HEALTHY FAMILIES NEW YORK

MULTI SITE POLICY AND PROCEDURES MANUAL

January 3, 2012

TABLE OF CONTENTS

Policy/Document Name	Effective/Revised	Page
About this manual	---	-5-
Glossary of Terms	---	-6-
Welcome to Healthy Families New York – Multi-Site Policies		-7-
HFNY Statement of Purpose	Effective July 2003 Revised June 2007	-8-
Overview of Healthy Families New York	---	-10-
Core Components of the HFNY Program & Summary	---	-13-
Healthy Families America Approach	---	-15-
HFNY Multi-Site System	---	-16-
Affiliation	Effective 2003 Revised June 2007	-18-
HFNY Home Visiting Council	Effective July 2001 Revised June 2007	-20-
Development and Revision of HFNY Policies and Procedures	Effective July 2003 Revised 2007	-22-
General Policies for Staff	Effective July 2001 Revised June 2007	-24-
Technical Assistance, Quality Assurance and Site Support	Effective July 2003 Revised June 2007	-26-
Critical Element 1		-32-
Identifying Potential Participants	Effective July 2001 Revised June 2007	-33-
Prenatal Enrollment	Effective June 2007	-37-
Criteria for Enrollment	Effective July 2001 Revised June 2007	-41-
Critical Element 2		-43-
Screening for Indicators of Need	Effective July 2001 Revised June 2007	-44-
Assessment of Family Strengths and Needs	Effective July 2001 Revised June 2007	-46-
Critical Element 3		-51-
Outreach to and Engaging Families	Effective July 2001 Revised June 2007	-52-
Critical Element 4		-56-
Length and Frequency of Services to Families	Effective July 2001 Revised June 2007	-57-
Home Visit Completion Rate	Effective June 2007	-62-
Transfer of Cases	Effective June 2007	-64-
Completion of HFNY Program	Effective June 2007	-65-
Critical Element 5		-66-
Culturally Responsive Services	Effective July 2001	-67-

	Revised June 2007	
Annual Service Review	Effective July 2003 Revised June 2007	-70-
Critical Element 6		-73-
Supporting the Parents and the Family	Effective July 2001 Revised June 2007	-74-
Review of Assessment	Effective June 2007	-75-
Individual Family Service Plan	Effective July 2001 Revised June 2007	-78-
Promotion of Positive Parenting, Knowledge of Child Development and Health and Safety Practices	Effective July 2001 Revised June 2007	-82-
Selection of Curriculum	Effective June 2007	-84-
Developmental Screening	Effective July 2001 Revised June 2007	-87-
Parental Stress Index	Effective June 2007	-89-
Breast Feeding	Effective March 2003 Revised June 2007	-92-
Critical Element 7		-94-
Medical Homes, Immunizations, Well-Baby Visits and Lead Assessments	Effective July 2001 Revised June 2007	-95-
Linkages to Other Programs and Services	Effective July 2001 Revised June 2007	-99-
Critical Element 8		-101-
Caseload Management	Effective July 2001 Revised June 2007	-102-
Critical Element 9		-104-
Staff Recruitment and Selection	Effective July 2001 Revised June 2007	-105-
Personnel Turnover	Effective June 2007	-109-
Critical Element 10 and 11 **(Credentialing Standard #10)**		-110-
Training Plan	Effective June 2007	-111-
Required Training *(Orientation Training, Core Training, Wrap-Around Training, On-going Training, Trainings on Assessment Tool, Cultural Sensitivity, Developmental Screens, Agency Executive /Supervisor of Program Manager Training, New Program Manager Training)*	Effective June 2007	-114-
Critical Element 12 **(Credentialing Standard #11)**		-119-
Supervision of Direct Service Staff	Effective July 2001 Revised 2007	-120-
Supervision of Supervisors and Program Managers	Effective 2007	-124-

Participant File/Binder Review	Effective 2007	-126-
Governance/Administration **(Credentialing Standard)**		-129-
Advisory Group Guidelines	Effective 2007	-130-
Participant Input into Program	Effective 2007	-132-
Evaluation/Review of Program Quality *(includes Internal Quality Assurance)*	Effective 2007	-133-
Family Rights and Confidentiality	Effective July 2001 Revised June 2007	-137-
Child Abuse and Neglect Reporting	Effective 2003 Revised 2007	-140-
Protocol for Death or Critical Injury of Any Child Residing in a Participant Home.	Effective March 2006 Revised June 2007	-141-
Appendices		-143-
Appendix A: TANF forms		
Appendix B: Welcome to HFNY		
Appendix C: Sample Forms Used by Sites (referenced in policies)		
Appendix D: Indicators of Excellence		

About this manual

This manual establishes policies, procedures and guidelines to ensure that standards of effective practice are met by our multi-site system. It is based on the policies set forth by Healthy Families New York and the Healthy Families America Critical Elements and is aligned with the Healthy Families America Self Assessment Tool. Individual Healthy Families New York programs can use this manual to guide them as they create site-specific policies for operationalizing the standards in ways that fit their own programs and communities.

Site specific policies can either be inserted in sections right behind or in front of state policies, or programs can choose to maintain two separate manuals.

Policies are organized within the related Critical Element, except for the first section "Welcome to Healthy Families New York" and the final section, "Governance and Administration." There is a heading box at the top of all policies that includes the subject, the policy, the multi site and/or site specific reference in the Healthy Families America Credentialing Self Assessment Tool, the effective and revised dates, and any attachments that can be found in the Appendices section. While most of the appendices contain the item, others will direct the user to a location on the Healthy Families website at www.healthyfamiliesnewyork.org to obtain the item.

When an attachment states that it is part of the Management Information System (MIS), that attachment can be found in the Center for Human Services Research Forms manual, located separately from this manual. All of these forms and reports can be found on the Healthy Families website.

There are samples of forms developed by HFNY programs referenced in the policies and included in the appendices section. These may be copied and/or modified for programs' use.

Family Support Worker (FSW) and Home Visitor are used interchangeably in this manual.

The Healthy Families New York Performance Targets are referred to in the policies where they are relevant, and are included in full in the appendices.

GLOSSARY OF TERMS

ASQ: Ages and Stages Questionnaire. Developmental screening tool used by HFNY programs.

Assessment: The Kempe (Family Stress Checklist) is a semi-structured, standardized assessment tool administered in HFNY programs to gather information about parents' strengths and capabilities and to identify the parents' experiences, expectations, beliefs, and behaviors that place parents at risk of child abuse, neglect and maltreatment. It assesses for the presence of factors including increased risk for child maltreatment or other poor childhood outcomes (e.g. social isolation, substance abuse, parental history of abuse in childhood, etc

Central Administration: refers to Office of Children and Family Services (OCFS), Prevent Child Abuse-New York (PCANY) and the Center for Human Services Research (CHSR).

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

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

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

Developmental Screen: A standardized tool used by HFNY home visiting programs at regular intervals in the course of home visiting to monitor child development, and delays and disabilities, and to ascertain appropriateness of referral Early Intervention Program (see "ASQ").

FAW: Family Assessment Worker

FSW: Family Support Worker (home visitor)

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

Kempe: See assessment

PSI: Parenting Stress Index. See policy.

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

Screen: A standardized tool for identifying families who might be appropriate for referral for a Kempe Assessment.

Self Sufficiency: While Healthy Families New York encourages families to provide for their own needs, it recognizes that healthy families are interdependent with extended family members, friends, fellow members of spiritual organizations and cultural and social groups, neighbors, co-workers, businesses, organizations, schools, day care and health care providers.

WELCOME TO

HEALTHY FAMILIES NEW YORK

Multi Site Policies

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**HFNY Statement of Purpose**
Policy	Healthy Families New York will have a written statement of purpose to guide the administration of services.
Multi-Site Reference	A-2
Effective date	July 2003
Revised date(s)	June 2007
Appendices	n/a

Rationale:

Healthy Families New York has a written statement of purpose that guides the administration of its services. It reflects the goals and criteria contained in the HFA Critical Elements and the needs of children and families in the broader community.

Procedures:

- The statement of purpose is reviewed every 4 years.
- Central Administration, the program sites and the Home Visiting Council provide input into the review of the Statement of Purpose.
- See attached Statement of Purpose

Healthy Families New York Statement of Purpose (Mission)

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

Program Goals:

Support parent child bonding and relationships

Promote optimal child and family health, development and safety

Enhance parental self-sufficiency

Prevent child abuse and neglect

Effective: June 2007

Overview of Healthy Families New York

Healthy Families New York (HFNY) is a voluntary home visiting program for expectant and new parents.

Healthy Families New York offers home visiting services to expectant families and new parents, beginning prenatally or shortly after the birth of the child. The program identifies which families could most benefit from home visits by means of systematic screening and assessment in designated, high risk communities. Families who participate in the program are offered long-term in-home services until the child is in school or Head Start.

The Goals of Healthy Families New York are to:

- Support positive parent-child bonding
- Promote optimal child health and development
- Enhance parental self-sufficiency
- Prevent child abuse and neglect

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

In 2000, a law was passed by the New York State Legislature making home visiting in New York permanent.

HFNY is affiliated with Healthy Families America, a national initiative of Prevent Child Abuse America.

Statewide Program Management

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

OCFS currently has a Program Coordinator and Program Contract Managers who manage the program and provide technical assistance and monitoring of funded programs.

OCFS contracts with Prevent Child Abuse New York (PCANY) to conduct all basic training, advanced training on selected topics, and through our statewide Continuous Quality Improvement efforts, to visit each site on a regular basis to observe home visits, assessments and supervision, provide a variety of site support activities geared to the needs and requests of each program, and provide technical assistance visits as needed. PCANY also manages a resource center for funded programs and communities interested in starting a Healthy Families program. They publish a quarterly newsletter. PCANY has a Director of Training and several HFA certified trainers.

OCFS contracts with the Center for Human Services Research (CHSR), Rockefeller College of the State University of New York at Albany to manage the data system for the program and to conduct the evaluation of the program. A computerized management information system (MIS) is used to collect comprehensive, yet anonymous, information for managing the program and for evaluating the outcomes. With the CHSR, OCFS is conducting a random assignment study of the program to determine families' characteristics, details of service delivery, and outcomes for the child and family. CHSR has a Director of Management Information and management information and evaluation staff.

A Home Visiting Council comprised of representatives from state agencies serving children and families, funded programs, and child advocacy organizations from across the state provides guidance to the program. PCANY co-chairs the Council with OCFS.

A number of measures are utilized to ensure program quality so that families receive effective and helpful services. They include:

- Regular, consistent supervision, support and training for all staff.
- Comprehensive training provided to all staff based on staff training needs
- Statewide leadership meetings consisting of all program managers and the members of Central Administration occur at least 3 times a year. The goals of these meetings include sharing resources, discussing training, multi-site policies, evaluation, technical assistance and quality assurance. Bimonthly meetings of all Program Managers have been held since the program began in 1995. These meetings have been used to develop and relay policies and share ideas, successes, and concerns. At least 3 times a year (sometimes more in certain regions) program managers and regional representatives from Central Administration also meet. These meetings serve the same function as the larger meetings, but can address more regional concerns in a smaller group setting.

- Technical assistance to sites and communities interested in starting a HFNY program, and those with a new program manager or experiencing some other type of transition.
- A structured system of mentoring new sites by experienced sites.
- A comprehensive Management Information System that collects information on all participants.
- Regular review of data submitted by funded programs.
- Standard performance targets that the programs report on that are related to the goals of the program.
- An ongoing evaluation of the program that includes a random assignment study at 3 sites.
- Regular on-site visits of funded programs by OCFS Program Contract Managers.
- A comprehensive quality assurance system based on HFNY policies that each site implements supplemented by regular and routine statewide quality assurance visits to each program by the HFNY training and staff development team.

CORE COMPONENTS OF THE HEALTHY FAMILIES NEW YORK PROGRAM

- Universal screening by means of a standard record screening tool of all pregnant women and new parents in certain designated-areas.

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

- Creative, persistent outreach approaches to isolated and hard to reach families, including those not receiving prenatal care.

- Home visiting services offered on a voluntary basis to families with a Kempe score of 25 or greater, ideally offered in the early prenatal period, or right after the birth of the child and continuing until the child is enrolled in school or Head Start.

- Intensive long term home visiting services by trained and caring home visitors called Family Support Workers. Visits occur weekly to biweekly during pregnancy and weekly during at least the first 6 months of the child's life with intensity decreasing thereafter based on family need.

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

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

- Supervision by health or social work professionals, or by experienced Healthy Families staff who meet specific criteria.

- Home visiting services that focus primarily on parent-child interaction, child development, parent support, and family functioning, including identifying and addressing self-sufficiency goals. The home visitors work with families to identify goals that build on family strengths, and facilitate referrals to any services the family may need including housing services, economic support, day care, GED programs, employment and training programs, or family resource centers.

- Periodic developmental screening and referral for Early Intervention Services if a developmental concern is identified.

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

- Manageable home visitor caseloads, beginning with a maximum of 15 families and increasing to a maximum of 25 based on the mix of families at different service delivery levels.

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

SUMMARY

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

THE HEALTHY FAMILIES AMERICA APPROACH

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

The following policies, guidelines and procedures are, in general, organized to reflect the critical elements for effective home visiting services. To operate a successful site, each program supplements this manual with Healthy Families America and HFNY training materials for Program Managers, Supervisors, Family Support Workers, and Family Assessment Workers.

Each program site develops its own site specific policies and procedures, i.e., more detailed and agency and community-specific, provided that the site's policies and procedures are not in conflict with those of HFNY, or in conflict with the critical elements that define the Healthy Families America model.

HEALTHY FAMILIES NEW YORK
MULTI-SITE SYSTEM

Healthy Families New York is a collaboration of state, local, private, and publicly –funded primary prevention home visiting programs affiliated with each other and with Healthy Families America (HFA). See Attachment "Multi Site System Flow Chart."

The partners in the multi-site system are:

- New York State Office of Children and Family Services (OCFS)
- Credentialed or "Affiliated" Healthy Families Programs in New York State
- Prevent Child Abuse New York (PCANY) - Training and Staff Development
- Center for Human Services Research, SUNY Albany- Evaluation & Data Management
- Healthy Families New York Home Visiting Council

Other partners or participants may include representatives of additional funding sources, and new and developing programs.

The Home Visiting Council functions as the Statewide Advisory Group (as per credentialing requirements).

State and Regional Leadership meetings
Statewide leadership meetings consisting of all program managers and the members of Central Administration occur at least 3 times a year. The goals of these meetings include sharing resources and information, and discussing and making decisions concerning training, multi-site policies, evaluation, technical assistance and quality assurance. They are also used share ideas, successes, and concerns. At least 3 times a year (sometimes more in certain regions) program managers and regional representatives from Central Administration also meet. These meetings serve a similar function as the larger meetings, but can address more regional concerns in a smaller group setting.

PURPOSE

The purpose of the multi-site system is to provide support and services to bring high quality services to the new and expectant parents and their children served by participating programs.

The multi-site system provides, at a minimum:

- Support to new and developing programs
- Data collection and analysis

- Staff training and professional development opportunities
- Informational and networking support
- Assistance with HFA credentialing
- Access to educational resources
- Quality assurance
- Technical Assistance
- Monitoring

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Affiliation**
Policy	All HFNY programs will achieve and maintain affiliated status within the Multi-Site system.
Multi-Site Reference	Multi-site M-4, M5
Effective date	July 2001
Revised date(s)	July 2003, June 2007
Appendices	n/a

Rationale:
To ensure all HFNY programs understand the expectations for achieving and maintaining affiliated status within the Multi-Site system.

Procedures:
1. All programs affiliated with the multi-site system agree to the following:

   a. Compliance with the Healthy Families America Critical Elements for providing quality home visiting services and guidelines included in the Healthy Families New York Policy Manual.
   b. Provision of Home Visiting Services in a specified target area including universal screening in collaboration with relevant community service providers.
   c. Coordination with local health and social service departments.
   d. Compliance with prescribed performance targets.
   e. Participation in State and Regional Leadership meetings.
   f. Participation in the home visiting Management Information System and ongoing evaluation conducted by OCFS with CHSR;
   g. Participation in all required core, wrap-around and advanced training.
   h. Agreement to be credentialed by Healthy Families America. Upon funding, new programs are required to apply for HFA affiliation as part of the HFNY multi-site system. Programs will submit a copy of their affiliation letter with HFA to OCFS, maintain their affiliation status, and pay their affiliation fee as determined by HFA.
   i. Programs in the planning stages may also participate in the multi-site system provided a letter of intent to affiliate with HFA is filed within two months of the initiation of services to families. Programs not funded may phase in implementation of the Management Information System.
   j. Programs agree to annual updating of affiliation and fees with Healthy Families America.

2. Revoking Affiliation

   a. Healthy Families New York affiliated programs will have their affiliation revoked if they fail to comply with the policies of HFNY after being informed of noncompliance in writing and after being given a period of

time not to exceed 6 months to make necessary revisions to practices or policies.

b. Programs having their affiliation revoked will be notified in writing and given 30 days to respond to complaints. If programs submit an acceptable corrective action plan for remedying areas of noncompliance, they will be given up to 6 months to correct the situation, at which time the program will be reviewed for compliance.
c. If the program has made acceptable progress, the affiliation will be continued. If the program does not make satisfactory progress, the affiliation will be immediately revoked.
d. Termination of funded program's contracts will be handled as a separate process according to the requirements specified in the OCFS contracts.

3. Resolving Conflicts

a. If a conflict arises, the parties involved with the conflict should each develop a clear written statement of the issue under discussion. Each party should make recommendations for resolution of the issue.
b. A plan will be developed by the Central Administration team in consultation with parties involved that includes a time frame for resolution, provision of technical assistance to parties involved if applicable, and steps needed to resolve the conflict. If necessary, a neutral facilitator will be identified to assist with conflict resolution.
c. If either party is dissatisfied with the resolution of the conflict, they can appeal the decision by requesting a review in writing. The review will be conducted by the supervisor of the HFNY Coordinator, OCFS.
d. Once the review is made, the final decision will be relayed to all parties in writing.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**HFNY Home Visiting Council**
Policy	HFNY will maintain a council that serves in an advisory capacity in the planning and coordination of program services and system activities.
Multi-Site Reference	Multi-site A-1, A-3
Site specific reference	no
Effective date	July 2001
Revised date(s)	June 2007
Appendices	N/A

Rationale:

The HFNY Home Visiting Council acts in an advisory capacity to the HFNY Program. It provides input into planning, policy, and advocacy for the HFNY initiative, including the development of the Strategic Plan for HFNY. The strategic plan guides its activities and is reviewed periodically.

HEALTHY FAMILIES NEW YORK HOME VISITING COUNCIL: DEFINITION

- The Council's purpose is to support and advance the Healthy Families New York Home Visiting (HFNY) Program and its statewide system. The Council exists in accordance with Healthy Families America credentialing standards.

- Council Members are persons from the public and private sectors who support the goals and purpose of the HFNY Program, including state and federal agencies serving children, the governor's office, children's advocacy groups, legislators' offices, HFNY program sites, other early childhood service providers, health and family service professional associations and may include other supporters and parents served by the program,. Members also include HFNY Central Administration, staff from NYS Office of Children and Family Services, Prevent Child Abuse New York, and SUNY Center for Human Services Research.

- **The HFNY Home Visiting Council is co-chaired by Prevent Child Abuse New York and NYS Office of Children & Family Services**

The co-chairs represents the public-private partnership that established and continues to support and promote the statewide program, one bearing primary responsibility for administration, management, and quality of HFNY Home Visiting, the other providing leadership in advocacy and education on behalf of the program.

- **The HFNY Home Visiting Council is responsible for developing and implementing a strategic plan**.

The Council meets on at least a biannual basis.

The Council provides input to the review of the Statement of Purpose (see HFNY Statement of Purpose.)

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Development and Revision of HFNY Policies and Procedures**
Policy	Programs use this multi-site manual and develop their own site-specific manual as a guide in the provision of services.
Multi-Site Reference	M-1, M-2, M-6
Site-specific reference	10-2A, GA-8
Effective date	July 2003
Revised date(s)	June 2007
Appendices	-Request to Add/Revise HFNY Policies and Procedures -Policy Manual Review Tool.

Rationale:
To establish a system for the creation, distribution, and regular review of the Healthy Families New York Policy and Procedures Manual. To ensure that there is a system for updating and revising policies and procedures. This is necessary to represent best practice approaches consistent with HFA critical elements and standards, address the needs of New York State's diverse communities and populations, and reflect current program experiences and home visiting research.

Procedures:

1. The HFNY State Policy and Procedure manual is distributed in hard copy and in electronic form to all HFNY sites. It is on the HFNY website. Each site is required to keep at least one hard copy in an accessible location for all direct service staff.

2. HFNY has formal and informal mechanisms for recommending new and revised policies. Formally, the form "Request to Add/Revise Healthy Families New York Policies and Procedures" may be used at any time to request a new policy or recommend a change. A policy question may also be raised at any time during the year by any party for discussion at the HFNY Leadership meetings by submitting it to the host entity as an agenda topic.

3. On an informal and ongoing basis, the Leadership Team and Central Administration partners and program staff communicate on the effectiveness and relevance of policies and procedures. This occurs during Leadership Team Meetings, quality assurance, technical assistance, and annual monitoring visits. Any member of the Leadership Team can bring ideas and concerns regarding existing policies to the Central Administration or Leadership Team for discussion. There are, however, some policies that cannot be revised due to legislative or funding requirements.

4. All new program managers are oriented to the HFNY Policy and Procedures Manual during their New Program Manager Overview and the Site to Site Mentoring program.

5. All HFNY policies are reviewed at least annually at a Statewide HFNY Leadership meeting to determine if any changes are warranted. New and revised policies are mailed to all sites and Central Administration partners who then have 10 days to provide any changes or feedback. After 10 days, the policies are included in the official version of the HFNY Policy Manual. The official version and any recent changes are posted on the HFNY website.

6. Each site develops its own policy and procedure manual that is consistent with HFNY and HFA policies, and incorporates the items specified in the Policy Manual Review Checklist. OCFS Program Contract Managers review each new site's policy manual after one year of operation and provide written feedback. Sites have 90 days to make recommended changes to their manual. After the initial start-up period, sites share any policy changes with OCFS Program Contract Managers at annual site visits for their review and approval. This is reflected in the report sent to the program after the visit by OCFS.

7. All staff must be oriented to their policies and procedures before contact with families as per Standard 10-2A.

8. The manual is reviewed and consulted throughout the year with Central Administration partners and program staff as situations may require.

GENERAL POLICIES FOR STAFF

The following are some general policies for staff of Healthy Families New York programs. Programs are required to develop policies around these topics more fully and with specifics to their own sites and communities.

Scheduled Work Hours

Family support programming requires flexibility. Each site determines its normal hours of operation. It is expected that programs will adopt flexible schedules, e.g., evenings and weekends in order to meet the needs of working families. (Overtime pay is not provided through the HFNY grant.)

Any changes in scheduled appointments, or calling in sick, are communicated to the immediate supervisor. Supervisors need to know where and when FAWs and FSWs are conducting visits each day. It is recommended that staff who are in the field call the office to speak with their supervisor and check on messages. If staff start their day before coming to the office or end their day without coming to the office, it is recommended that they call the office and speak with a supervisor.

Punctuality

Staff members are expected to schedule visits in a timely manner and to be on time for scheduled visits.

Staff Safety

Safety of staff members is a program priority. Each program site must have established a policy on safety to guide staff in their work in the office, families' homes and the community. This includes protocols around signing-in and out, calling in throughout the day, and assuring supervisors know staff's schedules. FSWs, FAWs, Supervisors, and Managers all share responsibility for maximizing safety of staff members. Staff members should never attempt to intervene in a domestic dispute. Program staff should leave if their safety is threatened for any reason and immediately contact a supervisor or manager.

Boundaries

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

Accepting Gifts or Favors

Programs develop policies to guide staff around accepting gifts. These state that staff will report to their supervisor any gifts given by participants and that they are unable to accept a gift of anything of significant value. Staff are encouraged to explain to the family that this is an agency policy and that they are not allowed to accept.

Transportation Guidelines

Each site determines its transportation guidelines. Out of state travel must be pre-approved by the OCFS Program Contract Manager. The following are examples of possible guidelines that may be used or adapted to best meet the administrative and fiscal tracking of the program and host organization.

For Staff Utilizing Automobiles: A copy of staff's valid driver's license and registration and insurance cards of the vehicle used for work must be on file with the organization. Mileage to and from your home and the office is not reimbursable. Mileage sheets are to be turned in to supervisors on a weekly basis.

For Staff Utilizing Mass Transit: Name, address and telephone numbers of the participants being visited are documented on the travel log sheet for token reimbursement.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Technical Assistance, Quality Assurance and Site Support
Policy	Central Administration will monitor and evaluate the quality of services of all individual program sites. Program sites will be active participants in this process and receive technical assistance and site support based on identified goals and areas of improvement.
Multi-Site Reference	T-5
Effective date	July 2003
Revised date(s)	June 2007
Appendices	FAW Observation Form, FAW Supervision Observation Form, Content Review Form, FSW Home Visit Observation Form, FSW Supervision Observation Form, Site Support Plan protocol, Site Support Feedback Form, TA feedback Form, Site Visit Protocol

Rationale:
To ensure the quality of services of all HFNY programs is routinely monitored, evaluated, and supported through a system of continuous quality improvement. This policy ensures that HFNY has a formal mechanism for reviewing the quality of all aspects of the program, planning for and delivering technical assistance and site support based on identified goals and areas for improvement, and reviewing progress toward goals and objectives. The allocation of this assistance to sites is based upon the individual site-identified needs, information gathered about the site through the quality assurance system and information gathered about the site through training.

TECHNICAL ASSISTANCE, QUALITY ASSURANCE, AND SITE SUPPORT

It is paramount that HFNY programs maintain a high degree of quality. Toward this end, all HFNY programs receive technical assistance, quality assurance, and site support from the three branches of Central Administration (CA). These services are part of the HFNY system for continuous quality improvement. Quality assurance activities provide individual program sites with an outside perspective on staff competence and program performance. After program strengths and challenges are identified in this way, CA supports program improvements by providing training, technical assistance, and site support that directly addresses each individual program's needs. Although all three branches of the Central Administration provide on-going assistance to programs through as needed phone calls and e-mail consultation, the following details the formal activities provided by each:

PCANY Training and Staff Development

- Trainings
- FAW QA visit
- Site Support Visit (includes the FSW QA visit)
- Technical Assistance Visit

OCFS

- Training and Technical Assistance
- Annual Site Review
- Monitoring quarterly and annual reports

CHSR

- Training and Technical Assistance
- Reports

PCANY Training and Staff Development

Trainings

In addition to required trainings such as Core (Role Specific) Trainings, the PCANY Training and Staff Development team also provides on-going and advanced training and coordinates workshops, seminars and conferences at the regional and state levels, some of which can help to meet the wrap-around training requirements. HFNY Training and Staff Development and/or OCFS, conducts a needs assessment each year to programs in order to determine the need for trainings. Topics for advanced training, whether provided at the local, regional or state level, are selected based upon annual training surveys of staff needs and other feedback from staff, information obtained by Program Contract Managers during site visits, and information learned by Training and Staff Development about particular needs of sites. In addition, advanced training takes into account program goals and workers' knowledge and skill base.

FAW QA visit

HFNY programs receive an FAW QA visit approximately once every 18 months from an FAW Training and Staff Development Specialist. The principle activities of the visit will be:

- Observation of an assessment
- Observation of FAW supervision
- In-person debriefing

Complete documentation and written review that includes identified strengths and recommendations will be sent to Program Managers within 60 days of visit. At the request of the Program Manager, FAW Supervisor, or Training and Staff Development Specialist, the visit might also include some review or discussion of outreach methods or materials.

Site Support Visits

The site support visit is a two-day visit that includes on one day, an Observation of Home Visit and an Observation of FSW Supervision. A second day is tailored to each program's needs as identified in advance by the Program Manager, the Program Contract Manager, CHSR-staff, and other members of Training and Staff Development. This day could consist of any of the following activities:

- In-service Training for all staff or Supervisors and Manager only
- Observations and feedback on the following:
    - A second home visit
    - A second FSW Supervision
    - Group Supervision or Case Conferences
    - Team Meetings
- A Nature of Nurturing Follow-up Day
- Individual consultation with Manager on specified topics, including but not limited to the following:
    - program management
    - supervision
    - home visitor and supervisor documentation review/discussion
    - personnel/staffing issues
    - outreach
    - assistance with utilizing and integrating MIS reports
    - developing an effective internal QA system
    - preparation for credentialing
- Individual consultation with Supervisors and Manager around a topic or issue identified by the Manager.

HFNY programs receive a Site Support Visit approximately once every 18 months from a PCANY Training and Staff Development Specialist. Allocation and content of site support visits is based upon individual sites' needs and requests, information learned about the site through the quality assurance system, on information learned about the site through training events, and on the dates of other on-site assistance provided by PCANY. Prior to a site support visit, the Staff Development person assigned to the site by the Director of Training and Staff Development will contact the Program Contract Manager, review the data reports for the last 2 quarters, contact CHSR staff, and contact the Program Manager in order to identify program concerns and goals and determine if there are any special requests for the visit. Following the initial information-sharing and planning discussion, the Staff Development person will draft a plan for the visit and send it to all parties for review. The plan that is developed may require assistance from someone other than a Staff Development Specialist, and in that case, Central Administration partners will attempt to come up with a plan to meet this need. Providing no requests are made for amendment, the visit will proceed according to the plan.

After the visit is conducted, programs have a formal opportunity to provide feedback on the usefulness and helpfulness of both the process and the report. A brief written evaluation should be mailed from the program to the Director of Training and Staff Development. Complete documentation and written review will be submitted to OCFS as well as the program. It includes identified strengths and recommendations and is sent to Program Managers within 60 days of visit. This documentation includes the Observation of Home Visit and Observation of FSW Supervision as well as the following:

- The process and individuals that were part of the planning phase,
- The goals for the Site Support Visit,
- The individuals and activities that comprised the Site Support Visit,
- A follow-up plan, if required, and
- The Program Manager's evaluation of the process.

After Program Managers have an opportunity to review the report, the staff development specialist will call again to answer questions and provide any additional follow-up.

TA Visits

A Technical Assistance (TA) Visit is typically a two-day on-site visit with a third day of follow-up either on-site or via phone calls and e-mail. These visits are made at the request of a program's Program Contract Manager. Situations that might lead to a TA request include the following:

- a change in program management/host agency,
- on-going challenges meeting performance standards
- new or recently expanded program

Prior to the visit, the Program Contract Manager will discuss the need for on-site TA and clearly identify his/her concerns with the Program Manager and Staff Development Specialist. The Staff Development Specialist may request specific documents, such as the most recent site visit reports and data reports specific to any identified challenges, to support the development of the plan for the TA visit. Each plan is tailored to individual program needs, so it is not possible to describe specific activities here. Once the draft plan for the visit is developed, it is shared with the Program Manager and the Program Contract Manager for approval. Based on the identified needs of the site, the Program Contract Manager and/or a representative from CHSR will also accompany the PCANY staff person for a portion of the visit.

An Action Plan, which may or may not be a formal Corrective Action Plan, is developed as a result of the visit. The responsibility for implementation and monitoring of the plan is held by the Program Contract Manager and the Program Site/ Program Manager and does not involve PCANY; however, PCANY

may supply some follow-up assistance, such as an additional day on site, or email and phone consultation. Decisions about follow-up assistance are made on a program-by-program basis and determined by the Program Manager, the Program Contract Manager, and Training and Staff Development.

After the visit has been conducted, a written review along with complete documentation of the visit is sent to the Program Manager within 60 days. Follow-up documentation includes a description of the goals, the activities that occurred during the planning phase, and the activities that occurred during the actual visit. Follow-up phone consultation is generally planned for a specific date.

After the visit is conducted, programs have a formal opportunity to provide feedback on the usefulness and helpfulness of both the process and the report using the TA feedback form. It is mailed from the program to the Director of Training and Staff Development and the Program Contract Manager.

OCFS

Training and Technical Assistance
OCFS staff provide on-site training and technical assistance for individual programs. Program Managers should contact their Program Contract Manager to make a request.

Annual Site Review
As part of their contracts, HFNY programs receive at least one two-day Site Review each program year. This review is conducted by the Program Contract Manager, who schedules the visit with the Program Manager at least one month prior to the Site Review. The Site Review is tailored for each program and typically includes topics in which the program manager self-identifies as needing assistance, issues that have been identified in any of the program's reports, and any other concerns the program contract manager may have. In addition, the Program Contract Manager will review a group of credentialing standards from the program's self-assessment during the visit. A Site Review may include a review of the following program elements:

- Universal Screening
- Referral Process
- Community Relations
- Staffing
- Supervision
- Annual Service Review
- Self-Assessment
- Policies and Procedures
- Quality Assurance

- Training
- Staff Meetings
- Fiscal Issues
- Documentation

At the end of the visit, the Program Contract Manager and Program Manager may discuss appropriate follow-up activities for reaching program goals. After the visit, the program contract manager will send the program manager a letter that includes a summary of findings and will request a response and/or corrective action plan for items noted in the findings.

OCFS also helps coordinate Bi-monthly Leadership Team Meetings and a Bi-Annual All Staff Training Seminar.

CHSR

Training and Technical Assistance
CHSR staff provides on-site training and technical assistance for individual programs. Program Managers may contact their Program Contract Manager to make a request, or contact the center directly.

Data Reports
All HFNY programs are contractually obligated to submit data to CHSR monthly. CHSR uses this data to generate two types of reports: quarterly data reports, and semi-annual performance indicator reports. These reports include data on the individual program as well as aggregate data on the entire HFNY program. While the primary purpose for collecting and reporting this data is accountability and evaluation of the entire HFNY program, this information can also support individual program's quality assurance and improvement efforts. Programs have the capacity to access all reports at their sites and can utilize them to (a) identify strengths, concerns and trends, and (b) develop quality improvement plans.

Critical Element #1

Initiate services prenatally or at birth

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Identifying Potential Participants**
Policy	All HFNY programs will have mechanisms to identify families so that home visiting or other services can begin prenatally (optimally), or as early as possible within the first 92 days after the birth of the baby. Programs use the HFNY screening form to identify potential participants. Programs develop memoranda of agreement with referral sources. Programs define, measure and analyze their acceptance rate for enrollment on at least an annual basis.
Multi-Site Reference	Q-6.1,Q-6.2
Site specific reference	1-1A-D, 1-2A-C
Effective date	July 2001
Revised date(s)	June 2007
Appendices	HFNY General Talking Points

Rationale:
To ensure that Healthy Families New York programs have well-thought out mechanisms for the early identification of families who could most benefit from HFNY services, or be referred to other services. For those who accept home visitor services, this policy also ensures that potential participants have been identified early enough for home visiting services to have occurred prenatally or within the first 92 days after the birth of the baby.

These mechanisms allow programs to initiate voluntary services prenatally or at birth through:

- Identification of pregnant women and parents of newborns within the target areas, through cooperation of prenatal care providers, hospitals, and other community service providers, and through community outreach
- Formal agreements with these entities to use standardized screening and assessment procedures to identify overburdened families
- Outreach efforts to build family trust in accepting services.

Procedures:

<u>Initiating Services</u>
HFNY programs identify pregnant women and parents of infants (0-3 months) in their target areas. The goals for initiating services include:

a. To systematically identify all pregnant women and parents of infants less than 92 days within the target area.
b. To systematically assess at least 80% of these families either prenatally or within two weeks of the birth of their new family member.

c. To assess the families' strengths and needs and provide appropriate information and referral.
d. To offer overburdened families intensive home visitation services and/or other resources appropriate to their needs.
e. For those families who accept home visitor services, to work toward increasing or maintaining a prenatal enrollment rate of 65%. (See Prenatal Enrollment.)
f. For those families who accept home visitor services, to conduct the first home visit prenatally or within the first 92 days after the birth of the baby.

2. Defining Target area

Each Healthy Families New York Program site along with OCFS defines the target area it will serve. Priority is given to high need areas, as indicated by high rates of child abuse, teen pregnancy, infant mortality, and poverty. A comprehensive description of the target population includes issues facing the community such as infant mortality and poverty. It also includes the number of live births per year and racial/ethnic/cultural/linguistic makeup of the population, and may also include other key demographic indicators, such as number of births to single mothers and to teen mothers.

3. Partnerships

Home visiting program sites are required to develop operational partnerships (Memoranda of Agreement) with hospitals and prenatal care providers serving families in the target area, and to work with the local Infant Child Health Assessment Program, Prenatal Care Assistance Program (PCAP), and/or Medicaid Obstetrical and Maternal Services (MOMS) programs. Partnerships are also developed with private physicians, schools, WIC clinics, and relevant community based organizations who may be involved in referring families. MOUs are reviewed and updated on an annual basis. It is required that HFNY programs establish an advisory board that includes representatives of major referral sources and community partners. This system of relationships enables the program to work toward universal screening of participants in the target population.

4. Standardized screening and assessment

Programs maintain working relationships with various referral sources within the community and keep them up-to-date with information about the program. Memoranda of agreement with referring entities are signed by appropriate staff from the home visiting program and the other organization, and include the following, when relevant:

a. Forms and procedures pertaining to standardized screening and assessment, including the following: names and position titles of the people who complete the forms, how families from the target population will be identified, how the screens will be conducted (e.g. outreach interviews, review of medical records, self screening surveys) and the means by which home visiting staff collect completed screens and referrals. (See Screening for Indicators of Need and Assessment of Family Strengths and Needs.)

b. Guidelines for ensuring role clarity between home visiting program staff and staff from the other provider/organization.
c. How to safeguard patient/family rights and confidentiality, including consents to be obtained and physicians to be notified.
d. Description of other forms of collaboration such as shared activities like staff training and parent groups.

5. Outreach
In order to identify and serve families most in need, programs use persistent, respectful outreach to isolated and otherwise hard-to-reach families, including those not receiving prenatal care or delivering in a hospital. Such outreach may include seeking the assistance of community organizations that may come in contact with hard-to-reach families and neighborhood outreach activities of program staff. These activities build family trust so that parents are more likely to accept services. (See Outreach to and Engaging Families.)

Required documentation for programs:

- Each program has a comprehensive and current description of its target area and population.
- Programs use the HFNY screening form to identify potential participants. They may opt to use a self-screening tool as long as they collect the required information. (See Screening for Indicators of Need.)
- Each program develops its own Memoranda of Agreement.
- Each program may develop its own forms and mechanisms to track information on sources of potential participants. These are to be available for review by the OCFS Contract Manager. These program forms may not replace the required forms and tracking systems contained within the HFNY Management Information System.
- The following Management Information System tools are useful for identifying potential participants in the target area:
  - Screen Form Referral/Recruitment Sources broken down by trimester at screen date, Kempe type and enrollment. (Request report from Center for Human Services Research.)
  - Report Tab N: Screen Referral Source Outcome Summary
  - Report Tab O: Screen/Referral Source Demographic and Outcome Analysis
  - Report Tab H: Program Demographics
  - Kempe Analysis 1-2A and B (measures the acceptance rate and refusal rates into the home visiting program for participants with positive Kempe scores.)

Each program defines the acceptance rate into the program and measures the acceptance rate at least annually. The acceptance rate (as defined for the MIS) is the percentage of participants with a positive Kempe who enroll in a time period or the number who enroll over the number of positive Kempes in a time period. The program analyzes who refused the program being offered services and addresses how it might increase its acceptance rate on an annual basis. It uses

both formal (Credential tab: 1-2A and B Kempe Analysis) and informal methods including programmatic, demographic, social and other factors. (See Annual Service Review.)

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Prenatal Enrollment**
Policy	Programs strive for a minimum of 65% prenatal enrollment.
Multi-Site Reference	Q-6.1
Site-specific Reference	1-1A, 1-1B, 1-1C
Effective date	June 2007
Revised date(s)	n/a
Appendices	-List of Outreach sites -Outreach Tracking Calendar -Prenatal Outreach "Talking Points"

Rationale:
Evaluation of Healthy Families New York (HFNY) and other studies have demonstrated clear benefits to identifying and serving families who otherwise would not have received adequate prenatal care or other supports during their pregnancies. Most notably, there has been a sizable impact on preventing low birth weight. The American Academy of Pediatrics stresses the prenatal period is an ideal time to begin doing anticipatory guidance about parenting. This is also the best time to begin effective promotion of breastfeeding. The resources put into prenatal enrollment are well worth the cost in terms of improved physical health for mothers and babies. For these reasons, HFNY has set a goal that programs will enroll at least 65% of its families during the prenatal period.

Procedure:
Each HFNY program will:

- Analyze the program and community dynamics or factors that help to create the current prenatal enrollment rate.
- Develop strategies to expand and maintain prenatal enrollment, and how it will achieve the target of 65% prenatal enrollment.

Guidelines:
Programs are encouraged to consider the following when developing or enhancing policies that address identifying potential participants early in their pregnancy. Programs are encouraged to seek input from Advisory Boards, referral sources, program staff and participants, and the Central Administration team on their enrollment strategies, and to utilize ideas from other HFNY programs. Programs are also encouraged to develop strategies that reflect the unique needs, culture and circumstances of their communities, staff and participants.

1. Materials/Presentations

The following are recommendations to improve and enhance materials and presentations:

a. Materials and presentations are culturally and linguistically responsive and are piloted with the target population.
b. Materials and presentations include information about the program's goal to serve families prenatally, and about the benefits. (See "Talking Points.")
c. Outreach to screening and referral sites emphasizes the primary prevention nature of the program and the importance of prenatal screening.
d. Graphics that are used in outreach materials (such as photographs or drawings) show both parenting and expectant parents.

2. Outreach (see List of Outreach Sites)

The following are recommendations to improve/enhance Outreach Efforts:

a. Program outreach includes various levels and approaches including
   - individual and family recruitment (word of mouth, door to door, self-referrals, current program participants)
   - community level (regular and routine visits to referral sites to leave information and meet with staff, posting flyers, staffing tables at fairs, speaking at faith based community settings, community meetings, schools, etc.)
   - organizational level (bidirectional agreements with screening sites that are systematically updated each year, regularly scheduled meetings with agencies, regular and routine visits to pick up screens, use of Advisory Board meetings,)

b. Programs use an outreach calendar or other tracking system that specifies places to be visited on a routine and regular basis and the outcome of the visits. Programs develop an accountability system (i.e. handed in to Program Manager every month.).

c. Outreach staff
   - Staff is trained and supported to reach out to prenatal families. Staff is supported to prioritize prenatal families even when there are families potentially "aging out" on their case lists. FAWs utilize the MIS tickler effectively to reach out to families well before the due date.
   - The program takes a team approach, utilizing the talents and relationships of staff and program participants so that the outreach net is cast as widely and as effectively as possible into the community.
   - The program recognizes and addresses the post assessment period when home visitors may need support and training around prenatal engagement in order to be successful (See "Talking Points").

d. Programs have activities in place to determine if the outreach is effective (See MIS Section 4.)

3. Advisory Board

The following are recommendations to improve/enhance Advisory Boards:

a. The Advisory Board is diverse, reflective and/or knowledgeable of the target population. It consists of relevant family, maternal and child

health entities and includes current and/or former program participants. Prenatal enrollment may be enhanced by including: the local Departments of Social Services and the Department of Health, WIC, Early Intervention, schools, Community Action Programs, Teen Parent Programs, OB/GYNs, midwives, doulas, PCAPs, and family and pediatric practices.

b. Bidirectional agreements are in place with these, and other, entities to facilitate screening, referrals, and case coordination. They are individualized to provide all the information necessary for effective collaboration. Information is provided on a regular basis to the Advisory Board members on their specific agency's referrals to the program. (Report Tab N in the MIS: Screen Referral Source Outcome Summary)

c. The Advisory Board is asked to provide feedback on increasing prenatal enrollment on a regular basis.

4. Use of Management Information System

The following tools in the Management Information System may be used for analyzing indicators related to prenatal enrollment:

- Screen Form Referral/Recruitment Sources broken down by trimester at screen date, Kempe type and enrollment. (Request report from Center for Human Services Research.)
- Report Tab N: Screen Referral Source Outcome Summary
- Report Tab O: Screen/Referral Source Demographic and Outcome Analysis
- Report Tab H: Program Demographics
- Credential tab: 1-2A and B Kempe Analysis

5. Annual Service Review

All programs complete an Annual Service Review (ASR) of their program. (See Annual Service Review.) Cultural sensitivity, outreach, and acceptance rates are included in the ASR and are also relevant to prenatal enrollment. The ASR provides an opportunity for programs to reflect how they will increase their prenatal acceptance rate based on their analysis of programmatic, demographic, social and other factors related to those families who have chosen not to participate in the program.

5. Internal Quality Assurance

Internal quality assurance measures occur on a routine basis so that success at reaching the prenatal target population can be analyzed and used to develop new approaches and effective outreach ideas. The following sources of information are useful:

- case records
- MIS reports (see Section 4 above)
- piloting of outreach and program materials with the target population

- quality assurance activities include specific attention to prenatal families (i.e. forms might include specific mention of when a participant is pregnant). These activities include supervisor interviews of those refusing to be assessed, supervisor observation of Family Assessment Workers and Family Support Workers, and information gathered from parent groups, Advisory Boards, and participant satisfaction surveys.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Criteria for Enrollment**
Policy	Healthy Families New York programs consistently use these criteria for enrollment in order to provide services to the targeted population.
Site specific reference	1-1A
Effective date	July 2001
Revised date(s)	June 2007
Appendices	no

Rationale:

Healthy Families New York Programs provide family support aimed at helping reduce the incidence of child abuse and neglect, improving child health and development outcomes and enhancing parental self-sufficiency within targeted areas served by each site. As voluntary programs, they are open to all prenatal, postpartum parents or other primary care givers of newborns who reside within the designated target area and are assessed at risk. To ensure that programs provide services to the targeted population and are consistent in the selection process, the following criteria for enrollment have been established.

Procedures:

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

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

3. Participants must live within the designated target area.

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

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

6. If the target child is placed in foster care or is not living with the primary caretaker, there must be a goal of return home with 6 months.

7. Individual programs may establish additional criteria for exclusion from program participation, but criteria must be in writing and must be approved by the OCFS contract manager. Examples of such criteria may include various mental health issues, substance abuse, or parent developmental delay issues. It may also include families residing in homeless shelters in the target area

where it is unlikely that the family will remain in the target area after leaving the shelter. Programs may also decide to make case-by-case decisions based on their ability to meet the family's needs (i.e. language requirements), lack of available resources, or there being other more appropriate services for the family. Participants should not be exempted solely because of high Kempe scores; however, programs may decide not to offer services to participants with high scores in conjunction with additional factors (e.g. untreated mental health issues, active substance abuse, etc.).

Critical Element #2

Use a standardized assessment tool to systematically identify families

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Screening for Indicators of Need**
Policy	Programs use the HFNY screening form to identify potential participants.
Site specific reference	2-1A-D
Effective date	July 2001
Revised date(s)	June 2007
Appendices	-HFNY Screening form (MIS) -Risk factor definitions for the screening process (MIS) -HFNY Pre-Assessment Form (MIS) -Self-screening Survey (sample form)

Rationale:
Healthy Families New York's goal is to screen all pregnant women and parents of newborns in each program's designated target area. This policy ensures that HFNY programs have an objective, standardized process for screening families to determine if an assessment is indicated.

Procedures:
1. A record screen is the first step taken to determine if home visiting could be of benefit to a family.

2. HFNY programs develop agreements with community entities such as prenatal clinics, WIC programs, hospitals, community agencies, etc to assure the collaborative nature of the screening and assessment process. These agreements allow programs to screen families in the target population using the Healthy Families New York Program Screening Form which is a risk factor screening tool. (See Identifying Potential Participants.)

3. The screening process is accomplished by a variety of acceptable methods. These include:
    a. Conducting a brief outreach interview ideally with families prenatally, or at the time of birth or after the baby is born.
    b. Review of medical records at prenatal clinics, OB-Gyn offices, family practice and pediatric offices, and hospitals.
    c. Contacting referral sources to identify families where there is a pregnancy or newborn less than 3 months.
    d. Some HFNY programs have developed user-friendly Self-Screening surveys for expectant parents to complete themselves. These surveys contain all of the information required on the screening tool to determine if an assessment is indicated. The forms are typically left in waiting rooms or are inserted into new patient packets at hospitals and medical offices. They are returned to the health care staff, or mailed to the home visiting program. (See Self-screening Survey for an example.)

e. Note that during the screening process, parents need to consent to being contacted by a HFNY representative.

4. The screens are completed by either home visiting program staff, typically Family Assessment Workers or staff at referral sites. For example, by Prenatal Care Assistance Program (PCAP) providers, MOMs staff, prenatal staff of private OB offices, Community Health Workers, Public Health Nurses, school personnel, and other professionals who come into contact with families in the area through outreach programs, medical linkages and other child welfare services.

- **Prenatal:** Coordinate with area clinics, private practices and other community organizations to collect completed referrals and conduct Record Screens on a regular basis.
- **Postpartum:** Review admissions in delivery units of area hospitals daily for births to perform a prescreening for families residing in the target area. Retrieve Record Screens from hospitals during routine visits.

If staff of collaborating hospitals and/or health centers conducts the record screens (instead of, or in addition to, home visiting program staff), the home visiting program provides in-services at those sites so staff can correctly administer and complete the Record Screen and carry out the process for promptly transmitting the information to the HFNY program.

5. The HFNY Screening Tool is defined as positive when it meets the criteria as described on the form. If a screen result is positive, the family is either offered an assessment interview, or a reason for not assessing the family is selected from the choices on the form.

6. A Pre-Assessment Form is completed by the FAW for all positive screens according to the instructions on the form. It is used to track families in the time period after the screen and through the Kempe Assessment, and to document outreach and engagement activities for a particular family.

7. If a screen result is negative, there is no need for further program contact with the family.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Assessment of Family Strengths and Needs**
Policy Reference	HFNY Programs will consistently use the Kempe Assessment tool to gather information about the specific strengths, risk factors, and needs of a family. All staff using the Kempe will be trained in its use prior to administering it. Programs will use the Kempe assessment to begin service planning with the family.
Site specific reference	2-1.A-C, 2-2.A-B
Effective date	July 2001
Revised date(s)	June 2006
Appendices	-Kempe Family Stress Checklist -HFNY Kempe Assessment Form (MIS) -Pre-Assessment Activity Form (MIS) -Return Referral Form (sample forms) -Consent for Assessment and Post Assessment Activities Form (sample form)

Rationale:

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

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

Procedures:

1. Standardized tool
    a. The Kempe (Family Stress Checklist) is the standardized assessment tool administered in HFNY programs to identify the parents' experiences, expectations, beliefs, and behaviors that place parents at risk of child abuse, neglect and maltreatment. It assesses for the presence of factors including increased risk for child maltreatment or other poor childhood outcomes (e.g. social isolation, substance abuse, parental history of abuse in childhood, etc.) It is also used to gather information about parents' strengths and capabilities. This information is used by FAWs to determine information and referrals to offer parents and if parents are referred to and accept home visiting, this information is then used by home visitors

(FSWs) and supervisors during the engagement process and for service planning.

b. HFNY Programs also use the Rating Scale and Guide to Gathering Assessment Information as described in the HFA Training Manual, ensuring that the tool is administered uniformly.

2. When to offer an assessment
   a. It is best to initially offer parents the opportunity to participate in the assessment without mention of home visitation. Reasons for refraining from presenting home visiting during outreach and at the start of the assessment include: Limited program capacity; home visitation may not be an appropriate referral for parents; family's Kempe score may not warrant a referral to home visiting. The assessment is best presented as a means to identify appropriate services within the community that may benefit the family.
   b. FAWs attempt to offer an assessment to all families with a positive HFNY record screen. Some programs may choose to establish additional criteria for program participation. These criteria must be submitted in writing for approval to OCFS. (See Criteria for Enrollment.)
   c. There are no requirements pertaining to the amount of time allowed from screen to assessment, although programs are encouraged to assess as soon after receiving the screen as possible.

3. Administering the assessment

   a. Ideally, assessment interviews should be done where families are residing. It is helpful to see the family and if possible, the child in the context of the family's environment. In addition, if the family is referred for home visiting, it sets the stage for family-centered work to occur in the home.
   b. Assessments may also be done-in hospitals, clinics, offices of private physicians, in the program's offices, and other community organizations' sites. Assessments must be done face-to-face.
   c. Prior to administering the assessment, a consent form must be signed by the family giving permission for the FAW to conduct and document the assessment. This consent also includes permission for the program to conduct and document any other program activities that might occur prior to enrolling the family in home visiting or closing the case. This form is developed by each program site. Programs also need authorization to Release Information where relevant, according to internal program policies. (See Appendices for sample Consent Form. These activities are documented in the case record narrative.
   d. Every effort is made to obtain consent from and assess both parents in the assessment, or significant other of the baby's mother when indicated. This might include flexing workers' schedules to accommodate the availability of this other family member.

   e. The assessment takes approximately 1 hour to administer and a "conversational-weave" approach is used to cover items on the Kempe, using skills learned for conducting a strengths-based assessment. This includes helping parents to self-identify their own strengths.
   f. FAWs are trained to accurately represent the nature of the assessment, treat parents respectfully, establish rapport and build trust in a short period of time. FAWs raise sensitive issues and remain non-judgmental of the parents' responses. These responses are used to score the Family Stress Checklist.

4. Documenting an assessment
   a. All assessments are written in a narrative format, including negative assessments, as per HFA Core training.
   b. The FAW accurately documents family strengths and needs in narrative form. Narrative form means that there is a written description of the information gathered from the family during the assessment process. It incorporates the information provided by the family that links to the assessment criteria. The assessment narrative does not include a conclusion based on information gathered in the assessment process.
   c. The FAW scores the assessment, assuring that the score is supported by the documentation, offers referrals as needed and responsibly transitions the family to the next appropriate service level.
   d. This assessment documentation becomes the basis for standards 6-1A and 6-1B requiring the use of the assessment in developing home visit content and Individualized Family Service Plans.
   e. Each individual site will develop in writing its own system for the flow of paperwork related to assessments.
   f. Each assessment is to be reviewed by a supervisor or Program Manager before a decision is made regarding its outcome.

5. Screen and Assessment Record Retention
   a. For families who enroll in the program, the assessment narrative and all forms signed by the participant during the assessment are maintained in their participant file along with the screening tool, and according to program policies for protection and confidentiality of participant information.
   b. All negative assessments and positive assessments for families that do not enroll in the program (including all forms signed by the assessed individuals) are maintained according to program policies.

6. Positive/Negative Assessments
   a. Intensive home visiting services are offered on a voluntary basis to families when:
      -Parents and/or significant other receive a Kempe assessment score of 25 or higher (positive), and
      -FAW and Program Manager or Supervisor determine that intensive home

visiting is an appropriate referral for family based on information contained in Kempe assessment, and
-Space is available on FSW caseloads to accommodate new enrollment.

b. Referrals and information to other community resources is offered to all families, including those where the parent(s) and/or significant other receive a Kempe assessment score of 0-20 (negative).

c. In very rare instances, the Program Manager or Supervisor can determine to offer intensive home visiting to a family receiving a negative Kempe score under a "clinical positive." The decision would be based on information obtained from a professional source or an FAW's strong belief that the parent withheld vital information that, if disclosed, would have resulted in a positive score. Factors justifying the clinical positive are documented within the family record.

6. Program Capacity
   a. If programs are at capacity, screening and assessment continues, but intake into Home Visiting Service ceases. Families who would otherwise be offered intensive home visiting are referred to other programs. Continuing to assess families even when there is no room in home visiting benefits families in that assessment is a service in itself, is used for referral purposes, and can be used to document program need.
   b. There are no waiting lists in HFNY. When a slot becomes available for enrollment into home visiting, the next available family who assesses positive is offered services.

7. Re-assessments
   a. Reassessments can be done if the initial assessment was negative and the family has had a subsequent child, or if the initial negative assessment was done prenatally and the family is identified again at or after birth. Additionally, a family can be reassessed if they were previously enrolled but dropped out of the program prior to two years of service and are expecting a subsequent child.
   b. If a family is receiving services, another assessment is not administered following the birth of subsequent children. The rationale for this is that FSWs work with the entire family, including subsequent children.

8. Assessment Refusals
   a. If a family refuses an assessment interview, they are encouraged to call the office with any questions or concerns about pregnancy or the newborn. They are asked to think about the program's services and if they change their minds, to contact the program at any time. The program may also mail information and/or include the parents on a mailing list. (See Outreach to and Engaging Families)

b. Supervisors periodically contact families who have refused an assessment interview as part of internal quality assurance measures. (See Evaluation/Review of Program Quality*).*

9. Training of those administering tool
   a. Assessments interviews are conducted by Family Assessment Workers (FAWs) who have been trained by a certified trainer who is trained to train others. (See Orientation Training, Core Training, Wrap-Around Training, and On-going Training.)
   b. The training FAWs receive ensures that they have adequate understanding and knowledge of using the tool appropriately. The training includes the theoretical background (i.e. the purpose of the tool, what it measures, etc.) and hands-on practice in using the tool.
   c. All FAWs are to be trained in the use of the tool prior to administering it.
   d. Programs are encouraged to cross train some staff to avoid disruption in their ability to assess in their community.
   e. FAWs submit 3 positive and 1 negative assessments to the trainer for review approximately 3 months post core training. Those whose primary role will not be administering the assessment (cross-trained staff) submit 2 assessments. Submitting these assessments is tracked by internal program QA systems. (See Evaluation/Review of Program Quality for details on internal quality assurance.)
   f. In addition to submitting the initial 2 assessments, staff that are cross-trained are required to administer at least 1 assessment every 6 months to help them retain their skills.
   g. FAW Supervisors are encouraged to retain their skills by conducting at least 1 assessment every 6 months.
   h. Volunteers who administer the assessment are required to have the same training and follow the same policies and procedures as paid staff.

10. Supervision of FAWs
    a. All staff responsible for FAW supervision and oversight must have completed the Core HFA training for FAWs before they begin supervising alone.
    b. Direct supervision of FAW staff and oversight of the screening and assessment process is provided by a trained FAW Supervisor or, depending on the site's staffing, by the Program Manager. (See Supervision of Direct Service Staff.)

11. Procedures for Staff

In order to adhere to this policy, each program develops internal policies and procedures for contacting families for assessment, and for administering the tool.

Critical Element #3

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

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Outreach to and Engagement of Families**
Policy	Healthy Families New York programs utilize persistent and creative outreach methods to engage and re-engage families as well as to maintain family involvement. Programs define, measure and analyze the retention rate of participants in the program in a consistent manner and on a regular basis at least once a year.
Site specific reference	3-1, 3-2A-B, 3-3A-B, 3-4A-C
Effective date	July 2001
Revised date(s)	June 2007, October 2010
Appendices	-Pre-Intake Activity Form (MIS) -Change Form (MIS) -Home Visit log (MIS) -Guidelines for Engaging Families and Building Trust -Creative Outreach Pre and Post enrollment activities and checklist

Rationale:
To ensure that HFNY services are offered on a voluntary basis. The voluntary nature of HFNY services demonstrates respect for the rights and decisions of potential and current program participants. While the decision to participate in program services at any point is voluntary, HFNY staff use persistent and respectful outreach methods in recognition of the fact that many families will want to establish trust and confidence in the program before agreeing to initiate services.

Similarly, a variety of circumstances may cause participating families to discontinue home visits for a time. This policy ensures that the program is structured to allow for these circumstances without immediate termination of services and to provide a framework for re-engaging families who have become disengaged. This policy ensures that programs have a process for reaching out to and engaging families, as well as for maintaining family involvement and re-engaging families who may be more challenging to serve.

Guidelines

1. Voluntary nature of services

HFNY Program sites must offer home visiting services voluntarily and programs have procedures in place to ensure services are offered to families solely on a voluntary basis. Materials such as brochures, service agreements and participant

Bill of Rights may be used to inform families about the voluntary nature of services.

2. Outreach and Engagement techniques

Each HFNY program develops comprehensive guidelines that specify the techniques used for outreach and engagement. They may include telephone calls, family centered practices, home visit attempts, mailings, parenting groups, and contacts to referrals sources, along with other techniques approved by your agency. Follow-up is an essential component of outreach.

3. Outreach Strategies

a. Traditional Outreach
- is used to introduce the family to the program and the services and might include flyers, posters, mailings, etc.
- materials should be culturally, gender, and language appropriate for the various groups in the target area.

b. Creative Outreach
- is used to engage or re-engage families in the program by building the family's trust and continuing to offer support.
- is a more flexible approach that is tailored to individual families.
- is used to assist families in understanding how the program could be of value to them in particular.
- program staff utilize their knowledge of the family, including their strengths, living situation (i.e. location, access to phone, etc.) challenges, and gestational age or age of the child in their selection of outreach activities.
- examples of creative outreach strategies might include phone calls to inquire about mother's and baby's well-being and inquire if they have any questions or concerns, materials that are geared specifically to the father's role in child development, or calling to provide information and referral based on existing knowledge of the family, letters that mention the stage of gestational development or the baby's developmental milestones, invitations to program activities, references to the child's age and development in both phone calls and mailers, and references to the family's strengths and goals.
- in the HFNY MIS, Creative Outreach refers only to post-intake activities.

4. Pre-intake Outreach

a. For parents who are offered an assessment, or who have been assessed and offered home visiting services but do not immediately accept, program sites develop and use positive, persistent outreach efforts to build family trust and attempt to engage them in an assessment or in the home visiting component of the program. Supervision is an excellent place to strategize ways to continue to build trust and engage families.

b. These outreach activities may continue, but do not have to continue, until the target child is three months old if it seems that continued efforts may result in engagement. Supervisors work with staff to determine if engagement efforts should continue. This decision is made using information about the family that is gathered from sources such as the referral agency or the Kempe. If a family has not been successfully engaged in home visiting services by the time the baby is three months old, efforts are discontinued and the family is taken off of the list.

5. Post-intake Outreach
   a. For enrolled families who seem to be disengaging from the program, (i.e. missing visits) positive and persistent outreach efforts are also to be used to re-engage them back into the program. Supervisors and staff spend time in supervision strategizing ways to continue to build trust, re-engage families and maintain involvement.
   b. Creative Outreach (Level X status) corresponds to the family's circumstances and not those of the worker or the program. For example, families may not be placed on Level X when a worker is on leave of absence or vacation, or when the program is having trouble filling a vacancy. It is the program's responsibility to visit the family according to the family's current home visit level.
   c. The Supervisor will help the FSW determine the frequency and type of outreach to pursue. In general, some form of contact with the family is attempted at least once a week with families in creative outreach. If the family is opposed to visits, phone contact may be attempted at least weekly and in-person visits attempted as appropriate with the family's permission.
   d. While the circumstances of families may vary, the program places families on outreach status (Level X on the MIS change Form) when they have missed 3 consecutive home visits and there has been no communication. This would not include a family who calls prior to the visit to reschedule. The date on the MIS change form corresponds to the date of the third missed home visit
   e. In order for a family to be placed back on their previous level, they need to have received two consecutive home visits. The date on the MIS change form is the same date as when the second consecutive home visit occurred.
   f. Families are returned to their same or a higher frequency of visits when they are taken off of Level X. This decision is made based on discussions between the supervisor, worker and family (not necessarily at the same time.)
   g. Programs try to re-engage families for a minimum of three months (92 days exactly) however, before 92 days, they are taken off of Level X status immediately if:
      - The family has refused services
      - The family has moved from the area.
      - The family has been re-engaged in services

h. Families may be maintained on creative outreach for as long as deemed appropriate if their circumstances make it likely that they will be re-engaged. Supervisors discuss these situations with staff and document them. Programs utilize the credentialing tab 3-3C Creative Outreach to assist them with managing families on Creative Outreach. Programs strive to keep the overall percentage of families on creative outreach at or below 10%.
i. When families leave the service area for extended periods of time, they may be placed on Level X. A full review of the case with the Program Manager and other relevant staff is held. This review includes the family's intentions to return and ideas for remaining in contact (~~e.g.~~ such as sending age appropriate child development curricula). This review ~~should be held and~~ documented. If a family does not return within 6 months, their case is closed. Programs need to have internal policies in place to guide them in their decision making.

6. Documentation of outreach and engagement
a. Evidence that above guidelines are being implemented is documented in participant files, supervision notes and the MIS.
b. Pre-intake outreach activities are documented on the MIS pre-intake activity form and, any internal forms such as progress notes, as specified in individual program policy.
c. Post-intake outreach activities are documented on internal forms such as progress notes as specified in individual program policy. Programs utilize the MIS Change Form to place families on, and remove them from, creative outreach status (Level X).
d. Acceptance of services, refusals of service, and family retention rates are reported by programs through the state Management Information System.

7. Definition and measurement of retention rates

Programs are required to define and measure the retention rate of participants in the program in a consistent manner and on a regular basis, at least once a year. Programs are required to address in writing in the Annual Service Review how they might increase retention rates based on its analysis of programmatic, demographic, social and other factors related to dropping out of the program after receiving services every year. Programs compare data for families who left the program to families who remained in the program. Program use data collection (Credential Tab: 08. 3-4. A and B Retention Rate Analysis) and informal methods, such as discussions with staff and others involved in program services. (See Annual Service Review.)

Critical Element #4

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

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Length and Frequency of Services to Families**
Policy	See Below
Site specific reference	4-1A-B, 4-2A, 4-2D
Effective date	July 2001
Revised date(s)	June 2007
Appendices	-Service Agreement - Criteria for Level Change and Level Completion form -Pre-Intake Activity Form (MIS) - HFNY Change Form (MIS) - HFNY Home Visit log (MIS) - Supervisor Case List (MIS) - FSW Case List (MIS)

Policy:

For those families who accept home visitor services, the first home visit occurs prenatally or within the first three months after the birth of the baby.

HFNY Home Visiting Services are offered intensely, i.e. at least once a week following the birth of the baby. Services are offered over the long term, i.e. for a minimum of three years and up to five years or until the child has entered school or Head Start.

Parents who accept home visiting services must be offered a minimum of weekly visits of approximately one-hour for at least 6 months (183 days) following the child's birth, excluding time spent on Level X. If a family enters the program postnatally, the family must be provided weekly services for a full 183 days. In other words, the baby turning 6 months old is not the marker which should be used by programs.

Families identified prenatally may receive less frequent home visits until the birth of the child, (twice per month minimally) but ideally they will receive visits more often to focus on prenatal bonding and preparation for parenthood for both mothers and fathers.

The home visiting schedule for the program will be consistent with that of Healthy Families America. Following weekly visits for at least a full six months (183 days excluding level X), staff will apply “Criteria for Level Promotion” (HFA Training Manual) to determine the frequency of home visits, except that, contrary to the criteria in the training manual, the Kempe Family Stress Checklist is not re-administered.

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

Rationale:
To ensure that HFNY programs have a well-thought out process for determining and managing the intensity and frequency of home visits that is consistent with the needs and the progress of each individual family. Offering services intensely for at least the first six months is critical for reasons such as relationship development, newborn care and safety, and monitoring the family's adjustment to parenthood.

Procedures

1. Frequency of Visits
The frequency of home visits will vary over the three to five years, as defined below. Participants are assigned to levels according to the intensity of service needed. All families enrolled will begin at either the Prenatal Level or, if enrolled post-partum, at Level One. In rare cases of exceptional need, families may begin services at Level 1SS (Special Services). Families may move to more or less intensive levels of service, depending on need, as defined in the "Criteria for Level Promotion." (See "Three party review of level completion" under Procedures section.) The levels are as follows:

- Prenatal Service Level: from two home visits per month to weekly home visits
- Level 1: weekly home visits, generally for a period of six to nine months, *excluding time spent on Level X.* For families who entered the program when the baby is older than 1 month, or for families who have been on creative outreach, it is important to have record keeping that will ensure a total of at least 6 months (183 days) active time spent on Level 1, and not remove families from Level One when the baby turns 6 months old.
- Level 2: home visits 2x per month
- Level 3: home visits 1x per month
- Level 4: home visits every three months
- Level X: Creative Outreach
- Level 1-SS: more than one home visit weekly, or weekly visits plus other contacts

7. Length of Visits
Home visits typically last 60 minutes. However, a visit of 30-50 minutes can be logged with supervisor approval on the corresponding forms (i.e. MIS Home Visit log and narratives forms). Approval is based on HV content and situational factors.

8. Scheduling of visits

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

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

4. <u>Definition of home visit</u>
A family is considered to have had their first home visit when the family states to the FSW that they want the program. This visit occurs in the family's home unless circumstances prohibit this and the alternate venue has been discussed with a supervisor. The first Home Visit Log (MIS) is submitted, and each program develops internal procedures for other paperwork such as Service Agreements/Consents that may need to be signed at the first home visit.

A visit is considered "in home" as long as it takes place on the property of the family and the worker is able to see the child and parent in the child's environment. HFNY is a family-centered program and there are occasions when the FSW may work with the child and someone other than the parent. For example, in some communities, the FSW may work to promote PCI with a caregiving grandparent since s/he is with the child for many hours each day. This does not replace working directly with the parents.

Workers meet with families in the family's home so that they can assess safety, experience the family's living environment, develop first hand knowledge of the strengths and stresses of the home environment, and to engage the family where they live. Programs provide a minimum of 75% of all visits in the participants' homes. This percentage is tracked by the MIS.

Home visits are face-to face interactions with the promotion of parent child interaction as a primary focus. They also focus on the promotion of healthy childhood growth and development and the enhancement of family functioning. Programs use the MIS to manage and track the intensity of home visitor services.

5. <u>Content of Home Visit levels</u>
- **Prenatal Home Visits**: During these home visits the FSW provides information to the family regarding prenatal care, fetal development, preparation for birth, and preparation for newborn care. A major emphasis is on encouraging the parent to obtain regular prenatal care, on supporting the parent in obtaining care, and on helping the parent to prepare a safe environment for themselves and the baby.

- **Level One Home Visits**: During this period, the emphasis is on educating about child growth and development, evaluating parent-child interaction and conducting activities to promote bonding and attachment and positive parent-

child interaction. Appropriate developmental assessments are completed and, when appropriate, referrals made for further developmental evaluation and intervention. Programs may document one group meeting per month as a home visit for families on Level 1 only when the home visitor is also involved with the group meeting.

- Families requiring very high level of service due to unusual circumstances may be placed on **Level One-SS (special service).** However, it is recommended that families be moved to One-SS only from Level One.

- **Level Two Home Visits**: The major emphasis is on activities that promote positive parent-child interaction, healthy child growth and development, family life stability, and self-sufficiency. Also on level two, as with all levels throughout the program, support is provided to the families on whatever issues are identified, by providing information and referrals as needed.

- **Level Three Home Visits**: The education that has occurred previously will have enhanced families' knowledge and understanding of community resources. The activities discussed for levels one and two continue on level three. IFSPs continue to be reviewed and developed at least every six months, as do all appropriate developmental assessments.

- **Level Four Home Visits**: During these visits, materials on child growth and development and parent-child interaction continue to be reviewed. Close monitoring of the child's health and development, and progress toward the family's IFSP goals are the main emphasis.

- **Level X Home Visits**: Attempting home visits is a useful strategy for re-engaging families who are on Level X and should be attempted when appropriate. During supervisory sessions, the supervisor and FSW make a judgment regarding the type and frequency of participant contact for Level X families. (See Outreach to and Engaging Families for procedures and ideas. See "Typical Course of Service," the HFA Training Manual, and the HFA Family Support Worker Training Manual for additional detail on services provided at the various levels.)

- **Out-of-Home Visits**: For Level 1 participants, one group meeting per month may be counted as a required weekly contact provided the family's FSW also attends, to encourage parent and FSW involvement in parenting, socialization and play groups. If a group is used as that week's contact, the FSW still completes documentation in the Home Visit Log. These visits are marked as "out of home" on the MIS home visit log form. Participants on Levels 2-4 may participate in group meetings, but these should not be counted in lieu of the required number of home visits.

Procedures for Staff

1. Introducing length and frequency of home visiting
Before the family agrees to participate in the program, they need to have a clear understanding of the length and frequency of involvement. Programs typically use a Service Agreement to assure that all important information about length and frequency of involvement is shared in advance with the family. Explain to the family that the program will be available until the child enters school or Head Start and their continued and consistent participation is needed for the family's goals to be accomplished. At the same time, since the program is voluntary, they can withdraw from the program anytime.

2. Three party review of level completion
a. The participant's progression to a new level of service is reviewed by the family, the home visitor, and the supervisor. All three parties do not have to be present at the same time to conduct this review. All conversations regarding the review are to be documented in the participant file and supervisor notes. Program data reflects that a participant was moved to a new level only after all three parties were involved in this review.

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

c. A family may be moved to a different level depending on their progress. Decisions about level change will be made by the Supervisor following a recommendation made by the FSW for review. Programs specify in their own policies how frequently the Family Support Worker and Supervisor will together review each family's progress; however, it should not be any less than every two to three months.

d. The Supervisor completes the case review and reaches a decision at that time. The decision to move the family to a different level, up or down, will depend on the following areas: stability of functioning, number of social supports, family problem-solving skills, number and type of family crises, percentage of scheduled home visits completed, appropriate use of medical services, medical well-being of the child, and quality of parent-child interaction, as stated in the "Criteria for Level Promotion." (See HFA Training Manual.) Programs may utilize a form such as a Level Completion Form (see attachment) to document which criterion have been met. Decisions to move a family to a different level are not made based on program need or the age of the child.

e. The FSW will discuss the plan to change levels with the family, and when the family is ready, they will be moved to the appropriate level, with the frequency of home visits changing accordingly.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Home Visit Completion Rate**
Policy	Seventy-five percent of HFNY participants receive a minimum of 75% of the appropriate number of home visits based upon the individual level of service to which they are assigned, with at least 75% occurring in the home. Visits that occur outside of the home have a similar focus as in-home visits, including focusing primarily on promoting parent-child interaction. Programs develop a plan, at a minimum of once a year, to address the home visit completion.
Multi-Site Reference	Q-2.6
Site specific reference	4-2B, 4-2C
Effective date	June 2007
Revised date(s)	
Appendices	-Credentialing Tool 4-1B Home visit completion rate analysis (MIS) -HFNY Home Visit Log

Rationale: Home visiting is the foundation upon which the HFNY program is built. In-home visits (taking place where the family lives) provide the opportunity to experience the family's living environment, to develop first hand knowledge of the strengths and stresses of the home, and to utilize this knowledge in working with the family.

This policy ensures that families at the various levels of service offered by the program receive the appropriate number of home visits, based upon the level of service to which they are assigned and that the program monitors and addresses how it might increase its home visitation completion rate.

Procedures:

1. The HFNY Management Information System collects information related to levels of service and home visitation completion rates by level of service and length of time in the program. This information is used to track and evaluate how individual sites and the system as a whole are doing in comparison to the HFA standard.

2. Programs submit monthly data (MIS home visit logs) into the MIS in order to monitor the home visit completion rate per FSW and per family. It tracks the number of completed visits against the number of expected visits.

3. Programs can access their home visit completion rates from the MIS as regularly as desired; however, it is best to look at these rates over a period of three months.

4. Supervisors review the home visit completion rate per FSW on a regular basis and work with FSWs to identify scheduling strategies, engagement issues, or other barriers to be addressed.

5. The supervisor and FSW review the MIS home visit completion rates per family during supervision to identify families who may be disengaging or having scheduling conflicts. They also reflect on the engagement process and various aspects of the FSW/family relationship and if there is anything about it that might be impacting the rates. These discussions for increasing the home visit completion rate are documented in the supervisor notes.

6. Programs are encouraged to focus on home visit completion rates during team and staff meetings. When rates are above the threshold, programs focus on what activities have contributed to their success; when rates have fallen below the threshold, programs brainstorm reasons for this, and develop program-wide strategies for increasing the rates. These discussions are typically documented in staff meeting minutes.

7. Based on regular monitoring of the home visit completion rate, programs can determine related patterns and trends. A plan is developed each year that may include actions related to staffing, policies, and program operations and included in the Annual Service Review. (See Annual Service Review.)

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Transfer of Cases**
Policy	Program services are not interrupted when a participant family moves from one HFNY target area to another.
Site specific reference	n/a
Effective date	June 2007
Revised date(s)	
Appendices	-Guidelines for Transfers from one HFNY Program to Another HFNY Program -Guidelines for Transfers from a HFA (non-NYS) Program to a HFNY Program -Site to Site Transfer Control Form

Rationale:

To ensure that Healthy Families services are not interrupted when a family moves out of the original service area.

Procedures:

When there is a transfer of a family from one HFNY Program (original program) to another HFNY Program (new program), the original program will close out the case by the usual procedure and follow the instructions detailed in the attachment "Guidelines for Transfers from one HFNY Program to Another HFNY Program."

When there is a transfer of a family from a non-NYS HFA Program to a HFNY Program, the HFNY program will attempt to obtain as much information on the case as possible from the non-NYS program or the participant, and follow the instructions detailed in the attachment "Guidelines for Transfers from a HFA (non-NYS) Program to a HFNY Program."

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Completion of HFNY Program**
Policy	Healthy Families New York offers voluntary services to families for a minimum of three years after the birth of the baby depending on the needs of the family.
Site specific reference	4-3
Effective date	June 2007
Revised date(s)	
Appendices	Service Status Sheet (MIS) Credentialing Tool Participant in program at least 3 years. 4-3B (MIS)

Rationale:
To ensure that HFNY programs offer voluntary services to families for a minimum of three years after the birth of the baby, depending on the needs of the family.

Procedures:

1. A family has completed the program when one of the following is true and is marked on the MIS Service Status sheet:
   - Participant graduated, met goals, target child in school, and completed program
   - Target child entered Kindergarten
   - Target child entered Head Start

2. Transition time of 3 months may be allowed for families to move out of the program.

3. A family may complete the program in between 3 – 5 years, depending on the family's progress.

4. The date of closure is the last home visit.

5. The MIS Credentialing tool "Participant in program for at least 3 years" provides evidence that the program is following its policy and procedures around this standard.

Critical Element #5

Services are culturally sensitive

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Culturally Responsive Services**
Policy	HFNY programs work toward making all aspects of service delivery culturally responsive and family-centered.
Multi-Site Reference	Q-4.3
Site specific reference	5
Effective date	July 2001
Revised date(s)	June 2007
Appendices	

Rationale:

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

Procedures:

Each site is to design its services in order to best serve the cultures, ethnicities, and spoken languages that are found in its target community(ies). Services are culturally sensitive and family centered. Materials and presentations for the public, for participants, and for the target population will be participant-centered. (i.e. relevant, culturally responsive, and understandable).

Programs must demonstrate a commitment to hire staff and involve volunteers and community partners who are representative of the language and culture of the population to be served and who are hired from the community targeted for services.

Healthy Families New York Program sites must ensure that cultural diversity training is provided for all staff.

GUIDELINES

1. Cultural characteristics

Programs have a description of the cultural characteristics of its current service population. Cultural characteristics may include features and attributes such as ethnic heritage, race, customs, values, language, age, gender, religion, sexual orientation, social class and geographic origin among others as identified by the

program. Programs can obtain and study records from City/County Planning Boards, City/County Departments of Health, Public Assistance agencies, the U.S. Census, etc. to determine ethnic and cultural characteristics of the community(ies) being served.

2. Personnel and Communication with participants
Programs demonstrate a commitment to hire staff and involve volunteers and community partners who are representative of the language and culture of the population to be served and who are hired from the community targeted for services. Hiring of staff members, particularly Family Assessment Workers (FAWs) and Family Support Workers (FSWs), reflect the ethnic and cultural characteristics of the families served. Programs strive for FAWs and FSWs who can converse with program participants in their native languages. At best, program staff should be able to understand a wide range of cultural belief systems and corresponding behaviors that may affect all aspects of achieving program goals. One avenue to achieving that is to recruit workers from the community and cultures being served. Job descriptions for all staff include relevant bilingual ability and knowledge/experience of cultures served.

3. Collaborating agencies/Advisory boards
Those involved in program planning and management, such as collaborating agencies and/or Advisory Board members include persons and organizations who reflect the ethnic and cultural characteristics of the community. Each program forms solid, working relationships with culturally and linguistically appropriate agencies and organizations in the community in order to best serve program participants.

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

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

6. Training
Healthy Families New York Program sites ensure that cultural diversity training is provided for all staff.

- Wraparound training, either prior to or following the week of HFA core training, includes at least one session on community-specific cultural competence.
- Follow-up training curricula addresses training needs specific to each community's cultural diversity. (See Required Trainings). Staff is required to attend at least one training per year related to culture. During their first

year, the wrap around training "The Role of Culture in Parenting" satisfies this requirement.
- Programs work with, or contract with, local agencies within the site's community, and within the region, to plan and provide cultural competence training, as appropriate.

7. Useful Mechanisms for Cultural Sensitivity Review

Programs' internal procedures include a process to examine how it is providing culturally sensitive services. (See Annual Service Review.) This process may include some of the following mechanisms to ensure they gather the necessary feedback from family and staff.

- participant satisfaction surveys distributed annually to all program participants that include specific questions related to cultural sensitivity
- quality assurance home visit and supervision observations
- resources (literature, journals) so staff can learn how cultural traits of families may be utilized in service delivery
- on-going input from staff documented in team meetings minutes
- annual staff break-out session on cultural competency as it relates to screening/assessment; outreach; home visits and service planning, materials and curriculum, forms, hiring and recruitment, training, and parent groups.
- group supervisors' planning meetings
- staff training evaluations
- piloting of materials with families, materials review
- participant input from Advisory Committee meetings, parent groups and informal opportunities for feedback to be shared.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Annual Service Review**
Policy	Programs conduct an annual review to address all components of the service delivery system related to cultural competences (e.g., family assessment, service planning, home visitation, and supervision, etc.). The review addresses the project's materials, training and service delivery system.
Site specific reference	1-1.A-B, 1-2,3-4, 5-1, 5-2, 5-3, 5-4, 9-1, 9-4
Effective date	July 2003
Revised date(s)	June 2007
Appendices	Annual Service Review with data reports

Rationale:

To ensure that programs have a process for examining critically and deliberately its current ability to provide culturally sensitive services.

Procedures:

1. All programs complete an Annual Service Review of their program based on the most recent information that is available. This review is reported to the appropriate supervisory or advisory group of the program. This review is completed in the fourth quarter of the program's contact year and submitted at the end of the contract year as the final report (within 30 days) to their OCFS Contract Manager.

2. The first quarterly report for the following contract year should include any comments made by the advisory board and any action plan in place to resolve issues identified in the review, as well as any steps implemented to resolve issues.

3. OCFS monitors the annual service reviews of culturally sensitive practices completed by each site within its system to identify and address any changes that may be needed in the areas of cultural and language diversity, participant-centered perspective, staffing and literacy level of program materials and to ensure ongoing adherence to the standards identified in the site self assessment tool.

Content of reports:

1. The review should be comprehensive. It includes information about the program's materials, training, and all aspects of the service delivery system (assessment, home visiting, and supervision). It includes input from families and program staff and identifies patterns and trends related to program

strengths as well as areas to improve upon such as any culturally sensitive service gaps. (See Culturally Responsive Services: Useful Mechanisms for Assuring Culturally Sensitive Services.)

2. The review includes the following information. (Included in this list are the MIS reports that will assist programs with their review.):

- Descriptions of how all aspects of service delivery are evaluated for cultural competency. (i.e. assessment, service planning, home visitation, supervision, materials, etc.) (See Culturally Responsive Services.) Credential report tab: 55. 5-3 Culturally Sensitive Practices
- A description of the target population that includes key demographic information. (i.e. Live births per year, number of women of child bearing age, number of single parents, age of target population, and race/ethnicity/ cultural/linguistic characteristics.) (Good website for demographics by county: http://www.nyskwic.org/access_data/map_select.cfm) For program demographics, Reports tab report: H. Program Demographics
- How many screens were completed this contract year? What are the barriers to reaching universal screening if any? Reports tab: N. Screen/Referral Source Outcome Summary and O. Screen/Referral Source Demographic and Outcome Analysis. Describe any new linkages or process established to achieve universal screening.
- A description of issues facing the community. (i.e. infant mortality rate, poverty level, teen pregnancy rate.)
- Where target population can be found. (i.e. agencies, hospitals, etc.)
- The program's definition of acceptance rate.
- A description of the population who accepted and refused assessment and why they refused. Credential Tab: 08. 3-4. A and B Retention Rate Analysis
- A description of how the program is attempting to improve acceptance of the assessment based on the analysis above.
- A description of the population that is determined eligible to receive services by virtue of scoring 25 or more on the Kempe Assessment tool. Credential tab: 1-2A and B Kempe Analysis
- A formal or informal analysis of those who refused the program who were determined to be eligible for services and the reasons why. Credential tab: 1-2A and B Kempe Analysis, Quarterly tab: D. Pre-intake Engagement
- A description of how the program addresses how it might increase its acceptance rate and a plan to improve this rate.
- A formal analysis of who dropped out of the program after enrollment and the reasons why. Credential Tab: 08. 3-4. A and B Retention Rate Analysis
- A description of how the program is addressing its retention rate based on the analysis of factors identified.
- An analysis of the home visit completion rate and plan to increase the rate.

- For each performance target achieved, are there any particular factors that you attribute success to? For each target not achieved, please describe steps taken, barriers to achievement and plan for overcoming barriers and achieving targets or technical assistance needed. Quarterly Tab: A. Performance Targets, L. Performance Targets for 4 Quarters
- Rate of personnel turnover and analysis of factors resulting in turnover. (See Personnel Turnover.) List any new staff hired during the contract period and date of hire. List any staff that left the program during the contract period, date they left, and reason for leaving. If FSW left the program, how was the caseload shift handled? Did families leave because of turnover? How many? A description of current staff including demographic information. Quarterly Tab: K. Worker Characteristics Summary.

Critical Element #6

Supporting the parent(s) and the parent-child interaction and child development

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Supporting the Parents and the Family**
Policy	Programs efforts focus on increasing knowledge and understanding of child development, reducing parental stress and increasing parental self-confidence.
Site specific reference	6
Effective date	July 2001
Revised date(s)	June 2007
Appendices	

Rationale:
While a secure attachment (which is supported in the development of positive parent-child interaction) provides a child with resiliency against a wide spectrum of risk factors, its development often requires support in the form of increased knowledge and understanding of child development, parental stress reduction, increased empathy for the child, and increased parental self-confidence. For this reason, the program focuses efforts on all four of these areas.

Basis for Working in Partnership with Families

Healthy Families New York Program services are family centered, based on the belief that parents, not home visitors or agencies, hold the strongest potential to help their children grow and develop with healthy, functional capacities. A fundamental belief of the program is that families are capable of change, are best able to know what changes need to be made, best able to choose solutions that fit them and best able to decide what support they choose to receive in making their family the best it can be.

Healthy Families New York offers flexible, collaborative services to families, identifying and building upon family strengths and competencies, and respecting family values, beliefs, and culture.

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

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Review of Initial Assessment**
Policy	The FSW, the supervisor and the participant family discuss strengths and address issues identified in the initial Kempe Assessment. These discussions are documented in participant and supervisor files, as appropriate. Referrals for current issues identified on the Kempe of domestic violence, substance abuse or mental health are made within 6 months of enrollment. All three parties use the Kempe for service planning during the course of services offered to families.
Site specific reference	6-1.A, B
Effective date	June 2007
Revised date(s)	
Appendices	

Rationale:
To assure that supervisors and home visitors use the initial assessment in service planning and that they refer back to it during the course of services offered to families to ensure that presenting risks have been discussed, re-evaluated as needed, and addressed, and to ensure that family strengths are used in service planning and in on-going work with each family.

Procedures:

Supervisors and Home visitors

1. Each program develops a system that ensures that the issues and strengths identified in the initial assessment are discussed and reviewed by and between the supervisor and the home visitor.

2. Many programs also include the FAW and/or FAW Supervisor in these initial discussions.

3. This discussion is documented in a consistent place such as supervisor logs and/or the back of the Pre-Intake Activity Form.

4. The assessment is reviewed with the supervisor to look for *potential* strengths, challenges, and goals. The discussion and documentation include efforts to understand the stresses experienced by the family and how the home visitor may begin to address issues that place families at-risk for negative outcomes. These efforts also include highlighting the strengths that families self-identified and those identified by workers during the assessment process so that both stresses and strengths are a part of the service planning.

5. Each program develops a system to assure that the issues identified on the Kempe are revisited over time, including the frequency of the review. If domestic violence, substance abuse, or mental health is identified as a current issue on the Kempe Assessment of an enrolled participant, a referral is made within 6 months of enrollment. There is a Kempe PC1 Issues report in the MIS to help assure that these referrals have been made in a timely fashion. This report tracks only referrals made for Primary Caregiver 1 (PC1) however, referrals are made for any family members, when appropriate. Programs are encouraged to print this report on a regular basis. (see Performance Target MLC7 where programs report these referrals on a quarterly basis.)

6. During supervision, supervisors will engage FSWs in discussion of issues that were brought up on the assessment, especially as they relate to IFSP development. Supervisors also strategize with FSWs how to raise these issues in appropriate, effective and sensitive ways i.e. culturally sensitive, recognizing potential safety concerns for families and workers.

7. Supervisors will discuss with FSWs that the information on the assessment has been voluntarily disclosed by the family, and to be aware that each new family likely knows the FSW has seen or discussed the content of the Kempe assessment and is likely expecting that the FSW will raise and provide help or support for issues identified on the Kempe.

Home Visitors and Families

1. Each program develops a system that ensures that the issues identified in the initial assessment are discussed between the home visitor and participant family.

2. This discussion is documented in the participant file.

3. The discussion and documentation include efforts to understand the stresses experienced by the family and initial plans to address issues that place families at-risk for negative outcomes. These discussions with the family also highlight the strengths that the families had self-identified during the assessment process and those identified by the worker, so that both stresses and strengths are a part of the Individualized Family Service Plan process.

4. At time of assessment, FAWs inform participants how the content of the interview is shared with program staff. This helps the participant to connect the assessment process with the on-going work of the program.

5. At the time of enrollment, the FSW reminds the participant that the FAW has shared the content of the interview. This sets the expectation that it will be an on-going aspect of work with the program, and it may increase the participant's comfort level when the FSW begins to discuss it.

6. The FSW reviews and does follow up on referrals made by the FAW.

7. Some programs have found it helpful to include the FAW in the initial visit by the FSW in order to facilitate discussion of the assessment.

8. During supervision, the FSW supervisor revisits the issues identified on the Kempe in order to provide historical context for what might be happening currently or help the FSW recognize a family's progress compared to what was happening with them at the time of enrollment.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Individual Family Support Plan (IFSP)**
Policy	HFNY programs use the IFSP to guide the delivery of program services. The process of developing the plan uses family support practices and is driven by the family in a collaborative effort with the FSW and the FSW supervisor.
Site specific reference	6-2 A-D
Effective date	July 2001
Revised date(s)	June 2007
Appendices	-IFSP worksheet and IFSP -IFSP Rules and Ideas

Rationale:
To ensure that the delivery of services to families is guided by the Individual Family Support Plan (IFSP) and that the process of developing the plan uses family-centered practices. The IFSP serves 4 main functions:

a. It is a guide for service delivery to ensure families are getting what they need from program services
b. It is a tool for supporting, assisting and in some instances, teaching, problem-solving skills
c. It provides recognition of family strengths, competencies, and accomplishments.
d. When successfully implemented, the IFSP sets the family up for success, thus increasing the tendency to plan and increasing self confidence, self-sufficiency and a sense of self-efficacy

Programs help families identify, plan for and obtain needed services and achieve specific goals they have set. The IFSP should never be viewed as a contract for service provision or a "service plan that the family agrees to."

Home visitors treat families as partners in this process, eliciting ideas from parents and providing information, but not persuading or pushing an agenda that the family does not share. Home visitors behave in ways that demonstrate respect for the attitudes, values and competence of program families.

The process of developing the plan uses family support practices and is driven by the family in a collaborative effort with the FSW and the FSW supervisor. This collaboration will help to yield IFSPs that are family centered and family directed.

Families and FSWs review and revise the IFSP on a regular basis. The review schedule establishes a timetable for the family and the home visitor to regularly review strengths and accomplishments, parent child interaction and relationships, stressors, needs, and any issues regarding the target child's development. The family reviews and revises goals and the methods by which

they will be addressed, with the FSW acting as a facilitator in the problem-solving process.

Procedures:

Initial IFSP

1. The IFSP is completed within 45 days of intake and may take 2 or 3 visits to complete. After an initial IFSP planning discussion with the Supervisor, that includes the content of the assessment, the FSW collaborates with the family to identify family strengths, competencies and family needs. Some ways that this may be accomplished are:

   - Informal discussion which takes place during home visiting.
   - Activities using a variety of tools (i.e. checklists that identify family strengths and needs)
   - Discussion regarding information gained through the Kempe Assessment or through the Parental Stress Index (PSI) when families have entered the program postnatally.

   These conversations and activities are documented by the FSW in the participant record.

2. Goals
   - Goals are specific, measurable (observable), attainable, realistic, time-limited, and stated in the positive.
   - Goals and specific objectives/strategies are developed for both family and parent-child interaction/child development needs.
   - IFSPs contain goals for the parent, the child and the parent-child interaction.
   - Goal setting is an opportunity for the home visitor to discuss with the family issues that impact healthy parenting such as those identified in the initial assessment, healthy lifestyle issues, self-sufficiency, and any other issues identified from other tools used by the program in an open and honest way as well as goals designed around child development and parent child interaction.
   - Typically, at least one child development/PCI goal (ex: help the baby learn to sit up) and one family functioning/self-sufficiency goal (ex: replace SS card so we can apply for a loan) are part of the IFSP.

3. Forms

Programs may identify their own IFSP worksheet forms. They contain the following, at a minimum:

- A place for the family's signature (at least two family signature spaces to attend to engagement of both mothers and fathers), the FSW's signature and the supervisor's signature.

- The date the IFSP was developed
- An area for identifying individual goals
- An area for identifying the steps toward achieving the goals
- Dates for completing each of the steps toward completing the goals
- Dates for completing the goals
- An area for documenting discussion of the family's strengths as they relate to developing the IFSP (may be documented on a separate sheet or other form if preferred.)
- Including space for recording pertinent referrals is also suggested.
- Programs are encouraged to document the discussion of, and/or celebration of successes.

4. All IFSPs (initial and updated) are reviewed and discussed with supervisors.
5. All IFSPs are signed by the FSW, the Supervisor, and the parents, although it does not need to be all at the same time.
6. It is recommended that the original IFSP goes to the family and copies are kept in family file and supervisor's binder, according to program protocol. FSWs find it useful to carry a copy in the folder they take for home visits so that it is available for on going conversation.

<u>On-going work with the IFSP</u>

1. Timeframes
    - The formal update of the IFSP is frequent enough to insure meaningful and relevant goals are being set. It is reviewed and revised with the family every six months, or more often. The IFSP is to be up-to-date and active throughout the family's work with the program.
    - Documentation of this process is recorded in the participant file. (As in #1 in the preceding section on "Initial IFSP") IFSPs may be updated sooner if a family has accomplished goals or decided to change them.
    - The FSW and FSW supervisor refer to the IFSP at least every month to assess its continuing appropriateness as a guide for services.
    - IFSPs are reviewed with the family and updated at least every six months for families on Levels 1, 2, and 3. If a family is on level 4, the IFSP can be revised annually.
    - If a family is on Level X because they have had to temporarily stop receiving services, the IFSP is updated or a new IFSP is completed once services are reactivated.
    - If the IFSP was completed prenatally, a new goal for the baby is added soon after the baby is born.

2. Supervisor Role

- Documentation of supervisory discussions is kept according to program protocol (i.e. in supervisor logs) with attention to charting families' progress toward meeting goals, discussion of progress, and how the home visitor will use the IFSP to guide interventions and activities with the family. This documentation occurs at least once a month.

- Many supervisors find they are able to better integrate the IFSP into discussions about families by maintaining the most current version of each family's IFSP in their supervisor binder.

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

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

5. An IFSP is considered updated when the FSW and participant have reviewed progress on goals and objectives on the plan, discussed and documented what happened, revised target dates for goals and/or added new goals based on the needs of the family.

Further detail on guidelines and procedures is included in the HFA Training Manual, page 93.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Promotion of Positive Parenting, Knowledge of Child Development and Health and Safety Practices**
Policy	Healthy Families New York programs promote positive parenting practices and knowledge of child development and health and safety through observing and supporting parent-child interaction, sharing parent-child activities, use of curricula, and regular developmental screening of target children.
Site specific reference	6-3 A-C
Effective date	July 1, 2003
Revised date(s)	June 2007
Appendices	Home Visit Records

Rationale:
To ensure that programs promote and share information and build skills and share activities regarding positive parent-child interaction, healthy physical and emotional child development, and family health and safety.

Procedures:

1. Program Policies
   - Each program develops its own policies to describe how home visiting staff promote and share information regarding positive parent-child interaction, healthy physical and emotional child development, and health and safety information.
   - Policies provide details about the types of activities staff are expected to conduct during home visits and how parenting skills are promoted within the context of the child's development.
   - Policies assure that health and safety practices focus on both preventative strategies as well as areas of concern.
   - Policies identify the curricula and/or materials used to share information and how frequently this information is shared with families. (See Selection of Curriculum.)

2. Skill building and information sharing with families to promote positive parent-child interaction and child development skills.

   a. Frequency:
      - Programs attempt to include time spent promoting positive parent-child interaction and optimal child development on all visits whether or not a family is experiencing crisis. There may be some exceptions to this; however, the goal is to include it on all visits.

- Interventions to promote positive parent-child interaction are a part of the FSW's daily routine with all families. These interventions may consist of discussion and observation of infant cues, calling attention to the child's emotions, introducing interactive games or activities, making positive comments that shape and reinforce desirable parent-child interactions, and education about key issues related to attachment such as: brain development, empathy, the development of trust, and fostering the development of self- esteem in children.

b. Documentation

- Programs document both observations of parent-child interaction and child development as well as what information is shared with families. Curriculum use is clearly documented to indicate what content was shared with families. Most effective documentation practices would also include a description of the family's response to the information and/or activity.
- Programs develop tools, checklists, resources, and specific methods to document the home visitors' observation and assessment of parent-child interactions (i.e. home visit records).
- Programs identify and use checklists or other tools to guide parents in understanding their infant's development. Programs develop tools, checklists, resources, and use specific curricula and other flexible methods to support parents learning about child development and positive parenting.

c. Staff/team meetings and supervision: Managers and Supervisors utilize some portion of ~~all~~ staff and team meetings, and individual supervision to help staff assess and improve their efforts to support parents in promoting positive parent–child interaction and child development (i.e. through case presentations and discussions). The content of these meeting and supervision discussions is documented in minutes and in supervisor logs.

3. Health and Safety Practices

- Health and safety information includes prevention strategies and also addresses any issues observed in the home. These strategies are discussed in supervision.
- Content shared with families includes health and safety issues such as smoking cessation, SIDS, shaken-baby syndrome, baby-proofing, safe sleeping practices, breast feeding materials and other safety issues.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Selection of Curriculum**
Policy	Healthy Families New York programs use parenting and child development curricula approved by OCFS, and other tools and resources to provide families with information about positive parenting practices, child development and health and safety skills.
Site specific reference	6-3 A-C
Effective date	June 2007
Revised date(s)	
Appendices	

Rationale:
To ensure that programs identify and use parenting and child development curricula, tools and other resources to provide families with information about positive parenting practices, child development and health and safety skills.

Guidelines

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

A variety of curricula are available for review through the Healthy Families New York Resource Library.

Programs select a core curriculum for home visiting in which all Family Support Workers and Supervisors are trained. Programs use other curricula as supplements or alternatives to the core curriculum, and while these can be selected at programs' discretion, materials should address the promotion of positive parent-child interaction, child development and health and safety for children prenatally to five years of age. Curricula may also address the psycho-social well-being of parents.

The following curricula are currently approved as core curricula:

Partners for a Healthy Baby. Florida State University Center for Prevention and Early Intervention Policy. 1- 850-922-1300.

Parents as Teachers.

Parents as Teachers National Center, Inc.
10176 Corporate Square Drive, Suite 230

St. Louis, Missouri 63132
Phone: (314) 432-4330

P.I.P.E.(Partners in Parenting Education)
http://www.howtoreadyourbaby.org/index.html

Healthy Babies…Healthy Families: San Angelo Curriculum
Healthy Families San Angelo
200 South Magdalene Street
San Angelo, Texas 76903
325-658-2771
www.hfsatx.com

For Supplementary curricula, three are currently recommended:

Partners for Learning Curriculum and Activity Cards. Isabelle Lewis, Joseph Sparling & Craig Ramey. Kaplan Press. 1-800-334-2014.

Helping Babies Learn: Developmental Profiles and Activities for Infants, and Toddlers. Setsu Furono, et. al. Communication Skill Builders. Tuscon, Arizona. 1-800-866-4446.

Growing Great Kids. Great Kids, Inc. 1-800-906-5581.
http://www.greatkidsinc.org

The following criteria are considered when selecting a home visiting curriculum:

- Materials and/or the training that aids the worker in using the materials in a relevant, interactive manner.
- Materials include activities on parenting, child development and health and safety.
- Materials include information and activities for promoting healthy birth outcomes.
- Materials should have a strong focus on the emotional as well as physical well-being of babies and young children.
- Materials guide home visitors to promote parenting skills within the context of the child's development.
- Materials on health and safety practices include preventative strategies.
- Materials are culturally and linguistically responsive to the community (i.e. have a multi-cultural focus, are available in Spanish and/or French, or other language relevant to the target community.)
- Materials that will be seen by families should be attractive to the target community, conveying the message that families are important. Materials and the manner in which they are used must be strength-based.

- Curricula that can be supported by specialized training on its use and implementation should be given priority.
- Curricula should come with positive recommendations from those who have used them.
- Cost should not be prohibitive.

* Note: All materials used with families should be reviewed by a supervisor prior to use with a family to ensure curricula is relevant and consistent with HFNY practices.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Developmental Screening**
Policy	All target children are screened using the Ages and Stages Questionnaire (ASQ) to determine developmental progress and/or to identify possible delays. HFNY programs administer the ASQ at designated intervals. Should a delay be suspected, all target children receive referrals and/or follow-up.
Site specific reference	6-5, 6-6, 6-7
Effective date	July 1, 2003
Revised date(s)	June 2007
Appendices	ASQ cover sheet (MIS)

Rationale:

To ensure that target children are regularly screened to determine developmental progress and/or identify possible developmental delays, and that when a delay is suspected, children receive appropriate referrals and/or follow-up.

Administering the Tool:

1. All Healthy Families New York programs implement a policy stating that they use a standardized tool, the Ages & Stages Questionnaire (ASQ), to determine and record developmental progress and/or to identify possible delays.
2. The ASQ is completed at the following intervals: 4, 8, 12, 16,20,24,30, 36, 48, and 60 months with optional intervals at six and eighteen months.
3. Premature babies have their ASQs completed on their corrected date of birth, (CDOB) up to but not including the 24-month assessment.
4. The purpose of the ASQ is thoroughly explained to the parent. The ASQ must be completed jointly by the parent and Family Support Worker. Ideally, the ASQ is done by the parent, with guidance from the FSW. A child development specialist reviews the completed ASQ and the FSW gives feedback and follow-up activities to the family.
5. Each program site employs a child development specialist, on staff or on a consultant basis, to consult with staff, to review ASQs, and provide child development training.
6. All FSWs are trained in the implementation of the ASQ, procedures for referral, follow-up, and data collection prior to administering the tool.

Scoring:

1. It is encouraged that scoring be done in conjunction with the parent. However, this decision should remain within the discretion of the FSW. All scores are explained thoroughly to the parent. In those cases where the score falls below the cut-off level, parents should be reminded that the ASQ is not

an IQ test. It is only meant to indicate if further developmental assessment and evaluation may be needed.

2. If a child scores under the cut-off in any area, a referral to the county Early Intervention Program must be made for further assessment. The family does not have to accept the referral.
3. If a child falls within the "suspicion" range, the developmental activities are presented and discussed with the parents. The child's score and potential implications and remedies should be explained to the parent. These children will have their development monitored closely by the FSW and discussed with the child development specialist at regular meetings. The child development specialist may recommend that a referral for further evaluation be made.

Documentation:

1. Referrals to Early Intervention (EIP) are documented by marking #13 on the ASQ coversheet. The outcome of the referral is documented by marking #14. FSWs also document the referral on the Referral Tracking sheet.
2. Even if a different party has made a referral to EIP, FSWs will follow the procedures in #1 concerning the ASQ coversheet.
3. Programs document in participant records when screens are not being administered (i.e. child already involved with Early Intervention Services.)
4. To assure appropriate follow-up, programs routinely print and review the MIS report of all children who scored below the cut-off on the ASQ and what their status is with EIP.
5. Participant files include the completed score and summary sheets of the ASQ. Some programs keep a participant's ASQs in a separate binder.
6. Programs are encouraged to document when a family declines early intervention services and document the home visitor's efforts to engage the family in continued discussion about these services. It is not uncommon for families to feel worry and fear over a delay in their child's development. Home visitors will be sensitive to these feelings. If the family has declined a referral to early intervention, the FSW will plan with supervisor and family activities to address areas of delay while continuing to find ways to discuss an EIP referral when it seems appropriate.
7. On a quarterly basis, programs report on the number and percentage of children who demonstrate age appropriate developmental milestones or need to be referred for further evaluations/service is delays are detected. (See Performance Target HD7).

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Parental Stress Index**
Policy	To assess families' situations and changes over time with respect to several parenting indicators, all HFNY families are provided the Parenting Stress Index to complete at the appropriate intervals.
Site specific reference	N/A
Effective date	June 2007
Revised date(s)	
Appendices	PSI cover sheet (MIS)

Rationale:
HFNY Programs use the Parental Stress Index (PSI) in order to identify and assess the stressors of parenting and assess families' situation over time with respect to various parenting indicators. This policy establishes guidelines for administering the PSI.

1. General Guidelines:

a. The PSI is copyright protected and each copy is purchased by HFNY.
b. The PSI is administered to primary caretaker one. (PC1). The program may additionally administer the tool to the child's other parent or to a significant other, however the Management Information System only requires completion of the tool for the PC1. (See the *Parenting Stress Index Professional Manual, Psychological Assessment Resources, Inc.* for further information on interpretation, validity, etc.)
c. The PSI is answered with the target child in mind. For multiple births, the parent identifies one target child for the initial and all subsequent PSIs.
d. The PSI is best completed in the presence of the FSW, whenever possible. Any exceptions are made at the discretion of the supervisor.
e. In order to ensure the most accurate reflection of the parent's feelings, the PSI is completed during one home visit.
f. FSWs encourage parents to answer all questions openly and honestly without fear of being judged or criticized.
g. Each program site develops internal protocols for discussing the PSI. Typically, if the score does not warrant immediate attention, the FSW and Supervisor will discuss the results during weekly supervision, and review the results with the family in a supportive, non-judgmental manner within two weeks of administration. (See below for "Referral Criteria" for results requiring more attention.)
h. The tool is administered on the following schedule:
   First Administration:
   a. Prenatal at intake: within one month of the target child's date of birth
   b. Postnatal at intake: within one month of intake
   After First Administration:
   - Age of target child: 6 months, 1 year, 2 years, 3 years, 4 years, and 5 years

- At discharge from the program

i. Programs report on items related to the PSI on a quarterly basis. (See performance targets PCI2-6.)

2. Responsibilities of the FSW

a. Attend training on administering the PSI prior to administering the tool to families. This training may be a formal training, an in-service, or may be delivered directly by a supervisor or co-worker. It is important that the training contain opportunities for the FSW to practice administering the tool with a supervisor or experienced peer. This practice also includes opportunities to introduce and describe the reasons for administering the tool to families.
b. Dates are planned for administering the PSI so that it is completed within the window period.
c. If the window period is missed, the PSI is still administered at the next opportunity.
d. Upon scoring the tool, the results are reviewed with the supervisor prior to discussing them with the family.
e. The results of the PSI are submitted to the MIS.
f. The results of the PSI are incorporated into IFSP discussions with supervisors and families.
g. Referrals are provided and documented as appropriate.
h. Discussions about the PSI are documented in home visit notes.
i. The PSI is maintained in the participant file, or a separate file, according to individual program protocol.

3. Responsibilities of the Supervisor:

a. Attend training on how to administer the PSI to families.
b. Provide opportunities for role-playing how to administer the PSI during supervision of FSWs if needed.
c. Shadow the FSW when administering the tool to ensure that it is being administered correctly and effectively.
d. Assist FSWs to establish due dates for the PSI, to ensure it is administered within the window period.
e. Review the scoring and work with the FSW to develop a plan for incorporating the results in follow-up work with the family.
f. Document the discussion of follow-up in supervisor notes.
g. Ensure that the PSI is included in the participant file or separate file according to program protocol, and that documentation regarding it is included in home visit notes and the IFSP, when appropriate.

4. Referral Criteria

a. Defensive Responding: A Defensive Responding score of 10 or less indicates that the individual may be responding in a defensive manner, and caution should be exercised in interpreting the remainder of the scores.

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

Timing and Families not Accepting Referrals

a. If upon completion of the PSI, any domain or total stress is outside the normal range, appropriate referrals or resources are ideally offered within 3 days. The FSW will follow up with the family, ideally within a week after the service referral is offered to see if the family has engaged with a referral or resource and/or to offer additional support and information.
b. If it is determined that the family is in need of referral and resources but does not accept such service, the FSW works with his/her supervisor to explore how to proceed. The FSW documents that the family did not accept the referral in the participant record and on the service referral form.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Breast Feeding**
Policy	Programs work toward having 30% of Healthy Families New York primary caretakers breast feeding the target child for at least 3 months from the birth of the child.
Site specific reference	6-3A-B
Effective date	July 1, 2003
Revised date(s)	June 2007
Appendices	HFNY Target Child Identification and Birth Outcomes HFNY Follow-Up Form (MIS)

Rationale:
Healthy Families New York recognizes breast feeding as the ideal method of feeding and nurturing of infants and recognizes breastfeeding as primary in achieving optimal infant and child health, growth, and development, in addition to providing many proven health benefits for mothers.

Guidelines:

The HFNY initiative supports the American Academy of Pediatrics policy statement on breast feeding. Each site develops its own policy regarding how to support and implement this policy. Minimally, sites will provide basic training on breast feeding for all new staff within 6 months of hire with annual updates for existing staff. This training will provide current, evidence-based and culturally responsive lactation information.

To promote breast feeding, programs implement the following, as appropriate in their communities:

- During both the prenatal and postpartum periods, enthusiastically encourage new mothers to breastfeed. Relay the numerous benefits to both the child and mother to ensure that all parents make an informed decision regarding infant feeding.
- Inform parents of breast feeding resources available in their community.
- Consider the benefits of having a certified lactation consultant available to staff and whether some staff may be interested in becoming certified lactation consultants.
- Make office space conducive to breast feeding whenever possible.
- Utilize educational materials that recognize breast feeding as the normal and preferred method of infant feeding.
- Avoid providing incentives that undermine breast feeding (i.e.: formula gift packs)
- Avoid posters, pamphlets, handouts, calendars and other materials provided by formula supplement corporations.

- Establish seamless lactation support programs between hospitals and communities that may include the establishment of participant breast feeding support groups.

Documentation:

- Staff document the family's chosen feeding method on the TC Identification and Birth Outcomes Form (MIS).
- There is an optional (local use only) "Feeding Method" field on the TC Identification and Birth Outcomes form. Programs may elect to have staff complete this section for their own use.
- Staff document how long the family breast fed on the Follow-Up form (MIS).
- On a quarterly basis, programs report on the number and percentage of babies who are breast fed (See Performance Target PCI1.)

Critical Element #7

Linkages to health and other services

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Medical Homes, Immunizations, Well-Baby Visits and Lead Assessments**
Policy	Healthy Families New York programs link, at a minimum, the primary care taker and target child to medical homes, and are strongly encouraged to link all family members to a medical home. Target children receive immunizations, well-baby visits, and lead assessments and screenings following the NYS Health Department Recommended Schedules for each, as found on the MIS TC Medical Form.
Site specific reference	7-1.A, B, 7-2, 7-3
Effective date	July 2001
Revised date(s)	June 2006
Appendices	HFNY Target Child Identification and Birth Outcomes (MIS) HFNY Target Child Medical Form (MIS) HFNY Follow-Up Form (MIS) HFNY Service Referral Form (MIS)

Rationale:
To ensure optimal health and development, programs link participant families with a medical home to receive on-going preventive and other health care services. To ensure that families are provided with information, referrals and linkages to available health care resources. To ensure timely receipt of immunizations and well-baby check-ups, including lead and developmental screenings

Procedures:

Medical Home
A medical home is a partnership between a family and a primary health care professional. The health care professional may be an individual provider, medical group, public and/or private health agency, or a culturally recognized medical professional where participants can go to receive a full array of health and medical services. "Culturally recognized medical professionals" refers to practitioners of alternative therapies widely recognized within a cultural system, such as traditional Chinese medicine.

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

Linkages to medical homes

1. Initially, the home visitor assists in linking the family with a physician, a prenatal care provider and/or pediatrician (depending on whether the family enrolls in services prenatally or postpartum) or other "medical home."
2. Part of the home visitor's role in connecting the family with a medical home is to facilitate clear communication between the child's medical provider and parents, and to assist parents in forming comfortable and informative relationships with medical providers.
3. Joint visits to medical providers soon after a family enrolls in the program and/or shortly after the baby is born may be a useful strategy for securing the medical home and helping to establish the relationship.
4. Joint visits are a useful way for the medical provider to learn about the HFNY program and the role of the home visitor. It is recommended that programs develop site specific memoranda of understanding with medical providers to facilitate these referrals and collaborative practice.
5. Home visitors document the target child's health care provider on the Target Child Identification and Birth Outcomes form in the MIS, and after that, on the Follow-Up form. Programs also document the current medical provider for the Primary Caretaker 1 and 2 on the Intake form and after that, on the Follow-Up form.

Information, referrals, and linkages to health care resources

1. When necessary, enrolled families are provided information, referrals and linkages to health care resources.
2. These activities are documented on the Service Referral Tracking Form (MIS).
3. Referrals to health care providers are also made when needed for families in the pre-intake stage or for those who were not offered the home visiting program.

Immunizations

1. Home visitors, parents, and medical providers collaborate to ensure that children receive regular, timely immunizations.
2. HFNY follows the NYS Health Department Recommended Childhood Vaccination Schedule as reflected on the Target Child Medical Form. Immunization dates may vary according to the preference and practice of the pediatrician or health care provider.
3. The home visitor verifies the target child's immunization status by either reviewing the health/immunization card from the medical provider or through written or verbal contact with the provider (with signed authorization of release). A description of the method of verifying immunizations is included in the programs' policies and procedures. Accepting a parent's report without written documentation from the provider is not recommended.
4. Documentation
   a. Home visitors document the dates the child received the immunizations on the Target Child Medical Form (MIS).
   b. HFNY sets a goal of having at least 90% of target children up-to-date with their immunizations as of their first and second birthdays. (See

performance targets HD1, HD2.) Where target children are not currently up-to-date, programs document the reasons why and attempts/steps that have been taken to obtain immunizations for these children. This may include instances where children were sick at the time the immunization was due, or that families are on Level X no information is currently available.

c. The percentage of up-to-date immunizations includes children whose family beliefs preclude immunizations. Evidence of their beliefs is documented in the participant file.
d. The original Target Child Medical Form record of immunizations is maintained in the participant file.

Well-Baby Visits, Lead Assessments, Developmental Screenings

1. Home visitors, parents, and medical providers collaborate to ensure that children receive regular, routine health care.
2. Home visitors help families to overcome barriers to accessing preventive health care. The home visitor may transport or provide program funds for mass or public transportation if these funds are included in the program's budget.
3. HFNY follows the well-baby visit intervals including lead screenings and developmental screenings as recommended by the NYS Health Department Recommended Schedule and as reflected on the Target Child Medical Form.
4. Well-baby visits may vary according to the preference and practice of the pediatrician or health care provider.
5. A well-baby visit includes height, weight, blood pressure, hearing, sight, developmental appraisal, dental care assessment and a nutritional assessment.
6. Acute care visits do not typically last long enough to include all of the required items to be counted as a well baby visit. If an acute visit is being counted as a well baby visit, it must contain all of the items specified in #5.
7. Home visitors conduct lead assessments with families at the intervals designated on the Target Child Medical Form. These do not replace lead screenings (blood work) done by the medical provider and tracked on the form.
8. Home visitors conduct developmental screenings on the target child using the ASQ. (See Developmental Screening.) These do not replace the medical provider administering a developmental screen as a routine component of the well-baby visit.
9. Documentation

a. The home visitor verifies the target child's well-baby visit by either reviewing the health/immunization card from the medical provider or through written or verbal contact with the provider (with signed authorization of release).
b. A description of the method for verifying immunizations is included in the programs' policies and procedures. A parent's report without written documentation from the provider is not recommended.

c. Home visitors document the dates the child received the well-baby visit on the Target Child Medical Form (MIS).
d. HFNY sets a goal of having all participating target children up-to-date with their well-baby visits at designated intervals. (See performance targets HD3, HD4, HD5, and HD6.) Where target children are not currently up-to-date, programs document the reasons why and attempts/steps that have been taken to obtain well baby visits for these children. This may include that families are on Level X and no information is currently available.
e. Documentation of emergency room visits and overnight hospitalizations is completed on the Target Child Medical Form following each occurrence. The family's verbal account of the visit is sufficient for documentation; emergency or other hospital records are not required. Information from the form is added to the management information system, and the original maintained in the family's chart.
f. It is recommended that supervisors review and sign off on the Target Child Medical Form on a monthly basis.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Linkages to Other Programs and Services**
Policy	Healthy Families New York participants will receive referrals to available health care and community resources based on their need(s). Staff will follow-up with referral sources, service providers and/or participants to determine if needed services were received
Site specific reference	7-4.A-B
Effective date	July 2001
Revised date(s)	June 2007
Appendices	-Referral Tracking Form (MIS) -Kempe PC1 Issues Report (MIS)

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

Procedures:

1. Staff makes referrals to health care and other community resources based on the information gathered in the assessment process, through the development of the IFSP and home visits.

2. A referral consists of either making arrangements for a participant to receive services or providing information about specific providers so that the participant can make arrangements him or herself.

3. Staff becomes familiar with the community agencies and the services they provide to be sure families are referred appropriately. Most referrals are discussed with the supervisor prior to providing information to the participant. During basic training, staff receive orientation to the program's relationship with other community resources (e.g. organizations in the community with which the program has working relationships. (See Required Training.)

4. Supervisors assist home visitors in identifying the need for referrals and staying informed about community resources and referral processes.

5. If domestic violence, substance abuse, or mental health is identified as a current issue on the Kempe Assessment of an enrolled participant, a referral is made within 6 months of enrollment. There is a Kempe PC1 Issues report in the MIS to help assure that these referrals have been made in a timely fashion. This report tracks only referrals made for Primary Caregiver 1 (PC1) however,

referrals are made for any family members, when appropriate. (see Performance Target MLC7)

6. To ensure families have access to available community resources, as well as to avoid duplication of services, program sites have established relationships (ideally described in a Memoranda of Agreement) with local social service districts including preventive services, local health departments, Infant Child Health Assessment, Early Intervention and Community Health Worker programs. Sites also have established relationships to ensure families access to community resources, with local Comprehensive Prenatal Perinatal Service Networks (CPPSN), family resource centers, adolescent pregnancy programs, Teenage Services Act program (TASA), employment programs, child development programs, food programs, WIC, Section 8 Housing, etc.

7. FSWs help families who are on public assistance to access the necessary supports (i.e. child care, transportation) to achieve their self-sufficiency goals, which may include obtaining a GED, employment, or entering an educational or vocational training program.

8. The FSW and supervisor also provide crisis intervention, assisting the family in managing crisis and linking them to appropriate community services to deal with and resolve the crisis. Over the course of working with the family, the FSW encourages the family to establish personal and community agency relationships to build ongoing support systems independent of the FSW and home visiting program.

9. All referrals are logged on the Service Referral Tracking form and all follow-up efforts are documented in the participant file.

10. On a quarterly basis, programs are required to report on Primary Care Taker 1 having a medical provider. (See performance target HD8.)

11. An important component of participant record review and of supervision includes attention to referrals and referral follow-up. This includes routinely checking the Service Referral Follow-Up tickler report to assure follow-up of referrals tracked in the MIS. After a referral has been made, FSWs seek information from the program participant (and the service provider, if the necessary consent forms have been signed) to determine if the service was obtained, if it was needed, and if the participant has found it helpful. The amount of time that it takes to make these determinations will need to be flexible based on the type of referrals. Procedures to follow up with agencies/programs to which referrals are made are developed by each site and may be included in the programs' Memoranda of Agreement.

Critical Element #8

Caseload Management

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Caseload Management**
Policy	Healthy Families New York services are provided by staff with limited caseloads to assure that home visitors have adequate time to spend with each family to meet their needs and plan for future activities. A full caseload typically has a total weight of 30.
Site specific reference	8-1.A, B, C, 8-2.A,B
Effective date	July 2001
Revised date(s)	June 2007
Appendices	-Supervisor Case List (MIS) -FSW Case List (MIS)

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

Procedures:
1. Healthy Families New York uses a weighted caseload system to manage the caseload size of FSWs who will be serving families at different levels of intensity.
2. A full caseload typically has a total weight of 30 (see below). However, a supervisor can limit the case weight to 25, with OCFS approval, if special circumstances exist. These special circumstances might include excessive travel time due to serving a large and rural target area, or excessive translation required in a community where there are limited bilingual service providers.
3. Programs cannot freeze intake until each worker reaches a weight of 25. Supervisors should monitor case weight during weekly supervisions to identify potential openings (e.g. a family on creative outreach declines services, or a family moves up a level or completes the program based on the number of years enrolled).
4. The maximum caseload size of Level I families receiving weekly home visits for a full time FSW is 15.
5. The maximum caseload for a full time FSW will not exceed 25 families.
6. Case weights and caseloads are prorated based on the staff person’s Full-Time Equivalency.

7. Values used to determine caseload size:

Level	Visits/Month	Value
Pre-Intake	-	.50
1-prenatal	2-4	2.00
1	4	2.00
2	2	1.00

3	1	.50
4	0-1	.25
X (creative outreach)	1-4	.50
1-SS (Special Services	4+	3.00

- Program Managers may request a lower overall program case weight assignment by discussing the special circumstances within the target community with their OCFS program contract manager.

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

- There may be temporary periods when case weights go over the maximum size. For example, a home visitor leaves and the caseload is dispersed among existing home visitors until another FSW is hired. When this occurs, the reason is clearly documented and includes the amount of time that the case weights were out of adherence with this policy. Programs make every effort not to let this time period exceed 2 months.

- Caseload/weight information is tracked and managed for programs in the Management Information System according to the criteria outlined in this policy. Information pertaining to caseload management can be found in the MIS under the following:
  - FSW Case List
  - Enrolled Program Caseload Information
  - FSW Home Visit Record
  - Supervisor's Case List
  - Home Visiting Completion Rate Analysis

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

Critical Element #9

Staff Recruitment and Selection

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Staff Recruitment and Selection**
Policy	Healthy Families New York programs screen and select direct service and supervisory staff based on a combination of personal characteristics, experiential and educational qualifications.
Site specific reference	9-1.A-C, 9-3.A, B
Effective date	July 2001
Revised date(s)	June 2007
Appendices	-Sample Job Description: Program Manager -Sample Job Description: Program Manager's Supervisor -Sample Job Description: Program Supervisor (FSW or FAW) -Sample Job Description: Family Assessment Worker -Sample Job Description: Family Support Worker -Interview Guidelines: Home Visiting Program Staff -Manager & Supervisor Interview Questions -Combined Sample Interview Questions: FAWs & FSWs -Interpersonal Rating Scale for Interviewing Home Visitor Program Applicants

STAFF RECRUITMENT AND SELECTION

Rationale:

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

Procedures:

Selection

1. Programs must strive to hire staff who are representative of the language and culture of the population to be served and who, to the extent possible, are hired from the community targeted for services. These efforts may be demonstrated through targeted recruitment, wording in job announcements, and other relevant mechanisms.

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

- ability to establish trusting relationships
- experience and willingness to work with the culturally diverse populations which are present among the program's target population
- ability to work effectively with both mothers, fathers, and extended family
- believe that children need to be nurtured
- are non-judgmental

3. In addition to the personal characteristics described above, each program establishes the educational and work requirements for each position. The minimum requirements for each position are discussed below:

   a. Program Manager
      - A solid understanding of and experience in managing staff;
      - Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development;
      - Experience in managing home visiting programs;
      - Knowledge and experience in strength-based and family centered provision of primary prevention services, and/or direct experience as a home visitor.
      - A master's degree in social work or health strongly recommended. Four years of direct experience with at-risk families, including work in the field of child abuse or family violence and previous supervisory experience.

   b. FAW and FSW Supervisor
      - Solid understanding of and experience in supervising and motivating staff, as well as providing support to staff in stressful work environments
      - Knowledge of infant and child development, parent-child attachment, maternal-infant health and the dynamics of child abuse and neglect.
      - Knowledge and experience in strength-based and family-centered provision of primary prevention services, and/or direct experience as a home visitor.
      - Experienced in home visitation with a background in prevention services to the 0-3 age population; and
      - A background in home visiting and/or services to families and young children, an advanced degree in a Health or Human Service field, or a bachelor's degree in a Health or Human Service field and five years experience in a home visiting program, with clinical supervisory experience preferred.
      - FSWs or FAWs with five years direct service in a Healthy Families Program, a documented history of progressive professional development, plus an associate's degree in a related field may be promoted to supervisory positions.

   c. FSWs and FAWs

- Experienced in working with or providing services to children and families
- Knowledge of infant and child development
- Able to observe and report accurately on the functioning of individuals and families
- Adequate writing skills
- Emotionally mature and capable of exercising judgment
- Able to handle stressful situations
- A high school diploma/GED with experience working with, or assisting, high-risk families in a community setting.

d. Additional Positions

i. Home Visiting Coordinator/Assistant Program Manager (programs use a variety of titles for this position)

- A solid understanding of and experience in managing, supervising and motivating staff, as well as providing support to staff in stressful work environments;
- Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development;
- Knowledge and experience in strength-based and family-centered provision of primary prevention services, and/or direct experience as a home visitor.
- Four years of direct experience with at-risk families, including work in the field of child abuse or family violence and previous supervisory experience.
- Strong clinical and/or administrative skills.
- A master's degree in social work or related field strongly recommended.

ii. Fatherhood Advocate

- Strong interpersonal skills which easily and quickly engage fathers of young children
- Knowledge of child and family development and ability to convey that knowledge in an interesting and useful manner
- Experience in fathering or working with fathers
- Experience providing services to children and families, and effectively conducting groups
- Problem-solving skills with a working knowledge of available community resources
- Ability to identify and assess social problems, including developing and implementing family service plans and making referrals to other agencies as appropriate
- A high school diploma/GED with experience working with, or assisting, high-risk families in a community setting. Bachelor's Degree in human services, mental health or education field preferred.

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

5. Consultation regarding child development is typically provided by a staff or consulting child development specialist or Public Health Nurse.

6. Sample job descriptions and the qualifications for each position are included in the Appendices Section.

Equal Opportunity

1. Each program must have a written policy on Equal Opportunity that states its recruitment, selection, transfer, and internal promotion procedures. The program disseminates the policy and uses recruitment practices and materials clearly specifying that the program employment practices are non-discriminatory.

2. Sample interview guidelines, interview rating tools, and sample interview questions are included in the Appendices section.

Background checks

Programs are required to do reference checks to verify education requirements and employment history. Programs conduct appropriate, legally permissible and mandated inquiries into the background of prospective employees and volunteers who will have responsibilities where participants are children.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Personnel Turnover**
Policy	Healthy Families New York programs measure and evaluate staff turnover every year and are proactive regarding their actions to address the principal causes for turnover.
Site specific reference	9-4
Effective date	June 2007
Revised date(s)	
Appendices	Quarterly Tab K Worker Characteristics Summary (MIS)

Rationale:
Low personnel turnover is generally associated with higher retention of program families.

Procedures:

3. Programs measure and analyze their turnover rate of employees every year.

4. The turnover rates are analyzed for the entire program as well as by specific job categories so that any unusual levels of turnover specific to certain categories can be identified.

5. Turnover rates are also examined in the context of measures of job satisfaction and personnel retention.

6. Information gathered from tools such as annual employee self appraisals, surveys of program staff, exit interviews and from the Worker Characteristics Summary in the MIS (quarterly tab K) may assist with this analysis.

7. The analysis is submitted to the Program Contract Manager as part of the Annual Service Review. (See Annual Service Review)

8. Steps are taken to address any identified problems. Programs are encouraged to utilize Central Administration and other program managers for ideas and support when needed.

Critical Element #10 and #11

Training

note that Self Assessment Tool Credentialing Standard for Training is #10 and not #10 and #11

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Training Plan**
Policy	All Healthy Families New York program staff (program managers, supervisors, FAWs, and FSWs, including interns and volunteers that work directly with families) must receive all required training according to the HFA standards and HFNY policies. It must be received and within the required timeframes. All training received must be documented in the Management Information System.
Site specific reference	10-1
Effective date	July 2001
Revised date(s)	June 2007
Appendices	-Orientation Checklist - Wraparound Training Checklist -Training Resume (MIS) -Guidelines for participants in Healthy Families New York Training/Conferences

Rationale:
To ensure that each program has a plan that adheres with HFA training standards and HFNY training policies. To ensure that each program has access for its staff to required trainings, provides them in a timely manner and tracks these trainings in a comprehensive fashion.

Guidelines:

As a key role of our program staff is to facilitate the delivery of services to families, it is paramount that staff members maintain a high degree of competence in the field of child and family services. Orientation, ongoing in-service and advanced training for all staff are integral parts of the Healthy Families New York State Program.

All service providers have a basic framework, based on education or experience, for handling the variety of issues they may encounter when working with at-risk, overburdened families. They receive basic training in areas such as culturally competent services, substance abuse, reporting child abuse, domestic violence, drug exposed infants, and services in their community.

Procedures:

Required Trainings

Each program develops a comprehensive training plan that assures access to and ongoing tracking and monitoring of required trainings in a timely manner for all

staff. This plan may be developed as, and contained within, a policy. These required trainings include:

- Orientation (10-2 A-E)
- Intensive role specific training (10-3.A-C)
- Additional Training within 6 months of hire (10-4A-F)
- Additional Training within 12 months of hire (10-5A-F)
- On-going Training Topics (10-6)
- Assessment Tool Training (2-2.A)
- Cultural Sensitivity Training (5-3)
- Developmental Screens (6-5)
- PSI administration (6)

Trainers and training methods

1. The plan includes how the program assures that trainings are provided within the specified timeframes and identifies how the training is provided and by whom.

2. Trainers for Intensive Role Specific Trainings (Core) must be provided by HFNY credentialed trainers or, if a training is unavailable from HFNY credentialed trainers, by HFA credentialed trainers.

3. Other required trainings are provided by qualified persons such as program managers, supervisors and community agencies, and through a variety of methods, such as videos and reading materials with supervisor follow-up, etc. It is recommended that programs work with presenters to assure that they understand the HFNY philosophy and how the topic relates to the field of home visiting. Workshops and/or seminars conducted at a regional or state level of the HFNY Program may serve as portions of the wraparound basic training. Wrap around trainings may be coordinated within regions in order to maximize local resources.

4. A variety of training videos, parenting and child-development curricula, and related materials that may be used in conjunction with training are available for use and/or review through the Healthy Families New York Resource Library.

5. Training should not be viewed as a one-time occurrence but as a continuous process. All staff should receive regular in-service training which varies in format and topic from site to site, depending on the issues affecting families in the community to be served, and attend annual regional and state training events.

Tracking and documentation

1. It is recommended that programs keep a record of the topics covered in each training (i.e. outlines, agendas). It is also recommended that programs maintain copies of training certificates given to training participants.

2. The MIS provides a training tracking system for HFNY programs and includes all of the topics listed in 1a above. All programs in HFNY are required to use this system. It contains the staff person's date of hire, date the training was received and the date the staff person began providing direct services (assessment, home visits, and supervision) and a tickler system to assure that trainings are provided within the required timeframe.

3. Formal education, previous training and previous experience must have occurred within three years prior to hire in the HFNY program and directly apply to the topics identified in order for the staff person to be exempted from training in the MIS. Program Managers and Supervisors determine whether or not someone may be granted an exemption for a particular topic. There are topics for which no exemption is permitted. (These are identified in the MIS.)

4. Programs may develop additional in-house tracking forms. See Appendices section for sample forms.

5. Programs track trainings for staff even if the training was received outside of the required timeframe. It is recommended that supervisors track (i.e. in a personnel file or in a specified section of the supervisor notes) the reason that employees do not receive the training within the timeframe.

6. Supervisors, program managers or other designated person must sign logs to verify that the training was received.

7. All volunteers and interns who perform the same duties as assessment, home visitors and supervisors are required to participate in all training activities available to regular staff.

Making Training Most Effective

1. It is recommended that training events are evaluated by participants as they occur and that this information is summarized and used to enhance/improve future trainings.

2. In order to maximize learning, programs are encouraged to incorporate Transfer of Learning activities into their training plan. (See FSW and FAW TOL Workbooks for more information.)

3. For further detail, refer to the HFA "Healthy Families America Orientation Training" section of the HFA Community Planning and Site Development Guide and HFA Credentialing Program Self-Assessment Tool.

4. Guidelines for participants in HFNY Trainings and Conferences have been established to assure that all trainings (wrap-arounds, regional, Core) and conferences offer an environment that is most conducive to learning. See appendices.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	Required Training *(Orientation Training, Core Training, Wrap-Around Training, On-going Training, Trainings on Assessment Tool, Cultural Sensitivity, Screening Tools, Agency Executive /Supervisor of Program Manager Training, New Program Manager Training)*
Policy	Healthy Families New York programs ensure that all staff receive training support and have the skill-set necessary to fulfill their job functions and achieve the program's goals by attending and/or providing required and recommended trainings.
Multi-site reference	T-1.1
Site specific reference	10-2A-E, 10-3.A-C, 10-4.A-F, 10-5.A-F, 10-6, 2-2.A, 5-3, 6-5, T-1.1
Effective date	July 2001
Revised date(s)	July 2007
Attachments	HFNY Training Code List (MIS) Training resume (MIS) Training Tickler (MIS)

Rationale: To ensure that staff receive the training support and have the skill-set necessary to fulfill their job functions and achieve the program's goals. To ensure that all staff has a framework for handling the variety of experiences they may encounter in their role.

Procedures:

(Note: when volunteers/interns perform the roles of supervisor, FAW or FSW, they are held to the same training standards as paid staff.)

1. Orientation Training

All program managers, FAW and FSW supervisors, FSWs and FAWs, interns and volunteers receive orientation *prior to direct services with families or supervision of staff.* The program is responsible for providing orientation training using resources within the program or the community. Core training does not meet any of the basic orientation requirements. Basic orientation includes orientation to the following:

- The program's goals, services, policies and operating procedures and philosophy of home visiting/family support.
- The program's relationship with other community resources (e.g. organizations in the community with which the program has working relationships.)
- Child abuse and neglect indicators and reporting requirements.
- Issues of confidentiality

- Issues related to boundaries.
- Role specific shadowing: Observing 1 home visit, assessment, and/or supervision session, depending on roles. While only 1 observation is required, programs are encouraged to make several shadowing opportunities available to new staff. For new sites, this will likely mean traveling to another HFNY site.)

2. Core Training (Role Specific Training)

All program managers, FAW and FSW supervisors, FSWs and FAWs, must receive HFNY Core Training specific to their position. The Healthy Families New York Training and Staff Development Team provides these Core trainings on a regular basis. This training must be provided by a trainer who is certified and trained to train others. Core Training provides an overview of the essential components including the roles and responsibilities of program staff. It also includes an orientation to the HFNY multi-site system according to the standards identified in the Healthy Families America self-assessment protocol. Ideally, hiring will proceed so that new staff receives the core training during the first 2-4 weeks of employment. FSW's may not make home visits alone until Core Training has been completed, nor should FAW's conduct assessments until Core Training has been completed.

The Healthy Families New York Training and Staff Development Team complete Core Feedback Forms for each staff person attending the FAW, FSW and Supervisor Core training. These forms provide behaviorally specific feedback and observations of the trainee's participation in the training. Program Managers and/or supervisors let staff know about these forms in advance of their attending the training. See appendix.

- Program Managers

Program Managers receive the FSW and/or FAW Core training before supervising staff. It is recommended that Program Managers receive both the FSW and FAW Core training, but minimally, they must receive at least one of them, and for the position they supervise. For example, a program manager who supervises the FAW or FAW supervisor attends FAW Core. Program Managers receive the New Program Manager Overview and Supervisor Core Training within 6 months of hire. They must attend either the FAW or FSW Core before attending the Supervisor Core Training.

- FSW Supervisors

FSW Supervisors attend the FSW Core Training before supervising staff This training is part of the "FSW Essentials." (See Twelve Month Training Wraparound section below.) They receive the first 3 days of the 4 day Supervisor Core Training within 6 months of hire. (The 4th day is scheduled approximately one month later as a follow-up and is not required within the 6 month window. FSW Supervisors are encouraged to attend FAW Core Training.) Supervisors must attend the FSW Core before attending the Supervisor Core Training.

- FAW Supervisors

FAW Supervisors attend the FAW Core Training before supervising staff. They receive the first 3 days of the 4 day Supervisor Core Training within 6 months of hire. (The 4th day is scheduled one month later as a follow-up and is not required within the 6 month window. FAW Supervisors are encouraged to attend FSW Core Training.) Supervisors must attend the FAW Core before attending the Supervisor Core Training.

- FAWs

FAWs receive the FAW Core Training prior to providing direct services and within 6 months of hire. FAWs may begin assessing families only after completion of the FAW Core training.

If assessing is to be their primary role, staff is required to submit a minimum of 3 positive and 1 negative assessments to the certified trainer approximately 3 months post core training. If assessing is not to be their primary role (i.e. staff is being cross-trained in order to provide back-up services should the need arise) they are required to submit a minimum of 2 assessments approximately 3 months post core training. Cross-trained staff and FAW Supervisors administer a minimum of 1 assessment for the program every 6 months in order to maintain their skill level.

Assessments are submitted to the certified trainer, entered into the MIS under "FAW 3 months Follow-Up Assessment Review" by the employee's supervisor, and are tracked as a part of internal quality assurance. For example, if grids are used to track quality assurance activities, the submitting of assessments would be included on that grid.

While staff can begin assessing, FAW Core certificates will be distributed when a minimum of 4 (or 2) assessments have been submitted and reviewed in accordance with HFNY standards.

- FSWs

FSWs receive FSW Core training prior to providing direct services and within 6 months of hire. Families cannot be assigned in the MIS to FSWs until they have completed their Core Training. FSW's may not make home visits unaccompanied by other staff until Core Training has been completed. The FSW Core is part of the "FSW Essentials."

3. Three-Month Training

FSWs and supervisors are required by HFNY to have training in Goal Setting and IFSP Development within 3 months of hire. This training is provided by individual programs when HFNY training is not available within the required timeframe. It is required that staff who has been trained in-house also attend a HFNY IFSP training when it next becomes available, within one year. This training is part of the "FSW Essentials."

4. Six-Month Training (Wrap Around)

Within six-months of date of hire, all program managers, FAW and FSW supervisors, FSWs and FAWs receive training on a majority of subtopics for each of the topics listed below. "A majority of subtopics" is defined as 51% of the subtopics. See attached HFNY Training Code List for a list of all subtopics. Arranging for these trainings is the responsibility of each site.

- Infant Care
- Child Health and Safety
- Maternal and Family Health
- Infant and Child Development
- Role of Culture in Parenting
- Supporting the Parent Child Relationship
- Data Forms training

5. Twelve-Month Training (Wrap Around)

Within twelve months of date of hire, all program managers, FAW and FSW supervisors, FSWs and FAWs receive training on a majority of subtopics for each of the topics listed below. Arranging for these trainings is the responsibility of each site. (See attached HFNY Training Code List for a list of all subtopics.)

- Child Abuse and Neglect
- Family Violence
- Substance Abuse
- Staff Related Issues
- Family Issues
- Mental Health

In addition, within twelve months of date of hire, all FSWs and FSW Supervisors need to have attended an IFSP training provided regionally by PCANY (see Three Month Training requirements), and the Prenatal Training (*Great Beginnings Start Before Birth*), also provided regionally by PCANY. The IFSP, Prenatal and FSW Core trainings comprise the "FSW Essentials."

6. On-going Training

After the first year of employment, all program managers, FAW and FSW supervisors, and FSWs and FAWs receive the following training:

- On-going training which takes into account the staff's knowledge and skill base. Staff work with their supervisor to identify their individual training needs and interests.
- Training on culturally competent practices based on the unique characteristics of the population being served by the program. Programs are encouraged to reflect on a broad definition of culture and identify training related to characteristics beyond race and ethnicity (i.e. working with fathers, grandparents as parents, language, specific issues for immigrant parents, parenting where there is domestic violence, etc.) Staff attends at

least one training per year related to culture. During their first year, the wrap around training "The Role of Culture in Parenting" satisfies this requirement.

7. Training on Screening Tools

All supervisors, FSWs and any staff who will be administering developmental screenings and the Parental Stress Index must receive training prior to using them. The training is conducted by a person who has been trained in and demonstrates understanding of the use of the tool.

8. Advanced Trainings

HFNY Training and Staff Development team provides advanced training on various topics based on the statewide evaluation, technical assistance and quality assurance visits and requests by the programs. Advanced trainings from HFNY can be used to fulfill the requirements for ongoing training. Advanced trainings offered by HFNY have included FAW, FSW, Supervisor and Program Manager Staff Development Days, Nature of Nurturing and Motivational Interviewing.

9. Agency Executive /Supervisor of Program Manager Training

This is a required training for the executive director and/or the supervisor of the program manager. This training provides critical information for oversight of Healthy Families New York Programs that includes the following: main characteristics and structure, program operations, program manager responsibilities, and their responsibilities for providing supervision and support of program managers. (Effective 9/07)

Critical Element #12

Supervision

(note that Self Assessment Tool Credentialing Standard for Supervision is #11, not #12)

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Supervision of Direct Service Staff**
Policy	Each direct staff person (FSW, FAW) receives ongoing, effective supervision and is provided with skill development and professional support and held accountable for the quality of their work.
Site specific reference	11-1.A-B, 11-2.A-B
Effective date	July 2001
Revised date(s)	June 2007
Appendices	Supervisor Note (FAW, FSW, Supervisors) Supervisor Binder Review Form (FSW) Supervisor Binder Review Form (Supervisor) Sample Team Meeting Agenda

Rationale:

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

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

<u>Direct Service Staff</u>

1. **Consistent Supervision**

a. Each fulltime Family Support Worker (FSW) receives a minimum of 1½ hours (2 hours preferable) of regularly scheduled protected* individual supervision per week. (For less than full-time staff, at least 1 hour of individual supervisory time is required). There may be occasional situations that require supervision be divided into 2 sessions per week, however supervisory sessions are typically completed in one session.

b. Each fulltime Family Assessment Worker (FAW) receives a minimum of 1½ hours (2 hours preferable) of regularly scheduled protected individual supervision per week. (For less than fulltime staff, at least 1 hour of individual supervisory time is required.) FAW supervision may be split into more frequent sessions to better support the assessment workers' job responsibilities.

c. The regularly scheduled supervision time is to be respected by both the worker (FSW or FAW) and the supervisor and rescheduled as infrequently as possible (e.g., FSW providing last minute transportation to participant for

a doctor's appointment, or the supervisor scheduling a conflicting meeting, would generally not be acceptable reasons for cancellation). Programs make every reasonable effort to assure that the only time supervision does not occur is when the FSW or FAW is out of the office for the entire week. Each program develops a protocol for providing weekly supervision for staff when the FSW or FAW supervisor is out of the office. This protocol is written into the program's policy and procedure manual and specifies the frequency and duration for supervision to direct service staff. Programs develop internal mechanisms to assure that their supervision policy is being followed.

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

2. Ratio of supervisors to direct service staff
To ensure that regular, on-going and effective supervision can occur, each supervisor directly supervises no more than 5 FTE FSW/FAWs.

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

a. Skill Development and Accountability for quality of work

i. Supervisory sessions focus on Parent-Child Interaction (observation and inquiry) and discussion of the worker's role in promoting it, Child Development, Family Strengths, Parent Support and Family Functioning (i.e. self-sufficiency).

ii. The following activities help assure that direct service staff are provided with the necessary skill development to continuously improve the quality of their performance and are held accountable for the quality of their work. While all supervision sessions will not contain all of these activities, programs' internal policies and procedures support these effective practice standards:

- Coaching and providing feedback on strength-based approaches and interventions used
- Identifying and promoting the use of behaviorally specific praise
- Reviewing IFSP progress and process, and discussion of the worker's role in supporting the family's goals; reviewing family progress and level changes
- Analyzing and discussing outreach, engagement and retention
- Integrating results of tools used (e.g. developmental screens, PSIs)
- Integrating information from MIS reports into clinical discussions
- Discussing home visit achievement and assessment rates
- Providing Transfer of Learning activities before and after trainings so that staff can integrate training information into their practice
- Assessing and discussing cultural sensitivity and practices

- Providing guidance and practice on communication style
- Providing guidance and practice on use of curriculum
- Providing opportunities for reflection on techniques and approaches
- Identifying and reflecting on potential boundary issues
- Sharing of information related to community resources and topics related to participant education
- Providing feedback on documentation (see Evaluation/Review of Program Quality for more information on Internal Quality Assurance.)
- Observations of home visits and assessments, participant satisfaction surveys, follow-up phone calls after assessment refusals, etc. Note: QA observations do not take the place of regular weekly supervision and it cannot be included as part of the 1 ½ hour requirement.)
- Integrating quality assurance results that include regular and routine review of assessments and assessment records, home visitor records and all documentation used by the program
- Identifying areas for growth and skill development needs. Creating a plan to address the need on a regular basis.
- Participating in first home visit with new participants if possible.

iii. Each program develops a protocol for assuring that supervisory policies and procedures provide staff with skill development and hold staff accountable for the quality of their work.

iv. Programs develop supervisor note forms to document and support the practices of their policies and procedures. (See attached Sample Supervisor note.) These forms will typically include space for notes taken during supervisor binder/file review to ensure integration of information gathered. These supervisor notes are reviewed by the supervisor's supervisor on a regular basis (as defined in the program's policy) to assure documentation of staff receiving skill development and are being held accountable for the quality of their work. (See Sample Supervisor Binder Review Form.)

b. Professional Support

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

- Supervisor coverage when staff are in the field (note: it is a requirement of HFNY that supervisors be available for consultation as needed, and in emergency situations
- Regular Staff/Team Meetings (note: these are required by HFNY.)
- Exploration and reflection of impact of the work on the worker and acknowledgement of burnout issues
- Clinical supervision

- Acknowledgement of performance
- Creating a nurturing environment that provides opportunities for respite (i.e. staff retreats) and scheduling flexibility

4. Each program develops a protocol for assuring that supervisory policies and procedures provide staff with professional support.

5. Volunteers and interns

Volunteers and interns who are performing the same functions as FSWs or FAWs must receive the same type and amount of supervision as paid staff. They must also receive all required trainings (See Required Training). Training and supervision needs to be documented in a manner consistent with paid staff. Volunteers and interns who perform other supportive functions such as assisting with parent groups and accompanying home visitors to homes to assist with activities, are exempt from the supervision and training requirement.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Supervision of Supervisors and Program Managers**
Policy Reference	Each supervisor and program manager receives ongoing, effective supervision on a regular and routine basis. They are provided with skill development and professional support and held accountable for the quality of their work.
Site specific reference	11-3.A-B, 11-4
Effective date	July 2001
Revised date(s)	June 2007
Appendices	- Sample Supervision of FSW Supervisor note - Sample Team Meeting agenda

Rationale:

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

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

<u>Program Supervisors</u>

1. **Consistent Supervision**
   Supervisors receive regular, supportive and on-going supervision. It does not have to be weekly, but it is recommended that program policies and procedures require bi-weekly supervision. One of these sessions may be a group supervision meeting. Supervisors receive supportive supervision from their program manager or other qualified designated consultant or staff member.

2. **Supervision elements**
   a. Supervision sessions provide supervisors with skill development, professional development and holds them accountable for the quality of their work. and professional support
   b. Documentation is kept of the content of these meetings.
   c. Programs' policies and procedures include a variety of mechanisms such as:
      - addressing boundary and personnel issues
      - discussing strategies for promoting professional development and growth
      - providing feedback on performance
      - reviewing documentation

- review of data management reports, program statistics
- review of quality assurance documentation and planning for feedback to FSW/FAWs.
- Observation of supervision session

Program Managers

1. Consistent Supervision

Program Managers receive regular, supportive and on-going supervision. It does not have to be weekly, but it is recommended that program policies and procedures require the Program Managers to meet with her/his direct supervisor on at least a monthly basis.

2. Supervision elements

a. Supervision sessions provide Program Managers with skill development, professional development and holds them accountable for the quality of their work, and professional support
b. Brief documentation is kept of the content of these meetings. This documentation may be written by and kept by the Program Manager.
c. Programs' policies and procedures include a variety of mechanisms such as:
    - discussing strategies for promoting professional development/growth
    - providing feedback on performance
    - addressing boundary and personnel issues
    - assisting with funding opportunities
    - assisting with credentialing requirements
    - reviewing quarterly and annual reports
    - reviewing data management reports, program statistics and performance indicators
    - reviewing external quality assurance and site visit reports
    - observation of supervision session
    - discussing strategies for promoting community support and participation in the referral process

Team/Staff Meetings

Programs are strongly encouraged to have team or staff meetings at least every two weeks at a regular set time. Programs document team meetings. This may include the agenda, and/or meeting minutes and who was present. See sample Team Meeting agenda.

HFNY POLICY AND PROCEDURE MANUAL	
Policy	**Participant File/Binder Review**
Multi-Site Reference	Each participant's file/binder will be regularly reviewed by the FSW/FAW's supervisor.
Site specific reference	11-2.A-B
Effective date	July 2001
Revised date(s)	July 2007
Appendices	Sample Home Visit Record

Rationale:

To ensure that each participant's progress is regularly reviewed by the FAW/FSW and Supervisor.

Procedures for FSW file/binder review

Effective supervision includes file reviews of all participants. To assure that quality services are being provided to all program families, it is important for the supervisor to review all families that had a visit due, or were seen, the previous week. It is recommended that families in "crisis" be reviewed last, avoiding the problem of not having enough time to focus on and learn from the work with the families who seem to be doing well. (These procedures do not refer to the activity of quality assurance binder reviews explained in the "Internal Quality Assurance policy.)

1. It is recommended that each home visit record that has been completed since the last supervision is read by the Supervisor in preparation for supervision. By reading notes in advance, supervision time can be used for more exploration, reflection, clinical depth and future visit planning than if most of the time is spent updating the supervisor on the basic details of the visit.
2. The supervisor initials and dates each note as it is reviewed and checks the Home Visit Log to assure that all activities documented in the record are also reflected in the Home Visit Log.
3. While reading the record, the supervisor looks for many of the following items:
    - Observations of parent-child observation (PCI), family strengths and successes
    - How PCI and Child Development were promoted (e.g. use of behaviorally specific praise)
    - Prenatal and father involvement strategies
    - Activities/handouts/curricula used with the family and the family's reactions
    - How the IFSP is guiding services and how is the worker supporting family goals

- Development screenings and PSIs completed and the implications of scores/strategies
- Significant events happening with the family
- How FSW set and observed boundaries.
- Health and safety
- Progress toward addressing issues identified at assessment or through working with the family
- Possible level changes
- Follow-up on referrals, and assessing if new referrals are needed
- Strategies to engage or re-engage families who seem to be losing interest in program
- Plans for next visit

4. The supervisor makes notes of the above issues to provide FSW with behaviorally specific praise, discuss follow-up activities, provide education and resources, assist with documentation skills, and raise issues of concern and/or missing information. These notes are brought into supervision.

During FSW Supervision
See Policy 11-1.A-B, 11-2.A-B: Supervision of Direct Service Staff, Elements of Supervision.

Procedures for Family Assessment File/Binder review

1. Programs develop their own internal systems, however, in order to provide feedback in a timely fashion and to assign families to FSWs quickly, FAW Supervisors are encouraged to review and discuss assessments with the FAW as they occur. For this reason, FAW supervision may be split into more than one session

2. Supervisors review items such as tracking forms, outreach calendars and MIS reports and ticklers in advance of supervision. As each form/document is reviewed, the supervisor initials where appropriate and makes notes regarding:

   - outreach to and engagement of families
   - review of referrals that have been made
   - successes
   - inclusion of fathers and other family members in outreach and engagement efforts
   - presentation of the home visiting program
   - completeness of forms
   - if items on the Kempe Assessment reflect the guidelines for scoring
   - if the written assessment is accurate and thorough

3. Supervisors note any issues that might help or challenge the transition to the FSW.

4. Supervisors are encouraged to highlight and discuss Kempe issues in need of follow-up within the first six months of service.

5. The supervisor makes notes of the above items to provide behaviorally specific praise to FAW, discuss follow-up activities, provide education and resources, assist with appropriateness and content of documentation, and raise issues of concern and/or missing information. These notes are brought into supervision.

During FAW Supervision
See Policy 11-1.A-B, 11-2.A-B: Supervision of Direct Service Staff, Elements of Supervision.

Governance and Administration

(Credentialing Standard)

The program is governed and administered in accordance with principles of effective management and of ethical practice.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Advisory Group Guidelines**
Policy	The program has an organized, broadly-based advisory/governing group which serves in an advisory and/or governing capacity in the planning, implementation and evaluation of program-related activities.
Site specific reference	GA.1 A-C
Effective date	
Revised date(s)	June 2007
Appendices	

Rationale:

The purpose of the Advisory Group is to bring together members of the health and human services community and recipients of Healthy Families services to help assure that the program is meeting the needs of children, families and the community as defined in the Healthy Families Statement of Purpose. Advisory group members serve as representatives and advocates for the program. Ideally, group members will possess a wide range of skills, strengths, community knowledge, perspectives and resources in order to effectively support the Program Manager in planning, implementing and evaluating program services.

Procedures:

- When the host agency has a governing board that is responsible for decisions and financial provisions for all of the agency's programs, Healthy Families programs are encouraged to have a separate Advisory Group with the primary purpose of advising the program manager and making recommendations on program planning, implementation, and evaluation. The Program Manager shares the advice and recommendations of the Advisory Group with the governing board.

- The Advisory Group meets at a frequency that is in accordance with its duties and the age/longevity of the program, although its members are available to the Program Manager as often as needed.

- The Program Manager typically initiates the agenda and requests input from the group members.

- The Advisory Group is updated on the program's efforts at achieving its stated goals and objectives, and is consulted on specific issues facing the program.

- The Advisory Group receives information from the program's annual report and is responsible for making recommendations.

- The State Leadership Meetings, held three to four times a year, are the forum where policies impacting the multi-site system are discussed and established. The Advisory Group is apprised of these policies when necessary, and develops implementation plans when appropriate in such a way that they match the needs of the program and the community.

- The Advisory Group may make recommendations to the program (and, if applicable, the program's governing body) on policy, operations, finances, and community needs.

- The Advisory Group reviews the Statement of Purpose (Mission) every four years.

- Membership on the Group is reviewed to ensure that all agency partners are represented. Any group member may make recommendations of new members to the group chair.

- Membership typically consists of professionals and participants in the HFNY service who are selected because they are aware of issues in their own programs and in the community. They provide information and awareness to the program so that all aspects of its management and service provision reflect knowledge of these issues.

- Members are selected for the Advisory Group in such a way that it represents a wide range of needed skills and abilities and is heterogeneous in terms of skills, strengths, community knowledge, professions, and demographics.

- There are no term limits for the Advisory Group.

- The Advisory Group may serve as one of several formal mechanisms for participants to provide input into the program.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Participant input into program**
Policy	HFNY programs offer participants formal mechanisms for providing feedback about the program.
Site specific reference	GA.2 A-B
Effective date	June 2007
Revised date(s)	
Appendices	Participant Bill of Rights

Rationale:
To ensure that programs receive feedback from participants as part of their efforts toward continuous quality improvement. To ensure that programs have policies and procedures regarding participant grievances.

To ensure that programs utilize participants' experiences in the program to inform decisions regarding training and support for staff, changes in program operations (i.e. systems, protocols), and as a way to highlight areas of strength or staff skill.

Procedures

Participant input into Program:

All HFNY programs will have formal mechanisms in place for participants to provide input into the program. These mechanisms may include:

- participant satisfaction surveys
- participant service on the advisory committee
- a family advisory committee
- participant feedback through focus groups.
- Random calls to participants by supervisors.

See Cultural Sensitivity Review for ideas on participant input into program.

Participant Grievances:

All HFNY programs have policies and procedures regarding participant grievances which include:

- how the participants are informed of the policy (i.e. many programs use a Bill of Rights)
- the program's process for reviewing any grievances
- the follow-up mechanisms used to address identified areas of improvement.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Evaluation/Review of Program Quality**
Policy	The program monitors and evaluates quality of services.
Site specific reference	GA.3 A-B
Effective date	
Revised date(s)	June 2007
Appendices	Sample Quality Assurance Plan Sample QA tracking grids Sample QA forms for required activities

Rationale:
To ensure that programs have a formal system for the continuous and systematic internal evaluation of the quality of services as well as follow-up mechanisms for addressing identified areas of improvement.

All HFNY programs are required to create a Quality Assurance Plan that allows them to review their progress toward their goals and objectives and address identified areas of improvement. The Quality Assurance Plan should include the activities that will be conducted, the timeframe for their completion, the persons responsible, and the mechanisms for following up on identified areas of improvement. It should include both practice activities and programmatic activities. (See below) The Quality Assurance Plan is reviewed and revised at least annually and ideally twice a year.

General Procedures:
- All tools used for assessing quality should be directly related to the program's goals, objectives, and expectations for performance and services.
- Staff is aware of the program's standards and expectations for their work as well as the documentation and QA activities that are part of ensuring they meet these standards prior to the enactment of QA activities. Program standards and staff expectations are laid out in the following resources:
  - HFNY Performance Targets and Indicators
  - HFA Critical Elements and Best Practice Standards
  - Policy and Procedures Manuals (HFNY's and individual site's)
  - TOL Workbooks with Competencies, and
  - Indicators of Excellence in Home Visiting, Family Assessment Work, and Supervision.

QA Practice Activities

- Quality assurance practice activities focus on assessment, home visiting and supervision.

- QA activities are regular and routine. When observations are conducted regularly and other QA activities are a routine part of their work, staff will become familiar and comfortable with these activities and see them as helpful to the program and supportive of their own professional development.
- Each program develops methods for tracking these activities, such as tracking grids and has procedures in place that explain the flow and timeframe for all related paperwork.
- The following activities are required elements of a program's Quality Assurance Plan (activities are pro-rated based on an employee's FTE in a particular position):
  - Observation of Assessment: 1x per quarter for the first year and 2x per year thereafter for each FAW
  - Observation of Home Visit: 1x per quarter for each FSW
  - Observation of FAW Supervision: 1x per quarter for first year and thereafter 1x per year for each FAW supervised.
  - Observation of FSW Supervision: 1x per quarter for each FSW Supervisor
  - Randomly-selected Participant Satisfaction Surveys: 2x per quarter for each FSW
  - Phone surveys of interview refusals: 1x per quarter for each FAW
  - Program-wide Participant Satisfaction Surveys: 1x year
  - FSW File/Binder Reviews: 1x per quarter for each FSW
  - FAW File/Binder Reviews: 1x per quarter for each FAW
  - Performance Appraisal: 1x per year for all staff

- It is recommended that newer FSWs, FAWs, and Supervisors are observed at higher frequency as needed during their first few months on the job.
- These additional activities are recommended for a program's Quality Assurance Plan:
  - Staff Satisfaction Survey: 1x per year for all staff
  - Supervisor Binder Reviews: At program's discretion for each Supervisor
  - Self-Appraisal of Performance: 1x per year for all staff
  - 360 degree evaluation of managers and supervisors (staff complete evaluations of their manager and/or supervisor that are submitted to the manager's and supervisors' direct supervisor.)
  - Exit interviews with staff and program participants

- Programs may use the observation tools and file review checklists created by PCANY or model their surveys and performance appraisals on the examples provided in the Program Manager Training Manual. They may also use tools developed by other programs or develop tools on their own. (See appendices for sample forms.)

- Programs can use some QA activities (e.g. Program-wide Participant Satisfaction Surveys) to gather information needed for the Cultural Sensitivity review. (See Culturally Responsive Services.)

Follow-Up

- QA activities recognize staff strengths, and positive feedback is shared with staff to provide encouragement and motivation. Areas for improvement are addressed in nonjudgmental ways to promote receptivity to feedback and be accompanied by support and staff development.
- Supervisors make every effort to integrate feedback and the learning from QA activities into supervision and direct practice.
- Written feedback is signed off on according to program policy and maintained in staff records.
- Ideally, Program Managers and Coordinators work with those conducting the QA activities (e.g. Supervisors) to ensure that the results of these activities lead to planning and implementing plans for improvement and professional development.
- When areas for improvement are identified, plans are developed to address these concerns. Planning for improvement may include the following activities:
  - Reviewing the results of the various QA activities with the staff member who was evaluated,
  - Offering feedback on the results, including identifying strengths,
  - Soliciting input from the staff member on her perceptions of her strengths, challenges, and needs,
  - Creating mutually agreed upon goals for improvement,
  - Using these goals to complete a new Professional Development Plan (PDP) or update an existing PDP.
- Once plans are developed, programs establish timelines for completing activities and follow through on their implementation. This may include the following activities:
  - Arranging for mentoring from supervisors or peers
  - Scheduling training
  - Planning for practice sessions
  - Getting outside support from PCANY, OCFS Program Contract Manager, or CHSR

Programmatic Activities

- Quality Assurance programmatic activities utilize the MIS reports and formal and informal mechanisms to assess areas of programmatic strength and those in need of improvement.
- Programs are encouraged to gather information from multiple internal and external sources, including the families served by the program, to create the most accurate total picture of how the program is performing.

- Programmatic areas of focus include those detailed in the Annual Service Review (see policy Annual Service Review). For example, analyzing and planning around universal screening and identifying potential participants; family engagement, acceptance and retention; home visit achievement rates, and staff development and retention.

Follow-up to practice and programmatic activities should result in improved services and outcomes. If activities do not produce these results, programs evaluate all stages of the quality improvement system (i.e. defining expectations, assessing quality, planning for improvement, and implementation) to identify remaining issues and approaches.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Family Rights and Confidentiality**
Policy	HFNY programs inform families of their rights, notify families of confidentiality both verbally and in writing, and have families sign consent every time information is shared with a new external source. Programs protect participant identity and privacy throughout the life of a research project.
Site specific reference	GA-4, 5A-C
Effective date	July 2001
Revised date(s)	June 2007
Appendices	-Consent for Assessment and Post Assessment Activities Form (sample form) -Sample Service Agreement (Consent to Participate) -Sample Participant Bill of Rights -Consent to Participate in Research (MIS)

Rationale:
To ensure that programs have policies and procedures for informing families of their rights and ensuring confidentiality of information both during the intake process as well as during the course of services. To ensure that parents are informed and sign consent every time information is to be shared with a new external source. To ensure that the program assures privacy and voluntary choice with regard to research conducted by or in cooperation with the program.

Notification of confidentiality and family rights.

1. Healthy Families New York Programs offer voluntary, confidential services to all families identified at risk of child abuse or neglect or to those at risk of poor health or developmental outcomes. Participant rights are protected in accordance with agency policy and federal and state requirements. Families are informed at intake of the limits of confidentiality.
2. All program managers, FAW and FSW supervisors, FSWs and FAWs, interns and volunteers receive orientation *prior to direct services with families or supervision of staff.* This orientation addresses issues of confidentiality and family rights. (See Training Plan.)
3. The mandatory reporting statute imposes specific limits on confidentiality. Officials or institutions required to report a case of suspected child abuse or maltreatment must follow all applicable federal and state laws and the guidelines developed for HFNY Home Visiting Programs.
4. Although anyone may report suspected cases of child abuse or maltreatment to the State Central Register, certain professionals are mandated to report. For example, certain categories of professionals such as registered nurses are mandated reporters. Registered nurses who are home visitors or assessment

workers and are employed by Healthy Families New York programs operated by county health departments, hospitals or clinics are mandated reporters. Home visitors per se are not considered mandated reporters unless they are one of those categories of professionals specified in law or if the local department of social services is the contract agency for the provision of home visiting services. In any case, home visitors are encouraged to discuss situations of alleged abuse or maltreatment with their supervisor and make a report to the State Central Register if appropriate.

5. Programs inform families about their rights, including confidentiality, before or on the first home visit, both verbally and in writing. All data is kept confidential.
6. Assessments: Prior to administering an assessment, a consent form must be signed by the family giving permission for the FAW to conduct and document the assessment. This consent also includes permission for the program to conduct and document any other program activities that might occur after the assessment and prior to enrolling the family in home visiting or closing the case (e.g. referrals, follow-up phone calls with initial referral entity). This form is developed by each program site.
7. Initial Home Visits: During the initial home visit, the FSW explains the voluntary nature of services, informs and reviews confidentiality and family rights, and provides reassurance that the FSW's role is to support and assist with needs and interests, explaining what will take place during home visits. The family is asked to sign a form stating that they understand the service in which they are enrolling and are reminded that they may refuse service at any time. These forms are typically referred to by programs as a Service Agreement form or the Consent to Participate.

On-going Informed Consent

1. Families are informed, and sign written consent, every time information is to be shared with a new external source. This may be referred to by some programs as an Authorization for Release of Information.
2. Programs develop systems to ensure that participant files contain evidence indicating that families provided written consent every time information was shared with a new external source.
3. Consent forms include the duration of the period of consent being agreed upon (i.e. 6 months, 1 year, etc.)

Privacy and Voluntary Choice with Regards to Research

1. Families are also asked to sign the "Consent to Participate in the Research" conducted by the CHSR and OCFS, although they are informed that program participation is not contingent on their agreement to participant in the research project.
2. Program policies protect participant identity and privacy throughout research projects conducted by or with the cooperation of the agency.
3. Programs have policies and procedures for reviewing and recommending approval or denial of research proposals, whether internal or external, and which involve past or present families.

Family Rights

The Family Rights and Confidentiality Form is reviewed and explained by the FSW on the first visit. Some programs refer to this as the Participant Bill of Rights. The family signs this form indicating that the information has been thoroughly explained. This documentation is kept in the participant file.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Child Abuse and Neglect Reporting**
Policy	Programs report suspected cases of child abuse and neglect.
Site specific reference	GA .6 A-B
Effective date	July 2003
Revised date(s)	June 2007
Appendices	HFNY Follow-up form

Rationale:
To ensure that programs' policies regarding reporting of suspected cases of child abuse and neglect specifies immediate notification of the program manager and/or supervisor and that other appropriate staff are notified as needed.

Procedures:

- Families are informed at intake of the limits of confidentiality.

- All program managers, FAW and FSW supervisors, FSWs and FAWs, interns and volunteers receive orientation *prior to direct services with families or supervision of staff.* This orientation must ensure that staff clearly understand how to identify child abuse and neglect indicates and fully understand the State's definition of child abuse and neglect and issues of confidentiality. (See Training Plan.)

- The mandatory reporting statute imposes specific limits on confidentiality. Officials or institutions required to report a case of suspected child abuse or maltreatment must follow all applicable federal and state laws and the guidelines developed for HFNY Home Visiting Programs.

- Although anyone may report suspected cases of child abuse or maltreatment to the State Central Register, certain professionals are mandated to report. For example, certain categories of professionals such as registered nurses are mandated reporters. Registered nurses who are home visitors or assessment workers and are employed by Healthy Families New York programs operated by county health departments, hospitals or clinics are mandated reporters. Home visitors per se are not considered mandated reporters unless they are one of those categories of professionals specified in law or if the local department of social services is the contract agency for the provision of home visiting services. In any case, home visitors are encouraged to discuss situations of alleged abuse or maltreatment with their supervisor and make a report to the State Central Register if appropriate.

HFNY POLICY AND PROCEDURE MANUAL	
Subject	**Protocol for Death or Critical Injury of Any Child Residing in a Participant Home**
Policy	The death or critical injury (described as a life threatening injury) of children residing with HFNY participants is considered a tragic situation requiring immediate attention. This policy addresses the death or critical injury of target or non-target children living in the home of an HFNY participant who has died due to natural causes or other causes other than alleged maltreatment, or died due to alleged maltreatment. This policy does not refer to the death of an infant at birth (unless the birth occurred at home) or prior to hospital discharge after the birth.
Site specific reference	GA .7
Effective date	March 2006
Revised date(s)	June 2007
Appendices	-Critical Incident Report -Case File -Report of Suspected Child Abuse or Maltreatment

PROCEDURES:

Each Healthy Families NY Program is required to have a policy and procedure which, at minimum, addresses the following procedures:

1. Notification of supervisors, program managers, and directors, immediately.

2. Notification of Program Contract Managers (OCFS), within 48 hours.

3. Referrals, support and continued services to family, including referrals for grief/trauma counseling.

4. Support of staff members, including referrals for grief/trauma counseling and EAP services.

5. Reports to the Statewide Central Register of Child Abuse and Maltreatment, where abuse or maltreatment is suspected. A call should be made by the worker, or in the presence of the worker, even if you are aware of a previous call made by another person outside of the program. The worker may provide valuable information unknown to other sources. Mandated reporters are required to submit LDSS-2221A *Report of Suspected Child Abuse or Maltreatment* to the local Child Protective Services (CPS).

Mandated Reporters 1-800-635-1522

Public Callers 1-800-342-3720.

6. Review of case record, supervisors' notes, Kempe Assessment.

7. Document the incident, including: the date and time of death or critical injury; the person who notified the HFNY program of the incident; the person(s) where applicable, who made the initial report to the Statewide Central Register of Child Abuse and Maltreatment, if known; the contact information for the CPS worker or supervisor, if known; the chain of command (notification) followed; whether follow-up services will be provided to the remaining family members, and length of time they will be provided.

8. Completion of the HFNY Critical Incident Report, within two weeks.
9. The OCFS Program Contract Manager will review the policy on a yearly basis.

APPENDICES