues creative outreach for at least three months. The only instances found when outreach was concluded prior to three months occurred when the family engaged in services, declined services, moved from the area, for other allowable reasons (parent no longer has custody, pregnancy ended in miscarriage, focus child or primary care provider is deceased, significant staff safety issues, or transferred to another program), or permanent staff assignment has been established.

2 Past instances may have occurred when families were not placed on outreach when disengaging from services; however, **recent practice** indicates the site places families on outreach, conducts activities while on outreach to engage the family, and continues outreach for at least three months. The only instances found when creative outreach was concluded prior to three months occurred when the family engaged in services, declined services, moved from the area, for other allowable reasons (parent no longer has custody, pregnancy ended in miscarriage, focus child or primary care provider is deceased, significant staff safety issues, or transferred to another program), or permanent staff assignment has been established.

1 Any of the following: the site does not yet place families on creative outreach when disengaging from services; does not yet conduct activities while on outreach to engage the family; or does not yet continue outreach services for at least three months.

Note: This is an Essential Standard.

TIP: Sites may place a family on creative outreach when a scheduled visit results in a cancelled visit without notice, followed by a consecutive rescheduled visit also resulting in a cancelled visit without notice, or an unsuccessful attempt to reschedule (i.e., parent cannot be located). The date of the first cancelled without notice visit can be used as the date CO began.

TIP: When returning a family to their previous service level, to avoid frequent back-and- forth placement from Level CO to an active service level, it may be beneficial to wait until the family has received more than half of expected visits over a one-to-three- month period based on level, i.e., a family returning to level 1 receives over half of expected visits, or at least 3 visits, in one month, a family returning to level 2 receives over half, or at least 4 visits, in two months, and a family returning to level 3 receives over half, or at least 2 visits, in three months.

TIP: Supervisors use discretion to determine family situations warranting a creative outreach period longer than three months, generally when engagement is imminent. This should be documented in supervision notes. Due to potential safety and liability concerns, caution should be exercised when families remain on outreach longer than three months if there has been no visual contact with the family.

3-4. The site measures the retention rate of families on an annual basis and in a consistent manner, and analyzes data associated with family retention at least once every two years to better understand why some families choose to leave services and others choose to stay.

3-4.A The site measures its retention rate using HFA approved methodology—first and last home visit of all who enrolled in a particular calendar or fiscal year (please see measuring retention rates in the glossary). Other methodologies may be used in addition. Sites can use the HFA Spreadsheet available for this standard.

Intent: Calculating the site's retention rate is a critical quality improvement measure. Sites look at the length of time families remain in services and identify patterns and trends associated with families leaving services at specified intervals. Comparing retention rates across various years (e.g., all families enrolled in 2018 with all families enrolled in 2019) allows sites to determine if improvement strategies employed one year are having impact the next, or if there have been significant demographic or programmatic shifts that have impacted retention from year to year. ***Please Note*: New sites without 2 full years since home visiting services began will complete an annual measurement of retention based on 6-month retention data.**

3-4.A RATING INDICATORS

3 The site annually measures its retention rate (using HFA methodology) for families enrolled in multiple years (e.g., **families enrolled the previous two fiscal or calendar years**) at multiple intervals (e.g., families enrolled in both of the previous two years have 6-month, 12-month, 18-month, etc., retention rates measured).

2 The site annually measures its retention rate (using HFA methodology) for **families enrolled during a single one-year period** at multiple intervals (e.g., measuring 6- month and 12-month retention rates).

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

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For example, if you want to measure retention for families that enrolled two years ago, you will first record each family that enrolled during the twelve-month period you selected with the date of each family's first home visit. And then, for any of these families that have left services, you will also record the date of their last home visit. Families that remain open (including those still on creative outreach) will only have the first home visit date recorded.

To calculate a valid six-month retention rate, you must wait until at least 6 months after the last day of the enrollment year you selected and then look at the percentage of families who remain in services as of that date. Similarly, twelve months after the last day of the enrollment period, you are able to calculate a valid 12-month retention rate looking at the percentage of families remaining in services out of all those enrolled. And twenty-four months after the last day of the enrollment period you will be able to calculate a valid 2-year retention rate.

Calculating retention at multiple intervals for one enrollment year will result in a 2 rating for this standard. Calculating retention at multiple intervals for two different enrollment years will result in 3 rating.

3-4.B For sites with 50 or more active families at any one time over the last two years, the site analyzes its data, to better understand why some families are choosing to leave and others are choosing to stay in services, comparing data for families no longer receiving services to data of families remaining in services (including reasons why families leave services). Please see glossary for common terms associated with analyses. Sites can use the HFA Spreadsheet available for this standard.

Intent: Sites conduct a thorough retention analysis at least once every two years to better understand why some families are choosing to leave and others are choosing to stay in services. The analysis examines various factors of those who remain enrolled with those, during the same time period, who are no longer enrolled. The site will determine which factors it analyzes based on trends or patterns it has observed. The intent is to ensure the analysis can yield meaningful results that lead to activities to address underlying causes and increase retention as a result (see GA-2.B).

For smaller sites with less than 50 active families in services at any one time over a two- year period, the site will at a minimum review anecdotal information from staff about any patterns associated with retention and reasons why families are leaving services, and to do a more comprehensive analysis when active families at any one time exceeds 50 or more over a two-year period.

Please Note: When a site completes this analysis every other year, sites may include two years of families (e.g., instead of choosing to analyze families that enroll over a one-year period, sites could choose to analyze families that enroll over two years combined). In this case, the annual measurement (3-4.A) and the analysis (3-4.B) will reflect different data sets and this is perfectly acceptable.

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

Please Note: New sites with less than two full years of home visiting services will complete a first analysis with one year of data instead of two. If the site is both new and small (less than 25 active families at any time in one year, or less than 50 over two years), they will also use one year of data and only analyze informal data and reasons why for families who have left services.

3-4.B RATING INDICATORS

3 The site uses data (numbers and percentages) and anecdotal information from staff to analyze, at least once every two years, families who leave services and reasons why. The analysis examines data to identify and better understand why some families are choosing to leave and other choosing to stay. The analysis **includes at least three (3) factors** in its comparison of those who remained in services and those who left during the same time period.

OR at least ninety percent (90%) of families enrolled in services over a two-year timeframe remained in services, in which case an analysis is not required. New sites not yet in operation for two full years with a retention rate of 90% during the first year are also exempt from completing an analysis.

2 The site uses data (numbers and percentages) and anecdotal information from staff to analyze, at least once every two years, families who leave services and reasons why. The analysis examines data to better identify and understand why some families are choosing to leave and others choosing to stay in services. The analysis includes **one or two factors** in its comparison of those who remained and those who left during the same time period.

Sites with fewer than 50 families active in services at any one time over a two-year period (or for new sites without two years of data, fewer than 25 active families over one year), have collected informal data and reasons why families left services.

1 Any of the following:

1) the site does not yet have an analysis of families who left services and reasons why
2) the analysis does not yet include data and anecdotal information from staff
3) the analysis does not yet include a comparison of any factors of those who remained in service with those who left during the same time period
4) the analysis is not yet conducted at least once every two years
5) if a smaller site, the site has not yet, at a minimum, collected informal data and reasons why families have left services

NA There were less than 10 families who left service during the two-year period to determine any patterns.

TIP: Sites whose 12-month retention rate has remained 90% or more over a two-year period (3 rating) are encouraged to collect informal data, along with reasons why, for families leaving services.

TIP: While sites choose which factors to include in their retention analysis it is recommended sites consider the role race and ethnicity may have on retention. In addition it is recommended that sites consider the impact of factors related to the program (such as staffing issues, or policy issues) may have on family retention. Sites are encouraged to reflect on any trends observed from the last retention analysis to the present one, and any lessons to be learned.

Tables of Documentation

3. Offer services voluntarily and use personalized, family-centered outreach efforts to build trust with families.

Standard	Pre-Site Documentation to include in Self Study
3-1.A | Policy - Voluntary Services	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
3-1.B | Services are Voluntary	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
3-2.A | Policy - Trust Building (Pre-Enrollment)	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
3-2.B | Trust Building (Pre-Enrollment)	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
3-3.A | Policy - Creative Outreach (Post-Enrollment)	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
3-3.B | Creative Outreach (Post-Enrollment) **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
3-4.A | Measure Retention	Submit the site's definition of family retention and method for calculating (unless using HFA spreadsheet) and retention calculation for families enrolled within at least one cohort year. HFA methodology for calculating a site's retention rate is: 1. Select a specified time frame (i.e., January 1, 2020 to December 31, 2020). This can be a 12-month period, a calendar year, or fiscal year. 2. Count the number of families who received a first home visit during this time frame. 3. Count the number of families in this group who remained in services at specified intervals (i.e., the number from this group remaining in services 6 months or longer, 12 months or longer, two years or more, etc.); 4. Divide #3 (totals remaining for 6 months, 12 months, etc.) by the number of families in step #2 (that received a first home visit during the time frame); 5. When selecting a time frame, it helps keep in mind the last day of your time frame will determine which intervals you can measure. A family who might have enrolled on the last day of that time frame could only be counted as retained or not for 6 months if at least 6 months have passed since they enrolled. Example: I have selected 1/1/2020-12/31/2020 and today is 1/1/2022, so any family that might have enrolled on the last day of that year has had the opportunity to be in the program for 1year and 1 day. For all the families who enrolled during that year, I can measure how many were still enrolled at the 6-month interval and the 12-month interval. I can't measure the 2-year interval yet because not all families who enrolled in that year (specifically, a family that might have enrolled on the last day) have had the opportunity to make it to the 2-year mark. Please note: An HFA Spreadsheet is available for this standard.
3-4.B | Retention Analysis	For all families who enrolled within at least one cohort year, analyze both formally (numbers and percentages) and informally (anecdotal information from staff and advisory members) 1. Families who remain in services in comparison to families who leave. 2. Includes at least one analysis factor 3. The reason why families leave. Please note: An HFA Spreadsheet is available for formal analysis Please see glossary for more information on analysis. For sites with less than 50 enrolled families at any one time over a two-year period, submit a narrative including: 1. The maximum number of families that were enrolled at any one time. 2. Informal data about families who leave service or are retained 3. Reasons why families are leaving services For sites with less than 50 enrolled families at any one time over a two-year period, submit a narrative of informal data and reasons why families are leaving services. Include the maximum number of families that have been enrolled at any one time. For sites not required to complete Retention Analysis, submit a narrative describing the reason for exemption. If at least ninety percent (90%) of families enrolled in services over a two-year timeframe remained in services, an analysis is not required. New sites not yet in operation for two full years with a retention rate of 90% during the first year are also exempt from completing an analysis.

STANDARD 4

4

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

Standard 4 Intent is to ensure sites offer services intensely at the onset of services to support relationship building between the FSS and the parent(s), and attachment and bonding between parents and child, through repeated positive experiences. This reflects the parallel process. HFA services are offered for a minimum of three years and up to five years, subsequent to the birth of the focus child or date of enrollment, whichever is later. Additionally, sites utilize HFA's Level Change process for determining the frequency of home visits consistent with the progress of each family.

4-1. The site offers weekly home visiting services at the onset of services.

4-1.A The site's policy and procedures state families are offered weekly home visits at the start of services until the family meets progress criteria to support moving to every- other-week visits.

Please Note: Families experiencing significant challenge(s), i.e., with elevated FROG Scale score, will likely continue with weekly visits for at least six months and often much longer before progress criteria are met and the family moves to every-other-week visits. Occasionally, families will remain at the most intense level for the full three-five year service length owing to the severity of the issues being faced.

Intent: The first several months of involvement with a family are critical for many reasons, i.e., building a trusting partnership with the parent(s), helping develop a strong parent-infant relationship, supporting infant care and safety, assisting with the adjustment to parenthood, and addressing immediate concerns.

If a family requests less frequent home visits prior to meeting progress criteria, sites will respect the family's wishes and adjust visit frequency to family request (documenting the parent's request on the home visit record when this occurs), while maintaining the family on Level 1 and continuing to offer and encourage the family's receptivity to weekly visits. This does not mean the Family Support Specialist must continually try to schedule or engage the family in weekly visits, but the family should be fully aware of the availability of weekly visits.

This ensures the FSS's caseload weight is safeguarded to allow for weekly home visits to occur until the family meets progress criteria to move to Level 2. This also ensures that movement to Level 2 is based on family progress vs family availability.

Please Note: Families whose infant is hospitalized in the NICU after birth will not be placed on Level 1 until the baby comes home from the hospital, unless the parents want weekly visits during that time. Otherwise, the family will be on level CO or TO while in the NICU and weekly visits will be offered once the baby comes home (as specified in the standard).

4-1.A RATING INDICATORS

3 No 3 rating indicator for standard 4-1.A.

2 The site's policy and procedures state families are offered weekly home visits at the start of services and continue to be offered weekly visits until the family meets progress criteria to support moving to every other week visits.

1 The site's policy and procedures do not yet state the expectation for the offer of weekly home visits as specified in the 2 rating.

4-1.B The site ensures families (with the exception of families who enroll on level 2P) are offered weekly home visits at the onset of services (including with transfer and re-enrolling families) and until progress criteria are met for moving to less frequent visits.

Intent: When families initiate services, whether new, transferred from another HFA site and re-enrolling at the same site, it is important to begin with the weekly offer of services. People have a natural tendency to like what is familiar to us (things we interact with or see repeatedly). More frequent contacts in the beginning increases familiarity and trust. When a family's immediate work/school schedule precludes the receipt of weekly home visits, home visits will continue to be offered weekly in the event the family's schedule later permits weekly visits, and until the family has met progress criteria to move to Level 2. If a family moves to creative outreach while on Level 1, their service level returns to weekly when the family engages again in services. It is not intended for families in these situations to automatically move to Level 2 since progression to less frequent home visits is based on indicators of increased family stability and parent-child well-being, as identified in level change criteria, and not based on scheduling conflicts.

Please Note: Any family that re-enrolls with the same focus child after previously being closed to services or that transfers into HFA services from another site (when the transfer or re-enrollment occurs postnatally) will be placed on Level 1 until progress criteria for movement to Level 2 have been met.

Please Note: Families enrolled as HFA Accelerated—when parent(s) score low risk on the FROG Scale—will remain on Level 1 until progress criteria for movement to Level 2 have been met.

4-1.B RATING INDICATORS

3 All families (with the exception of 2P families) are offered weekly home visits at the onset of services (including transfer and re-enrolling families).

2 Past instances may have occurred where families were not offered weekly visits at the onset of services, however **recent practice** indicates this is now occurring with all families (including transfer and re-enrolling families and excluding 2P families).

1 Families are not offered weekly visits at the onset of services.

TIP: Families who enroll early in pregnancy on level 2P may benefit from an initial offer of weekly visits for a brief period of time to support FSS-parent relationship development and family retention, rather than an immediate start of offering every other week visits.

4-2. The site utilizes a well-thought-out system for managing the intensity/frequency of home visiting services, which includes use of HFA Level Change forms for all levels requiring progress criteria to be met when moving to less frequent visits.

4-2.A The site has policy and procedures clearly defining the levels of service (i.e., visit frequency for weekly, bi-weekly, monthly, etc. and corresponding case weight at the various levels). The site's policy and procedures also include the process for reviewing progress and achievements made by families, and the involvement of parent, FSS, and supervisor in the level change decision.

Please download HFA Level Change Forms and Documents.

Intent: Sites are required to use HFA's "level system" for managing the intensity of services. This well-thought-out system is sensitive to the needs of each family, changes in family stability and competencies over time, and the responsibilities of the FSS. Clearly defined levels reflect in measurable ways the capacity of the family. Families with higher needs are able to receive more intensive services, and less frequent services are provided as stability and progress increase. Not only does an effective "level system" allow for individualized service delivery, but it also provides sites a mechanism to monitor caseload capacity more effectively, thus promoting higher quality services. It is important for the FSS to know where to locate information regarding levels of service and to be familiar with the process of how families progress from one level to another. Changes to visit frequency are based on progress, therefore the age of the child or the length of time on a particular level are not the basis for level change decisions.

HFA has the following levels and associated case weights are provided below. Supervisors may use discretion to assign higher case weight points (adding .5-1 point) on a permanent basis for families with ongoing circumstances that need extra time from the FSS to plan for and/or conduct regular visits. This includes but is not limited to: twins, triplets or other multiple birth, extensive travel to reach the family, ongoing translation needs, parents with cognitive impairment). Supervisors and FSS can also add weight on a temporary (3 month) basis by assigning the family a Special Services (SS) level - see below.

Please Note: At the time of enrollment, families are assigned to either Level 2P, Level 1P or Level 1.

Level 2P = 2 points - every other week visits when enrolled during first or second trimester of pregnancy (0-27 weeks gestation). Case weight of 2 pts ensures caseload space is retained to allow move to Level 1 at birth

Level 1P= 2 points - weekly visits when enrolled in third trimester of pregnancy (28 weeks gestation and later), or prior to 28 weeks when family needs warrant

Level 1 = 2 points - weekly visits

Level 2 = 1 point - every other week visits

Level 3 = 0.5 point - monthly visits

Level 4 = 0.25 point - quarterly visits

Level SS = additional 1 point added to Level 1, 2, or 3 weight during temporary periods of intense crisis

Level CO = 0.5 point - 2 points - creative outreach activities are carried out for 3 months when families are not engaged in regular visits. Sites maintain a family's case weight while on Level CO equal to the family's level prior to being placed on CO to ensure space is retained to move family back to that level if re-engaged.

Level TO = 0.5 point - 2 points - family plans to be temporarily out of area and unavailable for visits for up to 3 months. Sites maintain a family's case weight while on Level TO equal to the family's level prior to being placed on TO to ensure space is retained to move family back to that level if re-engaged.

Level TR = .5 point - temporary re-assignment to another staff person during extended staff leave or turnover up to 3 months. For families who are receptive and interested in receiving visits consistent with their previous level, sites should make every effort to do so, rather than using TR.

4-2.A Intent: (cont.) *Please Note*: Level change decisions based on family progress are specifically tied to when families move from one active service level to another (i.e., Level 1 to Level 2, Level 2 to Level 3, and Level 3 to Level 4) and these Level Change forms are required. It does not apply to moving families to Level CO, TO, or TR or from Level 2P to Level 1P or from Level 1P to Level 1. These levels are not based on progress and therefore these Level Change forms are optional. However, sites are required to keep track of the dates when families move from any of these levels to another, as well as documentation of activities that occur while on these levels.

Please Note: When fully completed, the Level Change form can suffice for all documentation required to demonstrate supervisor and FSS involvement in the level change decision. If sites use HFA Celebration forms (giving copy to the family and keeping a copy in the file with the date shared with the family), this will be sufficient for all documentation required to show the FSS and family discussed level change and no additional documentation in the home visit record is needed.

4-2.A RATING INDICATORS

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

2 The site's policy and procedures:

- define levels of service
- require use of HFA Level Change forms
- describe the process for FSS, family, and supervisor to review family progress when level change decisions are made

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

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

TIP: When families exit services and later express interest in re-enrolling, sites can use their discretion about whether to do so, based on their knowledge of the family and whether space is available to re-enroll. When a family has been discharged for longer than 6 months, a site should consider whether a brand new service record should be established, including obtaining updates on the FROG Scale and other intake information.

4-2.B Sites measure whether families at the various levels of service (e.g., weekly visits, bi-weekly visits, monthly visits, etc.) receive the expected number of home visits, based upon the level of service to which they are assigned. An HFA Spreadsheet is available for this standard.

Intent: Home visits provide the opportunity to experience the family's living environment and gain first-hand knowledge of the strengths and stresses of the home environment, to implement home safety checks with the family, and to engage the family on "their turf." It is acknowledged not all visits will occur in the home. Visits may happen outside the home for a variety of important, necessary, and beneficial reasons. For example when transporting to medical appointments, as an activity to reduce social isolation, when privacy and confidentiality concerns warrant a location outside the home, etc. Virtual visiting (via video preferably or phone) is also allowable when direct service staff safety is at risk, when the family is not initially comfortable with a new person coming into their home, when continuity of service can only be maintained virtually, etc. These visits can count as a home visit but only when the content of the visit matches the goal of a home visit and can be documented as such, including documentation of CHEERS. The goal of a home visit is to promote nurturing parent-child interaction, healthy childhood growth and development, and enhanced family functioning. Typically, an in-person home visit lasts about an hour and the child is present. Virtual visits may function similarly though often have a different cadence, i.e., shorter and multiple segments in the same week make up a visit, with less observation of the child.

For families assigned to a weekly level of service (Level 1 and 1P), one parent group meeting per month may be counted as a home visit if documented individually on a home visit record in the family file. The home visit documentation of the group meeting must be documented by an HFA-trained staff (does not have to be the assigned Family Support Specialist) and includes CHEERS observations when the group includes parent-child interaction time.

Some sites work in collaboration with other multi-disciplinary team members, such as doulas, lactation consultants, child development specialists, mental health therapists, etc. The site may choose to count one home visit per month conducted by these team members if the provider has received HFA Foundations core training, documents the visit on the site's home visit record, includes documentation of CHEERS, and receives supervision in accordance with standards 12-1 and 12-2. This can occur for any family regardless of level.

Please Note: When conducting virtual home visits, text messaging does not count as a home visit.

Please Note: The HFA Spreadsheet (or an equivalent database report) measures home visit completion rates (per family for each FSS caseload) over a period of three consecutive months (one quarter).If the staff supporting the family changes during the quarter, home visit completion is measured only for the period covered by the currently assigned staff person. Families who are on CO, TO, or TR during the entire quarter being measured are not included in the home visit completion calculation. Families on any of these levels for a portion of the quarter are only counted in home visit completion rates for the portion while on Level P, 1, 2 3, or 4.

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

4-2.B RATING INDICATORS

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

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

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

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when home visit completion rates fall below the 75% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase completion rates.

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

TIP: Patterns and trends associated with home visit frequency and duration are supported when viewed over time. HFA recommends quarterly review, which accounts for variations associated with family and staff schedules on a weekly or even monthly basis.

4-2.C Each family's progress (as identified on completed HFA Level Change forms) to a new level of service is reviewed and agreed upon by the Family Support Specialist and Supervisor prior to moving a family from one level of service to another. *Please Note*: completed HFA Level Change forms meet all documentation needs for 4-2.C. Any edit of these forms must be approved in advance by the national office.

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

4-2.C RATING INDICATORS

3 Each family's progress (as identified on completed HFA Level Change forms) serves as the basis to move to a new level of service and is reviewed and agreed upon by the Family Support Specialist and supervisor prior to moving families from one level of service to another.

2 Past instances may have occurred when families moved from one level of service to another in absence of completed HFA Level Change forms or review and agreement of family progress by FSS and supervisor; however, recent practice indicates staff and supervisor base level change decisions on family progress and complete the appropriate Level Change form prior to moving families to a new service level.

1 Families are moved from one level of service to another in absence of completed HFA Level Change forms; or a review and agreement on family progress by the supervisor and staff did not occur prior to level change.

Note: This is an Essential Standard.

4-2.D Once the supervisor and FSS agree a family's progress indicates readiness for movement to a less intensive service level, the FSS discusses with the family the change to visit frequency based on progress and celebrates family progress and achievements.

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

4-2.D RATING INDICATORS

3 The Family Support Specialist celebrates the progress and achievements with the family and discusses the change in visit frequency based on progress when families move from one level of service to another.

2 Past instances may have occurred when families moved from one level of service to another in absence of a celebration of family progress between the Family Support Specialist and family; however, **recent practice** indicates the Family Support Specialist and family celebrate progress and discuss the change in visit frequency based on progress.

1 Families are moved from one level of service to another in absence of a celebration of family progress, or the Family Support Specialist did not discuss the change in visit frequency based on progress.

4-3. The site offers HFA services to families for a minimum of three years (or five years when sites are funded to do so), after enrollment or after the birth of the baby (with exception of families identified as eligible for HFA Accelerated based on a low risk score on the FROG in which case may successfully complete and graduate from services sooner).

Please Note: Because HFA is voluntary, families may choose to end services at any time. FSS are encouraged to use HFA's Successful Completion of Program criteria, and to acknowledge the family as such when meeting these criteria, even when choosing to leave services early.

4-3.A The site has policy and procedures specifying HFA services are offered for a minimum of three years after enrollment or after the birth of the focus child (whichever is later), with the exception of families who transfer from another program.

Please Note: Sites who enroll families in HFA Accelerated when parent(s) score low risk on the FROG Scale, and remain at low risk, may successfully complete progress criteria and conclude services prior to three years.

Families who transfer from another program will be offered services until age three (or age five when funded to do so).

4-3.A RATING INDICATORS

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

2 The site policy and procedures specify HFA services are offered for a minimum of three years after enrollment or after the birth of the focus child (whichever is later).

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

TIP: Service length may also be extended beyond the norm on occasions where Level 3 or 4 families nearing service completion experience a crisis warranting a temporary return to more intensive services, such as a subsequent birth adding substantial risk to the functioning of the family.

TIP: When families have demonstrated progress and moved to less frequent visits, a normative situation, like a healthy subsequent birth, is not reason to extend service length or restart services with a new focus child. The family's progress and achievements reflect their ability to provide a nurturing, safe, and stable environment for the focus child and subsequent children, and space in the program can be opened for new families.

4-3.B Services are offered to families for a minimum of three years after enrollment or after the birth of the focus child (whichever is later).

4-3.B RATING INDICATORS

3 Services are offered for a minimum of three years after enrollment or after the birth of the baby (whichever is later).

2 Past instances may have occurred when the site did not offer services to families for a minimum of three years; however, **recent practice** indicates the site is offering services for a minimum of three years; or the site has not yet been in operation for 3 years.

1 Site is not yet offering services for a minimum of three years.

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

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

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

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

4-4.A RATING INDICATORS

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

2 The site has policy and procedures specifying the process for service closure and transition planning, including all components identified in the standard.

1 The site does not yet have policy and procedures; or the policy and procedures do not yet include the components outlined in the standard.

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

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

4-4.B RATING INDICATORS

3 The site conducts transition planning with families when there is a planned closure, and activities include all items included in the standard.

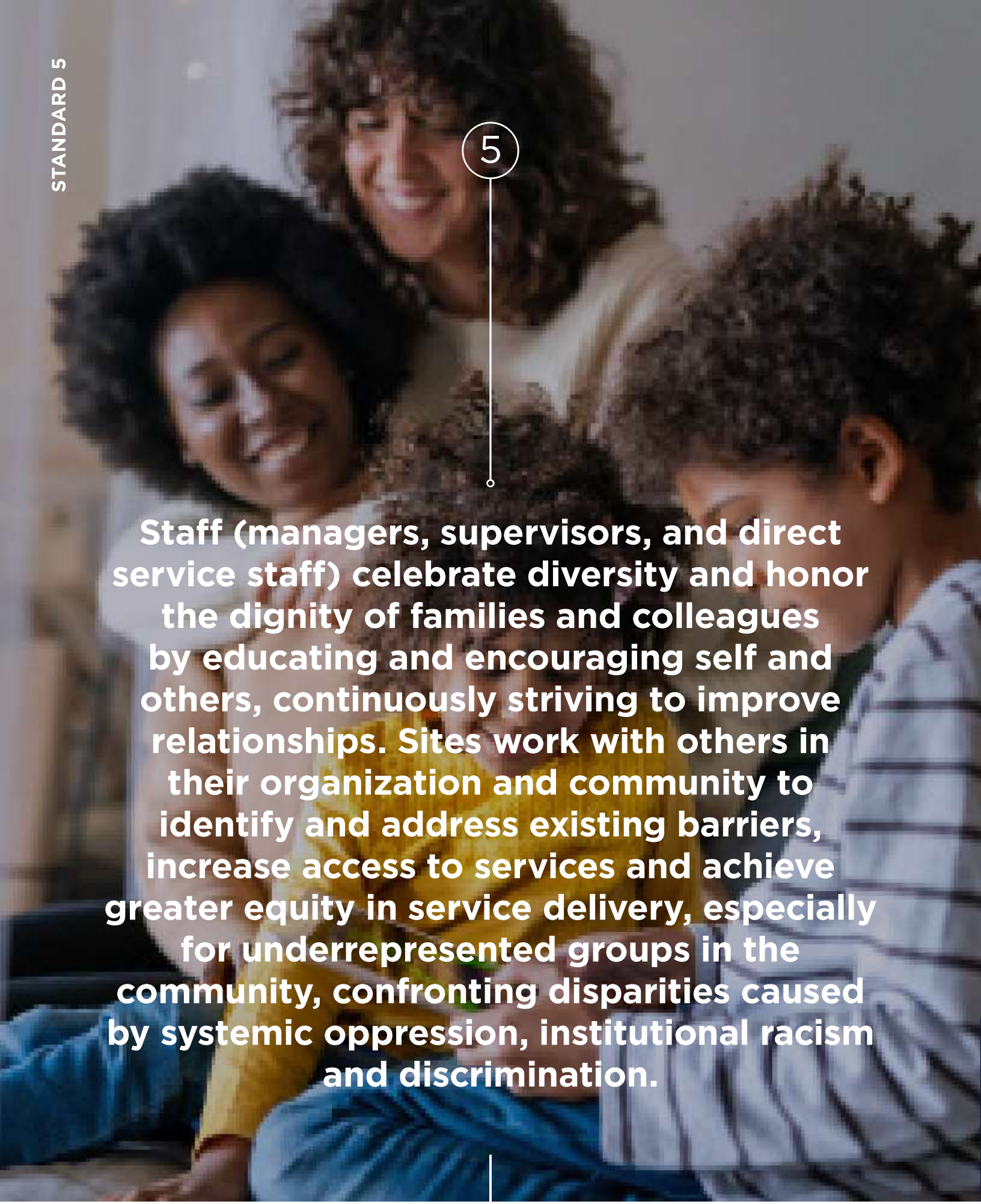
2 Past instances may have occurred when transition planning activities as outlined in the standard were not conducted; however, **recent practice** indicates the site conducts transition planning according to the standard; or there have been no planned closures yet, or families with planned closure declined a transition plan.

1 A transition plan for families with a planned closure is not yet offered or does not yet include all components identified in the standard.

Tables of Documentation

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

Standard	Pre-Site Documentation to include in Self Study
4-1.A | Policy - Weekly Visits	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
4-1.B | Weekly Visits	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
4-2.A | Policy - Levels of Service	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
4-2.B | Home Visit Completion Rate	Submit home visit completion report for the most recent quarter which includes: All active families by FSS including level of service, level changes that quarter, number of expected home visits that quarter and number of completed home visits that quarter (completed visits while on Level 1 or 1P may include one parent group per month or one multi-disciplinary team member visit per month when all requirements as stated in the intent are met). To calculate home visit completion: 1. Determine for each family over the course of a quarter the expected number of home visits (based on level of service alone). 2. Count the number of completed visits (while family is on active service level) for each family during the quarter. 3. For each family calculate: #2 (completed visits) divided by #1 (expected visits). 4. Count the total number of active families. 5. Subtract from #4 (total active families) the number of families who were on creative outreach for the entire quarter. 6. Count the number of active families who received at least 75% of expected home visits. 7. Program HVC rate is calculated by taking #6 (number of active families who received at least 75% of visits) divided by #5 (active families - minus CO entire quarter). Please Note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (75% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
4-2.C | Level Changes in Supervision Essential Standard	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
4-2.D | Level Changes with Families	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
4-3.A | Policy - Services for Minimum of Three Years	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
4-3.B | Services Provided For 3-5 Years	Submit a report indicating the current number of families who have been enrolled for 3 or more years. If families graduate after three years of service, provide a report indicating all families who have graduated within the last year, excluding any who meet criteria for HFA Accelerated and successful completion earlier than 3 years.
4-4.A | Policy - Transition Planning	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
4-4.B | Transition Planning	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.



5

Staff (managers, supervisors, and direct service staff) celebrate diversity and honor the dignity of families and colleagues by educating and encouraging self and others, continuously striving to improve relationships. Sites work with others in their organization and community to identify and address existing barriers, increase access to services and achieve greater equity in service delivery, especially for underrepresented groups in the community, confronting disparities caused by systemic oppression, institutional racism and discrimination.

Standard 5 ensures each site is intentional in its efforts to promote equity in all facets of operations with families, staff, and community. Doing so compels an honest look at existing flaws, individually and systemically, exposing and resolving blind spots previously unrecognized.

This level of intentionality allows us to listen and learn from the lived expertise of others, and to recognize how implicit bias and power imbalance impair authentic relationships. By examining and gaining greater clarity related to the causes of these and other challenges associated with long-standing health and social disparities, we are more likely to effect change through our advocacy, allyship, and meaningful dialogue with one another.

This work is hard, complicated, and at times uncomfortable. There is no quick fix and no one is exempt. It requires sustained, long-term, individual and organizational commitment. It is a unique and continuous journey we all must engage in. It involves an ongoing commitment to increasing one's self-awareness.

TIP: The policies discussed in Standard 5 may be referenced within existing policies, such as within supervision policies, training policies, personnel policies, etc., or may be standalone written guidance.

5-1. Through policy (or other written guidance) and practice, the site supports staff's ability to continually strengthen the skills required for authentic relationships, including self-awareness, self-regulation, self-reflection, skilled listening, and empathy.

Intent: Taking an honest and reflective look inward increases awareness and understanding of our biases, offering us an opportunity to be intentional in our efforts to counteract these. Being afforded safe space in supervision, team meetings, and peer-to-peer interactions enables greater likelihood for honest, respectful, and brave conversations. Recognizing the distinction between intent and impact, as well as the importance of repair, facilitates stronger relationships. These are the building blocks upon which growth and change become possible.

Sample Team Commitments / Ground Rules are available.

5-1.A The site has policy or other written guidance expressing the site's commitment to respectful staff interactions and supporting staff to continually strengthen their relational skills focused on diversity, equity, and inclusion.

5-1.A RATING INDICATORS

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

2 The site has policy and procedures, or other written guidance, including team commitments or ground rules regarding: 1) expectations for staff interactions, and 2) professional development and supervision expectations, to ensure staff have the resources needed to continually strengthen their relational skills as mentioned in standard 5-1.

1 The site does not yet have policies and procedures, or other written guidance, as stated above.

5-1.B The site's practices support a respectful team environment and staff ability to continually strengthen their relational skills.

5-1.B RATING INDICATORS

3 **All staff** are aware of the site's policies, or written guidance, and **are able to describe** efforts they have undertaken to strengthen their relational skills, and **multiple mechanisms** have been acted on to support a respectful team environment.

2 All staff are aware of the site's policies, or written guidance, and **the majority of staff are able to describe** efforts they have undertaken to strengthen their relational skills, and **at least one mechanism** has been acted on to support a respectful team environment,

1 All staff are not yet aware of the site's policies or written guidance; or a majority of staff are not yet able to describe efforts they have undertaken to strengthen their relational skills; or there have not yet been any mechanisms acted on to support a respectful team environment.

TIP: There are many mechanisms to support individual self-awareness and build team cohesiveness. Managers and supervisors play an instrumental role in creating a team culture supportive of self-learning and group exploration within a safe environment. This can happen through individual supervision, shadowing, team meetings, creating shared agreements, etc. Additionally, staff surveys, staff goal setting, and performance reviews are more formal ways to obtain staff input and support staff development.

5-2. Through policy (or other written guidance) and practice, the site supports development of a partnership with families that honors diverse family structures and the sources of strength derived from family cultures, values, beliefs, and parenting practices. Practice also recognizes the historic and current relevance of discrimination based on race, ethnicity, gender identity, sexual orientation, age, religion, and abilities and seeks inclusivity in all aspects of its work with families.

Intent: Cultural humility is not what one knows of another person's culture, though a certain level of foundational knowledge can be helpful. It is instead how we are in allowing another person to share their own story which reflects their identity, experiences, background, values, and beliefs. Allowing parents to teach us of their culture, and being observant and accepting of behaviors, attitudes, and beliefs that may be different from our own, reduces the risk of making faulty assumptions, and helps us evolve as individuals with appreciation for our common humanity.

Direct service staff observe cultural differences and use them as a springboard for inquiry and understanding, asking families about particular behaviors and practices. Family background and ethnicity influence value systems, how people seek and receive assistance, and communication style among other things. When staff express curiosity with open-ended questions, are non-judgmental, refrain from imparting their own belief and value systems, and seek to repair relationships when missteps occur, families and staff have an opportunity to grow and develop.

5-2.A The site has policy or other written guidance expressing the site's commitment to interact with families in a partnership that honors diversity and inclusivity and elevates family voice.

5-2.A RATING INDICATORS

3 No 3 rating indicator for standard 5-2.A.

2 The site has policy and procedures, or other written guidance, describing the site's intention and expectations for engaging with families in a partnership that honors diverse family structures and seeks inclusivity in all aspects of its work, and elevates family voice.

1 The site does not yet have policy and procedures, or other written guidance, as stated above.

5-2.B The site's practices engage families in partnership, elevating family voice and honoring family diversity.

5-2.B RATING INDICATORS

3 **All staff** are aware of the site's policy, or written guidance, and **are able to describe** efforts they have undertaken to work together in partnership with families, elevating family voice and honoring diverse family structures, values, beliefs, and parenting practices.

2 All staff are aware of the site's policy, or written guidance, and the **majority of staff are able to describe** efforts they have undertaken to work together in partnership with families, elevating family voice and honoring diverse family structures, values, beliefs, and parenting practices.

1 All staff are not yet aware of the site's policy or written guidance; or a majority of staff are not yet able to describe efforts they have undertaken to work together in partnership with families, elevating family voice and honoring diverse family structures, values, beliefs, and parenting practices.

5-3. The site works at the community level, through policy and practice, and with guidance from its community advisory board, as a champion for families and children, advocating for just and equitable opportunities within the community, and increasing access to services and supports for those it serves and employs.

Intent: Racial and ethnic minorities, and other underrepresented groups, face barriers in accessing services within their communities. Organizations within communities have a responsibility to utilize their influence and decision-making in ways that identify and address structural inequities brought about by privilege and discrimination. This includes actions taken both internally (in support of the organization) and externally (in support of the community).

Additionally, it is the site's responsibility to identify major cultural groups within the community, determine groups currently underserved, and prioritize hiring staff who represent these groups and can provide support in the family's preferred language. Sites will also make sure that, in addition to staff, graphics and materials are representative of the community.

5-3.A The site, and/or organization, has policy or other written guidance expressing its commitment to advocating at the community level to address barriers and promote equity for those it serves and employs.

5-3.A RATING INDICATORS

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

2 The site, and/or organization, has policy and procedures, or other written guidance, reflecting how it advocates at the community level and with its community advisory board to identify and address existing barriers, increasing equitable access to services, ensuring diverse representation in staff and materials, and meeting the cultural and language needs of those it serves and employs.

1 The site does not yet have policy and procedures, or other written guidance, as stated above.

5-3.B The site's practices demonstrate its commitment to working at the community level to address barriers and promote equity for those it serves and employs.

5-3.B RATING INDICATORS

3 Site leadership and community advisory members are aware of the site's policy, or written guidance, and can **describe multiple efforts** undertaken at the community level to identify and address existing barriers, increase equitable access to services, ensure diverse representation in staff and materials, and/or meet the cultural and language needs of those it serves and employs.

2 Site leadership and community advisory members are aware of the site's policy, or written guidance, and can **describe at least one** effort they have undertaken to identify and address existing barriers, increase equitable access to services, ensure diverse representation in staff and materials, and/or meet the cultural and language needs of those it serves and employs.

1 Site leadership and/or advisory members are not yet aware of the site's policy or written guidance; or a majority of staff are not yet able to describe at least one effort undertaken to identify and address existing barriers, increase equitable access to services, ensure diverse representation in staff and materials, and/or meet the cultural and language needs of those it serves and employs.

TIP: Sites are encouraged to include questions on employee satisfaction surveys related to equitable personnel practices, including hiring, promotions or other advancement, and performance evaluations.

5-4. The site gathers information to reflect on and better understand issues impacting staff and families served and to examine the effectiveness of its equity strategies. These strategies will vary from year to year and are based on family and staff input received and what the site has learned from implementing standards 5-1, 5-2, and 5-3. Family engagement and retention data, and staff engagement and retention data may also be used.

5-4.A The site starts by gathering information, ensuring parent/caregiver voice and staff input is obtained and used to improve its ability to provide culturally respectful and responsive services as referenced in standards 5-1, 5-2 and 5-3.

Intent: It is critical for sites, in their efforts toward continuous quality improvement, to receive and utilize feedback from families and staff. When families and staff provide their observations and experiences, it can help point out areas which would benefit from additional training or support, as well as highlight particular areas of strength or staff skill, and help identify ways in which the site can advance its work to achieve greater equity in service delivery and systems change. Families and staff may provide input in a variety of ways, e.g., through the use of a satisfaction and cultural humility survey for currently enrolled families, post-service questionnaires or interviews, service on the community advisory board, family advisory committee, focus groups, etc.

5-4.A RATING INDICATORS

3 The site obtains input from **current and former** families and staff that helps the site understand how it is doing with implementation of standards 5-1, 5-2 and 5-3. Input is sought at least once annually.

2 The site obtains input from **current** families and staff that helps the site understand how it is doing with implementation of standards 5-1, 5-2 and 5-3 Input is sought at least once annually.

1 The site does not yet obtain input from current families and staff to help the site understand how it is doing with implementation of standards 5-1, 5-2 and 5-3, or the site has not yet sought input at least once annually.

TIP: Staff surveys should be offered to all site staff, and ideally responses should be obtained by all, protecting worker anonymity to encourage candid feedback without repercussion. For very small sites when anonymity can not be ensured, cross-department or organization-wide surveys may be a better option.

5-4.B The site makes meaning of the information it collects and develops an equity plan based on what the site learns about itself, from an equity perspective, in the way it supports its staff, the families it serves, and the community it works within. The equity plan sets a course for continuous improvement to achieve greater equity in all facets of its work.

Intent: Taking time to thoughtfully review the information gathered from staff and families demonstrates respect and value for what has been shared, assists the site in focusing on particular areas where there is opportunity for growth, and provides the site an opportunity to reflect on the progress it is making to promote equity. The meaningful identification of growth opportunities is the basis of the site's equity plan, which also summarizes strengths and challenges, along with any patterns or trends noted over time. The equity plan provides an opportunity to identify strategies to combat implicit bias, address barriers to equitable service delivery, and work to dismantle the causes of disparity and inequity.

5-4.B RATING INDICATORS

3 The site has an equity plan that incorporates a **summary of family and staff input obtained in 5-4.A, along with** what it learns by **completing a formal self-assessment tool related to diversity, equity, inclusion, and belonging (DEIB).** Strategies are based on what it learns from this information

2 The site has an equity plan that incorporates a **summary of family and staff** input **obtained in 5-4.A,** and strategies are based on what it learns from this information.

1 Any of the following: there is no equity plan; the equity plan does not yet incorporate a summary of family and staff input obtained in 5-4.A, or strategies are not based on family and staff input.

Note: This is an Essential Standard.

TIP: It is helpful for sites to remember that strategies to obtain information in ways that yield more meaningful lessons learned can also be an important part of an equity plan.

TIP: There are a number of DEIB focused organization self-assessment tools available to the general public. Sites will choose the one that will work best for them. HFA provides links to a few different options to consider.

5-4.C The site's equity plan is reviewed and updated at least once annually to reflect progress associated with the strategies identified in it. Revisions and new strategies are included when appropriate based on lessons learned and new input received annually from staff and families. Regular focus on the equity plan is intended to foster growth and increased capacity to promote equity.

Intent: A site continually reviews and improves its service delivery system by integrating information learned. It can be difficult to self-identify gaps and determine strategies. This is why it is important to seek the perspective and assistance from staff and families on an ongoing basis.

5-4.C RATING INDICATORS

3 The equity plan is reviewed and updated at least once annually by **site staff and the community advisory board.** Equity strategies are updated and revised based on feedback received annually from staff and families (5-4.A) and lessons learned.

2 The equity plan is reviewed and updated at least once annually by **site staff**. Equity strategies are updated and revised based on feedback received annually from staff and families (5-4.A) and lessons learned.

1 Any of the following: there is no equity plan; or the equity plan has not yet been reviewed or updated at least once annually; or equity strategies are not yet updated and revised based on feedback received annually from staff and families (5-4.A) and lessons learned.

Tables of Documentation

5. Staff (managers, supervisors, and direct service staff) celebrate diversity and honor the dignity of families and colleagues by educating and encouraging self and others, continuously striving to improve relationships. Sites work with others in their organization and community to identify and address existing barriers and increase access to services, especially for underrepresented groups in the community, confronting disparities caused by institutional racism and discrimination.

Standard	Pre-Site Documentation to include in Self Study
5-1.A | Policy – Staff Interactions	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available. Sample Team Commitments / Ground Rules are available
5-1.B | Staff Interactions	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
5-2.A | Policy - Family Partnership	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
5-2.B | Family Partnership	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
5-3.A | Policy - Community Level Advocacy	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
5-3.B | Community Level Advocacy	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
5-4.A | Family & Staff Input	Submit a narrative summary of most recent efforts to obtain meaningful feedback from parents/ caregivers and staff. Include a summary of findings: summarize patterns and trends, strengths and challenges.
5-4.B | Equity Plan **Essential Standard**	Submit the most recent organizational self-assessment and equity plan. Please note: Sample of organizational self-assessments available
5-4.C | Advisory Input Regarding Equity Plan	Submit notes to illustrate review of the Equity Plan. Please highlight updated strengths and strategies based on feedback received from staff and lessons learned. If identified strengths and strategies are documented elsewhere, submit relevant supplemental documentation.

STANDARD 6

6

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

Standard 6 Intent is to reduce risk factors and build protective factors, ensuring site staff provide services that are family-centered and growth oriented; supporting parents in nurturing their children; setting meaningful goals; and enhancing health, development, and family functioning.

HFA employs an infant mental health approach in which services are relationship-focused, strength-based (building on parental competencies), and culturally respectful and responsive, and are anchored to the parallel process.

Healthy Families sites serve many families who are struggling with issues including substance abuse, intimate partner violence, developmental delay in parents, depression, and other mental health challenges, some of which may be an effect of early childhood trauma, multiple other life stressors, and institutionalized racism and systems of oppression that have limited equitable access to financial stability, housing stability, quality education, employment opportunity, health care, transportation, and nutrition. In order to address these challenges, site staff: 1) form healthy relationships with parents, 2) apply a strength-based approach that includes being honest when parents are responding to their environment in ways that may cause harm to themselves and their children, 3) accept families where they are, without judgment or bias, 4) build on parental competencies, and 5) focus on learning about the individual's lived experience and means of coping versus judging behavior as "right or wrong." These principles are core HFA components.

6-1. Risk factors and stressors identified in the FROG Scale, as well as risk factors that emerge later in the course of services (when not disclosed or present initially), are addressed during the course of services utilizing a Service Plan. The Service Plan is developed by the supervisor and Family Support Specialist and includes a focus on building protective factors. Practice demonstrates the Service Plan is being implemented.

Download HFA Service Plan Materials. Please Note: HFA's Service Plan template can be modified by the site without approval and an alternate Service Plan format can be created if desired. It is the responsibility of the site to ensure a uniquely developed Service Plan meets the documentation requirements.

Intent: A well-constructed Service Plan is the cornerstone of home visiting services that are effectively organized and coordinated and is based on each family's unique strengths and areas of concern. The purpose of a Service Plan is to operationalize the family "story" into a "road map" that supports Family Support Specialists in their ongoing and long-term work with the family and is the mechanism by which supervisors document their clinical support to staff that is specific to each family.

A Service Plan is fluid and dynamic in order to remain relevant to the family as changes to family systems, circumstances, and dynamics occur over time. As such, service priorities also are likely change over time and a Service Plan helps to manage and "visualize" the complexity of change and the re-prioritization of activities that result. A Service Plan ensures issues identified by the family can be systematically addressed and supported in partnership with parents, without interfering or compromising the family's choice in regard to goals they are motivated to achieve. Family goal setting is a distinct and separate activity and is discussed in Standards 6-2.

6-1.A The site has policy and procedures describing the review of each family's strengths and stressors as identified in the FROG Scale, as well as parent-child interaction/attachment concerns and challenging issues identified subsequent to administration of the FROG Scale (i.e., substance abuse, intimate partner violence, parent's cognitive impairment, and mental health concerns).

Policy and procedures include the Supervisor and Family Support Specialist working together to develop an HFA Service Plan with activities to address these issues over time and to build protective factors. Procedures also include the prioritization of these activities to support them being carried out successfully without overwhelming staff or the family.

Download HFA Service Plan Materials.

Intent: Research clearly demonstrates that past trauma and untreated disorders can have serious consequences for early learning, social competence, and lifelong health. Family Support Specialists are not counselors or therapists; however, the incredibly therapeutic nature of the partnership formed with parents cannot be overstated. The most important role as it relates to supporting the challenges parents face is to listen, acknowledge, and support the parent(s). Additionally, Family Support Specialists play an important role in:

- providing an atmosphere of safety and acceptance
- keeping the baby and the parent-child relationship at the center when helping parents recognize the impact of various challenges
- providing honest feedback with parents' permission
- pointing out discrepancies between stated values and actual behavior
- encouraging forward thinking (i.e., assist parent in developing a vision of what they want)
- providing information and referrals in a way that helps parents bridge the fear or uncertainty of accessing additional services
- using motivational interviewing (when trained on this technique)

When supporting families with challenging and complex issues, a Service Plan helps staff work with intention and can help staff focus on incremental progress being made despite at times feeling "stuck."

6-1.A RATING INDICATORS

3 No 3 rating for 6-1.A.

2 The site has policy and procedures regarding the review of each family's risk factors and stressors as identified in the FROG Scale, as well as parent(s) challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, and mental health issues) identified subsequent to the administration of the FROG Scale. Procedures include 1) the Supervisor and Family Support Specialist working together to develop a Service Plan which includes activities to address identified issues and build protective factors, 2) the prioritization/pacing of such activities, and 3) the Family Support Specialist and family working together on the implementation of these the activities during home visits initially and during the course of services.

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

6-1.B At the start of services, the Supervisor and Family Support Specialist review each family's stressors and strengths as identified in the FROG Scale, as well as parent-child interaction/attachment concerns (i.e., any item rated a 4 or less on the CCI is documented on the Service Plan to be addressed), and challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale. Together the Supervisor and Family Support Specialist develop a Service Plan and update it over time prioritizing/pacing activities to address risk and build protective factors.

Intent: Supervisors and Family Support Specialists develop a Service Plan at the start of services based on the strengths and concerns identified by families during the FROG Scale conversation, plus identifying activities to support the family and build protective factors. To support the family and Family Support Specialist, there will also be planning for the appropriate prioritization and pacing of these activities.

Activities reflect a thoughtful, purposeful discussion that assists the Family Support Specialist in understanding how early childhood trauma and the stressors experienced by the family impact parenting. Discussions acknowledge and build on family strengths (protective factors) and guide the Family Support Specialist's work with the family.

6-1.B RATING INDICATORS

3 The Supervisor and Family Support Specialist review and document in a Service Plan all the risk factors and stressors identified in the FROG Scale. Challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale are also documented, in addition to the pacing and prioritization of activities to address these issues and build protective factors with families initially and during the course of services.

2 Past instances occurred when the Supervisor and Family Support Specialist did not review and document in a Service Plan all the risk factors and stressors identified in the FROG Scale, or challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale, or the pacing and prioritization of activities to address these issues and build protective factors with families initially and during the course of services; however **recent practice** indicates this is now occurring.

1 The Supervisor and Family Support Specialist do not yet review and document in a Service Plan all the risk factors and stressors identified in the FROG Scale; or documentation does not yet include challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale; or documentation does not yet include the pacing and prioritization of activities to address risk factors and build protective factors with families initially and during the course of services.

TIP: Activities to address risk factors can include use of the Reflective Strategies along with intentional promotion of the protective factors.

TIP: Many sites utilize components of motivational interviewing, anchor to parents' values and dreams for their children, build on parental strengths, offer decision matrices (pros and cons regarding making decisions), and other strategies to support families in making healthy decisions about lifestyle.

TIP: The FROG Scale is expected to be completed by the fourth home visit (standard 2-1.A). It is recommended the initial Service Plan be developed within 2 weeks of that visit (or sooner when the FROG is completed sooner) followed by review and update of each family's Service Plan once monthly for families on Level 1, 1P, or SS, every other month for families on Level 2, and quarterly for families on Levels 3 or 4.

6-1.C The Family Support Specialist implements with the family over the course of services, the activities identified on the HFA Service Plan in an effort to build protective factors and to address the stressors identified in the FROG Scale, as well as parent(s) challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale.

Intent: The Family Support Specialist addresses with families the stressors identified in the FROG Scale over the course of a family's enrollment in home visiting services, ensuring families are offered ongoing opportunities and support to make positive healthy changes in their life. Utilizing a Service Plan ensures services are family driven and tailored to each family's unique strengths, concerns, stresses, and priorities articulated by the family. It is not expected a Family Support Specialist will discuss with the family all of the risk factors and stressors at one time, or that the Family Support Specialist "enforce" behavior-change or issue-resolution prior to a family's readiness to do so.

Implementation of the Service Plan is collaborative in nature, meaning family input and changing family dynamics are incorporated. Supervisors and Family Support Specialists will update the Service Plan and clarify how the issues that place families at-risk for poor childhood outcomes are addressed over time. The frequency of the update to the Service Plan depends on the complexity of each family's situation, including risk factors and challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, and mental health issues) that may emerge subsequent to the initial administration of the FROG Scale, all of which will be incorporated into the Service Plan. Family Support Specialists will need access to or their own copy of the most updated Service Plan.

Please Note: When the Family Support Specialist implements activities outlined on the Service Plan, the date this occurred is documented on the Service Plan to ensure it is easy to reference the home visit record for the detail on what the FSS did.

Please Note: HFA has developed a document, "Procedures: Working with Families in Acute Crisis" which may be helpful in clarifying staff roles and responsibilities for supporting families experiencing challenging issues.

6-1.C RATING INDICATORS

3 The Family Support Specialist implements with families activities documented in a Service Plan.

2 Past instances may have occurred when the Family Support Specialist did not implement with families activities documented in a Service Plan; however, **recent practice** indicates this is now occurring.

1 The Family Support Specialist does not yet implement with families activities documented in a Service Plan.

Note: This is an Essential Standard.

6-2. Setting and achieving family goals builds a family's resiliency and promotes protective factors. The process of setting and accomplishing goals is family driven, and the process is more important than the product.

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

Goal setting is a powerful activity for parents. When the activity is repeated often enough, it builds motivation and increases self-confidence and self-determination. For many, it becomes an internalized and lifelong process. That said, it is initially a new process for many families, making the encouragement from the Family Support Specialist very important.

The purpose of the **Family Goal** process is to amplify parents' problem-solving skills, support their ability to develop and implement options to improve their situation, and celebrate with them their successes in achieving goals and objectives. The Family Goal process allows Family Support Specialists to:

- offer the concept that change can happen and the family can have an impact creating their future
- help the family identify what they want to accomplish and the mechanism(s) by which the Family Support Specialist can assist
- develop opportunities for the family to experience success
- assist the family to identify and acknowledge their strengths
- celebrate success with the family

6-2.A The site has policy and procedures regarding the process of helping parents develop family goals throughout the course of services, with new goals set as previous goals are accomplished or retired.

6-2.A RATING INDICATORS

3 No 3 rating for 6-2.A.

2 The site has policy and procedures regarding the development and review of meaningful family goals, including:

- goal setting as an activity throughout the course of services with new goals set as previous goals are accomplished or retired
- projected dates for accomplishing the goal
- identifying family strengths to support goal achievement
- celebration of goal achievement
- FSS and supervisor support of the family goal process

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

6-2.B The Family Support Specialist supports the family in setting and achieving goals that are meaningful to the parent.

Please Note: It may take up to 3 months after the initiation of home visiting services for a family to be ready to set a goal; however, once an initial goal has been set and achieved, families will repeat the process of setting new goals throughout the course of services.

Intent: The Family Support Specialist invites the family to develop meaningful, manageable goals. There is a clear conversation to support parents in feeling competent, capable, and hopeful in being able to make positive changes in their own lives. Breaking larger goals into small goals assists parents in developing problem-solving skills, increases their sense of power over their situations, and supports adult brain development. Steps are incremental, measurable, and functional for the family. The focus is not on how many goals families accomplish; rather, it is entirely related to the skills parents build in the process of developing and working on goals, and especially in the celebration when there is success in making progress and achieving goals.

The goal setting process is 100% family-driven based on what the parent wants, needs, or dreams about. The process supports parental self-efficacy, enhances family functioning, and builds protective factors. The more success a family has, the more they change their world view. Helping families identify the strengths and competencies they have to address the goals they set develops critical thinking and problem-solving skills and promotes protective factors.

6-2.B RATING INDICATORS

3 The Family Support Specialist supports the family to have a goal with a projected date for accomplishing the goal, and helps the family identify strengths and resources specifically related to accomplishing the goal. Family Support Specialists support families in achieving their goals, celebrate successes, and help parent(s) develop new goals when the previous goal is accomplished or when a goal may no longer be relevant to the family.

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

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

Note: This is an Essential Standard.

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

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

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

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

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

6-2.C RATING INDICATORS

3 The Family Support Specialist and supervisor review family goal progress on an ongoing basis, ensuring families have a current goal, Family Support Specialists are supported to help problem-solve any challenges, and successes are celebrated.

2 Past instances were found when the Family Support Specialist and supervisor did not review family goal progress on an ongoing basis; however, **recent practice** indicates the site now ensures this occurs, families have current goals, Family Support Specialists receive support to help problem-solve any challenges, and successes are celebrated.

1 The Family Support Specialist and supervisor do not yet review family goal progress as indicated in the 2 rating.

TIP: Intervals for reviewing the family goal progress during supervision will vary based on a variety of factors, including family needs pertaining to a particular goal, the projected date for goal completion, and/or visit frequency.

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

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

6-3.A The site has policy and procedures requiring the use of CHEERS and indicating how the staff will partner with parents to assess, address, and promote nurturing parent-child interaction (PCI), attachment, and bonding. Site policy also includes the role of supervisors to support Family Support Specialists in the use of CHEERS, and that the validated CHEERS Check-In (CCI) tool will be administered at least twice annually.

Intent: Sites develop clear policy and procedures for how Family Support Specialists will assess parent-child relationships using CHEERS. Site policy also indicates how Family Support Specialists will partner with supervisors to develop plans for increasing nurturing parent-child interactions, beginning prenatally (when services are initiated prior to birth). Policy and procedures include the use of the strength-based reflective strategies introduced in HFA's **Foundations Core training**. Policy also includes expectations related to 1) documenting CHEERS on each home visit, 2) the reflective strategies used, curriculum material shared, or visit activities completed to address concerns and promote positive PCI, and 3) use of the CCI tool at least twice annually. It is expected the parent-child relationship is observed and discussed each visit.

6-3.A RATING INDICATORS

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

2 The site has policy and procedures regarding the use of CHEERS including when and how Family Support Specialists will partner with parents to assess, address concerning parent-child interaction, and promote nurturing parent-child interaction (through use of reflective strategies, visit activities, and curriculum material). Site policy also includes the use of HFA's Cheers Check-in (CCI) tool at least twice annually, and the role of the supervisor to support Family Support Specialists with CHEERS assessments and interventions.

1 Any of the following: the site does not yet have policy and procedures; or the policy and procedures do not yet require the use of CHEERS, including when and how Family Support Specialists partner with parents to assess, address concerning parent-child interaction, and promote nurturing parent-child interaction (through use of reflective strategies and curriculum material); or the policy does not yet include the use of HFA's Cheers Check-In (CCI) tool at least twice annually; or the role of the supervisor to support Family Support Specialists with CHEERS assessments and interventions.

6-3.B The site assesses parent-child interaction, attachment, and bonding with families, utilizing CHEERS on all home visits.

Intent: HFA requires CHEERS be used as a parent-child observation strategy during each home visit, with the exception of when the FROG Scale is being administered, or when the CHEERS Check-In tool is administered. A minimum of two domains of CHEERS is documented for all home visits (including virtual visits) based on observation or parent report (the focus is on quality over quantity of domains documented). It is also expected that any group session being counted as a home visit (1 per month allowed while a family is on Level 1 or 1P) will include some documentation of CHEERS.

HFA supports the concept of the strength-based approach with families; however, because of the strong relationships staff develop with families, the intent of "strength-based" may be distorted. This can lead to only positive interactions being recorded in documentation. In addition to seeing the strengths, capacities, and resources of parents related to attachment, observations and documentation must also be honest, and reflect the experience of the full home visit. Therefore, observations and documentation through CHEERS provide factual description of parent-child interactions. Only documenting positive PCI limits the FSS's capacity to have impact on creating nurturing attachment relationships.

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

6-3.B RATING INDICATORS

3 Family Support Specialists partner with parents to assess parent-child interaction, attachment, and bonding with all families, utilizing CHEERS on all home visits, with the exception of when the FROG Scale or CCI tool is used on a particular visit. At least one domain of CHEERS is documented in the second trimester of pregnancy beginning at 24 weeks gestation, and at least two domains of CHEERS are documented in the third trimester and for all families throughout the time they are enrolled (with the exception of home visits where the FROG Scale or CCI tool is administered).

2 Past instances were found when the Family Support Specialist did not partner with parents to assess parent-child interaction, attachment, and bonding with all families utilizing CHEERS; however, **recent practice** indicates this is now occurring (including at least one domain of CHEERS for prenatal families in the second trimester, and at least two domains of CHEERS for prenatal families in the third trimester and for all families throughout the time they are enrolled (with the exception of home visits where the FROG Scale or CCI tool is administered).

1 Family Support Specialists do not yet partner with families to assess parent-child interaction, attachment, and bonding with all families utilizing CHEERS as specified in the 2 rating.

Note: This is an Essential Standard.

TIP: When less than all six domains of CHEERS are assessed on a home visit, the FSS is encouraged to assess different domains on subsequent visits so that over the course of a few visits, all domains are assessed.

TIP: HFA has a prenatal and postnatal tip sheet for CHEERS with helpful prompts and space to document the requirements of 6-3.B and 6-3.C.

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

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

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

6-3.C RATING INDICATORS

3 Family Support Specialists address PCI concerns and promote nurturing parent-child interaction, attachment, and bonding with all families based on CHEERS observations.

2 Past instances were found when the Family Support Specialist did not address PCI concerns and promote nurturing parent-child interaction, attachment, and bonding with all families utilizing CHEERS; however, **recent practice** indicates this is now occurring.

1 Family Support Specialists do not yet address PCI concerns and promote nurturing parent-child interaction, attachment, and bonding with all families utilizing CHEERS.

Note: This is an Essential Standard.

6-3.D The site utilizes the CHEERS Check-In (CCI) tool at least twice annually during each year of the child's life from birth through thirty-six (36) months.

Please Note: Any item rated a 4 or less on the CCI will be documented on the Service Plan to be addressed. Items rated as 5 are to be strengthened and items rated 6 or 7 are to be promoted. All currently enrolled families, including those on levels CO, TO, and TR are included in the calculation. If the primary caregiver declines tool administration, in which case they are exempted from the calculation; however, the refusal must be documented on the tracking form. An HFA Spreadsheet is available for this standard.

Training on the CHEERS Check-In (CCI) is required for Standard 10-6.A.

6-3.D RATING INDICATORS

3 The site uses the CHEERS Check-In tool during home visits and at least **90% of all focus children** (including each child when multiples) are screened a minimum of twice per year of the child's life from birth - 36 months.

2 Past instances were found when the site did not use the CHEERS Check-In tool with at least **90% of focus children** a minimum of twice per year of the child's life from birth - 36 months; however this is now occurring during home visits and at least 90% of focus children have one CCI screen completed **in the last six months.**

1 Any of the following: the site does not yet use the CHEERS Check-In tool; or less than 90% of focus children up to age 36 months have had the CCI tool completed at least once in the last six months.

TIP: The CCI tool can be used beyond age 3. It is validated for children ages 2 months to 49 months and can also be used between 49 and 60 months if desired.

TIP: Tip: Suggested CCI intervals in the first year of life are 1) between 4-6 months and 2) between 8-10 months.

6-3.E Supervisors support Family Support Specialists to assess parent-child interaction (through use of CHEERS), address concerns, and promote secure attachment and the development of nurturing parent-child relationships.

Intent: Supervisors are critical in developing and maintaining a clear focus on parent-child interaction and attachment. It is the supervisor's role to partner with staff to ensure CHEERS is used to develop reflective strategies to increase secure attachment experiences during weekly supervision. The supervisor's documentation will reflect how they support staff's use of CHEERS. Supervisors do not need to restate the PCI observed on the visit, as this will be documented in the home visit record.

6-3.E RATING INDICATORS

3 Supervisors support staff to assess parent-child interaction, address concerns, and promote strengths of parent-child interactions with all families utilizing CHEERS.

2 Past instances were found when the supervisor did not support staff to assess parent-child interaction, address concerns, and promote the strengths of parent-child interaction with all families utilizing CHEERS; however, **recent practice** indicates this is now occurring.

1 Supervisors do not yet support staff to assess parent-child interaction, address concerns, and promote the strengths of parent-child interaction with all families utilizing CHEERS.

Note: This is an Essential Standard.

TIP: When less than all six domains of CHEERS are assessed on a home visit, the supervisor will support the FSS in assessing different domains on subsequent visits so that over the course of a few visits, all domains are assessed.

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

6-4. The site shares information (e.g. credible source parenting materials, evidence-informed curriculum) with parents to promote healthy child development, nurturing parent-child relationships, parenting skills, and health and safety practices with families.

Intent: Materials shared with parents are used with intentionality and a strength-based approach that builds on parental capacity and in response to parent-child interests and observations made by the FSS. Fact-based materials help Family Support Specialists provide anticipatory guidance, and supports parents in thinking about what their baby's next phase of development will be and how they can support this development.

When a parent has endured early childhood trauma, it is important for the Family Support Specialist to spend time with the parent to listen to what the parent is thinking, feeling, and experiencing before presenting reading materials or activities. It is only when the parent feels safe and supported that they can begin to absorb this type of information. Including parents in the discovery of their child's development by asking parents what they have noticed about their baby as related to the specific child development topics, before sharing specific information, is highly recommended.

The key to successful use of handouts and activities is tied most closely to how the materials are used with families versus what materials are used. Sites use materials that are culturally respectful, supported by research, and in response to parent and child needs versus the primary focus of each home visit as they represent just one piece of a comprehensive approach to working with families. The primary focus of each visit is on the relationship between parents and child. Over-reliance on parenting materials distracts from this primary focus and from the ability to be fully observant, attuned, and responsive to these relationship dynamics.

Parenting materials and evidence-informed curriculum contain a variety of components which include:

- information on how to promote nurturing parent-child relationships (e.g., makes parents 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, etc.)
- child development information and how to share this in a strength-based manner (e.g., build on parental competencies, engage parents' critical thinking skills, identify emerging skills, address language use and literacy, include all developmental domains, incorporate the use of developmental screens, etc.)
- content that is developmental in nature
- strategies that strengthen families and their relationships
- health and safety information such as safer sleep, breastfeeding, pre- and postnatal health care, well-child care, dental and oral health, and lead exposure

6-4.A The site has policy and procedures regarding the promotion of child development, nurturing parent-child relationships, parenting skills, and health and safety practices, and the policy specifies which evidence-informed parenting materials are used with families.

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

6-4.A RATING INDICATORS

3 No 3 rating indicator for standard 6-4.A.

2 The site has policy and procedures regarding the Family Support Specialist's role in promoting child development, nurturing parent-child relationships, parenting skills, and health and safety practices with families. The policy specifies how evidence-informed parenting materials are shared with families using a strength-based approach that builds on parental capacity and in response to parent-child interests and observations made by the FSS versus as the primary focus of the visit.

1 Any of the following: the site does not yet have policy and procedures; or the policy and procedures do not yet cover promotion of child development, nurturing parent-child relationships, parenting skills, and health and safety related issues; or the policy does not yet specify how evidence-informed parenting materials are shared with families using a strength-based approach that builds on parental capacity and in response to parent-child interests and observations made by the FSS versus as the primary focus of the visit.

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

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

6-4.B RATING INDICATORS

3 The Family Support Specialist shares information with all families on appropriate activities designed to promote healthy child development, nurturing parent-child relationships and parenting skills.

2 Past instances were found when the Family Support Specialist did not share information with all families on appropriate activities designed to promote healthy child development, nurturing parent-child relationships and parenting skills; however, **recent practice** indicates this is now occurring.

1 The Family Support Specialist does not yet share information with all families on appropriate activities designed to promote healthy child development, nurturing parent-child relationships and parenting skills.

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

6-4.C The Family Support Specialist shares evidence-informed parenting materials designed to promote health and safety practices based on family needs.

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

6-4.C RATING INDICATORS

3 The Family Support Specialist shares information with all families designed to promote evidence-informed health and safety practices.

2 Past instances were found when the Family Support Specialist did not share information with all families designed to promote evidence-informed health and safety practices; however **recent practice** indicates this is now occurring.

1 The Family Support Specialist does not yet share information with all families designed to promote evidence-informed health and safety practices.

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

6-4.D The Family Support Specialist promotes safer sleep practices with pregnant parents and families with an infant birth to twelve months of age.

Intent: Sites begin sharing safer sleep information with parents in the prenatal period, when enrolled prenatally, to support these practices occurring as soon as the baby comes home from the hospital. When enrolled postnatally, safer sleep information is shared early and as infant develops and sleep habits change over the course of the first year.

6-4.D RATING INDICATORS

3 The Family Support Specialist shares safer sleep information with all pregnant parents and families with an infant birth to twelve months of age.

2 Past instances were found when the Family Support Specialist did not share safer sleep information with all pregnant parents and families with an infant birth to twelve months of age; however **recent practice** indicates this is now occurring.

1 The Family Support Specialist does not yet share safer sleep information with all pregnant parents and families with an infant birth to twelve months of age.

6-5. The site monitors the development of participating infants and children with the ASQ (Ages and Stages Questionnaire) and ASQ:SE (Social Emotional), using current versions of both.

6-5.A The site has policy and procedures for administration of the ASQ and ASQ:SE, including the frequency these tools are to be administered with all focus children, unless developmentally inappropriate, and requires tracking of all children suspected of developmental delay, with appropriate referrals and follow-up, as needed.

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

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

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

6-5.A RATING INDICATORS

3 No 3 rating indicator for standard 6-5.A.

2 The site has policy and procedures for administration of the ASQ and ASQ:SE that require at a minimum:

1) the ASQ and ASQ:SE are used with all focus children, unless developmentally inappropriate
2) the ASQ is administered at least twice per year each year of the child's life for children under the age of three, and annually for children ages three through five years (for sites serving ages three through five)
3) the ASQ:SE is administered at least once annually each year of the child's life
4) how it tracks focus children who are suspected of having a developmental delay and provides appropriate referrals and follow-up as needed

1 Any of the following:

1) the site does not yet have policy and procedures to administer the ASQ and ASQ:SE
2) the policy and procedures do not yet specify when the tools are to be used with all focus children, unless developmentally inappropriate
3) the policy and procedures do not yet require use of the ASQ for children under the age of three at least twice per year, and at least once annually for children ages three through five years (for sites serving children ages three through five)
4) the policy and procedures do not yet require use of annual administration of the ASQ:SE
5) the policy and procedures do not yet indicate how it tracks focus children who are suspected of having a developmental delay and how it provides appropriate referrals and follow-up as needed

TIP: Sites are encouraged to screen more frequently than the minimum required in the standard.

TIP: Supervisors are encouraged to note any concerns identified from the developmental screens on the HFA Service Plan, with planned interventions/activities to address and track progress.

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

TIP: Sites are encouraged to contact early intervention services in their community to assist in the development of policy and procedures regarding the referral and tracking process for children suspected of having a delay. It is recommended collaboration occur (with parent permission and informed consent) in the development of an IFSP with both early intervention and HFA sites. Staff is encouraged to continue collaboration with early intervention services when the child is dually enrolled.

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

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

6-5.B RATING INDICATORS

3 The site uses the ASQ during home visits and **at least 90%** of focus children (excluding those when developmentally inappropriate) are screened a minimum of twice per year of the child's life for children under the age of three and annually for children ages three through five years.

2 Past instances were found when the site did not use the ASQ with at least 90% of focus children (excluding those when developmentally inappropriate) a minimum of twice per year of the child's life for children under the age of three and annually for children ages three through five years; however, this is now occurring during home visits and **90% of focus children have one completed screen in the last six months.**

1 Any of the following: the site does not yet use the ASQ during home visits; or the site does not yet use the ASQ at the specified intervals to ensure all focus children in the site (excluding those when developmentally inappropriate) were screened a minimum of twice per year for children under the age of three and annually for children ages three through five years; or less than 90% of focus children have completed ASQ screens due in the last six months.

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

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

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 90% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

6-5.C The site ensures the ASQ:SE (Ages and Stages Questionnaire: Social Emotional) is used during home visits, unless developmentally inappropriate, and is administered according to the developers' instructions to ensure valid results. An HFA Spreadsheet is available for this standard.

6-5.C RATING INDICATORS

3 The site uses the ASQ:SE during home visits at specified intervals and ensures **at least 90%** of focus children (excluding those when developmentally inappropriate) are screened a minimum of once per year of the child's life, for children birth to age five.

2 Past instances were found when the site did not use the ASQ:SE with at least 90% of focus children (excluding those when developmentally inappropriate) a minimum of once per year of the child's life, for children birth through age five; however, this is now occurring during home visits and **at least 90% of focus children have one completed screen in the last twelve months.**

1 Any of the following: the site does not yet use the ASQ:SE during home visits; or the site does not yet use the ASQ:SE a minimum of once per year for focus children birth to age five; or less than 90% of focus children have completed ASQ:SE screens due in the last twelve months.

TIP: The site is encouraged to make the ASQ:SE tool available to parents for subsequent births. If administered by site staff, the dates and results should be recorded in the family file.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 90% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

6-5.D The site tracks focus children suspected of having a developmental delay and provides appropriate referrals and follow-up as needed.

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

It is critical to support parents by tracking referrals and supporting the parent in following through with in-depth evaluations and therapy. It is recommended screens and developmental assessments administered by early intervention services be kept in the family files (however, this is not a requirement). At the site level the program manager/supervisor is aware of any challenges with referral sources for early intervention services and assists by advocating with referral entities/partners to reduce these barriers.

6-5.D RATING INDICATORS

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

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

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

NA No children identified with a developmental delay.

TIP: The site is encouraged to record concerns about possible developmental delay for the focus child, along with associated referrals and activities, on the Service Plan.

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

Tables of Documentation

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

Standard	Pre-Site Documentation to include in Self Study
6-1.A | Policy - HFA Service Plan	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
6-1.B | HFA Service Plan in Supervision	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-1.C | HFA Service Plan with Families **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-2.A | Policy - Development of Family Goals	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
6-2.B | Family Goal Development **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-2.C | Family Goals in Supervision	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-3.A | Policy - CHEERS	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
6-3.B | PCI Assessed using CHEERS **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-3.C | PCI Addressed & Promoted **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-3.D | CHEERS Check-In	Submit a report of all enrolled focus children (including multiples) that includes: 1. Child's date of birth 2. CCI administration dates 3. Documentation of declined screening by primary caregiver Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children. Please Note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
6-3.E | Supervision Support in Assessing, Addressing and Promoting PCI (Through Use of CHEERS and Validated PCI Tool) **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
6-4.A | Policy - Child Development, Parenting Skills, Health & Safety	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
6-4.B | Promote Healthy Child Development and Parenting Skills	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-4.C | Promote Health and Safety Practices	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-4.D | Promote Safer Sleep Practices	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-5.A | Policy - ASQ-3 and ASQ-SE-2 Screens	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
6-5.B | ASQ-3 Developmental Screening	Submit a report of all enrolled focus children that includes: 1. Child's date of birth 2. Enrollment date 3. ASQ-3 administration dates 4. Documentation of a. Indication of delay and if a referral was made b. Not screened due to involvement of early intervention services c. Revised screening schedule (prematurity or other reason) d. If the timing of re-enrolling, transferring into services, or Child Welfare Protocol enrollment precludes availability of 2 remaining intervals in a given year for contextual decision-making by Peer Reviewers or Panel. Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children. Please Note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
6-5.C | ASQ:SE-2 Social Emotional Screening	Submit a report of all enrolled focus children that includes: 1. Child's date of birth 2. Enrollment date 3. ASQ-3 administration dates since 1/1/2018 4. Documentation of a. Indication of delay b. Not screened when developmentally inappropriate Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children. Please Note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
6-5.D | Developmental Delay Tracking and Follow-Up	Submit a report the site uses to track currently enrolled focus children identified with suspected developmental delay, including referrals made and follow-up on referrals.

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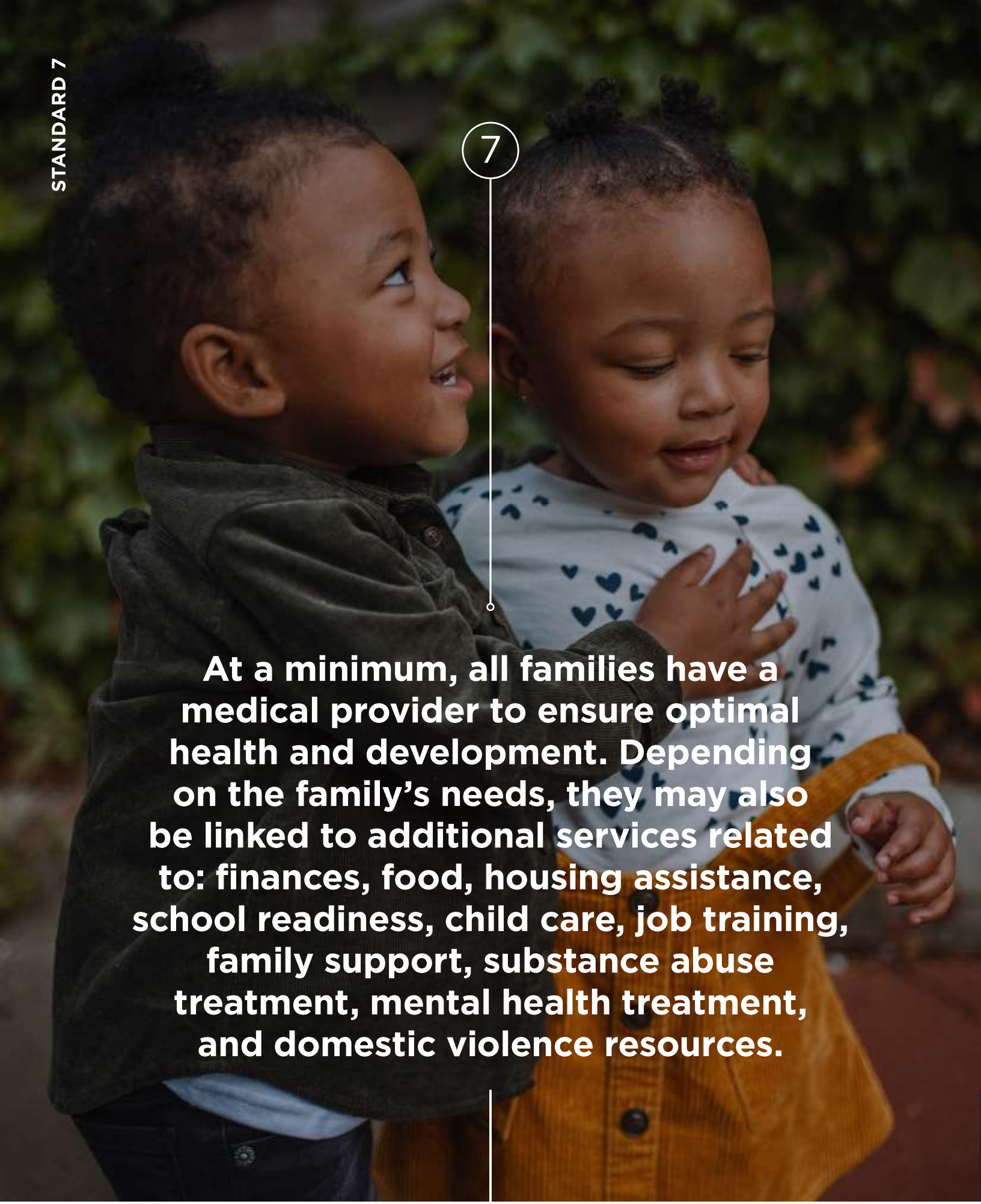


At a minimum, all families have a medical provider to ensure optimal health and development. Depending on the family's needs, they may also be linked to additional services related to: finances, food, housing assistance, school readiness, child care, job training, family support, substance abuse treatment,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

Standard 7 Intent is to ensure site staff link families to providers for preventative health care and timely receipt of immunizations, and appropriately refer families to additional community services based on each family's unique needs.

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

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

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

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

7-1.A RATING INDICATORS

3 No 3 rating indicator for standard 7-1.

2 The site has policy and procedures for linking all focus children to medical/health care providers and supporting parents in utilizing health care appropriately, including the receipt of well-child care for their child(ren).

1 The site does not yet have policy and procedures to link all focus children to medical/health care providers; or policy does not yet include how parents will be supported in utilizing health care, including well-child care, for their child(ren).

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

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

Intent: A medical home is crucial to the health and optimal development of the child. In addition to being a vital resource for ongoing preventive health and wellness guidance, and medical interventions as needed, a medical home plays a crucial role in child abuse prevention, as it allows another professional consistent access to the family to provide support and monitoring for the well-being of the child. An HFA Spreadsheet is available for this standard.

7-1.B RATING INDICATORS

3 Ninety-five percent **(95%) through one hundred percent (100%)** of focus children have a medical/health care provider.

2 Eighty percent **(80%) through ninety-four percent (94%)** of focus children have a medical/health care provider.

1 Less than eighty percent (80%) of focus children have a medical/health care provider.

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

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

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-1.C The site monitors the utilization of well-child care for focus children, and works to address barriers impacting access and receipt of well-child care.

Intent: Well-child visits are essential for preventive health care, to monitor growth and development, and to establish a regular connection with a medical provider. Sites track the receipt of well-child visits subsequent to enrollment in HFA and based on age of the child at the intervals recommended by the American Academy of Pediatrics (AAP) schedule (3 to 7 days, 2 to 4 weeks, 2 to 3 months, 4 to 5 months, 6 to 7 months, 9 to 10 months, 12 to 13 months, 15 to 16 months, 18 to 19 months, 2 to 2.5 years, 3 to 3.5 years, and 4 to 4.5 years). An HFA Spreadsheet is available to track the receipt of well-child visits. If the site uses a well-child visit schedule other than the AAP, a reference to it will be provided.

It is important for sites to understand what factors are impacting well-child care utilization rates. In some communities there is a documented shortage of primary care providers (HRSA, 2012). These shortages are most pervasive in urban and rural areas, in contrast to suburban areas, which generally have a larger supply of providers. In addition, accessing treatment may be difficult for some because of financial, transportation, language, or other barriers.

7-1.C RATING INDICATORS

3 The site monitors the receipt of well-child care visits for all focus children, and has **implemented** strategies to address identified barriers.

2 The site monitors the receipt of well-child care visits for all focus children; and the site has **developed** but not yet implemented strategies to address identified barriers.

1 The site does not yet monitor the receipt of well child care visits; or has not yet developed strategies to address identified barriers.

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

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

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

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

7-2.A RATING INDICATORS

3 No 3 rating indicator for 7-2.A.

2 The site has policy and procedures including all of the following:

- how Family Support Specialists will share information with all families designed to promote and educate families on the importance of immunizations
- how Family Support Specialists will obtain and track information regarding the receipt of immunizations
- how Family Support Specialists will follow up when immunization appointments are missed

1 The site does not yet have policy and procedures; or policy and procedures do not yet include all items listed in the 2 rating.

7-2.B The site ensures immunizations are up-to-date for focus children at one year of age. Please Note: the percentage does not include children whose permanent health conditions or family beliefs preclude immunizations; however, explanation of these exceptions must be documented in the family file. An HFA Spreadsheet is available for this standard.

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

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

Please Note: When calculating up-to-date immunization rates at one year of age, the site will look at all enrolled focus children ages 12-23 months (including those on creative outreach), and the number of those children who received all immunizations recommended for infants birth through six months.

For example, if at the end of one fiscal year there are 25 enrolled focus children who are ages 12-23 months, and 20 of them received all immunizations expected through 6 months of age, the rate for this age group is 20/25 x100 = 80%.

7-2.B RATING INDICATORS

3 Ninety percent **(90%) through one hundred percent (100%)** of focus children who are currently 12-23 months of age are up-to-date with all immunizations expected by six months of age.

2 Eighty percent **(80%) through eighty-nine percent (89%)** of focus children who are currently 12-23 months of age are up-to-date with all immunizations expected by six months of age.

1 Less than eighty percent (80%) of focus children who are currently 12-23 months of age are up-to-date with all immunizations expected by six months of age.

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

TIP: The Centers for Disease Control and Prevention (CDC) have an interactive immunization scheduler available online.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-2.C The site ensures immunizations are up-to-date for focus children at two years of age. Please Note: the percentage does not include children whose permanent health conditions or family beliefs preclude immunizations; however, explanation of these exceptions must be documented in the family file. An HFA Spreadsheet is available for this standard.

Intent: See intent for 7-2.B. *Please Note*: When calculating up-to-date immunization rates at two years of age, the site will look at all enrolled focus children 24 months and older (including those on creative outreach), and the number of those children who received all immunizations expected through 18 months.

For example, if at the end of one fiscal year there are 10 enrolled focus children who are 24 months old and older and 9 of those children received all the immunizations expected for children through 18 months of age, the rate for this age group is 9/10 x 100 = 90%.

7-2.C RATING INDICATORS

3 Ninety percent **(90%) through one hundred percent (100%)** of focus children who are currently 24 months or older are up-to-date with all immunizations expected by eighteen months of age.

2 Eighty percent **(80%) through eighty-nine percent (89%)** of focus children who are currently 24 months or older are up-to-date with all immunizations expected by eighteen months of age.

1 Less than eighty percent (80%) of focus children who are currently 24 months or older are up-to-date with all immunization expected by eighteen months of age.

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

TIP: The Centers for Disease Control and Prevention (CDC) have an interactive immunization scheduler available online.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

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

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

7-3.A RATING INDICATORS

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

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

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

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

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

7-3.B RATING INDICATORS

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

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

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

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

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

Intent: Families benefit by accessing community agencies and services to support the family in accomplishing goals or overcoming challenges they may be experiencing. Families may be reluctant to access additional services, and direct service staff are one way to bridge the gap. Site staff are familiar with the community agencies and the services they provide to ensure families are referred appropriately. Sites are encouraged to provide referrals as often as needed. Additionally, while there may be services to refer the family to within the community, it does not mean they are necessarily appropriate or needed by the family. Sites stay up-to-date on existing resources in the community so referrals can be provided appropriately when needed.

7-3.C RATING INDICATORS

3 Families are linked to additional services in the community when needed.

2 Past instances were found when families needing additional services were not connected to appropriate services (when resources exist in the community); however, **recent practice** indicates this is now occurring.

1 Families are not yet linked to additional services in the community on an as needed basis.

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

7-3.D RATING INDICATORS

3 The site has a method for tracking and following up on referrals of families to other community services as needed and the site is tracking and following up on referrals.

2 Past instances were found when tracking and follow-up did not occur; however, **recent practice** indicates this is now occurring.

1 Either the site does not yet have a method or the site has a method but is not yet tracking and following up.

TIP: Staff-initiated referrals related to addressing issues and activities on the Service Plan can be documented on the family's Service Plan along with follow-up on these referrals if it is helpful to keep this information in one location.

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

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

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

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

- administration guidelines
- ways to talk with parents about depression
- community resource information
- activities Family Support Specialists can do with families to reduce stress and increase serotonin
- ways to support parents in meeting their child's physical and emotional development

Additional training opportunities include:

- 11-2.D wraparound training on mental health
- access to the free online course through the National Child Traumatic Stress Network (Psychological First Aid Field Operations Guide)

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

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

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

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

7-4.A RATING INDICATORS

3 No 3 rating for standard 7-4.A.

2 The site has policy and procedures for administration of the depression screening tool and specifies the following:

- is to be used with the primary caregiver of all enrolled families
- what tool is used for depression screening
- the frequency of screening: at least once prenatally and at least once within three months of birth OR within 3 months of enrollment when enrolled after birth, AND at least once within 3 months of all subsequent births (born 1/1/18 or later)
- what score constitutes a positive screen
- referral and follow-up expectations with elevated screens
- activities appropriate for Family Support Specialists to do with families
- the requirement that all staff receive training on how to administer the tool prior to first use (unless already included in the site's training plan/policy – standard 10-1).

1 The site does not yet have policy and procedures; or policy and procedures do not yet include all components in the 2 rating.

TIP: Sites may choose to administer the depression screen during the assessment process.

TIP: Sites may consider conducting the depression screen with other caregivers, in addition to the primary caregiver.

TIP: Research has shown pre- and postnatal depression is not exclusive to mothers. Paternal depression is of concern as well with first births and subsequent births.

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

Intent: Depression screening is conducted prenatally and postnatally. Depression screens are completed even when families are in treatment to ensure treatment is meeting the needs of the family. Sites are expected to include Level CO families on their depression screening data reports (and to note time period the family was on Level CO), and to track receipt of depression screening during times the family is not on Level CO.

Please Note: Sites can use the HFA Spreadsheet to track depression screens.

7-4.B RATING INDICATORS

3 **At least 95%** of active primary caregivers enrolled in the past twelve months are screened using a standardized and validated depression screening tool at least once prenatally (when enrolled prenatally).

2 **80% - 94%** of active primary caregivers enrolled in the past twelve months are screened using a standardized and validated depression screening tool at least once prenatally (when enrolled prenatally).

1 Any of the following: the site does not yet use a standardized depression screening tool; or less than 80% of active primary caregivers enrolled in the past twelve months are screened prenatally.

NA The site does not enroll families prenatally.

TIP: If another service provider is involved and has completed depression screening, the Family Support Specialists may choose to coordinate to reduce duplicate screening. When doing so, a written consent to release information must be on file in the participant record and the site must be in receipt of a copy of the depression screen to show the screening was done, and to track any necessary follow-up referrals/interventions for the family.

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

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% "on-time" threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

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

Intent: Depression screens are completed even when families are in treatment to ensure treatment is meeting the needs of the family. Sites are expected to include Level CO families on their depression screening data reports (and to note time period the family was on Level CO), and to track receipt of depression screening during times the family is not on Level CO.

Please Note: Sites can use the HFA Spreadsheet to track depression screens.

7-4.C RATING INDICATORS

3 **At least 95%** of active primary caregivers enrolled in the past twelve months are screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the baby's birth (for those enrolled prenatally), or within 3 months of enrollment (for those enrolled postnatally).

Families not screened within 3 months are screened at least once within 6 months postnatally or post-enrollment (unless caregiver declined the screen).

2 **80% - 94%** of active primary caregivers enrolled in the past twelve months are screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the baby's birth (for those enrolled prenatally), or within 3 months of enrollment (for those enrolled postnatally).

Families not screened within 3 months are screened at least once within 6 months postnatally or post-enrollment (unless the caregiver declined the screen).

1 Any of the following: the site does not yet use a standardized depression screening tool; or less than 80% of active primary caregivers enrolled in the past twelve months are screened within 3 months as described in the 2 rating; or less than 100% have a depression screen within 6 months of enrollment.

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

TIP: If another service provider is involved and has completed depression screening, the Family Support Specialists may choose to coordinate to reduce duplicate screening. When doing so, a written consent to release information must be on file in the participant record and the site must be in receipt of a copy of the depression screen to show the screening was done, and to track any necessary follow-up referrals/interventions for the family.

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

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% "on-time" threshold or the 100% within 6 months threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

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

Intent: Postpartum depression is estimated to affect more than 5 percent of all women following childbirth, making it the most common postnatal complication of childbearing. The risk of recurrence is also known to be high and, given the impact of depression on parent and child health, HFA sites are required to screen all subsequent births to ensure appropriate supports are provided when indicated.

In a study, researchers analyzed data on 457,317 women who had a first child (and subsequent births) between 1996 and 2013 and had no prior psychiatric hospital contacts or use of antidepressants. Postpartum affective disorder (which included postpartum depression) was defined as an antidepressant prescription fill or hospital contact for depression within six months after birth.

In the cohort, 0.6% of all births among women with no history of psychiatric disease led to postpartum affective disorder. A year after their first treatment, 27.9% of these women were still in treatment; after four years, that number was 5.4%. For women with a hospital contact for depression after a first birth, the risk of postpartum affective disorder recurrence was 21%; the recurrence was 15% for women who took antidepressants after a first birth. These rates mean that, compared to women without history of affective disorder, the likelihood of depression with a subsequent birth is much higher for women with postpartum affective disorder after their first birth.

Rasmussen M-LH, Strøm M, Wohlfahrt J, Videbech P, Melbye M (2017). Risk, treatment duration, and recurrence risk of postpartum affective disorder in women with no prior psychiatric history: A population-based cohort study. PLoS Med 14(9): e1002392. *Please Note*: Sites can use the HFA Spreadsheet to track depression screens.

7-4.D RATING INDICATORS

3 In the last completed reporting year, **at least 95%** of active primary caregivers with a subsequent birth were screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the birth.

2 In the last completed reporting year, **80% - 94%** of active primary caregivers with a subsequent birth were screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the birth; or there have been no subsequent births.

1 Any of the following: the site does not yet use a standardized depression screening tool; or in the last completed reporting year less than 80% of active primary caregivers with a subsequent birth were screened within 3 months of the birth.

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

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% "on-time" threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-4.E Family Support Specialists provide activities to support primary caregivers whose depression screening scores are elevated and considered to be at-risk of depression, including items listed in the intent for standard 7-4, in addition to referral and follow-up on referrals, unless already involved in treatment, or treatment resources do not exist in the community.

Please Note: When caregivers are already involved in treatment or treatment resources do not exist in the community, these situations are noted in the tracking report.

7-4.E RATING INDICATORS

3 Primary caregivers with an elevated depression screening score are supported with appropriate activities by the Family Support Specialist and are referred (with consent when needed) for further evaluation/treatment and follow-up unless already involved in treatment, or treatment resources do not exist in the community.

2 Past instances were found when the site did not ensure all primary caregivers with an elevated depression screening score were supported with appropriate activities by the Family Support Specialist and referred (with consent when needed) for further evaluation/treatment and follow-up unless already involved in treatment or treatment resources do not exist in the community; however, **recent practice** indicates this is now occurring. Or there have been no elevated depression screens for currently enrolled families.

1 Any of the following: primary caregivers with an elevated depression screening score are not yet supported with appropriate activities by the Family Support Specialists; or are not yet referred for further evaluation/treatment; or there is no follow-up on those who are referred.

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

Tables of Documentation

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

Standard	Pre-Site Documentation to include in Self Study
7-1.A | Policy - Medical Providers for Focus Children	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
7-1.B | Focus Children with Health Care Provider	Submit a report reflecting: 1. List and count all active focus children 2. List and count all active focus children w/medical provider, include provider 3. Calculate: #2 (focus children w/medical provider) divided by #1 (total number of focus children) Please Note: An HFA Spreadsheet is available for this standard. Submit HFA Spreadsheet or report detailing all active focus children and their current medical/health care provider, including percent of children with a provider. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
7-1.C | Focus Children with Well-Child Care	Submit a narrative of how the site monitors well-child care along with any strategies developed to address identified barriers. Indicate what strategies have been implemented.
7-2.A | Policy - Timely Receipt of Immunizations	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
7-2.B | Measure Immunization Rates at 1yr	Submit the site's immunization schedule. Also submit a report reflecting immunization rates for all enrolled focus children ages 12-23 months (including those on Creative Outreach). 1. Count number of focus children currently between 12-23 months 2. Subtract from #1 (focus children between 12-23 months) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step #2), count how many are fully up to date with all immunizations expected through 6 months 4. Report number and calculate: #3 (those up to date) divided by #2 (number between 12-23 months minus those excluded from count) *Please Note:* An HFA Spreadsheet is available for this standard.
7-2.C | Measure Immunization Rates at 2yr	Submit a report reflecting immunization rates for all active focus children 24 months and older (including those on creative outreach). 1. Count number of focus children currently older than 24 months 2. Subtract from #1 (focus children 24 months and older) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step #2), count how many are fully up to date with all immunizations expected through 18 months 4. Report number and calculate: #3 (those up to date) divided by #2 (number 24 months and older minus those excluded from count) *Please Note*: An HFA Spreadsheet is available for this standard.
7-3.A | Policy - Health Care and Community Information and/or Referrals and Follow-up	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available

Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
7-3.B | Health Care Referrals	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
7-3.C | Community Resource Referrals	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
7-3.D | Referral Follow-up	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
7-4.A | Policy – Depression Screening	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
7-4.B | Prenatal Depression Screening	Submit a report of all current primary caregivers enrolled prenatally in the past 12 months. Include: 1. Enrollment date 2. Date of birth of focus child 3. Prenatal screening date(s) 4. Provide an explanation of any missed screens To calculate percent screened prenatally: 1. Count number enrolled prenatally 2. Count number screened prenatally 3. Divide #3 (screened prenatally) by #2 (enrolled prenatally) *Please Note:* An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
7-4.C | Postnatal Depression Screening	Submit a report of all current primary caregivers enrolled in the past 12 months. Include: 1. Enrollment date 2. Date of birth of focus child 3. Postnatal screening date(s) 4. Provide an explanation of any missed screens To calculate percent of primary caregivers screened within 3 months: 1. Count number enrolled 2. Count number screened a. For prenatal enrollments, count if received within 3 months of the child's birth b. For postnatal enrollments, count if received within 3 months of enrollment c. Add these counts together (a + b) 3. Divide #2 (screened) by #1 (enrolled) for percent screened To calculate percent of primary caregivers screened within 6 months: 1. Count number enrolled 2. Count number screened: a. For prenatal enrollments, count if received within 6 months of the child's birth b. For postnatal enrollments, count if received within 6 months of enrollment c. Add these counts together (a + b). 3. Divide #2 (screened) by #1 (enrolled) for percent screened *Please Note*: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.

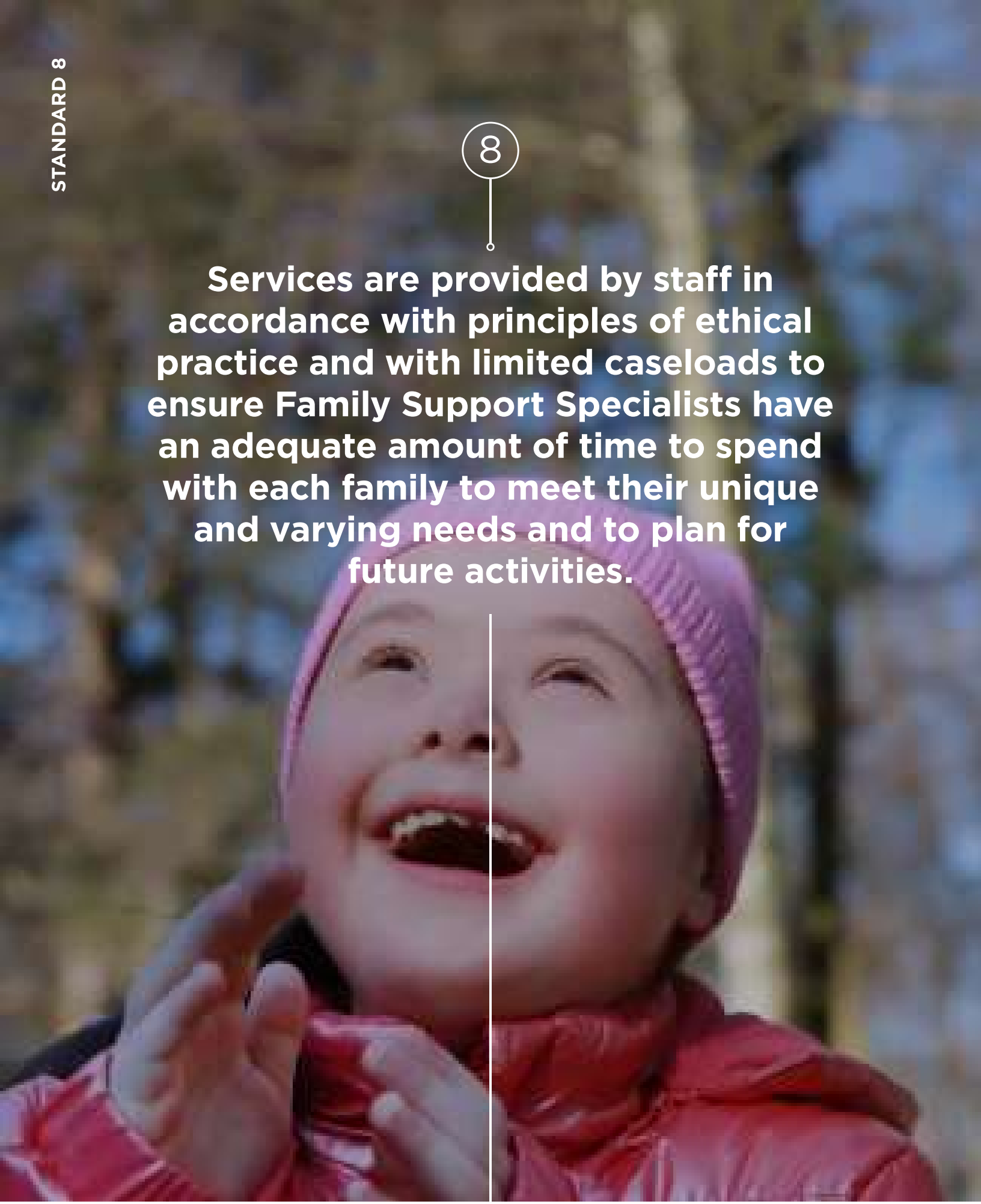
Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
7-4.D | Screening for Depression w/ Subsequent Births	Submit a report of all current primary caregivers with a subsequent birth in the most recent 12 months. Include: 1. Date of birth of subsequent child 2. Postnatal screening date(s) 3. Provide an explanation of any missed screens To calculate percent of primary caregivers screened: 1. Count number who had a subsequent birth 2. Count number screened within 3 months of the subsequent birth 3. Divide #2 (screened) by #1 (number with a subsequent birth) for percent screened *Please Note:* An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
7-4.E | Referral and Follow up for Primary Caregiver with Elevated Screens	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

STANDARD 8

8

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



Standard 8 Intent is to ensure site staff have limited caseloads to allow them the necessary time with families to build trusting, nurturing relationships.

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

Intent: The importance of a limited and manageable caseload for each Family Support Specialist cannot be emphasized enough. It ensures staff are able to work most successfully and families will be afforded the time, energy, and resources necessary to help build protective factors, reduce risk, and impact positive change.

When setting caseload size, it is important to consider staff tenure and experience, along with family complexity and service intensity. HFA's level change system assures each family is individually considered both in terms of need and in terms of progress being made. Maximum case weight of thirty points expresses the absolute ceiling, not the expected size of an FSS caseload.

In addition to guidance about assigning case weight based on level of service (standard 4-2.A), HFA allows sites to increase case weight for families when warranted (referenced in the Glossary and HFA's Level Change forms). Supervisors and FSSs will determine whether service intensity should be temporarily increased or if a more permanent increase in service intensity should be applied owing to case complexity, extensive travel, births of multiples, translation needs, etc.

8-1.A The site's policy and procedures regarding caseload size indicate full-time (40 hours/week) Family Support Specialists in their first and second year working in this role to typically carry a caseload of approximately 10-12 families, and full-time Family Support Specialists in the role for three years or more typically carry a caseload of approximately 15-20 families, with supervisors using discretion about the pace which staff build a caseload and size of each staff person's caseload, not exceeding thirty (30) case weight points.

8-1.A RATING INDICATORS

3 No 3 rating indicator for 8-1.A

2 The site's policy and procedures regarding caseload size are based on staff tenure, with full-time Family Support Specialists in their role for one-two years typically with a caseload of 10-12 families and full-time Family Support Specialists employed for three years or more typically with caseload of 15-20 families. Supervisors use discretion regarding the pace each staff person builds a caseload and, ensures regardless of time in role or number of families, caseload will not exceed thirty case weight points (prorated for staff working less and a 40 hour work week).

1 The site does not yet have policy and procedures regarding caseload size; or the site's policy states case weight exceeds the maximum allowable for full time Family Support Specialist (40 hrs/wk).

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

TIP: For sites serving families experiencing complex stressors, a tenured full-time staff person generally is maxed out with caseload of 12-16 families.

8-1.B Full-time Family Support Specialists do not exceed a case weight of thirty points.

Intent: HFA's case weight system helps to ensure the caseload of Family Support Specialists is manageable and family needs can be effectively supported. There are select circumstances when FSSs may exceed the maximum case weight of thirty points, e.g., a Family Support Specialist leaves and the caseload is temporarily dispersed among existing Family Support Specialists temporarily (3 consecutive months or less). Sites are to clearly document the reasons why the caseload has exceeded the limit, as well as the duration of this deviation.

Also, the maximum is based on a full-time schedule of 40 hours worked per week. When an organization employs full-time staff at less than 40 hours per week, and/or part-time staff, the maximum case weight will need to be prorated accordingly, and the proration calculation grid (below) can be used to determine maximum case weight.

An HFA Spreadsheet is available for this standard.

8-1.B RATING INDICATORS

3 Within the last twelve (12) months, **no Family Support Specialist exceeds the maximum case weight** of thirty points (or the prorated case weight for staff working less than 40 hour/week).

2 Instances were found when **Family Support Specialist(s) exceeded the maximum case weight of thirty points (or the prorated case weight** for staff working less than 40 hour/week); however, **any deviation in the past twelve (12) months was temporary (3 consecutive months or less).**

1 In the past twelve (12) months, Family Support Specialists have had case weights in excess of thirty points (or in excess of the prorated case weight for staff working less than 40 hour/week) for periods longer than 3 consecutive months; or data regarding case weight has not been maintained for the past 12 months.

MAXIMUM CASE WEIGHT			
Formula: 0.75 x # of hours per week			
40 HOUR WEEK	37.5 HOUR WEEK	35 HOUR WEEK	20 HOUR WEEK
30 pts	28 pts	26 pts	15 pts

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

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

Consideration when assigning families will need to factor in any potential boundary issues or conflicts to ensure staff avoid these situations. Other considerations include the length of time to travel to and from family homes, especially for rural or remote areas where travel time may exceed the norm. Considerations are also made when there are multiple births (see guidelines in HFA's Level System).

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

8-2.A RATING INDICATORS

3 No 3 rating indicator for standard 8-2.A.

2 The site's policy and procedures include all of the following criteria:

- experience, length of time in role, and skill level of the Family Support Specialist
- nature and difficulty of family dynamics
- work and time required to serve each family
- avoiding potential worker conflict or boundary challenge owing to an existing personal relationship
- current staff capacity
- travel and other non-direct service time required to fulfill responsibilities
- extent of other resources available in the community to meet family needs
- other assigned duties

1 The site does not yet have policy and procedures; or the policy and procedures do not yet include all the criteria listed above in the 2 rating.

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

TIP: Additionally, developing relationships with families who have lost their previous Family Support Specialist may require additional creative support to maintain engagement in services since there may be an additional sense of loss.

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

8-2.B RATING INDICATORS

3 The site assigns and manages its caseload sizes utilizing criteria identified in 8-2.A and outlined in the policy and procedures.

2 Past instances were found when caseloads were not assigned or managed according to the criteria identified in 8-2.A; however, **recent practice** indicates this is now occurring.

1 The site does not yet assign or manage its caseloads utilizing criteria identified in 8-2.A.

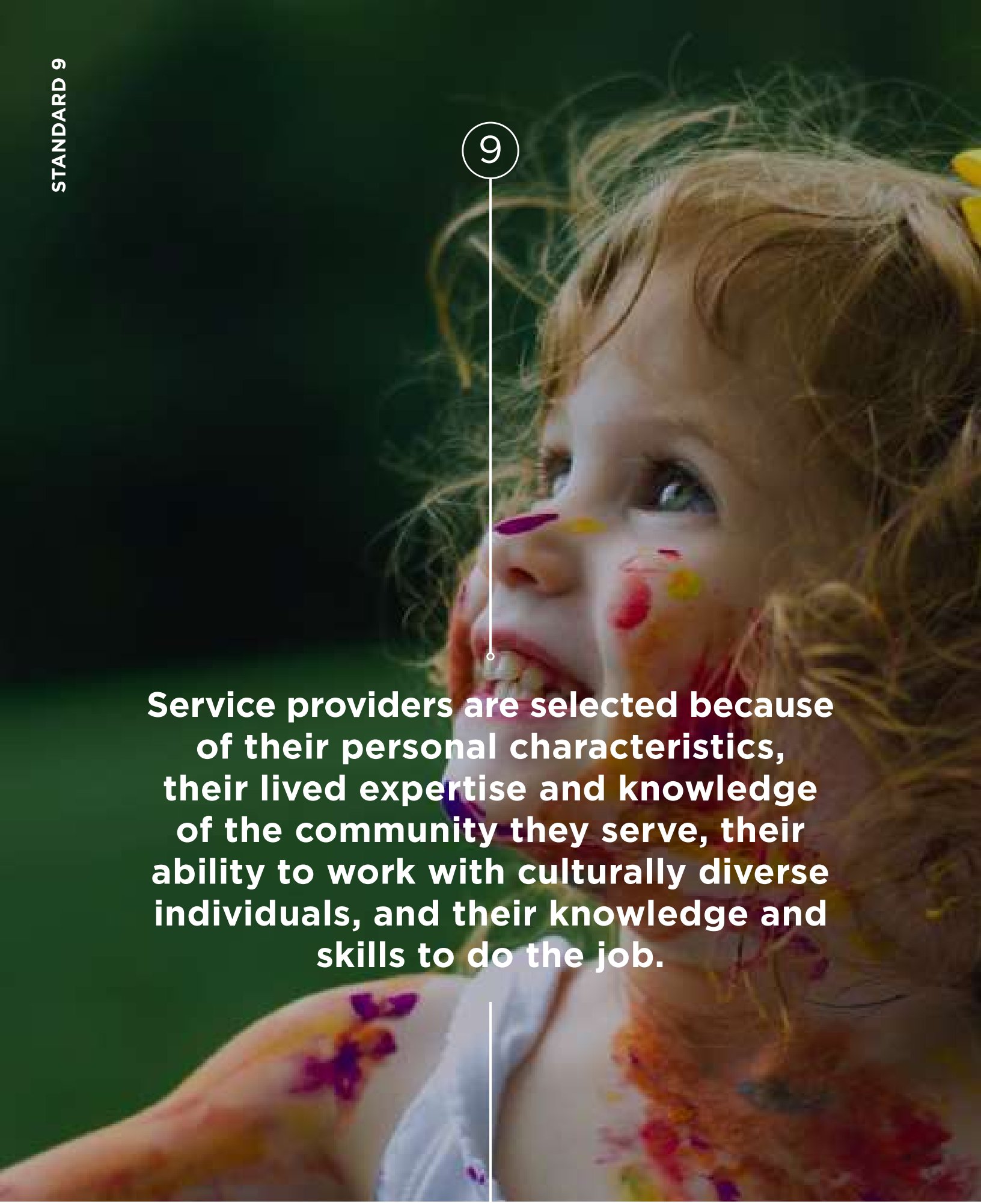
Tables of Documentation

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

Standard	Pre-Site Documentation to include in Self Study
8-1.A | Policy - Caseload Size	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
8-1.B | Monitoring Caseloads	Submit a report indicating the monthly caseload for all current FSSs over the past 12 months. Include each FSS's full time equivalency (FTE and work hours expected per week), the number of families assigned to him or her, the level/intensity of service each family is receiving, and the case weight for each family. Please Note: An HFA Spreadsheet is available for this standard.
8-2.A | Policy - Managing Caseloads	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
8-2.B | Caseload Management	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

STANDARD 9

9



Service providers are selected because of their personal characteristics, their lived expertise and knowledge of the community they serve, their ability to work with culturally diverse individuals, and their knowledge and skills to do the job.

Standard 9 Intent is to ensure staff are selected because they possess characteristics necessary to build trusting, nurturing relationships, and work effectively with families with different cultural values and beliefs than their own. Focusing on these characteristics also increases opportunities for diverse representation and equitable access to positions for historically and currently underrepresented individuals and groups.

Download Sample Staff Development Plan for Program Managers, Supervisors, and Direct Service Staff.

9-1. Direct service providers, managers, and supervisors are selected because of a combination of personal characteristics, experiences, and educational qualifications. The site's hiring system includes processes to ensure this can happen.

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

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

9-1.A RATING INDICATORS

3 No 3 rating for standard 9-1.A.

2 The site's system for screening and selection of new staff includes: 1) job descriptions with at least the minimum criteria listed for program managers, supervisors, and direct service staff (see standards 9-1.B-D), 2) standardized interview questions appropriate to each role with questions to assess each applicant's reflective capacity, and 3) policy regarding two reference checks and a criminal background check being complete prior to hire.

1 The site's system for screening and selection of new staff does not yet include all components listed in the 2 rating.

TIP: Please see the glossary definition of reflective capacity and the link to interview questions when considering an applicant's Reflective Capacity. These and other hiring tools in the HFA Supervisors Manual can be used by program and HR staff.

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

- a solid understanding of and experience in managing diverse staff with humility
- administrative experience in human service or related field including experience in quality assurance and continuous quality improvement
- master's degree in public health or human services administration or fields related to working with children and families, or bachelor's degree in these fields with 3 years of relevant experience, or less than a bachelor's degree but with commensurate HFA experience
- willingness to engage in building reflective practice (e.g., capacity for introspection, communicating awareness of self in relation to others, recognizing value of supervision, etc.)
- infant mental health endorsement preferred (if available in the state; if unsure, you can find out on the IMH website)

9-1.B RATING INDICATORS

3 The program manager, if hired after the last accreditation site visit, or if this is a first-time accreditation, **meets all of the required criteria** in the standard.

2 The program manager, if hired after the last accreditation, or if this is a first-time accreditation, **does not meet all of the criteria; however, the site documented its justification for the hiring decision and a staff development plan for the manager has been developed and implemented.**

1 The program manager, if hired after the last accreditation, or if this is a first-time accreditation, did not meet all of the criteria stated in the standard and reason for hire not documented; or a staff development plan has not yet been developed or implemented.

NA The Program Manager has worked as the Program Manager at the site prior to last accreditation site visit.

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

- master's degree in human services or fields related to working with children and families, or bachelor's degree in these fields with 3 years of relevant experience, or less than a bachelor's degree but with commensurate HFA experience
- a solid understanding of or experience in supervising diverse staff with humility, as well as providing support to staff in stressful work environments
- knowledge of infant and child development and parent-child attachment
- experience with family services that embraces the concepts of family-centered and strength-based service provision
- knowledge of parent-infant health and dynamics of child abuse and neglect
- experience supporting culturally diverse communities/families
- experience in home visiting with a strong background in early childhood prevention services
- willingness to engage in building reflective practice (e.g., capacity for introspection, communicating awareness of self in relation to others, recognizing value of supervision, etc.)
- infant mental health endorsement preferred (if available in the state; if unsure, you can find out on the IMH website)
- experience with reflective practice preferred (see standard 12-2.B for more detail)

9-1.C RATING INDICATORS

3 The site supervisors, if hired after the last accreditation site visit, or if this is a first-time accreditation, **meet all of the required criteria** in the standard.

2 The site supervisors, if hired after the last accreditation, or if this is a first-time accreditation, **do not meet all of the criteria; however, the site documented its justification for the hiring decision and a staff development plan for the supervisor has been developed and implemented.**

1 The site supervisors, if hired after the last accreditation, or if this is a first-time accreditation, do not meet all of the criteria stated in the standard and reason for hire not documented; or a staff development plan has not yet been developed or implemented.

NA The site supervisors have worked as supervisors at the site prior to last accreditation site visit.

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

- minimum of a high school diploma or equivalent
- experience in working with or providing services to children and families
- an ability to establish trusting relationships
- acceptance of individual differences
- experience and humility to work with the culturally diverse families
- knowledge of infant and child development
- willing to engage in building reflective capacity (e.g., capacity for introspection, communicating awareness of self in relation to others, recognizing value of supervision, etc.)
- infant mental health endorsement preferred (if available in the state; if unsure, you can find out on the IMH website)

9-1.D RATING INDICATORS

3 The site's direct service staff, if hired after the last accreditation site visit, or if this is a first-time accreditation, **meets all of the required criteria** listed in the standard.

2 The site's direct service staff, if hired after the last accreditation, or if this is a first-time accreditation, **meets the educational criteria but at the time of hire did not meet all the experiential criteria; however, a staff development plan for direct service staff is in place and has been acted upon.**

1 Any of the following: direct service staff, if hired after the last accreditation, or if this is a first-time accreditation, do not yet meet the educational criteria stated in the standard, or do not yet meet all the experiential criteria and there is no development plan to compensate for experiential gaps; or the development plan has not yet been acted upon.

NA All direct service staff have worked as direct service staff at the site prior to last accreditation site visit.

Note: This is an Essential Standard.

9-2. The site actively recruits, employs, and promotes qualified personnel and administers its personnel practices without discrimination based upon age, sex, gender identity, sexual orientation, race, creed, color, ethnicity, religion, nationality, political affiliation, citizenship status, marital status, veteran status, disability or handicap, genetic information, pregnancy, family medical history, or any other characteristic protected by applicable federal, state, or local laws of the individual under consideration. EEOC Discrimination Types.

9-2. RATING INDICATORS

3 The site:

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

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

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

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

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

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

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

Please Note: Each round of recruits for a particular role will be asked the same set of questions.

9-3.A RATING INDICATORS

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

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

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

TIP: It is recommended practice that all available positions are posted internally before posting externally.

TIP: HFA has sample interview questions in English and Spanish if needed.

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

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

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

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

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

9-3.B RATING INDICATORS

3 All currently employed site staff have had legally permissible criminal background checks completed **at the time of employment.** State child abuse and neglect registries may also have been checked.

2 All currently employed staff have had criminal background checks completed **at any point during employment**. State child abuse registries may also have been checked.

1 The site has conducted legally permissible background checks on some but not all currently employed staff; or does not yet conduct criminal background checks.

Note: This is a Safety Standard.

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

9-4. The site evaluates and reports on staff satisfaction and retention at least once every two years and addresses how it may increase staff retention, improve staff diversity, inclusion, belonging and promote equity.

Intent: A stable, qualified workforce is known to contribute to improved participant outcomes, with families more likely to be retained in services when staff are retained. Therefore, site management evaluates factors associated with staff turnover. By understanding the circumstances and characteristics of staff who leave, along with input from those who stay, strategies to increase retention can be developed (based on the data) and implemented with a greater likelihood of success. *Please Note*: While the site will want to include in their report all the reasons contributing to staff turnover, strategies for improvement do not need to be developed when reasons pertain to personal growth opportunities that could not be fulfilled on the job (e.g., returning to school, job promotion, etc.). *Please Note*: New sites without two full years since home visiting services began will monitor staff retention and satisfaction with one year of data. *Please Note*: If there has been no turnover in the last two years, the site will still monitor staff satisfaction among employed staff.

Download Sample Staff Satisfaction and Retention Template.

9-4. RATING INDICATORS

3 The site evaluates and reports on staff retention and satisfaction at least once every two years and has **implemented strategies** to address any issues identified from compiled satisfaction surveys or that impacted staff who left employment, including any issues associated with diversity, equity and inclusion.

2 The site evaluates and reports on staff retention and satisfaction at least once every two years and has developed strategies to address any issues identified from compiled satisfaction surveys or that impacted staff who left employment, including any issues associated with diversity, equity and inclusion, though **strategies have not yet been implemented.**

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

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

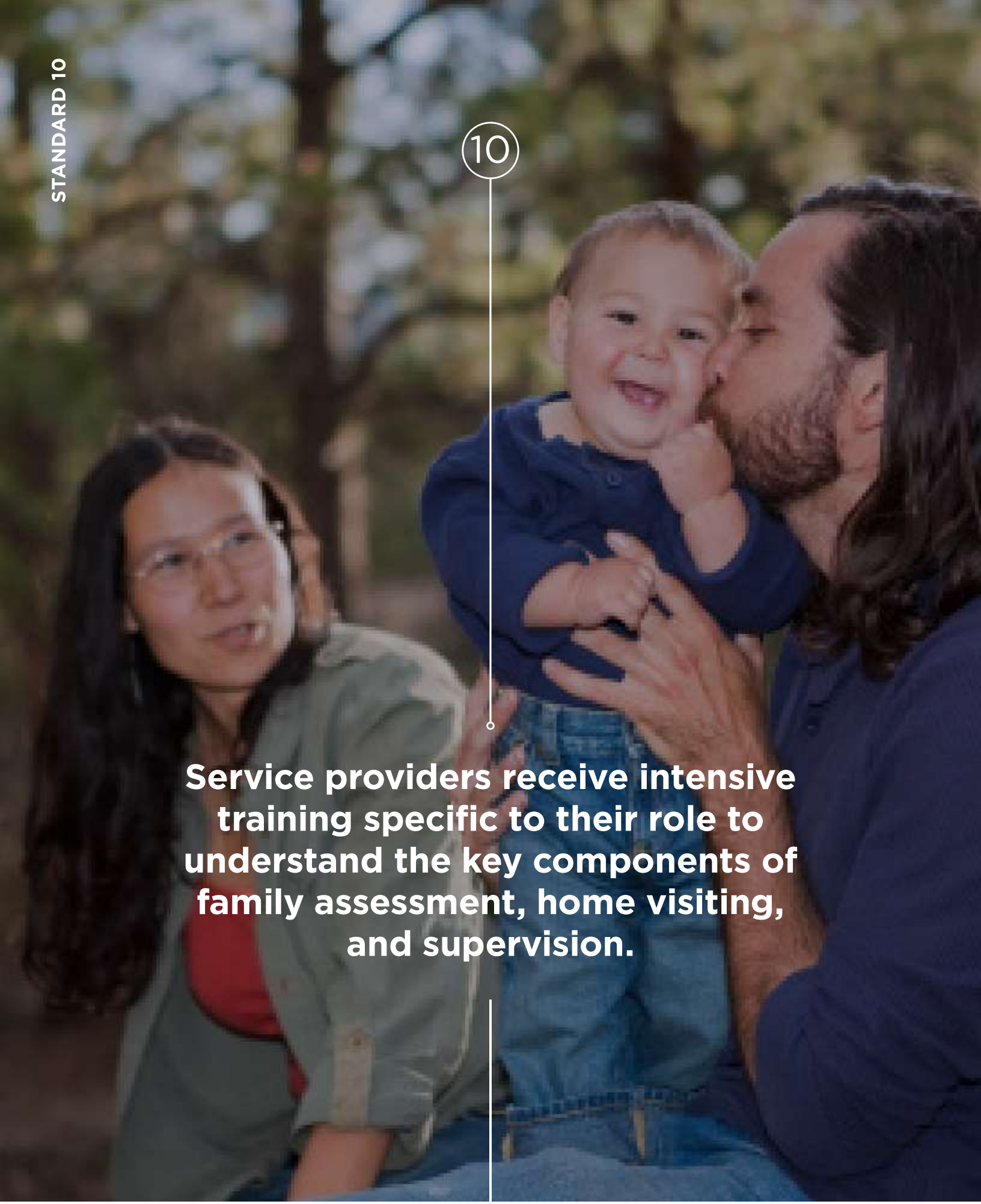
Tables of Documentation

9. Service providers are selected because of their personal characteristics, lived expertise and knowledge of the community they serve, their ability to work with culturally diverse individuals, and their knowledge and skills to do the job

Standard	Pre-Site Documentation to include in Self Study
9-1.A | Site's System for Hiring New Staff	Staff are selected because of a combination of personal characteristics, experiential, and educational qualifications, and the site's hiring system includes processes to ensure this can happen. 1. Job descriptions with at least the minimum criteria listed for program managers, supervisors and direct service staff (see standards 9-1.B-D), 2. Standardized interview questions appropriate to each role with questions to assess each applicant's reflective capacity, 3. Policy regarding at least two reference checks and a criminal background check prior to hire
9-1.B | Screening & Selection of Program Managers **9-1.C** | Screening & Selection of Supervisors **9-1.D** | Screening & Selection of Direct Service Staff, Volunteers, and Interns **Essential Standard**	If this is a first accreditation visit, submit resumes for all current staff. If this is a reaccreditation visit, submit resumes for all staff hired since the last accreditation visit. Please also provide narrative for staff who do not meet all the criteria as outlined in the standard, including justification for the hiring decision and staff development plans that have been developed and implemented. Sample Staff Development Plan for Program Managers, Supervisors, and Direct Service Staff.
9-2. | Equal Opportunity Employment (EOE)	Please provide a narrative description of the organization's current status with regard to EOE, whether with no violations, under current review, in remediation, or with a history of previous findings. Please also provide any HR policy or protocols or other descriptive documentation specific to how the organization applies EOE laws.
9-3.A | Recruitment and Selection Practices **9-3.B** | Legally Permissible Background Checks **Safety Standard**	Personnel files will be reviewed onsite. If peers are not permitted access to personnel files, a letter on agency letterhead signed by HR director can be provided verifying internal review of personnel records. If providing a letter, it must include the first and last names of all current HFA staff, date of hire, and confirmation that each of the following exist in the personnel record: - utilization of standardized interview questions that comply with employment and labor laws and interview responses or summaries maintained for currently employed staff - verification of two reference checks or letters of recommendation. If hired from within the organization, performance appraisals can suffice, - date criminal background check was completed, - if utilized, date of state child abuse registry check. Any items not maintained by HR in the personnel file, such as interview responses/summary or reference checks, and thus unable to be verified via a letter from HR, must be provided by the program manager to be reviewed onsite.
9-4. | Staff Retention and Satisfaction	Submit narrative indicating factors associated with staff who have left along with satisfaction feedback from existing HFA staff. Also indicate how this data has been used to develop staff retention strategies, improve staff diversity and inclusion, and promote equity. Include which strategies have been implemented. 1. For staff retention, include data of staff who have left. Include staff (by position title) who left during the timeframe (12 months for new sites, 24 months for all others), their hire date, termination date, reason why they left; and any other pertinent characteristics. 2. For staff satisfaction include a summary of staff satisfaction input in regard to work conditions that contribute both negatively and positively to job satisfaction (typically aggregated survey results) for those currently employed with the HFA site. Agency-wide staff satisfaction surveys, if used, must be filtered and reported for HFA staff only. 3. Include strategies developed for staff retention based on what was learned from retention and satisfaction data. *Please note*: Sample Surveys available.

STANDARD 10

10



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

Standard 10 Intent is to ensure staff receive training specific to their role. HFA Core training is required for all direct service staff, supervisors, and program managers within six months of hire. This training must be provided by a nationally certified HFA Core trainer. Stop-gap training is provided when staff begin providing direct services prior to receiving Foundations or Supervision training. In addition, there are seven orientation training topics required to be received by staff prior to work with families.

Please Note: For training standards (10 & 11) where "recent practice" is indicated for a 2 rating, at the time of the accreditation site visit, the site's most recent hire (whose hire date has allowed sufficient time to receive training) plus any staff hired three months prior to the most recent hire, will demonstrate training was received in accordance with the standard, specific to content and timeframe requirements, unless extenuating circumstances warrant contextual decision-making.

10-1. The site has a comprehensive training policy detailing all required trainings listed below for staff (direct service staff, supervisors, and program managers), including: 1) topics, 2) the method for obtaining training, and 3) the timeframe for each.

- orientation (10-2.A-G) and 10-2.H for sites in multi-site systems
- stop-gap training (10-3.A-C) when HFA Core is received after first direct service
- intensive model specific (HFA Core) training (10-4.A-C)
- implementation training (10-5) (program managers or designee only)
- CCI, ASQ and ASQ:SE, and depression screen (10-6.A-D) for staff who administer the tool and their supervisors
- wrap-around training topics within 3 months of hire (11-1.A-D)
- wrap-around training topics within 6 months of hire (11-2.A-G)
- wrap-around training topics within 12 months of hire (11-3.A-E)
- annual ongoing training (11-4.A)
- annual training on child abuse and neglect update (11-4.B)
- annual training on diversity, equity, inclusion and belonging (11-4.C)

Please Note: All interns and volunteers who perform the same duties as direct service staff and supervisors receive the same type of training as paid staff.

Intent: The policy guides the site toward achieving all required training in a timely manner and clearly identifies:

- topics covered in each training module or session
- how the training is provided and by whom (e.g., program manager/supervisor, community agency, HFA online training modules, video, reading materials, etc.)
- the required timeframe for each training
- mechanism for tracking and supervisor verification

If the site's policy references its training log for description of all topics and the method they will be received, then a link to the log must also be provided in the policy. Training logs include date of hire to HFA, date of 1st direct service (home visit, FROG, supervision), and date of training (even when dates fall outside the required timeframe). If sites use something other than HFA's recommended online wraparound training, the training will comprehensively address each of the overall topics with a variety of relevant subtopics critical for preparing staff to do this work.

Please Note: HFA provides online training options for receipt of wrap-around training. For sites that do not use these options, the site will create a crosswalk showing each of the required topic areas, with the corresponding training title, training provider, training agenda or list of training content, and method used to cover each topic. Sites can track training using the HFA Spreadsheet available for this standard.

10-1. RATING INDICATORS

3 No 3 rating for standard 10-1.

2 The site has a comprehensive training policy, including all required trainings and the method and timeframe for receipt of all trainings.

1 Any of the following: there is no training policy; or the training plan/policy is not yet comprehensive (does not list all required topics and method for receipt of training, e.g., e-learning, LMS, onsite, etc.); or does not yet include timeframe for receipt of all training.

10-2. Staff (direct service staff, supervisors, and program managers); receive orientation training after HFA hire date and prior to direct work with families or supervision of staff to familiarize them with site responsibilities. Program managers hired prior to July 1, 2014, are not required to document receipt of orientation topics.

Intent: When staff are hired, they often begin their work with families prior to receiving **HFA Core training**. Therefore, it is essential staff have been oriented to topics which will directly impact their immediate work with families or with direct service staff (for supervisors). Typically, these orientation trainings are designed and provided by the site and will reflect the resources, laws, and requirements specific to the host organization, local community, or state. The HFA National Office makes available online orientation that sites may choose to use in addition to any organization-required orientation training. Site administrators ensure these orientation topics are comprehensive and support the staff to succeed in their roles during this early part of employment. All of these training topics must be covered prior to direct contact with participants and prior to direct supervision of staff. *Please Note*: In the event staff did not receive these trainings within the required timeframes, for accreditation purposes it is expected all staff will receive the training regardless of the timeframe. *Please Note*: When a site is brand new, the program manager or supervisor may be involved in the writing of policy and procedure and the development of orientation procedures for staff. These activities, with documented dates relative to each orientation topic, can be referenced as completion of orientation for program managers or supervisors. *Please Note*: For any staff who are a re-hire to the HFA site, the expectation is to receive orientation again, if longer than three months since previously employed.

10-2.A Staff (direct service staff, supervisors, program managers, and the manager's supervisor) hired January 1, 2022 or later receive HFA Quick Start orientation training.

Orientation training prior to January 1, 2022 included: 1) the HFA goals and services, 2) the philosophy of home visiting/family support, and 3) the principles of ethical practice, subsequent to HFA hire date and prior to direct work with families or supervision of staff.

10-2.A RATING INDICATORS

3 Staff hired 01/01/22 or later receive HFA Quick Start training after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff hired 01/01/22 or later did not receive HFA Quick Start training after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required, and rated "2" if no new hires in the last five years.

1 Staff hired 01/01/22 or later do not yet receive HFA Quick Start after HFA hire date and prior to direct work with families; or supervision of staff.

TIP: Sites are encouraged to invite all Community Advisory Board (CAB) members to view HFA Quick Start orientation training at the start of their term with the CAB.

10-2.B Staff (direct service staff, supervisors, and program managers) are oriented to their roles as they relate to: 1) the site's parenting materials, curriculum, and other handouts shared with parents 2) policy and operating procedures, and 3) data collection forms and processes, after HFA hire date and prior to direct work with families or supervision of staff.

10-2.B RATING INDICATORS

3 All staff are oriented to their roles as they relate to the site's curriculum materials, policy and operating procedures, and data collection forms and processes, after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to their roles as they relate to the site's curriculum materials, policy and operating procedures, and data collection forms and processes, after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to their roles as they relate to the site's curriculum materials, policy and operating procedures, and data collection forms and processes, after HFA hire date and prior to direct work with families or supervision of staff.

10-2.C Staff (direct service staff, supervisors, and program managers) are oriented to the site's relationship with other community resources after HFA hire date and prior to direct work with families or supervision of staff.

10-2.C RATING INDICATORS

3 All staff are oriented to the site's relationship with other community resources (e.g., organizations in the community with which the site has working relationships) after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to the site's relationship with other community resources after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to the site's relationship with other community resources after HFA hire date and prior to direct work with families or supervision of staff.

10-2.D Staff (direct service staff, supervisors, and program managers) are oriented to: 1) child abuse and neglect indicators, and 2) reporting requirements after HFA hire date and prior to direct work with families or supervision of staff.

10-2.D RATING INDICATORS

3 All staff are oriented to child abuse and neglect indicators and reporting requirements after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to child abuse and neglect indicators and reporting requirements after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to child abuse and neglect indicators and reporting requirements after HFA hire date and prior to direct work with families or supervision of staff.

Note: This is a Safety Standard

10-2.E Staff (direct service staff, supervisors, and program managers) are oriented to issues of confidentiality and issues of ethical practice prior to direct work with families or supervision of staff.

10-2.E RATING INDICATORS

3 All staff are oriented to issues of confidentiality and principles of ethical practice after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to confidentiality and principles of ethical practice after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to issues of confidentiality and principles of ethical practice after HFA hire date and prior to direct work with families or supervision of staff.

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

10-2.F Staff (direct service staff, supervisors, and program managers) are oriented to issues related to boundaries after HFA hire date and prior to direct work with families or supervision of staff.

10-2.F RATING INDICATORS

3 All staff are oriented to issues related to boundaries after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received thetraining but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

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

1 Staff are not yet oriented to issues related to boundaries after HFA hire date and prior to direct work with families or supervision of staff.

10-2.G Staff (direct service staff, supervisors, and program managers) are oriented to issues related to staff safety after HFA hire date and prior to direct work with families or supervision of staff.

10-2.G RATING INDICATORS

3 All staff are oriented to issues related to staff safety after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to issues related to staff safety after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to issues related to staff safety after HFA hire date and prior to direct work with families or supervision of staff.

10-2.H Staff (direct service staff, supervisors, and program managers) who work at a site that is part of an HFA Multi-Site System are oriented to the Multi-Site System, including the goals, objectives, policies, and functions of the Multi-Site System and Central Administration.

10-2.H RATING INDICATORS

3 All staff are oriented to the Multi-Site System, including the goals, objectives, policies, and functions of the Multi-Site System and Central Administration, within three months of hire. For Multi-Site Systems in their first accreditation cycle, staff hired more than five years ago have received the training regardless of timeframe. For systems in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to the Multi-Site System, including the goals, objectives, policies, and functions of the Multi-Site System and Central Administration, within three months of hire; however, **recent practice** indicates this is now occurring and all staff (if system is in its first accreditation cycle) have received the training regardless of the timeframe. For systems in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to the Multi-Site System, including the goals, objectives, policies, and functions of the Multi-Site System and Central Administration, within three months of hire.

NA The site is not part of an HFA Multi-Site System.

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

Intent: When staff begin home visiting or supervision work prior to the receipt of role-specific **HFA Core training**, the site must have a policy for the provision of stop-gap training. Stop-gap training is defined as: customized training provided as-needed to meet an individual's urgent need for training in the skills necessary to perform their work prior to the receipt of HFA Core training. HFA has developed a series of stop-gap training webinars to be used in conjunction with on-site activities designed to set staff on a positive trajectory for their work with families. Stop-gap on-site activities do not need to be conducted by a certified trainer; however, it must be conducted by someone who has been intensively trained in the role. Stop-gap training does not replace the requirement to attend HFA Core training.

For established sites, all new staff will complete stop-gap training in order to begin their work with families when waiting to attend HFA Core Foundations or Supervision training, unless the site's policy requires HFA Core Training is received prior to direct service. Stop-gap training, including on-site activities, have been developed by HFA and may be conducted by the site supervisor or program manager. HFA stop-gap training includes:

- a clear description of the "HFA Advantage" (what makes HFA unique, including trauma-informed practice, the power of relationships/attachment, and reflective capacity)
- shadowing of other staff in a similar role
- hands-on practice (with observation and feedback)
- training on forms used by individuals in that role and expectations for documentation
- use of a strengths-based approach when working with others

Please Note: For brand new sites where there is currently no one on staff who has received HFA Core Training or there is not a neighboring site with which to connect, the HFA National Office can provide support allowing families to begin receiving services. Please contact your HFA Training and TA Specialist for more details.

10-3.A The site has policy and procedures for providing stop-gap training to direct service staff and supervisors of direct service staff when they begin their work prior to the receipt of HFA Core Foundations or Supervision training, to ensure staff has adequate understanding and knowledge of their role. The training must include the bulleted components described in the intent.

10-3.A RATING INDICATORS

3 No 3 rating for 10-3.A.

2 The site has policy and procedures for providing stop-gap training to direct service staff and their supervisors who will begin their work prior to the receipt of HFA Core Foundations or Supervision training. Stop-gap training includes all bulleted components described in the intent.

1 The site does not yet have policy and procedures for providing stop-gap training to direct service staff and their supervisors who will begin their work prior to the receipt of HFA Core Foundations or Supervision training; or the policy and procedures do not yet specify the training include all bulleted components described in the intent.

NA The site's policy requires that HFA Core training be received prior to providing direct service.

10-3.B Direct service staff who begin their work with families prior to completion of Intensive HFA Core Foundations training, and their supervisor, have received stop-gap training to ensure direct service staff and their supervisor have adequate understanding and knowledge of their role.

10-3.B RATING INDICATORS

3 Staff receive stop-gap training prior to their work with families and/or supervising direct service staff which includes all required components. For sites in their first accreditation cycle, staff hired more than five years ago have received training though it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired more than five years ago is not required.

2 Past instances may have occurred when stop-gap training was not received prior to beginning work with families and/or supervising direct service staff, or some of the required components were not included; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Site staff do not yet receive stop-gap training prior to beginning work with families and/or supervising direct service staff; or the training does not yet include the required components.

NA All staff have received HFA Core training prior to providing direct service.

10-3.C Supervisors who begin providing supervision prior to completion of intensive HFA Core Supervision training have received supervisor stop-gap training to ensure the supervisor has adequate understanding and knowledge of their role.

10-3.C RATING INDICATORS

3 Supervisors receive supervisor stop-gap training including all required components within four weeks of hire to HFA supervisor role. For sites in their first accreditation cycle, staff hired more than five years ago have received training though it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired more than five years ago is not required.

2 Past instances may have occurred when training was not received within four weeks of hire to HFA supervisor role or some of the required components were not included; however, **recent practice** indicates this is now occurring and all supervisors (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Supervisors do not yet receive training within four weeks of hire to HFA supervisor role; or the training does not yet include all of the required components.

NA All supervisors have received HFA Core Supervisor training prior to supervising staff.

10-4. Staff (direct service staff, supervisors, and program managers) receive intensive HFA Core trainings within the following timeframes. For those administering the FROG Scale, training is received prior to first use; for Foundations and Supervision training, and FROG training for Supervisors, within six months of hire. HFA Core trainings are provided by an HFA certified trainer.

Intent: Intensive training develops the knowledge and skills necessary to achieve site goals. It prepares staff to assess family needs, assist with parent-child interaction, strengthen family functioning, provide appropriate information, connect families with appropriate resources, and meet the expected standards of service delivery. Furthermore, intensive training allows staff to link theory to practice by developing and implementing practical approaches to real-life situations, to share information and experiences, and to learn from one another.

Please Note: In the event staff did not receive HFA Core training within the required timeframes, it is required all staff will receive the training regardless of the timeframe.

Please Note: When a staff member who has received Core training is re-hired for the same position, whether at the same site or at a different site, re-taking of HFA Core training is required if the staff person has not worked for HFA in three or more years.

10-4.A All staff administering the FROG Scale receive intensive HFA Core FROG Scale training by an HFA certified trainer prior to first use of the tool and all supervisors receive this training within six months of hire.

10-4.A RATING INDICATORS

3 All staff using the FROG Scale and all supervisors receive intensive HFA Core FROG Scale training by an HFA certified trainer within the timeframes indicated in the standard. For sites in their first accreditation cycle, staff hired more than five years ago have received the training, though it may have been received later.

2 Past instances were found when staff using the FROG Scale or supervisors did not receive intensive HFA Core FROG Scale training by an HFA certified trainer within the timeframes indicated in the standard; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe.

1 Staff using the FROG Scale or supervisors do not yet receive intensive HFA Core FROG Scale training within the timeframes indicated; or training was not conducted by an HFA certified trainer.

Note: This is an Essential Standard.

TIP: FROG Scale training is optional for program managers who do not supervise staff administering the FROG.

10-4.B All staff (including program managers hired January 1, 2022, or later) have received intensive HFA Core Foundations training by an HFA certified trainer, within six months of date of hire, to understand key components of the HFA model. Program managers hired prior to January 1, 2022, receive the training within eighteen months of hire.

10-4.B RATING INDICATORS

3 All staff receive intensive HFA Core Foundations training by an HFA certified trainer, within six months of the date of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training, though it may have been received later than within six months of hire. For sites in a reaccreditation cycle, training data for staff hired more than five years ago is not required.

2 Past instances were found when staff did not receive intensive HFA Core Foundations training by an HFA certified trainer within six months after hire; however, **recent practice** indicates this is now occurring, and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Staff do not yet receive intensive HFA Core Foundations training within six months of hire; or the training was not conducted by an HFA certified trainer.

Note: This is an Essential Standard.

10-4.C Supervisors and program managers have received intensive HFA Core Supervision training by an HFA certified trainer within six months of date of hire, to understand the key components of supervision. This includes FROG Supervision training for those who supervise staff administering the FROG Scale. Program managers hired prior to January 1, 2022, receive the training within eighteen months of hire.

10-4.C RATING INDICATORS

3 All supervisors and program managers receive intensive HFA Core Supervision training by an HFA certified trainer, on the key components of supervision, within six months of the date of hire or position change. For sites in their first accreditation cycle, staff hired more than five years ago have received the training, though it may have been received later than within six months of hire. For sites in a reaccreditation cycle, training data for staff hired more than five years ago not required.

2 Past instances were found when supervisors and program managers did not receive intensive HFA Core Supervision training by an HFA certified trainer, within six months after hire or position change; however, **recent practice** indicates this is now occurring and all supervisors and program managers (if site is in its first accreditation cycle) have now received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Supervisors and program managers do not yet receive intensive HFA Core Supervision training within the specified time frames; or training was not conducted by an HFA certified trainer.

Note: This is an Essential Standard.

TIP: After receiving HFA Core Supervision training, all supervisors are strongly encouraged to also obtain HFA's STARS training.

TIP: FROG Supervision training is optional for program managers who do not supervise staff administering the FROG.

10-5. All Program Managers (or those in a role and fulfilling expectation of program manager as defined in the glossary) hired to HFA on or after January 1, 2018, receive intensive HFA Core Implementation training from the HFA National Office within eighteen months of date of hire, to understand the key components of implementing the HFA model. HFA Implementation training is strongly encouraged and optional for program managers hired prior to January 1, 2018.

10-5. RATING INDICATORS

3 All program managers hired to HFA on or after January 1, 2018, receive intensive HFA Core Implementation training, by National Office staff, on the key components of implementing the HFA model, **within twelve months** of the date of hire or position change; or program managers hired prior to January 1, 2018, completed HFA Implementation Training.

2 All program managers hired on or after January 1, 2018, receive intensive HFA Core Implementation training by National Office staff **within eighteen months** of hire or position change; or have a plan to attend if less than eighteen months since hire.

1 Program managers hired on or after January 1, 2018, have not yet received intensive HFA Core Implementation training from National Office staff within eighteen months of hire or position change.

NA The site's program manager was hired prior to January 1, 2018, and is exempt from completing HFA Core Implementation Training.

TIP: When possible, it is recommended the program manager's supervisor also attend HFA Core Implementation training.

10-6. Staff who are responsible for the administration of required screening tools receive trainings on these tools prior to first use, and supervisors receive these trainings within six (6) months of hire.

10-6.A Those who administer the CHEERS Check-In (CCI) tool have been trained in the use of the tool before administering it, and supervisors also receive this training.

Intent: Staff must be trained before administering the CCI. Training can be accessed on HFA's Network Resources. CCI training received prior to HFA hire date is acceptable if the staff has been using the tool consistently (without lapse) since receipt of training.

10-6.A RATING INDICATORS

3 All staff hired in the past five years, who use the CCI, are trained in its use prior to administering the tool. Supervisors hired in the past five years receive training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred later than above. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired in the past five years did not receive training on the CCI prior to administering the tool, or for supervisors within six months of hire; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Staff administer the CCI tool prior to being trained; or supervisors have not yet received the training.

10-6.B Those who administer the ASQ have been trained in the use of the current version of the tool before administering it, and supervisors also receive this training.

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

10-6.B RATING INDICATORS

3 All staff hired in the past five years, who use the ASQ, are trained in its use prior to administering the tool. Supervisors hired in the past five years receive training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred later than above. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired in the past five years did not receive training on the ASQ prior to administering the tool, or for supervisors within six months of hire; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Staff administer the ASQ prior to being trained; or supervisors have not yet received the training.

10-6.C Those who administer the ASQ:SE have been trained in the use of the current version of the tool before administering it, and supervisors also receive this training.

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

10-6.C RATING INDICATORS

3 All staff hired in the past five years, who use the ASQ:SE, are trained in its use prior to administering the tool. Supervisors hired in the past five years receive training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred later than above. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired in the past five years did not receive training on the ASQ:SE prior to administering the tool, or for supervisors within six months of hire; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Staff administer the ASQ:SE prior to being trained; or supervisors have not yet received this training.

10-6.D Those who administer the depression screen/tool have been trained in the use of the tool before administering it, including ways to talk with parents about depression, and Supervisors also receive this training.

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

10-6.D RATING INDICATORS

3 All staff hired in the past five years, who use the depression screening tool, are trained in its use prior to administering the tool. Supervisors hired in the past five years receive training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred later than above. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required

2 Past instances were found when staff hired in the past five years did not receive training on the depression screening tool prior to administering the tool, or for supervisors within six months of hire; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

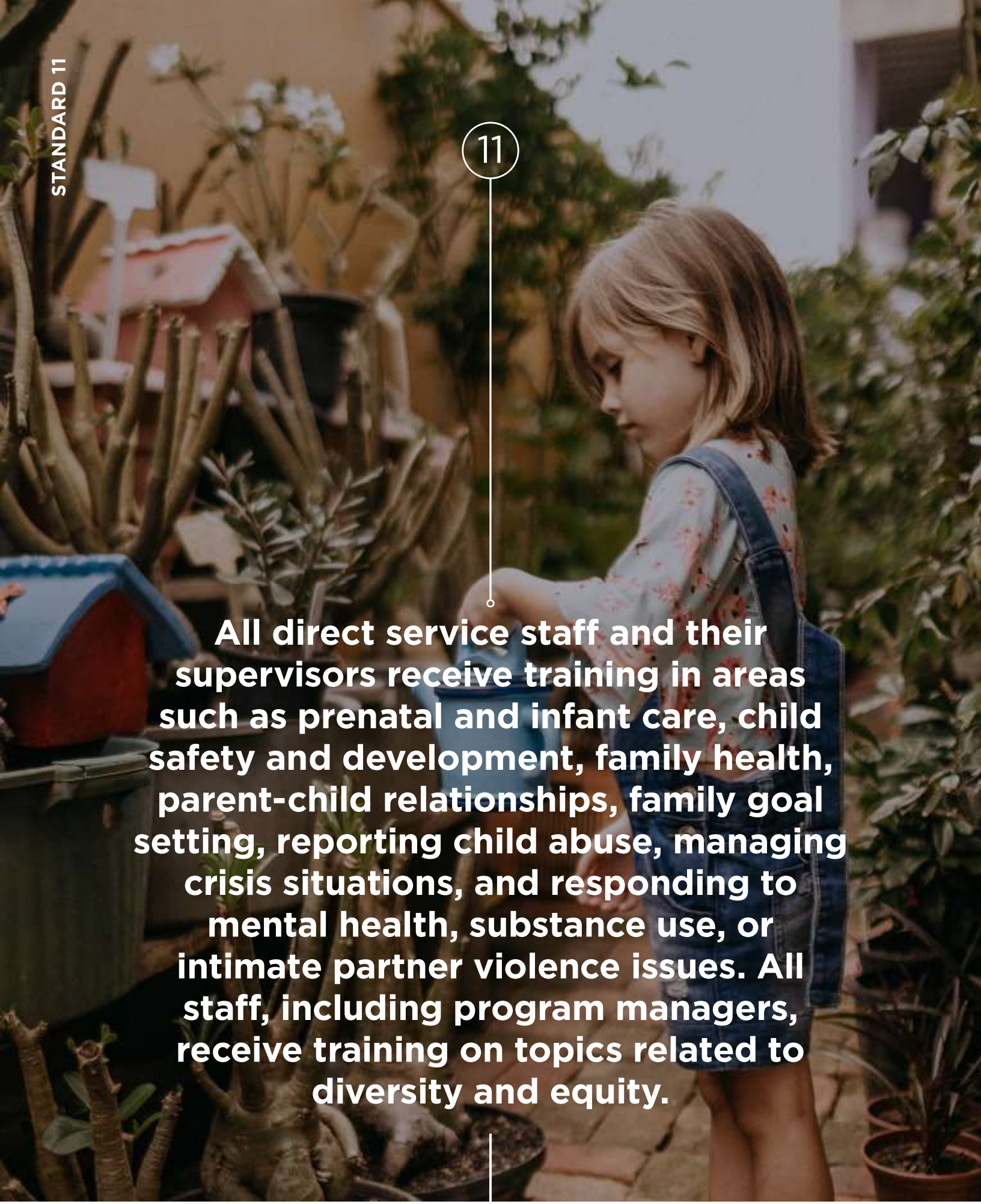
1 Staff administer the tool prior to being trained; or supervisors have not yet received the training.

Tables of Documentation

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

Standard	Pre-Site Documentation to include in Self Study
10-1. | Training Plan/Policy	Submit training plan/policy for all staff (direct service staff, supervisors, and program managers) including: all required topics, method for receipt of training (i.e. e-learning, onsite, etc.); and timeframe for receipt. Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
10-2.A-H | Orientation Training **10-2.D |** Safety Standard	Submit documentation indicating the date each staff person (direct service staff, supervisors, and program managers) completed each of the orientation topics (10-2.A-H), including the date of hire and the date staff person began providing direct service or supervision. Also include the date the program manager's supervisor completed 10-2.A. Please Note: HFA Training Log available.
10-3.A | Policy for Stop-Gap Training	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
10-3.B-C | Stop-Gap provided when needed	Submit documentation indicating receipt of Stop-Gap training (if used) including the date each training topic completed, as well as the date of hire for each staff (direct service staff, supervisors, and program managers). Please Note: HFA Training Log available.
10-4.A | HFA FROG Scale Training **Essential Standard** **10-4.B |** HFA CORE Foundations Training **Essential Standard** **10-4.C |** HFA Supervisor Training **Essential Standard**	Submit documentation indicating the date each staff person completed Core training (direct service staff, supervisors, and program managers) and include the staff date of hire. Documentation can be recorded in a training log with supervisor signature, or training certificates may be submitted. Please Note: HFA Training Log available.
10-5. | HFA Implementation training for Program Managers	Submit documentation indicating the date of hire for the Program Manager (or designee) and the date HFA Implementation training was completed. Please Note: HFA Training Log available.
10-6.A-D | Tools Training	For staff who are responsible for the administration of required screening tools, and their supervisors, submit documentation indicating the date each person completed training on each of the screening tools (CCI, ASQ-3, ASQ:SE, and depression screening) and the date they first administered (or supervised use of) each tool. Please Note: HFA Training Log available.

11



All direct service staff and their supervisors receive training in areas such as prenatal and infant care, child safety and development, family health, parent-child relationships, family goal setting, reporting child abuse, managing crisis situations, and responding to mental health, substance use, or intimate partner violence issues. All staff, including program managers, receive training on topics related to diversity and equity.

Standard 11 Intent is to ensure staff receive training support and have the skill set necessary to fulfill their job functions and achieve improved outcomes with families. Training can be received through a variety of methods including, but not limited to, the following: HFA wraparound training modules, in-person or virtual attendance at lectures, interactive presentations, workshops, and college coursework.

Intent 11-1 (training within 3 months), 11-2 (training within 6 months), and 11-3 (training within 12 months): Training that is specific and relevant to the field of home visiting and can translate to the work of HFA staff is critical in the first year of employment. It is intended for staff to receive training in all of the topics outlined in the rating indicators, incorporating suggested subtopics based on relevant community dynamics and the individual learning needs of staff. It is a site's responsibility to ensure competency of staff and determine their need for additional training beyond the required topics outlined in these standards. The intent of training is to provide staff with the knowledge and skills necessary to support family well-being.

Several formats are acceptable to accomplish training in each of the specified areas below and can include: attendance at trainings/workshops/in-services, online trainings developed by HFA, other online training, formal education, certification, licensure, and competency-based testing (individual's knowledge of a topic measured by written test or through observation of skills and abilities). Previous professional experience or formal education specific to the topics identified in the standards can be used to meet the standard when received no more than three years prior to HFA hire and when coupled with competency-based testing or supervision follow-up. Follow-up with the supervisor is to ensure successful knowledge acquisition and understanding of the concepts or materials within the context of home visiting and the individual's role, and whether additional training in this topic might be beneficial.

Please Note:

1. **All staff at affiliated HFA sites may use the online trainings developed by HFA (or other training resources provided by the National Office) to complete the 11-1, 11-2, and 11-3 training topics. If sites use something other than HFA's recommended online wraparound training, the training will comprehensively address each of the overall topics with a variety of relevant subtopics critical for preparing staff to do this work.**

2. **HFA Core training (standards 10-4.B-D) cannot be used to satisfy the 3-, 6-, and 12-month training requirements.**

3. **The purpose for specifying in the rating indicators a five-year timeframe is to allow sites that have been in existence more than five years to demonstrate their current capacity to achieve a 3 rating, rather than being hindered by practice that may have occurred prior to its last accreditation site visit.**

4. **For training standards (10 & 11) where "recent practice" is indicated for a 2 rating, at the time of the accreditation site visit, the site's most recent hire (whose hire date has allowed sufficient time to receive training) plus any staff hired three months prior to the most recent hire, will demonstrate training was received in accordance with the standard, specific to content and timeframe requirements, unless extenuating circumstances warrant contextual decision-making.**

TIP: (for 11-1, 11-2 and 11-3):

- Sites should have mechanisms for ensuring staff training needs are being met and the trainings are of high quality (e.g., post-training surveys, or input obtained during supervision sessions or team meetings).
- When circumstances prevent staff from attending a required training in a timely way, it is recommended sites document the circumstances that led to staff missing the training, so peer reviewers can take this information into consideration when assigning a rating.
- When staff complete wrap-around training very quickly after hire, they are encouraged to revisit these training topics as a refresher at a later point once they begin to increase their experience working with families. This will assist with the transfer of knowledge to practice, as training done very early or too quickly may not be readily applied if they have not yet begun serving families.

11-1. Staff (direct service staff and supervisors) receive training on a variety of topics necessary for effectively working with families and children within three months of hire.

11-1.A Staff (direct service staff and supervisors) receive training on Infant Care within three months of the date of hire. HFA's online training includes these subtopics:

- infant sleep and safer sleep practices
- feeding/Breastfeeding
- failure to thrive
- physical care of the baby
- infant crying and responses to crying

11-1.A RATING INDICATORS

3 Staff hired within the past five years received training on Infant Care within three months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than three months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Infant Care within three months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received training on this topic regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Infant Care within three months of hire; or staff hired within the past five years have not received training on this topic.

11-1.B Staff (direct service staff and supervisors) receive training on Child Health and Safety within three months of the date of hire. HFA's online training includes these subtopics:

- home safety (e.g., fire, child supervision, water temperature, pools, falls, etc.)
- abusive head trauma prevention
- sudden unexpected infant death
- seeking medical care
- well-child visits, immunizations, and oral health
- parenting children with special health needs
- community resources for child health

11-1.B RATING INDICATORS

3 Staff hired within the past five years received training on Child Health and Safety within three months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than three months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Child Health and Safety within three months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Child Health and Safety within three months of hire; or staff hired within the past five years have not received training on this topic.

11-1.C Staff (direct service staff and supervisors) receive training on Family Health within three months of the date of hire.
HFA's online training includes these subtopics:

- adult primary care
- family planning and reproductive justice
- disability and chronic health issues
- smoking cessation
- health equity and access to care
- community resources for adult medical care and nutrition

11-1.C RATING INDICATORS

3 Staff hired within the past five years received training on Family Health within three months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than three months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Family Health within three months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Family Health within three months of hire; or staff hired within the past five years have not received training on this topic.

11-1.D Staff (direct service staff, program managers and supervisors) receive training on Cultural Self-Awareness within three months of the date of hire.
HFA's online training includes these subtopics:

- seeking clarity on personal identity, values, and beliefs
- understanding privilege and its role in systems of oppression and racism
- how our own experiences play out in home visiting work
- implicit bias
- demonstrating compassion for self and others

11-1.D RATING INDICATORS

3 Staff hired January 2022 or later received training on Cultural Self-Awareness within three months of hire. Staff hired prior to January 2022 have received the training but it may have been later than three months after hire.

2 Past instances were found when staff hired January 2022 or later did not receive training related to Cultural Self-Awareness within three months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff have received the training regardless of timeframe.

1 The site's most recent hire(s) from January 2022 or later have not yet received training on Cultural Self-Awareness within three months of hire; or staff hired prior to January 2022 have not yet received training on this topic.

11-2. Staff (direct service staff and supervisors) receive training on a variety of topics necessary for effectively working with families and children within six months of hire.

11-2.A Staff (direct service staff, and supervisors) receive training on Infant and Child Development within six months of the date of hire.
HFA's online training includes these subtopics:
- brain development
- social and emotional development
- language development and early literacy
- physical development
- infant behavior (cues, states, reflexes)
- responding to developmental delays
- community resources to support children with delays

11-2.A RATING INDICATORS

3 Staff hired within the past five years received training on Infant and Child Development within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Infant and Child Development within six months of hire; however, for the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Infant and Child Development within six months of hire; or staff hired within the past five years have not received training on this topic.

11-2.B Staff (direct service staff and supervisors) receive training on Supporting the Parent-Child Relationship within six months of the date of hire.
HFA's online training includes these subtopics:
- observing parent-child interactions
- supporting attachment
- nurturing parenting strategies
- discipline

11-2.B RATING INDICATORS

3 Staff hired within the past five years received training on Supporting the Parent-Child Relationship within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Supporting the Parent-Child Relationship within six months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Supporting the Parent-Child Relationship topics within six months of hire; or staff hired within the past five years have not received training on this topic.

11-2.C Staff (direct service staff and supervisors) receive training on Professional Practice within six months of the date of hire. HFA's online training includes these subtopics:

- time management
- coping with stress
- recognizing and preventing burnout
- power imbalances in professional relationships
- reflective practice

11-2.C RATING INDICATORS

3 Staff hired within the past five years received training on Professional Practice within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Professional Practice within six months of hire; however with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Professional Practice within six months of hire; or staff hired within the past five years have not received training on this topic.

TIP: Program managers are encouraged but not required to complete training on Professional Practice.

11-2.D Staff (direct service staff and supervisors) receive training on Mental Health within six months of the date of hire.
HFA's online training includes these subtopics:

- promotion of positive mental health
- behavioral signs of mental health issues
- depression
- perinatal mood disorders
- coping with loss
- strategies for working with families with mental health issues
- mental health emergencies
- referral resources for mental health

11-2.D RATING INDICATORS

3 Staff hired within the past five years received training on Mental Health within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Mental Health within six months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Mental Health within six months of hire; or staff hired within the past five years have not received training on this topic.

11-2.E Staff (direct service staff and supervisors) receive Prenatal training within six months of hire.
HFA's online training includes these subtopics:

- fetal growth & development during each trimester
- warning signs: when to call the doctor
- activities to promote the parenting role, and the parent-child relationship during pregnancy
- preparing for the baby
- promoting parental awareness of what the baby is experiencing with a connection to what the parent is doing (reflection)

11-2.E RATING INDICATORS

3 Staff have received Prenatal Training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff received Prenatal Training later than six months after hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received Prenatal training within six months of hire; or staff hired within the past five years have not received training on this topic.

TIP: HFA's Great Beginnings Start Before Birth training meets the expectations of this standard and provides a deeper dive into work with prenatal families utilizing the HFA approach. This training is strongly encouraged.

11-2.F Staff (direct service staff and supervisors) receive training on the Family Goal process within six months of hire. HFA's online training includes these subtopics:

- purpose and importance of the family goal process in HFA services
- working with families to identify strengths and needs
- supporting the family's role in setting and achieving meaningful goals to assist families in taking charge of their lives
- development of family goals based upon the Family Support Specialist's knowledge about the family, as well as tools completed with the family
- practice writing family goals in ways that help families create measurable goals

11-2.F RATING INDICATORS

3 Staff receive training on the Family Goal process within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff received training on the Family Goal process later than six months after hire; however, with the **most recent hire(s)** practice indicates this is now occurring and all staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on the Family Goal process within six months of hire; or staff hired within the past five years have not received training on this topic.

TIP: HFA's Family Goal webinar builds on information provided initially during HFA Core Foundations training (10-4.B), and therefore it is recommended the webinar be viewed after staff receive Core, unless Core is received so close to the 6-month due date, waiting would put staff past 6 months for receipt of 11-2.F.

11-2.G Staff (direct service staff, program managers and supervisors) receive Cultural Humility in Home Visiting training within six months of hire.

HFA's online training includes these subtopics:

- HFA's approach to culture
- honoring diverse family structures
- LGBTQIA+ parenting
- family culture as a source of family strength
- acknowledging, respecting, and celebrating cultural differences

11-2.G RATING INDICATORS

3 Staff hired January 2022 or later have received Cultural Humility in Home Visiting training within six months of hire. Staff hired prior to January 2022 have received the training but it may have been later than six months after hire.

2 Past instances were found when staff hired January 2022 or later did not receive training related to Cultural Humility in Home Visiting training within six months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring and all other staff have received the training regardless of timeframe.

1 The site's most recent hire(s) from January 2022 or later have not yet received training on Cultural Humility in Home Visiting within six months of hire; or staff hired prior to January 2022 have not yet received training on this topic.

11-3. Staff (direct service staff, and supervisors) received training on a variety of topics necessary for effectively working with families and children within twelve months of hire.

11-3.A Staff (direct service staff and supervisors) receive training on Child Abuse and Neglect within twelve months of the date of hire.

HFA's online training includes these subtopics:

- parent and child risks for abuse and neglect
- prevention and education with families
- racial disparities in the child welfare system
- role of HFA with child welfare-involved families

11-3.A RATING INDICATORS

3 Staff hired within the past five years received training on Child Abuse and Neglect within twelve months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than twelve months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Child Abuse and Neglect within twelve months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required, and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Child Abuse and Neglect within twelve months of hire; or staff hired within the past five years have not received training on this topic.

11-3.B Staff (direct service staff, and supervisors) receive training on Intimate Partner Violence within twelve months of the date of hire. HFA's online training includes these subtopics:

- indicators of Intimate Partner Violence
- dynamics of Intimate Partner Violence
- strategies for working with families with Intimate Partner Violence issues
- effects on children
- universal education approach to discussing healthy and unhealthy relationships with families
- the impact of racially disproportionate policing on family responses to IPV
- referral resources for family violence

11-3.B RATING INDICATORS

3 Staff hired within the past five years received training on Intimate Partner Violence within twelve months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than twelve months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Intimate Partner Violence within twelve months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Intimate Partner Violence within twelve months of hire; or staff hired within the past five years have not received training on this topic.

11-3.C Staff (direct service staff, and supervisors) received training on Substance Use within twelve months of the date of hire. HFA's online training includes these subtopics:

- causes of and risks for substance use disorders
- alcohol use and dependence
- substances prevalent in the community
- talking with families about substance and alcohol use
- strategies for working with families with substance use challenges and families in recovery
- substance use and racial disparities in the judicial system
- referral resources for substance use disorders

11-3.C RATING INDICATORS

3 Staff hired within the past five years received training on Substance Use within twelve months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than twelve months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Substance Use within twelve months of hire; however, with the **most recent hire(s),** practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Substance Use topics within twelve months of hire; or staff hired within the past five years have not received training on this topic.

11-3.D Staff (direct service staff, and supervisors) receive training on Engaging Families within twelve months of the date of hire.
HFA's online training includes these subtopics:
- engaging fathers and co-parents
- multi-generational families
- working with adolescent parents
- engaging non-binary parents
- strategies for working with families impacted by personal, historical, or generational trauma

11-3.D RATING INDICATORS

3 Staff hired within the past five years received training on Engaging Families within twelve months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than twelve months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Engaging Families within twelve months of hire; however, with the **most recent hires**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Engaging within 12 months of hire; or staff hired within the past five years have not received training on this topic.

11-3.E Staff (direct service staff, program managers and supervisors) receive training on Inequity and Family Context within twelve months of the date of hire.
HFA's online training includes these subtopics:
- historically and currently marginalized communities
- racial wealth gap
- systemic barriers to access and accessibility
- systemic racism and social inequities
- intersectionality
- impacts of inequity on parenting and the home visiting relationship

11-3.E RATING INDICATORS

3 Staff hired January 2022 or later have received training on Inequity and Family Context within twelve months of hire. Staff hired prior to January 2022 have received the training but it may have been later than six months after hire.

2 Past instances were found when staff hired January 2022 or later did not receive training on Inequity and Family Context within twelve months of hire; however with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff have received the training regardless of timeframe.

1 The site's most recent hire(s) from January 2022 or later have not yet received training on Inequity and Family Context within twelve months of hire; or staff hired prior to January 2022 have not yet received training on this topic.

11-4. The site ensures direct service staff, supervisors, and program managers hired longer than twelve months receive annual training (i.e. at some time during each calendar year) that takes into account the individual's knowledge. Staff also receive annual child abuse and neglect training and annual training related to diversity, equity, inclusion, and belonging.

11-4.A The site ensures direct service staff, supervisors, and program managers hired more than twelve months ago receive ongoing training on an annual basis that takes into account the individual's knowledge and skill base, and supports ongoing professional development. Please Note: All staff do not have to attend the same training.

Intent: The worker and supervisor identify individual training needs and determine what additional training topics would be most beneficial in enhancing job performance. This determination would be based upon worker knowledge, skill base, and interest.

11-4.A RATING INDICATORS

3 The site ensures staff hired to Healthy Families for more than twelve months receive ongoing training on an annual basis, beyond the trainings identified in the 10-2, 10-3, 10-4, 11-1, 11-2, and 11-3 standards. Staff are offered and participate in ongoing training,

2 Past instances were found when staff hired more than twelve months did not receive ongoing training on an annual basis, beyond the trainings identified in the 10-2, 10-3, 10-4, 11-1, 11-2, and 11-3 standards; however, **recent practice** indicates this is now occurring.

1 The site does not yet ensure staff hired more than twelve months receive ongoing training on an annual basis; or staff does not yet participate in ongoing training opportunities.

TIP: It is recommended supervisors assist staff in identifying relevant training opportunities to meet each staff person's unique needs and all staff receive a minimum of fifteen (15) hours of ongoing training each year after the first year of hire to remain energized, enthused, and up-to-date on recent advances in the field.

TIP: Direct service staff and supervisors are encouraged to attend HFA's Facilitating Change training to meet ongoing training requirements for one year.

11-4.B All staff hired more than twelve months receive training annually related to child abuse and neglect. All staff do not have to attend the same training. Please Note: During the first year of hire, standard 11-3.A. (Child Abuse and Neglect), may be used to satisfy this standard.

Intent: Self-study training applies for this standard with appropriate documentation (e.g., reading manuals or literature, watching videos, etc.), Remote training, e.g., webinars produced by the state and updated regularly, can also be used to satisfy requirements of this standard, or professional experience when face-to-face training is not available.

11-4.B RATING INDICATORS

3 All staff hired more than twelve months receive annual training related to child abuse and neglect.

2 Past instances were found when staff hired more than twelve months did not receive annual training related to child abuse and neglect, however, **recent practice** indicates this is now occurring and all staff received the training regardless of the timeframe.

1 All staff hired more than twelve months have not yet received annual training on child abuse and neglect.

11-4.C The site ensures all staff hired more than twelve months receive annual training designed to increase awareness and understanding of concepts associated with diversity, equity, inclusion and belonging and how families, communities, home visiting services, and staff are impacted. All staff do not have to attend the same training. *Please Note*: During the first year of hire, standards 11-1.D (Cultural Self Awareness), 11-2.G (Cultural Humility in Home Visiting), and 11-3.E (Inequity and Family Context) may be used to satisfy this standard.

Intent: Staff are better prepared to serve and interact with families when they have increased awareness and understanding of diversity, equity, inclusion and belonging and how families, communities, staff, and services are impacted by social injustice, institutionalized racism, power imbalance, and implicit bias. Expanding learning opportunities in these areas on at least an annual basis clearly conveys the priority HFA places on supporting each individual's journey, and our collective effort to end racism and discriminatory practices and nurture inclusion and compassion for our common humanity.

11-4.C RATING INDICATORS

3 All staff receives, at least annually, training related to concepts associated with diversity, equity, inclusion and belonging, and how families, communities, home visiting services, and staff are impacted.

2 Past instances may have occurred when an annual training related to concepts associated with diversity, equity, inclusion, and belonging, and how families, communities, home visiting services, and staff are impacted was not received; however, **recent practice** indicates the site is now ensuring all staff receives training annually.

1 Staff do not yet complete training on an annual basis related to concepts associated with diversity, equity, inclusion and belonging, and how families, communities, home visiting services, and staff are impacted.

Tables of Documentation

11. All direct service staff and their supervisors receive basic training in areas such as prenatal and infant care, child safety and development, family health, parent-child relationships, diversity, equity, family goal setting, reporting child abuse, managing crisis situations, and responding to mental health, substance use, or intimate partner violence issues. All staff, including program managers receive training on topics related to diversity and equity.

Standard	Pre-Site Documentation to include in Self Study
11-1.A-D | Three-month wraparound training **11-2.A-G |** Six-month wraparound training **11-3.A-E |** Twelve-month wraparound training	Submit Training Logs including hire date and date of training topics received for current HFA supervisors & direct service staff. All staff at affiliated HFA sites may use the online trainings developed by HFA (or other training resources provided by the National Office) to complete the 11-1, 11-2, and 11-3 training topics. If sites use something other than HFA's recommended online wraparound training, the training will comprehensively address each of the overall topics with a variety of relevant subtopics critical for preparing staff to do this work. For staff utilizing formal education, previous training, and/or previous professional experience to satisfy the 3, 6 & 12 month training requirements, please include a narrative indicating any competency based testing and/or supervision follow-up to assure successful knowledge acquisition and understanding of concepts and/or materials provided to assure knowledge of the topics was satisfied. PMs will have documentation of training topics related to diversity and equity, (11-1.D,11-2.G,11-3.E) Please Note: HFA Training Log available.
11-4.A | Ongoing Training	Submit a list of all staff and the ongoing training(s) completed (this can be in the form of a training log or database printout). Please Note: HFA Training Log available.
11-4.B | Annual Child Abuse and Neglect Training	Submit a list of all staff and the annual child abuse and neglect training completed (this can be in the form of a training log or database printout). Please Note: HFA Training Log available.
11-4.C | Annual Diversity, Equity, and Inclusion Training	Submit a list of all staff and the annual diversity, equity, inclusion, and belonging training completed (this can be in the form of a training log or database printout). Please Note: HFA Training Log available.

STANDARD 12

12

Service providers receive ongoing, reflective supervision so they are able to develop realistic and effective plans to support families.

Standard 12 Intent: **The field of infant mental health has identified reflective supervision as a best practice approach, and recognizes and embraces the supervisory relationship as being central to the work with families. "Over 30 years of clinical experience and empirical evidence indicates that Reflective Supervision/ Consultation (RS/C) increases the quality of infant mental health services by reducing vicarious trauma, staff turnover, and bias, while increasing practitioner knowledge and improving practice, job satisfaction, efficacy, and responsiveness. This has led to a general consensus in the multidisciplinary field of infant mental health that RS/C is inextricably both a best practice and an essential component for those providing relationship-focused prevention, intervention, and treatment" (MI-AIMH, 2017). Therefore, reflective supervision is central to the effectiveness of the Healthy Families America model. The intent of reflective supervision is to promote self-awareness, increase clarity about the work being done with a family, build confidence in staff skills, encourage intentionality, and ultimately increase the quality of services provided to families. This approach to supervision recognizes the work with families is very personal work that requires continual introspection about who we are, what we bring to the work, and how the work is impacting us. Reflective supervision is a collaborative process in which all involved (supervisor, supervisee, parent, and child) play a role, whether intentional or not.**

Reflective supervision consciously connects the experiences individuals have in the context of their relationships of others. Reflective supervision is not just about understanding how these relationships affect one other. It is also about intentionally impacting relationships. In other words, if we want parents to see, hold, respond to, and nurture their infants, they must have experienced being cared for themselves. For parents who have not been provided such caregiving through a secure, nurturing relationship, staff may provide an environment for those parents to begin to experience secure relationships. And, in order for staff to be able to provide parents with such safety and security, staff must have someone to provide a safe place for them as well. This is what we refer to as the parallel process. This work often challenges our values and worldviews in ways that result in heightened emotions that can cloud our ability to interpret family circumstances both objectively and empathetically. In work with families, direct service staff's most powerful strategy is the intentional use of self. Reflective supervisors become someone with whom staff can feel seen, held, and supported. The hope is that, as staff experience the support, compassion, respect, and feeling of being seen and heard by their supervisor, this will spill over into their work with families.

During supervision, staff are recognized for the gifts they bring to the work, such as their compassion, wisdom, patience, and ability to see all the strengths each family has to offer their children. They have an opportunity to step back from the day-to-day tasks of their work (writing notes, completing home visits, tracking data, etc.) and are invited to look at what is working well and what is not working so well in their work with families. Supervisors partner with staff in this process of reflection by allowing space and time for honest conversations about the work. They use reflective strategies and conversations as a means of increasing staff's reflective capacity (including self-awareness of the impact of their own culture, values, and beliefs on others), their ability to identify and build on parental competencies, and, ultimately, their effectiveness in their interactions with families. Supervisory sessions encourage professional and personal development by providing a safe yet challenging environment where taking initiative is nurtured and supported. Reflection is a key component of all supervisory discussions, regardless of whether those discussions are administrative or clinical (related to the family) in nature.

12-1. The site ensures direct service staff receive weekly and ongoing supervision.

Intent: Providing weekly scheduled supervision helps direct service staff maintain perspective, evaluate their own performance, increase personal and professional development, learn and practice new strategies to effectively work with families, and develop reflective capacity, and ultimately enhances the quality of services families receive. Additionally, supervision promotes both staff and site accountability and reduces staff burnout and turnover by providing much needed support. Supervisors must ensure they have adequate time to spend with each staff person; therefore, the frequency and duration of supervision is monitored closely. Additionally, supervisors must have a limited number of staff to supervise, ensuring expectations of the supervisor role can be fulfilled, and each staff person being supervised receives the support they deserve.

Policy and procedures clearly define the frequency (weekly for anyone .25 FTE and above) and duration (minimum of 1.5 hours weekly) requirements for individual supervision of each direct service staff. When needs warrant, a single weekly supervision session can be split into no more than two sessions per week.

With regard to duration: For all full-time and part-time staff who are .75 FTE to 1.0 FTE, the requirement is 1.5 to 2 hours weekly. For part-time staff who are .25 FTE to .74 FTE, the requirement is 1 hour weekly. For staff or contractors working less than .25 FTE, supervision may be provided according to occurrence of services.

For full-time staff who serve in more than one role (e.g., a position is split with Supervisor time at 30% and Family Support Specialist time at 70%, or a position that is 100% FSS also responsible for conducting the FROG Scale with their families) 1.5 hours per week is the expectation to meet the supervision requirements of both roles and functions, and documentation clearly indicates both are being addressed.

12-1.A The site's policy states individual supervision is provided to all direct service staff (e.g., Family Resource Specialists and Family Support Specialists) and volunteers and interns (performing the same function) at the frequency and duration required within the standards.

Intent: All full-time direct service staff receive weekly individual supervision for 1.5 to 2 hours and part-time staff receive at least 1 to 1.5 hours as described above in the 12-1 intent. Supervision sessions must be received individually each week, unless excused due to the FSS or FRS being out the entire week. *Please Note*: For sites using reflective consultation groups, one session per month may apply towards the weekly supervision rates, when done in accordance with the expectations outlined in standard 12-1.C.

12-1.A RATING INDICATORS

3 The site policy and procedures specify all .75-1.0 FTE direct service staff receive a minimum of **2 hours per week** of scheduled individual supervision and part-time staff employed .25-.74 FTE receive a prorated amount of supervision as defined in the intent, and staff less than .25 receive supervision based on occurrence of service.

The site's policy also indicates:
- supervision can be divided into no more than two sessions per week
- reflective supervision groups (if used) count for 1 session per month when conducted by a qualified individual (for direct service staff who have been in their role for at least 12 months and who have demonstrated proficiency in their role as determined by the site and based on supervisor judgment)
- the ratio of supervisors to direct service staff is **1:5.**

2 The site policy and procedures specifies all .75-1.0 FTE direct service staff receive a minimum of **1.5 hours per week** of scheduled individual supervision and part-time staff employed .25-.74 FTE receive a prorated amount of supervision as defined in the intent, and staff less than .25 receive supervision based on occurrence of service.

The site's policy also indicates:
- supervision can be divided into no more than two sessions per week
- reflective supervision groups (if used) count for 1 session per month when conducted by a qualified individual (for direct service staff who have been in their role for at least 12 months and who have demonstrated proficiency in their role as determined by the site and based on supervisor judgment)
- the ratio of supervisors to direct service staff is **1:6.**

1 The site does not yet have policy and procedures; or the policy and procedures does not yet meet the requirements of the 2 rating.

12-1.B The site ensures weekly individual supervision is received by all direct service staff (Family Resource Specialists and Family Support Specialists) and any volunteers and interns who provide direct services to families independently in the role of a Family Support Specialist or Family Resource Specialist. Please Note: Volunteers or interns who perform supportive functions to assist direct service staff (e.g., assist with parent groups, data entry, accompanying a Family Support Specialist on home visits, etc.) are exempt from the supervision and training requirements of the standards. An HFA Spreadsheet is available for this standard.

Intent: It is understood that staff bring various experiences and educational backgrounds to their work; however, all staff have in common the need for regular supervision to obtain guidance and support in regard to the complex challenges many families present and the impact the work has on the worker. It is therefore required sites track and monitor in an ongoing way the receipt of weekly supervision for each staff. *Please Note:* When circumstances warrant, (i.e. sites exist in rural or frontier areas, the Family Support Specialists work in remote or off-site locations from the "main office" where the supervisor is located, or natural disaster, severe weather or community health advisory) the use of virtual sessions via video or telephone will count for weekly supervision. *Please Note*: Direct service staff who are new to their role or are without full caseloads are still expected to receive the required amount of weekly supervision. In these situations, supervision may be more focused on skill development than family discussion. *Please Note*: When supervisors are on leave, direct service staff will have a back-up supervisor they can obtain support from. If the supervisor's leave is for two weeks or less, the back-up supervisor does not have to have received HFA Core training, though it would be preferred. However, if the Supervisor's leave is for longer than two consecutive weeks, the back-up supervisor must have received HFA Core training, as required of all supervisors. Sites may want to consider establishing a "team lead" role, as a career ladder opportunity for a direct service staff person with capacity to perform as back-up supervisor, and to have that person obtain supervision training as well.

12-1.B RATING INDICATORS

3 All direct service staff receive **90%** of required weekly individual supervision for a minimum of 1.5-2 hours (excluding weeks when direct service staff is out all week). Supervision sessions are not split into more than two scheduled meetings and less than .75 FTE staff receive a prorated amount of supervision as defined in the intent above.

2 All direct service staff receive **75%** of required weekly individual supervision for a minimum of 1.5-2 hours (excluding weeks when direct service staff is out all week). Supervision sessions are not split into more than two scheduled meetings and less than .75 FTE staff receive a prorated amount of supervision as defined in the intent above.

1 The site is not yet following the guidelines as outlined in 2 rating above.

Note: This is a Safety Standard.

TIP: Frequency and duration of supervision sessions are most effective when viewed over time versus monthly, to account for times when staff are in training, on vacation, or for seasonal fluctuations in service delivery. Semi-annual and annual supervision rate reviews are recommended in addition to quarterly monitoring.

TIP: If providing supervision remotely by phone or video call, it is recommended the site have at least one supervision session per month as an in-person meeting, if possible.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 75% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

12-1.C A site may choose to provide once monthly reflective consultation groups in place of one weekly individual supervision session per month (for direct service staff in their role for a minimum of twelve (12) months. Documentation must include who attended and content topics covered, and must be facilitated by a qualified individual.

Intent: Typically, these sessions last approximately 1.5-2 hours. Reflective consultation groups include but are not limited to:

- family presentation
- focus on holding the space that encourages self-reflection and self-regulation for staff, both physically and emotionally
- observation of the staff member's internal responses to the work, including parallels between what might be going on for the worker as well as how that might impact the work
- focus on the parallel process by expanding to what might be going on for the staff in conjunction with what the family and the baby might be experiencing
- considering what the supervisor might do differently for the next supervision
- developing a plan with staff for work going forward
- opportunities for participants in the group to reflect on the group session they just observed

Supervision sessions must be received individually each week for a minimum of 12 months after initial hire to HFA role for all staff. Subsequent to that time, and with demonstrated staff proficiency, one reflective consultation group per month may substitute for one individual weekly supervision session for .25-1.0 FTE direct service staff (.24 FTE or less may attend reflective groups; however, it cannot be used to offset individual supervision). *Please Note*: Staff not yet in their HFA role for at least 12 months are encouraged to attend and benefit from group supervision (if held); however, attendance cannot be counted toward the required weekly individual sessions expected of staff during that time period.

Please Note: If group reflective consultation is done, there are specific documented qualifications the reflective practice consultant must have:

1 IMH Endorsement or Master's degree or higher in human services related field: Master of Arts (MA), Master of Science (MS), Master of Education (MEd), Doctorate in Education (EdD), Master of Social Work (MSW), Master of Nursing (MSN), Doctor of Psychology (PsyD), Doctor of Philosophy (PhD), Medical Doctor (MD), Doctor of Osteopathy (DO) or other degree specific to one's professional focus in infant mental health; university certificate program, and/or course work in areas such as infant/very young child development, family-centered practice, cultural sensitivity, family relationships and dynamics, assessment, and intervention.

2 Two years of work experience providing culturally sensitive, relationship-focused infant mental health services with infants and toddlers and their families. This specialized work experience must be with both the infant/toddler and his/her biological, foster, or adoptive parent on behalf of the parent-infant relationship. Infant mental health services will include early relationship assessment, and parent-infant/very young child relationship-based therapies and practices. Infant mental health services include parent-infant psychotherapy, interaction guidance, and child-parent psychotherapy. These therapies and practices are intended to explicitly address issues related to attachment, separation, trauma, and unresolved losses as they affect the development, behavior, and care of the infant/very young child.

3 Previous recipient of reflective supervision. The facilitator will need to have received relationship focused, reflective supervision/consultation, individually or in a group, post-Masters, while providing services to infants, very young children, and families from a qualified professional.

4 Training or experience facilitating groups and managing group dynamics.

This person may be sub-contracted by the agency. If reflective consultation is conducted by a contractor, a site supervisor attends as a group member in order to support staff with any recommended action steps pertaining to the family discussed during group.

TIP: It is recommended reflective consultation groups establish "group rules" to protect confidentiality and promote an environment of safety between and among members. See sample group rules.

12-1.C RATING INDICATORS

3 The site provides reflective consultation groups conducted according to the guidelines listed in the intent. Group reflective consultation is counted for no more than one session per month only for staff who have demonstrated proficiency in their role and have been with the site for at least 12 months. Group reflective consultation is provided by a qualified individual and documentation at minimum includes individuals in attendance and content areas discussed.

2 Past instances occurred when the site provided group reflective consultation not conducted according to the guidelines listed in the intent and with documentation at minimum including individuals in attendance and content areas discussed; however, **recent practice** indicates this is now occurring.

1 Any of the following: the site does not yet provide group reflective consultation according to the guidelines listed in the intent; or it is not yet conducted by a qualified individual; or documentation of reflective consultation group meetings has not yet occurred; or group reflective consultation is counted for more than one weekly individual supervision rate per month.

NA Site does not use reflective consultation groups to offset one weekly individual supervision session per month for any of its direct service staff.

12-1.D The ratio of supervisors to direct service staff and volunteers and interns (performing the same function) is sufficient to allow regular, ongoing, and effective supervision to occur.

Intent: It is critical supervisors have the time to prepare for supervision as well as complete all of the requirements of the site and host organization. It is estimated each direct service staff member requires approximately 8 hours per week of supervision time, including the actual supervision session as well as the supervision activities outside of the session including internal quality management activities, administrative work, arranging training, staff meetings, etc. *Please Note*: full-time equates to a 40-hour work week. Therefore, sites that employ staff considered full-time but working less than 40 hours per week must prorate staffing ratios accordingly. See the proration calculation tool for guidance. *Please Note*: In the event the Supervisor is not full time in their role (e.g., is hired 75%, or is hired full-time, but a portion of that time is as a part-time Family Resource Specialist, or is a Program Manager also providing supervision to direct service staff, or is full-time to the agency but only part-time to Healthy Families, etc.), they are to indicate the amount of time spent in their Healthy Families supervision role and calculate the ratio of direct service staff based on the percentage of time spent in the supervision role. For example: a supervisor who is 75% supervisor and 25% Family Support Specialist would have a ratio of .75 FTE supervisor: 4.5 FTE direct service staff. This is calculated by taking .75 (% FTE) X 6 (as allowed in a 2 rating) equals 4.5 FTE. This formula can be used to determine the ratio of supervisors to direct service staff regardless of the percentage of time.

12-1.D RATING INDICATORS

3 The ratio of supervisors to direct service staff is **one (1) full time supervisor to five (5)** full time direct service staff. The site is consistently following this standard.

2 The ratio of supervisors to direct service staff is **one (1) full time supervisor to six (6)** full time direct service staff (or 8 part-time staff). The site is consistently following this standard. Any overage within the past twelve (12) months due to turnover or unexpected staff shortage does not exceed more than three months.

1 The site ratio of supervisors to direct service staff has more than six (6) full time direct service staff (or more than 8 part-time staff) to one (1) full time supervisor; or the site is not yet following the standard as outlined in 2 rating above.

TIP: It is recommended that sites whose staff have caseloads largely comprised of families scoring with especially elevated risk on the FROG Scale maintain a 1:5 supervisor to direct service staff ratio.

TIP: It is recommended supervisors responsible for other agency program staff maintain a similar staff to supervisor ratio in order to balance workload of the supervisor.

12-2. Direct service staff (and volunteers and interns performing the same function) receive reflective supervision pertaining to their work and are provided opportunities for skill development and professional support.

Intent: HFA Supervisors support their staff in both a mentoring and monitoring role. As a monitor, supervisors oversee the completion of activities that meet the Best Practice Standards as well as other site or agency requirements and provide strength-based feedback to nurture the staff's professional development. As the mentor, supervisors support the integration of training into the work, add to the knowledge of direct service staff, discuss how to work with families, and generally enhance their abilities. Working with families who are experiencing complex life challenges is a high stress job, and as a result, supervisors have a critical role of offering guidance, emotional support, and insight into the impact of the work on the worker.

12-2.A The site has supervision policy and procedures to ensure all direct service staff (and volunteers and interns performing the same function) are provided with reflective supervision pertaining to their work and opportunities for skill development and professional support, including twice annual shadowed visits and debrief with their supervisors.

12-2.A RATING INDICATORS

3 No 3 rating indicator for standard 12-2.A.

2 The site has supervision policy and procedures which indicate supervisors are responsible for providing all direct service staff with reflective supervision and twice annual shadow visits (including debrief of shadow visits) to ensure all staff receive professional support and skill development to continuously improve the quality of their performance.

1 The site does not yet have policy and procedures; or the policy and procedures do not yet include the expectations described in the 2 rating.

TIP: In an effort to streamline supervisor documentation, supervisor activities that are clinical in nature may be documented on the HFA Service Plan for each family.

TIP: While it is not possible to engage in deep reflective conversation pertaining to each family each week, supervisors are encouraged to have in-depth reflective conversation for each Level 1, P, or SS family on a Family Support Specialist's caseload a minimum of one time per month, and a minimum of once every other month for Level 2 families.

TIP: When staff are new to their role, supervisors can demonstrate support shadowing visits more frequently than twice annually during the onboarding process.

12-2.B The site ensures all direct service staff (and volunteers and interns when performing the same function) receive reflective supervision pertaining to their work, and are provided opportunities for skill development and professional support to continuously improve the quality of their performance.

12-2.B RATING INDICATORS

3 The site ensures all direct service staff receive reflective supervision pertaining to all aspects of the work and are provided opportunities for skill development and professional support to continuously improve the quality of their performance.

2 Past instances were found when staff did not receive reflective supervision or opportunities for skill development and professional support to continuously improve the quality of their performance; however, **recent practice** indicates this is now occurring for all direct service staff.

1 Staff do not yet receive weekly reflective supervision as described in Standard 12-2.B.

Note: This is an Essential Standard.

TIP: Utilizing the Reflective Strategies as a supervisor during supervision will support staff in using Reflective Strategies effectively with families.

12-2.C The site ensures all direct service staff (and volunteers and interns performing the same function) are provided with twice annual shadow visits and debrief with their supervisor to continuously improve the quality of their performance.

Please Note: A shadow visit combined with debrief conversation between the supervisor and direct service staff counts as a weekly supervision session.

12-2.C RATING INDICATORS

3 All direct service staff (and volunteers and interns performing the same function) are provided with a minimum of twice annual shadowed visits and debrief with their supervisor.

2 Past instances were found when the direct service staff did not receive twice annual shadow visits and debrief with their supervisor; however, **recent practice within the past year** indicates this is now occurring consistently for all direct service staff.

1 Staff do not yet receive twice annual shadow visits and debrief with their supervisor.

TIP: For Family Support Specialists who administer the FROG it is recommended one of the two shadow visits per year is done on a FROG visit.

12-3. Supervisors receive regular, ongoing supervision which holds them accountable for the quality of their work and provides them with skill development and professional support.

Intent: According to the Best Practice Guidelines for Reflective Supervision/Consultation of the Alliance for the Advancement of Infant Mental Health, in order to maintain a reflective lens through the challenges and complexity involved in the supervisory role, it is essential that supervisors also engage in their own reflective supervision/consultation. Supervisors' experience of developing and advancing their supervisory reflective skills should include parallel dynamics to that of direct service staff's supervisory experience. The goal of supervisors' supervision should be to facilitate their ability to integrate a reflective lens into their work with direct staff and ultimately the work with families.

Sites are to have clear policy and procedures regarding the frequency of supervision for supervisors, including the professional support, skill development, and accountability measures in place to support supervisors. It is recommended supervisors receive individual supervision every other week; however, the minimum requirement is monthly. Supervision of the supervisors can occur face-to face or virtually (via video conferencing or phone). Supervision sessions are regularly scheduled to ensure the supervisor has the support they need to ensure quality at the staff and direct service level.

12-3.A The site has policy and procedures to ensure supervisors are held accountable for the quality of their work, receive skill development and professional support through regular and ongoing supervision, and are able to receive reflective supervision, individually or as part of a reflective group for supervisors (reflective consultation groups for supervisors are encouraged to utilize facilitators with the same qualifications as indicated in standard 12-1.C).

Intent: *Please Note*: For supervisors carrying small caseloads (one visit or less per week) on a permanent basis, or carrying a larger caseload, but on a temporary basis (i.e. when families are temporarily re-assigned due to staff leave or turnover), or occasionally administer the FROG Scale (as a back-up):

- The person providing supervision does not have to be trained as an HFA supervisor. It is preferred but not required.
- The supervision session can occur based on the frequency of contact and does not have to occur weekly.
- If the person providing the supervision is not trained as a supervisor in HFA, the supervisor can maintain the supervision notes based on the discussions being conducted.

Please Note: For supervisors carrying larger caseloads (2 or more visits each week) on an ongoing basis), or routine administration of the FROG Scale:

- The ratio of supervisor to staff (12-1.C) is to be taken into account based on the percentage of time the supervisor is providing direct services.
- Supervisors must receive supervision in accordance with the 12-1 and 12-2 standards.
- The individual providing supervision to the supervisor must have received all HFA required training as outlined in Standards 10 and 11.

12-3.A RATING INDICATORS

3 Policy and procedures include a requirement that, in addition to all components of monthly administrative supervision described in the 2 rating, supervisors will receive **monthly** reflective supervision.

2 The site has policy and procedures which specify supervisors receive a minimum of **once every other month** reflective supervision (individually or as part of a reflective consultation group for supervisors) and at least monthly individual administrative supervision focused on areas such as:

- addressing personnel issues
- team development and agency issues
- review of site documentation including monthly or quarterly reports
- site statistics (screening and initial engagement, home visit rates, content of home visits, quality assurance mechanisms, etc.)
- review of progress towards meeting site goals and objectives
- strategies to promote professional development/growth
- quality oversight that could include shadowing of the supervisor

1 The site does not yet have policy and procedures; or the policy does not yet meet the requirements specified in the 2 rating.

12-3.B The site's practice ensures supervisors receive individual administrative supervision and are held accountable for the quality of their work. Please Note: sites may use HFA's shadowing of supervision form.

12-3.B RATING INDICATORS

3 Site ensures supervisors receive at least monthly individual administrative supervision **and at least once annual shadowing with debrief of a supervision session**, and are held accountable for the quality of their work.

2 Past instances were found when the site did not ensure supervisors received at least monthly individual administrative supervision or were not held accountable for their work; however, **recent practice** indicates this is now occurring.

1 Individual administrative supervision of supervisors is not yet occurring at least monthly; or supervisors are not yet held accountable for the quality of their work.

12-3.C The site's practice ensures supervisors receive regularly scheduled reflective supervision.

12-3.C RATING INDICATORS

3 Site ensures supervisors receive at least monthly reflective supervision.

2 Past instances were found when the site did not ensure supervisors received at least every other month reflective supervision; however, **recent practice** indicates this is now occurring.

1 Reflective supervision for supervisors is not yet occurring at least once every other month.

TIP: Reflective consultation groups for supervisors are encouraged to utilize facilitators with the same qualifications as indicated in standard 12-1.C

12-4. Program managers are held accountable for the quality of their work and are provided with skill development and professional support.

12-4.A The site has policy and procedures to ensure program managers are held accountable for the quality of their work and receive skill development and professional support.

Intent: The program manager role is distinct from that of program supervisor and, while both roles can be assumed by the same person, the FTE status of both roles must be delineated and protected to ensure sustainable program leadership and adequate support to staff being supervised.

Program Managers are provided with skill development and professional support and are held accountable for the quality of their work. This can happen through accountability with quarterly reports, annual performance reviews, regularly scheduled meetings (in-person or virtually) with the program manager's Supervisor or chair of the advisory/governing board, peer supervision with HFA Program Manager from a neighboring site, and attendance at conferences or other training

12-4.A RATING INDICATORS

3 No 3 rating indicator for standard 12-4.A.

2 The site has policy and procedures ensuring program managers are held accountable for the quality of their work and receive skill development and professional support.

1 The site does not yet have policy and procedures; or the policy does not yet meet the requirements specified in the 2 rating.

TIP: While very small sites may be able to function with a part-time program manager, HFA recommends a full-time program manager as site size increases.

12-4.B The site ensures Program Managers are held accountable for the quality of their work and receive skill development and professional support.

12-4.B RATING INDICATORS

3 Site ensures program managers are held accountable for the quality of their work and receive skill development and professional support.

2 Past instances were found when programs managers were not held accountable, receiving skill development or professional support; however, **recent practice** indicates this is now occurring.

1 Program managers are not yet held accountable for the quality of their work; or do not receive skill development or professional support.

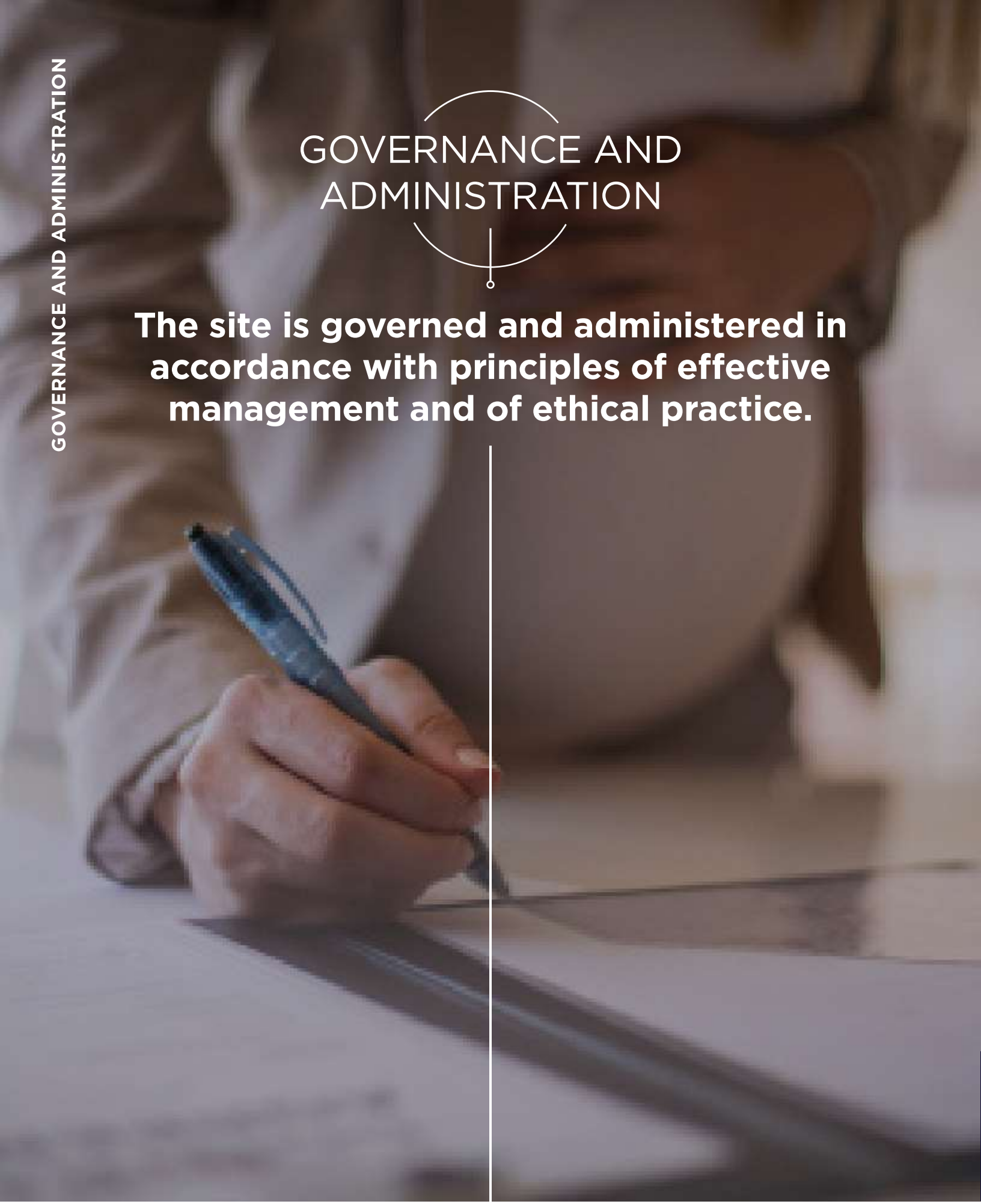
Tables of Documentation

12. Service providers receive ongoing, effective supervision so they are able to develop realistic and effective plans to support families

Standard	Pre-Site Documentation to include in Self Study
12-1.A | Policy for Frequency & Duration	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
12-1.B | Measure supervision frequency and duration **Safety Standard**	Submit a report indicating the frequency and duration of supervision sessions for the most recent quarter. 1. Determine needed frequency and duration of supervision per FTE guidelines within BPS for each direct service staff 2. Determine number of expected supervision sessions for each staff member for one quarter 3. Subtract from #2 (expected sessions) any excused sessions per guidelines provided by BPS 4. Count number of supervision sessions that occurred within proper timeframes and for expected duration 5. Divide #4 (number of supervision sessions at required duration) by #3 (expected sessions minus those excused) 6. Create report to communicate findings for each staff member Please Note: HFA Spreadsheet available. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (75% in this case). When the site's data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
12-1.C | Reflective Consultation Group	Submit a report indicating the date, time and attendees of group reflective consultation groups (if utilized) for the most recent quarter, along with content areas discussed. Also, please submit the qualifications of the individual facilitating groups.
12-1.D | Ratio of Supervisors to staff	Submit the HFA Face Sheet indicating each supervisor, their full time equivalency (FTE), percentage of time spent in a supervisor role, and the staff they supervise (with FTE for each position). For any staff with multiple roles, be sure to capture FTE for each role each staff person has.
12-2.A | Policy - Administrative, Clinical and Reflective Supervision and Professional Support	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
12-2.B | Reflective, Supervision, Skill Development and Professional Support **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
12-2.C | Shadow Visits	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
12-3.A | Policy - Supervision of Supervisor	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
12-3.B | Supervision of the Supervisor Received	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
12-3.C | Supervisors Receive Reflective Supervision	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
12-4.A | Policy - Program Manager Accountability	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
12-4.B | Program Manager Supervision Received	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

GOVERNANCE AND ADMINISTRATION

The site is governed and administered in accordance with principles of effective management and of ethical practice.



Governance and Administration Standards Intent is to ensure the site has feedback and oversight mechanisms to ensure high quality services to families. These practices include effective community advisory board operation, review of site quality, handling of family complaints, utilization of informed consent, protection for families related to research conducted, and appropriate reporting of child abuse and neglect.

GA-1. The site has a community advisory board that serves in an advisory or governing capacity in the planning, implementation, and continuous quality improvement of site-related activities.

Intent: Community advisory boards serve an important function in community-based agencies. They can be advocates for the site in the community, representing the site and agency in other venues and settings, which can bring more recognition and visibility. Community advisory members bring to the site different skills and perspectives than might be present within site staff. Members share strategies, brainstorming ideas and facilitating growth for the site. Additionally, members often have access to resources to strengthen the site or agency. It is important the group has the community connections to understand the needs of the families receiving HFA services.

Some HFA sites fulfill the need for the functions outlined in the Standards below by having two different groups. This happens most often when HFA sites function as part of a larger agency that has its own governing board. The agency board typically has many other functions outside of Healthy Families and usually does not have the capacity to serve in all the ways the Standards require, but it may be involved in making key decisions about the site and its financial status.

Regardless of whether or not HFA sites have this larger agency board, sites will need to create and maintain a community advisory board with the primary function of advising in the planning, implementation, and continuous quality improvement of site-related activities. Many times the host agency governing board will have final say, but the community advisory board can provide input to the Program Managers (or other representative from the local site) who can provide the information to the agency board. *Please Note*: Frequency of meetings may vary depending on the duties assigned to the advisory group and activities carried out by any subcommittees. A minimum of quarterly meetings is required.

GA-1.A The site's community advisory board meets at least quarterly and is an effectively organized, active body advising the functions specified in GA-1.

GA-1.A RATING INDICATORS

3 The site's community advisory board is an organized, active body that meets at least quarterly and advises the activities of planning, implementation, and continuous quality improvement of site services.

2 Past instances occurred when the community advisory board did not meet quarterly; however, **recent practice** indicates this is now occurring. The site's community advisory board advises the specified functions, but could be more active in one area of functioning.

1 Any of the following: the site's community advisory board meets less than quarterly; or is not yet active; or is not advising on planning, implementation, and continuous quality improvement.

TIP: Community advisory board involvement may be more intense and meet more frequently during the start-up phase. Community leadership is critical to the launch of the site, and well-established sites benefit tremendously from community advisory board involvement as well. Over time, a well-formed advisory board with strong member relationships is a huge asset to the continuation of a shared vision and the realization of intended impacts.

GA-1.B The community advisory board has a wide range of needed skills and abilities and includes representatives with a heterogeneous mix in terms of skills, strengths, community knowledge, professions, and cultural diversity, allowing it to effectively serve the interests of the community and advocate on behalf of the diverse needs of site participants.

GA-1.B RATING INDICATORS

3 The community advisory board has a range of skills, strengths, community knowledge, and cultural characteristics (as determined by the site to represent the diverse needs of site participants). **The site does not have any identified gaps in its membership.**

2 The community advisory board's membership has a range of skills, strengths, community knowledge, and cultural characteristics (as determined by the site to represent the diverse needs of site participants). The site has **identified gaps in its membership which it is working to address.**

1 The community advisory board's membership does not yet represent the skills, strengths, community knowledge, and cultural characteristics (as determined by the site to represent the diverse needs of site participants).

TIP: When parent/caregiver representatives participate as members of the community advisory board, the site is encouraged to provide support, and education to ensure parents are well-received, their voice heard and regarded equally, and their expertise used effectively.

GA-1.C The program manager (or other representative from the local site) and the community advisory board work together effectively. The program manager provides site information for each meeting. Advisory members participate in discussion and guidance in regard to this information.

GA-1.C RATING INDICATORS

3 The program manager (or other representative from the local site) partners with the community advisory board by providing members site information needed for each meeting and engages them in advising site operations.

2 Past instances occurred when the program manager (or other representative from the local site) did not provide site information needed for each meeting to engage members to participate in advising site operations; however, **recent practice** indicates this is now occurring.

1 The program manager does not yet provide site information or engage advisory members to advise on site operations.

GA-2. The site monitors and improves the quality of its services.

Intent: The site uses a variety of methods to monitor and improve the quality of all services offered to families. Both quality assurance activities (GA-2.A) and quality improvement activities (GA-2.B) are necessary and distinguished as follows:

QUALITY ASSURANCE	QUALITY IMPROVEMENT
Defines quality	Raises quality
Relies on inspection	Emphasizes prevention
Uses a reactive approach	Uses a proactive approach
Looks at compliance with standards	Improves the process to meet standards
Requires a specific fix	Requires continuous efforts
Relies on individuals	Relies on teamwork
Examines criteria or requirements	Examines processes and outcomes
Asks, "Do we provide good services?"	Asks, "How can we provide better services?"

Scamarcia Tews, Debra, et al. Embracing Quality in Public Health. 2nd ed., www.mphiaccredandqi.org, 2012.

GA-2.A The site develops a quality assurance plan for reviewing and documenting the quality of site implementation, to increase fidelity to the model within the four components of the service delivery system (initial engagement, home visiting, supervision, and management).

Intent: Sites will develop a Quality Assurance plan that includes activities such as satisfaction surveys, annual file review, reports related to site activities, etc. These activities help ensure accountability and commitment to implementing the HFA model with fidelity. Additionally, sites will document the completion of these activities Download Sample Quality Assurance Plan.

GA-2.A RATING INDICATORS

3 The site has a current quality assurance plan including all components of the service delivery system (initial engagement, home visiting, supervision, and management) and has **implemented quality assurance activities related to all** these components to increase fidelity to the model.

2 The site has a current quality assurance plan including all components of the service delivery system (initial engagement, home visiting, supervision, and management); and quality assurance activities to increase fidelity to the model have been **implemented for at least two but not yet all** of these components.

1 Any of the following: the site either does not yet have a quality assurance plan; or the quality assurance plan does not yet include all components of the service delivery system (initial engagement, home visiting, supervision, and management); or the site has not yet initiated quality assurance activities to increase fidelity to the model.

TIP: Sites are encouraged to document areas of improvement and demonstrate improvements have been accomplished.

TIP: Sites are encouraged to discuss QA findings with its community advisory board to obtain support on strategies to increase fidelity.

GA-2.B The site establishes a comprehensive quality improvement plan, utilizing site level data related to acceptance, retention, home visit completion, etc., to develop and apply strategies aimed at strengthening site services. The plan is reviewed and updated annually.

Intent: Each year the site identifies one or more areas it wants to focus on (such as increasing home visit completion rates, or increasing participant acceptance). The site usually identifies its goals based on areas it is striving to improve, though continuous quality improvement (CQI) expectations may also be established by an oversight entity or funder. However decided, once the site has articulated its goals, it should indicate what the baseline is (e.g., home visit completion is 62% at start of the year), what the goal is (home visit completion rate will increase to 75% by year end), and a process for monitoring and evaluating progress toward meeting its goals and addressing any identified issues. Sites use this information for continuous quality improvement. Sites may use PDSA (Plan-Do-Study-Act) cycles to illustrate their efforts to achieve identified goals.

Download Quality Improvement Plan.

GA-2.B RATING INDICATORS

3 Each year the site establishes one or more quality improvement goals, applies improvement strategies, and **monitors progress** toward reaching its goals **at least quarterly**, and implements follow-up mechanisms to address areas of improvement.

2 Each year the site establishes one or more quality improvement goals, applies improvement strategies, **monitors progress** toward reaching its goals **at least annually**, and implements follow-up mechanisms to address areas of improvement.

1 Any of the following: the site does not yet establish goals; or it is not yet conducted on an annual basis; or progress is not yet monitored at least quarterly; or follow-up mechanisms have not yet been implemented.

TIP: Sites are encouraged to discuss QA findings with its community advisory board to obtain support on strategies to increase fidelity.

GA-3. The site informs families of their rights at the start of services and ensures confidentiality throughout the course of services.

Intent: HFA values a family-centered approach to service delivery, which requires site practices that reflect a profound respect for personal dignity, confidentiality, and privacy. This approach is in all services provided, and the standards in this section are devoted to preserving the rights and dignity of all service recipients. In addition to addressing legally protected family rights, the standards in this section also center on the professional ethics of service delivery and promote privacy, honesty, and mutual respect.

Research Note (Client Rights: COA 8th Edition 2006): Ethics documents published by the National Association of Social Workers and the American Psychological Association. Both state an individual's right to privacy, confidentiality, and self-determination. Practitioners, while not always required by law, are ethically obligated to protect these rights for all individuals.

GA-3.A The site has policy and procedures and appropriate forms for timely communication with families about 1) their rights and confidentiality, 2) consent procedures when family information will be shared with another entity, and 3) the process for making a complaint. The policy and procedures also indicate when forms are to be completed, and the process for addressing any complaints, if received.

Rights and confidentiality forms are written in family-friendly language and include the following:

Family Rights

- the right to be treated fairly, with courtesy and respect
- the right to decline service (voluntary nature)
- the right to be referred, as appropriate, to other service providers
- the right to participate in the planning of services to be provided
- the right to file a complaint, who to contact should the need arise (including phone number or contact information), and the process and timeframes associated with response and resolution

Confidentiality

- the manner in which information is shared, with whom, and the process for release of information forms to be signed when exchanging information
- the circumstances when information is shared with consent (e.g., for purposes of referral, or if participating in a research or evaluation study where identifying information is shared, or when data required by funders or model developer includes identifying information)
- the circumstances when information is shared without consent (e.g., need to report child abuse and neglect)

Download Sample Rights and Confidentiality form in English and Spanish.

The release of information form includes the following:

- a signature from the person whose information will be released or parent/legal guardian of a person who is unable to provide authorization
- the specific information to be released
- the purpose for which the information is to be used
- the specific date the release takes effect
- the timeframe or date the release expires (not to exceed 12 months)
- the name of person/agency to whom the information is to be released
- the name of the HFA site providing the confidential information
- a statement that the person/family may withdraw their authorization at any time

Download Sample Release of Information Form in English and Spanish.

GA-3.A RATING INDICATORS

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

2 The policy and procedures address rights and confidentiality and the procedures for addressing any complaints, and states the family is informed about their rights and confidentiality before or on the first home visit, including the right to file a complaint. The policy and procedures also state the family is informed and signs written consent every time information is to be shared with a new external agency. Site forms currently in use include all required elements identified in the intent.

1 The site does not yet have policy and procedures addressing rights and confidentiality, on or before the first home visit, the procedures for addressing complaints, and the process for obtaining informed consent to release information, or the site's forms currently in use do not yet include all the required elements identified in the intent.

Note: This is an Essential Standard.

GA-3.B The site implements its policy and procedures ensuring all parents are notified and receive copy of family rights and confidentiality at the onset of services, both verbally and in writing. Documentation that the rights and confidentiality assurances were reviewed with families is placed in the participant file, and a copy is provided for the family to keep.

GA-3.B RATING INDICATORS

3 Families are informed and receive copy of their family rights and confidentiality, on or before the first home visit, both verbally and in writing.

2 Past instances were found when families were not being informed verbally and in writing, or provided copy of their rights and confidentiality on or before the first home visit; however, **recent practice** indicates this is now occurring.

1 Any of the following: families are not yet being informed about their family rights and confidentiality on or before the first home visit; or the site does not protect family confidentiality and privacy.

Note: This is an Essential Standard.

TIP: While the rights and confidentiality form is required to be completed only once at the initiation of services, sites are encouraged to consider renewing it annually with families as a best practice. Also, while the required components bulleted above pertaining to family rights and confidentiality can be addressed via more than one form, sites are strongly encouraged to utilize only one form so as not to overwhelm families with excessive paperwork.

GA-3.C Parents are informed and sign a new release of information form every time information is to be shared with a new external source or with the same source but for a subsequent time period.

Intent: When a site receives a request for confidential information about a family, or when a release of confidential information is necessary for the provision of services, the site must obtain the family's informed, written consent prior to releasing the information. All information on the form must be filled in before parents sign the form. It is not permissible to have parents sign incomplete forms. This consent may also apply to verbal sharing of information, and sufficient details about what staff may speak about must be clearly listed.

GA-3.C RATING INDICATORS

3 Families provide written consent every time information is to be shared with a new external source or with the same source but for a subsequent time period.

2 Past instances were found when families did not provide written consent for sharing of information however, **recent practice** indicates this is now occurring.

1 Information is shared without the family's written consent.

Note: This is a Safety Standard.

GA-3.D The site ensures complaints are responded to in accordance with its policy and procedures.

GA-3.D RATING INDICATORS

3 The site ensures participant complaints have been responded to in accordance with its policy and procedures.

2 Past instances may have occurred when participant complaints were not responded to in accordance with site policy and procedures; however, **recent practice** indicates this is now occurring.

1 Complaints have not been responded to in accordance with site policy.

NA No participant complaints have been received by the site in the past five years.

GA-3.E The site ensures participant privacy and voluntary choice with regard to research conducted by or in cooperation with the site.

Intent: A site that participates in or permits research conducted by an outside source involving service recipients establishes the right of individuals to decline to participate without penalty and guarantees participants' confidentiality. All research involving service recipients must be conducted in accordance with applicable legal requirements. Research includes all forms of internal or external research involving service recipients.

GA-3.E RATING INDICATORS

3 The site ensures participant privacy and voluntary choice for all families with regard to research.

2 Past instances may have occurred where participant privacy and voluntary choice with regard to research was not ensured; however, **recent practice** indicates this is now occurring.

1 Any of the following: individual researchers follow their own plans and potential for disclosure of identity or violation of privacy is high; or families are not yet provided an opportunity to decline disclosure.

NA No research is currently being conducted by or in collaboration with the site.

GA-4. The site reports all suspected cases of child abuse and neglect to the appropriate authorities.

Intent: Staff clearly understand how to identify child abuse and neglect indicators and the State's definitions of child abuse and neglect. This will assist them with knowing how and when to report. Additionally, it is important for staff to know who to contact for support when abuse or neglect is suspected. It is the intent that site leadership be notified in advance of a CPS report being made; however, imminent child safety concerns are of higher priority. Therefore, staff also clearly understand that contacting Child Protective Services prior to immediate notification of the site manager or supervisor is appropriate ONLY IF waiting to contact site leadership may cause greater risk to the child(ren). Exceptions must be fully documented. These criteria and reporting procedures are clearly outlined in the orientation training staff receive prior to their work with families (10-2.D) and reviewed annually throughout employment (11-4.B).

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

GA-4.A The site has policy and procedures to report all suspected cases of child abuse and neglect to the proper authorities.

Intent: The site must have policy and procedures to effectively guide staff in situations where abuse or neglect is suspected so appropriate and timely action can be taken. Sites may choose to reiterate information from the State's Children's Code, agency-wide policy, or training materials indicating the child abuse and neglect criteria and reporting requirements. At a minimum, these materials must be referenced in policy with a link so staff know where to locate them.

GA-4.A RATING INDICATORS

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

2 The site has policy and procedures that are in accordance with all applicable laws and specify the following:
- criteria used to identify and determine when to report suspected child abuse and neglect (or, at a minimum, policy must indicate where these criteria can be found)
- expectation of all staff (managers, supervisors and direct service staff) as mandated reporters
- immediate notification of the program manager or supervisor when abuse or neglect is suspected
- the site's mechanism to track and follow-up on all children with suspected abuse and neglect

1 The site does not yet have policy and procedures specifying the items listed in the 2 rating.

Note: This is a Safety Standard.

TIP: The site's policy can reference child abuse and neglect reporting criteria from a mandated reporter document written by the agency or by a local or state child welfare office. In such cases, the site must be sure to include access to this document so staff have easy access to the reference document when needed.

GA-4.B The staff reports all suspected cases of child abuse and neglect to the proper authorities, including situations where it is believed a report has already been made by another individual or organization.

GA-4.B RATING INDICATORS

3 Staff report all suspected cases of child abuse and neglect to the proper authorities.

2 Past instances were found when staff did not report suspected cases of child abuse and neglect to the proper authorities; however, **recent practice** indicates all suspected child abuse and neglect situations are reported or, **if there have been no situations of suspected abuse and neglect to report, all currently employed staff have awareness of site's policy on how they would respond to this type of situation.**

1 There are situations within the past twelve months when staff did not report suspected abuse and neglect to the proper authorities; or staff are unfamiliar with site policy.

Note: This is a Safety Standard.

GA-4.C The staff notifies the supervisor or program manager immediately in situations where staff suspect abuse or neglect. The supervisor or program manager tracks these situations to ensure safety concerns are addressed and appropriate follow-through occurs.

GA-4.C RATING INDICATORS

3 Staff immediately notify the program manager or supervisor when abuse or neglect are suspected, and a tracking mechanism is in place to ensure safety concerns are addressed and follow-through occurs.

2 Past instances were found when staff did not immediately notify the supervisor or program manager of suspected abuse or neglect; or the site did not use a tracking mechanism; however **recent practice** indicates this is now occurring; **or currently employed staff have had no suspected abuse and neglect situations in the past year to illustrate implementation.**

1 The site's staff do not yet immediately notify the supervisor or program manager of suspected abuse and neglect; or the site is not using a mechanism to track all suspected abuse and neglect situations; or staff is unfamiliar with site policy.

TIP: The site is encouraged to document on the Service Plan when there has been suspected abuse or neglect.

GA-5. The site responds to support families and staff in situations involving participant death.

GA-5.A The site has policy and procedures specifying immediate notification of the program manager or supervisor in cases of participant death (other appropriate staff/supervisors within the site are notified as needed) and specify staff are offered grief counseling when a participant death occurs, and families are offered extended support as needed.

GA-5.A RATING INDICATORS

3 No 3 rating for GA-5.A.

2 The site's policy and procedures specify immediate notification of the program manager or supervisor, staff are offered grief counseling when a death occurs, and extended support is offered to the family.

1 Any of the following: the site does not yet have policy and procedures; or the site's policy and procedures do not yet specify immediate notification of program manager or supervisor; or policy and procedures do not yet indicate staff are offered counseling when a death occurs; or do not yet indicate the family is offered extended support as needed.

GA-5.B The site responds in situations involving participant death to support family members and staff as needed. Program manager or supervisor is notified immediately.

Intent: This standard ensures both staff and family members are supported through the grief process. This could include additional reflective supervision, short-term transitional home visits with the family, the offer of grief counseling when these resources are available, etc. A death creates a deep sense of loss for families as well as staff, including direct service staff and supervisors with whom the family member had a relationship. At a minimum, reporting would occur if there were a death of a focus child or participating parent.

GA-5.B RATING INDICATORS

3 In situations involving participant death of a parent or focus child, immediate notification of the program manager or supervisor occurs. Support is provided to families and staff when a death occurs.

2 Past instances were found when notification of program manager or supervisor did not occur immediately or staff or families were not offered support; however, **recent practice** indicates this is now occurring; or if **there have been no participant deaths, all currently employed staff are aware of site policy on how they would respond to this type of situation.**

1 Program manager or supervisor have not yet been notified immediately; or staff or families are not yet offered support when a death occurs; or staff are unfamiliar with site policy.

TIP: Offering services to families after the loss of a child is crucial to supporting the grief process and services should not be closed too quickly. Sites may want to create an informal transition plan in partnership with the family to be intentional about services that will be provided after a loss. Services often continue for approximately three months when desired by the family.

GA-6. Updates to the site's Policy and Procedures Manual are communicated to all staff in a timely basis and staff have access to a copy of the Policy and Procedure Manual.

Intent: It is critical for all staff to know and understand the policies and procedures which guide their work. It is not necessary for staff to have the Policy and Procedures manual memorized, but they will, at a minimum, know where to look when they have a policy or procedure question and are able to use it as a support to practice when needed. *Please Note:* Orientation to policy and procedures is required before contact with families as per standard 10-2.A. For additional guidance see Policy and Procedure Checklist and Sample Policy and Procedure Template/Guide.

GA-6. RATING INDICATORS

3 The site has a Policy and Procedures Manual, all staff have access to it, and updates have been communicated to staff when they occur.

2 The site has a Policy and Procedures Manual. Past instances were found when the site staff did not have access to it or receive communication when updates occurred; however, all staff now have access to the Policy and Procedures Manual and **recent policy changes** were communicated to staff when they occurred.

1 Any of the following: the site does not yet have a Policy and Procedures Manual; or all staff do not yet have access to it; or staff have not yet received communication when updates to policy occur.

TIP: Staff receive orientation training to the site's policy and procedures (10-2.B). Communication with staff about policy updates can occur during supervision or team meetings with support provided to help staff understand and integrate policy changes into practice.

THIS IS THE END OF THE HFA BEST PRACTICE STANDARDS GUIDE

PRIOR TO AN ACCREDITATION OR CERTIFICATION DECISION,

the HFA National Office will confirm the following GA-7 requirements are in adherence. A site is required to remedy any that are out of adherence before the accreditation or fidelity assessment certification award can be conferred.

GA-7. In accordance with HFA's Affiliation and Licensing Agreement, which grants sites the ability to implement the model and access its intellectual property, affiliates are required to adhere to the responsibilities outlined therein, particularly those pertaining to data, fees, brand identity, and research.

GA-7.A The site ensures that all HFA required data pertaining to site staff and participants is provided as specified in the Overview of HFA Data Reporting Requirements.

Intent: HFA requires select data on sites, staff, and participants in order to accurately and effectively represent the entire HFA network and support continuous quality improvement. It is imperative that sites provide current information as defined in the Overview of HFA Data Reporting Requirements. When all site data is recorded accurately and is up-to-date, we are best able to understand, reflect on, and articulate to the field and key stakeholders and decision-makers the collective impact the HFA model has.

GA-7.A RATING INDICATORS

3 No 3 rating for GA-7.A.

2 All HFA required data, as defined in the Overview of HFA Data Reporting Requirements, is accurate and up-to-date and is consistent with expectations for all affiliated sites.

1 Data required of all HFA affiliates is not yet currently up-to-date as required of all HFA affiliates.

GA-7.B The site is up-to-date with all fees owed to the HFA National Office.

Intent: Sites must have any outstanding fees paid in full prior to accreditation or fidelity assessment certification.

GA-7.B RATING INDICATORS

3 No 3 rating for GA-7.B.

2 The site has no outstanding fees owed to the National Office or has now paid any fees previously owed.

1 The site currently has overdue or unpaid fees.

Note: This is a National Office Requirement.

GA-7.C The site utilizes the trademarked HFA name, logo, and brand according to HFA graphic standards.

Intent: The image and integrity of the HFA model is maintained through appropriate use of HFA graphics on all promotional materials and other documents and images shared publicly (electronically or in hard copy). Visual representation that is uniform across the HFA network conveys a stronger brand identity.

GA-7.C RATING INDICATORS

3 No 3 rating for GA-7.C.

2 The site utilizes HFA graphics (name, logo, etc.) in accordance with HFA graphic standards for site materials made available publicly.

1 The site is not yet utilizing HFA graphics (name, logo, etc.) in accordance with HFA graphic standards for site materials made available publicly.

Note: This is a National Office Requirement.

GA-7.D The site ensures that the National Office 1) is notified in advance of a site's participation in a research study involving a) the HFA model, or b) participant families, past or present, enrolled in HFA services; and 2) is provided information on the study, as described in the HFA Site Research Policy.

Intent: HFA encourages participation in research when feasible and appropriate. Notifying the National Office prior to participation and sharing information about the project 1) establishes ongoing communication between the National Office, participating site(s), and study investigators; and 2) provides the opportunity to ensure alignment with the HFA Site Research Policy, maximizing the value of study findings and their integration with existing HFA evidence and practice. *Please Note*:

- Another entity (state system or research partner) may submit the study notification and information on the site's behalf. The site ensures this information is received by HFA, as described in the HFA Site Research Policy.
- For sites not involved in any research studies, the site will indicate in writing they are not involved and indicate their understanding of HFA requirements should a request for participation in research occur at a later time.

GA-7.D RATING INDICATORS

3 No 3 rating for GA-7.D.

2 The site notifies the National Office prior to the site's participation in any research study involving 1) the HFA model, or 2) participant families, past or present, enrolled in HFA services; and receives study updates consistent with HFA's Site Research Policy. If the site is not involved in any research study, the site will provide a written statement indicating such, as described in the intent.

1 The site has not followed through with National Office requirements as listed in the 2 rating.

Note: This is a National Office Requirement.

TIP: The Research Department at the National Office is able to provide guidance and support to sites and study investigators. Sites (or the central administration when part of a Multi-Site System) are strongly encouraged to reach out to the Research Department through their Training and TA Specialist as early in the process as possible.

GA-7.E When critical incidents occur at the local site level, communication procedures are followed to ensure the national office is notified if the matter escalates to state or national level attention. This includes situations 1) involving child or caregiver death, or serious abuse incidents, which prompt local investigation or media involvement, and 2) litigation pertaining to Healthy Families work/services.

To inform the National Office, please submit this form as instructed.

Intent: Though not common, situations may arise when public relations for damage control is needed to minimize the negative effect caused by an event or series of events. Public relations is about building, improving and maintaining the public image and perception of an individual, company or organization. To ensure the most appropriate response and public communication about such events, sites are to promptly communicate critical incidents to the National Office, when the situation garners heightened media attention. Should the National Office be contacted by the media, national staff must employ its own public relations response. In each case, National Office can do effective public relations work when information of the incident has been communicated in a timely way. The National Office has a critical incident form to be used for communication purposes. *Please Note*: Sites that are part of an HFA Multi-Site System will communicate critical incidents to their Central Administration who will then report them to the National Office. Sites outside of a Multi-Site System will report directly to the National Office.

GA-7.E RATING INDICATORS

3 No 3 rating for GA-7.E.

2 Prompt communication to the National Office has occurred in the event of any critical incidents (as defined in the standard).

1 Communication to the National Office did not occur associated with a critical incident (as defined in the standard).

NA No critical incidents have occurred at the site in the last 24 months.

Tables of Documentation

GA. The site is governed and administered in accordance with principles of effective management and of ethical practice

Please Note: GA is not a Critical Element

Standard	Pre-Site Documentation to include in Self Study
GA-1.A | Organization and Function of Community Advisory Board	Submit a narrative, policy or bylaw describing the community advisory board's role in advising with regards to planning, implementation, and evaluation of site activities.
GA-1.B | Advisory with Wide Range of Skills & Knowledge	Submit a community advisory board roster which includes organization affiliation(s) and a summary of skills, knowledge and abilities to effectively serve the interest of the community.
GA-1.C | Program Manager & Community Advisory Board Work Effectively	Submit a narrative describing how the program manager (or other representative from the local site) partners with the community advisory board by providing members site information for each meeting and engages them in advising site operations.
GA-2.A | Quality Assurance Plan	Submit the site's Quality Assurance Plan. Please Note: Sample Quality Assurance Plan Template Available.
GA-2.B | Quality Improvement Plan	Submit the site's Quality Improvement Plan. Please Note: Sample Quality Improvement Plan Template Available.
GA-3.A | Policy - Family Rights & Confidentiality	Submit Policy and samples of relevant form(s) related to confidentiality, informing families of their rights and informing families of how to file complaints. Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
GA-3.B | Family Rights & Confidentiality **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
GA-3.C | Informed Consent **Safety Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
GA-3.D | Complaints Procedure Followed	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
GA-3.E | Participant Privacy & Voluntary Choice in Research	Indicate whether or not site is currently or previously involved in a research project in the past five years. Peers will review documentation and interview staff, advisory members and families onsite.
GA-4.A | Policy - Criteria to Identify Child Abuse & Neglect **Safety Standard**	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
GA-4.B | Child Abuse Reporting **Safety Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
GA-4.C | Suspected Child Abuse & Neglect Immediate Notification to Supervisors and Program Managers	Submit report of currently enrolled families where child abuse and neglect was suspected and reported to the proper authorities, documenting how safety concerns are addressed and appropriate follow-through occurs. Peers will review documentation and interview staff, advisory board members, and families on-site.

Tables of Documentation

Standard	Pre-Site Documentation to include in Self Study
GA-5.A | Policy - Participant Death & Grief Counseling	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
GA-5.B | Participant Death & Grief Counseling	Submit narrative indicating any incidents of participant death that have occurred within the past year.
GA-6. | Policy & Procedure Manual	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
GA-7. | National Office Requirements	No documentation required pre-site.

EXHIBIT G
HFO PROGRAM, POLICY, AND PROCEDURE MANUAL

(The remainder of this page has been left intentionally blank. The HFO Program, Policy, and Procedure Manual is included as an attachment.)

OREGON DEPARTMENT OF EDUCATION
EARLY LEARNING DIVISION

Healthy Families Oregon

Insert local site name here

PROGRAM POLICIES & PROCEDURES MANUAL

8th Edition – Version 1.1 2023

VERSION LOG

Version	Description	Author	Date
1.1	Revised language in Standard 10-4 for training registration process change.	Heidi Grogger	9/13/23

TABLE OF CONTENTS

Local Advisory Signature (optional):

The local Advisory Group for **insert site name** has reviewed and approves the local policies and procedures in this Manual:

_____ _____

Advisory Chair Signature Date

HEALTHY FAMILIES AMERICA

Mission	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
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

INTRODUCTION

This manual describes the statewide program policies and procedures for Healthy Families Oregon (HFO) that all local sites must follow and aligns with the standards and numbering system in the Healthy Families America (HFA) Best Practice Standards.

Local sites insert specific policies and procedures within the document, describing local practices in detail so staff clearly understand the expectations around their work. Local policies must not conflict with or substitute for state policies and are inserted into the PPPM directly below the instructions written in blue.

HFO MISSION STATEMENT

Healthy Families Oregon, following the Healthy Families America model and the HFA Best Practice Standards, promotes and supports nurturing parent-child relationships and healthy growth and development for all Oregon families expecting or parenting newborns that need and accept extra support.

May add local Mission Statement here:

PROGRAM GOALS

Healthy Families Oregon promotes positive parent-child relationships, supports healthy childhood growth and development and enhances family functioning by:

- Building trusting, nurturing relationships with parents
- Teaching parents to identify strengths and utilize problem-solving skills
- Improving the family's support system through linkages and appropriate referrals to community services

HOME VISITATION PROGRAM DESCRIPTION

Healthy Families Oregon, formerly known as Healthy Start, was created by the Oregon Legislature in 1993. It is a statewide program in Oregon's system of supports and services for families with young children. Healthy Families promotes wellness for Oregon families who need extra support during a pregnancy and at the time of birth by offering accessible and non-stigmatizing services tailored to the family's unique situation.

Healthy Families Oregon offers consenting families access to screening for and personalized referrals to community services. Families may receive a Welcome Baby gift packet filled with information about parenting and child development. Families determined to be at higher risk for adverse childhood outcomes (through the use of a standardized research-based screening tool) are offered ongoing home visiting services.

Home visiting services may continue for as long as the family wants to remain engaged, for at least three and up to five years in some situations, depending on local site policy. Visits assist families in achieving goals around parenting and improved family functioning by building on family strengths.

Today Healthy Families Oregon is a vital link in a network of integrated early childhood services.

May add local site description here

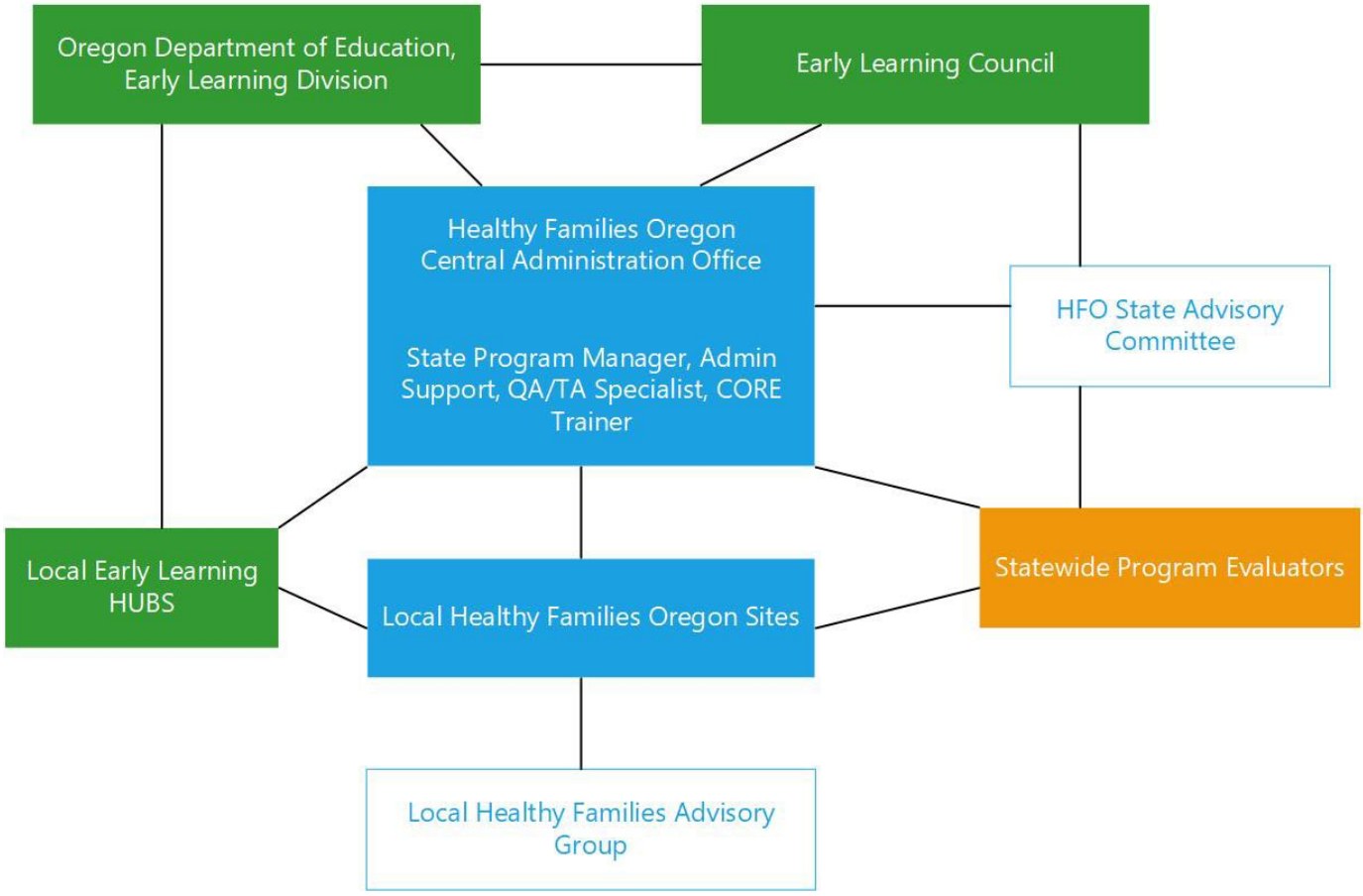
GOVERNING LEGISLATION

The Oregon Revised Statues (ORS 417.795) pertaining to Healthy Families Oregon (HFO) can be found in Appendix A.

The Oregon Administrative Rules (Division 414-525-0015) pertaining to HFO can be found in Appendix B.

HFO STATE SYSTEM

State System Organization



HFA SAFETY AND ESSENTIAL STANDARDS

HFA has identified the following areas critical to accreditation, and has designated them as Safety and Sentinel Standards. These standards are described below and marked in this manual with an identifying symbol. Note: Safety and Essential Standards will be indicated in BOLD font at the bottom of the rating indicator box.

SAFETY STANDARDS:

These are standards that **must be met** in order to be accredited as they impact the safety of the children and families being served and the staff serving them. Safety standards include personnel background checks (9-3.B), orienting staff on child abuse and neglect indicators, role as a mandated reporter, and reporting requirements (10-2.D), supervision of direct service staff (12-1.B), site practices related to informed consent when sharing family information (GA-3.C) and child abuse and neglect policy and procedures that include reporting criteria, definitions and practice (GA-4.A, GA-4.B). Each of these standards is identified as a safety standard in its respective rating indicator box.

Safety Standard

9-3.B	**Personnel background checks**
10-2.D	**Staff orientation training on child abuse/neglect indicators and reporting requirements**
12-1.B	**Supervision of direct service staff**
GA-3.C	**Site practices related to informed consent when sharing family information**
GA 4.A, GA 4.B	**Policies and procedures around child abuse/neglect reporting criteria, definitions, and practice**

ESSENTIAL STANDARDS:

Essential Standards are standards determined to be especially significant to the HFA model, as they embody the essence of what it means to implement HFA. The existence of Essential Standards within the BPS is not to suggest that the other standards are non-essential, but to bring additional emphasis to this set of standards as a representation of what it means to embrace the HFA Advantage. HFA's Essential Standards set HFA sites and systems apart from other family support or case management approaches and they stand out as essential in helping direct service staff meet the goals of Healthy Families America.

While adherence to each of these standards is not required in order to receive HFA accreditation, a site with any of these standards rated out of adherence will be required to prepare and submit an improvement plan that clearly indicates the site's efforts to bring the standard into compliance, coupled with documentation of implementation.

There are 15 essential standards. Each standard is noted in the body of the PPPM as below.

Essential Standard

2-1.B	**The administration of the FROG scale to learn about family strengths and challenges.**
3-3.B	**The use of Creative Outreach as a trauma-informed strategy to build trust and re-engage families who have missed visits.**

4-2.C	**The use of HFA Level Change Forms to review family progress and decrease the frequency of home visits.**
5-4.B	**The development of an Equity plan to support the site in achieving greater equity in all facets of its work.**
6-1.C	**The implementation of the Service Plan, the intentional work of the FSS to respond to concerns that families have shared.**
6-2.B	**The supports that FSSs provide around setting and achieving goals with families.**
6-3.B, C, E	**The use of CHEERS to observe, partner with and support families in developing nurturing parent child relationships, and the supervisor support to staff around this important aspect of their work.**
9-1.D	**The processes for hiring HFA direct service staff.**
10-4.A, B, C	**The Core trainings required of staff within certain timeframes**
12-2.B	**Sites ensure all direct service and volunteers and interns (performing the same function) are provided with supervision including administrative, clinical, and reflective components to continuously improve the quality of their performance**
GA-3.A	**Policies and forms related to family rights and confidentiality.**
GA-3.B	**The practice of informing families of their rights and about the processes around confidentiality at the start of HFA services.**

GLOSSARY

A

ASSESS, ADDRESS, PROMOTE: The complete process of identifying and utilizing CHEERS to support nurturing Parent-Child Interactions during visits with families. **Assess** refers to the factual parent-child interactions that are seen or heard during visits and documented on the visit record by the Family Support Specialist (FSS). Once the FSS has an opportunity to assess the parent-child interactions for CHEERS, this information is used to identify what to address and what to promote during the current visit or during future visits. **Address** refers to any CHEERS domains identified as opportunities for improvement or concerns that are addressed with the parent by the FSS through the use of HFA Reflective Strategies, visit activities, and/or parenting materials. **Promote** refers to any CHEERS domains identified as strengths, skills, or emerging strengths and skills that are promoted with the parent by the FSS using Accentuate the Positive, Strategic Accentuate the Positive, other affirmations, and celebratory visit activities.

ACCEPTANCE OF SERVICES: Participants, who voluntarily agree to participate in home visiting services after initial identification through eligibility screening that have accepted intensive services and have received a first home visit.

ADMINISTRATION: The personnel/staff with responsibility for leadership and oversight of the site including service delivery, accountability, data management, and managing the site's resources (fiscal and personnel).

ADVISORY GROUP: An organized voluntary group that advises HFO site operations. The functions and responsibilities of this group may include making recommendations to the HFO site and the organization's governing group (if different from the advisory group) regarding site policy, operations, finances, community needs, etc. Typically, advisory group members are a diverse group of individuals who represent the interests of the community as guided by the HFA Standards.

ANALYSIS: A detailed study and reporting of site trends and patterns. Typically, this would include demographic, social, systemic, and other factors that impact services to families.

ANNUAL STATUS REPORT: A comprehensive document prepared by the HFO evaluation team that describes and summarizes site activities and services and is available to the community. This document includes an overview of services provided in the past year, demographic profiles of site participants, and a summary of outcomes achieved during the year. These reports are provided if funds are available a mid-year report is also provided.

B

BYLAWS: Guidelines adopted by the site (or its host agency, collaborative, community partners, advisory/governing group, etc.) for the regulation of its operations.

C

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

CENTRAL ADMINISTRATION: The Early Learning Division staff and contractors that assure local sites are implementing the HFA model with fidelity. This monitoring is done through training, quality assurance, policy,

CENTRALIZED or COORDINATED INTAKE SYSTEMS: Sites can choose to use a centralized intake system for referrals into their program. This system needs to have a solid understanding of the site's eligibility criteria and service delivery priorities so the site receives referrals from the intake system that reflect the families the site intends to serve.

CHALLENGING ISSUES: Standard 6-1 uses terminology of challenging issues, which in this case refers to parent behaviors or life circumstances which can place children at especially high risk. These include parental substance use, mental illness,

cognitive disability, and intimate partner violence. Support from a supervisor, use of reflective consultation groups (where available), and additional training are critical, as are procedures for worker safety and addressing family safety concerns. The procedures outlined in this HFA Procedures for Working with Families in Acute Crisis can be a useful resource. The focus of this manual is to provide general guidelines to enhance understanding and awareness of supporting families who may be experiencing challenging issues and identifying safety practices for direct service staff.

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

Safety guidelines often need to be adapted or expanded to address the specific concerns of each location or situation. Supervision sessions provide an appropriate venue for discussion of specific safety concerns and fine-tuning of safety procedures. The supervisor should be available and immediately informed if the direct service staff fears for their safety. The safety of staff is of utmost importance.

CHARACTERISTICS: Distinguishing features, attributes, and/or qualities.

CHEERS: An acronym to support Home Visitors in understanding and observing the different dimensions of parent-child interaction. The elements of the acronym include Cues, Holding, Expression, Empathy, Rhythmicity/Reciprocity, and Smiles. These observations are expected to be made during each home visit as specified in the standard and intent. Training on CHEERS is also a significant part of HFA Core training.

CHEERS CHECK-IN TOOL: The CHEERS Check-In Tool is a validated measurement tool developed by HFA and used to assess parent-child interaction at least twice annually and up to quarterly. Web-based training (required) and support on the use of this tool is provided by HFA.

COMMENSURATE HFA EXPERIENCE: During the new hire recruitment process, applicants for HFA site level positions are screened based on a variety of factors. Individuals who themselves participated in HFA services and/or worked in other HFA roles (e.g. an FSS, FRS or team lead now applying for a supervisor position) bring highly valuable attributes given their HFA experience. When considering whether the level of HFA experience is commensurate with an educational degree, this will be decided on a case-by-case basis by the hiring team, factoring the length of their previous experience (though there is not an automatic 1:1 ratio where for example a 4-year degree is met by having 4 years HFA experience), and more importantly how the individual themselves describes the impact of HFA involvement on their readiness to take on a new role.

CONTEXTUAL DECISION-MAKING: On a site visit, the peer reviewers may see mixed information pertaining to a standard (e.g., an FSS has a first home visit with a prenatal family, and the Focus Child is born before the second visit. Because of this, the family is no longer prenatal, and the FSS was unable to complete a prenatal depression screen). In situations like this, where there may be extenuating circumstances, peer reviewers are trained to use contextual decision making to rate a standard, which means they must ensure the site is operating from best practice. For example, if in the example above, the missed prenatal depression screen was because the baby was born shortly after the first home visit, the site could be rated in adherence even though not all prenatal families received a prenatal depression screen. Or, in another example, if the site had a new staff signed up for Core training, however she missed it because she was out unexpectedly for 3 months on FMLA, but as soon as she returned from FMLA she went to Core, the site was operating from best practice so therefore this would be taken into account to rate the standard in adherence vs out of adherence. This means sites should document the reasons for variances when they arise, which allows peers to have the information they need to use contextual decision making.

CONTINUOUS QUALITY IMPROVEMENT (CQI) SITE VISIT: Annual site visit to each HFO region completed by HFO Central Administration staff to review and support the quality of the site's work, ensure adherence to the HFA Best Practice Standards, and fidelity to the HFA model.

CRITERIA: Standards and/or expectations on which judgments or decisions are based (i.e., criteria for moving participants from one level to the next).

CONTRACT: A formal written legal agreement between two or more parties that specifies the services, people, space, or products to be provided in exchange for some form of compensation.

CULTURE: Behaviors, habits/patterns, values and beliefs, language, customs/traditions, religious beliefs, arts, institutions, and all other products of human work and thought considered to be the expression of a particular population or group of people.

CULTURAL CHARACTERISTICS: Distinguishing features and attributes such as the ethnic heritage, race, customs, values, language, gender, religion, sexual orientation, income, and geographic origin among others that combine to create a unique cultural identity for families based on both experience and history.

CULTURAL HUMILITY: Originating in the health care field, the concept of "cultural humility" was developed as an alternative to the idea that we can become "competent" in the cultures of others. Cultural humility is a lifelong commitment to self-awareness, to addressing power imbalances and to developing partnerships with people and groups who advocate for others (Tervalon & Murray-Garcia, 1998). In HFA we embrace cultural humility in our approach to working with families from a place of self-awareness, understanding that each family has a unique culture and that our own culture and values can impact our interactions with families. It is our responsibility to continuously evaluate our interactions, interpretations and assumptions and to be committed to lifelong learning about ourselves and others. We reflect on our interactions with others and seek to understand how real or perceived power imbalances can influence our effectiveness. We align ourselves with other people or groups that advocate for others as we build authentic relationships with the families we serve. A culturally humble approach to our work ensures that we are successful in creating healthy relationships across the parallel process in alignment with the HFA Advantage.

CULTURALLY REPSONSIVE: Recognizing the diverse cultural characteristics of parents as assets. Culturally responsive teaching/coaching empowers parents intellectually, socially, emotionally and politically by using cultural referents to impart knowledge, skills and attitudes.

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

D

DATA MANAGEMENT SYSTEM: A systematic and standardized way of collecting and organizing information that allows for accurate monitoring of site activities and timely reporting of site statistics.

DIRECT SERVICE STAFF: Staff at an HFA site who carry a caseload of enrolled families to whom they provide HFA home visits and staff who administer the FROG scale with families.

DECLINES SERVICES: A family that is determined to be eligible and is offered services but declines (either verbally or in writing). Or a family who has been enrolled, and for whatever reason declines further participation.

E

ELIGIBILITY FOR SERVICES: The process utilized to determine potential families who may be most in need of or could benefit from intensive home visiting services. Sites will determine the best way to identify eligible families, based on HFO guidance, community need, and their own description of the families they intend to serve. HFA recognizes that in most situations, a well-developed screen will meet site needs for eligibility determination. Some sites may choose to use the FROG Scale to

determine eligibility for service. HFO uses New Baby Questionnaire (NBQ) to determine eligibility for intensive home visiting services.

ELIGIBILITY SCREENING: A process of identification of eligibility of potential site participants based on a standardized risk assessment. HFO uses the New Baby Questionnaire (NBQ) to identify risks associated with poor child and family outcomes to qualify families to receive intensive home visiting services.

EQUITY PLAN: An Equity Plan results from the site's intentional, honest, critical and reflective look inward (site self-assessment) that also integrates feedback received from families and staff. This level of exploration allows sites to assess their capacity to 1) provide families with equitable access to culturally respectful and responsive services, 2) create a diverse, inclusive and supportive work culture for staff, and 3) operate within the context of the community and in partnership with parents and other providers to strengthen services. Based on what the site learns, activities are applied to promote equity and advance the current level of cultural humility at the family, staff and/or community level. The Equity Plan also includes recommendations/suggestions from its community advisory board.

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

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

EQUAL OPPORTUNITY POLICY: An employer's written statement that describes how it ensures that all current and prospective employees are afforded equal employment opportunities and how it overcomes any effects of past discrimination.

EVIDENCE-INFORMED PARENTING MATERIALS: The information that sites staff share with families must be evidence-informed, meaning that the information is based on scientific knowledge or research. Strategies employed may also be grounded in scientific research (e.g., strive to strengthen the parent-child relationship, which research has shown to be a key factor in healthy development). The reason there is a focus on the use of evidence-informed materials is to ensure that families are receiving well-founded, factual, relevant, and credible information versus materials that are opinion-based or outdated and no longer accurate. Sites may choose to use a formal parenting materials that is designed for home visiting or parent support, or sites may identify other evidence-based sources of parenting materials.

F

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

FAMILY FILE: A confidential, written compilation of information that describes and documents services given to participating families.

FAMILY GOAL PROCESS: The Family Goal process sets the framework for Home Visitors to:

- Offer the concept that change can happen and the family can have an impact creating their future
- Help the family identify what they want to accomplish and the mechanism(s) by which the Home Visitor can assist
- Develop opportunities for the family to experience success
- Assist the family to identify and acknowledge their strengths
- Work together with the family to develop goals and break those goals into meaningful steps to ensure success for each family. This includes a clear conversation and partnering between the Home Visitor and parent that supports growth in families
- Celebrate success with the family

FIRST HOME VISIT: The first visit completed by the assigned Home Visitor after eligibility has been determined, where rights and confidentiality forms are signed (unless already signed), where CHEERS is typically observed, and at least one focus area (see glossary for home visit definition) occurs. The visit is documented on a Home Visit Record. .

FOCUS CHILD: Eligibility is determined early for HFA families, ideally during the prenatal period. Healthy Families services are centered on the focus child (or children in the case of multiples), who is the prenatal child at enrollment, or child most recently born to a newly enrolled family.

FROG SCALE: The FROG (Family Resilience and Opportunities for Growth) Scale is the psychosocial assessment tool used by HFA sites at the onset of services to gather information about each family's unique strengths (protective factors) and challenges (risks for child maltreatment). HFA sites use the FROG Scale as the foundation for the family's Service Plan which guides ongoing services. Some sites use the FROG Scale to determine eligibility for HFA. The FROG Scale is administered with families in conversational style, respectful of what families feel comfortable sharing. While staff will continue to learn about families throughout the course of services, early completion of the FROG Scale supports relationship building by:

- immediately offering services that are responsive to the concerns and interests of each family
- building on family strengths to address concerns or challenges
- sending a clear message that this is a safe place to share difficult experiences

Each of the protective factors and potential risks identified below are measured on a continuum from strength to risk, with low scores in each area reflecting significant strengths and high scores reflecting significant risk.

- parent's childhood experiences
- experiences with substances or other potentially addictive behaviors
- mental illness
- experience with child welfare
- coping skills and supports
- stressors (housing, finances, childcare, employment, etc.)
- relationship with partner (including level of support and history or current intimate partner violence)
- knowledge of child development
- plans for discipline methods
- perception of baby/child
- physical and emotional availability of parent

FOUNDATIONS OF FAMILY SUPPORT CORE TRAINING (FFS): 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.

FULL TIME EQUIVALENCY (FTE): The calculation of full-time equivalent (FTE) is an employee's scheduled hours divided by the employer's hours for a full-time workweek. When an employer has a 40-hour workweek, employees who are scheduled to work 40 hours per week are 1.0 FTEs. Employees scheduled to work 20 hours per week are 0.5 FTEs. Family Support Specialists caseload maximums are determined by their FTE This caseload expectation needs to be adjusted if the Family Support Specialist is less than 1 FTE. For example, sites will prorate a .5 FTE (1/2-time employee) so that their caseload does not exceed 15 points and that staff have an adequate amount of time to work with each family.

G

GOVERNING GROUP: An organized, voluntary group with the legal authority and responsibility to set policy and oversee the operation of an agency. Generally, the governing group is a group such as the Board of Directors.

H

HANDS-ON PRACTICE: Actual utilization of a tool during training or orientation to a new role, which may include role play, videotaping portions of home visits or FROG Scales, practicing documenting CHEERS or the Home Visit Record, or scoring a videotaped or shadowed FROG Scale.

HEALTHY FAMILIES AMERICA (HFA): The site model on which HFO is based and which provides accreditation for sites and Multi-Site systems that adhere to its research-based Standards.

HFA FROG SCALE TRAINING: FROG Scale training is an in-depth, formalized training for all direct service staff who will use the FROG Scale with families and their supervisors. The training includes but is not limited to: understanding the importance of telling one's story; using the framework of the FROG Scale to identify families' strengths and concerns; engaging families through conversation; documenting in narrative form; and using the FROG Scale scoring guide. The training is facilitated by a trainer who has completed an extensive training program and is certified by the HFA National Office.

HFA FOUNDATIONS for FAMILY SUPPORT CORE TRAINING: Foundations for Family Support (FFS) is an in-depth, formalized training required for all direct service staff, supervisors, and program managers. The training outlines the duties of the direct service staff in their role within HFA. Topics include but are not limited to: trauma-informed practice; communication skills; assessing, addressing, and promoting nurturing and sensitive parent-child relationships; creating a trusting partnership with families; goal setting; and strategies to enhance family functioning, address challenging situations, ensure healthy childhood development, and support healthy relationships. The training is facilitated by a trainer who has completed an extensive training program and is certified by the HFA National Office.

HFA CORE SUPERVISOR TRAINING: In-depth, formalized training that outlines the specific duties of the supervisor's role within Healthy Families and covers topics including, but not limited to: the role of direct service staff, the importance of reflective supervision, supervision session structure and content for all staff, reflective strategies for supervisors, sample tools and forms to use for continuous quality improvement, etc. The trainer is certified by the HFA National Office and has been trained to train others.

HFA IMPLEMENTATION TRAINING: In-depth, formalized training designed to prepare Program Managers and other Healthy Families America leaders for their important work. Implementation Training is an opportunity to become intensely immersed in HFA, the expectations of the model, and the responsibilities of HFA leaders, all while developing relationships with National Office staff and a network of support from other HFA colleagues throughout the country. Learners receive resources aimed at making implementation of the HFA model easier, gain familiarity with the HFA Best Practice Standards and have opportunities to consider the implementation of these standards within local sites or systems.

HFO FORMS: All HFO forms are located on the HFO SharePoint:

- **Standardized & Required forms (SR)**: Sites must use these specific forms. Cosmetic changes (such as adding the name of local site) are allowed, but the content of the existing form may not be modified.
- **Required forms (R)**: Sites are required to have forms that meet this purpose.
- **Optional forms (O)**: HFO has found these forms helpful in meeting best practice standards but they are not required. These forms may be modified as needed at the local level.

HFO NEW PROGRAM MANAGER ONLINE CORE TRAINING: In-depth training which outlines the duties and responsibilities of the Program Manager and Assistant Program Manager positions in HFO. This training is required to be completed within 3 months of hire.

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

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 nurturing parent-child interaction, healthy childhood growth and development, and enhance family functioning. Typically, home visits occur in the home, last a minimum of an hour and the child is present. 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 family's Home Visitor be present during the group meeting and that the group meeting be documented on a Home Visit Record, including some aspects of CHEERS for that particular family. The focus during home visits may include, but are not limited to:

Promotion of nurturing parent-child interaction/attachment:

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

Promotion of healthy childhood growth & development:

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

Enhancement of family functioning:

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

HOME VISITOR/HFA Family Support Specialist: HFO staff providing direct home visiting services to families. Internally, HFO will continue to use the term "Home Visitor." Locally, each site can choose the title *Home Visitor* or *Family Support Specialist* to use with the families they serve. Within HFO, these two terms are interchangeable.

I

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 relationship; 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).

IMMUNIZATION RATE: The percentage of focus children who are up-to-date with immunizations at a certain point in time (i.e., when the focus child is nine months old, 12 months old, two years old, etc.). The percentage does not include children whose family beliefs preclude immunizations. In order to not count these families, the site requests a written statement from the parents to be kept on file.

INDIVIDUAL TRAINING PLAN: All staff bring professional experience and education to the job. Each staff member brings strengths to build on, has areas to strengthen, 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. HFA recommends at least 15 hours of annual professional development, including annual ongoing training requirements.

L

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

LIVED EXPERTISE: HFA staff are often more effective in supporting families and achieving program outcomes if they have experience within the community, apart from the formal educational attainment that is commonly included in hiring standards. Staff with knowledge of the of the culture of the people that the site intends to serve, and self-awareness around their own place within the community will be more successful in building trusting working relationships with the families that come into contact with the HFA site. Focusing on lived expertise also increases opportunities for diverse representation, equitable access to positions, and elevation of family voice within the services the program provides.

M

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

MEMORANDUM OF UNDERSTANDING (MOU): A written agreement between two organizations or entities that outlines the scope, nature, and extent of services provided by each. HFO sites may have MOUs with hospitals or other community partners that provide access to families within the focus population. Other MOUs may be helpful as well to formalize relationships between the site and other entities.

MONITOR: To keep track of through the ongoing collection of available information. The extent of the information collected for tracking and monitoring purposes will vary and is a less rigorous process than compiling data for an analysis. Monitoring is not limited to review of data and reporting. Sites may find that they are able to learn more about the processes and outcomes that they are monitoring through the review of notes in family files, individual screening tool results or survey responses. For example, in monitoring well-child visit completion, sites may find that they are able to identify trends by reviewing a report of all families and the dates of their well child visits, but that they may learn more about site performance in this area through conversations in team meetings. For monitoring the systems related to referral relationships, sites may combine data related to the number and success of referrals

MOTIVATIONAL INTERVIEWING (M.I.): A collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a change goal by eliciting and exploring an individual's own arguments for change (William Miller, Steve Rollnick, 2012). When staff have been trained in motivational interviewing techniques, it is important for Supervisors to also be knowledgeable in order to support staff in their practice.

Example M.I. questions:

- What would you like to see different about your current situation?
- What has you thinking you need to change?
- What will happen if you don't change?
- If you make changes, how would your life be different from what it is today?
- How would you like things to turn out for you in 2 years?

MULTI-SITE SYSTEM: Oregon is a state system with multiple sites providing home visiting services (i.e., assessment, home visitation, supervision, and management). All sites follow the HFO Program Policies and Procedures Manual and the HFA Best Practice Standards. Multi-site systems receive support and guidance from their Central Administration office in the following: policy, administration, quality assurance, training, technical assistance, and evaluation services.

N

NEW BABY QUESTIONNAIRE (NBQ): A research-based eligibility screening tool adapted from the Hawaii Risk Indicators Inventory for use by Healthy Families Oregon. It is designed to be an easily administered screening tool to measure families' level of risk for negative family and child outcomes.

O

ONGOING TRAINING: Regularly scheduled training provided to staff based upon the specific needs, job responsibilities and issues of families within the community served. Ongoing training requirements include providing all HFO staff that have been employed for more than a year, annual Child Abuse and Neglect Reporting training, Medicaid Refresher training, and Cultural Sensitivity training that is related to the focus population that you serve. This also includes training focused on the staff's professional development, with an annual recommendation of 15 hours.

P

PARALLEL PROCESS: A key component of reflective practice, the parallel process encompasses all the relationships within the delivery of the HFA Services and focuses each person's ability to develop and promote a nurturing relationship. This includes an awareness of how focusing on the ways in which we are present and emotionally available for another creates a nurturing environment within all other relationships within the parallel process: Parent and Baby, Direct Service Staff and Parent, Supervisor and Direct Service Staff, and Program Manager and Supervisor. This is summed up in the Platinum Rule: "Do unto others as you would have others do unto others." Jeree Pawl.

PARTNERING WITH PARENTS AROUND CHEERS: HFA Family Support Specialists support families and promote nurturing parent-child relationships using CHEERS observations. In addition to the documentation of CHEERS to assess, address and promote attachment, FSSs support the parent-child relationship by discussing the domains of CHEERS with families through the use of reflective strategies, visit activities, and parenting materials. The more that parents become familiar with and reflect on concepts related to secure attachment, the more that they are able to make parenting choices that align with their family culture and build healthy relationships with their children. CHEERS is not something that is "done to" families, but an opportunity to come alongside families and create a shared language to talk about attachment and parent-child interaction.

PARTICIPANTS: Individuals/family members who are enrolled in HFO services.

PERFORMANCE INDICATOR: A measure of site success in reaching a desired result. Performance indicators are identified for both service delivery and family outcomes and monitored through the evaluation and delivered to HFO through the NPC Status Report.

PERSONNEL/STAFF: The body of employees, consultants, and/or volunteers that carry out the tasks of the site performing under the site's administration and/or supervision.

POLICIES: Written statements of principles and positions that guide site operation and services, which are reviewed and approved by the HFO State Advisory Committee, in the case of state policies, and the local Advisory Group and other appropriate administrative group, for local policies.

PLANNING, IMPLEMENTATION, AND CONTINUOUS QUALITY IMPROVEMENT (ADVISORY GROUP ROLE): Planning refers to the planning of events, additional referral sources, and integration of services between agencies serving families, etc. Implementation applies to supporting any implementation challenges the site faces, such as striving for early enrollment, engaging fathers, etc. Continuous quality improvement relates to feedback from the group related to the analyses and strategies aimed at strengthening site services.

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

PROCEDURES: The step-by-step methods by which broad policies are implemented and site operations are carried out are written in a manual.

PROGRAM GOAL PLAN: Annual plan created by each HFO region detailing goals and strategies in the areas of eligibility screening and initial engagement, assessment, delivering home visiting services, supervision and management in response to the areas of improvement noted on the site's annual Site Visit Report.

PROGRAM POLICIES AND PROCEDURES MANUAL (PPPM): This manual specifies policies and procedures for Healthy Families Oregon to assure that sites meet HFA accreditation standards as specified in the Best Practice Standards. All local sites follow the HFO Program Policies and Procedures Manual, and their local policies and procedures as written.

PROTECTIVE FACTORS: Conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk in families and communities: Parental resilience, social connections, concrete supports in times of need, knowledge of parenting and child development, nurturing and attachment (children's social and emotional competence).

Q

QUALITY ASSURANCE: A systematic and objective approach to monitoring and evaluating the appropriateness and quality of site implementation in order to identify and resolve any challenges and to improve performance.

R

REFLECTIVE SUPERVISION: The focus is primarily on the parallel process involving the relationships between the staff member and the parent, the parent and the baby, and the Supervisor and the staff member. It includes how the interactions within each of these relationships may be impacting the work and explores the reasons behind the strong feelings that relationships elicit. Reflection also requires attending to the emotional content and how these reactions may affect the process. Examples of reflective supervision are:

- Asking questions to encourage details about the emerging relationships between the infant, parent and staff member
- Listening and holding the space for/allowing inward reflection
- Remaining emotionally present
- Observing for emotional reactions, energy shifts
- Encouraging the staff member to explore thoughts and feelings the he/she has about the work
- Maintaining a balance of attention on the infant, parent, and staff member
- Maintain a neutral stance.

REFLECTIVE CAPACITY: The capacity to exercise introspection and the willingness to learn more about the fundamental nature, purpose, and essence of how humans experience this world and how our own world-view is impacted by that experience. HFA staff with reflective capacity are able to consider multiple points of view, have awareness of their own biases and feelings, can tolerate ambiguity and are able to recognize their own dysregulation. It is important 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 CONSULTATION GROUPS: Sessions generally last 1.5-2 hours and are conducted by an individual with advanced training or credential in the area of reflective practice and professional group facilitation. Reflective consultation groups include but are not limited to:

- case presentation
- focus on holding the space that encourages self-reflection and self-regulation, both physically and emotionally
- observation of the staff member's internal responses to the work, including parallels between what might be going on for the worker as well as how that might impact the work
- focus on the parallel process, expanding what might be going on for the staff to what might the family and the baby might be experiencing
- considering what the supervisor might do differently for the next supervision, developing a plan with direct service staff for work going forward
- opportunities for participants in the group to reflect on the group session they just observed

REFLECTIVE STRATEGIES: The HFA Reflective Strategies are specifically designed intervention tools that create an environment of empowerment and self-efficacy sustained within healthy helping relationships. The reflective strategies are in alignment with the trauma-informed approach and utilized by all HFA staff regardless of role. Each strategy has a unique purpose as follows:

- Mindful Self-Regulation encourages self-awareness and promotes self-regulatory, self-care practices.
- Accentuate the Positive builds self-esteem and confidence by promoting specific skills and strengths along with the impacts and benefits of the identified skills and strengths.
- Strategic Accentuate the Positive increases the frequency of healthy, safe, and nurturing behaviors that also builds self-esteem and confidence.
- Feel, Name, & Tame supports a persons' capacity to recognize and regulate their feelings.
- Explore & Wonder builds awareness, empathy, and sensitive responses to missed cues and the feelings of others.
- Problem Talk encourages creative thinking and problem solving by clarifying and learning more about a concern, problem, or situation.
- Normalizing addresses concerns related to dangerous or harmful beliefs, behaviors, and practices while offering alternative healthy and safe options for consideration and further exploration.
- The HFA Foundations for Family Support Core and Supervisor Core training include detailed descriptions, discussions, examples, handouts, and practice opportunities on all the HFA Reflective Strategies.

RELEASE OF INFORMATION: Consent must be given by the participating family and the HFO Release of Information form must be signed before any information is released about the family to another agency or person. The signed form is kept in the family file. Exceptions are made in the case of mandatory reporting of abuse and neglect.

RESEARCH: A systematic examination of information to answer a question and advance knowledge and any activity, including program evaluation and/or quality improvement activities, (i) that would, according to Federal regulations, require review by an Institutional Review Board, or (ii) that could be expected to yield generalizable knowledge that could be shared publicly with the professional, academic and/or lay communities. 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 or quality improvement is not considered Research.

S

SAFER SLEEP: HFA sites share information with families about infant sleep to reduce the risk of sleep related infant death. Sites provide information about evidence-based safe sleep practices and engage in conversations with families related to things that parents and caregivers can do to keep babies safe. For families whose choices around infant sleep may include co-sleeping or other culturally specific sleep practices, HFA staff may choose to take a harm reduction approach and share information with families about how to increase the safety of these practices.

SAFETY STANDARD: HFA standards that directly impact the safety of the families being served. These standards must be met in order to be accredited.

SELF-STUDY TRAINING: This type of training includes reading articles, books, manuals, watching DVDs, listening to tapes, etc., followed by individual activities (i.e., writing, discussing, and giving presentations), completion of the *Documentation of Learning* form, and Supervisory follow-up to assure that knowledge on the topic was gained.

SENTINEL STANDARD: Determined to be especially significant in the review of the HFO site quality. While adherence to each of these standards is not required in order to receive the HFA credential, a site with any of these standards rated out of adherence will be required to prepare and submit an improvement plan that clearly indicates how the site intends to bring the standard into compliance, coupled with documentation of implementation.

SERVICE PLAN: HFA requires sites to develop a Service Plan for each family. The Service Plan is a Supervisor's tool that brings collaboration and intentionality to the forefront of our work. A well-constructed Service Plan is the cornerstone of services that are effectively organized, coordinated, and based on each family's unique strengths and areas of concerns. A Service Plan operationalizes the family story into a road map that supports Family Support Specialists in their ongoing and long-term work with the family and is the mechanism by which Supervisors document their clinical support to staff that is specific to each family. Sites may adapt or develop their own Service Plan document if it meets the expectation of the 6-1 standard. The HFA National Office is happy to review and advise on any modified forms. Download HFA Service Plan Materials.

SITE: A host agency that administers HFO services to their region.

STAFF DEVELOPMENT PLAN: This plan is developed and implemented to support any experiential gaps at the time of hire, however it cannot compensate for education requirements of the position. The minimum education requirement must be met. Experiential criteria include all items bulleted in 9-1.B-D that are not educational requirements.

STANDARDIZED INTERVIEW QUESTIONS: Interview questions focused on the skills and abilities for each position the HFO program is seeking (Home Visitor, Supervisor, Assistant Program Manager, Program Manager, and Eligibility Screener). Each interviewee is asked the exact same questions, in the exact same order. These questions live at the local sites.

SUBCONTRACTOR: A legally binding relationship between two entities (individuals or organizations) for the purpose of procuring services or products consistent with an existing contract held by one of the parties for those services or products.

SUPERVISOR: Supervisors provide weekly individualized supervision to the Home Visitors within a Healthy Families site that incorporates administrative, clinical and reflective practices. The Supervisor assures quality of service provision, protects the integrity of the program, and demonstrates respect for the parallel process.

SUPERVISION: The process for providing oversight, guidance, and support to others in such a way to ensure accountability and professional development.

T

TRAINING:

The following are descriptions of the specific areas of training required by HFA/HFO:

Orientation Training*: Addresses the essential components of the job and may include site goals, services, policies, operating procedures, child abuse and neglect reporting requirements, history and philosophy of home visiting, and enrollment of families and confidentiality. Staff is oriented to the site's relationship with other community resources. This training is given before a staff person begins performing their duties or early in their employment. In Multi-Site state systems, orientation to the functions of the Multi-Site system is additional training for new HFO staff.*

Prior to Activity Training: *Training, such as family goals, depression screening, developmental screening, prenatal training, etc. are required before the activity can be completed with a family. The trainings are also required for Supervisors, and some are required for Program Managers and Assistant Program Managers as well.*

Stop-Gap Training*: Stop-gap training is defined as customized role-specific training (often conducted in-house on an as-needed basis to meet an individual's urgent need for skills necessary to perform work, prior to the receipt of HFA Intensive Role Specific Training. It does not need to be conducted by a certified trainer; however, it must be conducted by someone who has been intensively trained in the role. Stop-gap training does not replace the requirement to attend Intensive Role Specific Training. Stop-gap training is not available for FROG Scale.*

Intensive Role Specific Core Training: *In-depth formalized training which outlines the specific duties of the individual's role within HFO (i.e., Foundations of Family Support core [FFS], FROG Scale core, supervisor core, program manager core). This training must be provided within the first six months of employment for Home Visitors, Supervisors, Assistant Program Managers, and Program Managers. In order to qualify as intensive role specific training, Foundations of Family Support core [FFS], FROG Scale core, and supervisor core should be provided by an individual who has been certified by HFA national to train others in the materials specifically designed for the intensive components of their role within the home visitation site.*

3, 6, 12 Month Wraparound Training: *HFA required training that provides a framework for handling the variety of experiences staff may encounter when working with at-risk families. All service providers (Home Visitors, Supervisors, Assistant Program Managers and Program Managers) receive basic training in areas such as cultural competency, reporting child abuse, determining the safety of the home, managing crisis situations, responding to mental health, substance abuse, and/or domestic violence issues, drug-exposed infants, and services in their community.*

On-Going Training: *Regularly scheduled training provided to staff based upon the specific site needs and issues of families within the community served. Topics may include, but are not limited to: child development, infant care, culture, language development, substance abuse, family systems, and other staff related subjects****. It is required for all staff to have the following annual ongoing trainings: Cultural Sensitivity training, Medicaid training, and Child Abuse and Neglect Reporting training.***

Online Trainings: *Specific trainings created by Healthy Families Oregon to orient and train new staff. The following online trainings are listed and documented on the HFO Required Training Log:*

- ***Welcome to Healthy Families Oregon:*** *Overview of Healthy Families America (HFA) and Healthy Families Oregon (HF0) including model, philosophy, structure, research and the role of HFO central administration. Created for all new Program Managers, Assistant Program Managers, Supervisors, Home Visitors, Volunteers, Eligibility Screening staff and Agency Heads*

- ***New Eligibility Screener Tutorial:*** *Overview of Eligibility Screener qualities, HFO philosophy, relevant critical elements for Eligibility Screeners, and the role specific activities of screening for the HFO program. Created for all new Eligibility Screeners.*
- ***New Home Visitor Tutorial:*** *Overview of Home Visitor qualities, philosophy, relevant critical elements and the role specific activities of HFO home visiting. Created for all new Supervisors and Home Visitors.*
- ***New Supervisor Tutorial:*** *Overview of the qualities of effective Supervisors, the philosophy of HFO supervision, relevant critical elements and the role specific activities of an HFO Supervisor. Created for all new Program Managers, Assistant Program Managers and Supervisors.*
- ***New Program Manager Online Core Training:*** *Overview of the Program Manager position and their responsibilities within HFO. This is required to be completed within 3 months.*
- ***Training New Supervisors and Home Visitors:*** *Overview of the requirements for training new staff including specific forms required for training, tips and organizational strategies. Created for Program Managers, Assistant Program Managers and Supervisors.*
- ***Introduction to HFO Forms:*** *Overview of standard required, required and optional HFO forms, where to find forms and instructions, as well as a more detailed overview of the most commonly used forms for each HFO role. Created for all new HFO staff.*
- ***3 6 12 Month Training Tutorial:*** *Overview of HFO system for training staff on the HFA required wrap around trainings required the first year of employment.*

TRAUMA-INFORMED One component of the HFA Advantage is HFA's trauma-informed approach. Being trauma-informed requires an awareness of the impact that trauma has had on the lives of families, an awareness of behaviors and responses that might trigger re-traumatization, and an openness to understanding how current behaviors are often adaptations to past abuses. Trauma-informed support includes ensuring safety, emphasizing autonomy and a collaborative strength-based approach. The trauma-informed approach applies to all families, and across the parallel process to include site staff, and does not rely on specific knowledge of anyone's trauma experiences or require disclosure on the part of any individuals. Because trauma is a common experience, being trauma-informed does not mean that we treat certain individuals differently based on their trauma history, but instead we provide trauma-informed support to everyone. HFA sites and systems build successful working relationships with all families and staff that provide safety, predictability, comfort and joy and result in improved outcomes for all families.

V

VOLUNTARY SERVICES: 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).

W

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

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

HFA ACCEPTANCE RATE:

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

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

Measuring Acceptance Rates: HFA methodology for calculating a site's acceptance rate is:

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

The HFA National Office has a spreadsheet available that will calculate acceptance rates using HFA methodology.

HFA RETENTION RATE:

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

Measuring Retention Rates: HFA methodology for calculating a site's retention rate is:

1. Select a specified time period, e.g., January 1, 2016 to December 31, 2016 – this is called a "volume year" (see definition in the glossary above) and can be a calendar year or fiscal year.
2. Count the number of families who received a first home visit during this time period,
3. Count the number of families in this group that remained in services over specified periods of time (six months, 12 months, two years or more, etc.);
4. Divide this number by the total number of families defined in step 2 (that received a first home visit during the time period.)
5. For accuracy, a time period must be selected that ended at least one year ago for one-year retention rate, two years ago for two-year retention rate, three years ago for three-year retention rate, and so on. This is to ensure that all families beginning services during the specified time period have had the opportunity to stay for the full retention period being measured. For example, a family enrolled in December 2016 could not be counted as retained for one year until December 2017.

The HFA National Office has a spreadsheet available that will calculate retention rates using HFA methodology.

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

ANALYSIS:

A detailed study and reporting of site patterns and trends. For the purposes of analyzing HFA Acceptance Rates, sites will compare the families who accepted services (received first home visit) to those who declined (never received first home visit). HFA Retention Rates measure families who stayed in services (enrolled) compared to those who left of services. An

analysis must include:

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

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

Please note: Not all factors listed below are required to be analyzed, however sites should review as many as possible in order to isolate those that may be impacting acceptance and retention rates most.

Sites are strongly encouraged to choose factors that will allow them to uncover potential equity issues related to acceptance and retention in the program. In addition, the inclusion of at least one factor related to how the program operates allows the site to learn more about how adjustments to policies and practices may improve family experiences.

PROGRAMMATIC FACTORS:

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

Programmatic Factors to consider for Acceptance Analysis

- Relationships with partner agencies or other community providers
- Referral sources
- Staffing issues (patterns & trends among Home Visitors)
- Number of days between referral and assessment
- Eligibility screening or assessment timeframe (e.g., prenatal, at birth within two weeks, more than two weeks)
- If re-enrolled or transferred family
- Training of staff

Programmatic Factors to consider for Retention Analysis

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

PARENT AND FAMILY FACTORS:

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

- Gender identity
- Age
- Race & ethnicity
- Marital status
- Education level (last grade completed)
- Primary language
- Sexual orientation
- Employment status (not employed, employed part-time, full-time, or seasonally)
- Income level
- Location: urban, suburban, rural; and
- Families experiencing systemic oppression
- City/zip code, etc.
- FROG Scale score
- Work or school issues (barriers to engaging or retaining due to HS or college schedule, work hours, significant commute, works night shift, etc.)
- Family or friend support
- Teen parent(s) living independently or with parents
- Grandparents raising focus child
- Linkages to other community resources
- Religious affiliation
- Domestic/family violence
- Families with disabled parents or children
- Families impacted by substance use
- Families impacted by mental health
- Families impacted by violence or over-policing

INFORMATION USED IN ANALYSES: Sites are required to consider formal data and other information related to analysis factors to identify patterns or trends in family acceptance or retention. Formal data refers to information that can be numerically recorded, often regarded as "hard data," or quantitative data. Factors related to program processes and activities, and factors related to family or individual parent characteristics can all be reported as formal data using both numbers and percentages. Anecdotal information, often regarded as qualitative data, gathered from site staff, advisory board members and parents related to the analysis factors helps complete the story of what is impacting family acceptance or retention. Anecdotal information may be collected in staff meetings, individual supervision, parent focus groups or community advisory board meetings.

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

COMPREHENSIVE ANALYSIS: A comprehensive analysis is a thoughtful and intentional selection and examination of key programmatic and parent and family factors that includes a combination of raw (numeric) and aggregate (percentage) formal data as well as informal (anecdotal) data, and how various factors may relate to and influence other factors. A comprehensive analysis also includes a narrative that summarizes the findings including any patterns or trends. Data and conclusions from the analysis are used to develop and apply strategies aimed at improving site services in the site's Comprehensive Quality Improvement Plan.

COMMON ABBREVIATIONS:

AKA:	Also Known As
ASQ:	Ages and Stages Questionnaire
ASQ:SE:	Ages and Stages Questionnaire, Social- Emotional
BA:	Baby
CD:	Child Development
CHEERS:	Cues, Holding, Empathy, Expression, Rhythm & Reciprocity and Smiles
CPS:	Child Protective Services
CWP:	Child Welfare Protocols
DOB:	Date of birth
Dx:	Diagnosis
ELC:	Early Learning Council
ELD:	Early Learning Division
ES:	Eligibility Screener
FFS:	Foundations of Family Support Core Training
FROG:	Family Resilience and Opportunities for Growth
FSS:	Family Support Specialist
HFA:	Healthy Families America
HFO:	Healthy Families Oregon
HFGF:	HFO General Fund
HV:	Home Visit/Home Visitor
HVC:	Home Visit Completion
HVR:	Home Visit Record
Hx:	History of…
MAC:	Medicaid Administrative Claiming
MGM:	Maternal grandmother
MGF:	Maternal grandfather

MH:	Mental Health
MIECHV:	Maternal Early Childhood Home Visiting
MOTT:	Medicaid Online Time Tracker
MOA/MOU:	Memorandum of Agreement/Understanding
NBQ:	New Baby Questionnaire
NICU:	Neonatal Intensive Care Unit
PCI:	Parent Child Interaction
PCP:	Primary Care Provider
PGF:	Paternal grandfather
PGM:	Paternal grandmother
PM:	Program Manager
PMA:	Program Manager Assistant
PPPM:	Program Policies & Procedures Manual
Rx:	Prescription
SO:	Significant other
SP:	Service Plan
SSS:	Site Self-Study (HFA)
SUP:	Supervisor
TANF:	Temporary Assistance to Needy Families
U:	Unknown
UR:	Unknown Risk
WIC:	Women, Infants and Children

STANDARD 1: INITIATE SERVICES EARLY, IDEALLY DURING PREGNANCY.

HFA Standard 1 Intent *to ensure the site has a well-thought out mechanism for the early identification and engagement of families who could benefit from services. The earlier families are enrolled during pregnancy the greater the opportunity to support healthy practices during pregnancy which can lead to improved birth outcomes (Lee, E., et al, 2009) and longer term parent and infant health*

1.1

HFO has a description of its eligibility criteria and the community relationships in place to identify and initiate services during pregnancy or within 3 months of birth. Please Note: See glossary for limited exception and approval process related to HFA's Child Welfare Protocols.

HFA Intent:

Communities choose to implement the HFA model as a mechanism to improve family and child outcomes and do so because there is local, state, and/or federal interest in providing supportive home visiting services in partnership with parents of infants and young children. It is important for the site to focus on creating equitable access to services for families experiencing barriers to resources and to base its eligibility criteria on community data, ensuring a systematic process for identifying families is in place.

The site's eligibility criteria are reviewed at least once every four years and updated as changes in funding, site infrastructure, or community demographics warrant. When the site is approved to implement HFA's Child Welfare protocols for families referred from child welfare, this must be referenced in the site's eligibility criteria description.

Program Eligibility Criteria

1-1.A In accordance with Oregon Revised Statute 417.705 - 417.795, HFO has mechanisms for timely identification of families so home visiting services can begin prenatally or as early as possible within the first 3 months after the birth of the baby. All sites use the New Baby Questionnaire to identify potential participants. Families are eligible for services when they meet the scoring criteria on the New Baby Questionnaire (see 2-1A).

Healthy Families Oregon eligibility criteria is all births.

Please note: Sites are not required to conduct the NBQ with every single birth in their geographic service area, however eligibility screening is a priority for HFO and the NBQ screen should be offered to any pregnant woman or parent with a new baby that the site comes in contact with and has capacity to screen.

Characteristics of eligibility criteria at Local Site

Insert a description of the geographic service area:

Insert the total number of families projected annually to be served based on site capacity:

Service Delivery Priorities

Once families are screened and identified as eligible for home visiting services based on the New Baby Questionnaire criteria, families are assigned to a Home Visitor. When Home Visitor caseload capacity limits services to all eligible families, sites will utilize clearly defined criteria to prioritize families. In developing local service priorities, the site should be sensitive to the cultural, linguistic, socio-economic and geographic diversity of the population in the service area.

Each local site can select up to four service priorities (stressors/factors that are unique to your region) that will be used to prioritize which families receive home visiting services when need is greater than program capacity. With each additional priority, provide local data and any community/site discussions that supports this decision. HFO has identified four empirically sound priorities that are intended to help begin your conversations around setting priorities. They are suggestions, not required priorities. If you choose to select any of these suggested priorities, please include your justification and community data that helped inform your decision. Please do the same if you are selecting priorities not on this list. If your community feels it is vital to have more than 4 total priorities, please include rational for this need.

These suggested priorities are:

- Families with 4 or more risk factors on the NBQ
- Teen Parent(s)
- OHP Eligible (parent or child)
- Parents with 3 or more children under the age of five

The following are the chosen service priorities for your site (*not placed in order of significance*):

List the service priority for your site:

Insert the local community data (source and year) that informed your decision for this service priority:

List the service priority for your site:

Insert the local community data (source and year) that informed your decision for this service priority:

List the service priority for your site:

Insert the local community data (source and year) that informed your decision for this service priority:

List the service priority for your site:

Insert the local community data (source and year) that informed your decision for this service priority:

Sites with Full Capacity

If a family is found to be at higher risk, desires services, and there is not capacity at the site, every effort is made to link the family with other appropriate resources in the community. Sites work collaboratively with other early childhood service providers to assure that families receive available, timely services that meet their needs. Sites local policy should include referring families to other resources if caseload space is not available at the time of eligibility screening.

A note from HFA about using wait lists:

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

Referring Organizations

1-1.B Each HFO site identifies community partners and establishes organizational relationships where their focus population is found for purpose of obtaining referrals, identifying and screening families to establish eligibility for services. This may include, in some regions, a central intake system for referrals. Sites will pursue written (formal Memorandums of Understanding/Agreements), verbal and/or informal agreements with their community partners to provide access to sites focus population for eligibility screening.

List organizations/community partners where your site accesses families that you intend to screen for eligibility (NBQ), including partners that provide consent to contact information. Describe the formal and informal agreements that are in place for each of these organizations/community partners:

If implementing Child Welfare Protocols, insert details to ensure active MOU with local child welfare agency as a referral source for families receiving services using Child Welfare Protocols: *NA*

Insert details of other available early childhood services within your service area, their eligibility criteria, and how services are coordinated to ensure no duplication of services occurs:

Please note the following if your region is part of a centralized intake system:

When working in partnership with an external entity providing centralized intake, it will be important to have a formal agreement in place allowing reciprocal sharing of aggregate data in order to track screening data. Data tracking will include how many within the focus population are being screened/referred (by centralized intake) and how many are connecting to services (by the HFO site). When partnering with centralized intake entities, it is important to periodically review criteria prompting referral to Healthy Families to ensure it is neither too broad not too restrictive.

If applicable, insert details of the Centralized Intake System that your region is a part of:

Tracking Referrals and Site Capacity

1-1.C HFO sites track quarterly 1). The number of families identified or referred to Healthy Families services 2.) Indicating whether the family was eligible or not, 3.) The source of each referral. Families are reached via referrals from community partners (i.e. *Consent to Contact*, phone, email). Sites also monitor the coordination of organizational relationships when completing the *Quarterly Review of Screening* and is submitted via Quarterly Outcome Reporting SmartSheet to Central Administration.

> *HFA Intent:*
>
> *Tracking the number of families identified or referred allows the site to utilize data effectively to advocate for families in the community whose needs may go unmet. For example, there may be many more potential families than can be served owing to the site's current capacity. This data provides the site with valuable information to maximize existing staff capacity, allowing the site to determine what dynamics might be getting in the way of engaging families in services*

When tracking data over multiple quarters, determination of patterns and trends related to screening rates can be identified. Strategies to improve screening rates, based on information from site monitoring over four consecutive quarters may become a part of the sites *Quality Assurance Plan* or *Quality Improvement Plan*. This in no way precludes a site from taking earlier and more timely action when needed to correct a staffing or policy issue, or other situation requiring immediate action.

Describe how your site monitors and tracks referrals and site capacity (*HFA Spreadsheet: Entrance to Exit* available)

If implementing Child Welfare Protocols, describe how your site monitors and tracks referrals and site capacity for families enrolled through CWP: *NA*

Insert any additional local procedures showing how you regularly monitor eligibility screening process, rates and organizational relationships to increase the number of referrals to HFO:

If implementing Child Welfare Protocols, insert any additional local procedures showing how you regularly monitor and strategize to increase percentage of families identified, referred and enrolled through Child Welfare Protocols: *NA*

1.2

HFO ensures all referrals to sites are tracked and monitored from receipt of referral to the offer of services.

Initial Engagement Process (policy)

1-2.A Staff will follow initial engagement processes from referral to the offer of services to ensure a timely offer of services. Timeframes from receipt of referral to the first contact, and from first contact to offer of services will be tracked and monitored. The eligibility screening process at each HFO site includes completing the New Baby

Questionnaire (NBQ) with families to determine eligibility for the HFO program. Sites are required to provide a detailed description of their local screening process, mechanisms to ensure timely determination of eligibility, including timeframes between the receipt of a referral to completion of NBQ and from completion of NBQ to the offer of services to the family. The process will also include the site's tracking and monitoring requirements using the HFO Statewide Data System and/or local tracking system to monitor completion. HFA spreadsheet for Standard 1 available.

Describe your site's eligibility screening process in detail using the following numerical order:

1. **Clearly describe the overall eligibility screening process for your site:**

2. **Insert who screens families at your site for eligibility:**

3. **State the timeframe between the receipt of a referral (Consent to Contact) to initial contact with family to complete the NBQ and list the expected engagement activities between the receipt of a referral (Consent to Contact) to initial contact with family to complete the NBQ:**

4. **Describe your process for tracking and monitoring from receipt of referral (Consent to Contact) to initial contact to complete the NBQ:**

5. **State the timeframe between the initial contact (completion of NBQ) and offer of HFO services to the family and list the expected engagement activities between the initial contact (completion of NBQ) and offer of HFO services to family:**

6. **Describe your process for tracking and monitoring from initial contact (completion of NBQ) to offer of HFO services including documenting reasons why families are not offered services:**

7. **Describe how your site monitors and tracks initial engagement process (*HFA Spreadsheet: Entrance to Exit* available):**

Initial Engagement Process (practice)

1-2.B HFO sites follow the policy and procedures regarding its eligibility screening process, tracking the activities and timeliness from receipt of referral to offer of service, whether able to establish initial contact or not, whether services are offered or not and reasons why if families were not offered services as stated in HFO Policy 1-2.A.

HFA Intent:

Many families miss the opportunity to participate in services because site staff is unable, for a variety of reasons, to establish or maintain contact with them subsequent to the initial referral. Therefore, sites monitor closely the initial engagement process

Initial Engagement Process: Developed Strategies

1-2.C All HFO sites develop strategies, based on its data from 1-2.B, to strengthen its initial engagement process with families, aiming to reduce barriers and provide equitable access to HFA services as stated in HFO Policy 1-2.A.

1.3

HFO initiates services within 3 months after the birth of the baby with at least 80% of the families; for sites approved to use HFA's Child Welfare Protocols, the first home visit occurs within twenty-four months for at least 80% of families referred from child welfare.

First Home Visit within 3 months (policy)

1-3.A HFO services begin with the first official home visit that occurs prenatally or within the first 3 months after the baby's birth. Eighty percent of first home visits occur as soon as possible after being assigned and no later than three months after the birth of the baby. If Child Welfare Protocols apply to the HFO program site, the site ensures eighty percent of first home visits occur by twenty-four months after baby's birth. "Welcome Baby Visits" that some sites utilize to educate families about the program are not considered the first official visit. First official visits encompass the review and signing the Rights & Confidentiality form, meeting the definition of a home visit as stated in 4-2.A, as well as the completion of a Home Visit Record. Due to HFA research showing increased positive birth outcomes when home visiting services start prenatally, HFO sites are strongly encouraged to begin services with families during the prenatal period. The process will also include the site's tracking and monitoring requirements using the HFO Statewide Data System and/or local tracking system to monitor completion. HFA spreadsheet for Standard 1 available.

Describe whether your site begins home visiting prenatally or at birth. If it varies, indicate how the decision is made for each family:

Describe your sites activities to ensure the first home visit occurs prenatally or within the first three months after the birth of the baby:

Describe how your site monitors and tracks receipt of first home visit within 3 months after the birth of the baby (*HFA Spreadsheet: Entrance to Exit* available):

If using Child Welfare Protocols, describe sites activities to ensure the first home visit occurs with twenty-four months after the birth of the baby: *NA*

If using Child Welfare Protocols, describe how your site monitors and tracks receipt of first home visit within 24 months after the birth of the baby (*HFA Spreadsheet: Entrance to Exit* available): *NA*

Children in the NICU

Infants with an extended hospital stay in the NICU may not be able to begin home visits until after 3 months. These situations should be documented clearly in the family file and will be exempt from the requirement of this standard.

Services Following Focus Child

"Re-enrollment" of a family does not occur when a new baby is born during the provision of services and sites do not change the focus child to the new baby. Services continue to follow the original focus child.

Home visiting services can follow the focus child if the child is placed in another home, and may be offered to substitute care providers; the substitute care provider might include foster parents or grandparents. This does not include childcare providers or supervised visitation. For example: A child is removed from a parent's home and placed in foster care while the mother completes drug treatment. If the treatment is short-term and the mother is to be back within 3 months, Creative Outreach would be used in this situation to keep in contact with the mother and services would resume when she returned home with the child.

If, during the course of services, the child is removed from a parent's custody and parents are actively working toward reunification, home visiting services can continue in an effort to reach reunification goals. The content of home visits should include opportunities for CHEERS observations and parenting activities at each visit. Intensity of services would return to Level 1. Services can continue understanding that reunification is the plan and the parent is actively working toward this goal and meeting regularly.

If the duration of the separation is unknown and the child is placed at another care provider long-term, then the services would follow the child.

If services change to a substitute provider, it is required for the site to complete a new Consent to Participate and the Rights & Confidentiality form.

Sites monitor when participants are receiving their first home visit as stated below, and monitor this data and develop strategies to address challenges at least annually using the *Quarterly Review of Screening*.

Site Monitoring: First Home Visit

Supervisors monitor the timing between Home Visitors receiving a file/completed NBQ screen and the first official home visit date to ensure that Home Visitors are supported in scheduling families for a first home visit in a timely manner (within 3 months of the birth of the baby or prenatally). Supervisors will use supervision time to problem-solve strategies to decrease time between receipt of information on family (file/completed NBQ screen) and the first visit, if appropriate.

Program Manager/Assistant Program Managers monitor overall practices and rate for the site, communicating, and problem-solving strategies with Supervisors to meet the threshold to be in adherence with the standard.

First Home Visit within 3 months (practice)

1-3.B Each HFO site's practices ensure that, for families who accept services, the first home visit occurs prenatally or within 3 months after the birth of the baby as stated in HFO Policy 1-3.A.

1.4

Each site measures, analyzes and addresses how it might increase the acceptance rate into home visiting services at least once every two years, analyzes its data associated with family acceptance to better understand the underlying issues associated with families choosing to accept services or not.

Measuring Acceptance Rates

1-4.A The Program Manager/Assistant Program Manager assures appropriate and timely data collection, and includes the use of the NPC Status Report as well as HFO Statewide Data System and/or local tracking system (*HFA Spreadsheet: Entrance to Exit* available) to measure the acceptance rate of families into home visiting services based on receipt of the first home visit. Acceptance rates are monitored at least annually using the NPC Status Report, HFO Data System and/or local tracking system (*HFA Spreadsheet: Entrance to Exit* available), and *Quarterly Review of Screening*, using both numbers and percentages.

Describe your local process regarding tracking and monitoring family acceptance data using HFA methodology for the purposes of Quality Assurance or Quality improvement planning:

Acceptance Analysis

1-4.B The Program Manager analyzes at least every two years (both formally and informally), among those determined to be eligible, who declines the program and why to identify underlying reasons or causal factors associated with the site's acceptance rate. Information from the NPC Status Reports, HFO Statewide Data System and/or local tracking system (*HFA Spreadsheet: Entrance to Exit* is available) are utilized. Informal analysis includes local data review, discussions with staff and others involved in site services. The analysis addresses two factors as well as a comparison of those who accept and those who decline using the *Family Acceptance Analysis*. This analysis includes programmatic, and parent and family factors. The Program Manager completes and submits to Central Administration the *Family Acceptance Analysis* in accordance with the *Aligned QA Calendar* every two years. The Program Manager considers the results of the *Family Acceptance Analysis* and whether a plan for improvement should be a part of the *Quality Assurance Plan* or *Quality Improvement Pl*an.

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

STANDARD 2: SITES USE THE VALIDATED FAMILY RESILIENCE AND OPPORTUNITIES FOR GROWTH (FROG) SCALE TO IDENTIFY FAMILY STRENGTHS AND CONCERNS AT THE START OF SERVICES.

➢ **2.1**

HFA Standard 2 Intent *is to ensure the site has an objective process for learning about each family's strengths and concerns at the start of services. The FROG Scale is a family-centered tool used to identify the presence of both protective factors that promote resilience and factors associated with increased risk for child maltreatment or other adverse childhood experiences. It is used at the start of services to guide initial service planning and ongoing support services for the family throughout the course of services based on their identified strengths and needs.*

2.1

Each HFO site is required to use the FROG Scale at the start of services to provide the family an opportunity to tell their story, to identify the presence of protective factors as well as factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences, and to support the development of a service plan to support the unique needs of each family.

HFA Intent:

Parents/caregivers represent a broad variety of backgrounds, experiences, values, and cultural norms, and these are combined in unique ways in each individual family. What may appear as a risk factor in one family may be mediated by nurturing relationships and/or significant protective factors in another. By completing the Family Resilience and Opportunities for Growth (FROG) Scale, staff learn about each family's strengths and concerns and are better able to plan services and resources that will be of most interest and benefit to the family.

The FROG Scale is administered objectively and reliably, and in a relationship-building, conversational style. Using a conversational style allows parents to share their story in a way that makes sense to them and enables staff to follow up for greater understanding of the family's experiences. When parents are able to tell their story at the onset of service (or as soon as possible thereafter), the parent feels heard and valued. The intent with the FROG Scale is for staff to explore all areas while understanding parents are only expected to share as much as they are comfortable sharing. Doing so conveys the respect all families deserve, and sets the stage for a genuinely attentive and responsive relationship

Family Resilience and Opportunities for Growth (FROG) Scale (policy)

2-1.A The FROG Scale is administered with each family on or before the fourth home visit (ideally within 30 days of enrollment). The FROG Scale conversation is ideally administered within one visit (no more than 2 visits) with the family. The FROG Scale is meant to identify risk and protective factors that could contribute to or mediate the risk for child maltreatment or other adverse childhood experience. The Home Visitor will document when the FROG Scale was completed with the family on the *Home Visit Record*. If the FROG Scale was completed within one visit it is not necessary to complete documentation of CHEERS observation or offer a parenting activity using materials on that one visit.

Documentation of the FROG Scale

The FROG Scale is completed for the parents (or primary caregivers) present in relationship-building, conversational style. All FROG Scales are administered objectively and reliably and according to the FROG training.

The FROG Scale is scored (0-4 or UR) in all domains the parent is comfortable sharing information for and in accordance with HFA's FROG Scale training. Any domains not scored are explained in the narrative. Home Visitors will document the reason for any unknown risk (UR) score as the following: Did not assess, Parent chose not to share, or Parent did not know. These domains are identified for later conversation and inclusion in the service plan when warranted.

Home Visitors complete the *FROG Scale Summary* form in narrative format that documents the risks, needs, as well as strengths, expressed by the parent during the FROG Scale conversation. It is recommended that time is allotted immediately after completion of the FROG Scale visit to begin documentation on the FROG Scale Summary. The *FROG Scale Summary* will be completed within two (2) working days of administering the FROG Scale with the family. The Home Visitor will submit the completed *FROG Scale Summary* form, scored in all domains, to the Supervisor upon completion of the summary for review of the scoring, narrative content, strengths, risk factors and needs.

Supervisor Review of FROG Scale

The Supervisor is responsible for reviewing the *FROG Scale Summary* form scoring and narrative content before the next supervisory session with the Home Visitor.

The Supervisor will then review the summary in supervision with the Home Visitor, discussing the narrative content and scoring, offering feedback, and requesting updates to scores and/or narratives for a final draft, if necessary. The Supervisor will keep a copy of each *FROG Scale Summary* form draft, with documentation of the review, in the supervision notebook.

Please note: If a FROG Scale discussion includes a safety concern disclosure such as significant mental health challenges, substance abuse, or intimate partner violence, Home Visitors are expected to check-in with their Supervisor within 24 hours to assess mandatory reporting requirements and get emotional support. This discussion will be documented on the *Family Progress Review* form in the supervision notebook.

Site Monitoring

Supervisors will monitor the timeframe that FROG Scales are administered and ensure objective, uniform documentation, utilizing supervisory sessions for problem-solving and feedback, and follow up, if necessary.

FROG Scale Training

Home Visitors administering the FROG Scale, and staff supervising those who administer the FROG Scale, are trained in its use prior to conducting the FROG Scale with families by completing the FROG Scale Core Training that is conducted by a certified HFA trainer (See Standard 10 for details on this training).

Essential Standard

FROG Uniformity (practice) ESSENTIAL STANDARD

2-1.B FROG Scale is administered and documented uniformly as stated in HFO policy 2-1.A

FROG Timeframes (practice)

2-1.C FROG Scale is administered within the timeframe identified in accordance with HFO policy 2-1.A

FROG Supervision (practice)

2-1.D FROG Scale completed is reviewed by a Supervisor as stated in HFO policy 2-1.

STANDARD 3: OFFER SERVICES VOLUNTARILY AND USE PERSONALIZED, FAMILY-CENTERED OUTREACH EFFORTS TO BUILD TRUST WITH FAMILIES.

HFA Standard 3 Intent *is to ensure the site has an equitable process for reaching out to and engaging families initially as well as throughout the time families choose to remain enrolled. HFA's emphasis on trust-building informs the HFA Advantage–a relationship-focused and trauma-informed approach to working with families. Staff interact with families utilizing the components of secure attachment–safety, predictability, comfort, and pleasure–to develop trust. Providing outreach in this way reflects our commitment to families and demonstrates our understanding of the impact that institutional and generational mistrust and misuse of power have created. The HFA approach to outreach seeks to address some of the power imbalances that can be found in helping relationships by putting parents in control and engaging with them in partnership.*

3-1

HFO services are offered to families on a voluntary basis and cannot be mandated. Families may choose to discontinue services at any time.

Voluntary Service (policy)

3-1.A By law (Appendix A), HFO services are voluntary and cannot be a part of any mandated plan. This information is shared with families at screening for eligibility when reviewing the *Welcome to Healthy Families form* with the Eligibility Screener and during the first home visit when the family reviews and signs the *HFO Rights and Confidentiality form* with their Home Visitor. See GA-3.B regarding the *Rights and Confidentiality* form.

HFO Confidentiality and DHS Child Welfare

When HFO sites enroll families, who have an already open and active case with child welfare, HFO staff will not monitor family's progress on behalf of DHS Child Welfare, the court, or any other agency. Sharing of family service information with Child Welfare or the court system is bound by the confidentiality requirements of HFO and informed consent (unless subpoenaed) which indicates precisely what information is to be shared. Additionally, it may be important to inform families that sharing such information may not always be helpful to the family's situation. Sharing information with these agencies, except in a child abuse or neglect report, is bound by HFO confidentiality requirement and only allowable if a family gives consent via the HFO *Authorization to Release Information* form.

Non-participation in Program Evaluation

Please note the following regarding the HFO program evaluation: Families who choose not to participate in the statewide evaluation system are eligible to receive HFO home visiting services. Demographic information is recorded in the HFO Statewide Database and is not shared with the evaluators. Any additional family records are maintained locally on site.

Describe your local site's relationship, formal or informal, with your local DHS (child welfare):

Voluntary Services (practice)

3-1.B HFO site's practices ensure services are offered to families on a voluntary basis as stated in HFO Policy 3-1.A.

3-2

HFO staff use a variety of positive pre-enrollment methods to build family trust and engage new families.

HFA Intent:

This standard reflects the need for staff to reach out to families and utilize trust-building methods and tools, including supervision support, when establishing relationships with families. When parents have experienced unresolved early childhood trauma, or been marginalized by society, their sense of whether people are safe, predictable, and pleasurable may be compromised. As a result, families may be reluctant to accept services and may struggle to develop healthy, trusting relationships. Therefore, site staff must identify positive ways to establish a relationship with a family

Pre-Enrollment Outreach (policy)

3-2.A ***This standard applies to families who have not yet received a first home visit.*** Sites will utilize a variety of positive methods (listed below) to reach out to families to initially engage them, to build their trust, and ways to establish a relationship. Home Visitors will use Supervisory support to strategize initial engagement and problem solve ways to build trust.

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

Sites will document in the family file other reasons for ending services during the initial engagement period (e.g., parent no longer has custody, pregnancy ended in miscarriage, focus child or primary care provider is deceased, incarcerated, significant staff safety issues, transferred to another program, etc.).

The following activities are recommended by HFO and HFA:

- Warm telephone calls focused on the family's well being
- Creative and upbeat notes that encourage parents to want to participate
- Drop by visits leaving a card when families are not home, if appropriate
- Invitations to parenting groups
- Texting when approved by site policy
- Anchoring conversations with families to their interests and needs
- Demonstrating joy in being with the parent(s)
- Offering playful/fun activities
- Encouraging self-care practices
- Utilizing music and art in initial interactions, and
- Personalizing engagement efforts
- Offer "Welcome Baby Visit" for initial engagement
    - Documented on the Contact Log as "Welcome Baby Visit"

- Reminder: Rights & Confidentiality is required to be signed on the first official visit (which requires a Home Visit Record)
- Methods will be documented in the family file, preferably on the Contact Log.

Insert your site's local procedure if you provide "Welcome Baby Visits" as a pre-engagement activity including outlining what is provided in the visit:

List any additional positive methods or activities that your site uses that are not listed above to build trust and initially engage families:

If your site uses texting with families, please outline your site policy for this mechanism to build trust and initially engage families:

Pre-Enrollment (practice)

3-2.B Staff utilize positive methods to build family trust and engage them in services as stated in HFO Policy 3-2.A.

3-3

HFO staff offer creative outreach under specified circumstances for a minimum of three months or for a cumulative three-month period over six consecutive months before discontinuing services for families that have had at least one home visit subsequent to the offer of services.

HFA Intent:

It is the site's responsibility to reach out to families who have received a first home visit, yet for a variety of reasons may not be comfortable receiving ongoing home visits in a consistent manner. Often families who have experienced trauma in their own childhood, or have been marginalized or oppressed, will find it difficult to trust others. Additionally, families currently in crisis may find it difficult to continue participation due to a variety of factors.

Creative outreach activities are uniquely tailored to the individual family and are focused on demonstrating to the family that the Family Support Specialist is genuinely interested in them and wanting to continue to offer services. Creative outreach activities occur consistently and at the frequency associated with their previous level throughout the three-month time-period

Post-Enrollment Creative Outreach (policy)

3-3.A ***This standard applies to families who have received a first home visit.*** It is the site's responsibility to reach out to families who have accepted services, yet for a variety of reasons, may not be comfortable receiving ongoing home visits in a consistent manner. Families are placed on Creative Outreach for a minimum of 3 months or for a cumulative three-month period over six consecutive months. The three-month or cumulative three-month period over six consecutive months Creative Outreach timeframe applies to families who have received a first home visit subsequent to the offer and acceptance of services.

There is no maximum number of times that a family can be placed on Level CO. This decision is a contextual decision between the Supervisor and the Home Visitor. Research indicates that multiple efforts to reach out to reluctant families provide the family with time to reflect and warm up to services over time.

When families miss 1 scheduled visit, reaching out to re-connect with that family begins immediately. When staff successfully reschedule a visit that is also a missed visit (i.e. 2 missed scheduled visits), families are placed on Level CO and backdated to the date of the 1st missed visit. If the Home Visitor has made multiple efforts to reschedule with the family, and is unsuccessful, the family is also then placed on CO and backdated to the 1st missed visit.

Activities to be carried out consistently and at a frequency equal to or higher than that associated with their previous level, and documented during the course of Creative Outreach

Creative Outreach is concluded prior to three months only if the family has re-engaged in services, has moved from the service area, or has declined services. Other allowable reasons include parent no longer has custody, pregnancy is terminated or ends in miscarriage, focus child or primary care provider is deceased, significant staff safety issues, or family transferred to another program.

Families who are assigned a permanent worker from Level TR or returned to the service area from Level TO, but who are unable to be engaged on an active service level, will be moved to Level CO. In these situations, the cumulative time on TR or TO plus CO will be for a minimum of 90 days.

Strategies for Families on Creative Outreach

Sample strategies to use with families while on creative outreach are similar to those identified above (3-2.A) when working to initially engage families and may include:

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

It is strongly encouraged to use positive, attentive, creative outreach activities, demonstrating to the parent genuine caring for the family. Weekly contact recommended the first month of creative outreach, bi-weekly the second month, and at least one handwritten letter including a date the family will be exited from program services in the third month.

Placing Families on Creative Outreach

Families may be placed on Creative Outreach when a scheduled visit is missed/cancelled by the family formally (via text, phone call, etc.) or informally (i.e. family not at home), followed by two unsuccessful attempts to reschedule (i.e. parent cannot be located or rescheduled visit is also formally or informally cancelling). When moving to Level CO, the date of the first missed visit can be used as the date CO began on the Level Change Form. Sites maintain a family's case weight while on Level CO equal to the family's level prior to being placed on creative outreach to ensure space is retained to move family back to that level if re-engaged.

Supervisors may use their discretion to determine family situations warranting a creative outreach period longer than three months, and this should be documented on the *Family Progress Review* form. Families may not be placed on Creative Outreach due to site issues such as training or agency closures.

Describe your local procedure regarding frequency of contacts for families who are on Creative Outreach:

Describe the procedure for monitoring/holding Home Visitors accountable when a caseload shows a large number of families who are on Creative Outreach:

Essential Standard

Post Enrollment Creative Outreach (practice) ESSENTIAL STANDARD

3-3.B Each HFO site places families on creative outreach as stated in HFO Policy 3-3.A.

3-4

HFO sites measure the retention rate of families on an annual basis and in a consistent manner, and analyzes data associated with family retention at least once every two years to better understand the underlying reasons or causal factors associated with families choosing to stay versus leave services.

HFA Intent:

Sites conduct a thorough retention analysis at least once every two years to determine underlying reasons or causal factors associated with the site's retention rate. The analysis examines various factors of those who remain enrolled with those, during the same time period, who are no longer enrolled. The site will determine which factors it analyzes based on trends or patterns it has observed. The intent is to ensure the analysis can yield meaningful results that lead to activities to address underlying causes and increase retention as a result (see GA-2.B).

Measure Retention

3-4.A The Program Manager/Assistant Program Manager at each HFO site ensures appropriate data collection for the program evaluation so that the retention rate of families in services are measured annually and reviewed/monitored with the NPC Status Report as well as HFO Statewide Data System and/or local tracking system (*HFA Spreadsheet: Entrance to Exit* available). The data is collected and aggregated following the HFA approved methodology (first and last home visit) for families enrolled during a single one-year period at multiple intervals (e.g., measuring 6-month and 12-month retention rates). *HFA spreadsheet: Entrance to Exit* for Standard 3 available.

Describe your local process regarding tracking and monitoring family retention data using HFA methodology for the purposes of Quality Assurance or Quality Improvement planning:

Retention Analysis

3-4.B The Program Manager conducts an analysis of family retention at least every two years using the *Family Retention Analysis* template to better identify and understand underlying reasons or causal factors associated with families choosing to say versus leave services. The analysis is comprehensive and includes who drops out of the program and why, in comparison to families who remain in the program. Both formal and informal methods are utilized. The formal analysis is conducted using information from the NPC Status Reports, HFO Statewide Data System and/or local tracking system (*HFA Spreadsheet: Entrance to Exit* is available). Informal analysis includes local data

review, discussions with staff and others involved in site services. This analysis includes programmatic, and parent and family factors The Program Manager submits the *Family Retention Analysis to* Central Administration every two years in accordance with the *Aligned QA Calendar*. The Program Manager considers the results of the *Family Retention Analysis* and whether a plan for improvement should be a part of the *Quality Assurance Plan* or *Quality Improvement Pl*an.

For smaller sites with less than 50 families enrolled in services over a two-year period, the Program Manager is required, at a minimum, to collect informal data and reasons why families are leaving services, and to do a more comprehensive analysis when sample size reaches 50 or more over a two-year period.

STANDARD 4: OFFER SERVICES INTENSELY AND OVER THE LONG TERM, WITH WELL-DEFINED PROGRESS CRITERIA AND A PROCESS FOR INCREASING OR DECREASING INTENSITY OF SERVICE.

HFA Standard 4 Intent *is to ensure sites offer services intensely at the onset of services to support relationship building between the FSS and the parent(s), and attachment and bonding between parents and child, through repeated positive experiences. This reflects the parallel process. HFA services are offered for a minimum of three years and up to five years, subsequent to the birth of the focus child or date of enrollment, whichever is later. Additionally, sites utilize HFA's Level Change process for determining the frequency of home visits consistent with the progress of each family.*

4-1

All HFO sites offer weekly home visiting services on the onset of services.

Weekly Visits (policy)

4-1.A Families enrolling prenatally or after the birth of the baby are offered weekly home visits at the start of services until the family meets progress criteria to support moving to every other week visits. Families enrolling on Level 2P are initially offered weekly visits to support relationship development and family retention.

Families whose infant is hospitalized in NICU after birth will not be placed on Level 1 until the baby comes home from the hospital unless the parents want weekly visits during that time.

Families moved to a creative outreach level from Level 1 will return to Level 1 once re-engaged until the family has met the criteria outlined on the Level Change Form for movement to Level 2.

When a family is not able to meet weekly due to work/school schedules, home visits will continue to be offered weekly in the event the family's schedule changes. Weekly visits will be offered until the family meets progress criteria to move to Level 2.

Families transferring from another HFO site or re-enrolling with the same focus child will be offered weekly visits until progress criteria is met to move to every other week.

The supervisor and the FSS formalize all level changes during regular supervision.

Weekly Visits (practice)

4-1.B HFO sites ensure families (with the exception of 2P families) are offered weekly home visits at the onset of services (including with transfer and re-enrolling families) and until progress criteria are met for moving to less frequent visits.

4-2

All HFO sites use a well-thought-out system for managing the intensity and frequency of home visiting services that includes use of HFA Level Change forms for all levels requiring progress criteria to be met when moving to less frequent visits.

HFA Intent:

Because HFA is a family-centered model, sites are required to use HFA's "level system" for managing the intensity of services. This well-thought-out system is sensitive to the needs of each family, changes in family stability and competencies over time, and the responsibilities of the FSS. Clearly defined levels reflect in measurable ways the capacity of the family, such that families with higher needs are able to receive more intensive services, while less intensive services are provided as stability and progress increase. Not only does an effective "level system" allow for individualized service delivery, it also provides sites a mechanism to monitor caseload capacity more effectively, thus promoting higher quality services

Levels of Service (policy)

4-2.A Each HFO site is required to follow the HFA level system for managing the intensity of services as stated in the *HFA Level Change Tool Guidance* and on the *HFA Level Change Forms* (HFA Level Change Forms, HFA Parent Certificates)including the Home Visitor and Supervisor responsibilities. These documents are located on the HFO SharePoint.

Level Change Forms are not required for moving families to Levels CO, TO, and TR or for moving from Level 2P to 1P or Level 1P to 1. These levels are not based on family progress. Start and end dates for these levels, as well as documentation of activities is entered in family file and supervision binder *Level Change Tracking* form. Level Change Forms are required for changes from Level 1 to Level 2, Level 2 to Level 3, and Level 3 to Level 4, for changes to a previous level 1, 2, or 3, changes from any level to SS or back.

Level 2P (2 points)	Prenatal second trimester or earlier: weekly visits until relationship established, then every other week until the child is born
Level 1P (2 points)	Prenatal third trimester or later: families in first or second trimester when needs warrant; weekly home visits
Level 1 (2 points)	Weekly home visits
Level 2 (1 point)	Every other week home visits
Level 3 (.5 point)	Monthly home visits
Level SS (add 1 point)	Temporary need for more frequent home visits
Level 4 (.25 point)	Quarterly home visits
Level CO (.5 point – 2 points)	Creative Outreach (engagement activities) case weight determined by level family on prior to CO.
Level TO (.5 point – 2 points)	Family plans to be temporarily out of the area and unavailable for in person or virtual visits up to 3 months. (Sites maintain a family's case weight while on Level TO equal to the family's level prior to being placed on creative outreach to ensure space is retained to move family back to that level if re-engaged)
Level TR (.5 point)	Temporary re-assignment to another staff person during extended staff leave or turnover up to 3 months when family is not receptive or able to receive visits at previous frequency. If family is receptive and able to continue receiving services at

the frequency associated with previous level, then the level and case weight would not be changed to TR.

Prenatal Levels:

- Sites may move families from weekly to every other week visits (Level 1P to Level 2P) at any time during the pregnancy period, based upon families' needs when enrolled prior to the third trimester, with the intention of assuring that expectant parents receive at least 7 visits during the prenatal period.
- If a family enrolls services at 31 weeks gestational age, offering weekly visits is required to assure that at least 7 home visits occur during the prenatal period.
- When baby(ies) is not released from the hospital after birth (e.g., is placed in NICU), supervisors and Home Visitors may use contextual decision making to determine which level to place the family on pending baby's discharge. Potential levels include Level 1, Level TO, or Level CO.
- When gestational age is not known, supervisors and Home Visitor staff may use contextual decision making to determine when to start recording CHEERS. Once gestational age is established by medical professionals, sites should follow the existing CHEERS requirements.

Creative Outreach (.5 point - 2 points):

- Points are maintained at the last current level while on CO (for example: Family on level 1 (2 points), moved to CO (2 points).
- There is no maximum number of times that a family can be placed on Level CO.
- This decision is a contextual decision between the Supervisor and the Home Visitor.
- When families miss one scheduled visit, reaching out to re-connect with that family begins immediately. When staff successfully reschedule a visit and that visit is also missed (i.e. 2 missed scheduled visits), families are placed on Level CO and backdated to the date of the first missed visit. If the Home Visitor has made multiple efforts to reschedule with the family, and is unsuccessful, the family is also then placed on CO and backdated to the first missed visit.

Temporary out of Area Level (.5 point - 2 points):

- This level applies to families who are temporarily out of the service area for work, family or other issues but who still want to remain in the program.
- Please note that placing a family on Level TO after 2 weeks for Level 1 families when a family is out of the area is optional as changing levels frequently can be difficult to manage.
- It is limited to 3 months, however supervisors do have the ability to extend the use of this level keeping in mind that extended absences will impact the outcomes and services for the family, as well as staff productivity and the ability to enroll new families.
- No home visits are required while on this level.

Temporary Re-Assignment Level (.5 point):

- Level TR clarifies the expectation for sites to offer continuing services to families when a staff member is on temporary leave or while the site is hiring new staff.
- Please note that placing a family on Level TR after 2 weeks for Level 1 families when a Home Visitor is out is optional as changing levels frequently can be difficult to manage. This is a temporary level and a permanent decision must be made once a family has remained on Level TR for 3 months.
- While HFA is aware how difficult it can be for all sites to continue regular home visits for families when staff leave and recognize that completing home visits during this timeframe can be particularly difficult especially for smaller programs, HFA has always focused primarily on meeting the needs of families rather than the needs of sites.
- Level TR is utilized when a family is not receptive or able to continue receiving services at the frequency associated with previous level. However, when family is receptive and able to continue receiving home visits consistent with previous level then they should remain on that level and weight versus moving to TR.

- Level TR is meant to guide practice when sites are not able to meet the home visiting frequency that the families are assigned. Possible strategies that sites can use to cover Home Visitor absences:
    - Supervisor picks up some of the re-assigned families using the 2 hours per week normally allotted to supervision of the absent/departed Home Visitor
    - Screeners, interns or other agency staff can be trained with Orientation and Stop Gap Home Visitor Training to provide home visits
    - Part time Home Visitor can be offered additional hours

Special Service Status Level (1 point added to current level on a temporary basis):

- There may be times when families gain new skills, make progress and move to a less intensive service level yet later experience temporary setbacks. Supervisors and Home Visitor staff will determine whether service intensity should be temporarily increased using the SS Level process or whether a more permanent increase in service intensity should be applied (moving family to previous service level, e.g., from Level 2 to Level 1).
- Level SS is a temporary level that is limited to families that have need for special services that are more intense than the current level they are assigned to, typically for less than 3 months. This is a contextual decision between the Supervisor and the Home Visitor. This allows Level SS to be applied for truly "special services" and may be offered temporarily while still accounting for space within current caseload capacity.

Add-on Points (.5 to 1 point):

- Supervisors may use discretion to assign higher case weight points (adding .5-1 point) on a permanent basis for families with ongoing circumstances that need extra time from the Home Visitor to plan for and/or conduct regular visits. This includes but is not limited to: multiple births, extensive travel to reach the family, ongoing translation needs, parents with intellectual or developmental disabilities.
- When determining service intensity for families sites have discretion to add .5 to 1 point(s) for families based upon the amount of extra time required. If travel, translation, connections with other agencies requires an extra 30 minutes per visit, sites may add .5 points. If these activities require an extra one hour per visit, sites may add 1 point.

Insert how your site plans to actively monitor the use of add-on points. If your site does not use add-on points, specify N/A:

Level Change Tracking Requirement

Sites with use *HFO Level Change Tracking* form to track level changes throughout the course of services. *HFO Level Change Tracking* form will be kept in the Supervision Binder at a minimum and optionally in the Family File.

Optional HFA Level Certificates

- *HFA Level Certificate* has space for Home Visitors to add specific comments and truly celebrate with the parent(s) accomplishments and successes they have had (though this form is optional, if used and a copy is maintained in the family file, will replace the need to document level change discussion in the *Home Visit Record*).
- The *HFA Level Certificate* can be used to document that the required items under 'Parent Achievements' have been accomplished and offer staff a way to celebrate these accomplishments with families. There is no need to document specific dates for when parents accomplish these as this documentation can now be provided with the fillable certificates.
    - Home visiting staff are to give one copy to parent(s) and keep one copy in the family file.
    - Home visiting staff are encouraged to vary comments and to uniquely highlight the specifics for each parent.
    - Home visiting staff are encouraged to use the ATP structure for "celebrations" and include how each accomplishment will impact the future.
    - Since these certificates are optional, sites may choose to continue to document discussions of parent progress with parents on the Home Visit Record.

Review of Family Progress

Family progress is the basis for deciding to move the family from one level of service to another. As Supervisors and Home Visitors review parent progress using the *Level Change Forms*, the date each item was achieved will be noted under each area that states "Date Reviewed." *This date references the date that parent progress in that area was reviewed by the Supervisor and the Home Visitor and assists in determining parent readiness for a level change, based upon progress.* No additional documentation is required to demonstrate the supervisor and Home Visitor review of level change progress, when all required parent criteria are dated, and forms are signed by both the Home Visitor and Supervisor. Progress is reviewed by the Home Visitor and Supervisor prior to changing service levels. Supervisors know and understand the specific experiences each family faces. As such they have discretion, in partnership with their home visiting staff to make the final decision about whether a level change occurs or not (contextual decision-making).

Once the Supervisor and the Home Visitor agree a family's progress indicates readiness for movement to a less intensive service level, the Home Visitor reviews this progress and achievements with the family, and this serves as the basis for the decision, and agreement by the family, to move the family from one level of service to another. Level discussions with the family are documented on either the *Home Visit Record* or the *Level Certificates*, detailing the progress and achievements the family has made. If the *Level Certificate* is used, a copy will be made and put in the family's file before giving the family a copy. If the *Level Certificate* is NOT used, progress discussions and level changes are documented on the *Home Visit Record*.

Family progress is reviewed on an ongoing basis to determine if a family should move from one level of service to another. Service levels are not changed in response to barriers to full participation. These barriers may include the need for early morning, evening, or weekend visits, the need for translation at each visit, staffing issues, etc. Level change decisions are not made based on site needs, personnel issues or the age of the child.

See 4-3.A for information regarding families ending services that do not yet meet current level/graduation criteria.

Parent Group/Playgroups: Level 1 Requirement

A parent group meeting or playgroup may substitute for one home visit per month only if the family is on level 1. If counted as a home visit, a Home Visit Record is required to be written (with some areas of CHEERS observed and documented). These groups may count as home visits if:

- A Home Visitor is present
- The Home Visitor interacts with the family individually as well as in the group
- It is clearly documented on the *Home Visit Record* the visit occurred as part of a group
- Individual parent-child and group interactions are recorded on the *Home Visit Record*, including documentation of the items within the CHEERS assessment that were observed
- The interaction at the group meeting meets the definition of a home visit (see Glossary)

Please note: Groups can be formal or informal, and may be as small and simple as a "joint home visit" or "play date" with one or more Home Visitors present. Supervisors, Assistant Program Managers or Program Managers who are fully trained in Home Visitor duties and have received all current core training content may serve as Home Visitors in the group setting.

Insert parent groups/playgroups that your site currently hosts. If not specify, N/A:

Home Visit Definition

A home visit is defined as 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 home, last a minimum of an hour and the child is present. Circumstances may occur where visits take place outside the home, are of slightly shorter duration than an hour, or occur with the child

not present. These may be counted as a home visit if the overall goals of a home visit and some of the focus areas (listed below) have been addressed:

Promotion of nurturing parent-child interaction/attachment:

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

Promotion of healthy childhood growth & development:

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

Enhancement of family functioning:

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

In special situations such as when severe weather, natural disaster or community safety advisory impedes the ability to conduct an in-person visit with a family, a virtual home visit (via phone or preferably video platform), can be counted when documented on a *Home Visit Record* and the goals of a home visit are met including some of the focus areas (see above).

Documenting Home Visits

Each home visit is documented using the *Home Visit Record*. **All Home Visit Records and/or additional contact documentation (Contact Logs, etc.) are written within two (2) working days of contact with families. All Home Visit Records are required to be signed and dated by the Home Visitor and supervisor, according to the date it was completed and the date it was reviewed.** No more than one home visit per day is allowed per family.

Documentation of all additional contact with families is required (e.g., phone calls, texts, and letters) using an appropriate form (i.e. Contact Log, Progress Note).

Insert how your site monitors the timeliness of Home Visit Record completion:

Insert your site's procedure to address increased support for Home Visitors who are struggling with timely documentation (for example: supervisory monitoring, the use of the Home Visitor Development Plan, progressive discipline policies, etc.):

Home Visit Completion

Seventy-five percent (75%) of families receive at least seventy-five (75%) percent of the appropriate number of home visits based upon the individual level of service to which they are assigned. Home visit completion percentages are designed by HFA to account for situations when staff and/or family may not be available due to illness, vacation, training, etc. HFO Home Visit Completion reports are created each month by entering all home visits into the *HFA Spreadsheet: Tracking Home Visit Completion and Caseload* monthly.

Site Monitoring: Home Visit Completion

Supervisors are required to formally review quarterly HVC rates with Home Visitors, celebrating rates above the threshold and discussing exceptions, reasons, and problem-solving strategies to increase completion rates when below 75%. It is encouraged to review HVC rates monthly, especially if a Home Visitor needs additional support in this area. Supervisors document quarterly HVC rates and discussions on the *General Weekly Supervision* form. HVC rates for each Home Visitor are also documented annually on the *Annual Supervision Tracking Tool* for each Home Visitor. See QA Activities in 12-2.B for detailed HVC review information.

Program Managers will monitor site home visit completion on a quarterly basis (more often, if needed), communicate and problem solve with Supervisors, determining/addressing patterns and trends using the *HFA Spreadsheet: Tracking Home Visit Completion and Caseloads* (4-2.B, 4-2.C, and 8-1.B). These spreadsheets are used to complete the Quarterly Outcome Reporting SmartSheet and sent to Central Administration for tracking and monitoring home visit completion, caseload points, and number of families served. These reports are reviewed by the Home Visitor, Supervisor, Assistant Program Manager and Program Manager.

When tracking data over multiple quarters, determination of patterns and trends related to home visit completion and caseload weight can be identified. Strategies to improve home visit completion and caseload weight, based on information from site monitoring over four consecutive quarters may become a part of the sites *Quality Assurance Plan* or *Quality Improvement Plan*. This in no way precludes a site from taking earlier and more timely action when needed to correct a staffing or policy issue, or other situation requiring immediate action.

Home Visit Completion (practice)

4-2.B Sites use the *HFA Spreadsheet: Tracking Home Visit Completion and Caseloads* (4-2.B, 4-2.C, and 8-1.B) to monitor and discuss home visit completion and caseload points.

Insert local procedures describing who enters home visit completion and caseload data into the *HFA Spreadsheet: Tracking Home Visit Completion and Caseloads* monthly:

Insert local procedures for Program Manager monitoring home visit completion and caseloads on a quarterly basis for Quarterly Outcome Reporting SmartSheet sent to Central Administration:

Essential Standard

Level Changes in Supervision (practice) ESSENTIAL STANDARD

4-2.C HFO sites ensure that family's progress (as identified on completed HFA Level Change forms) to a new level of service is reviewed and agreed upon by the Family Support Specialist and Supervisor prior to moving a family from one level of service to another and is based on family progress.

Level Changes with Families (practice)

4-2.D Each family's progress (as identified on HFA Level Change forms) to a new level of service is reviewed by the Home Visitor and Supervisor, discusses with the family the change to visit frequency based on progress and celebrates family and serves as the basis for the decision to move the family from one level of service to another as stated in HFO Policy 4-2.A. Use of HFA Parent Certificates is encouraged.

4-3

HFO sites offer services to families for a minimum of three years.

Services for a minimum of 3 years (policy)

4-3.A Home visiting services are offered for a minimum of three years after the birth of the baby or three years after enrollment (whichever is later) and up to five years as needed and at the discretion of the Program Manager/Assistant Program Manager. Families who are participating in HFO services will not be exited from the program due to programmatic issues such as staff turnover.

Program Completion

A family's program completion from services is defined by a final home visit (and documentation of the last home visit on the *Home Visit Record*) occurring on or after receiving 3 years of home visiting services after the baby is born or after baby is enrolled, whichever comes later. For sites implementing Child Welfare Protocols, sites ensure services are offered for a minimum of years after enrollment (rather than the birth of the baby).

The Home Visitor, with the support of the Supervisor, works with the family to transition out of the program (see 4-4.A for transition planning) and to build their system of formal and informal supports before this time and up to program completion. Efforts are made to decrease the frequency of visits over time as the criteria for level changes are met to avoid fostering dependence. These efforts are documented on the *Home Visit Record*, and the *Family Progress Review.*

If a family should choose to leave services prior to three years of service, staff will determine if the family has met the criteria for HFA's Successful Completion of Program using the HFA Level form and acknowledges the family as having completed.

Families may still be on Level 1 or 2 when program completion occurs between 3 to 5 years. Home Visitors and Supervisors can support these families through a strong transition plan to ensure they are connected with other community resources once HFO services are discontinued. While these families would not meet the "completion of services from Level 3 or 4" criteria at the time of ending services, sites are encouraged to celebrate final home visits with all families, acknowledging

the commitment they made to themselves, their children and family by remaining connected to services for such an extended period.

Services for a Minimum of 3 years (practice)

4-3.B Practice shows that HFO services are offered through a minimum of three years after the baby is born or after enrollment (whichever comes later).

4-4

HFO sites ensure that families planning to discontinue or close from services have a well thought out transition plan.

Transition planning (policy)

4-4.A When a family prepares to end services (whether due to program completion, planned move out of the service area, etc.), transition planning efforts that involve the family, Home Visitor, and Supervisor, will be made to ensure a successful transition. This is documented on the *Home Visitor Plan-Transition Planning*.

Transition planning begins well in advance of the focus child reaching at least 3 years of home visiting services (3-6 months before the child's graduation date, if applicable). This provides sufficient time to plan the transition with the family. Transition planning will be required for any families that provide notice of leaving, at least three months prior to closure (circumstances leading to an unplanned or unexpected closure, or a planned closure with less than three months' notice would not be held to the standard, though the site is encouraged to provide as much support as possible in these situations).

Activities during this transition planning include:

- Documentation of a transition plan includes reason for planned closure and date the discussion was initiated with the family, or date family declined a transition plan, and date of planned closure.
- The family, Home Visitor, and the Supervisors are involved, though not required to be present at the same time,
- Sufficient time is allotted to conduct the plan (typically 3-6 months prior to transition),
- Resources or services needed or desired by the family are identified,
- Steps are outlined to obtain any identified resources or services,
- Prior to closure the site or family (based on family preference) follows-up with identified resources to determine availability and assist with successful case closing transition.
- All transition planning activities completed during home visits are documented on the *Home Visit Record* (discussions with the family) and the *Home Visitor Plan: Transition Planning*, and *Family Progress Review* (discussions between Supervisor and Home Visitor) including any decline of services and/or referrals.
- Following initial discussion, the topic of transition planning should be included in most discussions with the family at subsequent home visits, including identification of available resources/services needed or desired.

Examples of Formal/Informal Supports for Transition (based on family preference)

- Preschool
- Head Start
- Therapeutic Classrooms
- Community playgroups
- Church community activities
- Literacy programs
- Support Groups

Some circumstances leading to an unplanned closure will not be held to the policy:

- Planned closure that is less than 3 months
- The family has been on Creative Outreach for 3 months or more and has not re-engaged
- The family requests discontinuation of services
- The family moves out of the program's service area (and does not transfer to another Healthy Families Oregon site) without providing notice
- The focus child is no longer in the home and reunification is not planned
- The Home Visitor's safety is at risk

Transition planning (practice)

4-4.B HFO sites conduct transition planning according to the HFO Policies and Procedures in 4-4.A to support families discharging from services.

STANDARD 5: STAFF (MANAGERS, SUPERVISORS, AND DIRECT SERVICE STAFF) CELEBRATE DIVERSITY AND HONOR THE DIGNITY OF FAMILIES AND COLLEAGUES BY EDUCATING AND ENCOURAGING SELF AND OTHERS, CONTINUOUSLY STRIVING TO IMPROVE RELATIONSHIPS. SITES WORK WITH OTHERS IN THEIR ORGANIZATION AND COMMUNITY TO IDENTIFY AND ADDRESS EXISTING BARRIERS AND INCREASE ACCESS TO SERVICES, ESPECIALLY FOR UNDERREPRESENTED GROUPS IN THE COMMUNITY, CONFRONTING DISPARITIES CAUSED BY INSTITUTIONAL RACISM AND DISCRIMINATION

HFA Standard 5 Intent *ensures each site is intentional in its efforts to promote equity in all facets of operations with families, staff, and community. Doing so compels an honest look at existing flaws, individually and systemically, exposing and resolving blind spots previously unrecognized.*

This level of intentionality allows us to listen and learn from the lived expertise of others, and to recognize how implicit bias and power imbalance impair authentic relationships. By examining and gaining greater clarity related to the causes of these and other challenges associated with long-standing health and social disparities, we are more likely to effect change through our advocacy, ally ship, and meaningful dialogue with one another.

This work is hard, complicated, and at times uncomfortable. There is no quick fix and no one is exempt. It requires sustained, long-term, individual and organizational commitment. It is a unique and continuous journey we all must engage in. It involves an ongoing commitment to increasing one's self-awareness.

5-1

Through policy and practice HFO sites support staff's ability to continually strengthen the skills required for authentic relationships, including self-awareness, self-regulation, skilled listening and empathy.

HFA Intent:

Taking an honest and reflective look inward increases awareness and understanding of our biases, offering us an opportunity to be intentional in our efforts to counteract these. Being afforded safe space in supervision, team meetings, and peer-to-peer interactions enables greater likelihood for honest, respectful, and brave conversations. Recognizing the distinction between intent and impact, as well as the importance of repair, facilitates stronger relationships. These are the building blocks upon which growth and change become possible

Staff Interactions (policy)

5-1.A In order to ensure HFO staff have the resources needed to continually strengthen relational skills, the site develops team commitments or ground rules to provide guidance for authentic team interactions. Team commitments or ground rules are reviewed with all new staff during orientation, regularly and throughout the course of employment. Revisions to team commitments or ground rules are made as a team, at least annually or more often as needed or desired.

All HFO sites receive training focused on diversity, equity, and inclusion to strengthen their relational skills. This training will be tailored to the individual staff's needs and may include activities such as in person trainings, on-line webinars, conference presentations, independent readings, and podcasts. Training title, method of training and date received, will be documented on the HFO ongoing training log and the training topic will be discussed in supervision. Staff use time during

team meetings to reflect on and discuss lessons learned through professional development opportunities such as trainings, conferences etc.

All HFO staff will receive regular supervision (frequency and duration specific to their role) that supports staff in developing their relational skills including self-awareness, self-regulation, self-reflection, skilled listening and empathy. Supervisors use reflective practice to strategize new ways to relate to a family based on their unique characteristics. Supervisors encourage staff to keep a confidential, self-awareness journal to reflect on their personal growth focusing on diversity, equity, and inclusion.

Insert description regarding how your site plans to create, share, and review team commitments:

Insert local description regarding how your site plans to in ensure accordance to HFO policy 5-1.A that all staff have the resources needed to strengthen their relational skills focused on diversity, equity, inclusion and belonging using both professional development and supervision expectation:

Staff Interactions (practice)

5-1.B HFO sites' practices support a respectful team environment and staff ability to continually strengthen their relational skills in accordance with 5-1.A.

5-2

Through policy and practice HFO sites support the development of a partnership with families that honor diverse family structures and the sources of strength derived from family cultures, values, beliefs, and parenting practices. Practice also recognizes the historic and current relevance of discrimination based on race, ethnicity, gender identity, sexual orientation, age, religion, and abilities and seeks inclusivity in all aspects of its work with families.

HFA Intent:

Cultural humility is not what one knows of another person's culture, though a certain level of foundational knowledge can be helpful. It is instead how we are in allowing another person to share their own story which reflects their identity, experiences, background, values, and beliefs. Allowing parents to teach us of their culture, and being observant and accepting of behaviors, attitudes, and beliefs that may be different from our own, reduces the risk of making faulty assumptions, and helps us evolve our own humanness.

Direct service staff observe cultural differences and use them as a springboard for inquiry and understanding, asking families about particular behaviors and practices. Family background and ethnicity influence value systems, how people seek and receive assistance, and communication style among other things. When staff express curiosity with open-ended questions, are non-judgmental, refrain from imparting their own belief and value systems, and seek to repair relationships when missteps occur, families and staff have an opportunity to grow and develop greater reflective capacity we all must engage in. It involves an ongoing commitment to increasing one's self-awareness.

Family Partnership (policy)

5-2.A HFO sites will engage in a partnership with families to elevate family voice that honors the family's unique background, allow the family to share their own story and provide a space for parents to teach us about their culture and values.

All home visitors complete Rights & Confidentiality form with all families at the onset of services and explain to families the site's commitment to forming a partnership with them that honors their diverse family culture as defined by them.

Home Visitors express curiosity with open ended questions, are non- judgmental, refrain from imparting their own belief and value systems and seek to repair relationships when missteps occur. Home Visitors engage in reflective conversations with families to learn more about what is important to the family and use tools provided in HFA Home Visitor core training such as; *Values Cards activity* or *Wishes for My Child worksheet.*

Supervision is used to reflect on their own beliefs and values and reflect on how these may differ from the families they serve. Supervision is used to process and identify gaps in knowledge of other cultures, help understand one's own limitations, and to discover new ideas and behaviors that are healthy, respectful and safe.

HFO staff will engage in professional development activities that increase awareness of the historic and current relevance of discrimination based on race, ethnicity, gender identity, sexual orientation, age, religion, and abilities. This includes HFA wraparound training and ongoing annual training.

To intentionally elevate family voice, families are given opportunities to share their experiences partnering with staff. This includes conversations during home visits, quality assurance calls, family satisfaction surveys, focus groups, etc.

Insert local description regarding how your site plans to in ensure accordance to HFO policy 5-2.A partnering with families, elevating parent voice and honoring diverse family structures, values, belief, and parenting practices:

Family Partnership (practice)

5-2.B HFO sites' practices engage families in partnership, elevating family voice and honoring family diversity.

5-3

The site works at the community level, through policy and practice, and with guidance from its community advisory board, as a champion for families and children, advocating for just and equitable opportunities within the community, increasing access to services and supports for those it serves and employs.

HFA Intent:

Racial and ethnic minorities, and other underrepresented groups, face barriers in accessing services within their communities. Organizations within communities have a responsibility to utilize their influence and decision-making in ways that identify and address structural inequities brought about by privilege and discrimination. This includes actions taken both internally (in support of the organization) and externally (in support of the community).

Additionally, it is the site's responsibility to identify major cultural groups within the community, determine groups currently underserved, and prioritize hiring staff who represent these groups and can provide support in the family's preferred language. Sites will also make sure that, in addition to staff, graphics and materials are representative of the community.

Community Level Advocacy (policy)

5-3.A HFO sites are committed to advocating for staff and families to promote equity and address barriers. HFO Leadership teams work with their Community Advisory Board and other community partners to:

- Identify and address existing barriers,
- Increase equitable access to services,
- Assist leadership to ensure diverse representation in staff and materials to meet the cultural and language needs within the community, and to
- Work to establish Diversity Equity and Inclusion (DEI) policies and procedures to dismantle systemic inequities

HFO leadership at local sites and the Community Advisory Board annually review and monitor efforts undertaken at the community level to identify and address existing barriers, increase equitable access to services, ensure diverse representation in staff and materials, and/or meet the cultural and language needs within the community for those it serves and employs. This may be incorporated in the site's equity plan.

HFO Staff and families have opportunities every two years to provide feedback about their experiences related to barriers to obtaining services and representation in staff/material. This may be provided through satisfaction surveys, focus groups, provision of parent councils, etc. In addition to providing input regarding language and material needs, questions will also include how culture is considered in its personnel practices, hiring, promotion and organization- wide policies and procedures. As applicable, this may be incorporated in the site's quality assurance plan and family input provided for Standard 5-4.A.

Insert local description regarding how your site plans to in ensure accordance to HFO policy 5-3.A advocating within your community to identify and address barriers, increasing equitable access to services, ensuring diverse representation in staff and materials, and/or meet the cultural language needs of families and employees:

Community Level Advocacy (practice)

5-3.B HFO sites' practices demonstrate its commitment to working at the community level to address barriers and promote equity for those it serves and employs.

5-4

The site utilizes data to reflect on and better understand issues impacting families served and to examine the effectiveness of its equity strategies implemented in the course of delivering HFA services. These strategies will vary from year to year and may be related to family engagement and retention, staff engagement and retention, and the site's efforts associated with standards 5-1, 5-2, and 5-3.

HFA Intent:

It is critical for sites, in their efforts toward continuous quality improvement, to receive and utilize feedback from families and staff (including those involved in services and those who have discontinued their involvement in the past year). When families and staff provide their observations and experiences, it can illuminate areas which would benefit from additional training or support, as well as highlight particular areas of strength or staff skill, and help identify ways in which the site can advance its work to achieve greater equity in service delivery and systems change

Family and Staff Input

5-4.A HFO sites ensure parent/caregiver voice and staff input is sought, obtained and incorporated in effort so plan and improve on its ability to provide culturally respectful and responsive services, including input from those who have discontinued their involvement.

HFA Intent:

Utilizing an organizational self-assessment tool allows a site the opportunity to reflect on the status and progress it is making to promote equity. Most importantly, it assists the site in focusing on particular areas where there is opportunity for growth. The identification of these areas and corresponding strategies for improvement are the basis of the site's equity plan. The equity plan provides an opportunity to identify strategies to combat implicit bias, address barriers, and work to dismantle the causes of disparity and inequity. There are a number of equity focused organization self-assessment tools available to the general public.

Essential Standard

Equity Plan ESSENTIAL STANDARD

5-4.B HFO sites develop an equity plan based on what the site learns about itself, from an equity perspective, in the way it supports staff, families and the community it works within. The equity plan sets a course for continuous improvement for the site. Strategies are created and acted on, and are reviewed annually. If the site's Equity Plan is informed by a separate agency equity assessment, the site must find a way to disaggregate their program data to inform their Equity Plan.

Equity Plan Review with the Community Advisory Board

5-4.C HFO sites enlist the Community Advisory Board at least annually to review the equity plan and progress associated with the strategies identified. Equity strategies are revised based on input and feedback received and lessons learned.

STANDARD 6: SERVICES FOCUS ON SUPPORTING THE PARENT(S) AS WELL AS THE CHILD BY CULTIVATING THE GROWTH OF NURTURING, RESPONSIVE PARENT-CHILD RELATIONSHIPS AND PROMOTING HEALTHY CHILDHOOD GROWTH AND DEVELOPMENT WITHIN A CARING COMMUNITY.

HFA Standard 6 Intent *is to reduce risk factors and build protective factors, ensuring site staff provide services that are family-centered and growth oriented; supporting parents in nurturing their children; setting meaningful goals; and enhancing health, development, and family functioning.*

HFA employs an infant mental health approach in which services are relationship-focused, strength-based (building on parental competencies), and culturally respectful and responsive, and are anchored to the parallel process.

Healthy Families sites serve many families who are struggling with issues including substance abuse, intimate partner violence, developmental delay in parents, depression, and other mental health challenges, some of which may be an effect of early childhood trauma, multiple other life stressors, and institutionalized racism and systems of oppression that have limited equitable access to financial stability, housing stability, quality education, employment opportunity, health care, transportation, and nutrition. In order to address these challenges, site staff: 1) form healthy relationships with parents, 2) apply a strength-based empowerment approach that includes being honest when parents are responding to their environment in ways that may cause harm to themselves and their children, 3) accept families where they are, without judgment or bias, 4) build on parental competencies, and 5) focus on learning about the individual's lived experience and means of coping versus judging behavior as "right or wrong." These principles are core HFA components.

6-1

Risk factors and stressors identified from the FROG Scale are discussed and addressed initially and during the course of home visiting services at all HFO sites.

HFA Intent: *A well-constructed Service Plan is the cornerstone of home visiting services that are effectively organized and coordinated and is based on each family's unique strengths and areas of concern. A Service Plan operationalizes the family "story" into a "road map" that supports Family Support Specialists in their ongoing and long-term work with the family, and is the mechanism by which supervisors document their clinical support to staff that is specific to each family.*

A Service Plan is fluid and dynamic in order to remain relevant to the family as changes to family systems, circumstances, and dynamics occur over time. As such, service priorities also are likely change over time and a Service Plan helps to manage and "visualize" the complexity of change and the re-prioritization of activities that result. A Service Plan ensures issues identified by the family can be systematically addressed and supported in partnership with parents, without interfering or compromising the family's choice in regard to goals they are motivated to achieve. Family goal setting is a distinct and separate activity and is discussed in Standards 6-2.

HFO Service Plan (policy)

6-1.A The Supervisor and Home Visitor work together to develop an *HFO Service Plan* for each family that participates in services. This plan includes developing activities/strategies to address how to approach the family's challenges/risks and build protective factors. Activities will reflect a thoughtful, purposeful discussion that assists the Home Visitor in understanding how early childhood trauma and the stressors experienced by the family impact their parenting. Discussions with the family will acknowledge and build on strengths (protective factors) and guide the Home Visitor's strategies to support the family. This plan should support Supervisors in guiding discussions.

An *HFO Service Plan* will be created in supervision with the Home Visitor for each family when the FROG Scale is initially reviewed (see Standard 2-1 for detailed information). This does not mean that it is filled out in entirety, but at a minimum, the risks and strengths, as observed in the assessment with the family, are discussed and entered on the form. Home Visitors and Supervisors will prioritize and pace activities developed in the service plan with regard to safety concerns, immediate needs, and essential parent child interactions that are necessary for fostering the crucial bonding and attachment period in the baby's early life. Prioritization and pacing of these activities will occur to support their successful completion so as not to overwhelm the home visitor or family. Other risks that are disclosed or identified over the course of services will be added to the HFO Service Plan.

The minimum requirement for documenting review and progress of the Service Plan between the Home Visitor and Supervisor is as follows:

- One time a month while on Level 1, 1P, or SS
- Every other month for families on Level 2 or 2P
- Evey other month for families on Level 3

The HFO Service Plan will be kept in the Supervision Notebook under the family name. If each supervisor documentation is dated on the service plan, only the box on the Family Progress review ("HFO Service Plan") needs to be checked. It is beneficial for the Home Visitor to have a copy of activities and strategies to implement per the Service Plan, or to have access to the Service Plan.

Implementation of Service Plan Activities

The Home Visitor and family will work together to implement the activities on the *HFO Service Plan*, initially and ongoing throughout the course of services. This occurs with all families to address all risk factors/stressors and challenging issues (from FROG Scale and subsequent to FROG Scale), ensuring that families are offered ongoing opportunities and support to make positive, healthy changes in their lives. Concerning parent-child interactions, immediate needs, and safety concerns will be prioritized first.

Home Visitors will implement activities, addressing risk factors/stressors, parent/child attachment concerns, challenging issues (such as substance abuse, intimate partner violence, cognitive impairment, and mental health issues) by focusing on building protective factors to strengthen families using the following strategies:

- Use of Reflective Strategies
- Use of specific curriculum
- Parent-child activities that create focus on the child and bring joy to the parent(s)
- Healthy coping activities
- Collaborating with other supportive agencies that are involved
- Referrals to appropriate community agencies
- Wishes for My Child, Family Values Activity, Concerns and Referrals connections
- Building a healthy, safe relationship with the parent(s) based on acceptance so that they can provide honest feedback with the parent's permission
- Using motivational interviewing techniques
- Utilize other screening tools to determine if outside services are necessary

- Encouraging forward thinking by assisting the parent in developing a vision of what they want
- Anchor to parents' values and dreams for their children
- Build on strengths and protective factors
- Offer decision making strategies such as pros and cons
- Pointing out discrepancies between stated values and actual behaviors
- Utilizing reflective supervision to receive support and prevent burnout

Home Visitor Documentation of HFO Service Plan

Home Visitors are required to document all *HFO Service Plan* activities/strategies implemented and discussed with the family on the *Home Visit Record*, clearly demonstrating implementation of activities and strategies, and follow-up to the intervention.

Family Concerns & Referrals Form

Initial risk factors/stressors/challenging issues that were identified in the FROG Scale will be reviewed with the family using the *Family Concerns and Referrals Form*. This form is completed within the first six home visits. This tool is used as a conversation piece after FROG Scale administration is completed with the family and gives the Home Visitor and family an opportunity to review the concerns noted on the FROG Scale. It also aids in encouraging families to understand that the Home Visitor can support them throughout the course of services in the areas that they want support with, taking into account changing family dynamics and a parent's motivation, as well as 'treatment readiness,' or their openness to reach out for professional support, if needed. The conversation that Home Visitors have with the family concerning their needs is the foundation to start addressing the risk factors on the FROG Scale as well as family goals.

Working with Families in Acute Crisis
HFA has developed procedures for Working with Families in Acute Crisis (available through this link or on the HFA website in Network Resources) which can be used to address psychiatric emergencies, suicidal/homicidal ideation, and domestic violence issues. These procedures can aid in clarifying staff roles and responsibilities, and provide a guide to helping families in acute crisis, while possibly decreasing staff trauma and reducing the risk of burnout.

List your site procedure for responding to critical incidents such as psychiatric emergencies, suicidal or homicidal ideation, or domestic violence. List any forms that are utilized to document the crisis:

HFO Service Plan in Supervision (practice)

6-1.B Supervisors and Home Visitors follow procedures of reviewing all FROG Scale risk factors, challenging issues initially and when identified later in services in accordance with HFO Policy 6-1.A.

Essential Standard

HFO Service Plan with Families (practice) ESSENTIAL STANDARD

6-1.C Home Visitors implement the activities and strategies identified on the *HFO Service Plan*, during initial home visits and over the course of a family's enrollment as stated in HFO Policy 6-1.A.

6-2

The family goal process assists in the development of home visit activities, the identification of resources, and the successful achievements that build a family's resiliency and promote protective factors using family-centered practices.

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

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

Development of Family Goals (policy)

6-2.A The Home Visitor and family collaborate to set meaningful goals to help parents increase creative problem-solving skills, empower them, build protective factors, and experience success in the process of developing and working on goals.

HFO Activities Completed Prior to Family Goals

Because the goal setting process takes time to understand and may be the first time that a family has created a goal, the following activities will be completed *first* to encourage discussions about what they want for their family, think about strengths and needs, and assist them in identifying goals:

- *Family Concerns and Referrals Form* (See 6-1.A)
- *Family Values Activity*
- *Wishes for My Child Activity*

The *Family Values Activity* is required to be completed within the first 45 days of service (or the 4th home visit) and helps the family identify strengths and think about what they want for their family, including possible goals. As families may not fully understand or recognize their values, this activity is guided by the Home Visitor during the home visit, encouraging the family to explore and/or identify different beliefs. Home Visitors utilize the *Family Values Activity Cards* with the family during this activity.

The *Wishes for My Child Activity* is required to be completed within the first 60 days of service (or within the 6th home visit). This activity is guided by the Home Visitor during the home visit, encouraging the family to explore and/or identify what the family may want for their child. This activity can produce rich discussions for future goals for their child and family.

Completing these activities, as well as discussing areas in the FROG Scale, the Home Visitor and family work together to identify what is important to the family and offers the family opportunities to explore their strengths, build protective factors, and consider how these strengths can support parent goals as preparation for the family goal process.

The family goal process with families:

- Based on what is most important to the family, the Home Visitor and family collaborate to develop an initial family goal within 60 days of the first home visit.
- Home Visitors will support families in goal setting activities throughout the course of services.
- Home Visitors will take into consideration family needs, cultural ideologies, and family concerns when supporting families with their goals.
- Steps within each goal will have a focus date or projected date of completion for accomplishing the steps (smaller timeframes, for example, within one month, ensures that the Home Visitor and family have broken larger goals down into manageable steps, with the help of the Home Visitor).
- Once the goal is developed, Home Visitors will work with families to help them identify family strengths for, and resources specifically related to, accomplishing the goal, including encouraging utilization of those strengths to overcome barriers that arise.
- Home Visitors will celebrate successes with the families when accomplishing mini-steps within the process to meeting the goal, as well as celebrating the actual goal being achieved.
- Home Visitors will work with the family to develop new goals when the previous goal is accomplished or when a goal may no longer be relevant, or when they wish to retire a goal. Focus dates or projected dates of completion facilitate opportunities to reflect and discuss with families deciding if a goal is no longer relevant and they feel ready to change their goal to a different one.
- Discussions of the family goal process (new goals, strategies, activities, celebrations, etc.) with families will be documented on the *Home Visit Record* at least every 30 days after the goal is created. A critical component of goal accomplishment is supporting parents by keeping the goal "alive" through regular discussions, activities and provision of resources to keep families participating in the process (preferably most visits).

Home Visitors will use and document the following mechanisms to help families create a goal and support their progress:

- Use motivational interviewing to assist parents in choosing goals with the greatest meaning to the family
- Break down larger goals that families are interested in into smaller, achievable goals. A goal such as, "I want to get my GED," is a great goal, however, it might be more achievable if a Home Visitor asks, "What can you do in the next two weeks to get your GED?" This may translate that larger goal into, "I need to find a ride to the GED prep classes." This goal is achievable much sooner and gives the family something to celebrate when accomplished. Their next goal may be to complete the prep classes.
- Utilizing Reflective Strategies for barriers/problem-solving
- Use the family goal worksheet as a working document
- Remember that your ability to support a family to learn how to break something large down into manageable steps can be a long-term skill that you are helping them discover

Discussing Family Goals in Supervision

The Home Visitor and Supervisor review the family goal progress for each family regularly and on an ongoing basis. This review is documented on the *Family Progress Review* form for each family at least every 60 days, and encouraged to be discussed more often. Discussions between the Supervisor and Home Visitor regarding the family goal process will include:

- Supporting Home Visitors develop professionally in the area of supporting families with creating goals and how this builds protective factors
- Ensuring that goals for families remain current and active
- Problem solving challenges and barriers to achieving family goals
- Guiding interventions/discussing strategies utilized between the Home Visitor and the family
- Ensuring successes for steps/objectives are celebrated

As a Supervisor, it is important to remember that Home Visitors may not have had experience supporting families with creating goals or may not be confident in goal setting themselves. Effectively training new staff is especially critical in this area of service. A confident, capable Home Visitor who understands the connection between the process of goal setting and empowerment will support a family more effectively than someone who may not feel proficient in this skill. See 11-2.F for family goal process training requirements for new staff.

Essential Standard

Family Goal Development (practice) ESSENTIAL STANDARD

6-2.B HFO staff follow procedures for creating family goals in accordance with HFO Policy 6-2.A.

Family Goals in Supervision (practice)

6-2.C The Home Visitor and Supervisor review the family goal progress for each family regularly and on an ongoing basis, at a minimum of every 60 days, as stated in HFO Policy 6-2.A.

6-3

HFA Intent:

The promotion of parent-child relationships is a primary HFA goal. Many parents in this program have experienced significant early childhood trauma that can impact their ability to be emotionally present for their children. Parents who themselves have experienced early childhood trauma often struggle in being responsive and available to their children, distort emotional content in their relationships with others and have a restricted ability to utilize cognitive reasoning until their own basic needs for safety and trust are met.

HFA supports the concept of the strength-based approach with families; however, because of the strong relationships staff develop with families, the intent of "strength-based" may be distorted. This can lead to only positive interactions being recorded in documentation. In addition to seeing the strengths, capacities, and resources of parents related to attachment, observations and documentation must also be honest, and reflect the experience of the full home visit. Therefore, observations and documentation through CHEERS provide factual description of parent-child interactions. Only documenting positive PCI limits the FSS's capacity to have impact on creating nurturing attachment relationships.

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

Sites document observations of parent-child interaction and how these observations are used to develop and implement home visit activities and strength-based interventions to promote nurturing parent-child interaction.

Each HFO site utilizes assesses, addresses, and promotes nurturing parent-child interaction, attachment and bonding, and the development of sensitive, responsive parent-child relationships.

PCI CHEERS (policy)

6-3.A HFO Home Visitors will observe parent–child interactions utilizing CHEERS during every home visits. At least two areas CHEERS observations (Cues, Holding, Empathy, Expression, Rhythmicity/Reciprocity, Smiles) are documented in response to the home visit observations following the directions on the *Home Visit Record* using an objective, factual method. Exceptions to this requirement could include when the child is not present (which should be a rare occurrence) or when the CHEERS Check-In tool or FROG Scale is administered. Home Visitors will endeavor to partner with parents to assess all domains of CHEERS across multiple home visits. The intention is to attune to quality over quantity when documenting at least two areas of CHEERS observations on each home visit. Only documenting positive PCI limits the Home Visitors capacity to have impact on fostering nurturing attachment relationships.

Prenatal CHEERS Documentation

CHEERS are documented in prenatal visits beginning in the second trimester, with one domain of CHEERS documented in the second trimester and two domains documented in the third trimester.

Parent Group/Playgroup CHEERS Documentation

Any group session conducted with participants that is being counted as a home visit (one time per month allowed while a family is on Level 1) require a Home Visit Record be written.

Addressing and Promoting CHEERS Using Reflective Strategies

Home Visitors use Reflective Strategies as a strength-based intervention during home visits to address and promote the areas identified in CHEERS as needing support or where the parent is successful using teachable moments.

Reflective Strategies are used to acknowledge, address and promote positive parent-child interactions, enhance/strengthen/reinforce attachment and bonding to encourage the development of nurturing parent-child relationships. Home Visitors document Reflective Strategies utilized to address CHEERS observations on the *Home Visit Record*. Planning for the use of Reflective Strategies occurs in Supervision.

Addressing and Promoting CHEERS Using Parenting Materials and Curriculum

Parenting materials and curriculum will also be used by Home Visitors partner with parents to address concerning parent-child interaction and promote nurturing parent-child interactions throughout the family's enrollment in the program (See 6-4.A).

Supervision and CHEERS

The CHEERS section of each *Home Visit Record* is reviewed by the Supervisor prior to Supervisory sessions. Supervisors support Home Visitors with feedback during supervisory sessions in using an objective method of documenting CHEERS and using Reflective Strategies as a way to build parental competencies, address concerning parent child interaction, promote healthy relationships, and support families to enhance/strengthen and reinforce positive, nurturing relationships.

Home Visitors and Supervisors use the CHEERS observations in home visits as ground work for planning purposes and ongoing development of strategies, including but not limited to Reflective Strategies, to increase or reinforce nurturing parent-child interaction. Planning and development include discussing the CHEERS observations from the home visit, documenting those discussions on the *Family Progress Review* or *Service Plan* as well as documenting any strategies reviewed and follow up strategies for subsequent home visits.

Ongoing training, practice, review, and support by the Supervisor in this area is imperative for Home Visitor's professional development. HFO encourages working with individual Home Visitors on increasing skill capacity as well as a team approach to increasing and maintaining skills in using Reflective Strategies.

Quality assurance activities that Supervisors provide to Home Visitors, including home visit shadows, support staff in providing quality services to families and provide professional development crucial to become adept in the use of Reflective Strategies, and discern facts, feelings, and interpretations in CHEERS. Please see detailed quality assurance activities in 12-2.A.

CHEERS Check-In Tool

Home Visitors will use the *CHEERS Check-In* tool, a validated tool to assess parent-child interaction created by HFA, two times a year for each focus child during the course of services. To ensure validity, this tool is used for the focus child between 2 and 36 months of age.

It is recommended to use the tool between baby's age of 2-6 months, 7-12 months, 13-18 months, 19-24 months, 25-30 months, and 31-36 months. And with the spacing of at least 2 months between administrations of the tool. Scoring is completed after the visit, and the completion of the tool is documented on the *Home Visit Record*.

The Supervisor and Home Visitor will review observations, identify strengths and areas where support is needed, and discuss Reflective Strategies to be implemented. Any item rated a 4 or less on the CCI will be documented on the Service Plan to be addressed. Items rated as 5 are to be strengthened and items rated 6 or 7 are to be promoted. Supervisors will document discussions relating to the CHEERS Check-In tool on the *Family Progress Review* or *Service Plan*.

The Home Visitor will implement the Reflective Strategies, parenting activities, and curriculum in follow up home visits and document the strategies on the *Home Visit Record*.

When completing a CHEERS Check-In tool, it is not necessary to document CHEERS observation on that visit. However the Home Visitor will document per the 'comments' section of the CHEERS Check-In tool. In addition when completing the CHEERS Check-In tool it is advised to offer a parenting activity during that visit to support the completion of the tool.

CHEERS Check-In Tool Training

Home Visitors and Supervisors are required to be trained in the use of the tool using the HFA CHEERS Check-In recorded Webinar before the completing the tool with families or supervising staff who use the tool.

Site Monitoring: CHEERS Check-In Tool

Supervisors monitor the content and quality of the completed CHEERS Check-In Tool, as well as monitoring the frequency of the completion of the tool to ensure that it is completed at least twice annually for each family. *HFA Spreadsheet: Tool Tracker* for CHEERS Check In tool completion is available to monitor frequency of the completion. Sites will utilize HFO Statewide Data System and/or local tracking system to monitor completion.

Essential Standard

CHEERS Used to Assess PCI (practice) ESSENTIAL STANDARD

6-3.B HFO sites assess positive parent-child interaction, attachment, and bonding with all families, utilizing CHEERS on all home visits in accordance with HFO policy 6-3.A.

Essential Standard

PCI Addressed and Promoted (practice) ESSENTIAL STANDARD

6-3.C HFO sites address concerning parent-child interaction and promote nurturing parent-child interaction, attachment, and bonding with all families based on observations made using CHEERS according to HFO Policy 6-3.A.

Validated CCI Tool (practice)

6-3.D HFO sites utilize the CHEERS Check-in tool with all focus children twice annually according to HFO Policy 6-3.A.

Insert how your site plans to use a local tracking system to monitor timely receipt of CHEERS Check-In tool (*HFA Spreadsheet: Tools Tracker* for 6-3.D is available.)

Essential Standard

Supervisor support staff in assessing addressing, promoting PCI (practice) ESSENTIAL STANDARD

6-3.E Supervisors support home visiting staff in the assessing (through use of CHEERS and the CHEERS Check-In tool), addressing concerning parent-child interactions, and promoting parent-child interactions, attachment, and the development of nurturing parent-child relationships and support according to HFO Policy 6-3.A.

6-4

Each HFO site share information with parents to promote healthy child development, nurturing parent-child relationships, parenting skills, and health and safety practices with families, and provides credible source parenting materials, evidence-informed curricula on these topics.

***HFA Intent**:*

Materials shared with parents are used with intentionality and a strength-based approach that builds on parental capacity and in response to parent-child interests and observations made by the FSS. Fact-based materials help Family Support Specialists provide anticipatory guidance, and supports parents in thinking about what their baby's next phase of development will be and how they can support this development.

When a parent has endured early childhood trauma, it is important for the Family Support Specialist to spend time with the parent to listen to what the parent is thinking, feeling, and experiencing before presenting reading materials or activities. It is only when the parent feels safe and supported that they can begin to absorb this type of information. Including parents in the discovery of their child's development by asking parents what they have noticed about their baby as related to the specific child development topics, before sharing specific information, is highly recommended.

The key to successful use of handouts and activities is tied most closely to how the materials are used with families versus what materials are used. Sites use materials that are culturally respectful, supported by research, and in response to parent and child needs versus the primary focus of each home visit as they represent just one piece of a comprehensive approach to working with families. The primary focus of each visit is on the relationship between parents and child. Over-reliance on parenting materials distracts from this primary focus and from the ability to be fully observant, attuned, and responsive to these relationship dynamics.

Child Development, Parenting, Health & Safety (policy)

6-4.A HFO home visits include the promotion of child development, nurturing parent-child relationships, and health and safety practices with each family served. Individual HFO sites utilize an evidence-informed curriculum and parenting materials on a regular basis. The choice of parenting materials is based on the parent-child interests and or desires. The materials will be used in a strength-based approach that builds on parental capacity. The Home Visitor uses parenting materials based on what they see is needed to routinely nurture parent-child relationships, incorporating a variety of HFA reflective strategies to strengthen parental capacity.

Home Visitors build skills and share information with families; preparing and implementing appropriate activities designed to promote nurturing parent-child interaction, parenting skills, and child development at each visit unless there are

documented mitigating circumstances.

- Home Visitors' share evidence informed parenting materials using a strength-based approach that builds on parental capacity and is in response to parent-child interaction and observations (often CHEERS observations) made by the Home Visitor versus as the primary focus of the visit.
- Home Visitor's observations, interactions, activities, interventions, outcomes of interventions are all documented on the *Home Visit Record.*
- Home Visitors document not only what the child is able to do but also how the parent responds, and what the Home Visitor does to increase the parents' knowledge, building on parental competencies, and promoting child development and parenting skills in a thoughtful way.

Health and Safety

Home Visitors share routine health and safety information with families designed to promote positive health and safety practices:

- Staff will share information regarding Safe Sleep with moms prenatally (if enrolled prenatally) and at least once after birth (ideally within the second home visit after baby is born or enrolled) and before the child turns one year old. The sharing of this information will be documented in home visit record
- Home Visitors share prevention strategies and address any safety/health concerns observed in the home, taking advantage of teachable moments and anticipating developmental and seasonal changes.
- Thereafter, developmentally appropriate health and safety information will be shared at least monthly on level 1P, 1, 2 and every other visit on levels 3 or 4.
- All health and safety materials are given to parents are in accordance with the recommendations of the American Academy of Pediatrics.
- In addition to the above initial health and safety discussions, ongoing content may include safe sleep, smoking cessation, baby-proofing, feeding and nutrition, dental and oral health, etc.
- All safety discussions (both prevention and concerns) occurring between the family and Home Visitor are documented on the *Home Visit Record* in the safety section.

List the specific *initial preventative health and safety discussions* that routinely occur at your site between Home Visitors and families on the first several home visits:

Primary Curriculum

All HFO sites have a primary evidence-informed curriculum and parenting materials for use with families in the program. The primary evidence-informed curricula will contain a variety of components which include:

- Information on how to promote nurturing parent-child relationships (e.g., gives parents a positive sense of their new role, makes mom or dad unique to this baby, supports the development of empathy, focuses on experience versus what is "right or wrong", anchors baby's current behavior to future development, builds parental self-esteem, encourages parents to have fun playing with their baby)
- Child development information and how to share this in a strength-based manner (e.g., build on parental competencies, take advantage of teachable moments, engage parents' critical thinking skills, identify emerging skills, address language use and literacy, include all developmental domains, incorporates the use of developmental screens)
- Content that is developmental in nature
- Strategies that strengthen families and their relationships
- Health and safety information such as safe sleep, breastfeeding, pre-and postnatal health care, well-child care, dental and oral health, and lead exposure.
- A facilitator's manual (ideally) and family materials/manual (required)

  Some of the most common evidence-informed curricula include:

- Growing Great Kids
- Parents as Teachers
- Partners for a Healthy Baby
- Nurturing Parents
- PIPE

Curricula selected and used in home visits will meet the individual needs of families, with attention paid to cultural, linguistic, cognitive factors, and the interests of the family. Home Visitors are encouraged to share curriculum and parenting materials with families when it is appropriate and most meaningful.

List the primary evidence-informed curricula that your site uses (Note: list the primary curriculum only):

Insert local parenting materials that your site uses. *Please Note: This refers to other materials regarding parenting, health and safety and child development.*

Use of parenting materials on visits

Because the primary focus of each HFO home visit is the relationship between parents and child, over-reliance on parenting materials, i.e. curriculum, can distract from this primary focus. Home Visitors will use parenting materials to plan home visits, to share information, and will be brought as a handout to most visits, however, curriculum does not have to be utilized as a handout during every home visit.

Parenting materials will be used to promote nurturing parent-child relationships in conjunction with teachable moments, parental interest, and shared with parents using a strength-based approach building on parental capacity. The parenting materials will help 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 unforeseen circumstances occur, and parenting materials are not utilized, this is documented on the HVR.

It is not expected that parenting materials and curriculum are used on visits when other activities such as the FROG Scale, ASQs, Family Values, Wishes for My Child are planned.

Insert how your site supervisors will monitor the use of parenting materials and curriculum in home visits that adheres to the standard above:

Documentation of Parenting Materials and Curriculum

All curricula and parenting materials utilized in home visits will be documented on the *Home Visit Record* in the 'parenting materials and curriculum' section and includes the specific name of the activity

Curriculum Training for Staff

Home Visitors and Supervisors will be trained on the use of their primary curriculum prior to its use in home visits, or prior to supervising staff using the curriculum, according to the requirements of the curriculum developers. The training will be documented on the *HFO Role Required and Wraparound Training Log*.

Child Development, Parenting (practice)

6-4.B The Home Visitor routinely shares information with all families on appropriate activities designed to promote healthy child development and parenting skills at stated in HFO Policy 6-4.A.

Health & Safety (practice)

6-4.C The Home Visitor routinely shares curricula information with families designed to promote positive health and safety practices as stated in HFO Policy 6-4.A.

Safer Sleep (practice)

6-4.D The Home Visitor will share Safer Sleep information in accordance with HFO Policy 6-4.A.

6-5

HFO sites monitor the development of all participating children with the ASQ (Ages and Stages Questionnaire) and ASQ: SE (Social Emotional) using current versions of both.

Developmental Screening ASQ and ASQ:SE and Tracking Delays (policy)

6-5.A The ASQ (Ages and Stages Questionnaire) and ASQ:SE (Ages and Stages Questionnaire–Social Emotional) are used to monitor child development with all HFO focus children participating in services, unless developmentally inappropriate (e.g. when enrolled in Early Intervention or with permanent health condition impacting development).

In the instance of multiple births (twins, triplets, etc.), ASQs are completed with each child. Developmental screening is administered by trained staff in accordance with ASQ and ASQ:SE guidelines following a standard screening schedule. If a family is on a revised screening schedule, the reason for the adjustment is documented on the *Home Visit Record* and the Family File (*Data Tracking Sheet*).

- The ASQ is administered at a minimum of twice annually for each year of child's life until age three (typically at 4,8,12,18,24,30,36) and annually for children ages three through five years of age. The ASQ can be offered more often than twice annually.
- The ASQ:SE is administered at a minimum of once annually for each year of child's life (typically 6,18,30,42). The ASQ:SE can be offered more often than annually.
- Sites use the most current version of the standardized child development screening tool, ASQ and ASQ:SE for all focus children, unless developmentally inappropriate.
- The ASQ and ASQ:SE are administered in accordance with tool instructions to ensure accuracy, including adjusting for prematurity when needed.
- *HFA Spreadsheet: Tools Tracker* for ASQ and ASQ:SE is available to monitor frequency of the completion as well as tracking focus children suspected of having a developmental delay
- The *Data Tracking Form* is completed for tracking the ASQ and ASQ:SE scores in the family file.
- At a minimum, screen summary for the ASQ and ASQ:SE are required to be kept in the family file.
- Findings from the ASQ and ASQ:SE are documented on the *Home Visit Record.* This includes any follow up services, plans for re-screening, resources and/or referrals related to the ASQ and ASQ:SE.

- Results of ASQ and ASQ:SE are discussed in supervision including concerns for possible delays. The home visitor and supervisor ensure necessary follow up and appropriate activities and resources are offered to the parent/caregiver.
- Home Visitors discuss results of screening with parents/caregivers. If the scores of an ASQ or ASQ:SE indicate a possible delay, follow up supports, activities and resources are offered including Early Intervention if requested by parent/caregiver.
- If the family is on Creative Outreach when an ASQ is due, and then re-engages later, the next appropriate screen (based on age, or adjusted age, of child) is administered once home visits resume.
- ASQs are not required to be administered if the focus child has a permanent health condition impacting development.
- The site is encouraged to make the ASQ tool available to parents for subsequent births. With subsequent births, the ASQ can be provided to the parent for self-administration, or it may be administered by HFO staff. If administered by staff, the dates and results should be recorded in the family file.
- All staff who administer the ASQ and the ASQ:SE and their supervisor will complete training prior to use of the tool.

ASQs and ASQ-SE Age Adjustments

The ASQ and ASQ-SE are adjusted for babies born 36 weeks + 6 days or less. Age adjustments for the ASQ and ASQ-SE will continue until the child is 2 years of age. For example, if a baby is born at 36 weeks gestational age, the ASQ and ASQ-SE is administered four weeks later than the baby's chronological age until the baby is 2 years old.

Partnering with another Agency

In the instances where the ASQ and ASQ:SE are done as a part of a collaborative process with other service providers (other than Early Intervention) involved with the family, the site must be in receipt of a copy of the complete results of each tool to show that the tools were completed on time and to track any necessary follow-up referrals/interventions for the family.

If you are partnering with another agency to complete developmental screens, indicate what type of formal agreement is in place to support the partnership, and how you ensure that the ASQ-3 and ASQ:SE-2 are completed by the partner program/provider on time according to the above policy. Indicate how you receive a complete copy of the results of the screen from the partner program/provider and how you document this:

Site Monitoring: ASQs

Supervisors monitor ASQ scoring, referrals, and timing of the screens individually with Home Visitors to ensure that they are supported in screening families on time and uniformly, as well as use supervision time to strategize increasing rates, if appropriate.

Program Managers monitor ASQ screening for the site, communicating and problem-solving strategies with Supervisors to meet the threshold to be in adherence with the standard. *HFA Spreadsheet: Tools Tracker* for ASQ and ASQ-SE is available to monitor frequency of the completion. Sites will utilize HFO Statewide Data System and/or local tracking system to monitor completion.

ASQ-3 and ASQ:SE-2 Training

HFO Home Visitors and Supervisors at each site are required to be trained *prior to using the ASQ-3 and the ASQ:SE-2* and prior to supervising staff using the tool. Training is required to be completed by the local site by an individual who understands the use of the tool in a home visit setting and is documented on the *HFO Required HFO Training Log*. The ASQ-3 and the ASQ:SE-2 training can also be completed with a certified ASQ trainer.

- Observing a qualified staff member administering the tools and being observed administering the tools

- Orientation to local Early Intervention services to facilitate referral

Sites are required to ensure that all HFO staff understand the administration guidelines and referral protocol regardless of whether they administer the screen or not, as they need to be able to interpret and act appropriately on the results of the screen. Please note: *ASQ-3 training received prior to HFO hire date is acceptable if the staff person has been using the tool consistently (without lapse) since receipt of training.*

Insert local procedure describing the specific on-site training of new staff for the ASQ and ASQ:SE tool:

Tracking Developmental Delays

HFO Home Visitors, in coordination with their Supervisor, tracks children suspected of having a developmental delay and follows through with appropriate referrals and follow-up as needed to assist families in obtaining appropriate early intervention/early childhood special education services.

- The Supervisor and Home Visitor determine when a child should be referred based upon the ASQ and/or the ASQ:SE criteria for delays and scoring.
- Home Visitors document ASQ results, discussions with parent(s) about concerns, referrals, and follow up on the Home Visit Record in the ASQ and/or ASQ:SE section
- Supervisors document discussions with Home Visitor about the scores and concerns on the *Family Progress Review*.
- When families decline Early Intervention services, discussions and efforts to share information about Early Intervention services are documented in the Home Visit Record and Supervisory notes.
- When focus children do not meet eligibility criteria for Early Intervention services, the Home Visitor shares/completes activities to encourage skill development. The Home Visitor will encourage the family to stimulate the child's development through specific activities outside of home visits, and will continue to conduct developmental screenings using the ASQ and ASQ:SE. All follow up discussed with families will be documented on the Home Visit Record.

The Home Visitor collaborates with Early Intervention when children are dually enrolled (with consent from the family). Integrated services can include attending therapy services, joint family goals and possibly joint home visits. The continued use of the ASQ by the local Healthy Families site is determined on a case-by-case basis jointly by the agencies serving the family. If the focus child is receiving services from Early Intervention, the HFO site is not required to complete regular ASQ-3 or ASQ:SE. It is highly recommended that copies of developmental screens completed by EI, be requested with permission of the family, and kept in the family file. Discussions of the child's developmental status occur regularly in supervision and are documented on the *Family Progress Review*.

Insert how your site plans to use a local tracking system to monitor timely receipt of ASQ and ASQ:SE (*HFA Spreadsheet: Tools Tracker* for 6-5.B and 6-5.C is available):

Insert the local Early Intervention services that families are referred to by your site when a delay is indicated:

Insert the procedure and timeframe your site utilizes when a child shows a developmental/social emotional delay on the ASQ or the ASQ:SE including how you track services and follow up with the referring agency (*HFA Spreadsheet: Tools Tracker* for 6-5.D is available) :

ASQ (practice)

6-5.B Each HFO site ensures that the ASQ is used during home visits to monitor the development of all focus children at specified intervals, unless developmentally inappropriate, as stated in HFO Policy 6-5.A.

ASQ:SE (practice)

6-5.C Each HFO site ensures that the ASQ:SE is used during home visits to monitor the development of all focus children at specified intervals, unless developmentally inappropriate as stated in HFO Policy 6-5.A.

Tracks, Refers & Follow Up for developmental delay (practice)

6-5.D HFO Home Visitors, in coordination with their Supervisor, tracks children suspected of having a developmental delay and follows through with appropriate referrals and follow-up as needed to assist families in obtaining appropriate early intervention/early childhood special education services.

STANDARD 7: AT A MINIMUM, ALL FAMILIES ARE LINKED TO A MEDICAL PROVIDER TO ENSURE OPTIMAL HEALTH AND DEVELOPMENT. DEPENDING UPON THE FAMILY'S NEEDS, THEY MAY ALSO BE LINKED TO ADDITIONAL SERVICES RELATED TO: FINANCES, FOOD, AND HOUSING ASSISTANCE, SCHOOL READINESS, CHILD CARE, JOB TRAINING, FAMILY SUPPORT, SUBSTANCE ABUSE TREATMENT, MENTAL HEALTH TREATMENT AND DOMESTIC VIOLENCE RESOURCES.

HFA Standard 7 Intent *is to ensure site staff link families to providers for preventative health care and timely receipt of immunizations, and appropriately refer families to additional community services based on each family's unique needs.*

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

7-1

Participating focus children in HFO are linked to a primary medical/health care provider to ensure optimal health and development.

Medical/Health Providers for Focus Children (policy)

7-1.A Each HFO site will link focus children to a medical/health care provider and provide information and connect families to medical/health care providers available in their community.

A medical home is a crucial part of the health and development of the child. Preventative care can be established with a medical home as well as continued monitoring of the child by a consistent professional.

- The Home Visitor supports families in establishing a primary medical/health care provider for the focus child, and anyone else in the household, and document the Primary Care Physician's name in the family file at initiation of services.
- If serving a family prenatally, document discussions about choosing a primary provider and then the name of the provider when the baby is born.
- Home Visitors document information that is shared about medical/health providers on the *Home Visit Record.* It will be documented if the child does not have a medical/health care provider.
- Home Visitor will document receipt of well-child visits on *Data Tracking Form* and on *Home Visit Record.*
- The Home Visitor will work with families to address any barriers to accessing receipt of well-child care.
- The Home Visitor will provide information on the importance of well-child care to all families.
- The Home Visitor will document discussions and any attempts/steps taken to link the child to a medical provider.

- Up-to-date medical/health care provider is reported by all HFO sites to program evaluators using the NPC *Family Update Form*
- *HFA Spreadsheet: Tool Tracker* is available to monitor and track whether or not the focus child has a medical/health care provider. Sites will utilize HFO Statewide Data System and/or local tracking system.

Insert where in the family file your site documents the medical/health care provider's name (at minimum) for the child and use of local tracking system to demonstrate each focus child has a medical/health care provider (*HFA: Tool Tracker* for 7-1.B is available):

Insert how your site plans to monitor well-child care along with strategies to address barriers and support access to well child visits (*HFA: Tool Tracker* for 7-1.C is available):

Site Monitoring: Child's Medical/Health Care Provider

Supervisors monitor family files/Home Visit Records to ensure that Home Visitors are supporting families in establishing primary medical/health care providers and have documented the medical clinic/provider's name in the family file.

Program Managers conduct site monitoring by communicating problem-solving strategies with Supervisors to meet the threshold to be in adherence with the standard.

Medical/Health Providers for Focus Children (practice)

7-1.B Each HFO site will link focus children to a medical/health care provider and provide information and connect families to medical/health care providers available in their community at stated in HFO Policy 7-1.A.

Well-Child Care Visits (practice)

7-1.C Each HFO site will link focus children to well child visits and address barriers impacting access as stated in HFO Policy 7-1.A.

7-2

HFO sites ensure that Home Visitors promote and educate families regarding the importance of immunizing children, track the receipt of immunizations, and follow-up with parents when immunization appointments are missed. Focus children are up-to-date on immunizations.

Timely Receipt of Immunizations (policy)

7-2.A Home Visitors routinely share information with families concerning the importance of immunizations, initially at the onset of services and ongoing throughout the course of services, and use the ALERT system/parent report documented on the CDC immunization scheduler to monitor.

- Home Visitors utilize current recommendations from the Center for Disease Control and Prevention (CDC) to discuss with families the importance of getting timely immunizations for their children at the onset and throughout services, documenting discussions on the *Home Visit Record*.
- Home Visitors will track receipt of immunizations utilizing the site's local procedure below and Supervisors will monitor tracking by reviewing *Home Visit Records* and discussing immunization tracking in supervision.

- Home Visitors will also follow up with the family and document on the *Home Visit Record* when immunization appointments are missed. If a focus child is not up-to-date, Home Visitors will indicate the reasons why and document attempts to support families to get child immunized on the *Home Visit Record*.
- Immunizations for each focus child are to be monitored, as stated by your local procedure below, by Home Visitors and Supervisors at one and two years of age by documenting discussions with families on the *Home Visit Record*. (This does not include children whose permanent health conditions or family beliefs preclude immunizations; however, explanation of these exceptions must be documented on the *Data Tracking Form* and the *Home Visit Record*).
- If your site pulls ALERT immunization data or gets immunization data from a medical provider, you must obtain consent (ROI) from the parent first.
- Up-to-date immunizations are reported by all HFO sites to program evaluators using the NPC *Family Update Form*
- HFA Spreadsheet to track immunizations is available to monitor frequency of the completion. Sites will utilize HFO Statewide Data System and/or local tracking system to monitor completion.

Clearly indicate how your site obtains information to determine if focus children are up-to-date on their six months immunizations at age 12-23 months and up to date on their 18 month immunizations when 24 months or older (i.e. ALERT system or parent report documented on the CDC immunization scheduler):

Insert how your site plans to use a local tracking system to monitor up-to-date immunization (*HFA: Tools Tracker* for 7-2.B and 7-2.C is available):

If implementing Child Welfare Protocols, insert how your site plans to separate within the tracking system children enrolled through Child Welfare Protocols. (*HFA: Tools Tracker* for 7-2.B and 7-2.C is available):

If your site obtains ALERT data, at what point in services do Home Visitors obtain Authorization to Release Information from the family to access ALERT:

Site Monitoring: Immunizations

Supervisors monitor immunization information in files (Home Visit Records, and ALERT or CDC Tracker) and with Home Visitors, to ensure that they are supported in obtaining immunization information from families and/or ALERT in a timely manner. Supervisors will use supervision time to strategize ways to increase immunization rates with Home Visitors, if appropriate.

Program Managers monitor immunization tracking for the site, communicating, and problem-solving strategies with Supervisors to meet the threshold to be in adherence with the standard.

Measure Immunization Rates at 1 year (practice)

7-2.B The site ensures focus children who are 12-23 months of age are up-to-date with all immunizations expected by six months of age as stated in HFO Policy 7-2.A.

Measure Immunization Rates at 2 year (practice)

7-2.C The site ensures focus children who are 24 months or older are up-to-date with all immunizations expected by eighteen months of age as stated in HFO Policy 7-2.A.

7-3

HFO Home Visitors connect families to services in the community on an as needed basis.

Health Care and Community Information and/or Referrals and Follow-up (policy)

7-3.A Home Visitors and Supervisors will be trained on, become familiar with, and stay up to date on resources in their community. It is encouraged for newly hired Home Visitors and Supervisors to visit community agencies and gather information on current resources.

Home Visitors will provide information, referrals, and linkages to available health care, health care and community resources to all participating family members, on an as needed basis. This is one way to bridge the gap for families who may be reluctant to access these services. Referrals and resources should be given with cultural beliefs and norms in mind.

Health care referrals and linkages can include, but are not limited to: dental care, current and subsequent prenatal care, smoking cessation support, substance abuse/alcohol treatment, free health clinics, nutrition classes, immunization clinics, mental health support, etc. Community resources and linkages can include, but are not limited to: housing, food, clothing, utility assistance, and rent assistance, etc.

Because HFO believes in empowering families, it is strongly encouraged that Home Visitors ask families what they have accessed before, use motivational interviewing, and utilize Reflective Strategies whenever possible, so that the family is able to possibly find a solution before immediately sharing information on a referral.

Home Visitors document all referrals, linkages, and follow up on the *Home Visit Record*. Supervisors will support Home Visitors by reviewing *Home Visit Records*, suggesting, and problem-solving referral provision. Referrals and follow-up are also discussed within Supervisory sessions.

If the Home Visitor learns that another home visitation program, community service, or medical site is providing services to the family, efforts are made to arrange a joint staffing meeting or telephone conversation between the two sites (with written consent of the family) in order to avoid duplication of services. A lead site is identified and roles are clarified. Documentation of ongoing coordination of services is maintained by the Home Visitor in the *Home Visit Record*, if discussed during a home visit, and/or progress notes and located in the family file, as well as by the Supervisor in the *Family Progress Review*.

Documentation of Referrals and Follow Up

All referrals, resources, and linkages shared with families are documented on the *Home Visit Record* in the referrals/resources section. Follow up with families, including if the parents declined or received the services they were referred to, is required to be documented on the *Home Visit Record*. This also includes documentation if a family is already linked to a referral/resource that you suggest or share.

Health Care Referral (practice)

7-3.B Home Visitors will **provide** information, referrals, and linkages to available health care and health care resources for all participating family members in accordance with HFO Policy 7-3.A and as evidenced by documentation on the *Home Visit Record*.

Community Resource Referrals (practice)

7-3.C Home Visitors will **connect** families to appropriate referral sources and services in the community in accordance with HFO Policy 7-3.A and as evidenced by documentation on the *Home Visit Record*.

Referral Follow-up (practice)

7-3.D Home Visitors will **follow up** with families to determine if the family received the needed services in accordance with HFO Policy 7-3.A. This will be tracked and documented on the *Home Visit Record*.

7-4

All HFO sites conduct depression screening with all families using a standardized instrument.

HFA Intent:

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

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

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

Depression Screening (policy)

7-4.A Home Visitors conduct depression screening using the PHQ9 Depression Screening **or** the Edinburgh Depression Scale with the primary caregiver in accordance with the tool developer guidelines within the timeframes listed below.

Insert the specific depression screening tool used at your site (PHQ9 or Edinburgh):

Insert what score constitutes a positive (elevated) screen when using the above listed tool at your site (PHQ9 or Edinburgh):

- If family enrolls prenatally, depression screening is completed once prenatally and again within 3 months of birth.
- If family enrolls postnatally, depression screening is completed at least once within three months of enrollment.
- Depression screening is completed within 3 months of any subsequent birth.
- If for some reason (i.e., family is on outreach) it is not completed within three months, then a screen will be administered within six months of birth or six months of enrollment (whichever comes later).
- Screens with be conducted with the primary caregiver of all enrolled families, the individual with whom the baby lives and receives primary care from. This individual is generally, though not always, a parent, and is the primary point of contact for the Home Visitor when conducting home visits and observing PCI.
- In co-parenting or multi-generational parenting families, one person will be identified within the family system as the primary caregiver. Depression screens are only required to be offered with this person, however, fathers, the co-parent, or other caregivers will be offered screens as determined by the family, Home Visitor and the Supervisor.
- Supervisors are encouraged to note any concerns identified from the depression screen on the family's HFO Service Plan, with planned interventions/activities to address and track progress.
- If the primary caregiver declines the depression screen, this is documented on the *Home Visit Record* and discussed with the Supervisor to problem-solve any barriers and ensure continued support of the primary caregiver. Home Visitors will provide support with the listed activities below and document on the *Home Visit Record*.
- Depression Screens conducted within the timeframes specified are reported by all HFO sites to program evaluators using the NPC *Depression Screening Form*
- *HFA Spreadsheet: Tool Tracker* to track depression screens is available to monitor frequency of the completion. Sites will utilize HFO Statewide Data System and/or local tracking system to monitor completion.

Elevated Screening Scores

All sites will offer and follow-up on referrals, for parent(s) whose depression screening scores are elevated and considered to be at-risk for depression (based on the tool's screening criteria) unless they are already receiving treatment for depression. All referrals and follow-up are documented in the depression screening section on the *Home Visit Record*.

Activities for Supporting Parents with Depression

Although staff are not therapists, it is critical for Home Visitors to support parents in alleviating their depression while a parent is awaiting treatment, not yet ready to engage in treatment, or while considering treatment options.

Home Visitors will support parent(s) who are at risk for depression, or who are displaying symptoms of depression, by engaging in the following activities, as appropriate:

- Exploring and offering linkages and referrals to appropriate resources
- Exploring and offering referrals for mental health consultation (when available)
- Utilizing reflective supervision to support staff in discussing depression with parents
- Encouraging with families walking or engaging in other forms of physical movement
- Encouraging parents to smile (even a "practice" smile increases serotonin)
- Encouraging parents to keep hydrated (hydration increases brain functioning)
- Explore self-care and collective/community care
- Exploring and using healthy strategies that have worked for the parent in the past
- Utilizing Procedures for Working with Families in Acute Crisis (HFA BPS link)

- Using Reflective Strategies and motivational interviewing to increase awareness
- And using other strategies/activities identified locally

Please Note: when caregivers are already involved in treatment or treatment resources do not exist in the community, these situations are noted on the *Home Visit Record*.

List the specific local community resources that your site staff refer parents to that have an elevated depression score:

Collaboration with Other Agencies

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 (with written consent) to show that the screen was completed on time and to make and track any necessary follow-up referrals/interventions for the family.

Sites are required to ensure that all staff understand the administration guidelines and referral protocol regardless of if they administer the screen or not, as they need to be able to interpret and act appropriately on the results of the screen.

If you utilize a community partner to complete depression screens, insert how you ensure they are completed by the program/provider on time according to the above policy. Indicate how you receive a completed copy of the results of the screen from the partner program/provider:

Staff Training for Depression Screening

Staff who administer the site's depression screening tool are required to be trained at each local site, utilizing the developer's instructions in the use of the tool, *prior to administering it*. Supervisors also receive the training prior to supervising staff that are administering it. This training is documented on the *HFO Required Training Log* and entered into the HFO Statewide Database within 30 days of training.

Depression screening training completed at the local site must include:

- Reviewing the administration guidelines with someone who is experienced in using the tool
- Reviewing HFO requirements for completing the tool both prenatally and postnatally
- Reviewing scoring cutoff/elevated scores
- Training in ways to talk with parents about depression
- Explanation of appropriate activities that Home Visitors complete with parents who are experiencing depressive symptoms
- Documentation requirements on the Home Visit Record
- Requirements for subsequent births

Site Monitoring: Depression Screens

Supervisors monitor timing and scoring of the depression screens to ensure that Home Visitors are supported in screening families on time and uniformly. Supervisors use supervision time to strategize increasing depression screening rates and problem-solving barriers, if appropriate.

Program Managers monitor the depression screening rate for the site, communicating, and problem-solving strategies with Supervisors to meet the HFA threshold to be in adherence with the standard.

Depression screens will be completed even when active families are in treatment to ensure treatment is meeting the needs of the family. Sites are expected to include Level CO families on their depression screening data reports (and to note time period the family was on Level CO), and to track receipt of depression screening during times the family is not on Level CO.

Insert how your site plans to use a local tracking system to monitor completion of Depression Screening prenatally, postnatally and after each subsequent birth (*HFA: Tools Tracker* for 7-4.B, 7-4.C, 7-4.D, and 7-4.E is available):

Prenatal Depression Screening (practice)

7-4.B The site conducts prenatal depression screening as stated in HFO Policy 7-4.A.

Postnatal Depression Screening (practice)

7-4.C The site conducts postnatal depression screening as stated in HFO Policy 7-4.A.

Screening for Depression W/ Subsequent Births (practice)

7-4.D The site conducts depression screening after all subsequent births as stated in HFO Policy 7-4.A.

Referral and Follow up for Primary Caregiver with Elevated Screens (practice)

7-4.E Primary caregivers with an elevated depression screening score are supported with appropriate activities by the Home Visitor and are referred for further evaluation/treatment and follow-up unless already involved in treatment, as stated in HFO Policy 7-4.A.

STANDARD 8: SERVICES ARE PROVIDED BY STAFF IN ACCORDANCE WITH PRINCIPLES OF ETHICAL PRACTICE AND WITH LIMITED CASELOADS TO ASSURE THAT HOME VISITORS HAVE AN ADEQUATE AMOUNT OF TIME TO SPEND WITH EACH FAMILY TO MEET THEIR UNIQUE AND VARYING NEEDS AND TO PLAN FOR FUTURE ACTIVITIES.

HFA Standard 8 Intent *is to ensure site staff have limited caseloads to allow them the necessary time with families to build trusting, nurturing relationships.*

8-1

Services are provided by HFO staff with limited caseloads to assure that Home Visitors have an adequate amount of time to spend with each family to meet their needs and plan for future activities.

Caseload Size (policy)

8-1.A Full time Home Visitors carry no more than a maximum total weighted caseload of 30 points. Full time Home Visitors who have been employed more than one year carry no less than 18 points at any one time.

Caseload size is based on the length of time the Home Visitor has been in their role (tenure and experience), along with the complexity and difficulty of family dynamics and service intensity. Home Visitors will be expected in their first and second year working in this role to typically have a caseload range at any given time of approximately 10-12 families, and full-time Family Support Specialists in the role for three years or more to typically have a caseload range at any given time of approximately 15-20 families, and that the caseload does not exceed thirty (30) case weight points. Supervisors and Program Managers use discretion regarding pace staff build caseload size.

There are select circumstances when Home Visitors may exceed the maximum case weight of thirty points. (i.e. a Home Visitor leaves and the caseload is temporarily dispersed among existing Home Visitors temporarily - 3 consecutive months or less). Supervisors will clearly document the reasons why the caseload has exceeded the limit and the duration of this deviation.

Example of pro-rated caseload size (the same calculation can be used for building new staff caseloads):

Hours/FTE	HFO Pro-rated minimum caseload points	HFA Pro-rated maximum caseload points
	18 points x FTE = pro-rated caseload	**30 points x FTE = pro-rated caseload**
40 hr/week (1FTE)	18	30
37.5 hr/week (.94 FTE)	17	28
35 hr/week (.875 FTE)	16	26

20 hr/week (.5 FTE)	9	15

Caseload for Hiring New Staff

It is required that newly hired staff have adequate time to build a caseload so that they can integrate and learn the model, including an understanding of trauma-informed care (recognizing that "teaching" or "coaching" families without establishing a relationship can re-traumatize the parent), the power of healthy relationships, and the importance of reflection (the capacity to think about one's own experiences and how they could be impacting the work). The following are minimum requirements for the first year of hire for a full time (1 FTE) Home Visitor:

- At 3 months, a Home Visitor must have a minimum of 4 points
- At 6 months, a Home Visitor must have a minimum of 10 points
- At 12 months, a Home Visitor must have a full caseload (18-24 points)

These are minimum requirements and sites could choose to build caseload faster than this if they feel the Home Visitor is ready. However, caution should be used so as to avoid overloading a new Home Visitor as they have an abundance of training for the first year of hire.

Caseloads and Dual Roles

If a Home Visitor has a dual role as a Home Visitor/Eligibility Screener, FTE for each position is required to be clearly communicated and weighted caseload points are to be adjusted for *just the FTE of the home visiting position*. For example, if a Home Visitor is .5 as well as .5 Eligibility Screener, the maximum weighted caseload points he/she can have for .5 FTE is 12 points.

Caseload Monitoring at Site

The Program Manager and Supervisor will monitor caseload size closely and use discretion regarding the pace at which a new staff build their caseload as well as seasoned staff maintain their caseload. This ensures that now staff exceeds a case weight of 30 (except in select circumstances. And that staff are not consistently below case weight expectations.

Monitoring Caseloads (practice)

8-1.B HFO sites ensure that Home Visitors are within the caseload ranges utilizing the *HFA Spreadsheet: HVC and Caseload (4-2.B, 4-2.C, and 8-1.B)*, as stated in HFO policy 8-1.A.

Insert local procedures describing who enters home visit completion data into the HFA Spreadsheet for HVC and Caseload Report:

Insert local procedures for Program Manager monitoring home visit completion on a quarterly basis:

8-2

HFO Supervisors assign families within the framework of the weighted caseload management procedure when managing caseloads, including principles of ethical practice, to ensure that Home Visitors have an adequate amount of time to spend with each family.

Managing Caseloads (policy)

8-2.A Supervisors ensure that Home Visitors have sufficient time to support the needs of families during home visits, as well as time needed prior when planning for the visit and after the visit for documentation and follow up.

Home Visitor's caseloads are discussed during Supervisory sessions and are documented on the *General Weekly Supervision* form. Supervisors will review, take into account, and document discussions of the criteria below with the Home Visitor when discussing family assignments.

HFO sites will use the following criteria for managing caseloads and assigning families to Home Visitors.
The criteria include:

- Experience and skill level of the assigned Home Visitor
- Nature and difficulty of the problems encountered with families
- Work and time required to serve each family
- Avoiding potential worker conflict or boundary challenge owing to an existing personal relationship
- Current staff capacity
- Multiple births (twins, triplets, etc.),
- Number of families per Home Visitor that involve more intensive intervention
- Distance, travel time, and other non-direct service time required to fulfill the Home Visitor's responsibilities
- Home Visitor flexibility when family has many scheduling limitations
- Extent of other resources available in the community to meet family needs
- Number of children in the home
- Other assigned duties

Managing Caseloads (practice)

8-2.B. All HFO sites use the criteria as identified in 8-2.A to manage caseload sizes as evidenced in supervision documentation.

STANDARD 9: SERVICE PROVIDERS ARE SELECTED BECAUSE OF THEIR PERSONAL CHARACTERISTICS, THEIR LIVED EXPERTISE AND KNOWLEDGE OF THE COMMUNITY THEY SERVE, THEIR ABILITY TO WORK WITH CULTURALLY DIVERSE INDIVIDUALS, AND THEIR KNOWLEDGE AND SKILLS TO DO THE JOB.

HFA Standard 9 Intent is to ensure staff are selected because they possess characteristics necessary to build trusting, nurturing relationships, and work effectively with families with different cultural values and beliefs than their own. Focusing on these characteristics also increases opportunities for diverse representation and equitable access to positions for historically and currently underrepresented individuals and groups.

9-1

The site ensures that service providers and program management staff are selected because of a combination of personal characteristics, experiential, and educational qualifications.

There may be circumstances when the most appropriate and best suited candidate for a Program Manager, Assistant Program Manager or Supervisor role does not possess the required educational background identified in the standard. Special consideration may be given for individuals with significant experience and rural areas with limited applicants. While HFA encourages hiring the individual who is the best fit for the role, this standard will be rated out of adherence. However, given that sites are not required to have 100% of standards in adherence to be accredited, this alone will not impact a site's ability to be accredited and should therefore not be used as the sole basis for employee selection or termination.

Screening & Selection of New HFO Staff (policy)

9-1.A Each site's processes and system for hiring HFO staff is required to include **all** of the following:

- Job descriptions which include at least the minimum criteria indicated in standard 9-1.B-D for the positions of Program Manager/Assistant Program Manager, Supervisor, Home Visitor, and Eligibility Screener
- The use of standardized interview questions appropriate to each role including questions to screen for an applicant's reflective capacity (See glossary for definition of standardized interview questions).
- At least two reference checks and a criminal background check completed prior to hire. If a new HFO staff has been hired from within the agency, it is required to maintain documentation of the original background check at hire to that agency.
- Completion of the site's *HFO Program Staff Smartsheet* within one week of hire date
- Notification of any HFO hiring activity to Central Administration by email including submission of agency employment posting
- The Program Manager/Assistant Program Manager and Supervisor are required to participate in the hiring process of HFO core positions (Home Visitor, Supervisor, Program Manager/Assistant Program Manager). Participation includes, at a minimum, interviewing and participating in final hiring decisions.

The HFO Program Manager/Assistant Program Manager or Supervisor is expected to maintain copies in their own staff files if the host agency does not permit job descriptions, standardized interview questions (see glossary)/responses/summaries or reference checks to be maintained in personnel files.

Verify and provide details (especially in regards to job descriptions, standardized interview questions, two reference checks and criminal background checks prior to hire) that all the above requirements are being met at your site:

Screening and Selection of Program Managers/Assistant Program Managers

9-1.B Screening and selection of Program Manager/Assistant Program Managers considers characteristics including, but not limited to:

- A solid understanding of and experience in managing diverse staff with humility
- Administrative experience in human service or related field including experience in quality assurance and continuous quality improvement
- Master's degree in public health or human services administration or fields related to working with children and families, or bachelor's degree in these fields with 3 years of relevant experience, or less than a bachelor's degree but with commensurate HFA experience
- Willingness to engage in building reflective practice (e.g., capacity for introspection, communicating awareness of self in relation to others, recognizing value of supervision, etc.)
- Infant mental health endorsement preferred (if available in the state)

Screening and Selection of Supervisors

9-1.C Screening and selection of Supervisors includes all of the following, but not limited to:

- Master's degree in human services or fields related to working with children and families, or bachelor's degree in these fields with 3 years of relevant experience, or less than a bachelor's degree but with commensurate HFA experience
- A solid understanding of or experience in supervising diverse staff with humility, as well as providing support to staff in stressful work environments
- Knowledge of infant and child development and parent-child attachment
- Experience with family services that embraces the concepts of family-centered and strength-based service provision
- Knowledge of parent-infant health and dynamics of child abuse and neglect
- Experience supporting culturally diverse communities/families
- Experience in home visiting with a strong background in early childhood prevention services
- Willingness to engage in building reflective practice (e.g., capacity for introspection, communicating awareness of self in relation to others, recognizing value of supervision, etc.)
- Infant mental health endorsement preferred (if available in the state)
- Experience with reflective practice preferred (see standard 12-2.B for more detail)

Screening and Selection of Home Visitors ESSENTIAL STANDARD

Essential Standard

9-1.D Screening and selection of Home Visitors and volunteers/interns (if performing the same function as direct service staff) considers characteristics including, but 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 humility to work with culturally diverse families
- Knowledge of infant and child development
- Willing to engage in building reflective capacity (e.g., capacity for introspection, communicating awareness of self in relation to others, recognizing value of supervision, etc.)
- Infant mental health endorsement preferred (if available in the state)

9-2

HFO sites actively recruit, employ, and promote qualified personnel and administers its personnel practices without discrimination based upon age, sex, gender identity, sexual orientation, race, creed, color, ethnicity, religion, nationality, political affiliation, citizenship status, marital status, veteran status, disability or handicap, genetic information, pregnancy, family medical history or any other characteristic protected by applicable federal, state, or local laws of the individual under consideration .

Insert host agency's Equal Employment Opportunity Policy (attach to Appendix C):

9-3

HFO site's recruitment and selection practices assure that its human resource needs are met.

Recruitment and Selection Practices

9-3.A Each site follows recruitment and selection practices are in compliance with applicable law and regulations including:

- Notification of its personnel of available positions before or concurrent with recruitment elsewhere
- Utilization of standard interview questions that comply with employment and labor laws, and address knowledge and skills needed for the job
- Verification of a minimum of 2 references and/or letters of recommendation and credentials. If hired from within the organization, performance appraisals may suffice.

Safety Standard

Legally Permissible Background Checks SAFETY STANDARD

9-3.B All HFO staff and volunteers, including staff that are hired within the local agency (internal hires), who have responsibilities relating to HFO families, family data, or their files must have a legally permissible criminal background check before hire.

As stated in 9-1.A, all HFO sites will complete *HFO Program Staff Smartsheet* documenting date criminal history check was submitted and returned to site.

Hiring of Past Participants in HFO

Sites may hire past participants who were enrolled in the HFO program, at the same agency, using the following guidelines:

- At least one year has passed since the applicant ended services with the Healthy Families program (at the same agency they are applying for employment).
- Standard hiring procedures are followed, including screening and selection criteria as outlined in 9-1.A.
- The applicant's family file is not utilized during the hiring process and/or during the duration of employment for employment purposes.

These guidelines are applicable when hiring Eligibility Screeners, Home Visitors, Supervisors, Assistant Program Managers and Program Managers.

9-4

All HFO sites evaluate and report on personnel satisfaction and turnover at least once every two years and address how it may increase staff retention, improve staff diversity, inclusion, and belonging and promote equity

HFA Intent

A stable, qualified workforces known to contribute to improved participant outcomes, with families more likely to be retained in services when staff are retained. Therefore, site management should monitor factors associated with staff turnover. By understanding the circumstances and characteristics of staff that leave, in comparison to those that stay, strategies to increase retention can be developed (based on the data) and implemented with a greater likelihood of success.

While the site will want to include in their report all the reasons contributing to staff turnover, strategies for improvement do not need to be developed when reasons pertain to personal growth opportunities that could not have been fulfilled on the job, i.e. returning to school, job promotion, etc. If there has been no turnover in the last two years, the site will still monitor staff satisfaction among employed staff.

Staff Satisfaction & Retention Analysis and Plan

9-4 The Program Manager will complete and submit the *Staff Satisfaction & Retention Analysis and Plan* every two years in accordance with the *Aligned QA Calendar*. This includes updating and submitting the *Staff Turnover Analysis Table*.

Sites are required to use a mechanism to measure context of job satisfaction such as a staff satisfaction survey and compare staff that leave with the staff that stay. HFO encourages sites to use the *HFO Staff Satisfaction Survey*. It is required to address issues identified from the responses of staff or impacted staff who left employment, including any issues associated with diversity equity and inclusion and implement strategies to increase staff retention and satisfaction. Anonymity on surveys is encouraged whenever possible. Staff satisfaction and retention information that is included in the analysis and plan, and the survey, must be reported for HFO staff only.

Sites encourage any HFO staff that is leaving the program to complete the Exit Survey provided by the host agency. Sites are encouraged to offer exit interviews to all staff.

Insert your site's procedure describing how and when Exit Surveys and/or exit interviews are completed:

STANDARD 10: STAFF RECEIVE INTENSIVE TRAINING SPECIFIC TO THEIR ROLE TO UNDERSTAND THE ESSENTIAL COMPONENTS OF FAMILY ASSESSMENT, HOME VISITATION AND SUPERVISION.

HFA Standard 10 Intent *is to ensure staff receive training specific to their role. HFA Core training is required for all direct service staff, supervisors, and program managers within six months of hire. This training must be provided by a nationally certified HFA Core trainer. Stop-gap training is provided when staff begin providing direct services prior to receiving Core training. In addition, there are seven orientation training topics required to be received by staff prior to work with families.*

10-1

HFO has a comprehensive training policy detailing all required training listed below for all staff including: 1) topics, 2) the method for obtaining training, and 3) the timeframe for each.

Training Plan/Policy

10.1 HFO Central Administration created the *HFO Statewide Training Plan* to support training a multi-site system and reviews the plan at least every two years.

Each HFO site submits an *Annual Training Plan,* in accordance with the *Aligned QA Calendar,* detailing required ongoing trainings for that site and other applicable trainings that will be completed that year.

HFO Training	HFO Policy
Orientation (HFA Quick Start Webinar and HFO Orientation Manual)	10-2 A-H
Stop-gap when HFA Core is received after 1st home visit	10-3.A-C
HFA Core Training (Foundations, FROG Scale, Supervision)	10-4.A-C
Implementation Training (Program Manager, Program Manager Assistant only)	10-5
Wrap-around Training (within 3 months)	11-1.A-D
Wrap-around Training (within 6 months)	11-2.A-G
Wrap-around Training (within 12 months)	11-3.A-E
HFO Multi-Site Training	10-2.H
Annual Ongoing Training (including Medicaid)	11-4.A
Annual Training on Child Abuse and Neglect	11-4.B
Annual Training on Diversity, Equity, Inclusion and Belonging	11-4.C

CHEERS Check-In Tool	10-6.A
ASQ and ASQ:SE Training	10-6.B and C
Depression Screening Training	10-6.D

HFO Training Policies

HFO has comprehensive training policies detailing all required trainings listed below for staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers):

HFO Training Materials

The following materials are provided through a variety of platforms including the HFA Community, Oregon group, as well as HFA Network Resources and HFA Learning Management System. Additional trainings are provided by the local site and MESD platform for Medicaid Administrative Claiming training.

- **Healthy Families America Best Practice Standards** from HFA
- **HFO Program Policy and Procedure Manual** from HFO
- **HFA Quick Start Webinar** from HFA
- **HFO Orientation "QuickStart" Manual** from HFO
- **Program Evaluation Manual** from HFO
- **Medicaid Administrative Claiming Manual and Training Webinar** from MESD platform
- **Prenatal Training Recorded Webinar** from HFA
- **CHEERS Training Recorded Webinar** from HFA
- **ASQ and ASQ-SE tool training** provided by local site
- **Depression Screen tool training** provided by local site
- **Family Goal Recorded Webinar** from HFA
- **HFO New Hire Tutorials: (**from HFO)
  - Welcome to Healthy Families Oregon and Program Evaluation
  - New Eligibility Screener and Forms
  - New Home Visitor and Forms
  - New Supervisor and Forms
  - Training New Staff
- **Program Manager and Program Manager Assistant Orientation** from HFO
- **HFO Required Training Logs** (from HFO) show timeframes and documentation of Orientation, Activity, Stop-gap, Core, and Online trainings, and identifies the tools and/or manuals required to complete trainings for the first year. HFO staff are required to use the training log that is specific to the new hire's role:
  - *HFO Role Required and Wraparound Training Log for Home Visitors*
  - *HFO Role Required and Wraparound Training Log for Eligibility Screeners*
  - *HFO Role Required and Wraparound Training Log for Supervisors*
  - *HFO Role Required and Wraparound Training Log for Program Managers/ Program Manager Assistant*
- **Wraparound Training** from HFA Interim System
- **HFA FFS Core Training and FROG Scale Training Manuals** (given to trainees at Core Training)
- **Stop-gap Training for Home Visitors and Supervisors** from HFA and local site
- **Annual Ongoing Training** provided by local site
- **Annual Equity, Diversity, Inclusion and Belonging Training** provided by local site
- **Annual Child Abuse and Neglect Training** provided by local site

Please Note the Following Regarding Training Logs:

Home Visitors and Eligibility Screeners keep the *HFO Role Required and Wraparound Training Log* in their supervision notebook upon completion. Supervisors, Assistant Program Managers and Program Managers retain copies of the training logs in their training file. Central Administration will monitor new hire documentation of training in accordance with the *Aligned QA Calendar* and CQI Site Visits

10-2

HFO staff (Home Visitors, Supervisors and Program Managers) receive orientation training subsequent to HFO hire date and prior to direct work with families or supervision to staff to familiarize them with site responsibilities.

Orientation Training

10-2 All HFO staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers) are required to receive training on orientation topics including HFA Quick Start Webinar and HFO Required Orientation Training subsequent to HFO hire date and prior to direct work with families to familiarize themselves with the functions of the HFA model, HFO program and their local site. Program Manager/Assistant Program Manager are required to receive orientation training within 3 months of hire.

All Orientation training topics are documented on the *HFO Role Required and Wraparound Training Log* specific to staff role. The training log specifies what tool/mechanism is used to complete the training and the date completed. In accordance with the *Aligned QA Calendar*, orientation and wraparound training topics are sent to Central Administration and entered into the *HFA Spreadsheet: Training Log.*

HFO Orientation Training topics include:

- HFA Program Goals, Services
- HFO New Hire Tutorials (Welcome to *Healthy Families Oregon* and role specific training)
- Philosophy of Home Visiting/Family Support
- Principles of Ethical Practice
- Parenting Materials, Curriculum and other handouts shared with parents
- HFO Program Policies & Procedures
- Program Evaluation, Data Collection, NPC forms
- Relationship with Community Resources
- Child Abuse/Neglect Indicators and Reporting Requirements
- Confidentiality
- Boundaries
- Staff Safety

Wraparound Training

- Within three months of date of hire, staff receive training in the following topics: infant care; child health and safety; and family health, and cultural self-awareness. This training is completed following the HFA Interim Wraparound Plan
- Within six months of date of hire, staff receive training in the following topics: infant and child development; supporting parent-child relationships; professional practice; mental health; prenatal issues; family goal process; and cultural humility in home visiting. This training is completed through following the HFA Interim Wraparound Plan.
- Within twelve months of date of hire, staff receive training in the following topics: child abuse and neglect; intimate partner violence; substance use; engaging families; and inequity and family context. This training is completed through following the HFA Interim Wraparound Plan.
- Following the first year's wraparound training requirements, it is required that each staff person obtain a minimum of 15 hours each year of continuing education through in-service trainings, workshops, conferences, or other formal education.

Annual Required Diversity, Equity, Inclusion and Belonging Training

Following the first year of employment, all staff annually receive training to increase awareness and understanding of concepts associated with diversity, equity, and inclusion. Training includes how challenges related to diversity, equity, and inclusion impact families, communities, home visiting services and staff.

HFO Staff Safety Policy

Each local site has written procedures to address the health and safety of all HFO staff and volunteers. These procedures address precautions that must be taken to ensure the safety of all staff and volunteers, and must include identifying situations when:

- When it is unsafe to travel to make a home visit
- When the Home Visitor must not enter a home because of safety reasons
- When the Home Visitor must leave the home immediately
- When it is appropriate only to visit the home with another person (the Supervisor, another staff member, or a collaborating partner such as a nurse or mental health specialist).

Each HFO site is required to have communication systems in place that ensure staff safety (i.e., requiring cell phones and/or pagers while in the field, sign out boards, etc.). Supervisors or their designees are required to be available (in the office, by phone, etc.) at all times when Home Visitors are in the field.

Supervision of Home Visitors who are not housed in the same location as their Supervisor shall be conducted weekly and may be in person, by phone or Skype/webcam. Home Visitor safety is a priority. A face-to-face supervision session must be conducted at least monthly. Supervision support is required for staff safety, and immediate debriefing. Note: The intent of this part of the policy is for rural areas where the distance between Supervisor and Home Visitor is significant.

Insert local procedures for the safety of staff that address the above bulleted items:

Insert local procedure indicating how Supervisors know which home each Home Visitor is scheduled to be visiting at all times (i.e. schedules, updates, ets.):

10-2.A All HFO staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Manager and Program Managers) will receive HFA Quick Start Webinar and HFO Orientation Manual

10-2.B All HFO staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers) are oriented to their roles as they relate to 1) the site's parenting materials, curriculum and other handouts shared with parents 2) policy and operating procedures, and 3) data collection forms and processes, subsequent hire date and prior to direct work with families or supervision of staff as stated in HFO Policy 10-2.

10-2.C All HFO staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers) are oriented to the site's relationship with other community resources, subsequent hire date and prior to direct work with families or supervision of staff as stated in HFO Policy 10-2.

Child Abuse and Neglect SAFETY STANDARD

Safety Standard

10-2.D All HFO staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers) are oriented to 1) child abuse and neglect indicators and 2) reporting requirements and prior to direct work with families or supervision of staff as stated in HFO Policy 10-2.

10-2.E All HFO staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers) are oriented to issues of confidentiality and principles of ethical practice prior to direct work with families or supervision of staff as stated in HFO Policy 10-2.

10-2.F All HFO staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers) are oriented to issues related to boundaries subsequent hire date and prior to direct work with families or supervision of staff as stated in HFO Policy 10-2.

10-2.G All HFO staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers) are oriented to issues related to staff safety subsequent hire date and prior to direct work with families or supervision of staff as stated in HFO Policy 10-2.

10-2.H All HFO staff (Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers) are oriented to the Multi-Site System, including the goals, objectives, policies, and functions of the multi-Site System and Central Administration.

10-3

HFO Home Visitors and Supervisors who begin work prior to having the role-specific HFA Core training, are required to receive "stop-gap" training. It does not need to be conducted by a certified trainer; but by someone who has been intensively trained in the role they are providing stop-gap training for. This does not replace the required HFA Core training.

Stop Gap Training (policy)

10-3.A HFO staff are required to complete the following stop-gap training and all of the stop gap components listed below:

- Description of the "HFA Advantage" (what makes HFA unique including trauma-informed practice, the power of relationships/attachment, and reflective capacity) provided in the *HFA Advantage Webinar*.
- Shadowing other staff in a similar role
- Training on forms , form use, and expectations for documentation
- Hands-on practice with observation and feedback
- Use of strength-based tools and interviewing techniques (Reflective Strategies, etc)
- Consistency related to documentation (Home Visitor, Supervisor, Eligibility Screener)

Foundations for Home Visiting Stop-Gap Training

All Home Visitors and Supervisors receive stop-gap training that includes all of the above components, within one month of hire date, and prior to direct work with families, to ensure that staff has a thorough understanding of their role within Healthy Families Oregon. This includes staff from collaborative partnerships, volunteers, and interns functioning as Home Visitors.

Stop-gap training is conducted by staff that have been intensively trained in that role. Completion of the training is documented on the *HFO Role Required and Wraparound Training Log.*

Insert who performs the Foundations for Home Visiting stop-gap training at your site:

Insert the amount of home visit shadows that Home Visitors are required to complete (if in addition to *HFO Role Required and Wraparound Training Log* requirements):

Insert the amount of home visit shadows that Supervisors are required to complete (if in addition to *HFO Role Required and Wraparound Training Log* requirements):

FROG Scale Stop-Gap Training is not administered. Please note:

All Home Visitors and Supervisors are required to receive FROG Scale Core Training prior to conducting the FROG Scale or reviewing the FROG Scale. This does not exempt new staff from receiving in-depth training such as shadowing FROG Scale assessments and hands-on practice before and after the core training. One FROG Scale Shadow is recommended before completing FROG Scale Training. Completion of the training is documented on the *HFO Role Required and Wraparound Training Log*.

While Program Managers/Assistant Program Managers do not complete the FROG Scale assessments, they are still required to complete the core training.

Supervisor Stop-Gap Training

All Supervisors who begin providing supervision prior to completing the Supervisor Core Training receive stop-gap training within four weeks of hire, that includes all the stop-gap components listed above, before supervising any staff or completing any Supervisory sessions, to ensure that the Supervisor has adequate understanding and knowledge of their role. Completion of the training is documented on the *HFO Role Required and Wraparound Training Log*.

Insert who performs the Supervisor stop-gap training at your site:

Insert the amount of supervision shadows that new supervisors are required to complete:

Stop-Gap Provided (practice)

10-3.B Home Visitors and Supervisors receive stop-gap training prior to work with families or supervising direct service staff as stated in HFO policy 10-3.A.

10-3.C Supervisors receive stop-gap training as stated in HFO policy 10-3.A.

10-4

HFO Program Managers, Supervisors, Home Visitors will receive HFA Core training within six months of hire that is specific to their site role to help them understand the essential components of their position.

HFO Core Training: Home Visitors, Supervisors, Assistant Program Managers, Program Managers

- HFO Central Administration offers Foundations for Family Support trainings a minimum of two times per year.
- HFO program sites utilize the HFA community to register for FROG Scale, FROG Scale for Supervisors, and Supervisor Core: Relationships and Reflection
- Cost associated with FROG Scale, FROG Scale for Supervisors, and Supervisor Core: Relationships and Reflection are the responsibility of the local site
- Foundations for Family Support Core training is initiated and scheduled when a site updates Smartsheet with new staff or role changes.
- All core training is tracked using the HFO Role Required and Wraparound Training Log.

When an HFO staff member who has received core training is re-hired for the same position, whether at the same site or at a different site, re-taking of HFA Core training is required if the staff person has not worked for HFA for three or more years.

Essential Standard

HFA FROG Scale Training ESSENTIAL STANDARD

10-4.A All HFO staff using the FROG Scale and all Supervisors will complete the FROG Scale Training by an HFA certified trainer within six months of hire date and prior to first use of the scale.

Essential Standard

HFA Foundation Training ESSENTIAL STANDARD

10-4.B Home Visitors, Supervisors, and Program Managers/Assistant Program Managers will complete the Foundations Core Training by an HFA certified trainer within six months of hire date.

Essential Standard

HFA Supervisor Training ESSENTIAL STANDARD

10-4.C Supervisors and Program Managers/Assistant Program Managers will complete the three-day Supervisor Core Training by an HFA certified trainer within six months of hire.

10-5

HFO Program Managers and Assistant Program Managers hired on or after January 1, 2018 are required to complete HFA Implementation Training from the HFA National Office within 12 months of hire to understand the essential components of implementing the HFA model.

HFA Implementation Training Requirements

10-5. HFO Program Managers and Assistant Program Managers are required to attend the HFA Implementation training within 18 months of the date of hire. This training is documented on the *HFO Role Required and Wraparound Training Log*.

- Costs associated with attending the HFA Implementation Training are the responsibility of the local site.

- Contact HFO Central Administration for training locations and availability.

HFO Program Manager Orientation Training

HFO Central Administration provides a Program Manager Orientation Training that is required to be completed by all Program Managers and Assistant Program Managers within 3 months of hire. This training is documented on the *HFO Role Required and Wraparound Training Log for Program Managers.*

10-6

HFO staff who are responsible for the administration of required screening tools, and their supervisors, receive training on these tools prior to first use.

Eligibility Screener Training for using the NBQ: (HFO staff employed by an HFO program site)

HFO site program management (Program Manager/Assistant Program Manager/Supervisor) are responsible for coordinating training for all Eligibility Screeners who are employed at their site. Eligibility Screeners employed at local sites (hired from January 2018 and on) are required to complete the HFO Role *Required and Wraparound Training Log for Eligibility Screeners* that includes the following:

- Completing the following HFO webinars: New Eligibility Screener Tutorial and Welcome to Healthy Families
- Providing the "Talking Points for the Consent to Participate Form" and reviewing directions for administering the NBQ utilizing in the *Program Evaluation and Forms Manual*
- Shadowing an experienced Eligibility Screener, when available
- Hands-on practice in obtaining written informed consent and conducting the New Baby Questionnaire prior to completing on their own
- Review of the HFA Quick Start Webinar and HFO Orientation Manual
- Reviewing the importance of uniformity in completing the NBQ eligibility screen
- Review of the Consent to Contact form, if your site utilizes the form
- Feedback and outreach for NBQ's that are not uniformly completed

Insert who is responsible for training Eligibility Screeners and insert any additional local procedures for training at your site:

CCI Tool Training

10-6.A Home Visitors and Supervisors receive training on the CCI tool prior to administering the tool and supervising staff who use the CCI tool. Review HFO Policy 6-3.A for training expectations.

ASQ Training

10-6.B Home Visitors and Supervisors receive training on the current version of the ASQ prior to administering the tool and supervising staff who use the ASQ. Review HFO Policy 6-5.A for training expectations.

ASQ:SE Training

10-6.C Home Visitors and Supervisors receive training on the current version of the ASQ:SE prior to administering the tool and supervising staff who use the ASQ:SE. Review HFO Policy 6-5.A for training expectations.

Depression Tool Training

10-6.D Home Visitors and Supervisors receive training on the Depression Screening tool prior to administering the tool and supervising staff who use the Depression Screening. Review HFO Policy 7-4.A. for training expectations.

STANDARD 11: ALL DIRECT SERVICE STAFF AND THEIR SUPERVISORS RECEIVE BASIC TRAINING IN AREAS SUCH AS PRENATAL AND INFANT CARE, CHILD SAFETY AND DEVELOPMENT, FAMILY HEALTH, PARENT-CHILD RELATIONSHIPS, FAMILY GOAL SETTING, REPORTING CHILD ABUSE, MANAGING CRISIS SITUATIONS, AND RESPONDING TO MENTAL HEALTH, SUBSTANCE USE, OR INTIMATE PARTNER VIOLENCE ISSUES. ALL STAFF, INCLUDING PROGRAM MANAGERS, RECEIVE TRAINING ON TOPICS RELATED TO DIVERSITY AND EQUITY.

- 11-1
- 11-2
- 11-3
- 11-4

HFA Standard 11 Intent *is to ensure staff receive training support and have the skill set necessary to fulfill their job functions and achieve improved outcomes with families. Training can be received through a variety of methods including, but not limited to, the following: HFA wraparound training modules, in-person or virtual attendance at lectures, interactive presentations, workshops, and college coursework.*

Intent 11-1 (training within 3 months), 11-2 (training within 6 months), and 11-3 (training within 12 months): *Training that is specific and relevant to the field of home visiting and can translate to the work of HFA staff is critical in the first year of employment. It is intended for staff to receive training in all of the topics outlined in the rating indicators, incorporating suggested subtopics based on relevant community dynamics and the individual learning needs of staff.*

Wraparound Training Requirements

All 3, 6, and 12-month training requirements are documented on the *HFO Role Required and Wraparound Training Log* specific to staff role. The training log specifies the HFA Interim Wraparound Plan is used to complete the 3,6, and 12-month training and the date completed. The *HFO Role Required and Wraparound Training Log* must be completed by all new home visitors and supervisors. New Eligibility Screeners, Program Managers and Assistant Program Managers will complete the topic areas of: Diversity, Equity, Inclusion, and Belonging (11-1.D, 11-2.G, and 11-3.E) within the 3,6,12 month training requirements. In accordance with the *Aligned QA Calendar*, orientation and wraparound training topics are sent to Central Administration and entered into the *HFA Spreadsheet: Training Log.*

It is encouraged that all current HFO staff review or incorporate the HFA Interim Wraparound Plan on an ongoing basis in their annual training plans.

11-1

Home Visitors and Supervisors receive training on a variety of topics necessary for effectively working with families and children utilizing the HFO 3 6 12 Month Training System within 3 months of hire. And all HFO staff (including Eligibility Screeners, Program Managers/Program Manager Assistants) receive training on topic related to diversity and equity.

11-1.A Home Visitors and Supervisors receive training on all topic areas of Infant Care utilizing the HFA Interim Wraparound Plan and documenting all training within three months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- infant sleep and safer sleep practices
- feeding/Breastfeeding
- failure to thrive
- physical care of the baby
- infant crying and responses to crying

11-1.B Home Visitors and Supervisors receive training on all topic areas of Child Health & Safety utilizing the HFA Interim Wraparound Plan and documenting all training within three months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- home safety (e.g., fire, child supervision, water temperature, pools, falls, etc.)
- abusive head trauma prevention
- sudden unexpected infant death
- seeking medical care
- well-child visits, immunizations, and oral health
- parenting children with special health needs

11-1.C Home Visitors and Supervisors receive training on all topic area of Family Health utilizing the HFA Interim Wraparound Plan and documenting all training within three months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- adult primary care
- family planning and reproductive justice
- disability and chronic health issues
- smoking cessation
- health equity and access to care
- community resources for adult medical care and nutrition

11-1.D All HFO Staff (home visitors, eligibility screeners, program managers and supervisors) receive training on the topic areas of Cultural Self-Awareness utilizing the HFA Interim Wraparound Plan and documenting all training within three months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- seeking clarity on personal identity, values, and beliefs
- understanding privilege and its role in systems of oppression and racism how our own experiences play out in home visiting work
- implicit bias
- demonstrating compassion for self and others

11-2

Home Visitors and Supervisors receive training on a variety of topics necessary for effectively working with families and children utilizing the HFO 3 6 12 Month Training System within six months

of hire. And all HFO staff (including Eligibility Screeners, Program Managers/Program Manager Assistants) receive training on topic related to diversity and equity.

11-2.A Home Visitors and Supervisors receive training on all topic areas of Infant and Child Development utilizing the HFA Interim Wraparound Plan and documenting all training within six months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- brain development
- social and emotional development
- language development and early literacy
- physical development
- infant behavior (cues, states, reflexes)
- responding to developmental delays
- community resources to support children with delays

11-2.B Home Visitors and Supervisors receive training on all topic areas of Supporting the Parent Child Relationship utilizing the HFA Interim Wraparound Plan and documenting all training within six months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- observing parent-child interactions
- supporting attachment
- nurturing parenting strategies
- discipline

11-2.C Home Visitors and Supervisors receive training on all topic areas of Professional Practice utilizing the HFA Interim Wraparound Plan and documenting all training within six months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- time management
- coping with stress
- recognizing and preventing burnout
- power imbalances in professional relationships
- reflective practice

11-2.D Home Visitors and Supervisors receive training on all topic areas of Mental Health utilizing the HFA Interim Wraparound Plan and documenting all training within six months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- promotion of positive mental health
- behavioral signs of mental health issues
- depression
- perinatal mood disorders
- coping with loss
- strategies for working with families with mental health issues
- mental health emergencies
- referral resources for mental health

11-2.E Home Visitors and Supervisors receive Prenatal specific training (when the site serves families prenatally) utilizing the HFA Interim Wraparound Plan and documenting all training within six months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- Fetal growth & development during each trimester
- Warning signs: when to call the doctor
- Activities to promote the parenting role, and the parent-child relationship during pregnancy
- Preparing for the baby
- Promoting parental awareness of what the baby is experiencing with a connection to what the parent is doing (reflection)

11-2.F Home Visitors and Supervisors receive training on the topic areas of Family Goal process training utilizing the HFA Interim Wraparound Plan and documenting all training within six months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- Purpose and importance of the family goal process in HFA services
- Working with families to identify strengths and needs
- Supporting the family's role in setting and achieving meaningful goals to assist families in taking charge of their lives
- Development of family goals based upon the Home Visitor's knowledge about the family, as well as tools completed with the family
- Practice writing family goals in ways that help families create measurable goals

11-2.G All HFO Staff (home visitors, eligibility screeners, program managers and supervisors) receive training on the topic areas of Cultural Humility in Home Visiting utilizing the HFA Interim Wraparound Plan and documenting all training within six months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- HFA's approach to culture
- honoring diverse family structures
- LGBTQIA+ parenting
- family culture as a source of family strength
- acknowledging, respecting, and celebrating cultural differences

11-3

Home Visitors and Supervisors receive training on a variety of topics necessary for effectively working with families and children utilizing the HFO 3 6 12 Month Training System within twelve months of hire. And all HFO staff (including Eligibility Screeners, Program Managers and Program Manager Assistants) receive training on topic related to diversity and equity.

11-3.A Home Visitors and Supervisors receive training on all topic areas of Child Abuse and Neglect utilizing the HFA Interim Wraparound Plan and documenting all training within twelve months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- parent and child risks for abuse and neglect
- prevention and education with families

- racial disparities in the child welfare system
- role of HFA with child welfare-involved families

11-3.B Home Visitors and Supervisors receive training on all topic areas of Intimate Partner Violence utilizing the HFA Interim Wraparound Plan and documenting all training within twelve months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- indicators of Intimate Partner Violence
- dynamics of Intimate Partner Violence
- strategies for working with families with Intimate Partner Violence issues
- effects on children
- universal education approach to discussing healthy and unhealthy relationships with families
- the impact of racially disproportionate policing on family responses to IPV
- referral resources for family violence

11-3.C Home Visitors and Supervisors receive training on all topic areas of Substance Abuse utilizing the HFA Interim Wraparound Plan and documenting all training within twelve months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- causes of and risks for substance use disorders
- alcohol use and dependence
- substances prevalent in the community
- talking with families about substance and alcohol use
- strategies for working with families with substance use challenges and families in recovery
- substance use and racial disparities in the judicial system

11-3.D Home Visitors and Supervisors receive training on all topic areas of Engaging Families utilizing the HFA Interim Wraparound Plan and documenting all training within twelve months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- engaging fathers and co-parents
- multi-generational families
- working with adolescent parents
- engaging non-binary parents
- strategies for working with families impacted by personal, historical, or generational trauma

11-3.E All HFO Staff (home visitors, eligibility screeners, program managers and supervisors) receive training on the topic areas of Inequity and Family Context utilizing the HFA Interim Wraparound Plan and documenting all training within twelve months of the date of hire on the *HFO Role Required and Wraparound Training Log.*

HFA's online training includes these subtopics:

- historically and currently marginalized communities
- racial wealth gap
- systemic barriers to access and accessibility
- systemic racism and social inequities
- intersectionality
- impacts of inequity on parenting and the home visiting relationship

11-3.F All staff who work for HFO, which is accredited by HFA as a Multi-Site System are oriented to the Multi-Site System (goals, objectives, policies and functions of the Multi-Site System and Central Administration) by attending the *Welcome to Healthy Families Oregon and Program Evaluation* tutorial and documenting the date completed on the *HFO Role Required and Wraparound Training Log*.

11-4

All HFO staff employed longer than twelve months receive ongoing training on an annual basis including professional development, Child Abuse and Neglect, Medicaid Refresher training, and annual training related to Diversity, Equity, Inclusion, and Belonging.

Individual Training Plans and Ongoing Training

11-4.A All HFO staff are offered and participate in ongoing training. Home Visitors, Eligibility Screeners, Supervisors, Assistant Program Managers and Program Managers identify individual training needs and professional development goals with their Supervisor and determine what additional training topics would be most beneficial in enhancing job performance. An *Individual Training Plan* or other similar document (i.e. Professional Development Plan, Annual Review Plan, etc.) is typically created/updated in an annual review process. This determination is based upon the staff's knowledge, performance, skill base and interest. A copy of each staff's *Individual Training Plan* or similar document is kept in the staff's supervision notebook or folder. An *Individual Training Plan* or similar document will not be required for staff within the first 12 months of hire.

Supervisors assist staff in identifying relevant training opportunities to meet each staff person's unique needs. All staff are required to receive a minimum of fifteen (15) hours of ongoing training and professional development each year after the first year of hire to remain energized, enthused and up-to-date on recent advances in the field.

Insert local procedure for the development and completion of your site's Individual Training Plans for HFO staff that have been employed over one year:

Documentation of Ongoing Training

When completing documentation, the following are required to be retained in each staff's training records:

- Classes, Presentations, Webinars, etc.: Retain training certificates, brochures and/or agendas that describe the content of the training.
- Self-study: Complete and retain the *Documentation of Learning* form.

Annual Medicaid Training

Annual Medicaid Training is required for Home Visitors, Supervisors, Program Managers/Assistant Program Managers, and Eligibility Screeners to ensure that they understand coding and receive any necessary state updates. Although this is not an HFA standard, it is required by Healthy Families Oregon and the State of Oregon.

Annual Child Abuse and Neglect Training

11-4.B Home Visitors, Supervisors, Program Managers/Assistant Program Managers, and Eligibility Screeners are required to receive annual ongoing training on Child Abuse and Neglect each year in order to stay updated on current child welfare policies, practices, and trends in the local community.

Please Note: *During the first year of hire, standard 11-3.A. (Child Abuse and Neglect), may be used to satisfy this standard. In the second year of hire and every year thereafter, all staff (Program Managers, Assistant Program Managers, Supervisors, Home Visitors, Eligibility Screeners) receive at least one training related to child abuse and neglect updates All staff do not have to attend the same training.*

Annual Diversity, Equity, Inclusion and Belonging Training

11-4.C Home Visitors, Supervisors, Program Managers/Assistant Program Managers, and Eligibility Screeners are required to receive annual ongoing training designed to increase awareness and understanding of concepts associated with diversity, equity, inclusion and belonging and how families, communities, home visiting services, and staff are impacted.

Please Note: *All staff do not have to attend the same training. During the first year of hire, standards11-1.D (Cultural Self Awareness), 11-2.G (Cultural Humility in Home Visiting), and 11-3.E (Inequity and Family Context) may be used to satisfy this standard.*

HFA Intent:

Staff are better prepared to serve and interact with families when they have increased awareness and understanding of diversity, equity, inclusion and belonging and how families, communities, staff, and services are impacted by social injustice, institutionalized racism, power imbalance, and implicit bias. Expanding learning opportunities in these areas on at least an annual basis clearly conveys the priority HFA places on supporting each individual's journey, and our collective effort to end racism and discriminatory practices and nurture inclusion and compassion for our common humanity. Please see Standard 5-3 for details on Annual Diversity, Equity, Inclusion and Belonging Training.

STANDARD 12: SERVICE PROVIDERS RECEIVE ONGOING, EFFECTIVE SUPERVISION SO THAT THEY ARE ABLE TO DEVELOP REALISTIC AND EFFECTIVE PLANS TO EMPOWER FAMILIES.

HFA Standard 12 Intent *- The field of infant mental health has identified reflective supervision as a best practice approach, and recognizes and embraces the supervisory relationship as being central to the work with families. "Over 30 years of clinical experience and empirical evidence indicates that Reflective Supervision/Consultation (RS/C) increases the quality of infant mental health services by reducing vicarious trauma, staff turnover, and bias, while increasing practitioner knowledge and improving practice, job satisfaction, efficacy, and responsiveness. This has led to a general consensus in the multidisciplinary field of infant mental health that RS/C is inextricably both a best practice and an essential component for those providing relationship-focused prevention, intervention, and treatment" (MI-AIMH, 2017). Therefore, reflective supervision is central to the effectiveness of the Healthy Families America model. The intent of reflective supervision is to promote self-awareness, increase clarity about the work being done with a family, build confidence in staff skills, encourage intentionality, and ultimately increase the quality of services provided to families. This approach to supervision recognizes the work with families is very personal work that requires continual introspection about who we are, what we bring to the work, and how the work is impacting us. Reflective supervision is a collaborative process in which all involved (supervisor, supervisee, parent, and child) play a role, whether intentional or not.*

Reflective supervision consciously connects the experiences individuals have in the context of their relationships of others. Reflective supervision is not just about understanding how these relationships affect one other. It is also about intentionally impacting relationships. In other words, if we want parents to see, hold, respond to, and nurture their infants, they must have experienced being cared for themselves. For parents who have not been provided such caregiving through a secure, nurturing relationship, staff may provide an environment for those parents to begin to experience secure relationships. And, in order for staff to be able to provide parents with such safety and security, staff must have someone to provide a safe place for them as well. This is what we refer to as the parallel process. This work often challenges our values and worldviews in ways that result in heightened emotions that can cloud our ability to interpret family circumstances both objectively and empathetically. In work with families, direct service staff's most powerful strategy is the intentional use of self. Reflective supervisors become someone with whom staff can feel seen, held, and supported. The hope is that, as staff experience the support, compassion, respect, and feeling of being seen and heard by their supervisor, this will spill over into their work with families.

During supervision, staff are recognized for the gifts they bring to the work, such as their compassion, wisdom, patience, and ability to see all the strengths each family has to offer their children. They have an opportunity to step back from the day-to-day tasks of their work (writing notes, completing home visits, tracking data, etc.) and are invited to look at what is working well and what is not working so well in their work with families. Supervisors partner with staff in this process of reflection by allowing space and time for honest conversations about the work. They use reflective strategies and conversations as a means of increasing staff's reflective capacity (including self-awareness of the impact of their own culture, values, and beliefs on others), their ability to identify and build on parental competencies, and, ultimately, their effectiveness in their interactions with families. Supervisory sessions encourage professional and personal development by providing a safe yet challenging environment where taking initiative is nurtured and supported. Reflection is a key component of all supervisory discussions, regardless of whether those discussions are administrative or clinical (related to the family) in nature.

12-1

HFO sites ensure that home visitation staff receive weekly and ongoing supervision. This includes Home Visitors and any volunteers/interns in a Home Visitor role.

Supervision Frequency/Duration (policy)

12-1.A. Each HFO site ensures that Home Visitors receive weekly and ongoing supervision including:

- Supervisors providing regularly scheduled, individual supervision for each Home Visitor (including volunteers and/or interns who perform direct service or the same function) for a minimum of 1.5 to 2 hours per week for staff that are .75 to 1 FTE.
- Part-time Home Visitors that are .25 to .74 FTE receiving a minimum of 1 hour per week.
- Home Visitors that are less than .25 FTE receiving supervision according to occurrence of services. For example:
  - Home Visitors discuss all of the FROG Scales completed in a given week; however, this may not take the full hour of discussion.
  - Part-time Home Visitors with three or fewer families may have supervision discussions at a frequency based on the level of service the families are on.
  - Supervisors make sure the requirements of the 12-2 standards are being carried out throughout the shortened sessions.
- Supervisory sessions for Home Visitors begin the first full week of employment. This provides an opportunity and dedicated time to train, check in, review work, and offer feedback.
- Scheduled supervision that is not split into more than two regular sessions per week. A Supervisor or "acting Supervisor" must be available at all times a Home Visitor is working with families for support and consultation.
- It is highly recommended that private rooms are available for all supervisory sessions. Due to the nature of Reflective Supervision as well as family content discussed, all measures to assure confidentiality are encouraged.

Supervisors must ensure they have adequate time to spend with each Home Visitor, therefore, the frequency and duration of supervision is monitored closely. Also, every effort is made to set a specific time weekly for supervision. Supervisors document frequency and duration for each Supervisory session on the *Supervision of Home Visitor Log* for each Home Visitor and the *HFO Supervision Log for Eligibility Screeners*. Additionally the dates and duration for supervision of Supervisor is tracked using *HFA Spreadsheet: Tracking Supervision*

Supervision Log for Home Visitors:

- Sites are required to use the *Supervision of Home Visitor Log* to track supervisory sessions. Supervisors are required to track and submit the log to their Program Manager on a quarterly basis. This log is required to be present in each Home Visitor's Supervision Notebook.
- Program Managers will monitor this Safety Standard and review areas of concern with the Supervisor within one month of receiving the log. Program Managers will offer written strategies for support if a Supervisor is below 75% for any Home Visitor for two consecutive quarters to ensure adherence to this important standard.
- Documentation on the log includes the reason for missing supervision, cancellations and/or rescheduling.
- You can only "excuse" supervision and subtract it from the denominator if the Home Visitor is out all week. The supervisor being out does not excuse the session as the Home Visitor was still visiting families and should receive supervision. Please indicate the specific language "HV out all week" when excusing the session.
- If the HV is out on their typically scheduled supervision day, but not all week, it is not excused. It is expected that they reschedule supervision during the week as it should be a priority.

Distance Supervision for Home Visitors

Supervision of Home Visitors who are not housed in the same location as their Supervisor is conducted weekly and may be in person, by phone or by webcam. Home Visitor safety is a priority. *A face-to-face supervision session must be conducted at least monthly*. On-site staff support (not funded by Healthy Families State General Fund if not HFO Core position) is required for staff safety, and immediate debriefing support. (Note: The intent of this policy is for rural areas where the distance between Supervisor and Home Visitor may be significant).

If utilizing distance supervision, please insert local policy indicating how often in-person supervision occurs and how supporting staff and staff safety are addressed:

Eligibility Screeners Supervision Frequency/Duration

HFO sites are required to provide Eligibility Screeners with bi-weekly (every other week) and ongoing supervision including:

- Supervisors providing regularly scheduled, individual supervision for each Eligibility Screener at the site (including volunteers and/or interns who perform the same function) for a minimum of 1 hour bi-weekly for staff that are .5 to 1 FTE.
- Part-time Eligibility Screeners that are less than .5 FTE receive a minimum of a half hour bi-weekly or 1 hour monthly individual supervision.
- Supervision duration and frequency are documented on the *Supervision of Eligibility Screener Log* or *Home Visitor Log* if performing a dual role. Missed supervisory sessions will be documented with the reason noted.
- Supervisory sessions for Eligibility Screeners are required to begin the first week of date of hire. This provides an opportunity and dedicated time to train, check in, review work, and offer feedback.
- Documentation can be completed on *HFO Eligibility Screener General Supervision* form or *HFO General Weekly Supervision* form if performing a dual role.

Home Visitor/Eligibility Screener Supervision Frequency/Duration (Dual Roles)

If HFO staff has a dual role as a Home Visitor/Eligibility Screener, FTE for each position is required to be clearly documented and communicated with the staff member. This ensures that caseload points are reflective of the home visiting FTE and that the Home Visitor receives at least the minimum supervision for home visiting duties (For example: part-time Home Visitors that are .25 to .74 FTE receiving a minimum of 1 hour per week and pro-rated if less).

Home Visitors cannot have 1 FTE for a Home Visitor role and have regular screening duties added. This FTE is required to be divided to ensure FTE for screening duties. Eligibility Screening supervision time is added on to the minimum requirement of a Home Visitor role and supervision documentation clearly indicates both roles are being addressed (documentation can be completed for both roles on the *General Weekly Supervision)*.

<u>For example:</u>

A Home Visitor (.5 FTE) is also the Eligibility Screener (.5 FTE). The max caseload weight is 15 points (.5 FTE Home Visitor). The minimum weekly supervision is 1 hour/week (.5 FTE Home Visitor = 1 hour minimum per week). The minimum supervision for the Eligibility Screener is ½ hour, 2 times per month (pro-rated for ½ time). The staff would receive supervision weekly for 1 hour for the home visiting role, and two times during that month for their eligibility screening role (pro-rated .5 hours two times a month for .5 FTE). The total supervisory session would be 1.5 hours to cover the home visiting and eligibility screening roles.

List any local exceptions to the above policy (required to be approved by HFO Central Administration):

Safety Standard

Supervision Frequency and Duration (practice) SAFETY STANDARD

12-1.B. All direct service staff, which includes HFO Home Visitors and Eligibility Screeners, receive ongoing supervision as stated in HFO policy 12-1.A. Sites use the *HFA Spreadsheet: Tracking Supervision.*

Group Reflective Consultation

12-1.C. HFO sites may conduct reflective consultation groups. The groups must be implemented with the same degree of preparation and documentation as individual supervision (attendees, topics covered), and must be facilitated by a qualified individual.

The reflective consultation groups are required to have the following:

- Consultant with Infant Mental Health (IMH) Endorsement or Master's degree in counseling or related field with two years' post education, specialized work experience providing culturally sensitive, relationship-focused infant mental health services with infants and toddlers and their families, and has also been recipient of reflective supervision. If reflective consultation is conducted by a contractor, the Supervisor must attend in order to support staff with recommended action steps pertaining to the family discussed during group as well for this session to count as replacing individual weekly supervision.
- Time frame of two or more hours
- Family presentation
- Focus on holding the space that encourages self-reflection and self-regulation for staff, both physically and emotionally
- Observation of the staff member's internal responses to the work including parallels between what might be going on for the worker as well as how that might impact the work
- Focus on the parallel process; expanding to what might be going on for the staff in conjunction with what the family and the baby might be experiencing
- Opportunities for participants in the group to reflect on the group session they just observed

One reflective consultation group per month may substitute for a weekly supervision session only for Home Visitors who have demonstrated proficiency in their role and have been with the site longer than 12 months. Additionally they must be .25-1.0 FTE (.24 FTE or less may attend reflective groups; however, it cannot be used to offset individual supervision). New hires employed less than a year are not eligible to count the reflective consultation group towards weekly supervision requirements.

This person may be sub-contracted by the agency. If reflective consultation is conducted by a contractor, a site supervisor attends as a group member in order to support staff with any recommended action steps pertaining to the family discussed during group. Documentation must include who attended and content topics covered, and must be facilitated by a qualified individual.

Ratio of Supervisors to Home Visitors & Eligibility Screeners

12-1.D It is critical Supervisors have the time to prepare for supervision as well as complete all of the requirements of the site and host agency. It is estimated that supervising a Home Visitor requires approximately 8 hours per week of supervision time including the actual supervision session, as well as the supervision activities outside of the session including quality management activities, administrative work, and arranging training and staff meetings, etc. Part-time staff require nearly the same amount of supervision time, therefore the ratio for a staff of all part time direct service providers is limited to a maximum of 8 part-time Home Visitors to each full-time Supervisor.

The site maintains a ratio of one full-time Supervisor (with responsibilities only for supervision of the local HFO site) for up to six Home Visiting FTE (and/or volunteers/interns who perform the same function), not to exceed eight part-time Home Visiting staff. HFO recommends best practice of 5 Home Visiting FTE to 1 FTE Supervisor. If

the Supervisor supervises dual roles (Home Visitors and Eligibility Screeners), please see details below for ratio calculations. If the Supervisor is less than full-time or if the Supervisor is also the Program Manager, or has other duties besides HFO supervision, the FTE of home visiting staff FTE is adjusted to the percentage of time spent in the Supervisory role to maintain an overall ratio of 1:6, preferably 1:5.

Staff Ratios for Supervising Home Visitors & Eligibility Screeners

- Supervisors who are supervising dual staff roles (Home Visitors and Eligibility Screeners) are required to calculate Eligibility Screeners into their staff ratios in addition to Home Visitors.
- The ratio of supervisors to direct service staff (Home Visitors and Eligibility Screeners) is one (1) full time supervisor to six full time direct service staff or eight part-time staff (Home Visitors and Eligibility Screeners).
- Take the total FTE of the Eligibility Screener and multiply by .5. For example, you supervise an Eligibility Screener that is 1 FTE so 1 multiplied by.5 = .5. You would count .5 into your total staff ratio of Home Visitors and Eligibility Screeners.

Home Visitors: **Insert local site supervision staffing ratio including each Supervisor's FTE and each individual Home Visitor being supervised by the Supervisor and their FTE:**

Eligibility Screeners: **Insert local site supervision staffing ratio, including Supervisor FTE and The FTE of each Eligibility Screener they supervise:**

12-2

All HFO direct service staff (Home Visitors, volunteers/interns performing the same function, and Eligibility Screeners) receive reflective supervision pertaining to all aspects of their work and have opportunities for skill development and professional support.

Reflective Supervision and Annual Shadowing (policy)

12-2.A During supervision Home Visitors are provided with supervision that is reflective, whether discussing administrative issues or providing clinical guidance. Supervisors document reflective practice skills (active listening, thoughtful questioning) used to gain a better understanding of the reasons for the staffs thoughts and feelings to help determine the interventions going forward. Supervisors will document conversations depicting how family culture is considered when supporting staff in their work with families.

Supervisors maintain written documentation of the content of all Supervisory sessions. The content of weekly supervision regarding the individual Home Visitor is documented on the *General Weekly Supervision* form.

Home Visitors and Supervisors are accountable for the quality of their interactions with families on a regular and routine basis in supervision.

Families on each Home Visitor's caseload are to be discussed and documented on the *Family Progress Review* as follows:

- At a minimum of every 30 days for families who are on Level 1, 1SS, 1P and Creative Outreach (to discuss progress and strategies of re-engagement)
- At a minimum of every 60 days for families on all other levels

Home Visit Record Review

The Supervisor reviews all *Home Visit Records* of each Home Visitor before Supervisory sessions within 10 days of completed home visits. The review will include ensuring that Home Visitors are addressing all of the necessary items within required timeframes (CHEERS, FROG Scale risk factors/stressors, strengths and protective factors, Reflective Strategies, health and safety information, developmental and depression screening, referrals, etc.).

It is essential for Supervisors to provide feedback to Home Visitors regarding documentation on *Home Visit Records*. The *Home Visit Record* shows evidence of the work that Home Visitors are completing with families in a home visit and continuous feedback enhances professional and skill development.

Supervision Responsibilities for Eligibility Screeners

The position of the Eligibility Screener is one of the most important direct service roles in HFO as this is the first person that a family meets to introduce the program and services that HFO offers. Careful selection, training (see 10-2, 11-1, 11-2, and 11-3 for training details), and supervision of staff in this position is vital. Ongoing support and accountability, encouraging professional development, and preventing isolation and burn out, is equally important to ensure quality services and fidelity to the HFA model. During supervision Eligibility Screeners are provided with supervision that is reflective, whether discussing administrative issues or providing clinical guidance.

Staff supervising Eligibility Screeners and are responsible for:

- Providing crisis response and/or immediate debriefing
- Support and reflection for difficult/traumatic screenings
- Periodic review of the Eligibility Screener's presentation of the program
- Monitoring of NBQ uniformity and screening rate
- Reviewing HFA/HFO updates that affect the Eligibility Screener or HFO screening process
- Reviewing of pertinent agency issues
- Reviewing/monitoring outreach activities
- Monitoring training for newly hired Eligibility Screeners and ongoing annual training requirements (CAN, Medicaid, and Cultural Sensitivity)

Insert how your site keeps Eligibility Screeners connected to the rest of the HFO team (i.e. staff meetings, trainings, team buildings, etc.):

Insert your local procedure for staff meetings, including regularity and length:

Supervision Notebooks for Home Visitors

Supervisors are required to create a supervision notebook or binder for each Home Visitor that they supervise. Notebooks are required to contain the following documentation:

- Tab for each individual family they are currently serving that includes the *Family Progress Review,* copy of the reviewed FROG Scale Summary for each family
- General Supervision section that includes the *General Supervision Review form* that focuses on the Home Visitor, and the *HFA Spreadsheet: Supervision Log*
- Quality Assurance section that includes the *Annual Supervision Tracking Tool* and all completed QA forms
- Training section that includes the completed *HFO Role Required and Wraparound Training Log,* any necessary *Documentation of Learning* forms, yearly ongoing training documentation, and any additional training materials

Supervision Notebooks for Eligibility Screeners

Each Eligibility Screener will have a supervision notebook that will show documentation for the following:

- Supervision Log documenting required supervisory sessions (frequency & duration)
- General supervision notes that document discussions between Eligibility Screener and Supervisor using *HFO Eligibility Screener General Supervision* form
- Professional development activities including shadows, review of HFO introduction/talking points, NBQ scoring, *Consent to Contact and Consent to Participate*
- Training Section (if Eligibility Screener does not have a separate training notebook) that includes: *HFO Role Required and Wraparound Training Log.*

Staff Development Plans

The Staff Development Plan (template available on the HFO website) or other supportive plan (s) can be created to help support Home Visitors or Eligibility Screeners who are in need of additional assistance with challenging aspect of their work. This plan is created in supervision between the Home Visitor and their Supervisor.

The plan can be used for, but is not limited to, the following challenges:

- Continued boundary concerns
- Quality and/or timeliness of paperwork completion
- Ongoing home visit completion challenges
- Ongoing caseload management challenges
- Red flags for burn out
- Engagement/retention issues
- Documentation support
- Any challenge that the Home Visitor is open to problem-solving

QUALITY ASSURANCE ACTIVITIES FOR SUPERVISORS TO COMPLETE

Annual Supervision Tracking Tool

Supervisors complete the *Annual Supervision Tracking Tool* for each Home Visitor that they supervise. This tool is located in the Supervision Notebook and documents all quality assurance activities that are required to be completed by the Supervisor. Supervisors will submit the completed *Annual Supervision Tracking Tool* for each Home Visitor to the Program Manager or Assistant Program Manager for monitoring and review. Supervisors are given feedback if any items are overdue. If a supervisor is also a Program Manager, this document will be submitted to their Supervisor for monitoring and review.

The *Annual Supervision Tracking Tool* is submitted to HFO Central Administration annually for monitoring purposes. The completed forms are submitted by the Program Manager at least two weeks prior to the local site's annual Continuous Quality Improvement (CQI) Site Visit.

Specific Quality Assurance forms (Home Visit Shadow, FROG Scale Shadow, QA Phone Surveys, etc.) are kept in the Quality Assurance section of each Home Visitor's supervision notebook.

Quality Assurance and Quality Improvement Activities Completed for Home Visitors

- **FROG Scale Review:** Supervisors review each FROG Scale Summary to verify that the Home Visitor is acquiring the appropriate information, scoring each area correctly, and using the FROG Scale as a basis to get to know the family's risks factors, stressors, strengths, protective factors, and needs.

  The Supervisor will review each FROG Scale Summary submitted offering written feedback to Home Visitors to improve the quality of scoring. The Supervisor will also provide feedback to the Home Visitor on the content of the written narrative. Supervisor feedback is encouraged to be written directly on the summary. If changes need to be made, the draft is returned to the Home Visitor to resubmit a final draft with changes.

Discussions of the Home Visitor's narrative technique/skills/feedback are documented on the *General Weekly Supervision* form. Discussion of the FROG Scale risk factors/stressors/ strengths/protective factors specific related to the family are documented on the *Family Progress Review*. Completion of this QA Activity is documented by the Supervisor on the *Annual Supervision Tracking Tool*.

- **FROG Scale Shadow:** The Supervisor observes each Home Visitor conducting a FROG Scale at least annually (and more frequently for new Home Visitors or Home Visitors who may need more support in this area). FROG Scale shadows may be completed more often for newly hired Home Visitors, according to your local practice. Supervisors are required to fill out the *FROG Scale Shadowing Form*, preferably in conjunction with debriefing the observation with the Home Visitor. Home Visitor feedback is documented on the *General Weekly Supervision* form. Completion of this QA Activity is also documented by the Supervisor on the *Annual Supervision Tracking Tool.*

- **Home Visit Shadow:** The Supervisor observes each Home Visitor on a home visit every year after the first year of employment. Home visit shadows are completed more often for newly hired Home Visitors, according to your local practice. The *Home Visitor Shadowing Form* is completed with the Home Visitor, preferably in conjunction with debriefing the observation. Home Visitor feedback is documented on the *General Weekly Supervision* form. Completion of this QA Activity is also documented by the Supervisor on the *Annual Supervision Tracking Tool*.

- **Home Visit Completion (HVC) Rate Review:** Each Home Visitor's home visit completion rate is regularly reviewed and monitored by the Supervisor to assure adequate numbers of visits are made. HVC rates are reviewed and documented during Supervisory sessions each quarter, acknowledging success, and problem-solving strategies to improve the home visit completion rate. If a Home Visitor has an ongoing need for additional support, it is recommended that Supervisors strategize and problem solve on a monthly basis to increase HVC rates. These discussions are documented on the *General Week Supervision* form. Completion of this QA Activity is documented by the Supervisor on the *Annual Supervision Tracking Tool*.

- **Caseload Review:** The Supervisor and Home Visitor routinely discuss family progress during supervision to assure the appropriate level of service. Supervisors ensure appropriate use of the level system, to avoid dependence and encourage empowerment, while providing adequate support for families. The Supervisor ensures that each Home Visitor carries no more than the maximum total weighted caseload for the Home Visitor's full-time equivalency (FTE). Discussions concerning weighted caseloads are documented on the *General Week Supervision* form. Discussions concerned individual families' level is documented on the *Family Progress Review*.

- **Family Engagement/Retention Review:** The Supervisor reviews family engagement and retention rates for each Home Visitor they supervise. Together with the Home Visitor, the Supervisor develops and implements a plan to address engagement or retention, if this is an ongoing challenge, and/or the Home Visitor needs increased support in this area. These discussions are documented on the *General Week Supervision* form.

- **QA Family File Review:** The Supervisor thoroughly reviews every family's file a minimum two times per year reviewing the Data Tracking Form, as well as the documentation listed on the form (please see the *QA Family File Review Form* for detailed instructions). File review is strongly encouraged at 6- and 12-month intervals. For newly hired Home Visitors, or Home Visitors needing more organizational support, it is recommended that files are reviewed more frequently. Family files are also reviewed at closing, to ensure that all paperwork is included and completed correctly. Home Visitor feedback is documented on the *General Weekly Supervision* form. Completion of this QA Activity is documented by the Supervisor on the *Annual Supervision Tracking Tool*.

- **Family File Checklists Review:** Using the *HFO Family File Checklist*, the site completes a thorough documentation review, in accordance with the *Aligned QA Calendar*, one time a year that aligns with the HFA checklist to ensure adherence to the HFA standards. Supervisors review overall site trends with the team and also offer individual feedback to Home Visitors, if needed. The individual feedback is documented on the *General Weekly Supervision* form. Completion of this QA Activity is documented by the Supervisor on the *Annual Supervision Tracking Tool.*

- **Evaluation Paperwork Review:** The Supervisor is responsible for monitoring the complete and timely submission of all necessary evaluation forms (Family Intake, Family Update, My Parenting Experience I, and II A&B, ASQ and ASQ-SE, Depression Screening, and FROG Scale) for each Home Visitor to NPC Research. Supervisors review overall site trends with the team and also offer individual feedback to Home Visitors, if needed (i.e. incomplete/inaccurate submissions, improvements, etc.). The individual feedback is documented on the *General Weekly Supervision* form. The site is responsible for the accuracy and completeness of the data submitted to NPC and entered in The HFO Statewide Database. Program Managers are responsible for overall site submission.

- **QA Phone Calls:** The Supervisor contacts two families per Home Visitor every 180 days (total of four families per year per Home Visitor) to review parent satisfaction. This outreach may be completed in person, at parent meetings, or via phone. The Supervisor acknowledges positive feedback from parent regarding the Home Visitor, and also develops and implements a plan to support Home Visitor if challenges were identified by parent input. Feedback is documented on the *General Weekly Supervision* form. Completion of this QA Activity is documented by the Supervisor on the *Annual Supervision Tracking Tool*.

- **Medicaid Administrative Claiming Monitoring:** It is recommended Supervisors and/or Program Managers are to monitor at least one Medicaid Administration Day for each HFO staff at least once every 180 days using the *Medicaid Monitoring Form*. Monitoring includes, ensuring codes are properly used and verifying supporting documentation for any billable code. Attach the *Medicaid Monitoring Form* to the MOTT printout and Medicaid Time Tracker Log as verification of the review. Feedback is documented on the *General Weekly Supervision* form. Completion of this QA Activity is documented by the Supervisor on the *Annual Supervision Tracking Tool*.

- **Annual Training Log Review:** In addition to reviewing training logs on an ongoing basis to ensure that Home Visitors are supported in receiving required training on time, Supervisors will review ongoing and newly hired staff training logs each year. Supervisors will ensure that staff hired after one year have documented all professional development training (with a minimum of 15 hours per year), as well as annual Child Abuse & Neglect, Medicaid Training, and Equity Training. Completion of this QA Activity is documented by the Supervisor on the *Annual Supervision Tracking Tool.*

Quality Assurance Activities Completed for Eligibility Screeners

Supervisors in charge of supervising Eligibility Screeners are responsible for ensuring quality in the screening process. This includes ensuring that the screening process is being completed correctly and uniformly, following the standardized process required by HFO policy, and that the HFO program is being presented clearly and accurately. These activities are required to be documented, as well as feedback to staff, on the general supervision form per their role: Eligibility Screener or Eligibility Screener/Home Visitor dual role and kept in their notebook. And Eligibility Screener *Annual Supervision Tracking* tool will be used to support the completion of the following activities:

- Eligibility Screen (NBQ) Review for uniformity and accurate scoring on an ongoing basis
- Shadowing of Eligibility Screener at a minimum of one time per year (more often if staff need additional support or training or if the staff is newly hired)
- Review of HFO Program Presentation at a minimum of one time per year (more often if staff need additional support or training or if the staff is newly hired)
- Annual Training Log review for the first year if newly hired and at least one time per year for ongoing training

Reflective Supervision Provided (practice)

Essential Standard

12-2.B Each HFO site ensures direct service staff (Home Visitors and Eligibility Screeners) are provided with weekly reflective supervision pertaining to all aspects of their work and are provided opportunities for skill development and professional support to continuously improve the quality of their performance.

Annual Shadowing Provided (practice)

12-2.C Each HFO site ensures direct service staff (Home Visitors and Eligibility Screeners) are provided with a minimum of twice annual shadowed visits and debrief with their supervisor.

12-3

HFO Supervisors receive regular, on-going supervision and are provided with skill development and professional support and are accountable for the quality of their work and are able to receive reflective supervision, individually or as part of a reflective group for supervisors.

Supervision of Supervisor (policy)

12-3.A All HFO Supervisors will receive regular and on-going supervision and opportunities for reflection that occurs at a minimum, every 30 days, with a recommendation that it occurs every other week (particularly if the Supervisor is newly hired). Supervision sessions are regularly scheduled to ensure the Supervisor has the support they need to ensure that they are held accountable for the quality of their work, receive skill development and professional support and ensure quality services are provided at the staff and direct service level.

Supervisory sessions include, but are not limited to the following:

- Addressing personnel issues
- Feedback/reflection to Supervisors regarding team development
- Agency issues
- Review of site documentation such as monthly or quarterly reports, site statistics, and quality assurance mechanisms
- Site monitoring: supervision frequency & duration, ASQ and ASQ-SE tracking, medical provider tracking, immunization tracking, depression screening tracking, families 1st visit, within 3 months, Home Visit Completion, completion of CHEERS Check-In too completion
- Review of progress towards meeting site goals and objectives
- Strategies to promote professional development/growth
- Review and feedback of shadowing supervision
- Feedback of review of supervision notebooks
- Receive every other month reflective supervision

Supervisors Carrying Caseloads

For Supervisors carrying small caseloads (1-3 families) on a permanent basis, or carry a larger caseload, but on a temporary basis (when families are temporarily re-assigned due to staff leave or turnover), or conduct occasional FROG Scales (as a back-up):

- The person providing supervision does not have to be trained as an HFO Supervisor. It is preferred but not required.
- The supervision session can occur based on the frequency of contact and does not have to occur weekly.
- If the person providing the supervision is not trained as a Supervisor in HFO, the Supervisor can maintain the supervision notes based on the discussions being conducted.

For Supervisors carrying larger caseloads (i.e. 4 or more families on an ongoing basis), or routine completion of FROG Scales:

- The ratio of Supervisor to staff (12-1.C) is to be taken into account based on the percentage of time the Supervisor is providing direct services.
- Supervisors must receive supervision in accordance with the 12-1 and 12-2 standards.
- And the individual providing supervision to the Supervisor must have received all HFO required training as outlined in Standards 10 and 11.

Insert how often Supervisors receive skill development and professional support (separated by agency, if applicable) and by whom:

Insert how often Supervisors receive reflective supervision (separated by agency, if applicable) and by whom:

QUALITY ASSURANCE ACTIVITIES: REQUIREMENTS FOR SUPERVISION OF SUPERVISOR

Please note: The activities below are completed by the Program Manager or Assistant Program Manager. If you are in a dual role as a Supervisor/Program Manager, these activities need to be completed and documented by your direct report. If you do not have a direct report, these can be completed by another staff member that holds the same/more responsibility within an agency. They cannot be completed by someone you supervise.

- **Supervision Shadow:** Ongoing review of the content of supervision is completed annually through a required supervision shadow by the Program Manager or Assistant Program Manager using the *Supervision Shadow Form*. Newly hired Supervisors are required to be shadowed at a minimum of one time within the first three months of hire and two additional times within the first year of hire.
- **Supervision Notebook Review:** The Program Manager or Assistant Program Manager are required to review two supervision notebooks per Supervisor, two times per year using the *HFO Supervision File Checklists* (more often if the Supervisor requires more support in this area) by to ensure adherence to the HFA Standards. Feedback to the Supervisor is documented on the *Supervision of Supervisor* form and the checklists are submitted to Central Administration in accordance with the *Aligned QA Calendar*.
- **Monitoring of Supervision Quality Assurance Activities:** The Program Manager or Assistant Program Manager is required to complete an annual review of Quality Assurance activities completed by the Supervisor for each Home Visitor. This is done by the Supervisor submitting the *Annual Supervision Tracking Tool* to the Program Manager or Assistant Program Manager for review and feedback. This form will be submitted to Central Administration at least 2 weeks before the site's annual CQI Site Visit with the Program Manager's signature.
- **Annual Training Log Review:** The Program Manager or Assistant Program Manager is required to monitor training logs for the site, monitoring adherence to HFA training standards including:
    1. Ensuring that staff hired after one year have documented all professional development training (with a minimum of 15 hours per year), as well as annual Child Abuse & Neglect, Equity Training, and Medical Training.
    2. Ensuring that newly hired staff are documenting all 1st year training

It is especially important for the agency who has sub-contracted for direct services, and has multiple agency oversight, to have a tracking system in place for this purpose and communicate often with agency management and Supervisors to ensure completion.

Supervision of Supervisor (practice)

12-3.B HFO sites ensure Supervisors receive at least monthly supervision and are held accountable for the quality of their work, receive skill development and professional support as stated in HFO policy 12-3.A.

Reflective Consultation/Supervision of Supervisor (practice)

12-3.C HFO sites ensure Supervisors receive at least every other month reflective supervision.

12-4

All HFO Program Managers and Assistant Program Managers are held accountable for the quality of their work and are provided with skill development and professional support.

Program Manager Support, Accountability (policy)

12-4.A Program Managers are held accountable for the quality of their work, receiving both skill development and professional support. Program Managers are responsible for the following at each local site:

- Ensure that Central Administration has complete listing of all current HFO staff and update as needed in a timely manner
- Follow *Aligned QA Calendar* and submit all reports and paperwork to Central Administration in a timely manager.
- Submit the completed *Aligned QA Calendar* to Central Administration at least two weeks before annual CQI Site Visit.
- Update the HFO Program Policies & Procedures Manual in accordance with the Aligned QA Calendar, and create/update local policies and procedures, as needed, to align with the most current state policies
- Monitor overall site eligibility screening, acceptance, retention, and home visit completion data
- Develop, analyze and submit Quality Improvement/Quality Assurance plans to HFO Central Administration, required by HFA, regarding Eligibility Screening, Acceptance, Retention, Home Visit Completion, Cultural Sensitivity, and Staff Retention and Satisfaction
- Provide ongoing support and communication to Supervisor(s), complete all QA Activities required when supervising Supervisors
- Develop, implement and monitor comprehensive *Annual Training Plan* to ensure all requirements for training are being met and update as appropriate
- Strive to meet Oregon Performance Indicators and maintain HFA Standards
- Establish informal agreements and/or Memorandum(s) of Agreement with hospitals and/or other appropriate entities to provide access to the focus population
- Maintain and enhance relationships with volunteers providing donations to site
- Liaison and with the Early Learning Hub in their local community
- Liaison with Central Administration staff and attend required Program Manager meetings
- Organize, oversee, and work with Local Advisory Group to promote and support site
- Develop, monitor and submit site budget, including monitoring of expenditures
- Prepare and submit a yearly staffing plan to HFO Central Administration
- Manage all Medicaid Administrative Claiming and MOTT reporting leveraging community contributions and other additional revenue for match requirements
- Research opportunities for leveraged resources, alternative funding sources, cash contributions, in-kind services, and grant prospects
- Prepare for and follow up on annual CQI site visit by Central Administration including preparation of the Quality Assurance Plan and Quality Improvement Plan in response to the CQI Site Visit Report, addressing all areas to strengthen
- Complete and submit the previous year's Quality Assurance Plan and Quality Improvement Plan showing completed goals and strategies
- Review local data collection practices and reports to ensure that the site is in adherence for eligibility screening, family service, and outcome measurements, and that all data is accurate and complete
- Participate in HFO Webinars and Zoom calls
- Work with Supervisors to create a positive work environment and team atmosphere
- Have thorough knowledgeable of the HFA standards and the local PPPM
- Prepare the "Site Self-Assessment" in preparation for HFA re-accreditation every 5 years

Assistant Program Manager

Assistant Program Managers may share some of the above Program Manager Responsibilities. It is required that, at the time of hire, the Assistant Program Manager receive training on their specific job responsibilities and have a separate job description with these clearly outlined.

Insert the allotted FTE for the Assistant Program Manager. If the Assistant Program Manager has other duties, please include detailed description of each additional role(s):

Program Manager FTE Requirement

The Program Manager and Assistant Program Manager roles are distinct from that of Supervisor, and while both roles can be assumed by the same person, FTE status of both roles must be protected to ensure sustainable program leadership and adequate support to staff being supervised. Each HFO site must have one primary contact designated as the Program Manager. The minimum FTE for the role of Program Manager is .5 FTE or 20 hours per week.

Insert the allotted FTE for the Program Manager. If the Program Manager has other duties, please include detailed description of each additional role(s):

Supervision of Program Manager/Assistant Program Manager

Program Managers are provided with professional support and receive supervision holding them accountable for their work. Meetings documenting accountability occur at least quarterly. Some elements of accountability could be derived from quarterly reports, annual performance reviews, as well as regularly scheduled meetings with Supervisor of Program Manager/Assistant Program Manager, chair of the advisory group, or a peer Program Manager. Supervision of the Program Manager/Assistant Program Manager is documented on the *Supervision of Program Manager* form. *Please Note: See 12-3.A for additional program manager responsibilities regarding supervision of supervisor and required Quality Assurance activities.*

Insert local procedure that aligns with HFO Policy 12-4.A showing how the Program Manager and Assistant Program Manager receive professional support, skill development and accountability. Include the frequency of supervision and by whom:

Program Manager Support, Accountability (practice)

12-4.B Each local site assures Program Managers are held accountable for the quality of their work, receive skill development and professional support as stated in HFO Policy 12-4.A.

GOVERNANCE AND ADMINISTRATION: THE SITE IS GOVERNED AND ADMINISTERED IN ACCORDANCE WITH PRINCIPLES OF EFFECTIVE MANAGEMENT AND OF ETHICAL PRACTICES

HFA Governance and Administration Standards Intent *is to ensure the site has feedback and oversight mechanisms to ensure high quality services to families. These practices include effective community advisory board operation, review of site quality, handling of family complaints, utilization of informed consent, protection for families related to research conducted, and appropriate reporting of child abuse and neglect.*

GA-1

Each site has a broadly based, advisory group which serves in an advisory and/or governing capacity in the planning, implementation, and assessment of site related activities.

HFA Intent: *Community advisory boards serve an important function in community-based agencies. They can be advocates for the site in the community, representing the site and agency in other venues and settings, which can bring more recognition and visibility. Community advisory members bring to the site different skills and perspectives than might be present within site staff. Members share strategies, brainstorming ideas and facilitating growth for the site. Additionally, members often have access to resources to strengthen the site or agency. It is important the group has the community connections to understand the needs of the families receiving HFA services*

Organization and function of Community Advisory Board

GA-1.A Each local Healthy Families Oregon site has an Advisory Group. This local Advisory Group has bylaws and/or written operating procedures.

Roles and functions of the local Healthy Families Advisory Group:

- Meets at least quarterly, but as needed to support the site
- Regularly assesses the site's services and advises the local site
- May approve local policies and procedures and make recommendations for planning and implementation of policies and procedures at the local site
- Works to support Healthy Families Oregon role in the local community's early childhood system of supports and services
- Promotes and advocates for the local site
- Takes an active role in resource development for the site
- Serves as a forum for communication and resource sharing among community partners, and as a venue for building collaboration
- Forms subcommittees as needed to address specific issues and areas of interest
- Assures development and implementation of the Equity Plan and Annual Review of Screening
- Additional Analysis and Plans reviewed could include Quality Assurance Plan, Quality Improvement Plan, Staff Satisfaction & Retention Analysis, Family Acceptance Analysis and Family Retention Analysis.

Describe your local Healthy Families Advisory Group including how often it meets, its bylaws and the members of the group:

Insert how your Advisory Group keeps and makes public minutes/notes of all meetings (who does this and how):

Advisory with Wide Range of Skills & Knowledge

GA-1.B Healthy Families Local Advisory Group Membership:

- The local Healthy Families Advisory Group has a wide range of skills and abilities and provides a heterogeneous mix of skills, strengths, community knowledge, professions, cultural characteristics (as determined by the site to represent the diverse needs of site participants)
- Membership includes representation by community members (members of service groups, advocacy groups for young children, the business, public relations, arts, and recreation communities, etc.) and present or former site participants
- Partner agencies in the community are represented, including child welfare, wrap-around support agencies, health and mental health, education, and childcare,
- The site works to address any identified gaps in the advisory group membership
- Members select a chair and a vice-chair who work with the Program Manager to prepare the agenda
- Healthy Families Oregon providers/contractors/staff are non-voting members who attend meetings to provide information and expertise
- The Program Manager is responsible for keeping members informed and actively involved

Insert local procedures that the Program Manager uses to ensure that the Advisory Group works as an effective team:

Program Manager Role with Community Advisory Board

GA-1.C The HFO Program Manager provides site information for each meeting. Advisory members participate in discussion and guidance in regard to this information. The Program Manager and the Advisory Group work as an effective team with coordination, staffing, and assistance provided by the program manager to plan and develop site policies and procedures as stated in HFO Policy GA-1.A and B.

GA-2

HFO sites monitor and improve quality of their services.

HFA Intent: *The site uses a variety of methods to monitor and improve the quality of all services offered to families. Both quality assurance activities (GA-2.A) and quality improvement activities (GA-2.B) are necessary and distinguished as follows:*

Quality Assurance	Quality Improvement
Defines quality	Raises quality
Relies on inspection	Emphasizes prevention
Uses a reactive approach	Uses a proactive approach
Looks at compliance with standards	Improves the process to meet standards
Requires a specific fix	Requires continuous efforts
Relies on individuals	Relies on teamwork
Examines criteria or requirements	Examines processes and outcomes
Asks, "Do we provide good services?"	Asks, "How can we provide better services?"

Scamarcia Tews, Debra, et al. Embracing Quality in Public Health. *2nd ed., www.mphiaccredandqi.org, 2012*

Quality Assurance Plan

HFA Intent: *Sites will develop a Quality Assurance plan that will include activities such as satisfaction surveys, annual file review, reports related to site activities, etc. These activities help ensure accountability and commitment to implementing the HFA model with fidelity. Additionally, sites will document the completion of these activities and will implement strategies to address identified areas of improvement.*

GA-2.A HFO sites develop and implement a *Quality Assurance Plan* for reviewing and documenting the quality of site implementation including initial engagement, home visiting, supervision, and management, and implemented to increase fidelity to the model. The *Quality Assurance Plan* utilizes site level data related to screening, acceptance, retention, home visit completion, caseload capacity, staff retention etc., to develop and apply strategies aimed at strengthening site services. The plan is reviewed and updated at least quarterly at the program site, including their local advisory group, and submitted annually to HFO Central Administration at least two weeks prior to their CQI site visit.

Quality Improvement Plan (practice)

GA-2.B HFO sites develop and implement a *Quality Improvement Plan* utilizing site level data related to screening, acceptance, retention, home visit completion, caseload capacity, staff retention etc., to improve strategies, monitor progress toward reaching goals and follow up mechanisms to address areas of improvement. The plan is

reviewed and updated at least quarterly at the program site, including the local advisory group, and submitted annually to HFO Central Administration.

> ***HFA Intent:*** *Each year the site identifies one or more areas it wants to focus on (such as increasing home visit completion rates, or increasing participant acceptance). The site usually identifies its goals based on areas it is striving to improve, though continuous quality improvement (CQI) expectations may also be established by an oversight entity or funder. However decided, once the site has articulated its goals, it should indicate what the baseline is (e.g., home visit completion is 62% at start of the year), what the goal is (home visit completion rate will increase to 75% by year end), and a process for monitoring and evaluating progress toward meeting its goals and addressing any identified issues. Sites use this information for continuous quality improvement. Sites may use PDSA (Plan-Do-Study-Act) cycles to illustrate their efforts to achieve identified goals*

Each HFO site utilizes the *Annual CQI Site Visit Report*, which is completed by Central Administration after each annual CQI visit, to complete the annual *Quality Assurance Plan* and *Quality Improvement Plan*.

The *Quality Assurance Plan* is completed within 45 days of receiving the final *Annual CQI Site Visit Report*. The *Quality Improvement Plan* is completed within 60 days of receiving the final *Annual CQI Site Visit Report*. The annual *Quality Assurance Plan* and *Quality Improvement Plan* address site strengths as well as any areas to strengthen adherence to the HFA standards (site implementation) and state performance indicators, as well as all areas identified in the report, and is required to have at least one goal in each of the areas (initial engagement, home visiting, supervision and management). Specific goals, accompanying strategies, and dates of completion are created and implemented to address areas of improvement and strengthen outcomes/performance. Each site will monitor the progress toward reaching the goals at least quarterly, and implements follow up mechanisms to address areas of improvement.

The previous year's *Quality Assurance Plan* and *Quality Improvement Plan*, showing which goals were completed, dates of completion, and comments/updates for those that were not completed, will be submitted at least two weeks prior to the local site's annual CQI Site Visit for review.

Annual CQI Site Visits

Each HFO site receives an annual Continuous Quality Improvement (CQI) Site Visit to monitor quality assurance utilizing the *Annual CQI Monitoring Checklist* that includes initial engagement, assessment, home visiting, supervision, and management of the program locally.

Each site receives a *CQI Site Visit Report* within 30 days of the CQI visit, outlining areas of strengths in place as well as areas to strengthen. Each site utilizes this report to complete and submit the annual *Quality Assurance Plan* and *Quality Improvement Plan* (See GA-.A) to Central Administration within 45 days of receiving the *CQI Site Visit Report*. The annual *Quality Assurance Plan* and *Quality Improvement Plan* addresses site strengths as well as any areas to strengthen in meeting the HFO PPPM and HFA standards, state performance indicators, as well as any other issues identified in the report, by creating goals and strategies that will be implemented to address these areas.

At least two weeks prior to the scheduled CQI visit, local sites will submit all *Supervision Tracking Tool* forms and a completed copy of the previous year's *Quality Assurance Plan* and *Quality Improvement Plan*, identifying which strategies were completed to meet the goals and comments/updates for those that were not, along with any additional items requested.

Central Administration provides technical assistance and feedback in the development of the *Quality Assurance Plan* and *Quality Improvement Plan*, supporting sites to achieve identified goals.

Quality Assurance and Quality Improvement materials provided to all sites include:

- HFA Best Practice Standards
- HFO Program Policies and Procedures Manual
- HFO Family File Checklists, HFO Supervisor File Checklists
- Program Evaluation and Forms Manual
- HFA Quick Start Webinar and HFO Orientation Manual
- HFO Online Training
- HFA Wraparound Training
- HFO Required Training Logs for each HFO position
- Forms for Home Visit Shadows, QA Phone Calls, Supervision Shadows, FROG Scale Shadows
- HFO templates for all plans and analysis required by HFA
- Other tools made available to sites by Central Administration

Site Work Plan

If needed, Central Administration will create and implement a Site Work Plan identifying major concerns regarding site quality.

- Concerns identified can come from site staff, Central Administration, and/or the host agency.
- The Site Work Plan will include historical concerns and events that led up to the plan being written.
- This plan will be provided to the lead agency, if applicable, and the host agency.
- The site will prepare and submit a written response to Central Administration within 30 days identifying goals, addressing specific concerns, and implementing strategies to resolve each area of concern.
- Central Administration will review and approve the plan, provide technical assistance to the site, which can include Technical Assistance (TA) Site Visits and TA phone and email support.
- If the plan is incomplete or needs additional information added, Central Administration will provide site with guidance and the site will have 15 days to resubmit the plan.
- Central Administration and the site will follow up in accordance with the due dates on the plan.
- A follow-up site visit is conducted by Central Administration staff within 3 months of the implementation of the Site Work Plan to assess progress.
- Central Administration provides additional support and technical assistance as appropriate. Central Administration staff provide the local site with a written report after the follow-up site visit, addressing progress in all of the areas identified in the Site Work Plan.
- If site concerns are not remedied, Central Administration will provide follow up technical assistance and may extend the Site Work Plan.
- If the Site Work Plan is not successfully implemented within 3 months, HFO Central Administration will notify the Early Learning Division Director. The Program Manager, Central Administration Coordinator, and Early Learning Division Director analyze the site's willingness and/or ability to comply with the Site Work Plan. Central Administration prepares a written report that is sent to the site.
- A written analysis and history of the entire quality assurance process engaged with the site to date is prepared by Central Administration and presented to the HFO State Advisory Committee which may decide:
    - To continue with the Site Work Plan with specific timeframes for effective implementation,
    - To recommend local Healthy Families provider changes, or
    - To disaffiliate the site from the state system.

Concerns leading to a Site Work Plan may include:

- Non-adherence to the HFO Program Policies and Procedures Manual
- Concerns with meeting HFA standards (site performance that falls below the threshold for maintaining HFA credentialing)
- Issues with meeting the State Performance Indicators and Service Expectations
- Implementation concerns regarding the *Quality Assurance Plan*

- Concerns with data collection process and data quality
- Other areas of concern identified by Central Administration staff, parents, and/or the local site Advisory Board

Affiliation

Residents of each county in Oregon have potential access to Healthy Families Oregon services through a local Healthy Families site that meets the best practice guidelines outlined by HFA and which functions as part of a unified and consistent quality early childhood system. Healthy Families sites may be administered through regional partnerships, and their contracting agencies, or through individual county-based sites in alignment with the community's Early Learning Hub.

Each local site participates in all aspects of the statewide system and is affiliated with Oregon's HFA multi-site credential. Participation is defined as providing service delivery in adherence to the HFA Standards and the current HFO Program Policies and Procedures Manual.

Change of Provider/Temporary Affiliation

There are occasions when a county chooses to enter into a contract with a new local HFO provider, including:

- Failure of the host agency to provide quality, cost effective services
- Voluntary withdrawal of the current provider
- Desire of the local community to change the format of service delivery in order to more effectively or efficiently meet the needs of their population
- Other compelling reasons that may arise

Before making the decision to change providers, the region carefully considers the impact of the change on families.

If, for any reason, a current local Healthy Families provider stops providing contracted services prior to the end of their contract, Central Administration will be notified 45 days prior to signing a contract with the new provider so that Central Administration staff can provide site-specific training and technical assistance. The region and Central Administration may mutually agree to a notice period of less than 45 days if necessitated by specific circumstances.

Central Administration staff provides support and technical assistance through the process of changing providers.

The new local Healthy Families provider prepares and submits a site budget to Central Administration. This budget demonstrates adherence to the HFA Standards, willingness and ability to comply with the HFO Program Policies and Procedures, and capacity to successfully meet the HFO State Performance Indicators and Service Expectations.

The new provider receives a site visit by Central Administration staff within 3 months of initiation of the contract. The site visit includes training and technical assistance as needed to assure the effective implementation of the site model. When Central Administration is assured of the site's compliance with HFA standards and the HFO Program Policies and Procedures Manual, temporary affiliation with the state system is granted.

Full affiliation is granted to a new site provider after one full year of service delivery, with an annual site visit review that demonstrates adherence to the HFA Standards and compliance with HFO Program Policies and Procedures.

Affiliation of Sites or Sites Funded through Other Resources: Sites funded by other sources may use the HFO name if these sites adhere to the HFA standards and HFO Program Policies and Procedures. Sites request affiliation by establishing interagency agreements with Central Administration that include provisions for oversight and/or quality assurance of these sites.

HFO Central Administration will communicate a new site's request to affiliate and official affiliation status (after 1 year, as noted above) to HFA staff in writing within 5 working days of each status change.

Disaffiliation

Disaffiliation may occur when a site has not improved through the Quality Assurance and Site Work Plan process. In this case, the site is not adhering to the HFA Standards, and/or the HFO Program Policies and Procedures Manual, or meeting the HFO State Performance Indicators and Service Expectations.

Disaffiliation results in discontinuation of HFO funding to the site by HFO Central Administration for services. Funding resumes when HFO is again operational with a site that meets the criteria to become eligible to receive temporary affiliation.

A recommendation for disaffiliation of a site from the state HFO Advisory Committee is referred to the Central Administration state staff for action. (See OAR 423-101-0017 (9) (A), (C), (D) 2004 Revisions.)

Within 10 working days of the recommendation for disaffiliation, the ELD Director provides written notice to the site of intent to discontinue HFO state funding to the region and funding is discontinued after 60 days.

Funds to provide HFO services are held by Central Administration until a site that meets the criteria for temporary affiliation is in place.

If the funds are held for more than 90 days, they are pro-rated in order to avoid overpayment. The appropriate amount to provide services for the time remaining is sent to the new provider. The remainder is held by Central Administration for distribution to functioning HFO sites or is used by Central Administration for the HFO statewide system by providing additional training or materials to all sites statewide.

HFO Central Administration will communicate a site's disaffiliation to HFA staff in writing, within 5 working days of official disaffiliation.

Conflict Resolution and Appeals Process

Efforts are made to avoid conflict between the state system and local sites through open communication and ongoing technical assistance.

Efforts are made to resolve matters at the level of the parties immediately involved. After these efforts fail to reach resolution, the following procedures are used to resolve the matter.

In the event that a conflict arises between local sites and Central Administration that cannot be resolved through open communication among Central Administration staff, site, a skilled mediator agreed upon by all parties is called in to facilitate up to two sessions among the parties.

If mediation fails to resolve the matter, both parties submit a written statement describing their positions to the HFO State Advisory Committee for review. Copies are sent to the Early Learning Division Director. The state HFO Advisory Committee decides the proper resolution of the matter.

If the local site does not agree with this decision, it may make an appeal requesting the State HFO Advisory Committee review the matter. The Central Administration staff involved, local site staff, and the state HFO Advisory Committee each submit written documentation of their positions to the state HFO Advisory Committee. The state HFO Advisory Committee decides the matter. There are no further appeals.

Disciplinary Procedures

Each local HFO site ensures that the site has disciplinary procedures for all HFO employees. These procedures must provide appropriate progressive disciplinary actions for all HFO staff and volunteers who violate policies of the site or federal or state law, and be utilized if necessary.

Insert where your local written disciplinary procedures are located:

Staff Grievance
Staff grievances are addressed through personnel policies of the employing agency in a timely manner.

Insert local procedure for staff grievances:

Site Name
The name "Healthy Families" must be included in each site's name to support public recognition and marketing efforts of Healthy Families Oregon statewide.

State "official" site name:

GA-3

All HFO families are informed of their rights and confidentiality at the start of services and is ensured

HFA Intent: *HFA values a family-centered approach to service delivery which requires that practices reflect a profound respect for personal dignity, confidentiality and privacy. While this approach is evident throughout all service standards the standards in this section are devoted to preserving the rights and dignity of all service recipients*

Family Rights & Confidentiality (policy and forms)

Essential Standard

GA-3.A All areas of Family Rights & Confidentiality are discussed with each participating family using *HFO Family Rights & Confidentiality* form at the onset of services (on or before the first official home visit), both verbally and in writing. Families are given a copy and a signed copy is kept in the family file. Information on the form is provided in language the family understands, through use of a translated form and/or an approved interpreter, if needed. This informs families regarding their rights by including:

- The right to be treated fairly with courtesy and respect
- The right to refuse service (voluntary nature)
- The right to be referred, as appropriate, to other service providers
- The right to participate in the planning of services to be provided or the right to an individualized Family Goal
- The right to file a grievance/complaint and how to do so should the need arise
    - Specific steps for reviewing and acting on any grievance
    - Timeframe for addressing grievances
    - Follow-up mechanism to address needs areas of improvement

Confidentiality is an essential part of the agency's services. Every family has the right to private and confidential interaction with staff. Therefore, any information shared between the family and staff is protected and treated in a confidential manner. The only exception to this right occurs when the law mandates report of illegal or potentially life threatening behavior. Home Visitors inform families of their confidentiality when enrolling and provide the *HFO Family Rights & Confidentiality* at the time of enrollment. This informs families regarding confidentiality by including:

- The manner in which information is shared, with whom and the process for consent forms to be signed when exchanging information.

- The circumstances when information is shared with consent (e.g., for purposes of referral, or if participating in research or evaluation study where identifying information is shared, or when data required by funders or model developer includes identifying information).
- The circumstances when information would be shared without consent (i.e., need to report child abuse and neglect)
- A family's information cannot be discussed with an outside provider unless Consent for the Release of Information form has been signed. This consent 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 (not to exceed 12 months)
    - The name of the person/agency to whom the information is to be released
    - The name of the HFA site providing the confidential information
    - A statement that the person/family may withdraw their authorization at any time

Families are informed of the grievance process on the first home visit as part of the process of reviewing the host agency's family Grievance Procedure. They are provided a business card with name and contact information for the supervisor to contact if they have any concerns with services.

Essential Standard

Family Rights & Confidentiality (practice)

GA-3.B Families are informed of their family rights and confidentiality at the onset of services, both verbally and in writing (parents are notified and receive a copy), and that the *HFO Rights and Confidentiality Form* is signed on or before the first home visit, place in the family file as stated in policy GA-5.A.

Safety Standard

Informed Consent to Release Information (practice)

GA-3.C Families participating in home visiting services read and sign the Healthy Families Oregon *Authorization to Release Information* form (in a language they can understand or with interpretation provided) every time information is to be shared with family members, DHS, and/or another agency or provider (except in the case of mandatory reporting of abuse or neglect).

The Healthy Families Oregon *Authorization to Release Information* form (otherwise known as ROI) does not include open-ended time frames such as "during the course of services" or timeframes such as "ongoing", or dates exceeding 12 months. "Blanket" ROI forms, that list multiple entities on the same form, are not acceptable for use. All information on the form (including the specific information to be released, who it is being released to, the purpose for the sharing, etc.) must be filled in before parents sign the form. It is not permissible to have parents sign incomplete forms.

Sites are to be as specific as possible about what is to be shared (e.g., home visit notes, developmental screens, assessment information, etc.) so families are very clear about what will be released. This consent may also apply to verbal sharing of information, and sufficient details about what staff may speak about must be clearly listed. Since a signed release form remains in effect for a maximum of 12 months, a new consent form will need to be signed annually when communication or sharing extends beyond the 12-month time period with the same external source.

Participant Record/File Review

The HFO participant has access to review and receive copies of their records/file as provided by law.

HFO records/files of adolescent parents are confidential and are not shared with anyone, including the parents of the adolescent, unless the adolescent signs an ROI or if the ROI is otherwise required by law.

Complaint Procedure Followed

GA-3.D All families are notified of the host agency's family Grievance Procedure on the first home visit in addition to reviewing the *HFO Family Rights & Confidentiality form.*

Each local Healthy Families site utilizes the host agency's participant grievance policy, which is required to include the following: 1.) How the participant/families are informed of the agency policy for participant grievances 2.) The agency's process and timeframes for reviewing any grievances received 3.) The follow-up mechanisms used to address identified areas of improvement. These procedures ensure that grievances are addressed in a timely manner by an objective person or body. The Program Manager and/or the local Advisory Group may be called upon to help resolve grievances.

If the Supervisor and/or Program Manager receive a grievance, they are required to follow the host agency's procedures. Participant grievances are addressed in a timely manner, as stated in their local host agency policy, and appropriate action is taken. Participants may request a change in Home Visitor at any time and the site honors these requests whenever possible. Staff members are removed from work with families immediately pending resolution of a grievance involving allegations that, if true, would endanger site participants' safety and well-being. The site works with staff named in grievances through coaching in supervision and takes any additional personnel actions if need. If needed, informed written consent by families is obtained every time information is shared with any outside agency.

Insert host agency participant Grievance Procedure (attach to Appendix D) that is reviewed with families on or before the first official home visit.

Insert how translation and/or interpretation service are approved and provided if needed to translate the Family Rights & Confidentiality form, the host agency's Grievance Procedure, or the Release of Information:

Insert local procedures for an HFO participant to review their records/file:

Site ensures privacy and voluntary choice for families' w/research

GA-3.E All HFO state level research proposals are considered by Central Administration and then reviewed by the HFO State Advisory Committee to review ethical implications, confidentiality (family privacy and voluntary choice), and how research is monitored. A review of each research proposal must have at a minimum, a written summary of the proposal which includes the purpose, procedures to protect family privacy and voluntary choice, benefit to the HFO program, benefit to HFO families, potential risk and possible unintended consequences, timeline of project, cost (if any) to the state and/or local program and communication plan of results/outcomes.

Research proposals will be reviewed, and approved or denied, within 6 months of the original request. The review process will include review of proposal documents at an HFO State Advisory committee meeting, followed by a presentation from evaluators if deemed necessary. The proposal will also include steps to ensure privacy of participant information, including access to confidential family and staff information (i.e., data, files, reports, etc.) restricted only to authorized personnel, and that all participants are provided with voluntary informed consent without pressure to participate.

If approved, the HFO State Advisory Committee determines scope (required for all sites, selected sites, or optional for site participation) and receives updates from the evaluator throughout the life of the research project.

Research at Local Sites

Central Administration is informed of all research projects that local sites are participating in before projects begin.

Insert your local site's procedure for reviewing and recommending approval or denial of research proposals including whether internal or external, involving past or present families, and how you ensure participant privacy and voluntary choice. The local site policy and procedures includes:

- **Local site proposals are taken to the local Advisory Group for approval or denial**
- **Procedures (or steps) for the review of the proposal**
- **Timeline for completion of the process and, if approved/accepted,**
- **Steps to ensure participant privacy and voluntary choice**
- **Communication with National Office (via Implementation Specialist) regarding summary of research design and contact information for principal investigator.**

Please Note: For individual sites, if your stance is not to accept any research proposals, indicate that as the basis of your policy statement:

HFO Program Evaluation

HFO Central Administration provides for regular and ongoing program evaluation of Healthy Families Oregon through a qualified evaluator. The contracted evaluator prepares statewide and site-specific reports as agreed in their contract.

The contracted evaluator has a formal written plan that addresses site implementation, participant satisfaction, and participant outcomes:

- The plan is developed through active collaboration among the evaluators, Central Administration staff, local sites, and includes confidentiality assurances
- The evaluation plan is reviewed on an annual basis by the HFO State Advisory Committee to ensure that it is of sufficient scope to accurately describe progress toward identified implementation and outcome goals
- Each local site participates in the statewide HFO evaluation and ensures that all families participating in any Healthy Families service (eligibility screening, and/or home visiting services) sign a consent form indicating their express written consent to participate (or not) in the HFO evaluation and what that participation entails.
- Local sites ensure that participants who do not consent to the evaluation are not included in data collection.
- To ensure participant privacy, evaluation data is shared only in the form of aggregated results. Local sites use only a state identification number on all materials sent to the state evaluators, not the participant's name.
- Each local HFO site ensures that each staff member has appropriate training in data collection, data entry and submission to the evaluation.

Each site is responsible for the collection and entry of complete and accurate data on each participating family within the time parameters set by the evaluation. The Program Manager assures that staff are completing, entering and/or submitting all required forms in a timely manner.

Local sites are responsible to cooperate with the evaluation to ensure accuracy of the data reported, and to monitor their data through ongoing review of HFO Statewide Database reports and semi-annual reports. Sites must contact the evaluation team immediately to resolve any data discrepancies as soon as these are noted through review of the semi-annual reports or other data sets.

GA-4

All HFO sites report suspected cases of child abuse and neglect to the appropriate authorities.

Child Abuse & Neglect Reporting (policy)

Safety Standard

GA-4.A Sites are required to use the criteria to identify and determine when to report suspected child abuse and neglect from the "What You Can Do about Child Abuse" publication from the Oregon Department of Human Services. HFO staff will immediately notify the Supervisor and/or Program Manager at their local site when suspecting child abuse or neglect. Contacting the local Department of Human Services Child Welfare prior to immediate notification of the Supervisor and/or Program Manager is appropriate if waiting to contact site leadership may cause greater risk to the child (ren).

All HFO staff are responsible for reporting suspected abuse and neglect even if it is believed another individual or organization has made a report.

Sites will maintain a log of incidents of abuse/neglect reported by staff that includes:

- Date abuse/neglect was noted/suspected by staff.
- Brief description of the incident, including names of participants, children and any others present.
- Date and time it is reported/discussed with the supervisor.
- Date, time, and manner (e.g., phone call, fax, etc.) report is made.
- Brief description of follow-up or dates of supervision notes where follow-up was discussed.

All local HFO staff receive ongoing support from Supervisors/Program Managers in their role as mandatory reporters, including immediate assistance with problem-solving in cases of suspected abuse and neglect, support in making reports to Department of Human Services Child Welfare, opportunities to debrief, and ongoing support though regular scheduled supervision sessions.

Insert local site or host agency procedure when HFO staff need to report suspicion of child abuse or neglect, including the use of any incident reporting form (attach to Appendix E) and the mechanism to track and follow up on all children with suspected abuse and neglect:

HFO sites will follow HFO policies for working with families involved with DHS Child Welfare. By law, HFO services are voluntary and cannot specifically be a part of any mandated plan for families. Families who are receiving services from DHS Child Welfare at the time of enrollment are eligible for intensive home visiting services.

When local sites enroll families with an active or open case with child welfare, HFO staff are not to monitor family's progress on behalf of DHS or the court. Sharing of family service information with Child Welfare or the court system is bound by the confidentiality requirements of HFO and informed consent (unless subpoenaed) which indicates precisely what information is to be shared. Additionally, it may be important to inform families that sharing such information may not always be helpful to the family's situation.

Reports Suspected CAN to Proper Authorities (practice)

Safety Standard

GA-4.B HFO staff reports suspected cases of child abuse and neglect to the proper authorities at stated in the state and local HFO Policy in GA-6.A.

Supervisor/Manager Notification and Tracking of Suspected CAN (practice)

GA-4.C HFO staff immediately notify the supervisor or program manager of suspected abuse or neglect and has a tracking mechanism in place when such report occur.

GA-5

Each HFO site responds to support families and staff in situations involving participant death.

Participant Death & Grievance Counseling (policy)

GA-5.A It is required that the Program Manager or Supervisor are immediately notified by site staff in cases of participant deaths (child or caregiver). HFO site staff will be offered support and/or grief counseling when a participant or caregiver death occurs. Participant families are offered extended support from the HFO site as needed including short term transitional home visits and referrals for grief counseling.

Local HFO site staff will also immediately notify the HFO Statewide Coordinator of any participant death, as well as any serious abuse incidents involving program participants that prompt local investigation or media involvement.

All sites are required to complete and submit the *HFO Critical Incident Form* (via email) to Central Administration within 2 working days of the death or serious abuse incident.

Insert your local procedure ensuring that staff are offered support and grief counseling in the event of a participant death or as needed (i.e. Employee Assistance Program, etc.):

Insert local procedure outlining your site's process for staff to receive crisis/grief counseling as needed to help process issues they encounter in their work with families:

Insert your local procedure ensuring that families are offered extended support as needed after the death of a child:

Implement support when participant death (practice)

GA-5.B HFO sites respond in situations involving participant death to support family members and staff as stated in HFO Policy GA-7.A. The Program Manager and/or Supervisor, as well as the State Coordinator, is notified immediately as stated in HFO Policy GA-7.A.

GA-6

Updates to the HFO Policy and Procedures Manual are communicated to all staff in a timely basis and the HFO Program Policies and Procedures Manual is used to guide service providers in the delivery of services.

All HFO sites follow the HFO Program Policies and Procedures Manual (PPPM) as written and all HFO staff have access to a current copy of the PPPM.

HFO policies and procedures will be reviewed and updated biennially. This review includes requested changes from local programs, central administration and updating policy that changes through updated Best Practice Standards. Local proposed suggestions for changes to the PPPM may be made at any time and are submitted electronically or in hard copy to Central Administration.

Program Managers, Supervisors and Site Directors are notified of the approved changes to the PPPM. The HFO PPPM on the Central Administration website is updated within 30 working days of the approved changes.

Program Manager and Supervisors are required to inform and review policy and procedural changes with all staff, ensuring that changes are translated to practice in a timely manner.

Describe how your site informs all staff of policy and procedural changes when a new PPPM is released (please include specific timeframe):

Local site policies and procedures are formally revised every two years. The local HFO Advisory Group review and approve local policy changes (Advisory Group signature required on page 2). Addendums, approved by local Advisory Group, can be submitted during this time if local policy or procedure changes or is updated to reflect current practice.

All sites are required to follow their approved local policies and procedures, as well as the state policies and procedures, as written in the HFO PPPM to guide services. The local PPPM is submitted to Central Administration within 3 months of the final state HFO PPPM being released.

GA-7

In accordance with HFA's Affiliation and Licensing Agreement, which grants sites the ability to implement the model and access its intellectual property, affiliates are required to adhere to the responsibilities outlined therein, particularly those pertaining to data, fees and brand identity.

The HFAST system is used to maintain accurate demographic and programmatic details regarding all HFA sites. In order to accurately and effectively represent the entire HFA network it is imperative that sites update the information stored on HFAST at least annually (more often when there are staffing changes).

Data Up-to-Date (National Office Requirements)

GA-7.A HFO sites ensure that all HFA required data pertaining to site characteristics and outcomes is kept up-to-date, primarily though not exclusively, through HFAST (Healthy Families America Site Tracker).

Insert the procedure and the person responsible for maintaining timely and accurate data entry into the HFAST system:

Site Up-to Date with Fees (National Office Requirement)

GA-7.B HFO is required to be up-to-date with all fees owed to the HFA National Office.

Site uses HFA name, logo and brand (National Office Requirement)

GA-7.C HFO utilizes the trademarked HFA name, logo and brand according to HFA graphic standards.

Participation in Research (National Office Requirements)

GA-7.D HFO sites notify HFO Central Administration and the National Office prior to the site's participation in any research study involving 1) the HFA model, or 2) participant families, past or present, enrolled in HFA services; and receives study updates consistent with HFA's Site Research Policy.

Critical Incident Reporting (National Office Requirement)

GA-7.E HFO sites will promptly communicate with HFO Central Administration in the event of a critical incident. Prompt communication to the HFA National Office will occur in the event of any critical incident (as defined in the intent of the standard).

Local HFO site staff will immediately notify the HFO State Program Manager of critical incidents that could affect the integrity and reputation of the HFO site or statewide program within 1 days of disclosure .

Such critical incidents include:

- Child or caregiver death or serious abuse incidents prompting criminal investigation or media involvement
- Litigation pertaining to Healthy Families work/services against staff or agency.

All HFO sites reporting critical incidents to HFO are required to complete and send the *HFO Critical Incident Form* (via email) to Central Administration within the above time frames.

The HFO State Program Manager will notify HFA National Office if any critical incidents escalate to the state and/or nation level within one business day.

APPENDIX A: HEALTHY FAMILIES OREGON REVISED STATUTES

Oregon Revised Statutes-Sites (2013)

(1) The Early Learning Division shall establish Healthy Families Oregon programs in all counties of this state as funding becomes available.
(2) These programs shall be non-stigmatizing, voluntary and designed to achieve the appropriate early childhood benchmarks and shall:
(a) Ensure that express written consent is obtained from the family prior to any release of information that is protected by federal or state law and before the family receives any services;
(b) Ensure that services are voluntary and that, if a family chooses not to accept services or ends services, there are no adverse consequences for those decisions;
(c) Offer a voluntary comprehensive risk assessment of all children, from zero through three years of age, and their families in coordination with voluntary statewide early learning system screening and referral efforts;
(d) Ensure that the disclosure of information gathered in conjunction with the voluntary comprehensive risk assessment of children and their families is limited pursuant to ORS 417.728 (8) to the following purposes:
(A) Providing services under the programs to children and families who give their express written consent;
(B) Providing statistical data that are not personally identifiable;
(C) Accomplishing other purposes for which the family has given express written consent; and
(D) Meeting the requirements of mandatory state and federal disclosure laws;
(e) Ensure that risk factors used in the risk screen are limited to those risk factors that have been shown by research to be associated with poor outcomes for children and families;
(f) Identify, as early as possible, families that would benefit most from the programs;
(g) Provide parenting education and support services, including but not limited to community-based home visiting services;
(h) Provide other supports, including but not limited to referral to and linking of community and public services for children and families such as mental health services, alcohol and drug treatment programs that meet the standards promulgated by the Oregon Health Authority under ORS 430.357, child care, food, housing and transportation;
(i) Coordinate services for children consistent with other services provided through the Oregon Early Learning System;
(j) Integrate data with any common data system for early childhood programs;
(k) Be included in a statewide independent evaluation to document:
(A) Level of screening and assessment;
(B) Incidence of child abuse and neglect;
(C) Change in parenting skills; and
(D) Rate of child development;
(l) Be included in a statewide training program in the dynamics of the skills needed to provide early childhood services, such as assessment and home visiting; and
(m) Meet statewide quality assurance and quality improvement standards.
(3) The Healthy Families Oregon programs, in coordination with statewide home visiting partners, shall:
(a) Identify existing services and describe and prioritize additional services necessary for a voluntary home visit system;
(b) Build on existing programs;
(c) Maximize the use of volunteers and other community resources that support all families;
(d) Target, at a minimum, all prenatal families and families with children less than three months of age and provide services through at least the child's third birthday; and

(e) Ensure that home visiting services provided by local home visiting partners for children and pregnant women support and are coordinated with local Healthy Families Oregon programs.

(4) Through a Healthy Families Oregon program, a trained Home Visitor shall be assigned to each family assessed as at risk that consents to receive services through the trained Home Visitor. The trained Home Visitor shall conduct home visits and assist the family in gaining access to needed services.

(5) The services required by this section shall be provided by hospitals, public or private entities or organizations, or any combination thereof, capable of providing all or part of the family risk assessment and the follow-up services. In granting a contract, collaborative contracting or requests for proposals may be used and must include the most effective and consistent service delivery system.

(6) The family risk assessment and follow-up services for families at risk shall be provided by trained Home Visitors organized in teams supervised by a manager.

(7) Each Healthy Families Oregon program shall adopt disciplinary procedures for trained Home Visitors and other employees of the program. The procedures shall provide appropriate disciplinary actions for trained Home Visitors and other employees who violate federal or state law or the policies of the program. [1993 c.677

§1; 1999 c.1053 §21; 2001 c.831 §14; 2003 c.14 §209; 2005 c.271 §3; 2009 c.595 §362; 2012 c.37 §§53,95; 2013 c.624 §§32a,32b; 2013 c.728 §§5,6]

APPENDIX B: HEALTHY FAMILIES OREGON ADMINISTRATIVE RULES

Oregon Department of Education
Early Learning Division

Division 525
Healthy Families Oregon

Oregon Administrative Rules
414-525-0015
Program Restrictions

(1) Systems Requirements:
(a) Healthy Families Oregon services will be offered in a manner consistent with the local early childhood system planning.
(b) Healthy Families Oregon programs will collaborate with local home visiting partners within the context of the statewide home visiting system as a part of the voluntary local early childhood system, to identify and build upon existing services for families and to prioritize additional services if needed (e.g. mental health, drug and alcohol, and early intervention).
(c) If collaboration does not effectively occur, the Department of Human Services and the Early Learning Division will provide technical assistance to promote improved collaboration.
(d) Healthy Families Oregon programs actively participate in local community efforts to implement the early childhood system of supports and services towards the achievement of desired outcomes, working to maximize the effective use of available resources and avoid duplication of services.
(e) Local contracted agencies are not required to engage in a competitive bidding process, unless required by local policy, to select program providers for Healthy Families Oregon services each biennium. Local contracting agencies may conduct a competitive or collaborative funding process when significant deficits in program operations and services are found or when changes in the stability of service delivery systems present new options for these services.
(2) Age: Children ages prenatal through three and their families.
(3) Services: Funded services include: voluntary family support services, including but not limited to screening and follow-up services such as resource referral, further assessment, and intensive home visiting provided by highly trained Home Visitors organized in teams and supervised by a program manager and supervisor following the Healthy Families America model.
(4) Program Requirements:
(a) New Healthy Families Oregon Programs will make progress toward full compliance with ORS 417.795 as operationalized by the Healthy Families Oregon Implementation Manual: Statewide Program Policies and Procedures. All Healthy Families Oregon programs are required to be in full compliance within one year of program start up.

NOTE: Copies of the Healthy Families America model best practice standards and of the Healthy Families Oregon Program Policy and Procedure Manual are available from the Early Learning Division.

(b) Programs will develop site specific procedure manuals to further specify local program operations. Local procedure manuals will be submitted to the Early Learning Division at intervals specified by the Early Learning Division.
(c) Participation in services provided by the Healthy Families Oregon program is voluntary. Service providers will obtain express written consent before any services are offered.

(d) Local Healthy Families Oregon programs will ensure that parents have given express written consent prior to any release of information.
(e) Healthy Families Oregon program services will not be a part of a mandated plan for families. Mandated plans include plans developed by the Department of Human Services Self Sufficiency and Child Welfare services.
(f) Local Healthy Families Oregon Programs will:
(A) Participate in the independent statewide program evaluation;
(B) Participate in statewide training for program managers, supervisors Home Visitors and screening staff;
(C) Participate in annual meetings and trainings for program managers;
(D) Meet statewide and local early childhood system quality assurance standards;
(E) Participate in the Healthy Families America site self-assessment, as part of ongoing quality assurance;
(F) Ensure that voluntary home visiting services through Healthy Families Oregon are coordinated with home visiting services offered by the voluntary local early childhood system.
(5) Program Budget Requirements:
(a) All programs are required to participate in federal Medicaid (Title XIX) Administrative Claiming, following program procedures provided by the Early Learning Division.
(A) Medicaid earnings, except as described in 423-010-0023(3), must be used to maintain or expand Healthy Families Oregon program core services, as defined in the Healthy Families Oregon Program Policy and Procedure Manual.
(B) Programs will report on the use of their Medicaid (Title XIX) funds to the Early Learning Division at intervals specified by the Early Learning Division.
(C) All program staff will attend training provided by the Early Learning Division prior to participation in Medicaid (Title XIX) Administrative Claiming and annually thereafter.
(b) The local contracting agency will monitor the local Healthy Families Oregon programs to ensure fiscal and programmatic integrity.
(c) If, for any reason, a current provider stops providing contracted services prior to the end of the contract, the local contracting agency will notify the Early Learning Division 45 days prior to signing a new provider contract so that the Early Learning Division can provide program specific training and technical assistance. The local contracting agency and the Early Learning Division may mutually agree to a notice period of less than 45 days if necessitated by specific local circumstances.
(d) The Early Learning Division will manage the Title XIX Medicaid Administrative Claiming program in accordance with all state and federal rules and regulations.

[Publications: Publications referenced are available from the Early Learning Division.]

APPENDIX C: HOST AGENCY EQUAL EMPLOYMENT OPPORTUNITY POLICY

Host Agency Equal Employment Opportunity Policy

APPENDIX D: HOST AGENCY GRIEVANCE PROCEDURE

Host Agency Grievance Procedure

APPENDIX E: HOST AGENCY MANDATORY REPORTING INCIDENT FORM AND POLICY/PROCEDURE

Host Agency Mandatory Reporting Policy, Procedure, and/or Incident Form

APPENDIX F

Local Site Addition

APPENDIX G

Local Site Addition