

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:

Initiating Services

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.).