

# PROGRAM MANAGER

**&**

**SUPERVISOR**

**REFERENCE GUIDE**

**Updated 2015**

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# Healthy Families Oregon Staff and Resources

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# Evaluation Support (NPC): healthyfamilies@npcresearch.com

# Forms and Manuals: http://oregonearlylearning.com/healthy-family-providers-page/

# Useful Tools:

Healthy Families Oregon Program Policy & Procedure Manual

Healthy Families America Best Practice Standards

# Program Evaluation & Forms Manual (Red Book)

QuickStart Manual

NPC Status Report and Data Tables

# Useful Links:

<http://oregonearlylearning.com/other-priorities/healthy-families-oregon/healthy-family-providers-page/>

[www.npcresearch.com](http://www.npcresearch.com)

[www.healthyfamiliesamerica.org](http://www.healthyfamiliesamerica.org)

[www.preventchildabuse.org](http://www.preventchildabuse.org)

[www.zerotothree.org](http://www.zerotothree.org)

[www.aap.org](http://www.aap.org)

# Building Healthy Families Oregon

History

The 1993 Oregon Legislature established the Healthy Start/Family Support pilot project to assist families in giving their newborn children a “healthy start” in life through ORS 417.795. The Oregon Commission on Children and Families (OCCF) established pilot projects in selected counties throughout Oregon. There were several key ingredients:

* Healthy Start was designed to be for *all* families with newborns, reaching those with first-born children at a minimum.
* Services were built around the critical elements that provide the foundation for Healthy Families America (HFA) programs.
* A statewide performance measurement system identified outcomes for children and families.

In 1999, under Senate Bill (SB) 555, Healthy Start’s home visiting/family support services were reconfirmed as a primary prevention program dedicated to creating wellness for Oregon children and their families. In 2001, with HB 3659, Healthy Start services reached all of Oregon’s 36 counties although funding for the system remained level.

Voluntary

During the 2003 legislative session, ORS 417.795 was amended to ensure the voluntary nature of Healthy Start by requiring that express written consent be obtained from the family *before* any screening or other services could take place. The legislative intent at this session was to ramp up Healthy Start to reach

80% of first birth within the biennium. Due to diminished resources, this did not occur.

Restructuring

Faced with diminished resources, the 2005 legislature further reduced funds to Healthy Start by an additional 20%, requiring a re-examination of the Healthy Start delivery system. A Restructure Committee, formed with wide representation, recommended: continued adherence to the HFA model; performance-based decision-making; streamlining the system by which families were offered home visiting services; modifying the funding formula; and encouraging regionalization to reduce overhead and pool resources.

Accreditation

At the same time, Healthy Start embarked on the groundbreaking process of accreditation through the national HFA initiative, considered to be an evidence-based promising practice.

During the accreditation process, each site conducted an extensive self-study, documenting how each of the HFA Best Practices Standards was being met. Simultaneously, Central Administration at OCCF conducted a self-study of the state multi-site system. Throughout 2005-06, HFA reviewers examined the self-studies and interviewed families, staff and collaborators.

By June 2007, all requirements had been met and Healthy Start, now named Healthy Families Oregon, became fully accredited as a statewide system of exemplary home visiting through HFA.

# Healthy Families Oregon State System

The Healthy Families Oregon program operates under the Early Learning Council of the Oregon Department of Education. HFO has regional sites throughout the state. Central Administration provides specialized training and technical assistance to each site to ensure quality, cost-effective services.

Oregon’s Healthy Families state system enhances the capacity of individual sites to meet the needs of children and families. Healthy Families Oregon operates under governing legislation:

* Oregon Revised Statues (ORS 417.795)
* Oregon Administrative Rules (OARs), Division 45, 423-045-005-ff
* Oregon Revised Statute 417.705-417.797

# State System Organization

**Healthy Families Oregon**

**Central Administration Office**

**NPC Research for**

**Program Evaluation**

**Local Healthy Families** **Advisory Groups**

**Local Healthy Families Oregon** **Sites**

**Local Early Learning HUBS**

**Oregon Department of Education, Early Learning Division**

**HFO State Advisory Committee**

# Healthy Families Oregon at a Glance

Purpose of Home Visiting

Healthy Families Oregon (HFO) is a statewide home visiting program designed to prevent child maltreatment using the evidence-based Healthy Families America (HFA) program model.

HFO is a key component of Oregon’s system of supports and services for families with young children.

HFO promotes wellness for Oregon families, prenatally and with newborn babies, by offering universal, accessible, and non-stigmatizing screening and home visiting services tailored to the family's unique situation, focusing on reducing risks and increasing protective factors.

By enhancing family functioning and supporting positive parenting practices, HFO contributes to Oregon Early Childhood Benchmarks, including:

* prevention of child maltreatment,
* improvement of health outcomes for children and families and
* support of school readiness.

Goals

For families receiving home visiting services, HFO seeks to:

* Promote positive parent-child relationships,
* Support healthy childhood growth and development,
* Enhance family functioning by teaching parents to identify strengths and utilize problem-solving skills, and
* Improve the family’s support system through linkages and referrals to available community services.

Target Population

As of July 1, 2015, HFO’s target population is all births. Each region, through data collection, collaboration, and research, chooses service priorities for the high risk families in their community.

Families that are identified through HFO’s screening process as being at higher risk for adverse childhood outcomes are offered ongoing home visiting services. Services are offered to new families either during the prenatal period or at the time of birth (or soon after).

Screening and referral services

Screening systems vary across sites, and are designed to be cost-effective, locally organized systems that reach families during the prenatal period or within two weeks after birth.

Using a research-based screening tool, the *New Baby Questionnaire (NBQ),* HFO staff or volunteers screen new parents for characteristics associated with poor child and family outcomes, such as social isolation, lack of prenatal care, financial stress, depression and substance abuse.

Families with few, or no characteristics that place them at risk for poor outcomes, receive information and referral services. For example, lower risk families may receive a packet of child development and parenting information, or a telephone call with information about community resources such as parenting support groups or breast-feeding assistance.

In-depth information and training on the screening process and NBQ screening tool is available in the Program Evaluation & Forms Manual.

Home Visiting Services

Families who have a positive screen on the NBQ are offered home visiting services (as caseloads allow). Using the evidence-based HFA model, HFO offers a minimum of three years of home visiting services for Oregon’s at risk families. In some cases, families can remain in the program for up to five years of age.

Newly enrolled families receive weekly home visits from a qualified and trained Home Visitor. Visits decrease in frequency as the families build protective factors and increase parenting skills. Sites use the HFA system of well-defined levels of service to determine the frequency of home visits based on a family’s current needs and resources.

Home Visitors have limited caseloads in order to support their intensive work with families. Caseloads for a full-time worker may range from 15–25 families, depending on how frequently each family is being visited.

The Intake Process

Home Visitors spend the first several visits getting to know the family. The intake process begins with the Parent Survey assessment to discuss areas of stress and strengths. At the end of the Parent Survey, Home Visitors walk families through the Family Concerns and Resources activity to learn about the family’s concerns, needs and any resources the family may want to help meet those needs. Then the Family Values Activity is completed to learn about what is important to the family, their strengths, resources and culture.

During this time of getting to know the family, Home Visitors also lead a Wishes for my Child Activity that allows for a conversation about what the parent(s) want for their child and what they can do to encourage those qualities in their child.

Parent Survey

Over the first two to three home visits, Home Visitors use the Parent Survey assessment to better understand any issues, stressors, and challenges that may put the family at risk for negative outcomes. Many of the topics will naturally be addressed in the course of conversation when meeting the family. Home Visitors are tasked with ensuring that all of the family’s risk factors and stressors are addressed throughout the time in the program as well as building protective factors within the family.

Family Goal Plan (FGP)

The Home Visitor works with the family to assist them in setting meaningful goals, guiding service delivery. Through the development of a Family Goal Plan the Home Visitor and family discuss their strengths and resources to support them in achieving their goal, along with potential barriers to accomplishing the goal. Contingency plans, along with specific strategies for achieving the goal are discussed. Goals are broken down into small, mini goals that allow families to experience successes and build critical problem solving skills. FGP’s are discussed and updated regularly during home visits.

In addition, Home Visitors encourage families to be active participants in solving their problems. As part of that process, Home Visitors may share information and empower families to access needed community resources, including basic tangible supports such as food, clothing, baby supplies and housing, as well as more specialized assistance with challenging issues such as mental health counseling, substance abuse treatment, or drug and/or alcohol treatment services.

Positive Parent-Child Relationships

Promoting positive parent-child relationships is the cornerstone of this program. Home Visitors regularly promote and encourage positive, research-based attachment behaviors between parent and child to increase healthy functioning of the parents. The CHEEERS parent-child interaction assessment is conducted on every home visit, allowing Home Visitors and Supervisors to identify which areas of the parent-child interactions could use extra support and which are strengths. Home visits focus on supporting parents in their role as the child’s first teacher, providing

evidence-based parenting and child development information, coaching, and support. Parent-child activities are typically a part of each home visit. The Home Visitor ties the activities to encouraging a skill or behavior and encourages the parent to do the activities with their child, looking for ways to utilize items from the home environment for the activities.

Healthy Growth and Development

Home Visitors work with parents to make sure children are developing appropriately. They provide regular developmental screening utilizing the Ages and Stages Questionnaire and families are referred for early intervention services when appropriate to ensure the best possible developmental outcomes. Home Visitors monitor children’s immunization status and access to preventive health care, encouraging regular well-baby checks and appropriate use of medical services. Additionally, Home Visitors provide families with information about nutrition, stress-reduction, age appropriate toys and developmentally appropriate activities to encourage optimal growth and development.

# http://ioneadwnews.files.wordpress.com/2013/06/african-american-dad-baby-laughing1.jpg?w=490&h=306

# HFO Program Policy and Procedure Manual

The HFO Program Policy and Procedure Manual (PPPM) is an invaluable resource and tool for Program Managers, Supervisors, Home Visitors and HFO support staff. Every staff member should have access to the PPPM and have a working knowledge of the state and local policies as well as know how to access information from the PPPM when referencing policies and/or procedures.

Program Managers and Supervisors are tasked with training staff on the PPPM during orientation as a new hire and keeping staff updated with ongoing changes. This includes:

* Initial introduction and orientation to the PPPM manual
* Ongoing training and refreshers on each Critical Element so that staff understand the context and the “why” of their roles
* Training/updates on any policy and/or procedural changes

Program Managers are required to update the PPPM as directed by Central Administration. Keeping this document “alive” at the local level attributes to well-informed, educated staff and ensures continuous quality improvement.



# Roles of Program Manager and Supervisor

Managing a Healthy Families site and supervising Home Visitors are complex processes that are both challenging and rewarding. This handbook is designed to make the tasks easier by providing information, resources, and guidelines for Program Managers and Supervisors as they fulfill their roles.

## Program Manager

Program Managers are responsible for the day-to-day, hands-on management of the program, and are involved in program planning; staffing, training/service, program evaluation and office management. Program Managers are involved in creating their annual budget. They are also responsible for ongoing collaboration with community/state partners, public relations and for maintaining positive working relationships with health providers.

Depending on the size and resources of the site, Program Managers may have a combined role of Program Manager/Supervisor and provide direct supervision to Home Visitors. If a site has a supervisor, the Program Manager typically provides supervision to that supervisor, providing accountability and support. The Program Manager also is required to receive supervision in accordance with the HFA Best Practice Standards. Program Managers must be a minimum of .5 FTE at each site.

## Program Manager Key Responsibilities

|  |  |
| --- | --- |
| **Tasks** | **Frequency** |
| Ensure that site is educated on and meeting the HFA Best Practice Standards and striving to meet Oregon Performance Indicators  | Ongoing |
| Develop the local Healthy Families Program Policies and Procedures Manual and update this manual annually | At onset and then annual review |
| Analyze data and develop plans required by HFA regarding Screening, Acceptance, Retention, Home Visit Completion, Cultural Sensitivity, and Staff Turnover | One and Two year requirements |
| Monitor screening, program acceptance, and home visit completion data | At least quarterly |
| Develop, implement and monitor comprehensive Training Plan; update as appropriate and submit yearly | Annually |
| Establish Memorandum(s) of Agreement with hospitals and/or other appropriate entities to provide access to screen new parents | Ongoing |
| Maintain and enhance relationships with volunteers providing donations for program | Ongoing |
| Liaison with local HUB, early childhood team, appropriate community agencies and community partners | Ongoing |
| Liaison with Central Administration Healthy Families staff and attend statewide Program Managers Meetings | Ongoing |
| Work with local Advisory Group to promote and support program | At least quarterly |
| Develop and monitor program budget, including monitor expenditures, Medicaid Administrative Claiming, leveraging community contributions  | Ongoing |
| Research opportunities for leveraged resources, alternative funding sources, cash contributions, in-kind services, and grant prospects | Ongoing |
| Prepare for and follow up on annual site visit by Central Administration | Annually |

## Supervisor

The Supervisor is responsible for assuring the quality of service provision and protecting the integrity and respect of the families served. Supervisors provide administrative, clinical and reflective supervision to Home Visitors and assist Home Visitors by:

* Supporting the parallel process, reflect and make sense of Home Visitor’s experiences in working with over-burdened families, avoiding burnout.
* Supporting families in developing realistic and effective plans that will empower them to meet their objectives/goal Understand why a family may not be making the expected progress around personal and program goals, determining effective methods of intervention.
* Assisting in staff selection, leading orientation and training of new staff, conducting Quality Assurance activities, maintaining the data collection system, and monitoring the performance of the Home Visitors. The Supervisor may also act as a liaison with other agencies and works with the Program Manager to assure overall quality in program services.

## Supervisor Key Responsibilities

|  |  |
| --- | --- |
| **Tasks** | **Frequency** |
| Assign families to Home Visitors and manage caseloads | Weekly |
| Be available for immediate de-briefing with Home Visitors and provide individual reflective supervision | Min. 1.5 hrs. week  |
| Ongoing education of staff around the HFO Program Policies and Procedures and HFA Best Practice Standards, yearly changes, additions | As needed |
| Work with Home Visitors to complete, review, and plan interventions to address all risk factors in the Parent Survey | Initial and Ongoing |
| Monitor all aspects of home visiting  | Ongoing |
| Review home visit records before supervision, discuss strengths, barriers, struggles with Home Visitors | Weekly |
| Review home visit completion data with Home Visitors | Monthly |
| Monitor and ensure that Home Visitors submit NPC forms on a timely basis | Monthly |
| Research/coordinate training for staff to meet professional development and annual training requirements.  | As needed |
| Telephone four families per Home Visitor to ask about satisfaction | Annually |
| Observe one home visit per Home Visitor | Annually [[1]](#footnote-1) |
| Observe each Home Visitor conduct a Parent Survey | Annually [[2]](#footnote-2) |
| Comprehensive review of family files | 2 times per year |
| Review/discuss family retention rates with Home Visitors | Annually |
| Develop an individual training plans for Home Visitors | Annually |
| Participate in hiring, training, and performance evaluations | As needed |

To qualify for Healthy Families America (HFA) accreditation as a multi-site system, Healthy Families Central Administration meets standards established for the following five functional areas:

1. Program Policies
2. Training and Technical Assistance
3. Quality Assurance
4. Evaluation
5. Administration

State Policies and Procedures

The HFO Program Policies and Procedures Manual (PPPM) creates a statewide set of operational definitions for HFA’s evidence-based critical elements, also known as standards. Local sites adopt the state PPPM, adding procedures where noted to ensure that the site runs smoothly in the local community.

The PPPM is reviewed on an annual basis. The multi-site system has a period of time for revision suggestions and input. The manual is then finalized by the HFO State Advisory Committee and distributed electronically to individual sites. In turn, sites update local PPPMs to reflect changes within 90 days.

**Training and Technical Assistance** Central Administration provides a variety of trainings and training resources, including the Home Visitor Core Training, Parent Survey Assessment Core Training, Supervisor Core Training and Program Manager Core Training for new staff. QuickStart, and the Program Evaluation & Forms Manual are also available for training support.

Local sites are responsible for providing regular ongoing training on specialized topics to meet HFA requirements during the first year of employment. The required 3, 6, and 12 month training for new employees is available online through HFA (HFA Learning Center http://www.healthyfamiliestlc.com/). In addition, sites must provide regular ongoing training for the entire staff including required annual trainings.

Training Tracker, a web-based database, allows Central Administration to monitor the scope and timeliness of training statewide.

Technical assistance for programmatic issues and questions is provided on an as needed basis and through the annual site visit process. Central Administration conducts conferences for Program Managers at least annually.

Quality Assurance

A state Quality Assurance (QA) plan outlines quality management processes both for the state system and for local sites. Each site adopts the state QA plan as well as creates an annual training plan to address current training needs of staff.

Central Administration staff or contractors visit each site annually to assess quality assurance indicators and processes.

After receiving a written site visit report, sites develop a Program Goal Plan to discuss their strengths and address any identified challenges, setting goals for the coming year.

Evaluation

As required by legislation, HFO contracts with an independent evaluator to measure performance indicators and participant outcomes. Sites are responsible for ensuring that data reaches the evaluators in a timely manner. These status reports allow Central Administration and site staff to monitor progress on key indicators and outcomes.

The *NPC Status Report* presents a comprehensive review of implementation and program outcomes including the effects of HFO on child maltreatment rates. Data are reported in aggregated form and may be omitted when sample size is so small that family privacy would be threatened.

Central Administration

Central Administration staff is responsible for guiding the program statewide and assuring its continued quality. Central Administration staff serves as liaison between the program and the state Early Childhood System, linking the HFO sites to Early Learning Hubs and to the national Healthy Families America. Central Administration staff ensures local HFO sites are kept up to date on program goals, policies and procedures. Central Administration staff and contractors provide training and technical assistance, and support sites and Early Learning Hubs in their management of the HFO program. Central Administration staff administers all Web system databases. They maintain communication with the evaluation team, and represent the program through public relations and media relations.

State Advisory Committee

As a Standing Committee of the Early Learning Council, the State Advisory Committee is responsible to and advocates for the HFO program and its goals. In 2011 this committee merged with the Steering Committee, expanding its role and function. The Advisory Committee serves as a venue for communication among persons representing various aspects of the state system of supports and services for early childhood. This group is composed of community members (advocates and stakeholders) in addition to representation from local Program Managers/supervisors, , Central Administration staff, the evaluation team and HFO contractors.

This Committee is responsible for guiding, overseeing, and monitoring overall program implementation of HFO statewide to follow the HFA critical elements. The committee implements, reviews, and monitors the HFO Program Policies and Procedures Manual (PPPM), and the Quality Assurance, Training and Technical Assistance Plans. Other roles and functions include communicating with HFO sites regarding program implementation, overseeing system-wide training and technical assistance, reviewing annual status reports and developing the program implementation section of the of the Strategic Plan.

Budget

Program Managers are responsible for developing and monitoring their site-specific budget. This budget is submitted to Central Administration at the beginning of each biennium. State HFO staff report the amount of Medicaid earned each quarter to the site Program Manager. The Program Manager is responsible communicating changes to the lead agency and for implementing changes in the budget based on fluctuations in Medicaid earnings, unexpected costs or funding changes occurring during a legislative session.

# Building Community Connections

HFO sites work with their local Advisory Group members and Early Learning Hubs to ensure that the community understands Healthy Families mission and the successes that the local site has achieved. By creating a positive image of HFO and letting people know how they can help; sites can build community support for the HFO program.

Communication

Effective public relations depend on having a plan for what messages will be conveyed, how they can best be conveyed and by whom and/or what. In planning, Program Managers should recognize that people are drawn to positive visions and actions, not problems and guilt. Consider including the following strategies:

* Produce and distribute a local “Status Report” using the data from NPC ([www.npcresearch.com](http://www.npcresearch.com)). Use the information to trumpet local successes.
* Recruit parents to tell stories about how HFO has affected their lives. Statistics will have more punch when coupled with success stories from real people in the community.
* Use local media to get your messages out. Provide press releases to draw attention to successes. Develop information on positive parenting practices and make it available to the media. Write letters to the editor about Healthy Families.
* Make presentations about HFO to local organizations and agencies. Sponsor or co-sponsor special events for families and young children.
* For HFO sites, the key to success lies in partnering with other groups who share a commitment to children and families. Let people know how the community is working together to achieve HFO’s results. Highlight how others *can* and *do* get involved.
* Seek opportunities to present about HFO to community agencies, hospitals, and partners. Have these partners come present their services to your staff as well.

Hospitals, Clinics, Agencies

Establish working relationships and agreements with hospitals, clinics and other sources where first birth families will be identified. Written agreements will clearly define expectations and responsibilities for both the cooperating organization and the HFO site, and will usually provide stability when there are staff changes at these organizations.

Matching Funds

HFO programs are required to demonstrate at least a 25% local match as part of their base operating budget. At least 5% must be cash or cash equivalent. The match includes such items as cash contributions, in-kind contributions, volunteer hours and the value of donated items.

Some of the ways in which HFO sites have successfully involved community members and/or organizations to create these matching resources include:

* Sharing resources like space, staff, or training opportunities
* Receiving cash contributions or conducting fund-raisers
* Providing material goods, such as groceries or baby supplies
* Volunteering to assist with grant-writing or providing services such as screening/outreach and clerical support

# Promotional Materials

Central Administration has a variety of materials and other resources that programs can use to promote Healthy Families Oregon. Central Administration can provide information on these items and technical assistance for their effective use.

**Healthy Families Oregon Materials**

|  |  |
| --- | --- |
| **Materials** | **Availability** |
| *Healthy Families Oregon Brochures:* Family friendly program description – with information on local contacts.*Healthy Families Oregon Video:* Video presentation describing the program, showing the home visiting process and highlighting family success stories.*Reading for a Healthy Start:* Brochure describing the importance of and effective practices for reading to young children.*Healthy Families Oregon Display Board Layout* (words and pictures) for a standard table-top tri-fold display. Local contact information can be added.*Healthy Families Oregon Elevator Cards:* What you might say if somebody asked “What is Healthy Families?” | Available in English and SpanishAvailable in English on DVDAvailable in English, Russian and SpanishAvailable in English and Spanish Available in English |

# 15610970Performance Indicators

Healthy Families Oregon uses performance measurement strategies to systematically assess progress toward its goals. On a biennial basis, the State Advisory Committee reviews and approves a set of Service Delivery and Outcome indicators.

Expectations

Central Administration sets statewide expectations for the service and outcome indicators. When possible, expectations are based on HFA standards described in the PPPM.

**Service Delivery Indicators** Expectations for the first six indicators are related to specific HFA standards as outlined in the PPPM. These focus on:

* Identification and screening of families in a timely manner (#1)
* Timely first home visits (#2)
* Ensuring families receive appropriate numbers of home visits (#3)
* Engagement and retention for families (#4 and #5)
* Expected Average Caseload Capacity(#6)
* On time developmental screening (#8)
* On time depression screening (#9)
* Ensuring staff background checks (#10)

Two additional service delivery indicators follows legislative intent to serve as many at risk families as possible in a cost-effective manner.

* Match expectations ensures local contribution (#7)
* Family Service Units over the year (#11)

Family Outcomes Indicators

These indicators have been selected to assess interim progress toward HFO’s high-level outcomes of reducing child maltreatment and helping children become ready for school.

Outcome expectations for #1 (Children with a Primary Care Provider) and #2 (Children with up-to-date immunizations) follow HFA standards as described in the PPPM.

Expectations for the remaining outcome indicators are based both on past achievements and goals for these important supports.

Reviewing indicators

N*o single indicator* is sufficient to judge program quality. Different sites will have different strengths and different areas in need of further support. However as a group, the performance indicators provide a useful snapshot of successes and challenges in reaching and serving at risk families.

#

What is Healthy Families America?

Healthy Families America (HFA) is a national initiative to improve infant mental health and to help parents of newborns, who may be at risk, get their children off to a healthy start. Participation in HFA services is *strictly voluntary*. HFA offers home visiting and other services to families in over 600 communities.

In 1992, Prevent Child Abuse America launched Healthy Families America in partnership with Ronald McDonald House Charities. The initiative promotes positive parenting and child health and development, thereby preventing child abuse, neglect and other poor childhood outcomes.

What is the Relationship between HFA and Prevent Child Abuse America?

Prevent Child Abuse America is the nation’s leading child abuse prevention organization. Founded in 1972, Prevent Child Abuse America is committed to preventing child abuse in all its forms by working at national, state and local levels. Prevent Child Abuse America, in collaboration with its Chapter Network in most states, is improving quality of life for at-risk children and families.

Prevent Child Abuse America/Healthy Families America has nationally recognized strengths in public awareness, research, training, quality assurance, and a system to provide technical assistance to state HFA leadership teams. This combination of strengths enables HFA to put research into practice, and assures the consistent provision of quality services as programs grow and expand.

What are Healthy Families America’s Critical Elements?

All HFA programs adhere to a series of standards or critical elements, which represent the field’s most current knowledge about implementing successful home visitation programs. These standards serve as the framework for program development and implementation. Only those programs that apply for affiliation and show evidence of adhering to all the standards, as determined through the HFA accreditation system, may be referred to as HFA sites. In addition to helping assure quality, these standards allow for flexibility in service implementation to permit integration into a wide range of communities and provide opportunities for innovation.

What is Healthy Families America’s Accreditation Process?

The development of the HFA accreditation process was initiated as a result of requests from HFA sites and state leaders for a process that would help preserve the quality of the HFA movement as it grows and expands. This process supports each program in monitoring and maintaining it quality over the long term, as well as put into place a mechanism to ensure the overall quality of the HFA program.

Changes to the Accreditation Process

In 2007 HFA made significant changes to the accreditation process including streamlining the standards and adding *Intent* and *Tips* for many standards. This provides a concrete way for programs to demonstrate quality services. In 2014 and 2015, HFA made additional changes and updates to the standards and released the ***2014-17 HFA Best Practice Standards***.

**![MPj04140930000[1]]()**The critical elements, or standards, are the core of HFA program design, implementation and quality. They are split into three major categories: Initiation of Services, Service Content and Service Providers.

**The following are brief descriptions of each Critical Element:**

Service Initiation

1. Initiate services prenatally or at birth.
2. Use a standardized assessment tool to systematically identify families who are most in need of services.
3. Offer services voluntarily and use positive outreach efforts to build family trust.

Service Delivery

1. Offer services to participating families over the long term (i.e., three to five years), using well-defined criteria for increasing or decreasing frequency of services.
2. Services should be culturally sensitive; staff and materials should reflect the diversity of the population served.
3. Services focus on supporting the parent as well as the child, by cultivating nurturing parent-child relationships, and promoting growth and development.
4. All families should be linked to a medical provider; depending on the family’s need, they may also be linked to additional services.
5. Staff members should have limited caseloads.

Selection & Training of Service Providers

1. Service providers are selected based on their personal characteristics, their experience and skills.
2. Service providers receive intensive training specific to their role to understand the specific components of home visitation, family assessment and supervision.
3. All service providers should receive training in areas such as cultural competency, reporting child abuse, safety, managing crisis, mental health, substance abuse, domestic violence, drug-exposed infants, and services in their community.
4. Service providers receive ongoing, effective supervision so 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 to see they are making a difference, and to avoid stress-related burnout.

Programs are also held to Best Practice Standards in the **Governance and Administration (GA)** standard. This is not a critical element; however it ensures that the program is governed and administered in accordance with principles of effective management and ethical practice.



Safety Standards

The following Safety Standards **must be met for HFA accreditation** since they affect the safety of families being served:

* Background Checks (9-3.B)
* Orientation training on Child Abuse and Neglect Reporting (10-1.C)
* Reporting suspected cases of child abuse and neglect that include reporting criteria, definitions and practice (GA-6A) (GA-6B)

Sentinel Standards

Thirteen Sentinel Standards are also **identified as critical for ensuring program quality**. These also must be met to receive accreditation:

* Home visit completion (4-2.B)
* Length of service for a minimum of three years (4-3.B)
* Routinely assessing, addressing, promoting positive parent-child interaction, attachment, and bonding with all families (6-3.B)
* Developmental screenings used at specific intervals (6-6.B)
* Tracking child suspected of having a developmental delay (6-7.B)
* Conducting depression screening with all enrolled mothers (7-5.B)
* All staff conducting assessments, supervisors, program manager receive HFA Core Assessment Training (10-3.A)
* Home visitors, supervisor, program manager receive HFA Core Home Visitor Training (10-3.B)
* Supervisors and program managers receive HFA Core Supervisory Training (10-3.C)
* Ensure weekly individual supervision is received by all direct services staff (12-1.B)
* Policy and procedure assuring all direct services staff are provided with supervision that includes administrative, clinical, an reflective components

 (12-2.B)

* All parents are notified of family rights and confidentiality at the onset of services, bot verbally and in writing (GA-5.B)
* Parents are informed and sign a new consent form every time information is to be shared with a new external source (GA-5.C)

# Implementing HFO Program Standards

*Sites may find that there are many demands and pressures to take shortcuts. Examples of these demands include:*

* Pressure to hire or redeploy existing staff who may not be suitable for the site’s needs in order to “get started” with families
* Pressure to accept families whose babies are older than the eligibility age, who live outside the designated services area or who do not otherwise meet the established program eligibility criteria
* Pressure to accept higher caseloads “just for now” in order to meet organizational needs or funder requirements
* Pressure to shorten the training process for new staff in order to save money or start services sooner
* Pressure to reduce supervision time so that Program Managers or Supervisors can meet organizational demands such as budgeting, public relations, or identifying potential funders
* Pressure to take families as part of a mandated plan compromising the voluntary nature of services
* Pressure to focus solely on case management or crisis intervention rather than parent-child relationship or child development needs

**In order to maintain adherence to HFA and the critical elements, the program management team must clearly understand the years of research and practice experience which are the basis for the HFA approach. The most successful Program Manager will become an advocate for quality service delivery, knowing that following the critical elements will promote real success with families-even if this promotes short term challenges in program implementation.**

# HFA Critical Elements at a Glance

Healthy Families Oregon follows HFA’s Critical Elements that represent best practices for effective home visitation programs. Based on over 30 years of research, these critical elements form the backbone of the quality assurance system.

The HFO Program Policies and Procedures Manual (PPPM) creates statewide operational definitions for the research-based critical elements. The following tables, while not comprehensive, give an overview of key policies and procedures each site must follow.

# Overview of Key Policies and Procedures

## Service Initiation

Sections 1-3 of the PPPM cover identification and screening of parents and processes to engage those at higher risk in home visiting services:

***Critical Element 1*: Initiate services prenatally or at birth.**

* Through agreements with hospitals, clinics and other health providers, sites identify at risk families either while mother is pregnant (prenatally) or at the birth of the baby.
* Families receive information about the program and if they are interested, give their written consent for participation.

***Critical Element 2*: Use a standardized screening tool to systematically identify families who are most in need of services.**

* After consenting, families complete the New Baby Questionnaire (NBQ), a standardized tool for identification of risk factors associated with poor child/family outcomes.
* Screening process includes giving all parents information about community resources for families, parenting and child development information and individualized referrals to appropriate services.
* Where program capacity allows, home visiting is offered to families showing current/history of depression or substance abuse, or any two risk factors identified on the NBQ.

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

* Healthy Families home visiting services are offered to families on a voluntary basis and cannot be mandated.
* HFO staff uses a variety of positive methods to engage newly enrolled families, build trust and maintain engagement and involvement in the program.

## Service Delivery

Sections 4 – 8 of the PPPM describe the content and the processes for how home visiting services are delivered to higher risk families:

***Critical Element 4*: Offer services to participating families intensely and over the long term, with well-defined criteria for increasing or decreasing the intensity of service.**

* Families are offered weekly home visits for at least the first six months of service (Level 1) after the birth of the baby or after a post-natal first home visit (whichever is longer). After that time, visits may become less frequent depending on family progress (Levels 2 – 4).
* The program is offered at least until the baby is three years old.
* Sites ensure that families are supported upon graduation or leaving the program by utilizing transition planning at least 6 months before families leave the program.

***Critical Element 5*: Services should be culturally sensitive; staff and materials used should reflect the diversity of the population served.**

* Sites demonstrate culturally sensitive practices in all aspects of service delivery. Every two years, sites develop a Cultural Sensitivity Review to ensure that practices are appropriate.

***Critical Element 6*: Services focus on supporting the parent as well as the child by cultivating the growth of nurturing, responsive parent-child relationships, promoting healthy childhood growth and development.**

* Home Visitors conduct the Parent Survey assessment during initial home visits to identify risk factors, stressors, strengths, and better understand the family’s history and situation. All identified factors will be discussed over the course of services.
* Home Visitors complete activities with each family to discuss their beliefs, culture, wishes for their child and the family’s concerns and strengths.
* Home visits last for approximately an hour with the child present.
* Home Visitors observe and provide interventions and activities to encourage and promote positive parent-child interactions and positive parenting skills, as well as focus on health, safety and child development.
* Service delivery is guided by a Family Goal Plan, created together by the parent(s) and the Home Visitor. Steps to achieve goals are outlined and reviewed continually. Home Visitors provide activities, resources and referrals to assist with progress toward goal achievement.
* Home Visitors utilize CHEEERS observations to assess parent-child interactions.
* Home Visitors share curricula with families that helps to promote nurturing parent-child relationships, healthy child development, and preventative health and safety.
* Children’s development is regularly monitored using a standardized developmental screening tool.

***Critical Element 7*: All families are linked to a medical provider; depending on the family’s needs, they may also be linked to additional services.**

* Home Visitors inform families about available health care resources and assist them in connecting with a medical/health care provider for their child and themselves.
* Home Visitors support families in receiving timely immunizations according to current recommendations from Centers for Disease Control and Prevention (CDC) and tracks receipt of the immunizations.
* HVs provide families with preventative child health and safety information based on American Academy of Pediatrics (AAP) recommendations.
* Families are connected to additional services available in the community on an as needed basis.
* Sites ensure services are coordinated with other service providers who may be working with the family.
* Home Visitors strengthen families by addressing challenging issues such as substance abuse, intimate partner violence, mental health concerns, etc.
* Home Visitors conduct depression screening with all families using a standardized instrument and refer families when scores are elevated.

***Critical Element 8*: Services should be provided by staff with limited caseloads to assure that they have adequate amount of time to spend with each family.**

* Home Visitors have limited caseloads to ensure that they have an adequate amount of time to spend with each family.
* A full-time Home Visitor carries no more than 15 family’s at the most intensive levels. Sites pro-rate caseloads for part-time Home Visitors based on their Full Time Equivalency (FTE).
* Full time Home Visitors carry no more than 25 families at various service levels, or no more than a weighted caseload of 30 points at any one time. HFA encourages no more than 20 families and 24 points as optimal. Sites pro-rate caseload size for part time HVs.

## Selection and Training of Service Providers

Sections 9 – 12 of the PPPM focus on personnel, training and supervision:

***Critical Element 9*: Service providers should be selected because of their personal characteristics, willingness to work with culturally diverse communities, and their willingness to do the job.**

* Staff members are selected because of a combination of personal characteristics, educational qualifications and experience.
* All staff and volunteers who have responsibilities relating to families or family files must have a criminal background check before contact with families.
* The site monitors personnel satisfaction and retention at least every two years and addresses increasing staff retention..

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

* All staff receive Orientation Training (separate from core trainings) to familiarize them with HFO’s philosophy, policies and procedures, and the functions of the local site and the state system. Central Administration provides the QuickStart Manual to help cover these areas of training.
* Staff members receive Stop-Gap training, attend Home Visitor Core Training and Assessment Core trainings. These core trainings are 3-4 days in length and offered through Central Administration 2-3 times per year. Supervisors and Program Managers have an additional core training for their position.
* All staff receive ongoing training that takes into account the worker’s knowledge and skill base, as well as the required annual trainings (Child Abuse & Neglect, Medicaid Monitoring, Cultural Sensitivity)

***Critical Element 11*: Service providers should have a framework, based on education or experience for handling the variety of experience they may encounter.**

* Within the first year of service, all staff complete the wraparound trainings on a variety of topic necessary for effectively working with families and children at 3, 6, and 12 month intervals.
* All staff receive Prenatal Training and Family Goal Plan Training.
* The site will have a comprehensive training plan and submit it annually to Central Administration.

***Critical Element 12*: Service providers receive ongoing, effective supervision so they are able to develop realistic and effective plans to empower families.**

* Supervisors will provide staff with clinical, reflective and administrative supervision necessary skill development to continuously improve the quality of their performance while at the same time, holding them accountable for its quality.
* Full-time Home Visitors receive at least 1 ½ hours (2 is preferred) of individual supervision per week. Visitors who work between than 10 – 30 hours/week receive at least 1 hour of individual supervision.
* Each site maintains a ratio of 1 full-time supervisor to 6 Home Visitors. If the supervisor is part-time, the number of Home Visitors is adjusted to maintain an overall ratio of 1:6.
* Supervisors receive supervision at least one time a month, two times is preferred.
* Supervisors receive regularly scheduled supervision
* Program Managers are held accountable for the quality of their work and receive skill development and professional support.

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HFO: In-Depth Look

Reaching the Target Population

(CE 1-1)

As of July 1, 2015, the Healthy Families Oregon statewide program targets all births. Each local site has researched key information about the demographic characteristics of their community and has created priorities to serve their high-risk populations. This information is reviewed and updated every two years:

* Number of resident births per year
* Race/ethnicity/linguistic/cultural characteristics

Community partners where target families can be reached, such as hospitals, clinics, and health centers

* Populations within the area that are at risk for poor childhood outcomes

Collaborate with Partners

HFO sites collaborate with organizations where their target families can be reached. Screening and referrals come from a variety of partnerships including local hospitals, clinics, public health nurses, prenatal and postnatal health care providers, Department of Human Services - Self-Sufficiency and Child Welfare, Oregon’s Mothers Care, OHP and WIC.

These relationships may require formal Memorandums of Agreement and in other cases, may be verbal agreements or informal in nature. In either case, the system of organizational agreements should enable the site to identify families to offer screening services.

Memorandum of Agreement

A Memorandum of Agreement (MOA) is a document that clearly outlines the scope, nature and extent of services provided by each organization. Sample agreements are available from Central Administration.

The MOA should address:

• How your site will identify families of newborns (deliveries within past 24 hours) or expectant parents.

• The role of the community staff and HFO staff.

• Logistical arrangements to be made so screening can be completed in a timely manner (prenatally or within 14 days after the baby’s birth).

MOAs should be reviewed and updated annually, as attrition of sites, staff and other programmatic changes can impact the nature of relationships.

Neighboring Counties

Some families may give birth in a neighboring regions. Cooperative arrangements between sites can address this issue. An MOA can be established between neighboring sites to provide a structure for sending family screens to the county where the family resides. When families consent to screening, they are consenting to HFO statewide, so additional consent is not needed for this transmission of information. However, it may help to clarify expectations about this process among neighboring sites through the development of MOAs.

**Screening (CE 2-1)**

The New Baby Questionnaire (NBQ) screens for a number of risk characteristics research has shown are associated with poor child and family outcomes. While risk factors do not create a “destiny,” the more risks a family possesses raise the chance for poor outcomes. The risk factors identified by the NBQ are strongly correlated with those in the Parent Survey assessment[[3]](#footnote-3).

NBQ risk characteristics

* Teen parent, 19 years or younger
* Unmarried parent
* Late prenatal care (after 12 weeks)
* Lack of comprehensive prenatal care
* Parenting 3 or more other children under age 5
* Parenting a special needs child
* *Both*mother & partner (if present) not employed at least 30 hours/week
* Less than a high school education
* Trouble paying for basic expenses
* Unstable housing
* Problems in marital/family relationships
* Lack of social support
* ***Depression***
* ***Anxiety***
* ***Drinking/drug use issues***
* ***Known involvement in child welfare system***

NBQ Scoring

After the NBQ is administered to families, it is then scored to see how many risk factors are present to determine if the family is eligible for the program. Detailed training on administering the NBQ and the scoring process is located in the Program Evaluation & Forms Manual.

Training Screening Staff

Screening staff, volunteers, and any others who conduct screening **must have an adequate understanding of how to use the screening tool appropriately before they engage in the screening process**, including:

* Knowledge of the HFO program
* Theoretical background of the screening tool
* Process for obtaining written informed consent
* Scoring the NBQ

Training includes watching the training webinar, reading the training material in the Program Evaluation & Forms Manual, practice describing the program and obtaining informed consent, hands-on practice administering and scoring the NBQ.

Home visiting services are described to all families with a positive screen, who are then asked whether they would be interested in receiving home visiting services, if available. Screeners are trained to give families clear information on what follow-up to expect from the site after this initial “offer” of services.

The Program Evaluation & Forms Manual provides training and protocols for in-person and phone screening. Screening staff also need to complete sections 1-5 of the *QuickStart Manual* to familiarize themselves with HFO.

**Informed Consent (CE 3-1 & GA 5)**

By law, Healthy Families Oregon sites must obtain the express written consent of families before services can take place. Sites are responsible for obtaining informed, written consent from families BEFORE beginning the screening process. *Note: phone consent may be given. See PPPM for details.* Sites use a two-step approach to reach as many at risk families as possible in each region:

• **Consent to Contact:**  *Give Your Baby A Healthy Start* (*¡Dé su bebé un comienzo saludable!)* is an optional form that includes a description of Healthy Families. This form can be distributed to potential families by community partners for the parents to indicate interest. Completed forms are forwarded to the local site where staff contact the parent(s) to obtain informed consent for screening.

• **Consent to Participate:** *Welcome to Healthy Families (¡Bienvenidos a Comienzo Saludable!)is the* standardized and required form used to obtain express written consent from the parent. The back of each page explains what is involved in the evaluation and how information will be handled to ensure privacy. If parents give their “express written consent”, as specified in Healthy Families’ legislation, they complete a *New Baby Questionnaire (NBQ)*.

What is Informed Consent?

Prospective participants need to understand the purpose, the procedures, the potential risks and benefits of involvement with HFO as described on the reverse side of *Welcome to Healthy Families*. They need to know they can receive Healthy Families services without participating in the evaluation.

*In addition, prospective participants also must be provided with information regarding local privacy practices to meet requirements of the Health Information Portability and Accountability Act (HIPAA). These are specific to the host agency.*

Details about the consent need to be presented in simple language by someone knowledgeable about the program. Training on obtaining parents’ consent can be found both in *QuickStart Manual* and in the *Forms and Evaluation Manual* (“Red Book”).

HFO Statewide Data Base

Sites enter family information from the *Consent to Participate* form into the HFO Statewide Database, ensuring that consenting families have been provided with information regarding privacy practices to meet HIPAA requirements. Once entered, a family identification number is generated that will be used on all subsequent evaluation forms transmitted to NPC Research.

**Strategies for Screening and Enrollment (CE 3-2)**

Screening is a natural point to involve the community in HFO– as volunteers, in-kind contributors, or providers of a setting for screening to occur. Program Managers ensure that local outreach policies and procedures are described in the Program Policies and Procedures Manual (PPPM).

Effective strategies for reaching new parents include the following:

* Individual screening by partners, staff or volunteers – in hospitals, clinics, social service waiting rooms, and over the phone. Healthy Families Oregon screens can become a part of routine paperwork during prenatal care, the hospital stay, or TANF, WIC, OHP and Oregon Mothers Care (OMC) appointments.
* Screening by partner agencies. Potential screeners include hospital admissions or birth certificate clerks; home visiting nurses employed by hospitals, clinics or public health, and TANF, WIC, OHP or OMC workers.
* Screening in group settings, such as childbirth education or WIC classes, teen parent programs or “baby showers” sponsored by community groups.

Enrolling Families

Home visiting services are described to all families with a positive screen and, at that time, they are asked to indicate whether they would be interested in receiving services if services are available.

*If services are available*, sites use a variety of strategies to contact all families who indicate interest. When services are not available, sites ensure that interested families learn about any other community resources that may be available. Specific procedures are detailed in the local version of the PPPM.

Enrollment strategies that sites have used successfully include:

* Before the first home visit, offer a “sample” to hesitant families to see if they like it and want to continue.
* Provide incentives. Let the family know that the visitor will be bringing “gifts” from the community.
* Ask the parent(s) if the program can help with any immediate needs, and following through with promised help or linkages to services.
* Hold an open house to introduce the program. Assure transportation is not a barrier.

**Monitoring Screening (CE 1-2)**

The process of service initiation begins with screening. Sites monitor the screening process to ensure they are connecting appropriately with the target population. One service indicators focus on the screening process:

**Performance Indicator**

80% or more of screenings occur prenatally or within the first 2 weeks of the child’s birth:

Information regarding this indicator can be found in the NPC Status Report.

On-site monitoring (CE 1-2)

Screening information also is kept on-site for monitoring purposes. It is required that sites track and monitor screens, and to establish and maintain a system to track the information. Smaller sites may prefer to keep the information in a spreadsheet format. Tracking data usually includes:

* Contact date and, if available, child’s birth date (or expected birth date)
* Screening date and result (positive, negative, or refused screen)
* For positive screens, whether family is interested in Home visiting services
* For families interested in home visiting, date of first home visit

Questions to consider while monitoring the screening processes:

* Are processes for offering screening services to target families effective? What are the site’s strengths in identifying and offering services?
* What proportion of targeted families decline to be screened? What needs to happen to reduce this proportion?
* Are partners within the community referring families for screening in a timely manner? If not, why and what can be done to improve the process?

**Acceptance Analysis & Plan (CE 1-2)**

Program Managers are responsible for monitoring acceptance rates on an annual basis, using information from the Status Report as well as local data. Acceptance rates are calculated at two points in time:

1. **Initial Acceptance Rate**
* Counting the total number of participants with a positive NBQ who indicated that they were interested in home visiting services (if available) during the fiscal year (July 1 – June 30) and
* Dividing by the total number of participants with a positive NBQ who were asked if they were interested in home visiting services (if available) during that same time period.
1. **Final Acceptance Rate**
* Counting the total number of participants who receive a first home visit in the fiscal year (July 1 – June 30) and
* Dividing by the total number of potential participant*s* who screened eligible, indicated they were interested in home visiting services (if available) *and were offered* home visiting services during that same time period.

Acceptance Analysis

Every two years at a minimum, Program Managers conduct an in-depth analysis of patterns and trends in the acceptance rate to identify potential improvement strategies. The analysis includes data from the Status Report as well as informal, anecdotal information gathered through discussions with staff and others involved in program services. A standard required *Acceptance Analysis & Plan* template is provided.

The following criteria are included in the analysis:

***Programmatic***factors such as procedures for conducting outreach, staffing issues, training of staff, number of days between screening and offer of home visiting services and program funding,

***Demographic*** factors like age, race/ethnicity, language, marital status, education, and employment status, and

***Social***factors such as employment/school status, available support networks, relationships, and way of life.

Using the Status Report information, note the percentage of families who were offered home visiting services and the percentage of those who accepted the offered services. The latter is the final Acceptance Rate.

* What percentage of eligible families are offered home visiting? What are the reasons for not offering services?
* What percentage of eligible families accept offered home visiting services? What are the reasons families give for declining offered services?

Use anecdotal and other informally-gathered information from staff/partners to analyze site strengths and challenges in facilitating acceptance of services. *If the Acceptance Rate is less than 90%, consider what might be done to increase the rate.*

**Compare subgroups.** Demographic and social data from the Status Report compares acceptance among various subgroups. It may be helpful to display numbers and percentages for your site in chart form. Ask yourself the following questions:

* Are any groups of families more or less likely to accept services than another contrasting group? Do they vary by demographic or social factors?
* What reasons can you think of for any variations? What strategies might increase rates for these groups specifically?

Plan for Improvement

Review the analysis with the staff and your local Healthy Families Advisory Group. Include parents in the review wherever possible. Identify the site strengths in facilitating parent acceptance of services. Discuss the primary reasons for families not accepting services and strategize ways to address these reasons. Based on the review, develop, implement, and monitor a written plan to help increase acceptance rates.

Maintaining Family Involvement

(CE 3-2)

Sites identify a variety of positive methods to engage families, build their trust and maintain their involvement in the program. Guidelines for these strategies are then inserted in the local Policies and Procedures Manual and used in supervision with Home Visitors.

* Engagement strategies that sites have used successfully include:
* Telephone family to see how parent(s) and child are doing. Send a packet of parenting information.
* Send hand-written note (thinking of you, how is the baby?) and follow-up with phone call.
* Mail curriculum handouts that might of helpful, along with a personalized note.
* Offer help with practical concerns, such as getting a WIC appointment, filling out an application, or finding free/low-cost baby supplies.
* Ask if you can bring something for the baby next time, such as a book, quilt or baby clothes.

Creative outreach

When enrolled families have missed a home visit and then have not been available for home visits for at least 10 working days, they are placed on creative outreach for a period of at least 90 days. Many higher risk families have had past experiences with individuals who let them down and did not deliver on promises. Overcoming this kind of past history requires “creative” ways to reconnect, hence the name “creative outreach.”

Creative Outreach Documentation

Families on creative outreach are discussed in weekly supervision and documented on the Service Level Assignment form. Attempts to re-engage the family can be entered on Contact Logs or elsewhere in the family file.

Central Administration offers an *optional* *Level X (Creative Outreach) Tracking Form* designed specifically to monitor re-engagement efforts. This form, printed on pink paper for easy identification, provides information on Home Visitor responsibilities while the family is on creative outreach, and gives space for describing the date, type of contact, and notes about what happened.

Retention Analysis & Plan (CE 3-4)

Program Managers monitor retention rates utilizing information provided in the Status Report. Every two years, managers conduct an in-depth analysis of retention rates and then develop and implement a plan to increase retention.

Retention is a critical quality improvement issue and is measured by two performance indicators:

**Performance Indicators**

75% or more of families engaged in home visiting services for 90 days or longer

50% or more of families remaining in home visiting services for 12 months or longer

Measuring Retention

Families are considered to be enrolled when they have their first home visit – thus, ***retention rates are reported based on the time period between the first and last home visit*.** Rates are calculated as:

* Total number of families who had a first and last home visit during a given period
* divided by the total number of families who had a first home visit (may or may not have had a last home visit) during the same period.

The Status Report provides information on retention rates for 3, 6, 12, 18 and 24 month periods. Rates are calculated for the fiscal year ending two years previously to ensure that all families with children born during that year have had an opportunity to be enrolled for 24 months.

Retention Analysis

The analysis includes data from the Status Report as well as informal and anecdotal information gathered through discussions with staff and others involved in program services. The analysis considers the impact of a variety of factors on family decision-making:

***Programmatic***factors such as staffing issues, program policies, approaches to service delivery, relationships with other agencies, training and program funding

***Demographic*** factors like age, race/ethnicity, language, marital status, education, and employment status

***Social***factors such as existing risk characteristics, available support networks, employment/school status, family relationships, and connections to religious groups, and way of life.

**Retention Rates**

Use Status Report information to chart the percentage of families that remain after 3, 6, 12, 18 and 24 month periods. Is there any pattern to when families drop out?

* What is the median age of the child for exiting families at your site? How does that compare with the statewide median?
* What are the reasons for families dropping out? What informal/anecdotal information do you have relating to the reasons that parents decline further service?

Compare Subgroups

Demographic and social data from the Status Report compares retention among various subgroups. Numbers and percentages for your site can be displayed in chart form. For each comparison, look for differences that are larger than 10-20%.[[4]](#footnote-4) Which groups have lower retention rates? What reasons can you think of for this? Can you think of anything your site could do to increase retention rates for these groups specifically?

Plan for Improvement

Review the analyses with the staff you’re your Healthy Families Advisory Group. Include parents in the review wherever possible. Discuss the primary reasons for families dropping out of services and strategize ways to address these reasons. Based on the review, develop, implement, and monitor a written plan to help increase retention rates.

SERVICE INTENSITY (CE 4-2)

HFO programs use the Healthy Families America (HFA) Level System to ensure that home visiting services are offered intensively and over the long term. Services are most intensive in the beginning and gradually decrease in intensity as families achieve goals and gain confidence and skills.

Using the Level System

The Supervisor and Home Visitor routinely review each family’s progress during supervision. Families with higher needs are able to receive more intensive home visiting services, while less intensive home visiting services are provided to families as stability and progress increases.

While the goal is for families to progress through the levels, families may be moved from less intensive to more intensive levels of service at times, depending on individual needs.

After the birth of the baby, all families begin on Level 1 even if they began on a less intensive level during the prenatal period. Families stay on level 1 for at least six months after the birth of the baby or six months after enrollment (whichever is longer). At that time, if meeting the criteria, families participate in the decision-making process regarding moving to a less intense level of service.

* Level 1-SS is reserved for special circumstances and usually needs the Program Manager’s approval. This level can be used for families who live beyond the usual travel area/time, need an interpreter, or require short term, intensive case management.
* Level X is used for families who have missed at least one home visit
* Followed by at least 10 working days of unsuccessful attempts to reschedule. Level X also can be used for families who are temporarily out of the service area for over one month.
* Families receiving services during the prenatal period may be assigned to Levels P1, P2, P3 or P4 depending on the intensity of services required as determined by the Home Visitor, supervisor and family. However, it is recommended that families stay on P1 for at least the first 4 to 6 weeks to ensure required activities and documentation timelines are met and to encourage the development of a trusting relationship prior to the baby



**Supporting Home Visit Completion**

**(CE 4-2)**

Home visiting is the foundation of the Healthy Families Oregon program and the means by which family outcomes are achieved. Home visits are often described as “doses of prevention” underscoring the importance of completing each visit.

Home visit completion information allows Program Managers to monitor the following service indicator on at least a quarterly basis:

**Performance Indicator**

75% or more of families receive 75% of expected visits based on assigned level

Monitoring

Home visit completion rates are reported in the Status Report. Sites enter Home Visit Completion and caseload information into HFO Statewide Database. This data base tracks the number of home visits completed for each family and auto-calculates home visit completion rates and caseloads for each Home Visitor. In order to meet this standard, Home Visitors are expected to have at least a 75% home visit completion rate.

Reviewing Home Visit Completion

Supervisors review and discuss rates with the Home Visitor, problem-solving ways to improve the home visit completion rate and reinforcing higher rates. Questions to consider:

* Are some families routinely getting lower completion rates than others? What are the barriers for the families not receiving their expected visits? What can be done to reduce the barriers?
* What approaches does the Home Visitor use to schedule home visits? What reminders are used? How might “creative outreach” type strategies be used to improve rates?
* Are there any patterns or trends among the families relating to cultural characteristics? If so, what strategies can be used to ensure families receive the appropriate level of visits?
* Are there any programmatic barriers to home visit completion, such as scheduling issues where part-time staff are working the “wrong hours” for the family? What strategies can be used to address these barriers?

Planning for Improvement

Sites use a variety of organizational strategies and develop the required Plan to Increase Home Visit Completion Rates. Some strategies sites have used successfully include:

* Team approach, where team members may cover for each other during vacations, training or sick days,
* Planning periodic group meetings such as two or three families getting together for a play date, or meeting at the library (home visit components are covered for each family and home visit records completed),
* Flexible scheduling for Home Visitors, including after-hours visits, and/or
* Time management techniques such as scheduling a month at a time and dedicating time for make-up visits.

**Cultural Sensitivity (CE 5)**

For HFO sites, cultural sensitivity has been defined as the degree to which the site continually modifies or tailors its system of service delivery to the cultural characteristics in its service population including:

* Personnel/staff selection
* Training and development assessment
* Service planning, implementation
* Program evaluation/participant care monitoring

Broadly speaking, culture is a way of life of a group of people - the behaviors, beliefs, values and symbols that they accept, generally without thinking about them, and pass along from one generation to the next.

Many people think of culture as only ethnic heritage. Although ethnicity is important, other aspects such as language, gender, sexual orientation, age, religion, social class and geographic origin also play a role.

These elements combine to create a unique cultural identity, based on both experience and history. Understanding a family’s culture helps Home Visitors avoid stereotypes and biases that can undermine their work.

HFO sites are responsible for ensuring that services provided meet cultural sensitivity standards. Program Managers should:

* Know the cultural, racial/ethnic and linguistic characteristics of their service and target populations. Address the needs of the service population through appropriate staff volunteers and community partners, while conducting culturally appropriate outreach to the target population so no groups are unintentionally excluded
* Ensure that all staff receive training in cultural sensitivity which is *unique to the site’s community* within the first 6 months of hire, and annually thereafter
* Ensure program materials reflect the diversity of the current service population and target population, provide materials in families’ native languages and at various literacy levels
* Take cultural and linguistic factors into account when assigning workers to participants and in overseeing Home Visitor/family/participant interactions. Monolingual families are assigned to a Home Visitor who speaks their language. If that is not possible, skilled translators must be provided
* Hiring service providers from the same racial/ethnic background as the families in the program, reflecting the cultural characteristics of the community it services

**Cultural Sensitivity Review (CE 5-4)**

Each HFO site conducts an analysis every two years to assess the extent to which its service delivery systems are culturally competent. The required Cultural Sensitivity Review Template is available to all sites.

At a minimum, the review addresses materials, training and the service delivery system, includes both participant and staff feedback, and identifies future actions to be taken. This analysis is reviewed by staff, the site’s advisory group, and Central Administration staff to ensure the site meets cultural competence criteria.

A workbook for HFA sites, *Cultural Sensitivity: A Process of Self Awareness and Integration*, provides detailed information on conducting the review and is available electronically. The following are a sampling of questions to consider:

**Cultural Sensitivity Training:** What training has the staff had during the year that focuses on the unique characteristics of the families described in the target and service populations?

Are additional trainings necessary to broaden the scope of families with whom staff can work? What training needs are identified for the future and how do they connect with the unique characteristics of the target and service population?

**Culturally Sensitive Materials:**

* Does the site have materials written in the language(s) participants speak? If not, are there resources to obtain them?
* Are the cultural characteristics of the families served represented visually in curricula, videos, brochures, etc.?
* To what extent does the reading level of materials match the literacy level of participants? Is the writing style friendly? Easy to understand?

Service Delivery System

* Is the site able to meet the needs of the target population through the unique characteristics of its staff and its relationships with community agencies? Are there any groups among the target population that the site does not seem to be reaching?
* Any patterns or trends related to cultural characteristics for who is not accepting services? Dropping out of services? Are Home Visitors having higher completion rates for some groups of families than others?
* Is the site able to refer families to both medical providers and community agencies in a manner that respects the family’s individual cultural characteristics? Does the site need to create any new relationships to better serve families in the target and service populations?

**Parent Survey Assessment**

**(CE 6-1)**

HFO uses the standardized Parent Survey assessment to assess ten separate domains that may impact family well-being and parenting outcomes. The Home Visitor conducts a conversational interview with the parent(s) using the Parent Survey *within the first three visits*.

**Parent Survey Assessment Training**

All Healthy Families staff (Home Visitors, Supervisors, and Program Managers) must complete the Assessment Core Training within 180 days of hire. Local sites are required to provide stop-gap training on the use of the tool if they will be conducting the Parent Survey with families before core training. This training includes shadowing a certified staff member, working with the supervisor to learn the theory and practice, and preferably performing their first assessment with a skilled observer present.

Monitoring

Supervisors review, sign and discuss each completed Parent Survey assessment. Documentation is reviewed for thoroughness, accuracy of scoring and presence of referrals. Narrative descriptions for each domain include the family’s own words in quotes whenever possible.

Supervisors ensure that Parent Survey scores are entered into the database. Parent Survey assessments must be completed with no more than one unknown for the primary caregiver.Further, data can’t be used by NPC Research if there are more than two unknowns for the secondary caregiver.

**Inter-rater Reliability Checks** Supervisors complete a *Parent Survey* *Inter-rater Reliability* form for each Home Visitor at least once every 180 days. If a Home Visitor has not conducted a Parent Survey assessment for 180 days, s/he role plays conducting the assessment and writes up the assessment for the review and inter-rater reliability check.

Quality Assurance Parent Survey Observations

Supervisors shadow each Home Visitor for a minimum of one Parent Survey assessment per year, and more frequently for Home Visitors new to conducting the assessment. The *Quality Assurance Observation of Parent Survey* form is completed by the supervisor to summarize the observation and is shared with the Home Visitor during a supervisory session.

**The Home Visit (CE 6)**

The home visit is defined as a *face-to-face* interaction that occurs between the participant(s) and Home Visitor. Home visits last for a minimum of an hour; the child typically must be present.

* Visits may occur outside the home, but the content must match the definition of a home visit. These visits are documented using the *Home Visit Record* (HVR) form.
* A parent group meeting may substitute for one home visit per month for under conditions specified in the PPPM .These are documented using the *Home Visit Record* for every participant in the group for whom a “home visit” is being claimed. Each family for whom a home visit is claimed must have had the kind of interaction with staff that qualifies as a home visit by the criteria given above.

A combination of parent and child related goals differentiates HFO from traditional case management or early childhood education programs. The well-being of children is intimately linked to the well-being of their parents. Therefore, each visit typically includes activities designed around the goals for both, including but not limited to the following:

|  |  |
| --- | --- |
| **Goal: Promoting positive parent-child interactions**Support of bonding and attachmentSocial-emotional relationshipsSupport for parent role as child’s first teacher (language and emergent literacy)Parent-child play activities**Goal: Promoting healthy child growth and development**Child development milestonesChild development screeningChild health and safetyNutritionAccess to health careLinkage to appropriate early intervention services | Goal: Enhancing family functioningPromotion of positive parent-child interactionUsing strategies/interventions to address concerns or reinforce positive behavior between parent and childAssessment toolsCoping and problem-solving skillsHome management and life skillsLinkage to appropriate community resourcesAccess to health careSupport for the reduction of behaviors such as substance abuse and/or domestic violenceCrisis management Advocacy |

Monitoring Home Visits

(CE 6, 12, GA)

Home visits are documented using the standardized *Healthy Families Oregon Home Visit Record* *(HVR)* and are written within 48 hours of contact with families. The HVR is available as (1) a “form-fill” document for entering information on the computer and (2) a lined format for completing the record by hand.

Reviewing the Home Visit Records

Home visit records provide the structure for the supervision and are reviewed *prior to* the supervisory session. The review ensures appropriateness of support activities for the family, CHEEERS observations and strategic interventions, including referrals, parent-child activities, service level assignments and the timeliness and thoroughness of documentation. In reviewing the cases, the supervisor must keep in mind:

* How is the relationship (Home Visitor and family) impacting the family’s ability to develop competencies and become empowered to pursue their goals?
* How is the Home Visitor promoting positive, nurturing parent-child relationships in the family?

Sometimes Home Visitors find it difficult to see the progress families are making, or they are unable to assess for themselves the progress that they are making with a family. Supervisors can help to recognize the areas in which the family and/or the Home Visitor are achieving success.

Shadowing Home Visits

Supervisors accompany each Home Visitor they supervise on a home visit at least once annually and more frequently for new Home Visitors. The Supervisor reviews the Home Visitor’s documentation of the visit to assure it is consistent with the Supervisor’s observation. The *Quality Assurance Observation of Home Visit* form is completed by the supervisor and overall performance is described in terms of strengths identified, ideas for next time, and any necessary follow-up.

Phone Calls to Families

Every six months, supervisors contact two families per Home Visitor to determine parent satisfaction. Central Administration requires the *Quality Assurance Phone Survey for Active Families*form filled out that provides introductory language and then asks questions such as:

* What do you like best about Healthy Families?
* What happens on the visits?
* How would you like to see HFO changed?

The bottom of the form is for follow-up such as feedback to the worker, and whether any corrective actions were taken.

Family Goal Plan (FGP)

During the first few visits, the Home Visitor works with the family to identify needs, and the strengths or competencies the family has to address their needs. This along with the Referrals and Concerns form*, Family Values Activity* and *Wishes for my Child* help build a foundation for goal setting. The *Family Goal Plan* (FGP) is developed within 60 days of the first home visit.

With the Home Visitor’s support, families are encouraged to set at least one goal every six months. The family works on one or at the most two goals at a time. The goal is broken down into mini steps that will help ensure success. Having regular conversations about goal helps parents develop creative problem-solving skills and increases their sense of power over their situations.

Continued review by the parent, the Home Visitor, and the supervisor, helps families accomplish their goal. Additionally the FGP helps to guide service delivery. If a FGP is not developed, there is no road map for where the family is hoping to go. Still, most HFO families have had little experience in setting goals and creating change in their lives. Home Visitors often find it challenging to engage parents in the process. *Supervisors play a key role in supporting this process.* Here are a few tips:

* Encourage the Home Visitor to spend more than one visit developing the FGP
* Help the Home Visitor feel comfortable with the process by practicing and role-playing
* The goal of the FGP process is for families to feel empowered, not to further the program’s agenda. Home Visitors must avoid taking control and suggesting goals to the family. Encourage Home Visitors to keep asking questions so that the families explore what they really want.
* Assist the home visit to honor the family’s ideas even when goals appear unrealistic. If families are unable to meet the goals, see if they are prepared to make them more realistic. Don’t shortcut their learning process by spoon-feeding them goals, or judging their goals. “Unreachable” goals may be just the catalyst needed to get a family moving in a positive direction—but specific, small goals leading to those are the focus of the FGP and the ongoing work. Building on and celebrating small successes develop confidence and help the “big goals” to become more realistic.
* Coach Home Visitors on how to ask families about their activities towards the goals in a way that is positive and supportive, not judgmental. Open-ended questions such as “How are things going?” are helpful.
* Remind Home Visitors to read the FGP before they go on a home visit. This gives them an opportunity to discuss activities related to the family’s goals.
* Read FGPs regularly and during supervision, ask Home Visitors “where is the family on this particular goal?” Doing this models a parallel process for Home Visitors to go back to their families and check in with them about their FGP goals.
* Conduct a formal review of the FGP every 6 months, at a minimum.
* Provide “refreshers” for your staff on the FGP process. Have them pair up and help each other develop their own FGPs as a refresher exercise. Ask them to bring in some challenging situations to discuss.

Home Visitor Plan to Support the Family

The Supervisor and Home Visitor collaborate develop a Home Visitor Plan to Support to the Family (HVP), intended to thoughtfully focus on specific ways to support the family in meeting HFA goals. An initial approach is developed in conjunction with reviewing the Parent Survey with the Home Visitor in supervision. *The HVP addresses risk factors from the Parent Survey by strategizing on ways to build protective factors for families.*

Home Visitor Plans build on information from the Parent Survey and Home Visitor observations to get a picture of overall strengths and challenges. Areas of focus are targeted to high priority needs and/or issues that may or may not have been identified by the family but relate to the HFA goal areas of family functioning, parent-child relationships and child development.

Recognizing parent strengths, the Supervisor and Home Visitor discuss potential barriers/challenges for each focus area and develop strategies and activities to address the concerns. The HVP is kept in the supervision notebook and is meant to guide supervision discussions. A copy is given to Home Visitors or Home Visitors may document the strategies in another way. HVPs are working documents and need to be updated frequently with at least one area of focus current at any given time.

Curriculum Resources

HFO policy specifies that curricula are selected and used to meet the individual needs of the family with special attention to the interests of the family and any cultural, linguistic and cognitive factors that may be present.

All child development, health and safety information given to parents are in accordance with the recommendations of the American Academy of Pediatrics ([www.aap.org](http://www.aap.org)).

Supervisory Guidance

Supervisors provide guidance on curriculum resources to help Home Visitors weave information and materials together in a way that keeps parents interested, excited, and involved in their child’s development. Typically, resource materials focus on:

* Information on child development milestones
* parent-child activities that are appropriate to child’s developmental level and foster bonding and attachment
* health and safety such as prevention strategies or needed interventions

Some curricula that may be used are:

***Healthy Families San Angelo*** The focus of this curriculum is building healthy parent/child relationships and developing positive self-esteem in the child. Developmental stages, developmental needs, and parenting skills are among the topics covered. Lessons are written at a level most parents can understand. Available in English and Spanish.

***Parents as Teachers Born to Learn*** provides child development and parenting information for ages prenatal through 3 years, offering practical ideas on ways to encourage learning and parental interaction with children. To use the curriculum, Home Visitors must attend a 5-day training to become certified parent educators. Available in English and Spanish.

***Growing Great Kids*** prenatal to 36 month, evidence-informed curriculum that focuses on growing nurturing, empathic, parent-child relationships and strong attachment. This curriculum comes with parent-child activities, is culturally sensitive and father friendly. The curriculum was developed to meet the needs of families under stress.

***Partners for a Healthy Baby*** begins during the prenatal period and covers parenting issues during the first 3 years of life. Organized month by month, the curriculum includes instructions and prompts for Home Visitors and color handouts for families. Available in English and Spanish.

***HFA Great Beginnings Start Before Birth*** supplies service providers with strategies for supporting families during the prenatal period. Based on best practice standards, with a special focus on the psycho-social issues facing expectant parents, Home Visitors learn how to help parents enhance prenatal bonding, stimulate brain development and reduce stress, thereby increasing healthy mother/baby birth outcomes. Available in English and Spanish.

Monitoring Child Development

**(CE 6-6)**

The HFO program use the Ages and Stages Questionnaires® (ASQ) and the Ages and Stages Questionnaires® – Social-Emotional (ASQ-SE) to monitor children’s development. Both instruments have been shown to be reliable as a first-level screening program to identify those children who are in need of further evaluation to determine whether they are eligible for early intervention services.

* ASQ: Screens five developmental areas: communication, gross motor, fine motor, problem solving, and personal-social development.
* ASQ-SE: Screens seven behavioral areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people.

Questionnaires are completed by the parent with the Home Visitor’s assistance. Site staff converts each response to a point value, totals these values, and compares the total score to established screening cutoff points.

**Performance Indicator**

100% of children receive developmental screenings

Program Responsibilities

Home Visitors use the ASQ and ASQ-SE at designated timeframes (ASQ: 4, 8, 12, 18, 24, 30, 36, 48, and 60 months and ASQ-SE – due every six months) to monitor children’s development. The ASQ and the ASQ-SE must be administered within 30 days of the due date to ensure validity. Due dates are adjusted for babies born prematurely (36 weeks + 6 days or less). *Information on results is transmitted to NPC Research on a timely basis using the Family Update form.*

ASQ Training

All staff are trained prior to using the ASQ or ASQ-SE. Training dates are entered into the database. Training includes reading the ASQ manual, watching the training video, observing a qualified staff member administer the tool, being observed administering the tool, and receiving orientation to local Early Intervention (EI) services. The date if the first independent ASQ and ASQ-SE screening is entered into the HFO Statewide Database.

**Home visiting** is based on a relationship between parents and home visitor, encouraging parents to disclose personal information to their visitor. Ensuring family rights and confidentiality of information is an ethical obligation of all family support programs.

Family Rights and Confidentiality

On or before the first home visit, families are informed of their right to confidentiality using the standardized *HFO Family Rights and Confidentiality* form:

* All HFO sites use the same standardized form (available in both English and Spanish) to outline family rights and program expectations.
* Instances where information may be shared without the family’s consent are explained (i.e. mandatory reporting).
* The backside of the form describes confidentiality procedures including who can see material in the family file and how the information will be used for evaluation.

Security

Precautions are taken to ensure participant and staff information is secured so only authorized personnel have access to this information. This includes using locked file cabinets to store paper files or, for database users, using a password protection system. Procedures need to be in place to ensure former database users no longer have access.

Child Health and Safety Information

(CE 6-5)

Home Visitors regularly provide families with preventative child health and safety information that is based on recommendations from the American Academy of Pediatrics (AAP). Many sites have a library of safety information to provide families with at regular intervals during participation in services, for example, SIDS information provided at the beginning of services, home safety information discussed when the child is starting to crawl, etc. Other helpful information can be found on the AAP website, [www.aap.org](http://www.aap.org). Information provided to parents is documented on the Home Visit Record.

Developmental Delays (CE 6-6)

Sites follow the guidelines in the PPPM for tracking and following through for children suspected of having a developmental delay.

Home Visitors ensure integration of services between HFO and Early Intervention (EI). If children do not meet eligibility criteria for EI, Home Visitors ensure the family is encouraged to stimulate the child’s development and continue to conduct screening to monitor progress.

Immunizations (CE 7-2)

Families are supported in getting timely immunizations for their children. Some children may be ill or have other reasons preventing them from receiving immunizations according to the identified schedule. While children may not necessarily receive immunizations “on time”, it is essential to keep them up-to-date.

Home Visitors provide immunization schedules as recommended by the most current guidelines from the Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov)) and track the child’s immunizations. Individualized schedules with appropriate dates for coming immunizations can be printed from the CDC website by entering the child’s birthdate. Schedules are shared with families; copies are kept in the family file with dates for completion of each immunization.

**Health Resources (CE 7-3)**

Today’s families typically have a wide variety of needs. While sites can address some of the needs, other organizations in the community will provide needed services. HFO sites assist *all* participating family members to establish a consistent medical provider for health care. Medical/health care providers are defined as any health care provider licensed by the state. Information is recorded in the family file.

Referrals to community services

(CE 7-3)

Based on information gathered in the assessment process, and needs expressed by the family during the development of the FGP and home visits, families receive appropriate referrals for available community services that they may need. Some examples of community referrals include, basic needs, mental health support, housing assistance and intimate partner violence help. Follow-up ensures that families are connected to needed resources in a timely manner.

All referrals and follow-up activities are discussed in regular supervisory sessions and documented on the Home Visit Record.

Community partners

Be sure that staff are updated on community resources regularly so contacts can be facilitated. Nurturing relationships with community partners means better services for families. Sites are encouraged to invite partners to speak at staff meetings on a regular basis.

Addressing Challenging Issues

(CE 7-4)

Families participating in Healthy Families have challenging issues that they deal with frequently. Addressing these issues in home visits strengthens families by encouraging families to possibly become “treatment ready” and also understand the impact of untreated issues. Sites follow the procedures in the PPPM and Home Visitors actively address these issues to build protective factors. These interventions by Home Visitors are documented regularly on the Home Visit Record.

Depression Screening (CE 7-5)

Home Visitors screen families for depression both during the prenatal and postnatal period, assisting parents in becoming aware of potential depression, and determining if there are depressive issues that need to be addressed by a clinician.

Each site has identified a standardized depression screening tool, either the Edinburgh or PHQ-9, that is utilized at specific intervals as stated in the PPPM. Follow up and referrals for families with an elevated depression score is required to help support the parent’s mental health.

Home Visitor Caseload Management

(CE 8)

Reasonable caseload expectations for staff help to ensure that HFO sites provide necessary services to achieve success without risking worker burnout. Limited caseloads ensure that Home Visitors have enough time to spend with each family to meet the family’s needs and to plan for future activities.

* Full-time Home Visitors carry no more than 15 families at the most intensive levels (Levels 1 and 1-SS).
* Full-time Home Visitors carry no more than 25 families at various service levels, or no more than a maximum total weighted caseload of 30 points at any one time.
* HFA highly recommends that weighted caseloads be between 18-24 points and a maximum of 20 families at the most intensive levels for a full-time home visitor.
* Sites pro-rate caseloads for part-time Home Visitors based on their full-time equivalency (FTE).
* The amount of families on a Home Visitor’s caseload who have elevated Parent Survey scores (40 or above) are taken into account when looking at a Home Visitor’s appropriate caseload size and is adjusted due to the additional time it takes to work with these high risk families and provide quality services.
* Circumstances may arise when caseload size is exceeded, such as when a Home Visitor leaves and the caseload is dispersed among existing staff members. This practice must be limited to 3 months or less and sites are encouraged to clearly document the reasons and time period for the deviation.

**Personnel Practices (CE 9)**

Healthy Families Oregon sites administer personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, handicap or the religion of the individual. Each site must have a written Equal Opportunity Policy that clearly states its practices in recruitment, employment; transfer and promotion of employees.

Hiring Practices

Careful hiring practices are critical to successful delivery of services and include:

* Job descriptions that detail essential functions and responsibilities, requirements for education and
* experience, and any preferred personal characteristics[[5]](#footnote-5)
* Notification of its personnel of available positions before or concurrent with recruitment elsewhere
* Utilization of standard interview questions that comply with employment and labor laws
* Verification of 2-3 references and credentials

HFO sites may hire people who were previously enrolled in the program provided that at least one year has passed since the applicant participated in the program. Standard hiring procedures must be followed. The applicant’s HFO family file is kept locked and inaccessible to all staff during the hiring process and, if the individual is hired, during the duration of employment.

Research supports that fact that educational preparation alone should not be the basis for identifying individuals who will provide services to families. Without staff that are able to forge a relationship with parents that will facilitate and maintain positive parenting, the goals of HFA cannot be met.

The selection process should attempt to identify individuals who are:

* Nonjudgmental
* Compassionate
* Able to establish trusting relationships
* Work closely with their supervisors and have reflective capacity
* Advocate for themselves and families
* Work as team members

Background Checks (CE 9-3)

Sites ensure the safety of the families and children served by conducting criminal background checks on all prospective employees and/or volunteers who have responsibilities relating to families or their files. This is a sentinel standard.

Criminal background checks are conducted before contact with families and should include all states of residence in the past and records verified against all known names and social security numbers.

Sites are also encouraged to conduct background checks on Supervisors and Program Managers. Sites are not required to conduct background checks for licensed staff if the site has verified that background checks are part of the licensing process.

Staff Retention Analysis & Plan

(CE 9-4)

As a part of personnel management, sites measure and evaluate the rate of personnel turnover every two years. Turnover is examined for a given period, such as one or two years. Turnover rate is calculated as:

* The total number of staff who leave during the period divided by
* The total number of staff during the same period

Turnover rates are examined both for the site as a whole and for the various job categories to identify any patterns or unusual levels of turnover specific to certain categories.

Staff are given an opportunity to complete an exit survey. In addition, Supervisors are required to offer optional exit interviews to all staff leaving the program.

Turnover rates are examined in the context of job satisfaction as evidenced in interviews and/or surveys. Reasons for leaving are analyzed and actions are taken to correct any identified problems.

Staff Retention

Program Managers must continually think about ways to retain staff members. Turnover in this field can be high. While salaries and benefits play an important role, people are more likely to leave for reasons related to career progression, seeking new challenges and achieving greater recognition.

Job satisfaction

A variety of approaches support staff engagement and enthusiasm, key components of retention. Staff members need to know they are valued. Nurturing staff should be ongoing, day-to-day activity built through clear and open communication.

In addition, Program Managers can seek out opportunities for staff development that will open new doors and expand skill sets. Career development doesn’t only mean promotion to a more senior level. Rather, it means moving through different stages of contribution, each one adding more value to the individual and the program.

Other contributors to job satisfaction are time off, office space, special tasks that recognize skills and public recognition for achievements.

Intensive Role Training (CE 10)

Research supports formal training to prepare staff to assume the responsibilities of their job because of the following:

* Formal training prepares Home Visitors to assess families; strengths and needs, assist with the parent-child relationship, provide accurate information to the family, engage in appropriate case management activities, and meet certain standards of service delivery.
* Formal training also prepares Supervisors and Program Managers to support the program and provide reflective leadership to staff.
* Training establishes a link between theory and practice for all new staff.
* Training provides the opportunity for Home Visitors to develop and implement practical approaches to real situations in a safe environment.
* Training allows staff to share information and experiences and to learn from each other.
* Training helps Home Visitors feel supported in their work and promotes their professional development.
* Intensive role training for all staff ensures consistent service delivery and allows for improved program outcomes.
* In order for sites to provide quality services, the staff must be trained in the specific tasks of the job.

 It is required that all new staff, Home Visitors, Supervisors, and Program Managers, receive intensive training specific to their role as well as be oriented to the Healthy Families program in Oregon and Healthy Families America. If staff are not able to receive the core training before providing services, stop-gap training must be provided by the site.

HFO Central Administration has created training tools that will help guide new staff in completing all of the core trainings and orientation requirements. The *HFO Required Training Log* is the standardized form that all new staff are required to complete that will track these trainings.

Required Training (CE 11)

HFO standards require staff to have training in a variety of topics that are relevant to the field of home visiting. Web-based training for all of the areas is available to meet this standard. Each new staff is required to watch the competency-based modules within the 3, 6 , and 12 month timeframes detailed in the PPPM.

 Training for HFO site staff is an ongoing process, designed to ensure that children and families receive high quality services. Training should be geared to the unique aspects of home visiting services and be culturally sensitive, taking into account each staff member’s skills and needs. Annual ongoing training that is required for all HFO staff includes Medicaid/Mott Refresher, Child Abuse and Neglect Reporting, and Cultural Sensitivity training. These trainings are the responsibility of site leadership to make sure that all staff receive and document them within the required timeframe.

Training Records

Trainings are documented by training certificates, brochures or agendas that describe the content of the training and information about the qualifications of the trainer.

Initial Training Plans

Sites are required to have an Initial Training Plan that is used as a tool for newly hired staff. This will include the use of the HFO Required Training Log to track all initial training with newly hired staff. It’s very important to follow the timeline on the log to ensure that all staff receive required trainings before working directly with families, performing supervision, or performing certain activities.

The initial training period lasts for one year after the hire date. After all of the required trainings are completed, staff will

Documentation for all trainings, except for the core trainings, is a site level by inputting trainings into the database and completing the *Documentation of Learning* form.

Documentation for self-study should include (1) what was studied, (2) author or producer of the materials, (3) what was learned and (4) how learning was assessed. Central Administration provides a required form, *Documentation of Learning through Training or Self Study*, for this purpose.

All training is recorded in the database within 30 days of the training and approved by the supervisor.

Annual Training Plan

Sites develop a comprehensive annual training plan after the initial training plan has been completed. This plan assures timely access for all staff to training and includes ongoing training topics, selected to meet the needs and interests of current staff as well as the required annual trainings.

Remember that after the first year of service, staff are required to have at least 20 hours of ongoing training. Ongoing training often focuses on new information and/or specialized aspects of the position.

Individual Training Plans

Together with the Supervisor, each staff member creates an individual training plan that recognizes existing knowledge and competencies.

The plan shows how any training requirements will be met and identifies additional training topics that would be beneficial in enhancing job performance and supporting professional development. Elements of the plan include:

* Training goal–overall results or capabilities attained
* Training objectives–what you will be able to do as a result of the learning activities
* Learning methods/activities–what you will do to achieve the objectives
* Evaluation–assessment of what you learned

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# Supervision (CE 12)

Supervision of staff plays a critical role in the success of any program. Staff, who often work autonomously, need ongoing input from Supervisors to ensure that the work they are doing is consistent with program goals. Home Visitors receive a minimum of 1.5 to 2 hours per week if they are .75 to 1 FTE. Part-time staff that are .25 to .74 FTE receive 1 hour per week. Staff that are less than .25 FTE can have variable supervision duration based on their workload and schedule. Scheduled supervision is not split into more than two regular sessions. A Supervisor or “acting supervisor” must be available at all times a home visitor is working with families for support and consultation.

Supervision serves multiple purposes:

• Promotes both staff and program accountability

• Encourages personal and professional development

• Can reduce staff burnout and turnover

• Enhances the quality of service families receive

• Provides opportunity to teach, develop skills, and offer support

• Provides opportunity for supervisor to learn from staff

Types of Required Supervision

*HFA requires each Healthy Families site to provide staff with the following areas of supervision, both inside and outside of supervisory sessions:*

**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.

**Administrative Supervision** relates to the oversight of program policies, rules and procedures, and adherence to the Best Practice Standards.

**Clinical Supervision** is focused on the family, is 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.

Essential Features of Supervision

***Reflection*** *–* Sensitivity, authentic listening skills, explaining things well. Reflection helps the Home Visitor come to terms with what it means to go beyond doing what comes naturally in helping families to becoming a professional who work with families. The Supervisor should offer an enlarged perspective, another set of eyes, a mirror.

***Collaboration*** *–* Mutual respect, giving staff autonomy, constructive handling of conflict, willing to work alongside the Home Visitor. Collaborative relationships involve shared posed, clear mutual expectations and shared communication.

***Regularity*** – Time must be allocated and protected. Supervision is, above all, a relationship. The same steps utilized in developing trusting, supportive relationships with families should also be evident in the supervisory relationship.

Parallel Process

Reflective supervision is parallel to the service delivery process. Supervisors facilitate the conversation in the same way the Home Visitor works with the family by:

* Engaging in a two-way conversation about issues
* Genuinely listening to the staff member’s perspective and ideas
* Fostering creative problem solving

*Using the parallel process, the supervisor will rarely give advice or suggest solutions. In effect, the supervisor takes on the role of coach as she supports the staff member’s professional growth and the resolution of a specific problem.*

Both the Supervisor and Home Visitor should be able to observe the parallel between the relationship the Home Visitor establishes with the families to the relationship that the Supervisor and Home Visitor develop with each other.

The relationship between the parent, Home Visitor and Supervisor forms a triangle in which the Home Visitor has a relationship with the parents just as the supervisor has a relationship with the Home Visitor. The same qualities a Home Visitor demonstrates to establish the relationships with the parents are equally important for establishing a trusting, mutually supportive relationship between the Home Visitor and Supervisor.

Home Visitors have a very challenging and often stressful job. They are working with families that have multiple needs and are sometimes confronted with crisis situations. Staff working in these settings sometimes find it difficult to see the progress families are making, or they are unable to assess for themselves the progress that they are making with the family. During individual supervision, the Supervisor helps the Home Visitor recognize the areas in which the family and/or Home Visitor are achieving success.

It is hoped that the supervision session parallels best practice for home visiting by:

* Building trust
* Practicing rapport-building skills
* Demonstrating respect
* Building on strengths
* Accentuating the positives
* Practicing intervention strategies that support Home Visitors in critical thinking and problem solving

Keys to Motivating Staff

*Encourage team building:*

* In addition to regular supervisory sessions, foster time for staff to learn and share with one another
* Incorporate educational and fun activities into the agency’s work plan.
* Share outcomes of program evaluations

*Let staff know that they are valued:*

* Create opportunities for staff input in planning the direction of the agency
* Hold a staff retreat at least once a year
* Encourage staff to play a role in the hiring process
* Allow staff to attend and speak at conferences
* Create a staff development fund for conferences
* Develop a career ladder to encourage internal promotions
* Create an environment that encourages creative thinking
* Design the office space to promote interaction
* Set aside periods of time for brainstorming
* Put staff suggestions into practice
* Encourage staff to be in touch with other service providers of similar programs
* Encourage staff review of key journals that your agency receives

Accountability and Skill Development

All direct service staff are held accountable for the quality of their interactions with families on a regular and routine basis. Supervisors evaluate the performance of staff and shadow assessments and home visits. They ensure accountability and provide feedback encouraging professional development.

Documenting Supervision

Supervisors are responsible for keeping records of each supervisory session with Home Visitors.

HFO requires that Supervisors keep information in notebooks, either with a separate notebook for each supervisee as well as a section for each active family and staff section.

Reflective Supervision is documented on the standard required *General Weekly Supervision* form. Strategies, outcomes and next steps are documented on the standard required *Family Progress Review* form.

* *Supervision notes* provide detailed information about the session to show that supervisees are provided with (1) Clinical, (2) Administrative, (3) and Reflective Supervision.

Weekly Supervision (CE 12)

The purpose of weekly supervision is to offer an opportunity for Home Visitors to:

* Update Supervisors on what is going well and what concerns there are regarding all families on the caseload
* Receive support, guidance and suggestions on each family as appropriate
* Review in detail families in crisis
* Receive feedback on what they are doing right
* Vent! Home Visitors can discuss their frustrations, boundary issues, and when they are having trouble with families
* Discuss and plan what paperwork is due in the near future (next 30 days)

***It is not enough for Supervisors to do case management. In supervisory sessions, the Supervisor inquires about and reflects on the following:***

* The Home Visitor’s observations and interventions. How family members behaved and what they said as well as how the Home Visitor responded, etc.
* What the family values, strengths, and commitments are?
* What is the Home Visitor’s commitment to the family?
* Where does the Home Visitor get stuck with the family and why?
* How the family’s methods of interacting might be in conflict with the Home Visitors values.

*It is the supervisor’s responsibility to help the Home Visitor align oneself with the families and to creatively explore methods of intervention that support family growth.*

The Home Visit Record will be the structure for the supervision. The Supervisor will review the home visit records prior to supervision. Notes should be taken while reading the record to provide the structure for the supervisory session. The focus on supervision is parallel to the Home Visitors work with families.

Here are some sample questions or areas you may want to explore with the Home Visitor in supervision:

1. Who participated actively in the home visit?
2. What is the home like and is it safe for those who live there (pets, rodents, family violence, dangerous and unpredictable people, indicators of substance use/abuse, mental health problems, adequate heat, safe water, sanitation. Etc.)?
3. Have there been any significant changes since the last home visit?
4. What were the parents focused on (the child, relationships with others, domestic violence, expanding support systems, personal problem solving, etc.)?
5. Are there any indicators of substance abuse and/or mental health concerns? (Appropriate referrals made)
6. How are the parents demonstrating problem-solving skills? How is the Home Visitor assisting in this area?
7. What community resources is the family using?
8. What were the CHEEERS strengths? What were the interventions for the concerns in CHEEERS?
9. Is the baby up-to-date on well-care checks and immunization?
10. Are there any developmental concerns requiring interventions? If there are concerns, have referrals been made? How are parents and Home Visitor following up with these referrals?
11. What did the Home Visitor observe the parent saying or doing with the other children?
12. Are these children safe and healthy? Do they need referral to community resources?
13. Discuss any interventions the Home Visitor did regarding the other children and their relationships with the parents.
14. How did the Home Visitor use the curricula or assessment instruments and how did parents respond?
15. Discuss how the parents are incorporating this information into their relationships and daily living.
16. Supervisor should discuss and explore any boundary issues that might be impacting the relationship with this family.
17. What great thing did the parent and child do?
18. When did the work feel good, effective?
19. When did the child (parent/visitor) feel secure (valued/successful)?
20. When was your work most successful?
21. When did the parent seem most engaged?
22. What did you do that seemed most helpful?
23. What interventions were successful?
24. Are there any interventions you could use next visit?
25. Do you like to go to this home? (Why, why not?)
26. What was a successful approach that acknowledged the concerns and moved to action or a plan?
27. How did you help the parent feel in resolving concerns (guidance used vs. fixing)?
28. Who took the lead in this visit? (Home Visitor, parent, other)

Constructive Feedback

*It teaches. It motivates. It facilitates change. It improves performance.*

Feedback can enhance communication, generate new and better ideas, and support goals. It helps Home Visitors know where they stand and keeps them on track. It takes discipline, practice, and commitment.

*Feedback is only productive when it serves two functions.* The first and most obvious is **to discover —** identifying pluses and minuses of behavior. Improved performance comes more easily to people who are made aware of both the positives and negatives — their strengths and weaknesses.

Too often though, the process stops there. The second function of effectivefeedback is **to instruct**. Feedback is fundamental to learning and improving. Not only should we critique specific behavior(s), but as supervisors, we must indicate how or why such actions will produce a good outcome or a poor one.

*Feedback should be constructive*. Whether positive or negative, the purpose of feedback is to enhance performance and produce better outcomes. Flawed technique can quickly turn a feedback meeting into a fruitless scolding. Instead of blurting out every thought that comes to mind, successful supervisors are cognizant of how their words will be perceived by others. Keep the outcome in mind. Do you want the person to get angry or beat themselves up after the discussion, or do you want them to start fixing the problem? Maintaining a helpful attitude will keep feedback recipients comfortable and motivated to listen.

*Feedback should always be specific*. Global statements are to be avoided. No one can respond adequately to vague generalizations about performance.

*"That was a nice presentation,"* gives a person little to go on.

A more explicit assessment, such as: "*The information you presented was easy to follow. You looked confident, and your overheads highlighted your major points effectively,"* provides ample direction and establishes some firm performance expectations.

*Feedback should be immediate.* "Just-in-time" delivery keeps production on track. Likewise, "just-in-time" feedback keeps performance on track. Don’t wait for annual appraisals or other traditional feedback encounters. The shorter the interval between the work and the feedback, the more effective it will be. Such immediacy also implies the work being performed has importance. Seize every opportunity to provide constructive feedback.

*Feedback should be depersonalized*. The consequences that make all of us uneasy about giving feedback are usually produced when feedback becomes personal. Potential conflict and discord can be minimized by keeping the discussion on the issues. Focus on behavior, not on the person.

A simple tactic can be employed to keep feedback both impartial and constructive. When offering corrective feedback, use first-person statements. When offering positive feedback, use second-person statements. This may sound too simple, but it’s not an oversimplification It really works!

Performance feedback can be given two ways: through constructive feedback or through praise and criticism.[[6]](#footnote-6) Praise and criticism are personal judgments about performance- so these are best avoided. Instead, supervisors provide specific feedback to staff. Constructive feedback is information-specific, issue-focused, and based on observations. It comes in two varieties:

• Positive feedback is news or input to an employee about an effort well done.

• Corrective feedback is news or input to an employee about an effort that needs improvement. Corrective feedback provides information that helps to change behaviors so better outcomes will result. It’s normal that corrective feedback will need to be given at times to any employee.

Tips for giving feedback

Constructive feedback is collaborative, informative and non-judgmental. Here are a few tips for giving constructive feedback:

1. Start off by checking in with the person.
2. Begin each key point with an “I” message, such as “I have noticed, I have observed, I have seen” or when the need exists to pass on feedback from others, “I have had reported to me . . .” “I” messages help you to be issue focused and get into specifics.
3. Identify the behavior that you want to see changed. Direct your feedback at the action, not the person.
4. Make your comments specific and base them on observations, not interpretations. Instead of “You always miss deadlines” say “You missed the March 30th deadline for completing the Family Update.”
5. In positive feedback situations, express appreciation. That alone is praise. When you add specifics, your message carries an extra oomph of sincerity.
6. In corrective feedback situations, express concern. A tone of concern communications a sense of importance and care and provides the appropriate level of sincerity to the message.
7. Be sincere and avoid giving mixed messages. Mixed messages such as “Susan, you’ve worked really hard but . . .” create contradictions. In essence, putting “but” in the middle tells the other person, ‘Don’t believe a thing I say.’
8. Make sure the other person understands the reason for your feedback.
9. Don’t belabor the point. Keep it short and sweet -- no lectures. Follow up with something positive.
10. Offer incentives for changed behavior. Offer to help the person correct the problem.
11. Effective feedback needs to be specific and timely. Praise should be also be public, and a reprimand should be private.
12. Honest feedback, delivered at the appropriate time and place, can be a highly effective tool for employee morale.
13. Consider your motives for giving the feedback - Are you really trying to “help" the other person or show your superiority? There is seldom a more inaccurate statement than the often repeated, “I am doing this for your own good.”

Team Meetings

Because isolation from colleagues can create a serious occupational hazard and lead to burnout, team meetings take on even greater importance. Staff can share information and enjoy the support of other team members during these meetings, although they do not provide a substitute for individualized supervision.

Consider the following recommendations for team meetings:

* Team meetings form the foundation for reflective practice.
* The atmosphere of the team meeting encourages a feeling of inclusiveness. Staff input is valued and, if at all possible, included in the site’s decision-making process.
* Sites have team meetings on a regular basis (weekly, bi-weekly or monthly) and insist that *all* members of the team attend. Remember to begin and end on time.
* If a team is comprised of part-time workers, extra time is allowed for these members to come to the meeting, or a time should be determined that will allow them to attend.
* An agenda is created for each meeting and an opportunity given for each staff member to add to the agenda.
* The meeting is no longer than 1 to 1 ½ hours and is divided into three main components:
* Business/administrative (i.e., changes in policy or procedures, general agency information, etc.);
* Supportive (time for staff to discuss challenges that could be addressed through team input); and
* Educational (an opportunity for learning and sharing of new information).

Team meetings provide an excellent opportunity for building and restoring staff morale. Every team meeting does not have to be only business. One meeting every other month could be dedicated to fun and team-building activities such as potluck dinners or lunches, stress relief activities or make-it/take-it workshops. Some sites hold periodic meetings away from the office. The meeting’s agenda still contains business and educational items but the changed atmosphere allows the staff to develop and maintain supportive relationships with each other.



Data Monitoring

Supervisors are responsible for ensuring that evaluation forms are collected and mailed to NPC Research on a monthly basis. Data must be postmarked by the 10th of the month to ensure timely entry. The *Forms and Evaluation Manual* (Red Book) contains comprehensive information about data collection processes.

Screening

The *Consent to Participate* form (*Welcome to Healthy Families*) is completed for each family, even if the family declines to participate. Sites tabulate the results of the consent forms for end of the year reporting. Consent forms for families who participate home visiting are added to the family file.

***ID Numbers*.** Each *New Baby Questionnaire* is entered into the HFO Statewide Database. This creates an identification (ID) number that will be used for the evaluation project. Sites must keep a master list of the ID numbers assigned to each child along with the child’s name and family name for monitoring purposes.

Home Visiting Services and Data Tracking

Central Administration provides a *Data Tracking Form* to monitor due dates and completion dates for all required forms that track services. This Excel© spreadsheet automatically calculates due dates once the child’s birth date and the first home visit date have been entered. The form is organized by child’s age to ensure that appropriate information is collected in a timely way. *Evaluation forms should always be completed within one month of the scheduled due date* otherwise validity is threatened.

Supervision of Supervisors

Supervisors receive regular (at least monthly) and on-going supervision that assures supervisors are held accountable for the quality of their work, receive skill development and professional support.

There are many facets to a Supervisor’s position. It can easily become overwhelming to complete all of the requirements for this role. Providing Supervisor’s support is an important part in retaining this position and preventing burnout.

Supervision of Program Managers

Program Managers are held accountable for the quality of their work, receive ongoing skill development and professional support at least quarterly.

Supervision of Supervisors and Program Managers needs to be documented using the *Supervision of Supervisors* form.

# Forms and Documentation

A variety of forms are used to document and evaluate Healthy Families Oregon services throughout the state system. Forms have been designed to meet Healthy Families America (HFA) quality assurance standards while at the same time, streamlining paperwork as much as possible. Reference the *Forms and Evaluation Manual (Red Book)* as needed.

Evaluation

NPC Research provides “scannable” forms for the evaluation and detailed instructions can be found in the *Forms and Evaluation Manual* (Red Book).

Scannable evaluation forms are provided by NPC Research on an as needed basis by mail.

Forms Coding System

Forms are coded according to a system that establishes requirements for their use:

State Standardized & Required

**Standard Required (SR)** Sites must use these forms. Cosmetic changes (such as adding the name of local site) are allowed, but the content of the existing form may not be modified.

**Required (R)** Sites are required to have forms that meet this purpose. Sample forms are provided by Central Administration but sites may use local versions as long as key information is captured.

**Optional (O)** Sites have found these forms to be helpful in meeting Healthy Families America standards but they are not required. Sample forms are provided and may be modified depending on local needs.

**Tools/Samples (TS).** Tools and samples have been provided for a variety of forms and may be used to support sites.

**Color Coding** Service Level Assignment, creative outreach tracking Family Referrals and Concerns and the optional Referral Tracking Form are printed on colored paper for easy monitoring.

Future Changes

Changes to state standardized and required (SR) forms will be kept to a minimum and if needed, will occur at the beginning of a fiscal year. Sites that have versions of required or optional forms that are working particularly well are asked to transmit them to central administration so they can be offered as samples to others in the statewide system.

# Governance & Administration

Quality Assurance Plan (GA 3)

A state Quality Assurance (QA) Plan has been adopted to ensure that all local sites provide comprehensive, high quality and effective home visiting services. Sites base a local QA Plan on the state model, adding additional practices as necessary.

Policies and procedures

To ensure relevance, the state QA Plan specifies that the PPPM be reviewed annually by the Healthy Families Oregon Advisory Committee,

* Suggestions for changes are actively solicited 90 days before the annual review although proposals for changes may be submitted at any time.
* No later than 30 days after approval, Program Managers are notified of changes and date on which changes become effective.
* Sites receive an electronic copy of the updated PPPM and add local procedures where indicated. The updated manual is reviewed and adopted by the site’s local Advisory Committee – a copy is then sent to Central Administration within 90 days.

Internal QA Procedures

Under the state QA Plan, Program Managers and Supervisors use a variety of strategies to monitor service quality. These include:

* Monitoring the screening rate and screening processes
* Monitoring the Acceptance rate
* Monitoring the retention rate
* Monitoring staff retention and satisfaction
* Planning how to prioritize eligible families when the site does not have the capacity to provide home visiting services to all
* Observing Home Visitors periodically as they conduct visits and Parent Survey assessments
* Discussing Home Visit Records with Home Visitors to ensure appropriateness of support activities for family
* Reviewing caseloads and home visit completion routinely
* Examining family files often to ensure proper documentation
* Looking at family retention rates for each Home Visitor
* Ensuring evaluation paperwork is submitted in a timely manner
* Developing training plans and organizing in-service and ongoing training
* Periodically contacting families on an individual basis to determine parent satisfaction
* Conducting a Cultural Sensitivity Review that examines materials, training and the service delivery system.

Technical assistance and Monitoring

Central Administration offers sites technical assistance based on needs/requests and information gathered during the annual site review and program evaluation.

Program Managers and supervisors attend required state meetings for training and updates on program implementation.

Annual Site Visit

Each site receives at least one site visit per year from Central Administration staff and/or contractors to review quality assurance procedures and provide technical assistance for any identified issues. The intent of the visit is to (1) highlight and celebrate successes and strengths, and (2) identify areas of work for the coming year.

QA Review Team

The Program Manager and Central Administration staff work together to set the date for the visit.

Review Content

The review begins with an introductory *Welcome Meeting* to set the stage for the day. The agenda is set by the state in response to state changes, changes in the PPPM and HFA standards as well as overall opportunities for growth.

Following the annual site visit, sites receive a written report from Central Administration addressing site strengths, opportunities for growth, and follow up needed.

Program Goal Plan

Based on the report, each site then develops a Program Goal Plan (PGP) to address all areas that need improvement. The plan sets goals for the coming year and identifies actions needed to reach the goals.

The site’s advisory group are involved in the development and subsequent monitoring of the plan. Central Administration staff provide technical assistance and support during this process.

Quality Improvement Plan

There are times when sites may have difficulty meeting goals. When this occurs, sites receive specific written feedback from Central Administration about issues such as:

* Significant non-adherence to the PPPM
* Falling below the threshold for maintaining HFA credentialing standards
* Continued challenges with meeting performance indicators
* Data collection processes and data quality
* Significant staff retention challenges

*(Please review the PPPM for detailed information on this topic.)*

Site Work Plan

If steps to effectively address the issues in the improvement plan are not remedied or fully addressed, Central Administration will write a *Site Work Plan*. As outlined in the PPPM, inability to meet the implementation goals may lead to change of provider or disaffiliation from the state system.

Budget Process (GA 9)

*(Please review the PPPM for detailed information on budget guidelines and the use of funds)*

Sites prepare and submit an annual budget as part of their contract. The completed budget demonstrates the use of HFO General Funds and HFO Medicaid funds to provide core services according to HFO Fiscal Guidelines (found in the PPPM). This budget is submitted to and reviewed by Central Administration. The optional *HFO Budget Template* is available for site use.

**Budget Guidelines**

HFO General Funds are allocated solely for providing quality services to higher risk families who are first-time parents. These Core Services include:

* Screening to identify higher risk families (including resource referral and providing parenting information)
* Home visiting services following the HFA model for higher risk families
* Materials and supplies, administrative costs, staff training, etc., as needed to support these services

If a local community wishes to provide additional services to lower risk families who are not eligible for home visits, resources other than General Funds and Medicaid Funds must be used. Any activities for lower risk families must be clearly distinguishable from core services.

Screening

Central Administration recommends that no more than 10 – 15% of General Funds be used for this function. Costs of screening can be kept low through the use of linkages with community partners.

Screening activities eligible for General Funds include:

* Conducting screens
* Community outreach to screening partners and coordination of any screening volunteers
* Materials for information and referral packets distributed during the screening process

Staffing

The following positions are central to Core Services and may be paid with General Funds:

* Home Visitors

Supervisors for Home Visitors

* Program Managers
* Clerical support staff
* Any community outreach workers necessary for screening

In planning the budget, the total FTE allocated for Home Visitors must be adequate to meet Performance Indicators, HFO policies and procedures, as well as all HFA Best Practice Standards (including Home Visitor caseloads).

Supervision

Because supervision plays such a critical role in quality assurance, standards require that sites maintain one fulltime Supervisor for every six Home Visitors. When a Supervisor is part-time, the number of Home Visitors is adjusted to keep an overall ratio of 1:6. This is particularly important to plan for at sites where the roles of Program Manager and Supervisor are combined. FTE will need to be delineated for each role.

Non-Required Positions

Note that additional staff such as nurses, early childhood specialists, mental health consultants, the Supervisor of the Program Manager, or playgroup coordinators whose roles are not required under the PPPM may not be paid for with General Funds. Supervision for the Program Manager may be included as part of the indirect costs.

Indirect Costs

Costs of indirect support to the Healthy Families site from the host agency/parent organization may be charged to General Funds but should be maintained within reasonable limits, generally not exceeding 5% of the total budget. Note that if indirect costs are too high, there may not be adequate funds to provide necessary core services.

Not eligible for Healthy Families General Funds

Services that are not appropriate for GF include the following:

* Services to low risk families beyond screening
* Welcome Baby home visits to lower risk families
* Welcome Baby gifts
* Incentives such as diapers or transportation vouchers

# Healthy Families Advisory Groups (GA-1)

All Healthy Families Oregon sites are required to establish and maintain local Advisory Groups to support and advise the site as it plans, implements, and reviews its services. The Advisory Group provides a venue for community collaboration and supports the creation of stronger links between formal and informal systems of support for young children and their families.

Program Managers are responsible for keeping members informed and actively involved. The Advisory Group meets at least quarterly to regularly assess the site’s services. The group plays a variety of roles:

* Makes recommendations for planning, implementation, and policies of the site
* Promotes and advocates for the site
* Takes an active role in resource development for the site, including the 25% local community match
* Leverages important non-monetary resources through their time and commitment
* Serves as a forum for communication and resource sharing among community partners

Organization

Advisory Groups operate under by-laws or written procedures that include the purpose, membership, order of business and meeting schedule, parliamentary authority and other organizational processes. Minutes are kept for each meeting and circulated to members unable to attend.

The Program Manager is responsible for keeping members informed and actively involved, however, as non-voting members, HFO staff may not participate in decision-making nor are staff members involved in preparing reports to the Early Learning Hubs or Central Administration.

Membership

Advisory group members are recruited both from partner agencies and from other venues such as service groups, advocacy groups for young children, businesses, the arts, and present/former program participants. This heterogeneous mix of skills, strengths and community knowledge leads to increased understanding of diversity and more inclusive community decision-making.

Tips for Successful Advisory Groups

Here are some proven ideas for developing advisory groups to become interested and supportive friends.

**Timing** Meet at a convenient time and place. Sometimes the difference between good and poor attendance is simply choosing the right time. Establishing a regular meeting schedule helps. Telephone conferences, mailed reports and individual contact, either by telephone or face-to-face, can be useful to keep interest alive between meetings.

**Size** Advisory Groups are most effect what every person has an opportunity to voice an opinion. Studies have shown that as members participate more in a meeting, they judge the meeting to be more successful and are more likely to continue.

**Task-oriented** Make the advisory group a working group, not strictly an advising one. Identify tasks that are relevant and timely, require input from all the members and will have visible results. The strength of a group is proportional to the activity level. As members work together, they become a stronger, more cohesive group, better able to advise.

**Organize** Set up a process for selecting and rotating chairpersons who will preside at the meetings and work with you to set agendas. Don’t fall into the trap of serving simultaneously as chairperson, secretary, refreshment server, and idea generator!

**Rewarding** Make the advisory experience personally rewarding for the members. They’re giving their time and expertise– they need to get something as well. Members should have the satisfaction of seeing that their ideas have some real impact on the program. When appropriate, publicize their names and pictures, and activities.

**Communication** Encourage members to keep other community groups with whom they may be involved informed about Healthy Families activities and successes. Public awareness and public support are central to the success of Healthy Families Oregon sites. Advisory Group members can play a powerful role in advocating for the program, both in the community and statewide.

**Fun** Along with the advising and activities that are their work, advisory group members usually want some fun, sociability, and informal contacts with people. This helps build group cohesiveness and returns dividends in group morale and productivity. The kind of sociability will depend on the group, but food and time to talk are staples.

# About Medicaid

 Medicaid is a means-tested entitlement program providing health care coverage and medical services to millions of low-income children, pregnant women, families, persons with disabilities, and elderly citizens. Medicaid is financed jointly by the state and federal government.

The majority of HFO families receiving home visiting services are eligible for Medicaid/OHP health care coverage. Results from the state evaluation, presented in the annual Status Report, show that, on average, about 80% of the families have low incomes and are potentially eligible for Medicaid/OHP.

In order to assist low-income families to receive vital health care services, federal matching funds under Medicaid are available for administrative activities in support of the State Medicaid plan, including efforts to identify and enroll potential “eligibles” into Medicaid. Other allowable Medicaid Administrative Claiming activities are case planning, monitoring, coordination, referral of Medicaid covered services, and training of outreach staff on the benefits of the Medicaid/OHP program.

Through an interagency agreement, HFO sites receive reimbursement from the state Medicaid/OHP office for providing these outreach and coordination activities. This process, termed Medicaid Administrative Claiming (MAC), requires all HFO staff to track their activities each calendar quarter.

How does this work?

No greater than five days in advance, HFO Central Administration advises local sites of the random day selected for time study via email. On that day, employees of the local HFO site record all paid activities conducted during the time they are on the job. If they are working for other programs during that day, that time is not recorded on the HFO claiming forms.

Activities are then allocated in 15 minute increments according to the codes on the following pages. Examples of reimbursable activities include:

* Discussing access to health care with an HFO family
* Assisting in early identification of children who could benefit from health services provided by Medicaid
* Discussing well baby care and immunizations
* Providing referral assistance to families for Medicaid-covered services

Each HFO employee enters the coded time study into the web-based Medicaid Online Time Tracker (MOTT) System. The Medicaid Online Time Tracking (MOTT) System is a web-based application designed to monitor the administrative activities of HFO staff members that are eligible for reimbursement from the Office of Medical Assistance Programs (OMAP). Please contact Central Administration for additional questions.

Time Sheets

Central Administration notifies sites of each Random Time Study day using the electronic time sheet, each employee enters information on how time was spent during the Random Time Study day. Once information has been entered and successfully saved, employees print a paper copy of the online time study for documentation purposes.

All blocks within the electronic time sheet must be completed. Hours within the day that are not paid by HFO (either because the person is part-time and didn’t work during those hours/day or is employed on a different program for those hours) are filled in as “non-HS.”

Program Manager/Supervisor

responsibilities with Medicaid

• Ensure that employees receive Medicaid training and participate in time studies on each Random Time Study day, regardless of what they are doing.

• Review time sheets to ensure correct coding. Enter time sheets into MOTT for employees who are unable to do so themselves.

• Notify Central Administration when employees change FTE, roles, or positions by submitting the *Staff Role Change* *Form.* The *New Staff Form* is submitted to Central Administration for each new hire. Hire and termination dates are especially important since they are used in calculating reimbursement. Omitting a termination date negatively impacts reimbursement due the program.

 • Maintain and update salary information for each employee by quarter and current year. Salary information must reflect total Healthy Families dollars expended on the person in a specific quarter. If the salary is omitted for a quarter, then that staff person’s time will not appear in the final reimbursement report and reimbursement will be adversely affected.

1. More frequent shadowing for newly employed Home Visitors [↑](#footnote-ref-1)
2. More frequent observations are done for Home Visitors who are new to conducting the Parent Survey. [↑](#footnote-ref-2)
3. Korfmacher, J. (1999). The Kempe Family Stress Inventory: A review. *Child Abuse & Neglect,* 2*4(1)*, 129-140. [↑](#footnote-ref-3)
4. Remember that percentages can be misleading when numbers are small. Comparing differences (without appropriate statistical tests) only gives some possible ideas or hypotheses to explore with other available evidence. [↑](#footnote-ref-4)
5. Sample job descriptions for Healthy Families positions are available through Central Administration. [↑](#footnote-ref-5)
6. Adapted from *Coaching and Mentoring for Dummies* by Marty Brounstein [↑](#footnote-ref-6)