Family & Children's Center

HEALTHY FAMILIES PROCEDURE

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Overview of Healthy Families

Healthy Families is a voluntary home visiting program for expectant and new parents.

The program offers home visiting services to expectant families and new parents, beginning in the third trimester prenatally or shortly after the birth of the child. The program identifies which families could most benefit from home visits by means of systematic screening and assessment in our community. Families who participate in the program are offered long-term in-home services until our target child turns five or is in school. We serve subsequent births in the family as additional target children.

The Goals of Healthy Families are to:

- 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.

The Healthy Families Program is a comprehensive prevention program that focuses on the safety of children while at the same time supporting families. The services are easily accessible to isolated, at risk families, and are respectful of cultural and community diversity.

Healthy Families is affiliated with Healthy Families America, a national initiative of Prevent Child Abuse America, and hosted by Family & Children's Center of La Crosse.

Critical Elements According to Healthy Families America

Critical Elements

The Healthy Families America approach includes a series of service elements that have been identified through research as associated with desirable family outcomes. These are known as the "Critical Elements" for effective home visitor services to comply with national standards.

1. Initiate services prenatally or at birth.

2. Use a standardized (i.e., in a consistent way for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of

various factors associated with increased risk for negative childhood outcomes (i.e., social isolation, substance abuse, and parental history of abuse in childhood).

3. State clearly that families' participation is voluntary and use positive, persistent outreach efforts to build family trust.

4. Offer services intensely (i.e., at least once a week) with well-defined criteria for increasing or decreasing intensity of service over the long term (i.e., three to five years).

5. Services should be culturally competent in order that staff understands, acknowledges, and respects cultural differences among participants. Materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served.

6. Services should focus on supporting the parent as well as supporting parent-child interaction and child development.

7. At a minimum, all families should be linked to a medical provider to assure timely immunizations and well-child care. Depending on a family's needs, they may also be linked to additional services such as financial, food and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

8. Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their varying needs and to plan for future activities (i.e., for most communities, no more than 15 families per home visitor on the most intensive service level. For some communities, the number may need to be significantly lower (e.g., less than 10).

9. Service providers should be selected because of their personal characteristics (i.e., nonjudgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

10. Service providers should have a framework, based on education or experience for handling the variety of experiences they may encounter when working with at-risk families. All service providers should receive basic training in areas such as: cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and existing services in their community.

11. Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation. These should include, but are not limited to identifying at-risk assessment, offering services and making referrals, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing a family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, managing crisis situations, etc.

12. Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives, to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference in order to avoid stress-related burnout.

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About this manual

This manual establishes procedures and guidelines to ensure that standards of effective practice are met by our program. It is based on the procedures set forth by Healthy Families America Critical Elements and is aligned with the Healthy Families America Best Practice Standards. Wording used, in many cases, is directly from Healthy Families America's Best Practice Standards, from other HFA Procedure Manuals (HF New York, for example) or from the HFA website.

Procedures are organized within the related Best Practice Standard, except for the first section "Healthy Families" and the final section, "Governance and Administration." There is a heading box at the top of all procedures that includes the subject, the procedure, the specific reference in the Healthy Families America Best Practices, the effective and revised dates, and any related attachments that can be found at the rear of each Critical Element section or in the Appendix section.

Glossary of Terms

Advisory Committee: An organized voluntary group with responsibilities to advise on aspects of the program's operation and to advocate for the program.

Analysis: A detailed study and reporting of site patterns and trends.

Assessment: The Parent Survey/ Family Stress Checklist is a semi-structured, standardized assessment tool administered in the program to gather information about parents' strengths and capabilities and to identify the parents' needs. It assesses for the presence of factors including increased risk for child maltreatment or other poor childhood outcomes (e.g. social isolation, substance abuse, parental history of abuse in childhood, etc.). It is done face-to-face and most often completed in the home. It is used to determine service eligibility and is used to support the development of the participant's Family Goal Plan.

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

Cultural Sensitivity Review: A process the program undertakes to examine critically and deliberately its current ability to provide culturally informed services. The review, as a final product, is a written document that summarizes the strengths and needs for improvement in all

areas of the service delivery system, and the review identifies recommendations/suggestions for how the site might advance its current level of cultural sensitivity.

Creative Outreach: Respectful efforts to engage or re-engage families in the program. Creative Outreach refers only to post-intake activities

Credentialing: Process by which programs are reviewed for most effective practice standards as measured by HFA Critical Elements.

Critical Elements: A national set twelve of best practice standards for home visiting as determined by research and extensive field experience, and adhered to by all HFA credentialed programs.

Developmental Screen: A standardized tool used by the program at regular intervals in the course of home visiting to monitor child development, and delays and disabilities, and to ascertain appropriateness of referral to Birth to Three. ASQ-3 and ASQ-SE-2 are developmental screening tools the program uses.

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

Engaged Families: Families interested in, and consistently available for visits and involved in services. Some families may become disengaged throughout the course of services.

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.

FRS: Family Resource Specialist (assessment worker) or the Home Visitor performing the functions of assessment using Healthy Families America's Parent Survey.

FSW: Family Support Worker (home visitor), in our program referred to as Case Manager (CM**)**.

HFA: Healthy Families America. HFA is a national initiative to establish a universal voluntary home visitor system for all new parents to help their children get off to a healthy start.

Home visit: A face-to –face interaction that occurs between the family and 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 an hour, and the child is present. The focus during home visits may include, but is not limited to:

Promotion of positive parent-child interaction/attachment:

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

Promotion of healthy childhood growth & development:

- Child development milestones
- Child health and Safety
- Nutrition
- Parenting skills (discipline, potty use, 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 and problem-solving skills
- Stress management and self-care
- Home management and life skills
- Linkage to appropriate community resources (e.g., food share, employment, education)
- Access to health care
- Reduction of challenging issues (e.g., substance abuse, domestic violence)
- Reduction of social isolation
- Crisis management
- Advocacy

HFA Best Practice Standards: The document that outlines expectations of model fidelity for Healthy Families America sites. Referred to as BPS, it is the tool used to identify the procedures and practices necessary for HFA sites to implement. It is a tool used for accreditation to measure site performance relative to each of the standards.

Infant Mental Health: Developing the capacity of the child from birth to age five 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. 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).

Monitors and Addresses: Monitors: to keep track of through the ongoing collection of available information. The extent of the information collected for tracking/monitoring purposes will vary and is a less rigorous process that compiling data for an analysis. Addresses: to attempt to resolve and /or improve that which is learned from the monitoring process through identification of issues that may be affecting the outcome, along with development of strategies that seek to improve the outcome.

PCAA: Prevent Child Abuse America. National, not-for-profit organization of professionals and volunteers committed to preventing child abuse in all its forms through education, research, public awareness, and advocacy.

Policy: Written statements of principles and positions that guide our program's operation and services which are approved by Family & Children's Center (our host agency).

Procedure: The step-by-step methods by which broad procedures are implemented and program operations are to be carried out, contained in writing in an operating manual.

Protective Factors:

- Resiliency
- Social support
- Concrete support
- Child development knowledge
- Nurturing and attachment

Risk Factors:

- Childhood history of abuse (early childhood trauma)
- Substance abuse, intimate partner violence, criminal history, mental illness
- Past history with Child Protective Services
- Compromised coping skills, social isolation
- Multiple stressors (housing, finances, relationship)
- Potential for violence
- Unrealistic child development expectations
- Discipline methods that include physical punishment
- Perception of fetus/infant as difficult
- One or more biological parents not available to child

Screening: A process for early identification of potential families that often occurs via our medical partners, other community partners, and self-referral. Determination of service eligibility is a two-step process. Screening is the first step and a more detailed assessment is the second.

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Core Components of the Healthy Families Program

- Universal screening by means of a standard record screening tool of pregnant women and new parents residing in La Crosse County.

- Families with a positive record screen are offered an assessment. The Parent Survey is the standardized risk assessment tool administered. The purpose of the tool is to identify the parents' past and current behaviors, beliefs, experiences and expectations that place them at risk of child abuse and neglect. Through the administration of the Parent Survey, the family's strengths – successes, abilities, hopes, and memories – are identified, as well as their challenges and needs. Based on information gathered through the assessment, the family is linked to referrals and resources in the community, one of which may be intensive home visiting services through the Healthy Families program.

- Creative, persistent outreach approaches to isolated and hard to reach families.

- Home visiting services offered on a voluntary basis to families with a Parent Survey score of 25 or greater, typically offered in the third trimester of the prenatal period, or right after the birth of the child and continuing until the child five years old or is enrolled in school.

- Intensive long-term home visiting services by trained and caring home visitors called Case Managers. Visits occur weekly during at least the first 6 months of the child's life (not counting time on creative outreach) with possibility of intensity decreasing thereafter- based on family need.

- Family centered services, recognizing that the adults in the family are the primary decision-makers, not program staff.

- Home visitors representing the language, culture and community of the families served.

- Case supervision by a mental health professional and by experienced Healthy Families staff meeting specific criteria.

- Home visiting services that focus primarily on parent-child interaction, child development, parent support, and family functioning, including identifying and addressing self-sufficiency goals. The home visitors work with families to identify goals that build on family strengths, and facilitate referrals to any services the family may need including (but not limited to) linking to school readiness programs, housing services, economic support, day care, nutritional programs, educational degree programs/ institutions, employment and training programs.

- Periodic, regular, developmental screening; referral to Birth to Three service, if a developmental concern is identified. Screen scores are shared with the child's medical provider via the parent or directly from staff (if there is a signed, current Release of Information).

- Periodic, regular, home safety assessments that identify areas of potential harm within the home.

- Periodic, regular, post-partum depression screening and referral.

- Connection of the family with medical providers to ensure that the mother receives proper prenatal care, the child receives regular well baby care and immunizations, and the rest of the family receives primary health care services.

- Manageable home visitor caseloads, beginning with a maximum of 14 families and increasing to a maximum of 25 based on the mix of families at different service delivery levels.

- Formalized community collaboration, which helps to ensure that families receive the services they need and that services are not duplicative.

Summary

The Healthy Families Program is a comprehensive prevention program that focuses on the safety and healthy development of children while at the same time preserving and supporting families. The services are easily accessible to isolated at risk families and are respectful of cultural and community diversity. The services come at a time in a family's life when infants are most vulnerable. It is also the time when planned early intervention makes the greatest impact. Healthy Families is a comprehensive approach to meeting the health, social, and emotional needs of La Crosse's children.

Healthy Families America Approach

The Healthy Families Program is part of the nation-wide Healthy Families America (HFA) initiative. All program services are planned and delivered in accordance with the Healthy Families America program model.

The following guidelines and procedures are, in general, organized to reflect the Healthy Families America critical elements for effective home visiting services. Much of the wording,

and the referenced research, is directly from Healthy Families America's Best Practice Standards.

Procedure Name:	HEALTHY FAMILIES STATEMENT OF PURPOSE
Procedure Number:	104
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	

STATEMENT OF PROCEDURE & RATIONAL

Healthy Families will have a written statement of purpose to guide the administration of services. It reflects the goals and criteria contained in the HFA Best Practice Standards and the needs of children and families in the broader community.

AREAS OF RESPONSIBILITY

Advisory Committee, Family & Children's Center Senior Leadership Team, and program staff provide input into the review of the Statement of Purpose.

PROCEDURE

The statement of purpose is reviewed every 4 years.

HEALTHY FAMILIES STATEMENT OF PURPOSE (MISSION)

The mission of Healthy Families is to provide supportive home visiting services to new and expectant families through a community wide collaboration, utilizing a wellness/strength based approach.

Program 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.

GETTING HELP

Support can be obtained by connecting with the program supervisor or coordinator.

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Procedure Name:	STAFF SAFETY
Procedure Number:	105
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	Healthy Families Safety Manual

STATEMENT OF PURPOSE

Safety of staff members is a program priority. The program has an established procedure on safety (Safety Manual) to guide staff in their work in the office, families' homes and the community.

AREAS OF RESPONSIBILITY

Program staff will follow safety procedures as outlined in the safety manual, and the procedure outlined if their safety is threatened and contact supervisor or manager immediately.
Program supervisor or manager will respond to support the safety of program staff.

PROCEDURE

Safety: Program staff should leave if their safety is threatened for any reason and immediately contact a supervisor or manager.

Boundaries: Program staff receives initial orientation before their first home visit, and on-going support and training on maintaining effective boundaries between the personal and the professional. Feelings such as excessive worrying, 'rescuing," and over-identification should all be recognized by staff as issues where support is needed and to bring to the attention of the supervisor.

GETTING HELP

Contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	GIFT ACCEPTANCE
Procedure Number:	106
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	Healthy Families Safety Manual

STATEMENT OF PURPOSE

To establish a uniform procedure regarding acceptance of gifts. This procedure does not apply to gifts given to Family & Children's Center or through the agency fund raising efforts.

AREAS OF RESPONSIBILITY

Program staff will not accept gifts of significant value or favors from participants.

PROCEDURE

Staff will report to their supervisor any gifts given by participants, and they are unable to accept a gift of anything of significant value. Staff members are encouraged to explain to the family that this is an agency procedure and that they are not allowed to accept.

GETTING HELP

Contact the Program Manager and/or Supervisor with any questions or concerns.

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Procedure Name:	QUALITY ASSURANCE
Procedure Number:	107
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	

STATEMENT OF PURPOSE

Family and Children's Center's Senior Leadership Team, program staff, and Advisory Committee will monitor the quality of services provided by Healthy Families staff. Healthy Families America's input will be sought for technical guidance.

AREAS OF RESPONSIBILITY

Healthy Families maintains a high degree of quality. Program Manager routinely runs monitoring reports for the benefit of the direct staff reporting results quarterly.

PROCEDURE

To ensure the quality of services provided by Healthy Families is routinely monitored, evaluated, and supported through a system of continuous quality improvement. This procedure ensures that the program has a formal mechanism for reviewing the quality of all aspects of the program: which include:

Trainings:

In addition to required trainings such as Core (Role Specific) Trainings and Healthy Families annual trainings, Family &Children's Center also provides on-going access to advanced trainings, workshops, seminars and conferences; some of which can help meet the wrap-around training requirements. Advanced trainings take into account program goals and the workers' knowledge and skill base.

CM:

Approximately once a year, each CM is observed "in home" by the clinical supervisor. Observations of the worker are recorded and then shared with the worker during supervision.

Data Reports:
The program makes data available to program staff, Family & Children's Center's Senior Leadership Team, and Advisory Committee quarterly. The program will utilize the data to (a) identify strengths, concerns and trends, and (b) develop quality improvement plans.

PROGRAM IMPROVEMENT PLAN:
Healthy Families is required by its host agency to develop strategic initiatives to address identified concerns periodically. The entire Healthy Families staff is involved in developing the plans goals. The plans include but are not limited to the measure, time frame, and completion indicator.

GETTING HELP

Healthy Families America:
Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	IDENTFYING POTENTIAL PARTICIPANTS
Procedure Number:	201
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	1-1.A-C, 1-2.A-E, 1-3A&B, 1-4.A-C

STATEMENT OF PURPOSE

The program has a mechanism to identify families so that home visiting or other services can begin prenatally (during the third trimester), or as early as possible within the first 3 months after the birth of the baby. We use the Healthy Families screening form to identify potential participants. We define measure and monitor our acceptance rate for enrollment on a quarterly basis.

Initiating Services

Healthy Families program identifies expectant parents and parents of infants (0-3 months) who reside in La Crosse County. The goals for initiating services include:

a. To systematically identify expectant parents and parents of infants less than three months old, residing within the target area of La Crosse County.
b. To systematically screen at least 80% of these families either prenatally or within two weeks of the birth of their new family member.
c. For those families with a positive screen, to further assess the families' strengths and needs and provide appropriate information and referral.
d. To offer overburdened families intensive home visitation services and/or other resources appropriate to their needs.
e. For those families who accept home visitor services, to conduct the first home visit prenatally or within the first three months after the birth of the baby at least 95% of the time.

Description of target population and the community partnerships in place to ensure the program identifies and initiates services with families in the target population while the mother is pregnant or at the birth of the baby.

PURPOSE

To ensure that Healthy Families program has well thought out mechanisms for the early identification of families who could most benefit from services, or be referred to other services.

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For those who accept home visitor services, this procedure also ensures that potential participants have been identified early enough for home visiting services to occur prenatally or within the first 3 months after the birth of the baby.

There are several reasons to initiate home visiting services prenatally or at birth. An early delivery system:

- Links parents and infants to early preventive medical care, improves service utilization, and results in improvement of overall healthy status.
- Reaches families when parents are eager to learn how to care for their child and are receptive to information.
- Helps promote parent-child bonding and attachment, a process that begins even before birth.
- Assists families in developing appropriate expectations for their child's development and helps foster that development.
- Provides support for families with children at an exciting and potentially stressful time, when most physical abuse and neglect occurs (under the age of two).
- Identifies overburdened families early on and provides guidance and support to curb drastic outcomes related to child abuse.
- Facilitates the formation of a long-term, trusting relationship between home visitors and families.

AREAS OF RESPONSIBILITY

The Lead Assessment/Intake Worker will keep records and process all referrals. All program staff are responsible for following outlined steps of ensuring potential participants are assessed for services within a timely manner.

PROCEDURE

1. Participants must be pregnant or have a child less than 3 months of age.

2. If there is no expectant, biological or adoptive parent of target child available, participant(s) can be other primary care givers (i.e., biological or adoptive father, grandparent, etc.). The age of the target child must not exceed 92 days at initiation of home visiting services.

3. Participants must be from the target population and live within the designated geographical target area.

4. Participants must have a positive screen and assessment according to the measures described in Screening for Indicators of Need and Assessment of Family Needs and Strengths.

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5. Participants accept the referral for intensive home visiting services.

6. If the target child is placed in foster care or is not living with the primary caretaker, and continued work with the family is considered to have potential benefits for the family, the worker and clinical supervisor must develop a plan for service delivery with the basis of preparing the child to return home. This plan will include collaboration with other involved service providers and must be re-evaluated after 6 months.

1-1A: Description of how the target population was established, including current relevant community data. Our target population was established by our host agency's Board of Directors, at the inception of our program prior to 1992. The Board sought to implement the HFA model as a mechanism to positively effect family and child outcomes. The board set the **target population definition** as expectant mothers and families with the child(ren) less than three months old, having a positive Healthy Families screen, residing in La Crosse County, and realistic to reach. Those zip codes include city of 54601 &54603, and rural of 54650, 54636, 54614, 54669, 54642, 54644, and 54653. Both medical centers were instrumental in setting up the program and volunteered to be referral sources.

We have identified the volume of potential families according to the latest available (2013) statistics. There were 1233 births in La Crosse County. According to Healthy Families America, twenty-five percent (308) of those births should qualify for a positive screen. In 2013, we received 68 positive screens from our referral sources, which is 22% of the expected number of positive screens for La Crosse County. The program measures screened percentage as related to target population. Because this process is largely not within program control, we will continue to identify strategies to utilize other partner agencies to reach the unidentified families. (Statistics from Wisconsin Department of Health Services, division of Public Health, Office of Health Informatics. Table 2-1. Births by Sex, Crude and General Fertility Rates, and Population Estimates by County of Residence, Wisconsin, 2013.)

1-1B: Ideally, the Healthy Families screening tool would be completed on every La Crosse County pregnancy/birth at the two major regional healthcare facilities (Gundersen Health System and Mayo Clinic Health System); however, due to our program's reliance on outside agencies (medical center staff: nurses, doctors and social workers) to conduct the screenings, this does not occur. Typically, the individual making the referral conducts the screening on families that present with evident stressors. The screen is used more as a referral form to the program versus a tool to use with every family. Healthy Families has made significant efforts to communicate the importance of universal screening to each of the area medical centers.

1-1C: Partnerships within the community. The program was founded on the premise of a partnership with our two regional healthcare facilities (Gundersen and Mayo) serving families in the target area. Partnerships have also been developed with area schools, and The Parenting Place. This system of relationships enables the program to work toward universal screening of participants in the target population. The program's goal is to identify families during the prenatal period or during the child's first three months of life, who reside in La Crosse County and are realistic to reach. Part of the role of the Healthy Families Assessment Workers is to be in continuous communication with the agencies who are completing the screening tool and referring families to the program. Primarily this includes the nursing and social services staff of both health care facilities. The lead Assessment Worker takes responsibility for and routinely provides information about the program to these agencies and potential and current collaborating partners; delivering program brochures, and meeting with referring staff one-on –one or during staff meetings. In order to avoid bias within partnering agencies regarding whom to screen/refer, we will continue to work with our partners to move toward a systematic plan for screening all families that fit within the definition of the target population.

Additionally, program staff will identify any gaps in the ability to connect with potential families and address how the system of relationships might be improved (e.g. strategies to form new relationships). Recently (2012) a target list was developed and split among the staff for contact and education about the program.

Standardized screening and assessment

Program maintains working relationships with various referral sources within the community and keep them up-to-date with information about the program. Memoranda of agreements were signed with our two healthcare organizations at the program's inception.

Outreach

In order to identify and serve families most in need, the program uses, respectful outreach to isolated and otherwise hard-to-reach families, including those not receiving prenatal care or delivering in a hospital. Such outreach may include seeking the assistance of community organizations that may come in contact with hard-to-reach families (such as HUB (housed at WIC and also at FCC) and La Crosse County Alternative Response).

1-2. A-E: Healthy Families will ensure our screening and assessment processes are regularly tracked and monitored, including all referrals received, from initial referral to completion of contact to the offer of services.

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Referrals are received as completed screens (from hospital social workers) or as names and contact information (from all other sources). All referrals are processed by our Lead Assessment/Intake Worker. Our Intake Checklist is attached to the referral. In the case of a screen not completed, our Lead Assessment/Intake Worker will contact the potential participant within 10 working days, completing the screen over the phone or in person. Referrals with a negative screen, or families whose child is older than 3 months, are routed to our partner agency: The Parenting Place.

Referrals with a positive screen are then passed to the CM with an opening in their caseload and having a "best fit" for the CM and potential participant. The fit is determined by geographic location of participant (rural vs. urban) and the nature of the challenges facing the family (intimate partner violence, cognitively delayed, history of criminality, etc.) The timeline for assignment to CM is determined by the site's waiting list. If there are a number of families on the waiting list, they are prioritized by age of child. Families closest to the 3-month mark are given top priority for assignment to an CM. Ideally, family's assignment to CM occurs prenatally or within the first two weeks after the birth of the baby.

CM encouraged to run a CCAP (Wisconsin Public Court Records system) report, for safety purposes, within 5 working days.

CM contacts the referral source in order to inform their approach with the family, within 5 working days, provided referral source has expressed appreciation for this courtesy.

CM contacts the potential participant to set up assessment (The Parent Survey) meeting, within 5 working days. The time and location to be determined by mutual agreement between the CM and the potential participant, ideally this is in the home.

If the potential participant is found to assess positive (by a score of 25 or more on the Parent Survey), the participant is offered home visiting services, and the initial home visit is scheduled. If the potential participant is found to assess negative, the family is offered resource information and a referral to our partner agency, The Parenting Place. They have a continuum of services from a warm line, to parenting classes, to home visitation in the Parents as Teachers model.

CM follows up with referral source regarding disposition of the referral within 10 working days.

CM returns screen, notes and Intake Checklist form to Lead Assessment/Intake Worker if family declines services. Progress in contacting the families is monitored at our weekly staffing. Final attempt (Contact Letter) is within 30 days of receipt of positive screen by CM. Families

accepting services are reported at our weekly staff meeting, including first home visit date, to Lead Assessment / Intake Worker; who keeps a status log of the positive screens.

Returned Intake Checklists are monitored and the information recorded. Reasons for families not accepting Healthy Families is compiled and reported quarterly. The categories generally are: 1. Contact letter sent (When CM has exhausted all reasonable avenues to contact the potential participant, and failed.)

2. Not interested (When the family has been contacted, but decline an assessment visit.) 3. Baby not in home (When the child didn't go home with the family or has been removed from the home due to involvement with Child Protective Services.) 4. Moved out of area (When the family has moved out of La Crosse County.) 5. Other

The intake process is monitored in the following way. If the assessment ultimately takes place and the family accepts services, the Clinical Supervisor reviews the Intake Checklist for timeliness and completeness. Timeliness and completeness is monitored for all the Intake Checklists and their associated screens that are returned, by the Lead Assessment/Intake Worker.

1-3. A-B: For families who accept services, the first home visit occurs prenatally or within the first three months after the birth of the baby.

CM, once the family assess positive, offers home visiting services at the end of the assessment. The family is not transferred to another worker; they stay with the assessing CM. The next visit, once services are accepted, is considered the first home visit. Since the family would be assigned level I, the first visit is scheduled for the following week. For those families with unusual circumstance, such as the infant is in the NICU, visits occur where ever the family feels most comfortable.

Lead Intake Worker will maintain records tracking all families who accept services. The record is to indicate when the families' first home visit occurred (prenatally or within the first three months after the baby's birth). This information will be reported to the Program Manager on a quarterly basis for monitoring purposes.

1-4. A-C: "Acceptance", as defined by Healthy-Families—La Crosse, occurs when a family agrees to services following a positive assessment and follows through with a minimum of one home visit. The family assessment worker keeps quarterly lists of completed assessments and tracks whether or not the family follows through with a home visit. The acceptance rate is calculated each quarter by dividing the number of families who have accepted services by the number of families who were assessed. "

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Healthy Families measures and tracks acceptance rates of families on a quarterly basis. Acceptance rates are determined by comparing the rate of positive assessment to acceptance of a first home visit. This data is compiled and reported quarterly. Should acceptance rate ever be below 90%, a thorough analysis would be undertaken by the staff, and potential improvement strategies would be identified. Increase in acceptance rate would be based on the analysis of those refusing to accept services vs. those accepting services.

Supporting Literature

Services initiated prenatally or at birth reach parents when they are most open to information and assistance. Early interactions between parents and home visitors serve as the basis for all future interactions. "Pregnancy is a time of anticipation and preparation, and for first-time mothers it brings anxiety that makes them especially eager for the information and reassurance that the program worker can provide." (Fair Start for Children, 1992, p. 227)

The assumption that mothers who have had more than one child all less apt to benefit from Healthy Families than first time mothers was challenged by research conducted by Joseph Galano Ph.D. and Lee Huntington Ph.D.) using Healthy Families sites in Virginia. "Despite the assumption that they would not benefit from home visiting programs to the extent seen in primiparous families, and despite the fact that programs that serve them face additional challenges to meet their more complicated needs, this study demonstrated that multiparous families can participate similarly to primiparous families and can achieve similar outcomes." (p.vi executive summary, Comparison of Primiparous and Multiparous Mothers, published in June of 2012.)

Early initiation of services results in healthier babies. Between 1987 and 1990, the Hawaii Healthy Start program provided home visiting services starting at birth for 2,256 families. (State of Hawaii, Department of Health, 1994) Comparisons of families receiving home visiting services and Hawaii's general population showed that 90 percent of children receiving services were fully immunized at two years of age compared to 60 percent of the general population. Furthermore, 95 percent of eligible children receiving services were enrolled in Early Periodic Screening Diagnostic Treatment (EPSDT) services, while only 43 percent of eligible children in the general population were enrolled in EPSDT services.

The quality of parent-child interactions plays a significant role in determining positive child outcome. "Infants thrive on one-to-one interactions with parents. Sensitive, nurturing parenting is thought to provide infants with a sense of basic trust that allows them to feel confident in explaining the world and forming positive relationships with other children and adults."

(Carnegie, 1994, p.5) By initiating services at birth or earlier, home visitors are in a position to help shape the quality of these early interactions. Home visitors can help parents learn how to touch, hold, soothe, and communicate with their babies in ways that promote healthy development.

Early initiation of services facilitates the development of an attachment relationship between parents and children. Bowlby (1969, 1973, 1980) indicates that attachment relationships between parents and children are generally formed by nine months. A good quality parent-child relationship that is developed early in life leads to a secure attachment relationship, which provides the cornerstone for all later development. By supporting parents through stressful situations and helping them to bond with their babies, home visitor services beginning prenatally or at birth have the greatest opportunity to assist in fostering positive parent-child relationships.

GETTING HELP

Contact your Program Manager and/or Supervisor with any questions.

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Procedure Name:	SCREENING FOR INDICATORS OF NEED
Procedure Number:	301
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	Screening Form

STATEMENT OF PURPOSE

Healthy Families' goal is to screen all expectant parents and parents of newborns in our designated target area of La Crosse County. This procedure ensures that HF has an objective, standardized process for screening families to determine if an assessment is indicated.

Program uses the Healthy Families screening form to identify potential participants.

AREAS OF RESPONSIBILITY

Lead Assessment Worker or CM will conduct the screen via phone conversation with the parent.

PROCEDURE

Eligibility Requirements for Healthy Families:

- Families must live in La Crosse County to be considered geographically eligible for services.
- Families who move into La Crosse County with infants under three (3) months of age may be screened if referred to the Healthy Families program.
- Child Protective Services will allow the child to be in the home.

A screen is the first step taken to determine if the family will be offered an assessment.

1. HF has developed agreements with our two healthcare facilities to conduct the screen themselves or allow us to screen families. During the screening process, if conducted by a healthcare professional, the parent(s) must consent to being contacted by a representative of HF.

2. If a referral is received by HF without an attached screen, the Lead Assessment Worker or CM will conduct the screen via phone conversation with the parent. This takes place before an appointment is set up for conducting the Parent Survey, but may be in the same conversation.

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3. The HF Screening Tool is defined as positive when it meets the criteria as described on the form and we have determined that Child Protective Services will allow the child to be in the home. If a screen result is positive, the family is either offered an assessment interview, or a reason for not assessing the family is noted on the form.

4. If a screen result is negative, participants will be offered appropriate referrals.

There will be a screen run and assessment taken.

SCREEN	**ASSESSMENT**
1. Completed by answering the 15 psychosocial indices as True, False or Unknown. a. Screen can be completed by perusal of mom's medical chart Or b. In person by asking mom the questions **Defining the Screen** *1. Negative Screen* a. #1, 9, and 12 on chart are "False" b. No more than one other "True" appears. *2. Positive Screen* a. #1, 9, or 12 are "True". b. Any two items are "True". c. There are 7 or more "Unknowns".	1. Completed for all **positive screens**. 2. Gathers information necessary for completion of Parent Survey. a. Information to include parents' childhood history, current/past substance abuse history, support systems, problem solving/coping skills, stressors/concerns, potential for violence, expectations of infant and attachment/bonding issues, perception of infant, discipline issues and previous/current CPS history. 3. Assessment is **scored** based on the responses to all of the above items. a. A score of 25 or above identifies the assessment as <u>POSITIVE</u> and makes the family eligible for home visiting services and/or referrals to any other appropriate community

	resources. b. A score of 20 and below identifies the assessment as NEGATIVE and indicates that the family (based on their self-reporting) does not currently qualify for Healthy Families home visiting but will receive referral to other appropriate community resources.

GETTING HELP

Contact your Program Manager and/or Supervisor at any time.

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Procedure Name:	ASSESSMENT OF FAMILY STRENGTHS AND NEEDS
Procedure Number:	302
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	2-1.A-C, 2-2.A-B: Parent Survey, Letter to Family upon Assessment Refusal (Contact Letter)

STATEMENT OF PURPOSE

HF will consistently use the Parent Survey to gather information about the specific strengths, risk factors, and needs of a family.

PURPOSE

To ensure that HF has an objective and standardized process for assessing the strengths and needs of families, and for referring families to appropriate program services. Home visiting is not an appropriate service for all parents and HF is interested in engaging parents who have been identified as most likely to benefit from intensive home visiting as early as possible in the child's life. Consistent use of a standardized assessment tool by trained staff provides the program with information about the specific strengths, risk factors, and needs of a family.

Should the family accept intensive home visiting services, the assessment provides key information for the CMs and supervisor to begin service planning with the family, and building upon their strengths.

HF will consistently use the Parent Survey to gather information about the specific strengths, risk factors, and needs of a family.

AREAS OF RESPONSIBILITY

Case Managers who have been trained by an HFA certified trainer will conduct Parent Surveys. Supervisors who have completed the Core HFA training for FRSs and Supervisors will provide supervision and oversight to CM.

PROCEDURE

1. Standardized tool
   a. The Parent Survey is the standardized assessment tool administered to identify the parents' experiences, expectations, beliefs, and behaviors. It assesses for the presence of factors including increased risk for child maltreatment or other poor childhood outcomes

(e.g. social isolation, substance abuse, parental history of abuse in childhood, etc.) It is also used to gather information about parents' strengths and capabilities. This information is used by CMs to determine information and referrals to offer parents. If parents are referred to, and accept home visiting this information is then used by the CM and supervisor during the engagement process and for ongoing service planning.

2. When to offer an assessment
   a. It is best to initially offer parents the opportunity to participate in the assessment without committing to the opportunity of home visitation services. Reasons for refraining from committing to home visiting during outreach and at the start of the assessment include: limited program capacity; home visitation may not be an appropriate referral for parents; family's Parent Survey score may not warrant a referral to home visiting. The assessment is best presented as a means to identify appropriate services within the community that may benefit the family.
   b. CMs attempt to offer an assessment to all families with a positive screen.

3. Administering the assessment

   a. Ideally, assessment interviews should be done where families are residing. It is helpful to see the family and, if possible, the child in the context of the family's environment. In addition, if the family is referred for home visiting, it sets the stage for family-centered work to occur in the home.
   b. Assessments may also be completed in hospitals, clinics, offices of private physicians, in the program's offices, and other community organizations' sites. Assessments must be done face-to-face. Occasionally, follow-up information is obtained by phone or electronically.
   c. Every effort is made to assess both of the baby's parents or primary caretaker, when indicated. This might include flexing workers' schedules to accommodate the availability of this other family member.
   d. The assessment takes approximately 1 hour to administer and a "conversational-weave" approach is used to cover items on the Parent Survey, using skills learned for conducting a strengths-based assessment. This includes helping parents to self-identify their own strengths.
   e. CMs are trained to accurately represent the nature of the assessment, treat parents respectfully, establish rapport and build trust in a short period of time. CMs raise sensitive issues and remain non-judgmental of the parents' responses. These responses are used to score the Parent Survey.

4. Documenting an assessment
   a. All assessments are written (within 7 days of the assessment) in a narrative format, including negative assessments, as per HFA Core training.

b. The CM accurately documents family strengths and needs in narrative form. Narrative form means that there is a written description of the information gathered from the family during the assessment process. It incorporates the information provided by the family that links to the assessment criteria. The assessment narrative does not include a conclusion based on information gathered in the assessment process.
c. The CM scores the assessment, assuring that the score is supported by the documentation, offers referrals (including home visiting) as needed.
d. This assessment documentation becomes the basis for standards 6-1A and 6-1B requiring the use of the assessment in developing home visit content and Family Goal Plans.

5. Screen and Assessment Record Retention
   a. For families who enroll in the program the assessment narrative is maintained in their participant file along with the screening tool, and according to program procedures for protection and confidentiality of participant information.
   b. All negative assessments and positive assessments for families that do not enroll in the program are maintained by the Lead Assessment Worker.

6. Positive/Negative Assessments
   a. Intensive home visiting services are offered on a voluntary basis to families when:
   -Parents and/or significant other receive a Parent Survey score of 25 or higher (positive), and CM determines that intensive home visiting is an appropriate referral for family based on information contained in Parent Survey , and
   -Space is available on CMs caseload to accommodate new enrollment.
   b. Referrals and information to other community resources is offered to all families, including those where the parent(s) and/or significant other receive a Parent Survey assessment score of 0-20 (negative).
   c. In rare instances, the CM can determine to offer intensive home visiting to a family receiving a negative Parent Survey score under a “clinical positive.” The decision would be based on information obtained from a professional source or a CM’s strong belief that the parent withheld vital information that, if disclosed, would have resulted in a positive score. Factors justifying the clinical positive are documented in the family record.

7. Program Capacity
   a. If programs are at capacity, screening continues, but assessments and intakes into Home Visiting Service ceases. Families who would otherwise be offered assessments or intensive home visiting are referred to other programs.
   b. When a slot becomes available for enrollment into home visiting, the next available family who assesses positive is offered services.

8. Re-assessments for Re-Enrollment

a. Re-assessments of families not currently being served can be done if the family has had a subsequent child.
b. If a family is receiving services, another assessment is not administered following the birth of subsequent children. The rationale for this is that home visitors work with the entire family, including subsequent children.

9. Assessment Refusals
   a. If a family refuses an assessment interview, they are encouraged to call the office with any questions or concerns about pregnancy or the newborn. They are asked to think about the program's services and if they change their minds, to contact the program at any time.

10. Training of those administering tool
    a. Assessment interviews are conducted by Case Managers who have been trained by an HFA certified trainer to conduct Parent Surveys.
    b. CMs are to be trained in the use of the tool prior to administering it.

11. Supervision of CM's assessments.
    a. All staff responsible for CM assessment supervision and oversight must have completed the Core HFA training for Family Resource Specialists and Supervisors before they begin supervising.

GETTING HELP

Seek help from management or clinical supervisor when needed.

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Procedure Name:	OUTREACH TO AND ENGAGEMENT OF FAMILIES
Procedure Number:	401
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	3-1 A-B, 3-2A-B, 3-3A-B, 3-4A-C Pre-Intake Referral Form, Service Record, Home Visit Record, Participants Rights/Informed Consent, Healthy Families brochure, Release of Information form, Family & Children's Center Notice of Privacy Practices, Level X form

STATEMENT OF PURPOSE

Healthy Families utilizes a process for reaching out to and engaging families as well as attempting to stay connected with and re-engaging families who may have more barriers to accepting and maintaining services. Program defines, measures, and analyzes the retention rate of participants in the program in a consistent manner and on a regular basis at least once a year.

PURPOSE

Healthy Families utilizes a process for reaching out to and engaging families as well as attempting to stay connected with and re-engaging families who may have more barriers to accepting and maintaining services. HF defines, measures, and analyzes the retention rate of participants in the program in a consistent manner and on a regular basis at least once a year.

Staff must use trust-building methods and tools, including supervisory support, when establishing and maintaining relationships with families. Families who are reluctant to engage in services may have difficulty building trusting relationships.

Home visitation services must be voluntary, such that the entire context and tone is one of respect for families--their desires and their strengths (Gomby, 1993).

Research indicates that 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 home visitors (Fraiberg, 1975).

A variety of circumstances may cause participating families to discontinue home visits for a time. This procedure ensures that the program is structured to allow for these circumstances without immediate termination of services and to provide a framework for re-engaging families who have become disengaged. This procedure ensures that programs have a process for reaching

out to and engaging families, as well as for maintaining family involvement and re-engaging families.

Calculating the length of time families are retained in services is a critical quality improvement measure. Patterns of retention and of dropping out of services need to be identified in order to improve and target strategies to increase family retention.

AREAS OF RESPONSIBILITY

All program staff are responsible for outreach as outlined in the procedures.

PROCEDURE

3-1. A. Voluntary nature of services. Healthy Families Program offers home visiting services solely on a voluntarily basis. Materials, such as brochures, may be used to inform families about the voluntary nature of services. Families are also notified of the voluntary nature of the program's services at the time staff meet or talk with our pre-intake participants.

3-1. B. Families are offered services on a **voluntary** basis. At the time families are offered services, participants are notified of the voluntary nature of services. This is accomplished verbally by staff and the Participant's Rights form. All participant families must sign this form to initiate home visitation services. The Participant's Rights form also indicates that the family may discontinue services at any time.

Healthy Families allows external agencies to refer participants, but does not allow those agencies to mandate our service. Nor do we: 1) monitor or report the family's progress on behalf of the referral entity, or 2) perform job functions required by that entity. We ensure that the referring agency and the families are verbally notified of our procedure in this regard, if any misunderstanding is suspected.

Participants are verbally, and through Family & Children's Center's Notice of Privacy Practices document, notified that any sharing of information with external agencies is bound by the confidentiality requirements of Family & Children's Center.

3-2. A. Healthy Families specifies a variety of positive methods to build family trust, engage new families, and maintain family involvement in the services.

Identified positive ways to establish a relationship with a family and keep families interested and connected over time include, but are not limited to:

- Telephone calls and texts
- Visits

- Mailings (interesting articles, referral to useful community partners, etc.)
- Providing supplies needed by the family
- Other techniques identified through supervisory support.

Follow up is an essential component of outreach. Materials are culturally informed and language use is appropriate to its intended audience.

These outreach activities may continue, but do not have to continue, until the target child is three months old if it seems that continued efforts may result in engagement. If the family doesn't return initial phone calls, but the child is under three months old, a letter is sent offering services and requesting a contact. Should this fail, assigned staff is to contact the referral source to verify contact information. If the referral source has updated information staff acts accordingly. For example, family moving out of service area would result in ceasing of creative outreach, family has new contact information would result in additional outreach attempts. Ceasing of creative outreach of families, we have been unable to contact occurs once the baby is three months old or if there has been no response within two weeks of our final attempt letter.

3-2. B. Staff must use positive methods to build family trust, engage them in services, and maintain family involvement.

Strategies, as listed above, are used by staff to connect with families both at intake and throughout the course of service delivery. Staff is encouraged to develop creative ways, based on the individual families' needs and interests, to connect and maintain involvement. Service (via phone, text, note, or in person visit) should be tailored to the family being served. Examples of such strategies include:

- Warm phone calls focused on the family's well being
- Upbeat notes
- Leaving a card when families are not at home
- Anchoring conversations with families to their interests and needs
- Demonstrating joy in being with the family
- Offering playful/ fun activities
- Personalizing engagement efforts.

3-3. A. Healthy Families offers creative outreach to families who have accepted services, yet have not been consistent in participation of services.

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A family who has accepted services is one who has received their first home visit. The circumstances under which a family is provided creative outreach includes when a participant is ambivalent about Healthy Families home visiting program, is avoiding services, or cannot be located.

- Outreach strategies include program staff utilizing their knowledge of the family, including their strengths, living situation (i.e. location, access to phone, etc.) challenges, and gestational age or age of the child in their selection of outreach activities.
- Examples of creative outreach strategies might include phone calls to inquire about mother's and baby's well-being and inquire if they have any questions or concerns, materials that are geared specifically to the father's role in child development, or calling to provide information and referral based on existing knowledge of the family, letters that mention the stage of gestational development or the baby's developmental milestones, invitations to program activities, references to the child's age and development in both phone calls and mailers, and references to the family's strengths and goals.

3-3. B. Creative Outreach is continued for three months and is only concluded prior to three months when families have engaged in services, refused (decline verbally or in writing) services, have moved from the service area, the child is no longer in the home (ex: removed by Child Protective Services or has died), family is being served by Child Protective Services past 60 days or their "initial assessment" period, or upon supervisor's discretion (ex: concern for worker's safety).

The date used to indicate Creative Outreach status (level X) corresponds to the date of the third consecutive missed home visit or one month from last completed home visit, based on the supervisor's recommendation. Families are returned to their same or a higher frequency of visits when they are taken off of Level X. This decision is based on discussions between the supervisor, worker and family (not necessarily at the same time). In order for a family to be taken off of Level X, they need to have received at least two consecutive home visits. The date on the Level form is the same date as when the second consecutive (or otherwise designated) home visit occurred.

Duties of the CM during Creative Outreach vary according to each family's circumstances. In general, some form of contact with the family is attempted at least once a week for three weeks, then twice a month, and finally one last time during the third month. Visits, phone, or mail contact may be attempted. Families, depending on

circumstances, may be offered visits that are not in their home. Examples of these circumstances include families experiencing intimate partner violence, resistant spouse or parent/guardian of the participant, or circumstance that would cause undue stress for the participant.

3-4. A. Healthy Families measures its retention rate using HFA approved methodology (first and last home visit) at least annually.

3-4. B. Retention, once measured, is analyzed yearly. This is accomplished through discussion with staff and others involved in the program. Trends are determined and noted. A comparison is made between those who dropped out of the program and those who remained. The comparisons include significant programmatic, demographic and social factors. Families who were discharged because of graduation, moved from the service area, child was no longer in the home, Child Protective Services became involved past their 60 day "initial assessment" period, or at supervisor's discretion (for example due to concern for workers' safety) are not considered among those who dropped out of the program.

3-4. C. Based on the program's yearly retention analysis, the program develops and implements a plan to increase retention rates among the families currently being served. The plan is connected to the patterns or trends noted in the retention analysis.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	LENGTH AND FREQUENCY OF SERVICES TO FAMILIES
Procedure Number:	501
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	4-1A-B, 4-2 A-E, 4-3 A-B, 4-4 A-B, Participant's Rights, Level Completion forms

STATEMENT OF PURPOSE

To ensure that HF has a well-thought out process for determining and managing the intensity and frequency of home visits that is consistent with the needs and the progress of each individual family.

PROCEDURE

For those families who accept home visitor services, the first home visit occurs prenatally or within the first three months after the birth of the baby.
HF home visiting services are offered intensely, i.e., at least once a week following the birth of the baby. Our services are offered over the long term, i.e., for a minimum of three years and up to five years or until the child has entered school or Head Start.

Parents who accept home visiting services will be offered a minimum of weekly visits of approximately one-hour for at least 6 months following their child's birth, excluding time spent on Level X. If a family enters the program postnatal, the family will be provided weekly services for a full 6 months. In other words, the baby turning 6 months old is not the marker that will be used to assign a family to another level.

The exception to the above procedure is in isolated instances (up to 10% of active caseload) due to family, school, and/or work restrictions. When families request a less frequent home visiting schedule during this timeframe, our program procedure is to keep the family on Level 1 and the worker is to clearly indicate to the family the availability of weekly visits. Keeping the family on Level 1, saves the space in a worker's caseload to allow for weekly visits, should the family's situation change.

Families accepting services prenatally may receive less frequent home visits until the birth of the child, (twice per month minimally) but ideally they will receive visits more often to focus on prenatal bonding and preparation for parenthood for both mothers and fathers. The case weight of Level 1- Prenatal is the same as Level-1 during the last trimester. This saves the space in the worker's caseload to allow for weekly visits and is in preparation for attaining Level 1 status.

The home visiting schedule for the program is consistent with that of Healthy Families America. There is a defined set of levels of service: Level 1-Prenatal, Level 1, Level 1-SS, Level 2, Level 3, Level 4 and Level X. These levels are a well thought-out system for managing the intensity/frequency of home visiting services.

The participant's progression to a new level of service or to the transition of closing is planned and reviewed by the family, the home visitor, and the clinical supervisor; although all three parties do not have to be present at the same time to conduct this review/planning.

HF will monitor home visit completion rates on a quarterly basis. If rates fall below 75% of families receiving 75% of their visits, based upon the individual level of service to which they are assigned; staffing time will be set aside to explore exceptions, reasons, and problem solve to increase the completion rate.

Performance Goal: 90% of families receive at least **75%** of the appropriate number of home visits based upon the level of service to which they are assigned.

AREAS OF RESPONSIBILITY

Staff will meet goals and complete home visiting agreements and complete all necessary paperwork and assessments. Staff will adjust the length and frequency of services to families based on plan and the progression or regression of the families.

PROCEDURE

1. Frequency of Visits

The frequency of home visits may vary over the three to five years, as defined below. Participants are assigned to levels according to the intensity of service needed. All families enrolled will begin at either Level 1-Prenatal or, if enrolled post-partum, at Level 1. In isolated instances (limited to 10% of active caseload) due to family, school, and/or work restrictions; when families request a less frequent home visiting schedule during the first 6 months of enrollment, our program procedure is to allow it. We keep the family on Level 1 and the worker is to clearly indicate to the family the availability of weekly visits. The worker is not required to continually try to schedule weekly visits, just make it known that the visits are available to the family. Keeping the family on Level 1, saves the space in a worker's caseload to allow for weekly visits, should the family's situation change. In rare cases of exceptional need, families may begin services at Level 1-SS (Special Services).

Families may move to more or less intensive levels of service, depending on need, as defined on our "Completion of Level" sheets. Our level sheets define the Case Manager's responsibilities and the parent(s) achievement requirements to change levels.

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Our level sheets carry a notation of the family's case weight. Our case weights correspond to the level that a family is assigned. The case weights allow us to manage our caseload capacity. We have a base case weight, to which we add our drive time (variable, based on family location), note time and data entry time. Our levels set out the following schedule of expected visits and base case weight:

- Level 1- Prenatal: from two home visits per month to weekly home visits. Base case weight of 2.
- Level 1: Weekly home visits for a minimum of 6 months after the birth of the baby or 6 months after enrollment date (whichever is longer), *excluding time spent on Level CO*. For monitoring purposes, this level expectation is 4 visits per month, or 12 per quarter. Base case weight of 2.
- Level 2: Home visits every other week. For monitoring purposes, this level expectation is 2 visits per month, or 6 per quarter. Base case weight of 1.
- Level 3: Home visits once per month. For monitoring purposes, this level expectation is 1 visit per month, or 3 per quarter. Base case weight of .5.
- Level 4: Home visits every three months. For monitoring purposes, this level expectation is 1 visit per quarter. Base case weight of .25.
- Level CO: Creative Outreach and zero visit expectations. Base case weight of whatever the family's level was before being placed on CO.
- Level 1-SS: Home visits at least weekly. For monitoring purposes, this level expectation is 4 visits per month, or 12 per quarter. Base case weight of 3.

1. Length of Visits

Home visits will last 60 minutes, on average. Based on visit content and situational factors, a visit may last 30 to 90 minutes.

2. Scheduling of visits

Workers should schedule home visits when both the child and the caregiver will be available. While the worker may discover otherwise at the visit, the intent is to schedule when both are available in order to address parent-child interaction.

CMs are encouraged to create a consistent schedule of visits. However, if a family does not have a phone and is not available for a scheduled visit, the worker may attempt an unscheduled visit. Phone contact is not recognized a visit.

3. Definition of home visit

A family is considered to have had their first home visit when the family states to the CM that they want to enter the program. A Participant's Rights form is reviewed with, and then signed by, the family and their worker.

A visit is considered "in home" as long as it takes place, at some point during the visit, on the property of the family and the worker is able to see the child and parent in the child's

environment. Occasional visits may be conducted at other locations, in response to the needs of the family i.e. parks, doctor's office, food pantry, other community resources. On rare occasions, family circumstances preclude visits in the home. An alternative location may be approved by the supervisor, based on the family's special circumstances. Examples of special circumstances may be sensitivity to resistive parents of teen participants, in cases involving intimate partner violence, or for the safety of the home visitor.

Workers meet with families in the family's home so that they can assess safety, experience the family's living environment, develop first-hand knowledge of the strengths and stresses of the home environment, and to engage the family where they live.

Home visits are face-to face interactions with the promotion of parent child interaction as a primary focus. They also focus on the promotion of healthy childhood growth and development and the enhancement of family functioning.

5. Content of Home Visit levels

- **Prenatal Home Visits**: During these home visits the CM provides information to the family regarding prenatal care, fetal development, preparation for birth, and preparation for newborn care. A major emphasis is on encouraging the parent to obtain regular prenatal care, on supporting the parent(s) in building healthy support systems, reducing parental stress, and making referrals based on family needs. . Screens are conducted according to our Master Screening Schedule. This includes depression screening and may include our home safety assessment. Issues identified during the initial assessment are addressed. One of the ways this is accomplished is collaborating with the family to develop a The Family Plan (Goal Plan).

- **Level One Home Visits**: During this period, the emphasis is on educating about child growth and development, evaluating parent-child interaction, conducting activities to promote bonding and attachment and positive parent-child interaction, supporting parent(s) in building healthy support systems, reducing parental stress, advocating for nurturing discipline techniques, and collaborating with families to develop meaningful Family Goal Plans. Appropriate screens and assessments (per our Master Screening Schedule) are completed and, when appropriate, referrals made for further evaluation and intervention. These include: Edinburgh Depression Screen, Wisconsin Home Safety Assessment, ASQ-3 and ASQ-SE, HOME Inventory for Infant/Toddler or for Early Childhood, recording of immunizations and well-child exams being up to date per the child's health care provider, recording of utilization of formal and informal support

- Families requiring very high level of service due to unusual circumstances may be placed on **Level 1-SS (Special Service).** Requirements at this visit level are the same as Level 1.

- **Level Two Home Visits**: The major emphasis is on activities that promote positive parent-child interaction, healthy child growth and development, utilizing support system, enhancing problem solving skills, family life stability, and self-sufficiency. Also on level two, as with all levels throughout the program, support is provided to the families on whatever issues are identified, by providing information and referrals as needed. Family Goal Plans and all screens and assessments (per our Master Screening Schedule) are required.

- **Level Three Home Visits**: The education that has occurred previously will have enhanced families' knowledge and understanding of community resources. The activities discussed for levels one and two continue on level three. Family Goal Plans continue to be reviewed and developed at least every six months, as do all screens and assessments (per our Master Screening Schedule).

- **Level Four Home Visits**: During these visits, materials on child growth and development and parent-child interaction continue to be reviewed. Monitoring of the child's health and development, health care utilization, stability in the home, enhancing coping and problem solving skills, use of positive support networks, and progress toward the family's Family Plan (Goal Plan) are emphasized. All screens and assessments are still conducted, per our Master Screening Schedule.

- **Level CO Home Visits**: Healthy Families has two categories for our Level CO participants. If the family is temporarily out of our service area (for more than 2 weeks and they've informed their CM) they are placed on Level TO, but no contact is required. Participants will resume service at their former level upon return.

  If the family is ambivalent about home visiting, is avoiding services, or cannot be located, they are placed on Level CO. In this case, the CM is to conduct creative outreach for 90 days; discontinuing when the family reengages, declines services, or the 90 days is up. During supervisory sessions, the supervisor and CM make a judgment regarding the type and frequency of participant contact for Level CO families.

Procedures for Staff:

1. <u>Introducing length and frequency of home visiting</u>

a. Before the family agrees to participate in the program, they need to have a clear understanding of the length and frequency of involvement. Explanation is made to the family that the program will be available until the child enters school or Head Start and their continued and consistent participation is needed for the family's goals to be accomplished. At the same time, since the program is voluntary, they can withdraw from the program anytime.

b. The frequency of visits is dependent on such factors as the quality of parent-child interaction, the level of risk, number of family crises, family problem-solving skills, family needs and the use of community resources.

c. A family may be moved to a different level depending on their progress. Decisions about level change will involve and are agreeable to the family, CM and Clinical Supervisor. Discussions regarding family progress, potential level change, and formal level change will be documented by CM and Clinical Supervisor.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.
Always contact the Program Manager and/or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	COMPLETION OF HEALTHY FAMILIES
Procedure Number:	502
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	

STATEMENT OF PURPOSE

The Completion of Health Families procedure ensures that the needs of the family are assessed in order to create an appropriate plan for ending services.

PURPOSE

To ensure that HF offers voluntary services to families for a minimum of three years after the birth of the baby, depending on the needs of the family. Services will not be interrupted because of programmatic issues. When a family discontinues services, a transition plan is developed based on the wishes of the family that increases the likelihood that needed supports and services will be accessed after service closure.

AREAS OF RESPONSIBILITY

Staff will assess the needs of the family to create a plan for closing the case.

PROCEDURE

1. A family has completed the program when one of the following occurs;
    - Participant graduated, met goals, target child in school, and completed program. A family may complete the program in between 3-5 years, depending on the family's progress.
    - Target child entered Kindergarten
    - Target child entered Head Start
2. A family will be offered a contact phone number when a worker is scheduled to be unavailable for more than one week. When a worker is scheduled to be unavailable for more than two weeks, the family will be offered temporary services from an alternate worker and the family will maintain their current level of service. If the family refuses, they will be placed on Level-X; services will clearly be made available, however families will not be required to accept an alternate worker.
3. A family may close before they complete the program if they move out of our service area, the child is no longer in the home, Child Protective Services is involved past 60 days or "initial assessment" period, ninety days of creative outreach has elapsed, upon supervisor's discretion (an example is worker's safety), or if the family declines further services for any reason.

4. When a family prepares to terminate 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. All parties do not have to be present at the same time to develop the plan. The plan will be noted on the family's home visit records and part of The Family Plan (Goal Plan). The CM should take the initiative to explore suitable resources and follow-up on the transition plan, as appropriate, when possible, and with permission of the family. Circumstances leading to an unplanned or unexpected closure are not held to this procedure.
5. Transition planning should begin 3-6 months before closure, if at all possible. It is expected that following the initial discussion, the topic of transition planning will be included as part of discussions with the family at all subsequent home visits; and documented on the home visit record.
6. Topics to be covered as part of transition planning are: identification of resources and/or services needed or desired by the family, steps are outlined to obtain any identified resources or services, and future contact information with CM/Healthy Families Program shared.
7. The date of closure is the last home visit.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

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Family & Children's Center

Procedure Name:	CULTURALLY RESPONSIVE SERVICES
Procedure Number:	601
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	

STATEMENT OF PURPOSE

HF works toward making all aspects of service delivery culturally responsive and family-centered.

PURPOSE

To ensure that HF staff conduct themselves in a culturally aware manner, with regard to families' and communities' unique characteristics. To ensure that all aspects of service delivery (i.e. outreach materials, trainings, assessment, home visiting curriculum, parenting groups, etc.) are culturally responsive and family-centered. To ensure that programs employ ongoing efforts to heighten staff members' awareness of the impact of culture on service delivery, and utilize culture as a family strength and resource.

AREAS OF RESPONSIBILITY

Staff members will ensure that all services are culturally sensitive, responsive and family-centered.

PROCEDURE

Materials and presentations for the public, for participants, and for the target population will be participant-centered. (I.e. relevant, culturally responsive, and understandable).

Healthy Families adheres to Family & Children's center's training requirement that cultural awareness training is provided for all staff.

1. Cultural characteristics

Cultural characteristics of La Crosse County residents are identified and may include features and attributes such as ethnic heritage, race, customs, values, language, age, gender, religion, sexual orientation, social class and geographic origin, among others.

2. Personnel and Communication with participants

Healthy Families hires staff and involves volunteers and community partners who are representative of the language and culture of the population to be served and who are hired from

the community targeted for services. Hiring of staff members, particularly Family Resource Specialists (FRSs) and Case Managers (CMs), reflect the ethnic and cultural characteristics of the families served. Program staff should be able to understand a wide range of cultural belief systems and corresponding behaviors that may affect all aspects of achieving program goals.

3. Collaborating agencies/Advisory Committee

Those involved in program planning and management, such as collaborating agencies and/or Advisory Committee members include persons and organizations who reflect the ethnic and cultural characteristics of the community. Healthy Families works to form solid, working relationships with culturally and linguistically appropriate agencies and organizations in the community in order to best serve program participants.

4. Staff-Family Interactions

Staff work with families in a manner that is individualized and tailored to the unique strengths and needs of each family and is respectful of family traditions, religious beliefs, values, norms, parenting styles, etc.

5. Materials

Written materials for use with families or on display in the program offices reflect the cultures and languages of the participants to as great a degree as possible. When feasible, the program uses materials most appropriate for the target population (i.e. appropriateness of reading level).

6. Training

Family & Children's Center ensures that cultural diversity training is provided for all staff, annually. In addition, new hires are required to view HFA's wraparound online training within twelve months of hire.

7. Cultural Sensitivity Review

Programs' internal procedures include a process to examine how it is providing culturally sensitive services. This process may include the following mechanisms to ensure we gather the necessary feedback from family and staff:

- Participant satisfaction surveys distributed annually to all program participants that include specific questions related to cultural sensitivity
- Quality assurance home visit and supervision observations
- On-going input from staff documented in team meetings minutes
- Annual staff meeting session on cultural competency as it relates to screening/assessment, outreach, home visits and service planning, materials and curriculum, forms, hiring and recruitment, training, and parent events (such as socials)
- Participant input from Advisory Committee meetings, parent events and informal opportunities for feedback to be shared

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	ANNUAL SERVICE REVIEW
Procedure Number:	602
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	

STATEMENT OF PURPOSE

An annual review is conducted to address all components of the service delivery system related to cultural awareness (e.g., family assessment, service planning, home visitation, and supervision, etc.). The review addresses the project's materials, training and service delivery system.

PURPOSE

To ensure that our program has a process for examining critically and deliberately its current ability to provide culturally sensitive services.

AREAS OF RESPONSIBILITY

Healthy Families supervisor will conduct the Annual Service Review

PROCEDURE

Healthy Families conducts an Annual Service Review of the program based on the most recent information that is available. This review is reported to the Healthy Families Advisory Committee.

Content of reports:

1. The review should be comprehensive. It includes information about the program's materials, training, and all aspects of the service delivery system (assessment, home visiting, and supervision). It includes input from families and program staff and identifies patterns and trends related to program strengths as well as areas to improve upon such as any culturally sensitive service gaps.
2. The review includes the following information:
   - Descriptions of how all aspects of service delivery are evaluated for cultural competency. (I.e. assessment, service planning, home visitation, supervision, materials, etc.)

- A description of the target population that includes key demographic information (i.e., live births per year, number of women of childbearing age, number of single parents, age of target population, and race/ethnicity/cultural/linguistic characteristics)
- How many screens were completed this year? What are the barriers to reaching universal screening?
- A description of issues facing the community (i.e., infant mortality rate, poverty level, teen pregnancy rate)
- Where target population can be found (i.e., agencies, hospitals, etc.)
- The program's definition of acceptance rate
- A description of the population who accepted and refused assessment and why they refused
- A description of how the program is attempting to improve acceptance of the assessment based on the analysis above
- A description of the population that is determined eligible to receive services by virtue of scoring 25 or more on the Parent Survey assessment tool
- A formal or informal analysis of those who refused the program who were determined to be eligible for services and the reasons why
- A description of how the program addresses how it might increase its acceptance rate and a plan to improve this rate or attribute success
- A formal analysis of who dropped out of the program after enrollment and the reasons why
- A description of how the program is increasing its retention rate or attributing success.
- An analysis of the home visit completion rate and plan to increase the rate or attribute success
- Rate of personnel turnover and analysis of factors resulting in turnover

GETTING HELP

Healthy Families America:

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Procedure Name:	SERVICE FOCUS
Procedure Number:	701
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	

STATEMENT OF PURPOSE

Program efforts 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.

PURPOSE

Healthy Families program goals include reducing risk factors and building or strengthening protective factors; by providing services that are family-centered, process oriented, supportive to parents in nurturing their children, in setting meaningful goals, and enhancing family functioning and sharing child development information.

AREAS OF RESPONSIBILITY

The home visitors address the needs of all family members and builds on family strengths by routinely exploring accomplishments with parents and what is going well. Services focus on familiarizing parents with child development, fostering positive parenting skills, and promoting healthy parent-child interactions and encouraging self-sufficiency. Families are assisted with establishing their own goals and identifying and accessing resources (i.e., child development, social, medical, employment, and housing services).

PROCEDURE

Healthy Families Program services are family centered, based on the belief that parents, not home visitors or agencies, hold the strongest potential to help their children grow and develop with healthy, functional capacities.

Healthy Families employs an infant mental health approach in which services are relationship focused, strength-based (building of parental competencies), culturally informed and are anchored to the parallel process during interactions with families. This process along with HFA trained skills and methods create an alliance between visitors and parents to support the parents in responding sensitively in a nurturing manner with their young children.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	REVIEW OF INITIAL ASSESSMENT (PARENT SURVEY)
Procedure Number:	702
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	6-1 A-C, Parent Survey, Home Visit Record, Family Goal Plan

STATEMENT OF PURPOSE

The CM, the supervisor and the participant family discuss strengths and address issues identified in the initial Parent Survey. These discussions are documented in participant and supervisor files, as appropriate. All three parties use the Parent Survey (and subsequent Ongoing Assessment as found on the Family Goal Plan) for service planning during the course of services offered to families.

PURPOSE

To assure that supervisors and home visitors use the initial assessment (Parent Survey) in service planning. The Parent Survey, along with the Ongoing Assessment as found on the Family Goal Plan, is referred to during the course of services offered to families; to ensure that issues that place families at risk for poor childhood outcomes have been discussed, re-evaluated as needed, and addressed; and to ensure that family strengths are used in service planning and in on-going work with each family.

AREAS OF RESPONSIBILITY

Program Staff will do a Parent Survey and Follow through. There will be Ongoing evaluations and assessments.

PROCEDURE

Clinical Supervisor and Case Managers

1. All of the families' issues and strengths, as identified in the initial assessment (Parent Survey), are discussed and reviewed by and between the supervisor and the home visitor. The issues and strengths are to be revisited over time; and revised in the Ongoing Assessment section of subsequent Family Goal Plans and considered in planning family activities.
2. This discussion is documented in the clinical supervisor logs.
3. During supervision, the clinical supervisor will engage CMs in discussion of issues that were brought up on the initial or subsequent assessment, especially as they relate to service planning and the Family Goal Plan development. The clinical supervisor is also to strategize with CMs how to raise these issues in appropriate, effective and sensitive ways i.e. culturally informed, recognizing potential safety concerns for families and workers.

Home Visitors and Families

1. The issues identified in the Parent Survey, or subsequent assessments, are reviewed and discussed between the home visitor and participant family; ensuring that families are offered ongoing opportunities and support to make positive healthy changes in their lives. It is not expected that a CM discuss all of the risk factors and stressors at one time, or that the CM "enforce" behavior-change. Rather, it is a collaborative process between the visitor and family.
2. This discussion is documented on the Home Visit Record.
3. The discussion and documentation include efforts to understand how the stressors experienced by the family impact parenting. These discussions with the family also highlight the strengths that the families had self-identified during the assessment process and those identified by the worker, so that both stresses and strengths are a part of the service process.
4. During supervision, the clinical supervisor revisits the issues identified on the Parent Survey, or subsequent assessment, in order to provide historical context for what might be happening currently or help the CM recognize a family's progress compared to what was happening with them at the time of enrollment.
5. The CM implements with families the activities developed during supervision to address issues identified in the Parent Survey or subsequent assessment, addressing all of them over time.
6. These activities are documented on the Home Visit Record.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	FAMILY GOAL PLAN
Procedure Number:	703
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	6-2 A-D, Family Goal Plan

STATEMENT OF PURPOSE

HF uses a Family Goal Plan to guide the delivery of program services: home visit activities, identification of resources, and the successful achievements that build a family's resiliency and promote protective factors.

PURPOSE

To ensure that the delivery of services to families is guided by the Family Goal Plan and that the process of developing the plan uses family-centered practices. The Family Goal Plan serves 5 main functions:

1. It is a guide for service delivery to ensure families are getting what they need from program services.
2. It is a tool for supporting, assisting, and in some instances, teaching, problem-solving skills.
3. It provides recognition of family strengths, competencies, and accomplishments.
4. When successfully implemented, the Family Goal Plan sets the family up for success and changes the way parents view the world, thus increasing the tendency to plan, increasing self-confidence, internal motivation, self-sufficiency and a sense of self-efficacy. As a result, families feel less like victims and more in control of their lives.
5. It provides a location for assessment notes indicating the revisiting and updating of the family's Parent Survey.

Programs help families identify, plan for, and obtain needed services and achieve specific, meaningful, goals they have set.

Home visitors treat families as partners in this process, eliciting ideas from parents and providing information, but not persuading or pushing an agenda that the family does not share. Home visitors and families collaborate to set meaningful goals taking into consideration family needs and concerns.

The process of developing the plan uses family support practices, is culturally informed, and is driven by the family in a collaborative effort with the CM and the clinical supervisor. This

collaboration will help to yield Family Goal Plans that are family centered and family directed and meaningful to the families.

Once goals are developed, the CM and the family identify family strengths, resources, and competencies specifically related to supporting parents in accomplishing the goals and objectives developed.

Families and CMs review and revise the Family Goal Plan every six months. The family and the home visitor review strengths and accomplishments, parent child interaction and relationships, stressors, needs, and any issues regarding the target child's development. The family reviews and revises goals and the methods by which they will be addressed, with the CM acting as a facilitator in the problem-solving process.

AREAS OF RESPONSIBILITY

CMs develop, review and revise the Family Goal plan with the family. The Supervisor will review the Family Goal Plan with the CM and keep documentation of supervisory discussions.

PROCEDURE

Initial Family Goal Plan

1. The Family Goal Plan is completed within 2 months of intake and may take 2 or 3 visits to complete. After an initial Family Goal Plan planning discussion with the clinical supervisor that includes the content of the Parent Survey, the CM collaborates with the family to identify family strengths, competencies and family needs. These conversations and activities are documented by the CM on the participant's Home Visit Record.

2. Goals
   - Goals are specific, measurable (observable), attainable, realistic, time-limited, and stated in the positive. Goals are recorded on Family Goal Plan forms.
   - Family Goal Plans may contain goals for the parent, address the child's development, and the parent-child interaction or other parenting issues.
   - Goal setting is an opportunity for the home visitor to discuss with the family issues that impact healthy parenting such as those identified in the initial assessment, healthy lifestyle issues, self-sufficiency, and any other issues identified from other tools used by the program in an open and honest way as well as goals designed around child development and parent child interaction.

3. Family Goal Plans (initial and updated) are reviewed and discussed with the clinical supervisor.

Family & Children's Center

4. Family Goal Plans are signed by the CM, the Clinical Supervisor, and the parents, although it does not need to be all at the same time.

5. The original Family Goal Plan goes in the families' file. A copy may be made for the family and supervisor's binder. CMs find it useful to carry a copy in the folder they take for home visits so that it is available for ongoing conversation.

Ongoing work with the Family Goal Plans

1. Timeframes
   - The formal update of the Family Goal Plan is frequent enough to ensure meaningful and relevant goals are being set. The Family Goal Plan is to be up-to-date and active throughout the family's work with the program.
   - Documentation of this process is recorded on the Family Goal Plan copy that the CM carries with them to the home visits. Family Goal Plans may be updated sooner if a family has accomplished goals or decided to change them.
   - Family Goal Plans are reviewed with the family and updated at least every six months for families on Levels 1, 2, and 3. If a family is on level 4, the Family Goal Plan can be revised annually.
   - If a family is on Level CO because they have temporarily stopped receiving services, the Family Goal Plan is updated or a new Family Goal Plan is completed once services are reactivated.

2. Supervisor Role
   - Documentation of supervisory discussions is kept in clinical supervisor logs with attention to noting families' progress toward meeting goals, discussion of progress, and how the home visitor will use the Family Goal Plan to guide interventions and activities with the family.
   - Clinical Supervisor may find it is easier to integrate the Family Goal Plan into discussions about families by maintaining the most current version of each family's Family Goal Plan in their supervisor binder; but is not required to do so.

3. When families do not accomplish goals, it is useful for the CM, the family and the Clinical Supervisor to look at whether the family still wants to accomplish that goal, and consider whether the goal has been realistically written and identify what barriers exist before continuing the goal on an updated plan.

4. Goals that are accomplished are recognized as such on the Family Goal Plan and celebrated.

5. Workers provide resources and referrals to families based upon goals.

6. Contingency plans are in place for potential barriers, as appropriate. Barriers are addressed by building on family strengths and competencies.

7. Goals for children are to be anchored in the family's general routines.

8. Prior to writing a new Family Goal Plan, the CM brings his/her working copy to the home visit to discuss with the family accomplishments over the past six months, stresses, needs, and any issues regarding the target child's development. The family decides if they want to continue to work on items they have not achieved. The CM and parent(s) will discuss other progress the family has made during the past six months.

9. A Family Goal Plan is considered updated when the CM and participant have reviewed progress on goals and objectives on the plan, discussed and documented what happened, revised target dates for goals and/or added new goals based on the needs of the family.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	PROMOTION OF POSITIVE PARENT-CHILD INTERACTION, ATTACHMENT AND BONDING
Procedure Number:	704
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	6-3 A-B, Home Visit Record

STATEMENT OF PURPOSE

Healthy Families routinely assesses, addresses, and promotes positive parent-child interaction, attachment, and bonding with all families; and utilizes CHEERS on all home visits.

PURPOSE

- Parents may have experienced early childhood trauma that can impact their ability to be emotionally present (responsive and available) for their children. Using an infant mental health approach (which supports the formation of a dyadic alliance between the parents and the home visitor) 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.
- HF home visitors are able to build on parental competences and promote healthy relationships in a thoughtful way using reflective strategies such as: Accentuate the Positives (ATP's), and address concerns or build skills with Strategic Accentuate the Positives (SATP's), Explore and Wonder, Feel Name and Tame and Mindful Self-Regulation.
- The use of CHEERS provides a structure to assess the parent-child relationship to be used for service planning.

AREAS OF RESPONSIBILITY

Staff will assess, address, and promote positive parent-child interaction, attachment, and bonding with all families; and utilizes CHEERS on all home visits.

PROCEDURE

1. Skill building and information sharing with families to promote positive parent-child interaction, attachment, and bonding
    - Interventions to promote positive parent-child interaction are a part of the CM's home visit routine with all families. As part of the intervention strategy, workers may use a

variety of skills to address and promote positive parent-child interactions including but not limited to: Accentuate the Positives (ATP's), Strategic Accentuate the Positives (SATP's), Explore and Wonder, Feel Name and Tame, Problem Talk, Normalizing and Mindful Self-Regulation. These interventions may consist of discussion and observation of infant cues, calling attention to the child's emotions, introducing interactive games or activities, making positive comments that shape and reinforce desirable parent-child interactions, and education about key issues related to attachment such as: brain development, empathy, the development of trust, and fostering the development of self- esteem in children.

2. Frequency:

   - CM attempts to spend time promoting positive parent-child interaction on all home visits, including visits that are pre-natal beginning in the second trimester.

3. Documentation:

   - CM will document observations of parent-child interaction in the CHEERS section of the Home Visit Record, unless the child is absent or asleep.
   - The documentation will include parental competencies and struggles. These observations will be used to develop and implement home visit activities and strength-based interventions that promote positive parent-child interaction (Reflective Strategies, for example).

4. Support:
   - Staff/team meetings and supervision: some portion of staff meetings and individual supervision are utilized to help staff assess and improve their efforts to support parents in promoting positive parent-child interaction and child development. The content of these meetings and supervision is documented in supervisor logs.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Number:	705
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	6-4 A-C, Home Visit Record

STATEMENT OF PURPOSE

Healthy Families routinely promotes healthy child development, parenting skills, and health and safety practices with families.

PURPOSE

Healthy Families identifies and uses parenting and child development resources to promote and share information with parents about positive parenting practices, healthy physical and emotional-social child development and health and safety skills.

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 which are chosen with care can promote parent-child interaction and developmental stimulation.

AREAS OF RESPONSIBILITY

Staff will attempt to include time spent promoting positive parent-child interaction and optimal child development on all visits whether or not a family is experiencing crisis.

PROCEDURE

Child development information is shared based upon naturally occurring experiences as well as through curriculum and other resources. This sharing of information is documented, and should indicate not only what the child is able to do, but also how the parent responds and what the home visitor does to take advantage of "teachable moments".

1. Health and Safety Practices
    - Home Safety Assessment (HSA) developed by the Wisconsin Department of Health Services- Division of Public Health will be administered within the first three months of enrollment and again at least annually, with follow up within 2 months when safety concerns are identified. If a family moves, an assessment of the new residence is completed. CMs will provide health and safety information when hazards that cannot be corrected or reduced immediately are identified.

- Content shared with families includes health and safety issues such as smoking cessation, SIDS, shaken-baby syndrome, babyproofing, safe sleeping practices, breast feeding materials and other safety issues.
- CM will cover health and safety practices focusing on both preventative strategies as well as areas of health and safety issues observed during home visits that could be detrimental to parents and their children, not just when a HSA is due.

2. Skill building and information sharing with families to promote positive parent-child interaction and child development skills.
   - Examples of activities to enhance parent-child interaction include "Explore and Wonder" and the use of "SATPs".
   - Examples of ways to share child development skills is through the use of Healthy Families San Angelo monthly handouts, Brain Games for Babies and for Toddlers.
   - Both parent-child interactions and child development are enhanced by use of our curricula: Learning Games, Portage, and Partners for a Healthy Baby.
   - Visits may be enhanced by use of information customized to the family

3. Documentation
   - Observations of child development as well as what information is shared with the family is to be recorded on that day's Home Visit Record.
4. Frequency:
   - CMs will attempt to include time spent promoting positive parent-child interaction and optimal child development on all visits whether or not a family is experiencing crisis. There may be some exceptions to this; however, the goal is to include it on all visits.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	CURRICULA
Procedure Number:	706
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/3/2016
Date(s) of Revision:	9/15/2020
References:	6-5 A-B

STATEMENT OF PURPOSE

Healthy Families uses evidence-informed curricula with families.

PURPOSE

Healthy Families uses evidence-informed curriculum for use with each family that promotes nurturing parent-child relationships, healthy child development, positive parenting, and includes information for preventive health and safety.

AREAS OF RESPONSIBILITY

Staff will use available evidenced based curricula to support families.

PROCEDURE

1. Healthy Families home visitors will use their choice of Partners for a Healthy Baby, Learning Games, and Portage as primary curricula in working with families, based on needs of the family. Topics or activities discussed are to be noted each home visit record.
2. We use substitute or supplemental materials as deemed appropriate to meet the needs of the individual family. Substitute materials can include but are not limited to: Little Bits, Brain Games for Babies or Toddlers, or Healthy Families San Angelo handouts.
3. Regardless of the materials used, it is to be in conjunction with teachable moments, parental interest; and shared with parents using a strength-based approach building on parental capacity.
4. A handout of some sort is not required at every home visit. It is expected at least monthly, except for those families on level 4.
5. Training for curricula use entails reading the associated manual, attending Home Visitor training, and shadowing mentor visitor (s).

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	6-5

STATEMENT OF PURPOSE

Healthy Families uses parenting and child development curricula approved by HFA, and other tools and resources to provide families with information about positive parenting practices, child development and health and safety skills.

PURPOSE

To ensure that our program identifies and uses parenting and child development curricula, tools and other resources to provide families with information about positive parenting practices, child development and health and safety skills.

To ensure that we, as a program, promote and share information and build skills and share activities regarding positive parent-child interaction, healthy physical and emotional child development, and family health and safety.

AREAS OF RESPONSIBILITY

Staff will use available evidenced based curricula to support families.

PROCEDURE

The use of parenting and child development curricula approved by HFA establishes an organized, sequential method by which the programs support parents in obtaining the information needed to learn positive parenting and child development and facilitates the promotion of parenting skills within the context of the child's development.

Our materials address the promotion of positive parent-child interaction, child development, and health and safety for children prenatally to five years of age. Our materials also address the psycho-social well-being of parents.

The following curricula are currently approved as core curricula:

- **Partners for a Healthy Baby**
  Florida State University
  Center for Prevention and Early Intervention Procedure
  850-922-1300
- **Learning Games**, published by Mind Nurture

Birth through 60 months in 5 volumes
www.mindnurture.com

- **Portage Guide Birth to Six**
  2003 Portage Project
  CESA 5 P.O. Box 564
  Portage, WI 53901
  www.portageproject.org
  (608) 742-8811

For Supplementary curricula or handouts, four are currently recommended:

- **125 Brain Games for Babies**, by Jackie Silberg, Birth to 12 months
- **125 Brain Games for Toddlers and Twos**, by Jackie Silberg, Twelve to 36 months
- **ASQ-3 Learning Activities**, published by Brooks Publishing, Birth through 60 months
- **Healthy Babies…Healthy Families**
  San Angelo Curriculum
  Healthy Families San Angelo
  200 South Magdalene Street
  San Angelo, Texas 76903
  www.hfsatx.com
  325-658-2771

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	6-6. A-C, 6-7 A-B, ASQ-3 ASQ-SE-2 Home Visit Record

STATEMENT OF PURPOSE

Healthy Families monitors the development of participating infants and children with a standardized developmental screen, tracks target children who are suspected of having a developmental delay, and follows through with appropriate referrals and follow up, as needed.

PURPOSE

To ensure that our program administers standard developmental screens following a schedule so that we may identify possible developmental delays. Then, once identified, to use program resources and referral to appropriate individuals or agencies to provide families with intervention services, if needed.

AREAS OF RESPONSIBILITY

Staff will complete standard developmental screens according to the schedule and procedure and enter results.

Program Manager will run required reports.

PROCEDURE

Healthy Families visitors will use Ages and Stages Third Edition (ASQ-3) and Ages and Stages Social Emotional (ASQ-SE-2) by Brooks Publishing as the developmental screening tools.

These screening tools are used to determine the need for further assessment by partner agencies in our community (Birth to Three, for example).

All visitors must be trained to use the ASQ-3 and ASQ-SE-2 before they may begin to use it.

All visitors have access to the User Guide for ASQ-3 and ASQ-SE-2.

The ASQ questionnaire selected for use is based on the calculated age of the child. Visitor must adjust for pre-maturity following the guidance in the ASQ training and User Guide.

Family & Children's Center

The ASQs are administered in the home by the home visitor when both the parent and the child are present and awake. It is recommended that when at all possible, the questionnaire is to be completed in partnership with the parent(s).

The ASQ-3 is to be administered at least once before the child is 6 months of age, and at the child's age of 9, 12,18, 24, 30, 36, 48 and 60 months. The correct ASQ-3 is to be administered according to the ASQ-3 age administration chart in the ASQ-3 User Guide. There is a one-month window on either side of the target age, to complete the screen except for the 9-month screen. The ASQ-3 is to be entered into DAISEY within 4 weeks of completion, on the individual child's record. It is important to check with the most current screening schedule to verify due dates for this and other screens as they change frequently depending on funding sources requirements.

If the visitor is unable to complete an entire ASQ-3 at the time of the visit, the home visitor may return within 2 weeks to complete the same age interval questionnaire if the child is still eligible for that age interval. If the child's age at the time of the return visit indicates the child is now eligible for the next age interval, the new age interval should be used. When after two weeks, the child is still eligible for the same questionnaire interval; the entire questionnaire should be re-administered.

If the visitor elects to repeat only one domain of an ASQ-3, the re-screening of that domain should be done within two weeks of the initial ASQ-3 and the score of the re-screened domain and the re-screened date should be entered into the notes on the initial ASQ-3 activity date. (Do not change the initial domain score and do not enter the second domain score as a separate ASQ-3). The Plan of Action should also be completed checking off "Repeat same age ASQ-3 or domain or administer the next age appropriate ASQ-3" and indicating that the re-screening occurred in the results section. Note that the re-screening is a follow up to the initial screening, not a separate screening. If the child is eligible for the next age interval ASQ-3, when the visitor is ready to do the re-screening, a complete new ASQ-3 using the appropriate age interval should be done. Do not repeat only the domain, instead a full new age appropriate screening should be done. Likewise, if more than two weeks has passed from the initial ASQ-3, a completely new age appropriate screening should be done.

The ASQ-SE-2 is to be administered at least once by the time the child is 6 months old, at 12, 18, 24, 30, 36, 48 and 60 months of age. The same 30-day window before and after the due date that applies to the ASQ-3 also applies to the ASQ-SE. The ASQ-SE-2 is to be entered into DIASEY within 4 weeks of completion, on the individual child's record.

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If a visitor is unable to complete an entire ASQ-SE-2 at the time of the visit, the visitor may return within 2 weeks to complete the same age interval questionnaire if the child is still eligible for that age interval. If the child's age at the time of the return visit indicates the child is now eligible for the next age interval, the new age interval should be used. When after two weeks, the child is still eligible for the same questionnaire interval; the entire questionnaire should be re-administered.

All Plans of Action are to have follow-up with the family within 2 months of the identified potential delay and/or parental concern.

All follow-up to Plans of Action are to be documented under Plan of Action – Results within two months of identification of a potential delay or parental concern.

Do not administer an ASQ questionnaire interval which is beyond the child's age eligibility window.

The ASQ summary sheets may be completed and shared with the family at the time of the visit or upon return to the office- to be shared at a following visit. Copies of the summary sheet should be offered to the family, and a duplicate offered for them to share with their child's primary care provider. Share comments on strengths and areas for discussion "areas for growth" or "areas where more expert information would be helpful"; discuss next steps. Start and end the discussion with strengths of the child and parent.

When a child is currently receiving special education services, the ASQs administration schedule may or may not be followed by the home visitor. This is to allow the visitor to tailor our services to the individual family; at times it is not only unnecessary but could be hurtful to administer a developmental screen when there is obvious delay and services are already in place.

When a child's ASQ score indicates typical development, the knowledge gained from the screening process will be used to tailor services that support the child's continued development.

When a child's ASQ score falls in the monitoring zone, the knowledge gained from the screening process will be used to either tailor program services to identified developmental areas or refer for further assessment. These plans are to be documented in the Plan of Action and is associated Results.

Visitors are to provide a continuum of responses that may include:

1. Continue to provide appropriate experiences for families that encourage ever-changing development of the child.

2. Support the parent's role by addressing their concerns and listening to their points of view.

3. Focus on an area that is not a concern but may be less developed than other areas in upcoming visits.

4. Continue to monitor any areas of concern when a referral is not indicated.

5. When a child's score indicates a concern and it is decided with the parent that a formal referral is needed, ask the parent to sign Family & Children's Center Authorization for Use & Disclosure of Health Information form. Place the completed form in the participating family's file.

When a child's ASQ-3 score falls on or below the cut-off in one or more areas the child should be referred for further assessment. When a child's ASQ-SE-2 score is above the cut-off, a referral is indicated and the child should be referred for further assessment; and the knowledge gained from the child's screening process will be used to tailor services that specifically support the child's social-emotional development.

Referrals are tracked on the family's home visit records.

As a double check, DAISEY reports are run monthly to alert staff of passing of screen due dates and of Plan of Actions and the Results.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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	REFERRING
Procedure Number:	801
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	7-1.A- B, 7-2. A-B, 7-3. A-D, 7-4. A-B, 7-5 A-D, DAISEY Reports, Action Plan, Healthy Families Safety Manual

STATEMENT OF PURPOSE

Healthy Families links, at a minimum, the primary caretaker and target child to medical homes. All family members are encouraged to link with a medical home. Target children receive immunizations, well-baby visits, and screenings following their pediatrician's schedule.

PURPOSE

To ensure optimal health and development, the Healthy Families program links participant families with a medical home to receive on-going preventive and other health care services. To ensure that families are provided with information, referrals and linkages to available health care resources. To ensure timely receipt of immunizations and well-baby check-ups, including developmental screening. To ensure that families benefit by accessing community agencies and services that can support the family in accomplishing goals and overcoming challenges they may be experiencing. Some of the challenging issues could include substance abuse, intimate partner violence, developmental delay in parents, and mental health concerns.

To ensure that participants receive information and referrals to available resources based on their need(s). To ensure that programs follow-up with referral sources, service providers and/or participants to determine if needed services were received.

AREAS OF RESPONSIBILITY

Staff follow a family and ensure optimal health and development for children.

PROCEDURE

Medical Home: A medical home is a partnership between a family and a primary health care professional. The health care professional may be an 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 and medical services. "Culturally recognized medical

professionals" refers to practitioners of alternative therapies widely recognized within a cultural system, such as traditional Chinese medicine.

The emergency room may not be considered the family's medical provider. An OB/GYN may not serve as the primary medical provider beyond six weeks postpartum, unless continuing to provide primary care to the participant.

7-1. A. Linkages to medical homes

Initially, the home visitor assists in linking the family with a physician, a prenatal care provider and/or pediatrician (depending on whether the family enrolls in services prenatally or postpartum) or other "medical home."

7-1. B. Part of the home visitor's role in connecting the family with a medical home is to facilitate clear communication between the child's medical provider and parents, and to assist parents in forming comfortable and informative relationships with medical providers.

Home visitors offering transportation and offering joint visits to medical providers soon after a family enrolls in the program and/or shortly after the baby is born may be a useful strategy for securing the medical home and helping to establish the relationship.

–Home visitors document the target child's health care provider on the database associated (DAISEY) Wisconsin Department of Children and Families grant and also document connection to a medical home in the programs' quarterly report data spreadsheet. Additionally, the information may be listed on the participating families' Face Sheet located in their file.

7-2. A. Home visitors' role includes having conversations around immunizations and educating families regarding the importance of immunizing their children.

Home visitors routinely share topical, updated information with families about immunizations. Home visitors, parents and medical providers collaborate to ensure that children receive regular, timely immunizations. Exceptions are based on family beliefs or care provider's recommendation. Tracking of immunizations is to be completed by reviewing the child's immunization card or other communication from the child's medical provider or use of the Wisconsin Immunization Record Database. It is also acceptable, but not recommended, to verify immunization status through parental report. Immunization status is recorded within DAISEY database and in the program's quarterly report data spreadsheet. Follow up with parents when immunizations are missed is expected.

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7-2. B. Percentage of target children receiving their expected immunization is tracked and reported in the program's quarterly and year end reports. This percentage is also tracked in the database. Lists of unimmunized children are generated through database Follow up with home visitors is conducted monthly.

7-3. A. Home visitors will provide information, referrals, and linkages to available health care, health care resources, and community resources for all participating family members.

Well-Baby Visits

1. Home visitors, parents, and medical providers collaborate to ensure that children receive regular, routine health care.
2. Home visitors help families to overcome barriers to accessing preventive health care. The home visitor may transport or provide program funds for mass or public transportation.
3. Well-baby visits may vary according to the preference and practice of the pediatrician or health care provider.
4. A well-baby visit includes height, weight, hearing, sight, developmental appraisal, dental care assessment and a nutritional assessment. An Acute care visit that includes all of the above, counts as a well- baby visit.

Developmental Screening

Home visitors conduct developmental screenings on the target child using the ASQ-3 and ASQ-SE-2. When appropriate, families are referred to their child's healthcare provider and to Birth to Three.

7-3. B. Home visitors provide information, referrals and linkages to available health care and health care resources for all participating family members as part of their role.

This information could include a variety of topics that may benefit all participating members. Examples include smoking cessation hot line, free health clinic, nutritional classes, dental care for Badger Care recipients and immunization clinics. Program staff will stay abreast of health care resources within La Crosse County.

Referrals and follow up is documented on the participating families' Home Visit Record. It is not necessary to provide community health resource referrals to families that are already receiving those services.

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7-3. C. Home visitors connect families to appropriate referral sources and services in the community as needed. Home visitors will support families accomplishing their goals or overcoming challenges that they may be experiencing through access to community resources. Home visitors may accomplish this through a variety of strategies: addressing barriers, offering a joint visit, offering transportation, use of motivational interviewing for example.

1. Staff makes referrals to health care and other community resources based on the information gathered in the assessment process, through the development of the Family Plan and home visits.
2. A referral consists of either making arrangements for a participant to receive services or providing information about specific providers so that the participant can make arrangements him or herself.
3. Staff becomes familiar with the community agencies and the services they provide to be sure families are referred appropriately. During basic training, staff receive orientation to the program's relationship with other community resources (e.g. organizations in the community with which the program has working relationships.)
4. Supervisors assist home visitors in identifying the need for referrals and staying informed about community resources and referral processes.
5. CMs help families who are on public assistance to access the necessary supports (i.e. childcare, transportation) to achieve their self-sufficiency goals, which may include obtaining a GED, employment, or entering an educational or vocational training program.
6. The CM and supervisor also provide crisis intervention, assisting the family in managing crisis and linking them to appropriate community services to deal with and resolve the crisis. Over the course of working with the family, the CM encourages the family to establish personal and community agency relationships to build ongoing support systems independent of the CM and home visiting program.

7-3. D. Healthy Families staff track their referrals and referral follow up on the participant's Home Visit records. The rates of follow up are recorded on the Quarterly Report data spreadsheet and are reported in each program report.

7-4. A. Home Visitors are in a unique position to be able to address challenges the family is facing. Staff must form healthy relationships with the parents, 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, accept families where they are without bias or judgment, build on parental competencies and focus on the experience versus trying to establish "right or wrong".

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

1. Providing honest feedback with parent's permission.
2. Pointing out discrepancies between stated values and actual behavior.
3. Providing an atmosphere of safety and acceptance.
4. Encouraging forward thinking--assist in developing a vision of what they want
5. Providing information and referrals.
6. Using motivational interviewing skills (when trained)
7. Using reflective supervision to receive support and prevent burnout.

Through identification in Parent Survey, continued assessment, or scheduled screening tools (such as EDPS), the CM will address family concerns and challenges as soon as feasible within the scope of practice and with the support of the supervisor.

7-4. One of the home visitor's roles is to address challenging issues such as substance abuse, intimate partner violence, developmental delay in parents, and mental health needs by actively focusing on building protective factors. Training to build these protective factors is required within the first twelve months of hire and ongoing. Safety guidelines are found in our Safety Manual and to be trained upon hire. Home Visit Record or Service Record will be used to document conversations with families that indicate addressing challenging issues.

7-5. A. Healthy Families conducts depression screening with all families using a standardized instrument called Edinburgh Postnatal Depression Scale (EPDS). The screen is conducted with the pregnancy/birth of the first target child and each subsequent pregnancy/birth.

7-5. B. Healthy Families' schedule to administer the EPDS is as follows: during the third trimester (if enrolled during that time), not during the first two weeks post-partum, then again between 14 and 90 days postpartum. Results of screen are recorded in the database. To cast a wide "net", we adhere to the DAISEY cutoff number of 9. If a participant's score is 9 or higher or indicates any level of self-harm thoughts other than "never", or is struggling or suffering from symptoms even if they do not screen above a 9 score, CM is to create an action plan. Components of the action plan may include:

1. Referral
2. Ensuring Safety
3. Support from Community
4. Support from Family
5. Support from Home Visitor
6. Nutrition
7. Rest/Sleep (Mom and Infant)
8. Exercise-Activity
9. Self-Care
10. Support to Family

7-5. C. Referral and follow-up on referrals occur for mothers, whose depression screening scores are elevated and considered to be at-risk of depression, unless already involved in treatment. Depression screenings are not intended to be used as formal diagnostic tools. Screening tools are used to determine the need for a more intensive evaluation by a licensed mental health clinician.

In the case that the mother is already involved treatment, visitor is to ask permission to contact the mental healthcare provider in order to let them know of the screen results.

If the mother is indicating self-harm, has the means, and has a plan (see Depression Action Plan located in the Safety Manual), worker is to stay with and support calling for professional assistance.

Results of Referral are recorded in the DAISEY database.

7-5. D. Home visitors administering the EPDS are to be trained in its use before administering it. Supervisors also receive this training.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	CASELOAD MANAGEMENT
Procedure Number:	901
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	8-1. A- C, 8-2. A,B, Healthy Families Case Load Form

STATEMENT OF PURPOSE

Healthy Families services are provided by staff with limited caseloads to assure that home visitors have adequate time to spend with each family to meet their unique and varying needs and to plan for future activities.

PURPOSE

Program services are provided by staff with limited caseloads, to assure that home visitors have an adequate amount of time to spend with each family to build trusting, nurturing relationships, and to meet the families' varying needs.

AREAS OF RESPONSIBILITY

Caseload/weight information is tracked and managed for the program by the Program Manager according to the criteria outlined in this procedure.

PROCEDURE

1. Healthy Families uses a weighted caseload system to manage the caseload size of CMs who will be serving families at different levels of intensity.

2. A full caseload typically has a total weight of 30 (see below). Note that this weight contains a time allotment for case notes in addition to the face to face home visit time, drive time, case management, and contact time before or between visits.

3. Healthy Families will not pause intake until each full-time worker reaches a weight of 30 and part time workers at 15.

4. The maximum caseload size of Level I families receiving weekly home visits for a full time CM is 14.

5. The maximum caseload for a full time CM will not exceed 25 families nor 30 base case weight (without travel, case management, and documentation time). A caseload of 25 would be a rarity as travel would all have to reside in La Crosse and the caseload would consist of all level 3 & 4.

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6. Case weights and caseloads are prorated based on the staff person's Full-Time Equivalency.

7. Values used to determine caseload size:

Level	Visits/Month	Value
1-prenatal	2-4	2
1	4	2
2	2	1
3	1	.5
4	0-1	.25
CO (creative outreach)	1-4	Prior levels' weight (to save space in caseload)
1-SS (Special Services)	4+	3+

- Additional time is allotted based on geographic location. An additional .25 hour is added for families located in Onalaska and on French Island, .5 hour for families located in West Salem or Holmen, .75 hour for families located in Bangor, and 1 hour for families located in Mindoro and Rockland.

- The following factors are considered when establishing case weights:
  - Experience and skill level of the home visitor,
  - Nature and difficulty of the problems encountered (Parent Survey score),
  - The work and time required to serve each family,
  - Number of families per CM which involve more intensive intervention,
  - Travel and other non-direct service time to fulfill required responsibilities,
  - Extent of other resources available in the community to meet family needs, and
  - Other assigned duties.

- There may be temporary periods when case weights go over the maximum size. For example, when a home visitor's position is vacated (either permanently or when on extended leave) the caseload is dispersed among existing home visitors until the CM returns or another CM is hired, as the case may be. When this occurs, the reason is clearly documented and

includes the amount of time that the case weights were out of adherence with this procedure. The program makes every effort not to let this time period exceed 3 months.

- Caseload/weight information is tracked and managed for the program by the Program Manager according to the criteria outlined in this procedure (see Healthy Families Caseload form).

- More details on caseload management are contained in the HFA Program Manager and Supervisors Training Manual.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	STAFF RECRUITMENT AND SELECTION
Procedure Number:	1001
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	9-1 A-C, 9-2, 9-3 A-B, 9-4, Job Description: Program Manager/Supervisor, Job Description: Program Manager's Supervisor (Coordinator of Programs), Job Description: Clinical Supervisor/Consultant, Job Description: Case Manager, Interview Guidelines: Home Visiting Program Staff Manager & Supervisor Interview Questions, Interview Questions: for Case Managers, Family & Children's Center Application form, Family & Children's Center written procedure on Equal Opportunity, Family & Children's Center written procedure on Background Checks, Family & Children's Center Hiring Checklist

STATEMENT OF PURPOSE

Healthy Families screens and selects direct service and supervisory staff because they possess characteristics necessary to build trusting, nurturing relationships and work with families with different cultural values and beliefs than their own, based on experience, education, and qualifications.

PURPOSE

To ensure that staff is selected based on a combination of personal characteristics, experiential and educational qualifications. To ensure that they possess characteristics necessary to build trusting, nurturing relationships at all program levels, and work with families with different cultural values and beliefs than their own.

AREAS OF RESPONSIBILITY

Program Manager and/or Supervisor will follow agency procedure below to select experienced and qualified staff. .

PROCEDURE

Selection:

1.The program will strive to hire staff who are representative of the language and culture of the population to be served.

2. All program staff are selected because of their personal characteristics, including but not limited to:

- acceptance of individual differences
- ability to establish trusting relationships

- experience and willingness to work with the culturally diverse populations which are present among the program's target population
- ability to work effectively with both mothers, fathers, and extended family
- believe that children need to be nurtured
- are non-judgmental
- experience working with or providing services to children and families
- knowledge of infant and child development
- open to reflective practice (i.e. has capacity for introspection, communicates awareness of self in relation to others, recognizes value of supervision, etc.)

3. In addition to the personal characteristics described above, the following are the educational and work requirements for each position.

1) Program Manager/Supervisor:

a) A solid understanding of and experience in managing staff;
b) Administrative experience in human service or related field, including experience in quality assurance/improvement and program development;
c) Experience in managing home visiting programs;
d) Knowledge and experience in strength-based and family centered provision of primary prevention services, and/or direct experience as a home visitor.
e) A Master's degree in public health or human services administration or fields related to working with children and families, or Bachelor's degree with 3 years of relevant experience.

2) Clinical Supervisor/ Consultant:

a) Solid understanding of and experience in supervising and motivating staff, as well as providing support to staff in stressful work environments
b) Knowledge of maternal-infant health and the dynamics of child abuse and neglect.
c) Knowledge and experience that embraces the concept of strength-based and family-centered provision of primary prevention services, and/or direct experience as a home visitor.
d) Experienced in home visiting with a strong background in prevention services to the 0-6 age population.
e) Knowledge of infant and child development and parent-child attachment
f) A background in home visiting and/or services to families and young children, an advanced degree in a Health or Human Service field, or a bachelor's degree in a Health or Human Service field and five years' experience in a home visiting program, with clinical supervisory experience preferred.
g) Infant mental health endorsement level III or IV preferred
h) Experience with reflective practice preferred

3) **Case Manager**
   a. Able to observe and report accurately on the functioning of individuals and families
   b. Emotionally mature and capable of exercising judgment
   c. Able to handle stressful situations
   d. Minimum of a Bachelor's degree in human services field
   e. Infant mental health endorsement level I or II preferred

4. If a program site uses volunteers/interns in any capacity, those volunteers/interns must be selected and supervised with the same rigor as paid staff in similar jobs.

Equal Opportunity:

1. Healthy Families adheres to our parent organization's (Family & Children's Center) written procedure on Equal Opportunity that states our recruitment, selection, transfer, and internal promotion procedures are conducted without discrimination based upon age, gender, race, ethnicity, nationality, handicap, sexual orientation, or religion of the individual under consideration.

2. Healthy Families' recruitment and selection practices are in compliance with applicable law or regulation and include:
   a. Notification of position openings before or concurrent with recruitment elsewhere
   b. Utilization of standardized interview questions that comply with employment and labor laws and address knowledge and skills needed for the position. Retention of interview notes to be placed in new employee's personnel file.
   c. Verification of 2-3 references and/or letters of recommendation and credentials. If hired from within Family & Children's Center, performance or current supervisor's verbal appraisals or may suffice.

3. Background checks. Healthy Families complies with our parent organization's reference checks procedure to verify education requirements and employment history, legally permissible criminal history records, driving records, and pre-employment drug test.

Personnel Satisfaction/Retention:

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. Healthy Families participates in staff retention efforts by our parent organization (Family & Children's Center). This includes 6 months from hire, and then, yearly staff satisfaction surveys.

Should turnover become an issue (staff turnover within the last two years, not related to personal growth opportunities that could not have been fulfilled on the job, like returning to school or a promotion), retention strategies will be developed and put into place.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	ROLE SPECIFIC ORIENTATION/ TRAINING
Procedure Number:	1101
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	10. 1-3, Family & Children's Center/Healthy Families-La Crosse Employee Program Orientation Checklist, CM Training Logs – 3 mo., 6 mo., and 12 mo., Wraparound training checklist

*Note that our reference numbers 10 and 11 constitute our comprehensive training plan. Number 10 addresses newly hired staff and their orientation and initial training. Number 11 focuses more on ongoing staff training. All training must be recorded on our Training Logs or in Relias to be counted as completed.

STATEMENT OF PURPOSE

Service providers will receive intensive training specific to their role.

PURPOSE

Healthy Families service providers must understand the essential components of family assessment, home visiting, and supervision to ensure that Healthy Families- La Crosse adheres to the training standards of HFA and our host agency, FCC. All service providers will have a basic framework, based on education or experience, for handling the variety of issues they may encounter when working with at-risk, overburdened families. They will receive basic training in areas such as culturally competent services, substance abuse, reporting child abuse, domestic violence, drug exposed infants, and services in their community.

AREAS OF RESPONSIBILITY

Program Manager will provide supervision of on-boarding process of new staff. Staff will complete required trainings within approved timeframe.

PROCEDURE

1. All staff will receive orientation training provided by our host agency, Family & Children's Center within 3 months of hire. Agency orientation includes agency overview, Human Resources information, and Development overview. This orientation also includes the following trainings: Privacy and Confidentiality, Ethics and Boundaries, Mandated Reporting, Computer Security, Training and Education Overview, and Relias Learning Management System.
2. Training on Defensive Driving and Blood Borne Pathogens will be completed within 10 days of hire.

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3. CPR (including child and infant) and First Aid will be completed within 6 months of hire.
4. All staff will assist the new hire; offering shadowing experience, sharing knowledge of area resources, and providing introductions to collaborative partners and clinical supervision. One staff member will act as mentor, coordinating and assisting in recording training, and being available for questions and concerns.
5. Program Orientation Checklist will be completed by new staff member and Program Manager, then routed to FCC's Human Resources Department. Once the Orientation Checklist is completed, and orientation topics covered, independent direct service with families may begin. Among the orientation topics are: community resources (including face to face introductions), child abuse/neglect indicators and reporting requirements, confidentiality, boundaries, and staff safety.
6. Healthy Families training logs are to be completed by any new hire (i.e. case manager, clinical supervisor, and program manager).
7. Prior to independently performing their work, new hires must either receive HFA Core training by a certified trainer who has been trained to train others, or stop-gap training (provided in-house) for their roles. This includes the Parent Survey Training (HFA Core Assessment Training), HFA Family Support Worker Core Training, HFA Core Supervisory Training. Check list steps for stop-gap training are:
   (a) Training to be conducted by staff member that has been trained and has experience in the specific role to be trained.
   (b) Training must include theoretic background of the role; including use of the strength-based tools and interviewing techniques.
   (c) Training must include shadowing of other staff in similar role.
   (d) Training must include information regarding forms and their use.
   (e) Training must include "hands-on" practice, with observation and feedback provided to ensure inter-rater reliability. Once the appropriate HFA core training becomes available, the new hire will receive that training.
8. Wraparound training, as offered online by HFA, is required of all new hires.
9. All supervisors, CMs and any staff who will be administering developmental screenings, HOME Inventory, or Edinburgh Depression Screen must receive training prior to using them. The training must be conducted by a person who has been trained in and demonstrates understanding of the use of the tool.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	ONGOING ROLE SPECIFIC TRAINING
Procedure Number:	1102
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	11. 1-5, Training Log for 3, 6, and 12 months after hire date. FCC's training logs (organized by staff member and by year).

STATEMENT OF PURPOSE

Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with our participants.

PURPOSE

Ongoing training ensures that staff will receive the training support and have the skill set necessary to fulfill their job functions and achieve our program's goals with the families we serve. To support ongoing training, our program has a plan that adheres with HFA and FCC training standards and procedures that ensures that our staff has access to required ongoing trainings, providing them in a timely manner and tracking these trainings in a comprehensive fashion.

AREAS OF RESPONSIBILITY

Staff will complete required trainings within approved timeframe.

PROCEDURE

Training listed below can be received through a variety of methods including, but not limited to the following: lecture or interactive presentations by individuals with particular expertise in an area, workshops, college coursework, multi-disciplinary clinical consultations, training presentations by members of the agency or staff, and self-study through FCC's Relias System/scholarly books and journal articles and webinars. Training outside of Relias must be described in Ascentis Time Keeping System (in order to be recorded in the System) before it may be counted as completed.

On-going Training is required (and completion logged) in the following topics within the first 3 months of hire:

- Infant care (including but not limited to sleeping, feeding, breastfeeding, physical care to the baby, and crying and comforting the baby)

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- Child health and safety, including but not limited to, home safety, shaken baby syndrome, SIDS, seeking medical care, well-child visits/immunizations, seeking appropriate childcare, car seat safety, and failure to thrive.
- Maternal and family health (including but not limited to family planning, nutrition, pre-natal and post-natal health, pre-natal and post-natal depression, and warning signs for when to call the nurse advisor/doctor).

On-going Training is required (and completion logged) in the following topics within the first 6 months of hire:

- Healthy Families America Core Training (for home visitors)
- Healthy Families America Assessment Worker Training (FRS)
- Pre-natal Training (including but not limited to fetal growth and development during each trimester, warning signs regarding when to call the doctor or nurse advisor, 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 i.e. reflection)
- Infant and Child Development (including but not limited to language and literacy development, physical and emotional development, identifying developmental delays, and brain development)
- Supporting the Parent-Child Relationship (including but not limited to supporting attachment, positive parenting strategies, discipline, parent-child interactions, observing parent-child interactions, and strategies for working with difficult relationships)
- Staff Related Issues (including but not limited to stress and time management, burnout prevention, personal staff safety, ethics, crisis intervention, and emergency protocols)
- and Mental Health Topics (including but not limited to promotion of positive mental health, behavioral signs of mental health issues, depression, strategies for working with families with mental health issues, and referral resources for mental health).

On-going Training is required (and completion logged) in the following topics within the first 12 months of hire:

- Child abuse and neglect (including but not limited to etiology of child abuse and neglect and working with survivors of abuse)
- Family violence (including but not limited to indicators of family violence, dynamics of family violence, intervention protocols, strategies for working with families with family violence issues, effects on children, and referral resources for family violence)
- Substance abuse (including but not limited to etiology of substance abuse, culture of drug use, strategies for working with families with substance abuse issues, smoking cessation, alcohol use/abuse, fetal alcohol spectrum disorders, street drugs, and referral resources for substance abuse)
- Family issues (including but not limited to life skills management, engaging fathers, multigenerational families, teen parents, and relationships)

- Role of Culture in Parenting (including but not limited to working with diverse cultures/populations, culture of poverty, and values clarification)
- Family Goal Plan process (Offer the concept that change can happen and that 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. Discuss with the family issues that impact healthy parenting. Develop a plan with families ensuring they are getting what they need from program services. Work together with the family to develop goals and break those goals into meaningful steps to ensure success for each family. This includes clear conversation and partnering between the home visitor and parent that supports growth in families.)

On-going Training after the first year of employment, all program staff receive the following training:

- On-going training which takes into account the staff's knowledge, skill base and interest to complete the 20 hours (if part time) or 40 hours (if full time) host agency training requirements.
- Annual required training on culturally aware practices based on the unique characteristics of the population being served by our program. We employ a broad definition of culture and identify training related to characteristics beyond race and ethnicity (i.e. working with fathers, grandparents as parents, language, specific issues for immigrant parents, parenting where there is domestic violence, etc.) During their first year, the wrap around training "The Role of Culture in Parenting" satisfies this requirement. Our host agency will list these trainings on our Training Logs as "Diversity".
- Annual refresher training for the HOME Inventory to prevent drift. Other screens (ASQ's and Edinburgh for example) will be brought to staff meetings as necessary, to reinforce Best Practices.
- As necessary training within the topic of Family Goal Plan Process.
- Annual training within the topic of Self-Care (of staff).
- Annual training on Mandated Reporting AND topics related to child abuse and neglect so that staff stay updated on current child welfare procedures, practices, and trends in the community.
- Re-certification every two years in CPR/ 1st Aid.
- Curriculum topics will be brought to staff meetings on an ongoing basis.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	SUPERVISION OF DIRECT SERVICE STAFF
Procedure Number:	1201
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	12-1. A-D and 12-2. A-C, Sample Supervisor Note (FRS, CM), Sample Team Meeting Agenda

STATEMENT OF PURPOSE

Each direct staff person (CM, FRS) receives ongoing, effective supervision and is provided with skill development and professional support and held accountable for the quality of their work.

PURPOSE

To ensure that direct service staff and supervisors collaborate effectively to facilitate healthy growth in families. To ensure that staff receive consistent, intensive, and reflective supervision, are provided with skill development and professional support and are held accountable for the quality of their work. To reduce stress resulting in staff burnout and increase job satisfaction and staff retention.

AREAS OF RESPONSIBILITY

Direct service staff are to receive all three components of supervision; administrative, clinical, and reflective.

Documentation of assessment worker supervision will be kept by the Clinical Supervisor.

The Program Manager will be responsible to verify the occurrence of assessment supervision by matching record of assessments and record of assessment supervision, on a quarterly basis.

PROCEDURE

The primary roles of a supervisor are to create an environment that encourages staff to grow, provide motivation and support, maintain ideals, standards, quality assurance and safety, and facilitate open, clear communication.

Direct Service Staff

1. **Consistent Supervision**

a. Each full-time Case Manager (CM) receives a minimum of 1½ hours of regularly scheduled, protected*, individual clinical supervision per week. (For less than full-time staff, supervisory sessions are pro-rated. For example, staff at .25 to .75 FTE are required

to have 1 hour of individual supervisory time). Clinical Supervisory sessions contain elements of clinical, administrative and reflective supervision and are completed in one session (see Healthy Families CMs Clinical Supervision Schedule). In addition to Clinical Supervision, weekly staff meetings may contain an element of Reflective Supervision. When meeting in a reflective consultation mode, documentation is required of the case or topic presented and who attended. Administrative Supervision is supported through monthly review of outcome data entries and caseload calculations for all staff. This may or may not be in-person sessions.

b. When performing the duties of an Assessment Worker, staff includes discussion during their regular supervisory session. Documentation of assessment worker supervision will be kept by the Clinical Supervisor. The Program Manager will be responsible to verify the occurrence of assessment supervision by matching record of assessments and record of assessment supervision, on a quarterly basis.
c. The regularly scheduled clinical supervision time is to be respected by both the worker and the supervisor and rescheduled as infrequently as possible (e.g., CM providing last minute transportation to participant for an appointment, or the supervisor scheduling a conflicting meeting, would generally not be acceptable reasons for cancellation). Clinical Supervisor should make every reasonable effort to assure that the only time supervision does not occur is when the CM is out of the office for the majority of the week.
d. Clinical Supervision rate is to be calculated quarterly by the Program Manager, to ensure weekly individual supervision is received by all direct service staff. All direct staff should receive at least 75% of their required individual supervision for a minimum of 1 ½ hours each, for full time CMs.

*** Protected means an environment that is safe, without interruption, and secluded from the remainder of the staff.**

2. Ratio of supervisors to direct service staff

To ensure that regular, on-going and effective supervision can occur, each supervisor directly supervises no more than 5 FTE CMs.

3. **Elements of Supervision to direct service staff:** Supervision to CMs includes skill development, professional support and accountability for the quality of their work.

a. Skill Development and Accountability for quality of work

i. Clinical supervisory sessions focus on parent-child interaction (observation and inquiry) and the worker's role in promoting it, child development, family strengths, parent support and family functioning (i.e. self-sufficiency).
ii. The following activities help assure that direct service staff are provided with the necessary skill development to continuously improve the quality of their performance and are held accountable for the quality of their work. Documentation of the activities to be kept by the Clinical Supervisor. All supervision sessions need not contain all of these activities, but should support these effective practice standards:

- Coaching and providing feedback on strength-based approaches and interventions used
- Exploring/reflecting on impact of the work on the worker
- Coaching and providing feedback on strength-based approaches and interventions used (e.g., problem-solving, crisis intervention, etc.)
- Strengthening engagement techniques
- Discussing family acceptance, retention, and attrition
- Supporting parent-child interaction work and CHEERS observations
- Identifying and promoting the use of reflective strategies.
- Reviewing Family Goal Plan progress and process, and discussion of the worker's role in supporting the family's goals
- Reviewing family progress and level changes
- Analyzing and discussing outreach, engagement and retention
- Integrating results of tools used (e.g. developmental screens, EPDSs)
- Integrating information from data reports into clinical/reflective discussions
- Discussing home visit achievement and assessment rates
- Providing transfer of learning activities before and after trainings so that staff can integrate training information into their practice
- Assessing and discussing cultural sensitivity and practices
- Providing guidance and practice on communication style
- Providing guidance and practice on use of curriculum
- Providing opportunities for reflection on techniques and approaches
- Identifying and reflecting on potential boundary issues
- Sharing of information related to community resources and topics related to participant education
- Providing feedback on documentation
- Observations of home visits, assessments, and participant satisfaction surveys (see Observation of CM's Home Visit and Healthy Families Participant Survey). Note: QA observations should not take the place of regular weekly supervision and it should not be included as part of the 1 ½ hour requirement.
- Integrating quality assurance results that include regular and routine review of assessments and assessment records, home visitor records and all documentation used by the program
- Identifying areas for growth and skill development needs. Creating a plan to address the need on a regular basis.
- Creating a nurturing work environment that provides opportunities for respite
- Assuring an open door procedure with supervisors when possible
- Offering regular staff meetings
- Offering employee assistance program (EAP)
- Provide a career ladder for direct service staff

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Direct service staff are to receive all three components of supervision; administrative, clinical, and reflective.

Administrative supervision relates to the adherence to program procedures; for example, reviewing screening schedule to ensure screens are conducted on time.

Clinical supervision is focused on the family, collaborative in nature, and revolves around developing intervention or home visit activities based upon the needs of the families, the challenges families face, and builds upon family competencies. Examples of clinical supervision include reviewing the staff members' work with families, discussing the potential actions and home visit strategies used by staff, developing a plan of action, reviewing and evaluating progress, providing guidance and coaching, and anticipating and responding to challenging situations.

Reflective supervision focuses primarily on the parallel process involving the relationships between the staff member and the parent, the parent and the baby, and the supervisor and the staff member. It 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 include 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 or energy shifts, encouraging the staff member to explore thoughts and feelings that they have about the work, maintaining a balance of attention on the infant, parent, and staff member, and maintaining a neutral stance.

iii. Supervisor note forms document and support the practices of the program's procedures. (See attached Sample Supervisor note.) These supervisor notes are reviewed by the Program Manager on a regular basis to assure documentation of staff receiving skill development and are being held accountable for the quality of their work.

b. Professional Support

Providing professional support includes utilizing reflection, being available when staff is in the field, and assuring a nurturing, positive work environment that is conducive to productivity. The following are some activities that help assure direct service staff is provided with professional support:

- Supervisor coverage when staff are in the field (note: supervisors should be available for consultation as needed, and in emergency situations. If Clinical Supervisor is not available, worker is directed to call the Program Manager, or Coordinator of Programs, in that order.)
- Regular Staff/Team Meetings
- Exploration and reflection of impact of the work on the worker and acknowledgement of burnout issues
- Clinical supervision
- Acknowledgement of performance
- Creating a nurturing environment that provides opportunities for respite (i.e. staff retreats) and scheduling flexibility
- Quarterly availability of adult/child psychiatrist for case consultation

4. **Volunteers, interns and non-employee consultants**
   Volunteers and interns who perform supportive functions such as assisting with parent groups or social events, or non-employee consultants who provide professional case consultation (a psychiatrist, for example) are exempt from the supervision and training requirement; however, they are required to observe and abide by FCC's hiring standards.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	SUPERVISION OF SUPERVISORS AND PROGRAM MANAGERS
Procedure Number:	1202
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	12-3. A-B and 12-4. A-B, Sample Supervision of CM Supervisor note

STATEMENT OF PURPOSE

Each supervisor and program manager receives ongoing, effective supervision on a regular and routine basis. They are provided with skill development and professional support and held accountable for the quality of their work.

PURPOSE

To ensure that supervisory staff receive consistent and supportive supervision, are provided with skill development and professional support, and are held accountable for the quality of their work. To reduce stress resulting in staff burnout and increase staff retention and job satisfaction.

Program Manager and Supervisor familiarize themselves with the HFA Supervisors Training Manual. They are encouraged to seek and participate in educational and training opportunities to further their supportive supervision skills.

AREAS OF RESPONSIBILITY

Staff will attend weekly staff meetings.

Supervisors provide supportive supervision to the Program Manager.

PROCEDURE

Program Supervisors

1. **Consistent Supervision**
   Supervisors receive regular, supportive and on-going supervision. Supervisors receive supportive supervision from their Program Manager, at least monthly.

2. **Supervision elements**

a. Supervision sessions provide supervisors with skill development and professional development. It holds them accountable for the quality of their work and provides them with professional support.
b. Documentation is kept of the content of these meetings.
c. Supervision of supervisors include a variety of mechanisms such as:

- addressing boundary issues, as necessary
- addressing personnel issues, as necessary
- strategies for promoting professional development and growth, at least yearly
- providing feedback on performance, at least yearly
- reviewing documentation, at least yearly
- review of progress towards meeting site goals and objectives, at least yearly
- review of data management reports and program statistics, quarterly
- review of quality assurance documentation and planning for feedback to CM/FRSs, at least yearly

Program Manager

1. **Consistent Supervision**
   The Program Manager receives regular, supportive and on-going supervision, with his/her direct supervisor on at least a monthly basis.
2. **Supervision elements**

a. Supervision sessions provide Program Managers with skill development, professional development and professional support. This holds them accountable for the quality of their work.

b. Brief documentation is kept of the content of these meetings. This documentation may be written by and kept by the Program Manager or Program Manager's direct supervisor.

c. Supervision sessions include a variety of mechanisms such as:

- discussing strategies for promoting professional development/growth, at least yearly
- providing feedback on performance, at least yearly
- addressing boundary and personnel issues, as needed
- assisting with funding opportunities, as needed
- assisting with credentialing requirements, as needed
- reviewing quarterly and annual reports
- reviewing data management reports, program statistics and performance indicators, quarterly
- reviewing external quality assurance and site visit reports, as needed
- discussing strategies for promoting community support and participation in the referral process, as needed

Team/Staff Meetings

- Healthy Families schedules a team or staff meeting every week at a regular time. Team meetings should be documented. This may include the agenda and/or meeting minutes.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	PARTICIPANT CASE REVIEW
Procedure Number:	1203
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	Sample Home Visit Record Sample Parent Survey

STATEMENT OF PURPOSE

Each participant's status will be regularly reviewed by the CM and Supervisor.

PURPOSE

To ensure that each participant's progress is regularly reviewed by the CM and their Clinical Supervisor.

AREAS OF RESPONSIBILITY

CM and Clinical Supervisor will review each case according to outlined procedure.
Assessment Supervisor reviews each Parent Survey document.

PROCEDURE

Effective supervision includes staffing (review) of all enrolled program participants. To assure that quality services are being provided, it is important for the supervisor to review all families that had a visit, or had a visit due, within a given month.

1. The supervisor notes which family is reviewed in the Supervision Log to assure that supervision of families is tracked and that each family is reviewed at least once a month.
2. While staffing each participant, the supervisor looks for many of the following items:
    - Observations of parent-child interaction (PCI), family strengths and successes
    - How PCI and child development were promoted (e.g. use of reflective strategies)
    - Prenatal and father involvement strategies
    - Activities/handouts/curricula used with the family and the family's reactions
    - How the Family Goal Plan is guiding services and how is the worker supporting family goals
    - Development screenings completed and the implications of scores/strategies
    - Significant events happening with the family
    - How CM set and observed boundaries
    - Health and safety
    - Progress toward addressing issues identified at assessment or through working with the family

- Possible level changes
- Follow-up on referrals, and assessing if new referrals are needed
- Strategies to engage or re-engage families who seem to be losing interest in program
- Plans for next visit

3. The supervisor makes notes of the above issues to provide CM with emotional support (parallel process), reflective strategies, discuss follow-up activities, provide education and resources, assist with documentation skills, and raises issues of concern and/or missing information.

Procedures for Family Assessment review

1. Assessment Supervisor reviews each Parent Survey document. As each document is reviewed, the supervisor may make notes regarding:
    - outreach to and engagement of families
    - review of referrals that have been made
    - successes
    - inclusion of fathers and other family members in outreach and engagement efforts
    - presentation of the home visiting program
    - completeness of forms
    - if items on the Parent Survey reflect the guidelines for scoring
    - if the written assessment is accurate and thorough
    - processes and reflects on CM's feelings about the family and ways to connect with them
2. Assessment Supervisor is encouraged to highlight and discuss Parent Survey issues in need of follow-up within the first six months of service.
3. The supervisor makes notes of the above items utilize reflective strategies with the CM, discuss follow-up activities, provide education and resources, assist with appropriateness and content of documentation, and raise issues of concern and/or missing information.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	ADVISORY COMMITTEE GUIDELINES

Family & Children's Center

Procedure Number:	1301
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	

STATEMENT OF PURPOSE

The program has an organized, broadly-based advisory group which serves in an advisory capacity in the planning, implementation and evaluation of program-related activities.

PURPOSE

The Advisory Committee serves an important function in this community-based program in that they can be advocates for the program in the community, representing the program and agency in other venues and settings which can bring more recognition and visibility. The advisory Committee members can bring to the program different skills and perspectives than might be present within program staff. Members can share with the program other ideas or strategies, brainstorming ideas that might arise and facilitate growth for the program. Additionally, members often have access to resources to strengthen the program or agency. It is important that the group has the community connections to understand the needs of the participant population.

Family & Children's Center's Board of Directors has the actual responsibility in making final programmatic decisions and financial provisions. The primary function of the Advisory Committee is of advising in the planning, implementation and evaluation of program related activities; providing input to the Program Manager.

AREAS OF RESPONSIBILITY

The Program Manager typically schedules the Advisory meetings, initiates the agenda and requests input from the group members.

PROCEDURE

- Family & Children's Center has a governing board that is responsible for decisions and financial provisions for all of the agency's programs. Healthy Families has a separate Advisory Committee with the primary purpose of advising the Program Manager and making recommendations on program planning, implementation, and evaluation. The President/CEO may share recommendations of the Advisory Committee with the governing board.

- The Advisory Committee meets quarterly, although its members are available to the Program Manager as often as needed.
- The Program Manager typically initiates the agenda and requests input from the group members.
- The Advisory Committee is updated on the program's efforts at achieving its stated goals and objectives, and is consulted on specific issues facing the program.
- The Advisory Committee may make recommendations to the program (and, if applicable, Family & Children's Center's Board of Directors) on procedure, operations, finances, and community needs.
- The Advisory Committee reviews the Healthy Families Statement of Purpose (Mission) every four years.
- Membership on the Advisory Committee is reviewed to ensure that a variety of agency partners are represented. Any group member may make recommendations of new members to the group chair.
- Membership typically consists of professionals and participants (usually former participants) in the Healthy Families program. They are selected because they are aware of issues in their own organization and in the community. They provide information and awareness to the program so that all aspects of its management and service provision reflect knowledge of these issues.
- Members are selected for the Advisory Committee in such a way that it represents a wide range of needed skills and abilities and is heterogeneous in terms of skills, strengths, community knowledge, professions, and demographics.
- There are no term limits for the Advisory Committee.
- The Advisory Committee may serve as one of several formal mechanisms for participants to provide input into the program.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	PARTICIPANT INPUT INTO PROGRAM
Procedure Number:	1302
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	GA-2. A-C, Participant Bill of Rights

STATEMENT OF PURPOSE

Healthy Families offers participants formal mechanisms for providing feedback about the program.

PURPOSE

To ensure that the program receives feedback from participants as part of their efforts toward continuous quality improvement. To ensure that the program has procedures regarding participant grievances.

AREAS OF RESPONSIBILITY

Staff will provide participants with a copy of Participant's Rights. Program Manager will ensure satisfaction surveys are completed annually.

PROCEDURE

Participant input into Program:

Healthy Families has formal mechanisms in place for participants to provide input into the program. These mechanisms include:

- Participant satisfaction surveys
- Participant service on the Advisory Committee
- Invitation on Participant's Rights to contact Program Manager and/or FCC's Grievance Officer regarding any input, concerns, or grievances. A copy of Participant's Rights is given to each family as they enroll in the program, so that they have the phone number and contact information.

Should a participant bring forward a grievance, the Program Manager and/or FCC's Grievance Officer will review the grievance with all relevant/ involved parties within 10 working days. Appropriate action will be taken. All grievances will be tracked and followed up on by the Program Manager. Grievances will be reported in the program's quarterly report. Documentation that the grievance was reviewed with the family is placed in the participant's file.

Participant feedback surveys are to be conducted yearly. The information is then shared with the program staff and Advisory Committee in an aggregated format. These surveys can illuminate areas in which staff would benefit from additional training or support, as well as highlight particular areas of strength or staff skill.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	EVALUATION/ REVIEW OF PROGRAM QUALITY
Procedure Number:	1303
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	GA-3. A-B, File Review Checklist

STATEMENT OF PURPOSE

The program monitors and evaluates quality of services.

PURPOSE

Healthy Families has our own specific set of standards and therefore quality assurance procedures (superseding our host agency's procedures) which ensures that the Healthy Families program has a formal system for the continuous and systematic internal evaluation of the quality of services as well as follow-up mechanisms for addressing identified areas of improvement.

AREAS OF RESPONSIBILITY

Program Manager evaluates all stages of the quality improvement system to identify remaining issues and improved approaches.

PROCEDURE

General Procedures:

- All tools used for assessing quality should be directly related to the program's goals, objectives, and expectations for performance and services.
- Staff is aware of the program's standards and expectations for their work as well as the documentation and quality assurance activities that are part of ensuring they meet these standards. Program standards and staff expectations are laid out in the following resources:
    - HFA Critical Elements and Best Practice Standards
    - Procedure Manual
    - DAISEY (online) Guidance.

Quality Assurance Practice Activities:

- Quality assurance practice activities focus on assessment, home visiting and supervision.
- Quality assurance activities are regular and routine. When observations are conducted regularly and other quality assurance activities are a routine part of their work, staff will become familiar and comfortable with these activities and see them as helpful to the program and supportive of their own professional development.

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- The following activities are elements of Healthy Families program quality assurance activities:
    - Observation of Assessment: Once per year per CM, if possible.
    - Observation of Home Visit: Once per year per CM.
    - Assessment Supervision: via conversation with direct supervisor
    - CM Supervision: via conversation with direct supervisor
    - Program-wide Participant Satisfaction Surveys: Once per year. To be consolidated and reported to staff and included in the appropriate quarterly report.
    - Performance Appraisal: Once per year for all staff. To be copied for each staff, in their program file, and in FCC's Human Resources file.
    - Exit interviews with staff, and informally with participants. To be recorded in FCC's Human Resources file and participant's file, respectively.
    - Staff Satisfaction Survey: Once per year (FCC Survey) This is shared with FCC Leadership, advisory committee, and also discussed during a weekly staff meeting.
    - File Review (using HFA's Participant Family File Checklist) such that all files are reviewed at least yearly. This activity is conducted quarterly, reviewing one quarter of each CM's caseload's files. All files to be reviewed are brought to staffing on the designated day and passed to any other CM to review contents for completeness. Those files found incomplete are corrected immediately or reviewed during the next week's supervisory session to bring them into compliance with our standards.
    - Monthly "run" of DAISEY reports- indicating status of immunizations, identification of medical homes, screen administration (on time, late, missing), follow up on plans regarding children with possible developmental delay (to ensure action has been accomplished within 2 months), and follow up on safety issues identified through our home safety screens.
- Newer CM's and supervisors will have more frequent quality assurance activities.

Follow-Up:

- Quality assurance activities recognize staff strengths, and positive feedback is shared with staff to provide encouragement and motivation. Areas for improvement are addressed in nonjudgmental ways to promote receptivity to feedback and be accompanied by support and staff development.
- Written feedback (yearly review) is signed off on by both the staff member and Program Manager, and maintained in staff records.
- When areas for improvement are identified, plans are developed to address these concerns. Planning for improvement may include the following activities:
    - Reviewing the results of the various quality assurance activities with the staff member who was evaluated,
    - Offering feedback on the results, including identifying strengths,

- Soliciting input from the staff member on their perceptions of strengths, challenges, and needs,
- Creating mutually agreed upon goals for improvement

- Once plans are developed, the Program Manager establishes a timeline for completing activities and follow through on their implementation. This may include the following activities:
  - Arranging for mentoring from supervisors or peers
  - Scheduling training
  - Planning for practice sessions

Programmatic Activities

- Staff and Advisory Committee utilize the program's quarterly and yearly reports to assess areas of programmatic strength and those in need of improvement.
- Additional information is gathered from internal (FCC Senior Leadership) and external (Advisory Committee) sources, including the families served by the program (yearly Participant Survey), to create the most accurate total picture of how the program is performing.
- The program may create a Program Improvement Plan (sometimes termed Continuous Quality Improvement) that allows for the review of progress toward goals, objectives, and identified areas of improvement. The Program Improvement Plan includes the activities that will be conducted, the timeframe for their completion, the persons responsible, and the mechanisms for following up on identified areas of improvement. It may include both practice activities and programmatic activities. The Plan is in effect for a specified duration of time and is reviewed/evaluated for effectiveness after completion of the time period.
- Follow-up to practice and programmatic activities should result in improved services and outcomes. If activities do not produce these results, the Program Manager evaluates all stages of the quality improvement system (i.e. defining expectations, assessing quality, planning for improvement, and implementation) to identify remaining issues and improved approaches.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	APPROVAL OR DENIAL OF RESEARCH
Procedure Number:	1304
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	GA-4 Sample Participant's Rights (Consent to Participate)

STATEMENT OF PURPOSE

The program has a committee available to make recommendations regarding the ethics of proposed or existing research, decide whether to approve research proposals, and monitor ongoing research activities. The program will protect participant identity and privacy throughout the life of a research project

PURPOSE

To ensure that the program assures ethical participation in research; plus, privacy and voluntary choice with regard to research conducted by or in cooperation with the program.

AREAS OF RESPONSIBILITY

Ongoing research will be monitored by the Healthy Families staff, Program Manager and Coordinator of Community Services

PROCEDURE

The responsibility for review of proposed research is the consensus opinion of the following:

- Program staff, Coordinator of Community Services, and Healthy Families Advisory Committee, and any person whose opinion is deemed appropriate by Family & Children's Center's Leadership Team.
- Ongoing research will be monitored on a yearly basis by the Healthy Families staff, Program Manager and Coordinator of Community Services. Additional opinions will be sought out as appropriate.
- Once a research project is approved, all families must be fully informed of the scope of their possible involvement. They must be given a choice to participate, and sign consent if they do.
- In cases when a funder requires research as a condition of the funding, the procedures still apply.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Procedure Name:	FAMILY RIGHTS AND CONFIDENTIALITY
Procedure Number:	1305
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	GA-5. A-D, -Sample Release of Information -Sample Release of Information instruction sheet -Sample Participant's Rights

STATEMENT OF PURPOSE

HF will inform families of their rights, notify families of confidentiality both verbally and in writing, and have families sign consent every time information is shared with a new external source and when conducting research projects, as well as assuring voluntary participation.

PURPOSE

To ensure that the program has procedures for informing families of their rights and ensuring confidentiality of information both during the intake process as well as during the course of services. To ensure that parents are informed and sign consent every time information is to be shared with a new external source.

AREAS OF RESPONSIBILITY

Staff will inform participants of their rights and follow all confidentiality procedures.

PROCEDURE

Notification of confidentiality and family rights.

1. Healthy Families offers voluntary, confidential services to all families identified at risk of child maltreatment or to those at risk of poor health or developmental outcomes. Participant rights are protected in accordance with agency procedure and federal and state requirements. Families are informed at intake of the limits of confidentiality.
2. All program staff, interns and volunteers receive orientation *prior to direct services with families or supervision of staff.* This orientation addresses issues of confidentiality and family rights. (See Training Plan regarding staff/ FCC Procedure Manual regarding interns and volunteers.)
3. Program informs families about their rights, including confidentiality, before or on the first home visit, both verbally and in writing. All data is kept confidential.
4. Initial Home Visits: During the initial home visit, the CM explains the voluntary nature of services, informs and reviews confidentiality and family rights, and provides reassurance that the CM's role is to support and assist with needs and interests, explaining what will take

place during home visits. The family is asked to sign a form (Participant's Rights) stating that they understand the service in which they are enrolling and are reminded that they may refuse service at any time. It also specifies when a participant could expect limits to confidentiality i.e. safety concerns.

On-going Informed Consent

1. Families are informed, and sign written consent, every time information is to be shared with a new external source. This is referred to as an Authorization for Release of Information.
   CM places releases in participant files so that the files contain evidence indicating that families provided written consent every time information was shared with a new external source.
2. Release of Information forms include the duration of the period of consent being agreed upon (i.e. 6 months, up but not exceeding 1 year) and contain a specific date the release takes effect.
3. Release of Information forms include the specific information to be released, and its purpose.
4. Release of Information forms contain the name of the person/agency to whom the information is to be released and the name of the person/agency providing the confidential information.
5. Release of Information forms contain a statement that the person/family my withdraw their authorization at any time.
6. Release of Information forms contain the signature of the person whose information will be released or the parent or legal guardian of a person who is unable to provide authorization.

Notice of Privacy Practices

- Family & Children's Center's Notice of Privacy Practices is reviewed by the CM on the first visit. The family signs Family & Children's Center Notice of Privacy Practices Written Acknowledgement of Receipt, indicating that the information has been received. The family is given a copy of Family & Children's Center's Notice of Privacy Practices.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	CHILD ABUSE AND NEGLECT REPORTING
Procedure Number:	1306
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	GA-6. A-B

STATEMENT OF PURPOSE

Program reports suspected cases of child abuse and neglect to the appropriate authorities.

PURPOSE

The mandatory reporting statute imposes specific limits on confidentiality. Officials or institutions required to report a case of suspected child abuse or maltreatment must follow all applicable federal and state laws. Healthy Families staff are mandatory reporters.

AREAS OF RESPONSIBILITY

Staff will report suspected cases of child abuse and neglect to the appropriate authorities and to program manager and/or supervisor.

PROCEDURE

- Families are informed at intake of the limits of confidentiality.
- All program staff receive orientation *prior to direct services with families or supervision of staff.* This orientation ensures that staff clearly understand how to identify child abuse and neglect indicates and fully understand the State's definition of child abuse and neglect and issues of confidentiality. (See Training Plan.)
- All staff are required to have annual training and ongoing professional development on child abuse and child welfare, and example is Wisconsin's online Mandated Reporter training: http://wcwpds.wisc.edu/related-training/mandated-reporter/.
- Training should prepare staff to:
  - Understand current Wisconsin Rules and Standards for reporting child welfare concerns.
  - Accurately identify abuse, neglect and endangerment;
  - Understand obligations and procedures of documenting concerns and making mandatory reporting.
  - Work effectively with high risk families;
  - Work effectively with child and adult survivors of child abuse and neglect
  - Maintain professional boundaries and self-care strategies for working with high risk families.
  - Although anyone may report suspected cases of child abuse or maltreatment to the Child Protective Services, all Healthy Families program staff are mandated reporters.

- Criteria used to identify and determine when to report suspected child abuse and neglect is found on the Wisconsin Department of Children and Families website http://dcf.wisconsin.gov/ . Staff can refer to Safety Manual for signs of child abuse and neglect.

Mandated Reporting Procedures:

Healthy Families program staff will:
1. Report all concerns regarding child abuse, neglect or endangerment to a Supervisor. When possible, this should occur prior to reporting, but should not delay or prevent a staff from making a report.
2. Report all concerns regarding child abuse, neglect or endangerment directly to La Crosse County Human Services Department (608-784-4357) and document this in the family file without delay.
3. Document both their observations and concerns and a detailed account of actions taken in the family file.

Supervisors will:
1. Be available by telephone or in person at all times while staff are in the field for consultation and support.
2. Provide guidance and support to CM making child welfare reports; and document all conversations and actions taken concerning child welfare reporting and follow-up in the staff supervision file.
3. Consult with the Program Manager as needed

GETTING HELP

Healthy Families America:
Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

	CHILD RESIDING IN A PARTICIPANT HOME
Procedure Number:	1307
Domain:	Healthy Families
Approved By:	Mary Jacobson, Director of Programs
Created/Written By:	Katie Rommes, Program Supervisor
Effective Date:	10/1/2016
Date(s) of Revision:	9/15/2020
References:	GA -7

STATEMENT OF PURPOSE

The death of a participant or death or critical injury (described as a life threatening injury) of children residing with participants is considered a tragic situation requiring immediate attention. This procedure addresses the death or critical injury of target or non-target children living in the home of an HF participant who has died due to natural causes or other causes other than alleged maltreatment, or died due to alleged maltreatment. This procedure does not refer to the death of an infant at birth (unless the birth occurred at home) or prior to hospital discharge after the birth.

PURPOSE

The program will assure both staff and family members are supported through the grief process. A death creates a deep sense of loss for families, as well as staff.

AREAS OF RESPONSIBILITY

If there is a death of a participating parent or child, or a child living in the home of a participating family, staff is to notify the Supervisor or Program Manager immediately

PROCEDURE

1. If there is a death of a participating parent or child, or a child living in the home of a participating family, staff is to notify the Supervisor or Program Manager immediately.
2. Referrals, support and continued services to family, including referrals for grief/trauma counseling.
3. Support of staff members, including referrals for grief/trauma counseling and EAP service.
4. Review of case record, supervisors' notes, Parent Survey Assessment by Program Manager.
5. Document the incident, including: the date and time of death or critical injury; the person who notified the program of the incident; the person(s) where applicable, who made the initial report to Child Protective Services, if known; the notification of Supervisor/ Program Manager; whether follow-up services will be provided to the remaining family members, and length of time they will be provided.

GETTING HELP

Healthy Families America:

Input will be sought from appropriate personnel at Healthy Families America whenever guidance is necessary to maintain fidelity to the critical elements.

Always contact the Program Manager and/ or Supervisor with any questions or concerns.

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Family & Children's Center

Procedure Name:	HUNGER TASK FORCE
Procedure Number:	1401
Domain	CSP, Healthy Families, Stepping Stones, Sandcastles, Youth Home
Approved By:	Tita Yutuc, CEO/ President
Created/Written By:	Mary Jacobson, Director of Programs
Effective Date:	3/15/2019
Date(s) of Revision:	
References:	Meal Tracking Log, Pantry Monthly Report Cover Sheet, Pantry Register Spreadsheet, Meal & Shelter Monthly Cover Sheet, Hunger Task Force Contract Agreement

STATEMENT OF PURPOSE

This procedure describes how to properly utilize the Hunger Task Force (HTF) food pantry.

AREAS OF RESPONSIBILITY

All programs that utilize the HTF food pantry in serving meals and/or allowing clients to obtain food through our pantry. The Hunger Task Force food pantry can and should be utilized by any client being served by an FCC program. Current programs using this service include CSP, Healthy Families, Stepping Stones, Sandcastles, and Youth Home.

PROCEDURE

Each program that wants to participate in receiving food from HTF needs to appoint a staff or volunteer that will be responsible for all training and paperwork associated with HTF. Once appointed, the Director of Wisconsin Programs will be notified. Programs can distribute food in two ways:

1. Program staff can escort clients to the food pantry located across from the lunchroom on first floor at GVC. The key is located with the front desk receptionist. The Pantry Clientele Register needs to be filled out for each client that takes items from the pantry. There is no real limit, but clients should only take what they can use.
2. Program staff can utilize food from HTF to cook a meal or provide snacks for clients served. This can be for a meeting, regularly scheduled mealtime (Youth Home, Hope Academy) or an event we are hosting for clients. When this occurs, the Meal Tracking Log would be utilized.

The appointed staff will need to shadow an existing person that currently handles the HTF paperwork. Shadowing will consist of physically going to HTF, being introduced to the staff there, being given a tour of the facility, picking up needed items for their program, and filling out the proper documentation required at HTF for items taken.

All HTF appointed staff are required to fill out the Pantry Clientele Register for people that utilize our food pantry and the Meal Tracking Log for people that we provide a meal/snack to with food we acquire from HTF for their program areas. Both reports are maintained throughout the month and submitted to the Wisconsin Director of Programs by the fifth of the following month.

The Wisconsin Director of Programs will gather all program information and compile the data into the Pantry Monthly Report Cover Sheet and Meal Program and Shelter Report Cover Sheet. All reports are submitted to the HTF via email to lacrossehunger@gmail.com by the 10th of each month.

GETTING HELP

If you have questions regarding this procedure, please contact:

1. Program Supervisor
2. Program Coordinator
3. Director of Wisconsin Programs

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Procedure Name:	TELEHEALTH SERVICES
Procedure Number:	103
Domain:	Client Rights All FCC Programs
Approved By:	Leah Morken, Clinical Director
Created/Written By:	Mary Jacobson, Director of Programs, Director of Programs
Effective Date:	6/15/2020
Date(s) of Revision:	
References:	APA Telehealth Training Informed Consent for Telehealth Services form Procedure 407: Case Record Overview Revenue Cycle Homepage Provider Assurance Statement for Telemedicine Telephonic Telemedicine Provider Assurance Statement

STATEMENT OF PURPOSE

Telehealth services have been approved through the end of the State of Emergency related to COVID-19. The agency anticipates that telehealth will remain an important method of service delivery throughout the COVID-19 pandemic and beyond. As such, we will stay abreast of rules and regulations regarding telehealth and update this procedure accordingly. This procedure outlines the roles, responsibilities and processes related to providing telehealth services.

AREAS OF RESPONSIBILITY

All staff proving telehealth services are responsible for knowing and understanding the information in this procedure. All staff providing telehealth services must participate in the online APA telehealth training or other telehealth training approved by the Clinical Director.

PROCEDURE

Telehealth is the practice of health care delivery of services, diagnosis, consultation, or treatment of medical data by means of audio, visual, or data communication. Telehealth services must be provided through a 2-way, real-time, interactive method of communication. This excludes voicemails, texting, emailing, faxing, and chat rooms.

Telehealth is not a “check-in”. It is a purposeful and intentional service that is medically needed as determined by a licensed medical professional or mental health professional. Services must be clinically appropriate for the consumer’s needs.

Methods of Telehealth:
Providers are expected to use HIPAA compatible modalities to protect consumer rights. Family & Children's Center complies with established state and federal regulations for telehealth.

Family & Children's Center prefers the use of doxy.me for secure telehealth services and has provided a select number of accounts for providers in need of a secure platform that allows for screen sharing capabilities. Providers are responsible for ensuring the platform they are using is an approved platform by confirming with the Clinical Director. Approved platforms may vary with time based on regulations.

FCC expects all providers to adhere to the requirements of Health Insurance Portability and Accountability Act (HIPAA). This requires taking necessary steps to protect the privacy of clients and the confidentiality of information related to providing services via telehealth. Providers should refer to agency procedures related to HIPAA as well as the APA telehealth training or other approved training if they have questions. For additional help, they should contact the Clinical Director.

Telehealth Process:
Prior to providing any telehealth services, providers must obtain consent from clients via the Informed Consent for Telehealth Services form. Signed and written consumer consent is preferred; however, if written consent is unable to be obtained, then verbal consent is allowable while documenting the efforts to obtain written consent. This can be done via email or regular mail. If verbal consent is utilized, it must be obtained at the start of every session after the risks of telehealth to privacy are discussed.

Providers must adequately address client safety before, during, and after the telehealth service is rendered. This may include but is not limited to a review of client records to identify history of safety risks, creation of a safety plan and protocol for staff members, on-going assessment of client's symptoms and potential safety risks via question and aftercare referral and submission of the created safety plan to the next provider.
The following information must be communicated and discussed with the client at the start of every session:

- An understanding that others may hear the conversation in the background
- Staff's location and environment (ex: working from home with dogs that may bark in the background)
- An understanding that the platform used may not be confidential (e.g., if the platform is

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not HIPAA compatible, such as Skype, data storage, 3rd party recordings, internet security breaches, etc.)
- An understanding that the consumer has the right to refuse or stop the session at any time
- An understanding that the provider may end the session if the connection is poor or for other reasons that should be explained to the client

Requirements for Documentation:
Staff documentation expectations remain in effect, including the use of the SIRP method of documentation. However, additional requirements must be clearly documented in every case note. This information includes:
- Method/mode of transmission used for session (e.g., Skype, telephone call, etc.)
- A description of the provider's basis for determining that telehealth is an appropriate and effective means for delivering service to the client (e.g., due to COVID-19, due to Safe at Home Order, due to client being unable to come into the office, due to client not having internet connection—in the case of a telephone session, etc.)
- Type of service provided (e.g., outpatient counseling session, supervised visit, etc.)
- Location of consumer (as confirmed by provider) and location of provider (e.g., "Due to consumer self-quarantine, writer called from office to consumer in their home", etc.). This is also known as the location of the originating and the distant site.
- That risks were reviewed and provider received consent for telehealth (Ex: "Current signed consent for telehealth", "Verbally reviewed risks and received verbal consent to conduct session via telehealth", etc.)
    - Ask and document assurance that the client is in a place with privacy, and if they are not, who else is present?
    - Ask and document that the client moved their camera around so you can see the physical setting of the room they are in.
    - Review and document the procedures for disconnection (sign back into the telehealth platform, and if that does not work what number to call by telephone to reconnect with the client) and your safety plan for emergency contact if needed.
- Time the service began and ended, with a.m. and p.m. designations

Addressing How and When to Discontinue Telehealth Services:
The following criteria should be utilized to address how and when telehealth services should end:
- Evaluation of service (intervention used and client's response): Daily review of progress notes

- Evaluation of on-going needs of the client: Clinical consultation of client cases either weekly, monthly, or as needed depending on circumstances
- Evaluation of scope of practice and client's needs: Clinical consultation of client cases either weekly, monthly, or as needed depending on circumstances
- If it is determined a client is not a fit for telehealth services, then an option may be to initiate in person services.

Process for discontinuation:

Context

- Client demonstrates deterioration or a need for higher level of care
- Client has on-going missed appointments or cancellations over a 3-week period
- Client decides to discontinue services
- Client's additional community providers report concern due to client's deterioration in functioning

Protocol

- Staff will consult with Clinical Supervisor
- Staff will consult with outside providers (e.g., County Case Manager)
- Staff will make 3 attempts to discuss potential discharge with client
- Staff will complete a discharge summary
- Staff will provide a referral for aftercare and follow-up

Billing Requirements:

There are no changes to service note billing requirements. However, invoices must add an indicator for telehealth services. For information on how to bill for telehealth services by payer, please go to the Revenue Cycle Homepage on the Depot. This can be accessed by going to Directory > By Department > Revenue Cycle Management > Click here to visit the Revenue Cycle Homepage!

In Minnesota, billable provides must complete the Provider Assurance Statement for Telemedicine, which is submitted to Medicaid and other payers as required, by the Revenue Cycle Department. Also, in Minnesota if any provider offers telephonic services, they must complete the Telephonic Telemedicine Provider Assurance Statement.

GETTING HELP

If you have questions regarding this procedure, please contact your Program Supervisor, Coordinator, Director or Clinical Director.

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