healthy families america®

a program of Prevent Child Abuse America

HFA BEST PRACTICE STANDARDS

Effective July 1, 2014- December 31, 2017

QUALITY ASSURANCE AND ACCREDITATION

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HFA BEST PRACTICE STANDARDS:

A **best practice** is a method or technique that has consistently shown results superior to those achieved with other means, and that is used as a benchmark. In addition, a "best" practice can evolve to become better as improvements are discovered. Best practice is used to describe the process of developing and following a standard way of doing things that multiple organizations can use.

Best practices are used to maintain quality as an alternative to mandatory legislated standards and can be based on self-assessment or benchmarking.[1] Best practice is a feature of accredited management standards.

The ***HFA Best Practice Standards*** describe expectations for fidelity to the Healthy Families America model. Herein referred to as the "*Standards*", it is the tool used to identify the policies, procedures and practices necessary for HFA sites to implement. It is also the tool used for accreditation to measure site performance relative to the each standard.

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

THE QUALITY ASSURANCE AND ACCREDITATION PROCESS:

The Healthy Families America (HFA) model is based upon twelve research-based critical elements. Sites that implement HFA commit to provide high quality home visiting services and demonstrate model fidelity through the Quality Assurance (QA) and Accreditation process. The "*Standards*" are at the heart of the QA and Accreditation process and serve as the site's guide to model implementation. The "*Standards*" are also the tool used to determine the site's status toward achieving model fidelity. The tool identifies the policies, procedures and practices necessary for site implementation. The "*Standards*" define the Healthy Families America model and are organized by each of the twelve critical elements and a section on Governance and Administration (GA).

Coupled with each standard are rating indicators used to determine the site's current degree of implementation. The rating indicators are used to determine if the site is exceeding, meeting, or not yet meeting the expectation of the standard. Each rating indicator is represented by a numerical system (3-exceeds, 2-meets, 1-does not meet).

The QA and Accreditation process is structured into three steps or phases. Each of these steps allows the site to modify or tailor its current policies, procedures, and/or practices. While the QA process is required every four years to maintain HFA accreditation, sites are encouraged to embrace a philosophy of continuous quality improvement by making the "*Standards*" a part of every day practices (i.e., referencing standards and intents in team meetings, supervision, training, etc.).

Step 1 - The Self-Study

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

Step 2 - The Site Visit

The second step in the QA and Accreditation process is the peer review site visit. The self-study document is used in conjunction with the peer review site visit to determine the site's current rating for all the "*Standards*". Peer Review teams familiarize themselves with the site's processes during the weeks leading up to the site visit by reviewing the self-study and identifying areas requiring further clarification. On-site, the peer team completes a review of family files and other documentation (i.e., personnel records, meeting minutes, supervision documentation, training logs, etc.) and conducts detailed interviews with site staff, families and advisory board members. Once compiled, the peer team utilizes its findings to determine the rating of each standard. As described above, a rating of 1, 2 or 3 is assigned to each standard and when a 1 rating of non-adherence is assigned to a standard, peer teams are required to provide detailed information to indicate the basis for the rating. The peer team's rating for each of the standards is provided in the Accreditation Site Visit Report (SVR).

Step 3 - Response Period

The final step in the QA and Accreditation process requires sites to address the standards rated out of adherence as outlined in the SVR. Sites submit detailed narratives, much like a Quality Improvement Plan, coupled with evidence of implementation to the HFA Accreditation Panel (the Panel). Upon review of the materials, the Panel determines if the site has shown sufficient evidence to warrant an upgrade of the standard. The final decision to accredit a site is made by the Panel based on the site's demonstrated improvement and ability to fully implement a minimum number of standards. All sites must meet the established minimum threshold requirements (certain percentage of standards in adherence). The minimum threshold requires 100% of 1st order standards rated as a 2 or a 3, 100% of safety standards rated as a 2 or a 3, plus at least 85% of all remaining 3rd order and unsupported 2nd order standards (standards with Rating Indicators) rated as a 2 or a 3.

THE STRUCTURE OF THE HFA BEST PRACTICE STANDARDS:

The Standards:

The *HFA Best Practice Standards* contain a series of inter-related standards. A standard establishes the expectation for policy and practice that has been determined either through research or consensus from the field, as a demonstration of excellence. The "*Standards*" are broadly organized by the first order standards (the critical elements) and a section on governance and administration. The first order standard states the overall purpose or aim of the practice within each section. Each first order standard is supported by a series of second order standards (e.g., 1-1, 1-2, 2-1, etc.). While the second order standards provide more detail and specificity than the first order standards, their main purpose is to provide further context for the third order standards. In some cases second order standards are unsupported or stand-alone (e.g. 5-1, 5-3, 11-1, etc.), meaning they are not broken down any further into third order standards; however, most second order standards are supported by a series of third order standards (e.g., 1-1.A, 1-1.B, 1-2.A, 1-2.B, etc.). The third order standards and the stand-alone second order standards are the building blocks of the system. They allow for the formation of strong programmatic practice and are the most specific standards with which the site needs to show evidence of implementation.

Adaptations to the HFA Best Practice Standards:

The HFA National Office views an adaptation as an actual adjustment or modification to the specific best practices that relate to the critical elements. In rare situations, a site or system may be compelled to seek an adaptation to the model. In these situations, the site/system must complete and submit to the HFA National Office an Adaptation Request Form. Permission to implement any proposed adaptation is at the sole discretion of the HFA National Office. The HFA National Office will approve or deny the adaptation request and will provide its decision in writing. Whether the adaptation will be considered in adherence

to HFA standards is also at the sole discretion of the HFA National Office. Sites should be aware that requests pertaining to any 1st order standard, safety standard or sentinel standard will not be approved.

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

2nd Order and 3rd Order Standards Intent:
Intent has been added to many of the 2nd and 3rd order standards to further clarify what is expected, or the purpose of the standards as they relate to the best practice process. The intent focuses on providing more detail on the "why" behind the standards.

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

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

Safety Standards:
These are standards that **must be met** in order to be accredited as they impact the safety of the families being served. Safety standards include personnel background checks (9-3.B), orienting staff on child abuse and neglect indicators and reporting requirements (10-1.C), and child abuse and neglect policy and procedures that include reporting criteria, definitions and practice (GA-6A, GA-6B). Each of these standards is identified as a safety standard in its respective rating indicator box.

Sentinel Standards:
Sentinel Standards are standards determined to be especially significant in the review of HFA site quality. These standards include key site functions in the areas of home visit completion and length of service (4-2.B, 4-3.B), parent-child interaction (6-3.B, 6-3.C), developmental screenings (6-6.B, 6-7.B), depression screening (7-5.B), core training (10-3.A, 10-3.B, 10-3.C), supervision (12-1.B, 12-2.B), notifying families of their rights, of confidentiality practices, and obtaining informed consent when family information is to be shared with others (GA-5.B, GA-5.C), and upholding responsibilities as an HFA affiliate including maintaining up-to-date information in HFAST and having fees paid and up-to-date (GA-9 and GA-10). While adherence to each of these standards is not required in order to receive HFA accreditation, a site with any of these standards rated out of adherence will be required to prepare and submit an improvement plan that clearly indicates the site's efforts to bring the standard into compliance, coupled with evidence of implementation.

Tables of Evidence:
At the end of each Critical Element and the Governance and Administration section is a Table of Evidence. In preparation for accreditation, this table indicates if there is a requirement for a site's Policy and Procedures linked to the standard, along with any additional evidence related to particular standards. The site will compile the indicated Policy and Procedures and additional evidence into its self-study. The self-study is sent to the Peer Reviewers 6 weeks prior to the site visit. Sites should utilize the Tables of Evidence to assist them in determining the necessary information to submit. Additionally, the listing of on-site evidence provides guidance on materials that will need to be available to the peer team when they arrive for the site visit.

Use of HFA Analysis Tools and HFA Tracking Forms:
For certain standards (1-1.C, 1-2.C-E, 1-3.B 1-4.A-C, 3-4.A-C, 4-1.B, 4-2.B, 6-6.B, 7-5.B, 12-1.B and all required training in standards 10 and 11) forms have been created to support sites in presenting evidence in a concise and manageable format. These forms should be used if the site does not have a current system to present the information. If sites or systems provide their own tracking forms they should ensure they include the same fields of information outlined in the tools.

Forms may be obtained here and include:
Standard 1 Spreadsheet (1-1.C, 1-2.C-E, 1-3.B and 1-4.A-C Screening/Assessment Data plus Acceptance Analysis Grid), 3-4.A Retention Measurement Worksheet and 3-4.B-C Analysis Grid, 4-1.B Tracking Form, 4-2.B Tracking Form, 6-6.B HFA ASQ Tracking Form, 7-5.B Depression Screening Form, HFA Required Training Log, and 12-1.B Tracking Form

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

ADVISORY GROUP:
An organized voluntary group with responsibilities to advise on aspects of the HFA site's operations. The functions and responsibilities of this group may include making recommendations to the HFA site and the organization's governing group (if different from the advisory group) regarding site policy, operations, finances, community needs, etc. Advisory group members are a diverse group of individuals who represent the interests of the community as guided by the critical elements.

ASSESSMENT TOOL:
HFA requires the use of the Parent-Survey/Family Stress Checklist as the initial assessment tool used for eligibility and/or service planning. The Parent Survey is administered in a standardized manner by staff trained in the use of the tool. The initial assessment process is designed to more thoroughly explore family strengths and needs. An assessment is done face-to-face and is completed in the home during the prenatal-newborn period or in the hospital (when conducted at birth). The Parent Survey is often used to determine service eligibility, except for when the site has determined through extensive study that a comprehensive screening will be the basis for eligibility determination. Regardless if used to determine eligibility or not, the Parent Survey assessment is completed at the start of services to support the development of individualized service/intervention plans. Unless there are extenuating circumstances, the Parent Survey is administered during one visit within 30 days of the first home visit. A site seeking permission to use an alternate assessment tool instead of the Parent Survey must contact their HFA Implementation Specialist to obtain the necessary request form and process for submitting all assessment tool materials including instrument validity, training protocols for staff, etc. Approvals are at the sole discretion of the National Office and the Accreditation Panel.

CASELOAD:
The total number of families assigned to a direct service staff person.

CHALLENGING ISSUES:
Standard 7-4 refers to parental capacities and/or behaviors which can place their children at especially high risk and can be particularly challenging for home visitors to address. These include parental substance use, mental illness, developmental delay, and intimate partner violence. Support from a supervisor, use of reflective consultation groups (where available) and additional training are critical, as are protocols for worker safety and addressing family safety concerns. This training developed by FRIENDS NRC can be a useful resource as are the procedures outlined in this Safety Manual. The focus of this manual and training is to provide general guidelines to enhance understanding and awareness of safety issues for home visitors.

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

Safety guidelines often need to be adapted and/or expanded to address the specific concerns of each location or situation. Supervisory sessions provide an appropriate venue for discussion of specific safety concerns and fine-tuning of safety procedures. The supervisor should be available and immediately informed if the home visitor fears for his/her safety. The safety of the home visitor is of utmost importance.

CHEEERS:
An acronym to support home visitors in understanding and observing the different dimensions of parent-child interaction that ultimately result in attachment over time. The elements of the acronym include Cues, Holding, Expression, Empathy, Environment, Rhythmicity/Reciprocity, and Smiles. These observations are expected to be made during each home visit as specified in the standard and intent. Training on CHEEERS is also a significant part of HFA Core – Integrated Strategies for Home Visitors training.

CRITERIA:
Rules upon which judgment or decisions are based.

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

CULTURAL SENSITIVTY REVIEW:
A process the site undertakes to examine critically and deliberately its current ability to provide culturally sensitive services. The Cultural Sensitivity Review (CSR), as a final product, is a written document that summarizes the strengths and needs for improvement in all areas of the service delivery system. The CSR includes recommendations/suggestions for how the site might advance its current level of cultural sensitivity. Sites are encouraged to reference the Cultural Sensitivity Workbook as a resource tool when compiling a CSR.

CULTURALLY SENSITIVE:

A site's ability to be aware of and respectful to the diversity of each family it serves and its ability to integrate this awareness into practice. It is the degree to which the site continually modifies or tailors its system of service delivery to the *cultural characteristics* in its *service population* including *personnel/staff* selection, training and all components of the service delivery system (assessment, home visiting and supervision). In striving to find the richness of culture, both our own and that of the families we serve, we are able to learn more about ourselves, our families and the context of their life circumstances.

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

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

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

EVIDENCE-INFORMED PARENTING CURRICULA:
Parenting curricula should be evidence-informed, meaning that the information contained within it is based on scientific knowledge and/or research. Strategies employed, or goals of a curriculum, may also be grounded in scientific research i.e. - strive to strengthen the parent-child relationship which research has shown to be a key factor in healthy development. The reason there is a focus on the use of evidence-informed materials is to ensure that families are receiving well-founded, relevant and credible information versus materials that are opinion-based vs fact-based, or outdated and no longer accurate.

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

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

HANDS-ON PRACTICE:
Actual utilization of a tool during training, which may include role play, videotaping assessments, or scoring a videotaped or shadowed assessment.

HFA CORE ASSESSMENT TRAINING:
In-depth, formalized training which outlines the specific duties of the assessment role within Healthy Families and covers topics including, but not limited to: the role of family assessment, identifying overburdened families, interviewing skills, conducting risk assessments, completing necessary paperwork and documentation, family-centered support services, communication skills, etc. The trainer is certified by the HFA National Office and has been trained to train others.

HFA CORE HOME VISITOR TRAINING:

In-depth, formalized training which outlines the specific duties of the home visitor's role within Healthy Families and covers topics including, but not limited to: establishing and maintaining trust with families, completing necessary paperwork/documentation, the role of the home visitor, communication skills, and crisis intervention, etc. The trainer is certified by the HFA National Office and has been trained to train others.

HFA CORE SUPERVISOR TRAINING:
In-depth, formalized training which outlines the specific duties of the supervisor's role within Healthy Families and covers topics including, but not limited to: the role of family assessment staff and home visitors, effective supervision, quality management techniques, crisis management, understanding the site's policy and procedures; and case management, etc. The trainer is certified by the HFA National Office and has been trained to train others.

HOME VISIT:
A face-to-face interaction that occurs between the family and the home visitor. The goal of the home visit is to promote positive parent-child interaction, healthy childhood growth and development, and enhance family functioning. Typically, home visits occur in the home, last a minimum of an hour and the child is present. Sites are permitted to count one group meeting per month as a home visit while families are on Level 1, however to do so requires that the home visitor be present during the group meeting and that the group meeting be documented on a home visit note, including some aspects of CHEEERS for that particular family. The focus during home visits may include, but are not limited to:

Promotion of positive parent-child interaction/attachment:

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

Promotion of healthy childhood growth & development:

- Child development milestones
- Child health & safety,
- Nutrition
- Parenting skills (discipline, weaning, etc.)
- Access to health care (well-child check-ups, immunizations)
- School readiness
- Linkage to appropriate early intervention services

Enhancement of family functioning:

- Trust-building and relationship development
- Strength-based strategies to support family well-being and improved self-sufficiency
- Identifying parental capacity and building on it
- Family goals
- Building protective factors
- Assessment tools

- Coping & problem-solving skills
- Stress management & self-care
- Home management & life skills
- Linkage to appropriate community resources (e.g., food stamps, employment, education)
- Access to health care
- Reduction of challenging issues (e.g., substance abuse, domestic violence)
- Reduction of social isolation
- Crisis management
- Advocacy

IMMUNIZATION SCHEDULE:
Immunization schedules follow different guidelines, depending upon the schedule adopted by the site/multi-site system. The American Academy of Pediatrics, the Centers for Disease Control, and most Departments of Public Health at the state level issue immunization schedules which spell out what immunizations a child should have and at what age. The CDC has an interactive immunization scheduler where child's name and birthdate can be entered and an individualized schedule created for printing. HFA expects its sites site to follow one of these generally accepted immunization schedules, but does not recommend one schedule over another.

INFANT MENTAL HEALTH:
Developing the capacity of the child from birth to age three to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn - all in the context of family, community and cultural expectations (*Zero to Three IMH Task Force*). Additionally, children must master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system (*World Assn. IMH*).

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

MONITORS & ADDRESSES:
Monitors: to keep track of through the ongoing collection of available information. The extent of the information collected for tracking/monitoring purposes will vary and is a less rigorous process than compiling data for an analysis. In some situations, available data will be minimal, such as when tracking missed screens, in which case the site may not be able to determine much more than the total number missed and possibly referral source. In other situations, such as when monitoring families that assessed positive yet verbally declined further involvement, the site will have more data available that it can use to address issues and inform its decision-making.

Addresses: to attempt to resolve and/or improve that which is learned from the monitoring process through identification of issues that may be affecting the outcome, along with development of strategies that seek to improve the outcome.

MOTIVATIONAL INTERVIEWING (M.I.):
A collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a change goal by eliciting and exploring an individual's own arguments for change. --William Miller, Steve Rollnick, 2012

Example M.I. questions:
What would you like to see different about your current situation?
What has you thinking you need to change?
What will happen if you don't change?
If you make changes, how would your life be different from what it is today?
How would you like things to turn out for you in 2 years?

ONGOING TRAINING:
Supportive and regularly scheduled training provided to staff based upon the specific needs, job responsibilities and issues of families within the community served.

PARENT:
When referenced in the HFA Best Practice Standards, parent is inclusive of biological mother and father, as well as parent figures who have a significant relationship with the target child.

PARENT GROUP MEETING:
HF sites are encouraged to hold regular parent group meetings as a way to build informal support systems and reduce social isolation for participant families. For those families assigned to a weekly level of service, one HF site hosted parent group meeting per month may be counted as a home visit if the home visitor is present for the group meeting and the goals of a home visit are met.

PLANNING, IMPLEMENTATION, AND ASSESSMENT (ADVISORY GROUP ROLE):
Planning refers to the planning of events, additional referral sources, integration of services between agencies serving families, etc. Implementation applies to supporting any implementation challenges the program faces, such as striving for early enrollment, engaging fathers, etc. Assessment relates to feedback from the group related to the analyses, cultural sensitivity reviews, and other performance measures developed by the program.

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

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

PROGRAM MANAGER:
Program managers (PM) are responsible for the day-to-day, hands-on management of the program, and are involved in program planning, budgeting, staffing, training, quality assurance and evaluation. PMs are also responsible for ongoing collaboration with community/state partners, public relations and for maintaining positive working relationships with early childhood partners and providers.

If a site has a supervisor, the PM typically provides supervision to that individual. The PM receives regular supervision according to the personnel policies of the employing agency and in accordance with the "*Standards*". Depending on the size and resources of the site, program managers may also provide supervision to Home Visitors and/or Assessment workers in a dual role as Supervisor (see Supervisor definition).

PROTECTIVE FACTORS:

- Parental resilience
- Social connections
- Concrete supports in times of need
- Knowledge of parenting and child development
- Nurturing & attachment (children's social and emotional competence)

Additional description of these protective factors can be found at the Center for the Study of Social Policy website. Staff are encouraged to also access free online Protective Factors training made available by the National Alliance of Children's Trust and Prevention Funds.

QUALITY ASSURANCE PLAN:
A plan to monitor and track quality of all aspects of implementation that includes performance measures, screening process, program acceptance, family retention, satisfaction surveys, case file reviews, shadowing, quality assurance phone calls, supervision rates, etc.

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

REFLECTIVE CAPACITY:
The readiness a particular individual may have for practicing in a reflective way. It may be worthwhile for hiring organizations to think about an applicant's reflective capacity during the recruitment and screening process. Reflective Capacity questions may be useful at this stage.

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

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

REFLECTIVE PRACTICE:
A safe place (where trust is established) for a regularly scheduled meeting to collaboratively examine thoughts and feelings about an experience. The practice includes active listening and thoughtful questioning of both parties to gain a better understanding of the reasons for the thoughts and feelings and thus determining the best interventions for moving forward. Example: How does it make you feel when the participant doesn't accept your referral for substance abuse? What factors do you think contribute to the participant not accepting your referral? How do you think she feels about it?

REFLECTIVE STRATEGIES:
Reflective Strategies are intervention tools that create an environment of empowerment in which the parent can experience safety, predictability, comfort and pleasure; all of which lead to healthy relationships. These Strategies build on parental competencies rather than teaching. Reflective Strategies include: 1) Accentuate the Positive, 2) Strategic Accentuate the Positive, 3) Feel, Felt, Found (with emphasis on the Feel), 4) Explore and Wonder, 5) Normalizing and 5) Problem Talk, all of which are taught during HFA Core *Integrated Strategies for Home Visitors* training.

REFUSED SERVICES:
A family that is determined to be eligible for services, is offered services and declines participation in services (either verbally or in writing). Or a family who has been enrolled, and for whatever reason declines further participation.

RESEARCH:
Scientific research refers to a systematic examination of information to answer a question and advance knowledge. Evaluation can be a type of research if the knowledge to be gained is applicable to and will be applied beyond the immediate participants and context of the study. Evaluation solely for purposes of quality assurance is not considered research and Standard GA-5D does not apply in these "evaluation for QA purposes" situations.

REVIEWS (QUALITY ASSURANCE):
The process a site undertakes to examine or study judicially, to go over or examine critically or deliberately an aspect or aspects of the site. The review (as a final product) should be in a narrative format and identify areas for improvement.

RISK FACTORS (FROM PARENT SURVEY ASSESSMENT):
- Childhood history of abuse and/or other early childhood trauma
- Substance abuse, criminal history, mental illness (depression)
- Past history with child welfare
- Compromised coping skills, social isolation
- Multiple stressors (housing, finances, relationship)
- Potential for violence and history or current intimate partner violence
- Unrealistic child development expectations
- Discipline methods that include physical punishment
- Perception of fetus/infant as difficult
- One or more biological parents not emotionally and/or physically available to child

SCREEN/SCREENING: A process for early identification of potential families that often occurs via medical record review, community or self-referral, questionnaire that gathers needs/risk data, or similar information collection system. Sites may establish screening criteria that when evident either results in the determination of service eligibility, or results in the completion of a more detailed assessment.

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

SERVICE POPULATION:
The individuals currently enrolled and receiving services.

SERVICES:
When referenced in the "*Standards*", services include the Healthy Families assessment and home visiting services delivered by the site, and does not include Healthy Families service enhancements (i.e. groups, augmented support from clinicians, or other programs housed at the agency.

SITE:
The term used to describe an HFA affiliate.

STAFF DEVELOPMENT PLAN:
All staff bring professional experience and education to the job. Training and self-study are added to broaden the knowledge base and expertise. Each staff member brings strengths to build on and will develop goals for professional development with their supervisor. To understand and document previous learning and experience, supervisors discuss topics with the staff member to ensure knowledge and how it is used in the work. The staff member and supervisor then develop a plan to support ongoing staff development. This can occur during regular supervision and often is formalized during an annual review process.

SUPERVISOR:
Supervisors provide weekly individualized supervision to the home visitors and assessment workers within a Healthy Families site that incorporates administrative, clinical and reflective practices. The supervisor assures quality of service provision. The supervisor protects the integrity of the program and demonstrates respect for the parallel process by supporting, guiding and building on the strengths of staff so that they may best support, guide and build on the strengths of the families served.

TARGET POPULATION:
Members of a group the site has determined it will serve. The boundaries of the designated target population may be set by a variety of factors such as specific social problems, age, and/or community needs.

VOLUNTARY:
This term is used to differentiate between activities in which an individual chooses to participate (i.e., voluntary) and activities in which an individual is required, without choice, to participate (i.e., mandatory).

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

HFA ACCEPTANCE RATE:
The methodology for tracking the percent of families who accept HFA home visiting services during a particular time period. The point at which a site offers services impacts the acceptance rate. The earlier in the recruitment process a family may formally accept, the higher the acceptance rate will appear to be. This is because some number of families may initially accept services (verbal acceptance), but quickly change their mind.

To ensure uniformity in measurement, HFA requires sites to track the acceptance rate of families based on the receipt of the first home visit (behavioral acceptance), regardless of how a site may define its enrollment date. Sites may choose to measure rates at other intervals as well.

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

1. Count the total number of families, during a specified time period, who completed a first home visit, and
2. Divide this number by the total number of potential families who, during the same time period, were offered services after being determined eligible at the time of the initial screen/assessment (whichever is used to determine eligibility).

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

HFA RETENTION RATE:

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

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

1. Select a specified time period, e.g., January 1, 2012 to December 31, 2012;
2. Count the number of families who received a first home visit during this time period,
3. Count the number of families in this group that remained in services over specified periods of time (six months, 12 months, two years or more, etc.);
4. Divide this number by the total number of families that received a first home visit during the time period.
5. For accuracy, a time period must be selected that ended at least one year ago for one year retention rate**,** two years ago for two year retention rate, three years ago for three year retention rate, and so on. This is to ensure that all families beginning services during the specified time period have had the opportunity to stay for the full retention period being measured. For example, a family enrolled in December 2012 could not be counted as retained for one year until December 2013.

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

NOTE: To improve measurement of retention rate, HFA requires that retention calculations use first and last home visit dates, even if sites define enrollment and termination differently. The *retention rate* is impacted by the way sites measure from the beginning to the end of services. For example, if retention is measured from initial screening/assessment date to termination date, retention will calculate lower than it does for sites that define acceptance later in the recruitment process (e.g., first home visit). Also, at the end of services, the termination date is often assigned after a period of creative outreach, which artificially extends the period of time a family was considered to be receiving home visiting services.

ANALYSIS:

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

1. Data (both raw numbers and percentages) that depicts demographic, programmatic, and social factors, along with reasons why families refuse/drop-out of services;

2. A narrative that reflects informal findings from discussions with staff in team meetings or supervision sessions, advisory board conversations etc.; and
3. A narrative summary of the data that illustrates the patterns and trends, or in some cases the absence of patterns or trends among families. Patterns and trends are determined by comparing data across opposing groups (i.e., those accept compared to those who do not or families that stay compared to those that leave) over the same periods of time.

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

Please note: Not all factors listed below are required to be analyzed, however sites should review as many as possible in order to isolate those that may be impacting acceptance and retention rates most. At a minimum, sites need to analyze at least one factor within each of the three overall categories: demographic, programmatic and social. Doing so will increase the likelihood of improvement given that targeted strategies can be developed to address the most highly correlated factors.

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

Programmatic Factors to consider for Acceptance Analysis
- Target population
- Referral sources
- Staffing issues (patterns & trends among assessment staff)
- Number of days between referral and assessment
- Assessment timeframe (e.g., prenatal, at birth within two weeks, more than two weeks)
- Training of staff
- Site funding, etc.

Programmatic Factors to consider for Retention Analysis
- Target population
- Enrollment timeframe (e.g. enrolled prenatally, at birth, or at a later period)
- Staffing issues (patterns and trends among home visitors) depending on site size home visitor trends can be evaluated by individual, by team and by satellite
- Current service level
- Length of time in services
- Age of target child(ren)
- Approaches to service delivery and evaluation of these approaches (use of curriculum, Family Goal Plan development – information may be gathered through the Quality Assurance Plan)
- How policies impact what happens with families and site outcomes
- Relationships with other agencies or community providers
- Training of staff
- Site funding, etc.

DEMOGRAPHIC FACTORS:
General population characteristics. Below are some suggested demographic factors that sites may consider using in the analysis.

- Gender
- Age
- Race & ethnicity
- Marital status
- Education level (last grade completed)
- Primary Language
- Employment Status (not employed, employed part-time, full-time, or seasonally)
- Income level
- Location: urban, suburban, rural; and
- City/zip code, etc.

SOCIAL FACTORS:
The set of characteristics linked to a family's formal and informal support network that may contribute and/or influence human development, relationships, way of life, group dynamics, etc. Below are some suggested social that sites may consider using in the analysis.

- Assessment score (level of risk)
- Work or school issues (currently attends HS or college, significant commute, works night shift, etc.)
- Family or friend support
- Teen parent(s) living independently or with parents
- Grandparents raising target child
- Linkages to other community resources
- Religious affiliation
- Domestic/family violence
- Cognitively delayed parents
- Substance abusing parents
- Parents with mental health issues
- Heightened gang or other criminal activity, etc.

REASONS WHY:
Staff should attempt to determine the reasons why a family did not want to accept services, or dropped out of services prior to completion. At times the specific details may not be available (i.e., a family said yes to assessment staff person's offer, yet never received a first home visit or a family was on creative outreach and is eventually closed). In these instances, staff may draw upon anecdotal assumptions about the reasons why.

COMPREHENSIVE:
A comprehensive analysis is a thoughtful and intentional selection and examination of key programmatic, demographic and social factors that includes a combination of raw (numeric) and aggregate (percentage) formal data as well as informal (anecdotal) data, and how various factors may relate to and influence other factors. A comprehensive analysis also includes a narrative that summarizes the findings of any patterns or trends.

PLAN FOR INCREASING ACCEPTANCE RATES AND RETENTION RATES:
The plans developed by staff to increase the acceptance and retention rates should be directly linked to the patterns and trends identified in the analysis. Staff should utilize team meetings, supervision, advisory board meetings as venues to strategize ways to increase these rates. Additionally, staff should take sufficient time to implement the strategies, determine the effectiveness of a particular strategy, while working to improve rates over time.

Summary and Guidance for Data Collection Timeframes

Timely and thorough data collection provides sites with an opportunity to study how particular practices are being carried out, the degree to which those practices may or may not meet the expectations of the standard, and the identification of data-informed opportunities for improvement. Therefore, where standards ask that sites report data, the data must also be aggregated and summarized to ensure the site understands and can take appropriate action based on their findings. For example, for standard 6-6.B, in addition to maintaining a list of all developmental screens administered by staff, the site should also be able to interpret that data and report on whether all target children have received the minimum expectation of two per year from birth to three and annually thereafter, and if not the reasons why and how the practice might be improved. Please access your Implementation Specialist for guidance on how to make the best use of data specific to expectations of the standards.

Note: Spreadsheets are available to support data collection requirements. ***See page 8 for links to all of the HFA spreadsheets.***

Measuring/Monitoring/Reporting Timeframes

Annual Monitoring/Measuring/Reporting - Site selects the most recent 12 months, most recent calendar year, or most recent fiscal year.

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

Acceptance & Retention Analysis, Cultural Sensitivity Review, Personnel Satisfaction & Retention - At least every two years. Unless site is new and does not have 2 full years of data at the time of the first accreditation site visit, in which case sites will use one year of data.

1-1.C	Annual Reporting: Total in Target population and total screened/identified (number and percent).
1-2.C	Annual Reporting: Total eligibility screens or assessments including (number and percent) completed prenatally, within 2 weeks of birth and after two weeks of birth.
1-2.D	Annual monitoring: Positive screens not assessed or not offered. Include strategies for improvement.
1-2.E	Annual monitoring: Families offered services that verbally decline services. Include strategies for improvement.
1-3.B	Annual Reporting: Total first home visits including (number and percent) completed prenatally, prior to three months of birth and after three months of birth.
1-4.A	Annual Measuring of Acceptance: Total number of eligible families offered home visiting services and the number (and percent) of first home visits completed.
1-4. B&C	At least every two years - Acceptance Analysis: Analyze both formally and informally families that refused services in comparison to families who accept services. Analysis includes programmatic, demographic and social factors as well as the reason why families decline. Develop a plan to increase acceptance addressing any programmatic, demographic and social factors identified in the analysis.

3-4.A	Annual Measuring of Retention: Total number of families who received a first home visit in a specific period of time that ended at least 12 months ago (for 12 month retention) and the number (and percent) of those families who are still enrolled at least 12 months after the end of that time period. *For instance, if we look at the cohort of families who enrolled between Jan 1 ,2013 and Dec 31, 2013, the families who enrolled in December of 2013, will not have had the opportunity to be enrolled for a full 12 months until December of 2014. After December 2014 (12 months after all families in that cohort enrolled), you can look at this group of families (who received a first home visit between Jan 1 ,2013 and Dec 31, 2013) and compare those families who remained in services with those who left to determine 12 month retention for that cohort of families. In December 2015, you could look at 24 month retention for this same cohort of families.*
3-4. B&C	At least every two years - Retention Analysis: Analyze both formally and informally families that remain in services in comparison to families who leave. Analysis includes programmatic, demographic and social factors as well as the reason why families leave. Develop a plan to increase retention addressing any programmatic, demographic and social factors identified in the analysis.
4-1.B	Annual Reporting: Total number of families who have been enrolled at least six months after the birth of the baby, or six months after enrollment (whichever is longer) and the number (and percent) of those families who remained on level 1 (weekly visits) for a minimum of six months, excluding time on creative outreach.
4-2.B	Quarterly Reporting: All active families by home visitor including level of service, level changes that quarter, number of expected home visits that quarter and number of completed home visits that quarter. Summarize home visit completion (HVC) by home visitor by taking the number of families who completed at least 75% of the expected home visits based on their level of service divided by the total number of families on their caseload (exclude families who were on creative outreach the entire quarter). *Note: The overall site level HVC is determined by taking the total number of families who completed at least 75% of the expected home visits based on their level of service, divided by the total number of families on active caseloads for the site (exclude families who were on creative outreach the entire quarter). It is **NOT** calculated by averaging the HVC for all home visitors.*
4-3.B	Annual Reporting: Report families who were still enrolled on the target child's 3rd birthday.
5-4.A	At least every two years - Cultural Sensitivity Review (CSR): The CSR must include review of materials, training and the service delivery system (assessment, home visits & supervision). Staff and families must provide feedback on materials, communication or language factors and the staff-family interactions. Many sites incorporate information gleaned from the acceptance analysis, retention analysis and staff satisfaction to inform the CSR.
6-6.B	All Active Families: Report indicating which target children received at least two a developmental screens per year (unless developmentally inappropriate) for children under the age of three and at least one screen per year for children ages three through five years and which did not. Include if delay was indicated. Provide a summary of the total families (number and percent) who received the required screens divided by the total number of active families.

7-1.B	All Active Families: Report indicating which target children have a medical/health care provider and which do not. Include a summary of the total number target children who do, divided by the total number of active target children.
7-2.B	All Active Families: Report indicating which target children have up-to-date immunizations at one year of age (received all scheduled immunizations through six months of age) and two years of age (received all scheduled immunizations through 18 months of age). This standard allows a window of six months to complete the scheduled immunizations (hence 6 month and 18 month timeframe expectations by the first and second birthday). It may be easiest to provide one report for children between one and two years of age and a separate report for children over two years of age. Include a summary of the total number target children who are up-to-date, divided by the total number of active target children over the age of one year.
7-5.B	All Active Families: Report indicating which mothers received depression screening prenatally (if enrolled prenatally) **and** postnatally before the target child is three months of age. Include if the screen indicates the mother is at-risk for depression and if she is already involved in treatment. Include a summary of the total number of mothers meeting the screening requirement, divided by the total number of active families.
8-1.C	All Active Families: Report indicating the active caseload for all current home visitors over the past 12 months. Include each home visitor's caseload for the most recent quarter, the home visitor's full time equivalency, the number of families assigned to him or her, and the level/intensity of service each family is receiving.
9-4	All Current Staff: Monitor factors associated with staff turnover comparing circumstances and characteristics of staff what leave with those who stay. Include strategies for improvement.
10-1	All Current Staff: Submit training records indicating hire date and date all Orientation Topics were completed.
10-2	All Current Staff: Submit training records indicating hire date and date all Stop-Gap topics were completed (if utilized).
10-3	All Current Staff: Submit training records indicating hire date and date all HFA Core Trainings were completed.
11-2 thru 11-4	All Current Staff: Submit training records indicating hire date and date all Wrap Around Training topics were completed. If The Learning Center (TLC) is utilized, submit TLC report to meet these standards.
11-5	All Current Staff: Submit training records indicating hire date and dates of all Ongoing Training topics.
12-1.B	Quarterly Reporting: Submit frequency and duration for the most recent quarter for all current direct service staff.

1. *Initiate services prenatally or at birth*.

Standard 1 Intent: ***The overall intent of the standards in this section is to ensure the site has a well-thought out mechanism for the early identification of families in the community that could benefit from services.***

1-1. The site has a description of its **target population** and the community partnerships in place to ensure it identifies and initiates services with families in the **target population** while the mother is pregnant and/or at the birth of the baby.

1-1.A The site has a description of its target population and how the current target population definition was decided upon. The description includes the use of relevant community data (i.e. a needs assessment, state rankings, etc.) used in the decision-making.

Intent: *Communities choose to implement the HFA model as a mechanism to improve family and child outcomes and do so because there is local, state and/or federal interest in providing supportive home visiting services to parents, infants and young children who reside in at-risk communities or segments of a community where families or children may be experiencing increased stress. It is therefore vitally important that site leadership has the data upon which to base target population decisions and can utilize it to ensure that a systematic process for identifying families is in place. Demographic data that quantifies (as closely as possible) the volume of potential families (as defined by its target population) is gathered. This data is specific to the families actually giving birth within the identified target population. Target populations can be defined by factors such as: maternal age, Medicaid eligibility, geographical area, first time pregnancy, etc. Some cities have multiple HFA sites working together by serving different target populations.*

The site's target population is reviewed periodically and updated as changes in funding, site structure and/or community demographics warrant. A site's target population describes the characteristics and total number (or close approximate) of all potential families. Each site defines its own target population in order to meet the unique needs of the community.

1-1.A RATING INDICATORS

3 - The site has a description of its target population including the relevant and up-to-date community data that was used in the decision-making. Both the description and data utilized are comprehensive and have been updated within the last two years.

2 - The site has a description of its target population including the community data that was used in the decision-making; however, the description and/or data utilized could be more comprehensive and/or up-to-date.

1 - The site does not have a description of its target population; or community data was not used when deciding on its current target population.

☺ Tip: Sites are encouraged to identify target populations that are realistic to reach. For example, while it is commendable to want to reach out to all families giving birth in a given year, staffing capacity may make this goal unrealistic.

☺ Tip: When compiling demographic data to quantify information about the target population, applicable data should be used (e.g., if the site intends to serve teen parents from a particular geographic area, then the site should gather data that establishes how many teens from that area give birth in a given year; or if the target population is all families enrolling in WIC, the site should gather data to determine how many families make-up

this target population; or 1st time families giving birth at XYZ Hospital, etc.).

1-1.B The site identifies places where the **target population** is found, and the site has established organizational relationships with these entities for purposes of identifying families and obtaining referrals (e.g., local hospitals, prenatal clinics, high schools, etc.).

Intent: *In addition to the site's target population definition/description of families it intends to serve, it will also indicate the community partners which will enable the site to gain access to the families. Sites are encouraged to focus on building these relationships with other community entities to help ensure the target population is well defined and easy to access. In order for sites to access families within the target population, it is essential to create relationships with community entities that come into contact with potential families within the target population. In some cases these community partnerships may require formal Memorandums of Understanding/Agreements, and in other cases these relationships may be verbal agreements or informal in nature. In either case, it is important that these relationships allow site staff to connect with families in the target population. These connections may include the agencies providing referrals/screens and/or contact information to the HFA site for the purpose of assessing families to determine eligibility.*

1-1.B		RATING INDICATORS
3	-	The site identifies organizations within the community in which the target population can be found; both formal and informal agreements are in place and working smoothly to ensure families in the target population are identified and referred.
2	-	The site identifies organizations within the community in which the target population can be found, and agreements (either formal or informal) are in place; however relationships with some referral sources could be strengthened to improve identification of families.
1	-	Any of the following: the site does not identify organizations within the community in which the target population can be found; or identified organizations are not referring families.

1-1.C The site measures the number of families in the **target population** that are identified/referred through its system of organizational relationships and develops strategies to increase the percentage screened/identified.

Intent: *Measuring the percentage of families in the target population that are being reached allows the site to utilize data effectively to advocate for families in the community whose needs may go unmet. For example, it may be that there are many more potential families in the target population than can be served owing to the site's current capacity. Measuring the data in this case provides the site with valuable information to support a funding request to increase staffing. In other cases, the site might be reaching the vast majority of its target population yet staff **caseload**s are not filled. The data can then help the site determine whether its current target population definition is too restrictive. Monitoring the system of organizational relationships is a key component to understanding how more families might be reached. And if working in partnership with an external entity providing centralized intake, it will be important to have an MOU/MOA in place to allow reciprocal sharing of aggregate data about how many within the target population are being screened (by centralized intake) and how many are connecting to services (by the HFA site). The site will also use this data to develop strategies for how the screening/referral process might be improved (e.g., strategies to form new*

*relationships, provide in-service training for referral agencies, create more effective ways to screen/identify families in the target area, etc**.).***

*To measure the percentage of the target population identified for HFA services, a site must start with a total projected number of families in the service area over an upcoming 12 month period that are believed will meet its target population descriptor(s). This does not have to be an exact number and can be informed by both formal and informal data sources. At the end of the 12 month period the site totals the number that were actually identified for services who met target population descriptor(s). The actual number may be based on referrals received or screens completed depending on how families are identified at the site). The **actual number** identified/**number projected** x 100 = the percentage reached.*

1-1.C		RATING INDICATORS
3	-	The site measures annually (as described in the intent) the percentage of families from the target population that were identified/referred to Healthy Families services, monitors the system of organizational relationships in place and has implemented strategies to increase the percentage screened/identified and/or strengthen relationships with referral sources.
2	-	The site measures annually (as described in the intent) the percentage of families from the target population that were identified/referred to Healthy Families services, monitors the system of organizational relationships in place and has developed, but not yet implemented, strategies to increase the percentage screened/identified and/or strengthen relationships with referral sources.
1	-	Any of the following: The site has not measured at least annually (as described in the intent) the percentage of the target population being reached; the site has not monitored the system of organizational relationships; and/or has not developed any improvement strategies.

☺ Tip: Use of the Standard 1 Spreadsheet (1-1.C, 1-2.C-E, 1-3.B and 1-4.A-C Screening/Assessment Data plus Acceptance Analysis Grid) will allow the site to calculate its rate of identifying potential families from the target population, and to do so the site will want a close approximation of how many families in the service area potentially fit the target population descriptors.

1-2. The site ensures screening/assessment processes are tracked and monitored, including all referrals received, from initial referral to completion of contact to the offer of services.

1-2.A The site has policy and procedures regarding its screening/assessment processes and mechanisms to ensure timely determination of eligibility. Policy and procedures also include the site's tracking and monitoring requirements. **Please note:** For sites providing "universal" services (where all families are considered eligible to participate in site services), the "universal" status is considered a positive screen.

1-2.A	RATING INDICATORS
3 -	No 3 rating indicator for standard 1-2.A.
2 -	The site's policy and procedures include the following information: screening/assessment processes; mechanisms to ensure timely determination of eligibility, including timeframes between receipt of a referral/screen to the completion of contact to offer services (when used for eligibility) or assessment; and the site's tracking and monitoring requirements.
1 -	One of the following: There is no policy and procedures; or the policy and procedures do not address the requirements listed in the 2 rating.

☺ Tip: Sites are encouraged to follow-up with referring entities to provide information regarding the outcome of their referral(s) especially when the initial contact with the family is not completed.

1-2.B The site follows its policy and procedures regarding its screening process and utilizes a systematic process for receiving referrals and screening families in a timely manner.

1-2.B	RATING INDICATORS
3 -	The site utilizes a systematic process for receiving referrals and screening families.
2 -	Past instances may have occurred when the site did not utilize a systematic process for receiving referrals and screening families; however **recent practice** indicates this is now occurring.
1 -	The site does not utilize a systematic process for receiving referrals and screening families.

1-2.C Determination of **eligibility for services** occurs either prenatally or within the first two weeks after the birth of the baby.

Intent: *Screening/Assessment is used together in this standard to allow sites flexibility in determining family eligibility.* ***Please note:*** *Sites are encouraged to utilize a 2-step process that includes initial screening followed by the assessment (*Parent Survey/Family Stress Checklist*) to determine family eligibility. For sites using a 2-step process, assessment data will be used as evidence for this standard. For sites using a positive screen for determining eligibility, screening data will be used for this standard. For sites providing "universal" home visiting services (where all families are considered eligible to participate in site services), the "universal" status is considered a positive screen. Sites will use the number of families referred as evidence for this standard.*

1-2.C RATING INDICATORS

3 - Ninety-five percent (95%) through one hundred percent (100%) of eligibility screenings or assessments occur prenatally or within the first two weeks after the birth of the baby.

2 - Eighty percent (80%) through ninety-four percent (94%) of all eligibility screenings or assessments occur either prenatally or within the first two weeks after the birth of the baby.

1 - Less than eighty percent (80%) of all eligibility screenings or assessments occur either prenatally or within the first two weeks after the birth of the baby.

☺ Tip: Sites are encouraged to establish systems that allow the connection with families to occur as early as possible, ideally during the prenatal period.

1-2-D The site **monitors and addresses** families that screen positive but were not assessed and either 1.) not offered services (when the site offers services universally or uses a positive screen to determine eligibility or 2.) not offered assessment (when the site uses a positive assessment to determine eligibility.

Intent: *Many potential families miss the opportunity to participate in services because site staff is unable, for a variety of reasons, to maintain contact with them subsequent to the initial screening process. Therefore, sites are to monitor the screening/identifying process in order to develop strategies for increasing the capacity of the site to connect with the **target population**. The depth of the monitoring will depend on the amount of information gathered through the screening/identifying process or from referral agencies, but at a minimum must include the number of families over the course of a year that screen positive and the number of those that are not offered service (for sites using a 1-step eligibility process), or assessed (when using a 2-step process).*

1-2.D RATING INDICATORS

3 - The site monitors at least annually the screening process particularly as it relates to any families who screen positive and then are not assessed (when assessment is used to determine eligibility), or offered services (when screen is used to determine eligibility) and has developed and implemented strategies to address any issues.

2 - The site monitors at least annually the screening process particularly as it relates to any families who screen positive and then are not assessed (when assessment is used to determine eligibility), or not offered services (when screen is used to determine eligibility) and has developed strategies to address any issues.

1 - Any of the following: The site has not monitored, at least annually, the screening process as it relates to families who screen positive and then are not assessed (when assessment is used to determine eligibility)or offered services (when screen is used to determine eligibility), or has not developed strategies to address issues.

1-2.E The site **monitors and addresses** families who verbally declined the offer of services subsequent to either, 1.) a positive assessment (when the site uses assessment to determine eligibility), or 2.) the offer of services (when the site uses a positive screen to determine eligibility or offers services universally).

Intent: *Sites are to monitor families who verbally decline the offer of services after being determined eligible in an effort to develop strategies for increasing the ability to connect with, engage and enroll families.*

1-2.E RATING INDICATORS

3 - The site monitors families who verbally decline the offer of services after a positive assessment or when contacted to offer services (screen or universal determines eligibility), and has implemented strategies to address any issues; or ninety to one hundred percent (90-100%) of families offered services verbally accept, in which case improvement strategies do not need to be developed or implemented.

2 - The site monitors families who verbally decline the offer of services after a positive assessment or when contacted to offer services (screen or universal determines eligibility), and has developed strategies to address any issues; however, these strategies have not yet been implemented.

1 - Any of the following: The site has not monitored the families who verbally declined services or has not developed strategies to address issues.

1-3. The site ensures the first **home visit** occurs within three months after the birth of the baby.

Intent: *HFA research, as well as significant anecdotal evidence, points clearly to a site's ability to achieve improved outcomes the earlier services are initiated. This is owing to multiple variables including the particular vulnerability of the infant during the prenatal and newborn period, and an opportunity to help shape better health, nutrition and lifestyle practices that can impact the infant during this particularly sensitive period. The patterns of the parent-infant relationship, including parental responsiveness and interpretation of infant behavior begin during this period as well, and strategies employed by home visitors can promote healthier bonding and attachment. Finally, and especially for families that have had limited exposure to healthy, trusting relationships during their life, the ability to form a trusting relationship with a home visitor requires time. Therefore, the earlier the alliance between home visitor and parent is formed, the greater the likelihood of increased family retention.*

1-3.A The site has policy and procedures stating that, for families who accept services, the first **home visit** occurs prenatally or within the first three months after the birth of the baby, and includes tracking and monitoring requirements.

1-3.A RATING INDICATORS

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

2 - The site's policy and procedures clearly indicate the following:
the first home visit occurs prenatally or within the first three months after the birth of the baby; and detail the site's tracking and monitoring requirements.

1 - One of the following: There is no policy and procedures; or the policy and procedures do not address the requirements listed in the 2 rating.

1-3.B The site's practices ensure that, for families who accept services, the first home visit occurs prenatally or within the first three months after the birth of the baby. **Please Note**: When infants begin life with an extended hospital stay in the NICU, it may not be possible to begin home

visits until after 3 months. These situations must be documented clearly and will be exempted from the requirements of this standard.

1-3.B RATING INDICATORS

3 - Ninety-five percent (95%) through one hundred percent (100%) of first home visits occur prenatally or within the first three months after the birth of the baby.

2 - Eighty percent (80%) through ninety-four percent (94%) of first home visits occur prenatally or within the first three months after the birth of the baby.

1 - Less than eighty percent (80%) of first home visits occur prenatally or within the first three months after the birth of the baby.

☺ Tip: Sites are encouraged to begin providing services as early as possible, ideally during the prenatal period.

1-4. The site measures, analyzes, and addresses how it might increase the acceptance rate of families into the site on a regular basis and in a consistent manner.

1-4.A The site measures the acceptance rate of families using HFA methodology (based on receipt of first home visit). **Please see measuring acceptance rates on page 16**. When measuring and analyzing sites can use the Standard 1 Spreadsheet (1-1.C, 1-2.C-E, 1-3.B and 1-4.A-C Screening/Assessment Data plus Acceptance Analysis Grid)

Intent: *Calculating the rate of families accepting services is a critical quality improvement measure. Sites are to look at the total number of families offered services over the course of a year and what number and percent of those families accepted site services (as demonstrated by completion of a first home visit after the offer was made). To ensure uniformity in measurement, HFA requires sites to track the acceptance rate of families based on acceptance of the first home visit, regardless of how a site may define its enrollment date. Sites can measure rates at additional intervals if desired.*

1-4.A RATING INDICATORS

3 - The site measures its acceptance rate of families (based on receipt of a first home visit) into services and evidence indicates acceptance rates are being measured more than once a year.

2 - The site measures its acceptance rate of families (based on receipt of a first home visit) into services and evidence indicates acceptance rates are being measured at least annually.

1 - The site is not measuring its acceptance rate at least annually.

1-4.B The site comprehensively analyzes at least once every two years (e.g., both formally, through data collection, and informally through discussions with staff and others involved in the screening and assessment process), families that **refused services** among those determined to be eligible for services and the reasons why. **Please see common terms associated with analyses on pages 17-19.**

Intent: *Sites are to measure site acceptance data at least annually (as indicated in standard 1-4.A) and conduct a thorough analysis, at a minimum, once every two years to determine patterns or trends; the analysis compares families who accept site services with those who refuse site services, and identifies potential improvement strategies to increase site acceptance, based*

on the analysis. Sites may choose to analyze data more often if patterns or volume suggest this need. ***Please Note: New sites without 2 full years since home visiting services began will complete a first analysis with one year of data instead of two.***

1-4.B RATING INDICATORS

3 - The site uses both formal and informal methods to analyze, at least once every two years, families that **refused services** and why. This analysis is comprehensive, addressing multiple factors within each of the 3 categories, **1) programmatic, 2) demographic, and 3) social**, and compares these factors for those who accept and those who decline during the same time period; **or** at least ninety percent (90%) of families offered services over the 2-year timeframe accepted services by receiving a first home visit, in which case an analysis is not required.

2 - The site uses both formal and informal methods to analyze, at least once every two years, families that refused the services and why. This analysis compares those who accept with those that declined during the same time period, and addresses at least one factor within each of the 3 categories, **1) programmatic, 2) demographic, and 3) social.**

1 - Any one of the following: The site does not have an analysis of who **refused services** and why; the analysis does not include both formal and informal methodology; the analysis does not include at least one factor from each of the 3 categories, **programmatic, demographic, or social;** the analysis does not include a comparison of those who accept and those who decline during the same time period; or the analysis is not conducted at least once every two years.

NA - The site did not accept any new families in the last two years.

☺ Tip: The HFA 1-4 Acceptance Analysis Grid provides guidance on various programmatic, demographic and social factors to consider when conducting a comprehensive analysis.

☺ Tip: For those whose acceptance rate has remained 90% or more over a 2 year period (3 rating) the site is still encouraged to informally look at programmatic, social, and demographic factors, along with reasons why a group might not be accepting program.

1-4.C The site addresses how it might increase its acceptance rate based on its analysis of those refusing the site in comparison to those accepting services.

1-4.C RATING INDICATORS

3 - Based on the analysis, the site has implemented a plan for increasing its acceptance rate among the individuals who are not currently choosing to participate in services. The plan addresses programmatic, demographic, and/or social factors identified within the analysis; **or** at least ninety percent (90%) of individuals offered services over the two-year timeframe accepted services, in which case an analysis and plan is not required.

2 - Based on the analysis, the site has a plan for increasing its acceptance rate among the individuals who are not currently choosing to participate in services. The plan addresses the programmatic, demographic, and/or social factors identified within the analysis; however, the plan has not yet been implemented.

1 - Any of the following: the site does not have a plan; the plan is not based on the analysis; does not address programmatic, demographic, and social factors

		identified within the analysis; or does not address how it might increase its acceptance rate.
NA	-	The site did not accept any new families in the past two years.

*Note: See Link for Self Study Face Sheet in Glossary section (page 5) to submit with Self Study			
1. Initiate services prenatally or at birth			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study** **Please note: Programs may submit the HFA Standard 1 Spreadsheet (Standards 1-1.C, 1-2.C-E, 1-3.B, 1-4.A-C)**	**Site Visit Activities**
1-1.A Target Population		Submit a narrative definition of the current target population (who the program intends to serve) including how the current target population was decided upon and the relevant and up-to-date (within the last two years) community data that was used in the decision-making.	**Interview:** * Program Manager * Assessment supervisor * Assessment Workers * Partner agency where families are identified (if possible) **Review:** * formal and/or informal agreements with collaborating agencies * updated reports showing recent improvements if needed * Advisory Group Survey
1-1.B Referring Organizations		Submit narrative indicating where the target population is found (e.g., local hospitals, prenatal clinics, high schools, etc.) and the type of organizational relationship (formal or informal agreement) that exists with those entities.	
1-1.C Monitoring Screens		Submit the total number of families in the target population and the number (and percent) of families in the target population who were screened/identified in the last year (or HFA Standard 1 Spreadsheet if used). Include the identified and implemented strategies to increase the percent screened/identified.	
1-2.A Policy for screening process	The processes for initiating screening/assessment, timely determination of eligibility, and tracking and monitoring mechanisms	Submit Policy	
1-2.B Practice for screening process		Submit documentation or form used for tracking of referrals and screens received.	
1-2.C Screening Timeframe		Submit a report (or HFA Standard 1 Spreadsheet if used), illustrating the number of screens/assessments (whichever is used to determine eligibility) that occurred prenatally, within the first two weeks of the birth of the baby, more than two weeks after the birth of the baby, and the total percentage within two weeks of the birth of the baby in the last year.	
1-2.D Monitor and Address Not Offered		Submit narrative (or HFA Standard 1 Spreadsheet if used), describing how the program monitors and addresses families who 1.) were not offered home visiting services (when the program offers services universally or uses a positive screen to determine eligibility) or 2.) were not assessed (when the program uses a positive assessment to determine eligibility). Include strategies developed to address any issues.	

1-2.E Monitor and Address Declines		Submit a narrative (or HFA Standard 1 Spreadsheet if used), describing how the program monitors and addresses families who verbally declined further program involvement subsequent to either, 1.) a positive assessment (when program uses assessment to determine eligibility), or 2.) the offer of services (when program uses positive screen to determine eligibility or offers services universally). Include strategies developed to address any issues.	
1-3.AFirst Home Visit within 3 months	The process and timeframe for initiating home visiting services prenatally or within the first 3 months, and tracking and monitoring requirements	Submit Policy	
1-3.B First Home Visit within 3 months		Submit a report (or HFA Standard 1 Spreadsheet if used), indicating the date of the first home visit and the date of the baby's birth for all families who entered the program during the last year.	
1-4.A Measure Acceptance Rate		Submit a narrative describing the program's definition of program acceptance rate, a description of the program's process for measuring the acceptance rate including method of calculation, and the current acceptance rate. **Please note:** programs may submit the HFA Standard 1 Spreadsheet or program database report that includes all required elements (i.e., comprehensive, comparative and with reasons why).	**Interview:** * Program Manager * Supervisors * Direct Service Staff as needed **Review:** * Previous Acceptance Rates * Previous acceptance analysis and plans to increase * Staff Survey * Advisory Group Survey
1-4.B Acceptance Analysis		Submit a narrative describing how often the program conducts its acceptance analysis and a copy of the most recent acceptance rate analysis.	
1-4.C Plan to Increase Acceptance		A copy of the most recent plan to increase the acceptance rate based on the comprehensive analysis.	

2. *Use standardized screening and assessment tools to systematically identify and assess families most in need of services. The Parent Survey or other HFA approved tool is used to assess the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences.*

Standard 2 Intent: ***The overall intent of the standards in this section is to ensure the site has an objective, standardized process for identifying and assessing the strengths and needs of families at the onset of services.***

2-1. The site has clearly defined eligibility requirements for families offered services.

2-1.A The site has policy and procedures that clearly define the eligibility requirements for families offered services.

2-1.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 2-1.A.
2	-	The site has policy and procedures that clearly define eligibility requirements for families offered services.
1	-	One of the following: there is no policy and procedures; or the policy and procedures do not clearly define eligibility requirements for families offered services.

2-1.B The site follows its policy and procedures regarding eligibility requirements for families offered services.

2-1.B		RATING INDICATORS
3	-	The site follows its policy and procedures regarding eligibility requirements for families offered services.
2	-	Past instances may have occurred when the site did not follow its policy and procedures regarding eligibility requirements for families offered services; however, **recent practice** indicates this is now occurring.
1	-	Any of the following: the site does not follow its policy and procedures regarding eligibility requirements for families in the **target population**; there is no policy and procedures; or the policy and procedures do not clearly define eligibility requirements for families offered services.

2-2. The site uses the *Parent Survey/Family Stress Checklist* or other HFA approved tool (must prepare and submit request materials and receive approval – see Assessment definition on page 8) to assess for the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences.

Intent: *No single factor is sufficient to predict who faces the high levels of stress that may lead a parent to abuse or neglect a child. It is also not possible for a single factor to predict when a child is at risk for developmental delays, poor childhood outcomes or adverse childhood experiences.*

*Therefore, sites will use the Parent Survey or other HFA approved tool to determine family strengths and needs. When it is not fiscally possible to provide services universally, standardized **assessment tool**s identify families most in need of services in an objective manner and ensure services are offered to families the model is designed to serve.*

2-2.A The site has policy and procedures requiring that Parent Survey assessment ***criteria*** and documentation of assessment ***narratives*** indicate the presence of factors that could contribute to increased risk for child maltreatment and/or other adverse childhood experiences. The policy and procedures identify who completes the narrative and the timeframe for completion.

Intent: *Site policy and procedures ensure all staff involved in the assessment process provides such service objectively and reliably, so that all families are assessed in the same way regardless of who conducts the assessment. In addition, the policies are in line the HFA Core assessment training expectations (sites may state in their policy "as referenced in HFA Core Parent Survey training materials" as long as staff administering the tool have retained access to these materials). Sites state clear expectations for the documentation of the assessment narrative to ensure it conveys accurately the depth and detail of each family's strengths, **risk factors**, and needs. Consistent documentation in this way provides home visitors with an understanding of each family, and affords the opportunity to provide individualized service that builds upon their strengths and is specific to their unique needs.*

Sites are also encouraged to highlight/document specific conversations that indicate a parent(s) motivation for change (e.g. statements such as "I don't want to parent the same way as my parents", "I really want to finish school", "I want to learn everything I can to meet my baby's needs", "I want to stay clean for my baby," and/or "I am not going to use a belt to discipline my baby"). Statements like these assist home visiting staff in identifying potential starting points for home visit activities and can facilitate connections with families. The ongoing use of this assessment documentation becomes the basis for standards 6-1.A, 6-1.B and 6-1.C.

Please note: *If services are offered based on a positive screen or universally to all families in the **target population**, The Parent Survey/Family Stress Checklist (or other HFA approved tool – see glossary – **Assessment Tool** on page 8 for details on how to seek permission to use an alternate tool) is to be completed at the onset of services (within first 30 days of first home visit) to provide home visitors and supervisors with an understanding of the unique strengths, **risk factors**, and needs of a family, such that interventions uniquely tailored to the family can be planned.*

2-2.A		RATING INDICATORS
3	-	No 3 rating for standard 2-3.A.
2	-	The site has policy and procedures regarding the following: Assessment ***criteria*** and documentation of assessment ***narratives*** that detail the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences (when using the Parent Survey, the site's policy may reference the HFA core training materials vs having extensive procedural narrative). The policy and procedures identify who completes the narrative and the timeframe for completion.
1	-	The site does not have policy and procedures that meet the **criteria** listed in the 2 rating.

2-2.B The Parent Survey/Family Stress Checklist or other HFA approved tool is administered uniformly with the families and in accordance with site policy and procedures.

2-2.B		RATING INDICATORS
3	-	The *Parent Survey/Family Stress Checklist* or other HFA approved tool is administered uniformly with families and in accordance with site policy and procedures.
2	-	Past instances may have occurred when the site did not administer the *Parent Survey/Family Stress Checklist* (or other HFA approved tool) uniformly with families and in accordance with site policy and procedures; however, **recent practice** indicates this is now occurring.
1	-	The site does not administer the *Parent Survey/Family Stress Checklist* (or other HFA approved tool) uniformly with families and in accordance with site policy and procedures.

2. Standardized Assessment Tool			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
2-1.A Eligibility Policy	Eligibility requirements for families	Submit Policy and a copy of the screening and/or assessment tool along with any related documentation, and a description of the factors identified by each tool.	**Interview:** * Program Manager * Supervisors * Assessment Workers **Review:** * Family Files * Advisory Group Survey
2-1.B Policy Followed		No additional pre-site evidence required.	
2-2.A Assessment Policy	Assessment criteria and documentation of assessment summaries/narratives, including who completes assessment documentation and timeframe for completion	Submit Policy	**Interview:** * Program Manager * Supervisors * Assessment Workers **Review:** * Family Files * Staff Survey
2-2.B Parent Survey/Assessment Practice		No additional pre-site evidence required	

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

Standard 3 Intent: ***The overall intent of the standards in this section is to ensure the site has a process for reaching out to and engaging families initially, as well as attempting to stay connected with and re-engaging families who may have more barriers to accepting and maintaining services.***

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

Intent: *Offering services voluntarily (allowing families to choose to participate) increases trust and receptivity. Research suggests that an important reason for voluntary services is that mandatory services shift emphasis from one of social support to one of social control (Daro, 1988). Home visiting services must be voluntary, such that the entire context and tone is one of respect for families – their desires and their strengths (Gomby, 1993).*

3-1.A The site has policy and procedures that state services are **voluntary** and include how this information is shared with families. See Standard GA-5B regarding the need to have a written Family Rights form that includes but is not limited to the voluntary nature of services and a family's right to refuse service.

3-1.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 3-1.A.
2	-	The site has policy and procedures regarding the voluntary nature of site services, including how this information is shared with families.
1	-	The site does not have policy and procedures regarding the voluntary nature of services; and/or does not describe how this information is shared with families.

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

Intent: *While HFA is very clear that services to families are offered voluntarily, there may be some external agencies that require HFA as part of mandated treatment or service plans (e.g., child welfare, court systems, substance abuse treatment facilities, etc.). HFA does not have authority to prevent this type of referral, however must be certain to clarify with families that regardless of the intent of the referral entity, HFA services are voluntary and families may end services at any time.*

Additionally, when the site accepts families that have active child welfare cases, staff may not monitor family's progress on behalf of the referral entity nor perform the job functions required by that entity. Sharing of information with child welfare and/or other service systems is bound by the confidentiality requirements of HFA and informed consent that indicates precisely what information is to be shared. Additionally, it may be important to inform families that sharing such information may not always be helpful to the family's situation.

3-1.B	RATING INDICATORS	
3	-	The site practice clearly indicates services are offered to all families solely on a voluntary basis.
2	-	Past instances may have occurred when services were not provided voluntarily to all families; however, **recent practice** indicates that services are now offered to families solely on a voluntary basis.
1	-	There are instances in which services are not provided voluntarily.

3-2. Staff utilizes positive methods to build family trust, engage new families, and maintain family involvement.

3-2.A The site has policy and procedures specifying a variety of positive methods to build family trust, engage new families, and maintain family involvement in the services.

Intent: *This standard reflects the need for staff to utilize trust-building methods and tools, including supervisory support, when establishing and maintaining relationships with families. Families are often reluctant to engage in services and may have difficulty building trusting relationships. Therefore, site staff must identify positive ways to establish a relationship with a family and keep families interested and connected over time. Utilizing a* ***family centered*** *approach, throughout the course of services, allows staff to focus on what is important to the family. Supervision is an excellent place to strategize ways to continue to build trust, engage families and maintain involvement.*

3-2.A	RATING INDICATORS	
3	-	No 3 rating indicator for 3-2.A.
2	-	The site has policy and procedures specifying a variety of positive methods (e.g., telephone calls, visits, mailings, parenting groups, family-centered practices, etc.) to build family trust, engage new families, and maintain family involvement in services.
1	-	The site has no policy and procedures or the policy and procedures do not address the requirements in a 2 rating.

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

Intent: *Staff utilize a variety of strategies to connect with families both at intake and throughout the course of service delivery. Research indicates that families who have experienced generational abuse are at greater risk for difficulty in developing healthy relationships with others and are often reluctant to accept a partnership with home visitors (Fraiberg, 1975). Staff will need to develop creative and unique ways to connect with families. Sample strategies to use with all families, including those who have experienced generational abuse, may include:*

- *Warm telephone calls focused on the family's well being*
- *Creative and upbeat notes that encourage parents to want to participate*
- *Drop by visits leaving a card when families are not home*
- *Texting when approved by site policy*
- *Anchoring conversations with families to their interests and needs*
- *Demonstrating joy in being with the parent(s)*

- *Offering playful/fun activities*
- *Utilizing music and art in initial interactions, and*
- *Personalizing engagement efforts*

3-2.B		RATING INDICATORS
3	-	Site staff uses positive methods to build family trust, engage them in services, and maintain family involvement.
2	-	Past instances may have occurred when positive methods were not used; however, **recent practice** indicates that the site now uses positive methods to build family trust, engage them in services, and maintain family involvement.
1	-	The site does not use positive methods to build family trust, engage them in services and maintain family involvement.

3-3. The site offers creative outreach under specified circumstances for a minimum of three months for each family before discontinuing services.

3-3.A The site policy and procedures specifies the circumstances under which a family is placed on creative outreach status, the activities to be carried out during the course of creative outreach, that creative outreach is continued for families for at least three months and is only concluded prior to three months when families have **(re)engaged** in services, **refused services**, have **moved** from the area, or other allowable reasons (bolded below in the intent).

Intent: *It is the site's responsibility to reach out to families who have accepted services, yet for a variety of reasons, may not be comfortable availing themselves for an initial visit or consistent participation in services. Often, families that have experienced trauma in their own childhood histories find it difficult to openly trust and welcome others into their homes. Additionally, families in crisis may find it difficult to continue participation due to a variety of factors.*

The circumstances that warrant a family being placed on creative outreach may vary from site to site; however, the number of missed visits or length of time without contact prior to placing the family on creative outreach must be clearly outlined in the policy. Additionally, the activities required to (re)engage families in services while on creative outreach are identified. Please keep in mind services are to be uniquely tailored to the individual family. Activities are to be focused on strategies that demonstrate to the family the home visitor is genuinely interested in them and willing to continue to offer services. Creative activities designed to reach out to families occur throughout the full three-month timeframe. Sites are advised to avoid correspondence that threatens or demands the family to contact the site, lest they be terminated from services. While services may in all likelihood be terminated after the three-month timeframe, correspondence indicating that plan will likely add to the feelings of alienation and lack of trust that families have. Personalized, handwritten notes may be more effective in establishing a trusting relationship.

The three-month creative outreach timeframe applies to families who have received a first home visit subsequent to the offer and acceptance of services. Outreach to families after verbal acceptance and prior to the first home visit is not bound by this standard nor held to the 90 day requirement. Generally pre-engagement outreach (outreach services provided prior to the first home visit) concludes within 30-45 days.

Policies include how the site will address other allowable reasons for ending services (e.g., parent no longer has custody, pregnancy ended in miscarriage, target child or primary care provider is deceased, significant staff safety issues, transferred to another program, etc.).

3-3.A	RATING INDICATORS
3 -	No 3 rating indicator for standard 3-3.A.
2 -	The policy and procedures specify: - the types of circumstances under which a family is provided creative outreach, - the activities to be carried out during the course of creative outreach, - that creative outreach is continued to families for a minimum of three months, and is only concluded prior to three months when families have engaged in services, **refused services**, the family has moved from the service area, or other allowable reasons listed in the intent.
1 -	Any one of the following: There is no policy and procedures; or the policy and procedures do not address all points required in the 2 rating indicator.

☺ Tip: Often families with early childhood trauma may not have identified healthy support systems. It is recommended that home visitors check in with families regularly to obtain new or additional emergency contacts. Having updated secondary contact information can make a significant difference in maintaining connections with families over the course of service delivery.

3-3.B The site places families on creative outreach, as defined by their policy and procedures, and continues creative outreach for at least three months, only concluding creative outreach services prior to three months when families have (re)engaged in services, **refused services** or moved from the area.

3-3.B	RATING INDICATORS
3 -	The site places families on creative outreach at any time after a first home visit when disengaging from services, conducts the activities to be carried out during the course of creative outreach and continues creative outreach for at least three months. The only instances found when outreach was concluded prior to three months occurred when the families (re)engaged in services, **refused services** or moved from the area.
2 -	Past instances may have occurred when families were not placed on outreach appropriately; however, **recent practice** indicates the site places families on creative outreach, conducts the activities to be carried out during the course of creative outreach and continues outreach for at least three months. The only instances found when creative outreach was concluded prior to three months occurred when the families (re)engaged in services, **refused services** or moved from the area.
1 -	Any of the following: The site does not place families on creative outreach when families disengage; does not conduct the activities to be carried out during the course of creative outreach; and/or does not continue creative outreach services for at least three months.

3-4. The site measures, analyzes and addresses how it might increase the retention rate of families in a consistent manner and on a regular basis.

3-4.A The site measures its retention rate using HFA approved methodology (first and last home visit – (**please see measuring retention rates on page 17**). Other methodologies may be used in addition. 3-4.A Retention Measurement Worksheet

Intent: *Calculating the length of time families are retained in services is a critical quality improvement measure. Sites are to look at the length of time families remain in services and identify patterns and trends associated with families dropping out of services at specified intervals.* ***Please Note: New sites without 2 full years since home visiting services began will complete an annual measurement of retention based on 6-month retention data.***

3-4.A		RATING INDICATORS
3	-	The site measures the retention rate of families in services (using HFA methodology) and evidence indicates retention rates are being measured more than once a year.
2	-	The site measures its retention rate using HFA methodology and evidence indicates retention rates are measured at least annually.
1	-	The site is not measuring its retention rate at least annually.

3-4.B The site comprehensively analyzes at least once every two years (e.g., both formally through data collection and informally, through discussions with staff and others involved in site services) which individuals dropped out of the site, at what point in services, and reasons why. **Please see common terms associated with analyses beginning on pages 17-19.** 3-4.B-C Analysis Grid

Intent: *It is required that sites measure family retention annually and conduct a thorough analysis once every two years to determine patterns or trends; to compare families who stay enrolled with those who drop out of services, and to identify improvement strategies to increase family retention. Sites may choose to analyze data more often if patterns or volume suggest this need.* ***Please Note: New sites without 2 full years since home visiting services began will complete its first analysis with one year of data instead of two.***

3-4.B		RATING INDICATORS
3		The site uses both formal and informal methods to analyze, at least once every two years, families that leave services and reasons why. This analysis is comprehensive, addressing multiple factors within each of the 3 categories, **1) programmatic, 2) demographic, and 3) social**, and compares these factors for those who remain in services and those who drop out during the same time period; Or no families have dropped out in the past two years.
2	-	The site uses both formal and informal methods to analyze, at least once every two years, families that leave services and reasons why. This analysis compares those who remained in service with those that dropped out during the same time period, and addresses at least one factor within each of the 3 categories, **1) programmatic, 2) demographic, and 3) social.**
1	-	Any of the following: the site does not have an analysis of families that dropped out of services and reasons why; does not include both informal and formal methodology; the analysis does not include at least one factor from each of the 3 categories, **programmatic, demographic, or social**; the analysis does not include a comparison of those who remained in service with those who dropped out during the same time period and/or the analysis is not conducted at least once every two years.

☺ Tip: The HFA Retention Analysis Grid provides guidance on various programmatic, demographic and social factors to consider when conducting a comprehensive analysis.

3-4.C The site has a plan to address how it might increase its retention rate based on its analysis of families that dropped out of services, at what point in services, and the reasons why.

Intent: Some reasons for ending services are not factors that can typically be influenced by developing retention strategies and therefore do not need to be included in the plan for increasing retention. Though sites will be expected to capture all reasons why families are discontinuing services earlier than expected, reasons that do not require improvement strategies include *parent no longer has custody, pregnancy ended in miscarriage, target child or primary care provider is deceased, staff safety issues, transferred to another program, and/or family moved out of service area.*

3-4.C		RATING INDICATORS
3	-	Based on the analysis, the site has implemented a plan for increasing its retention rate among the families currently dropping out of services. The plan addresses programmatic, demographic, and/or social factors based upon the trends identified in the analysis. Or no families dropped out of the site in the past two years.
2	-	Based on the analysis, the site has a plan for increasing its retention rate among the families currently dropping out of services. The plan addresses programmatic, demographic, and/or social factors based upon the trends identified in the analysis; however, the plan has not yet been implemented.
1	-	Any of the following: the site does not have a plan; the plan is not based on the analysis; does not address programmatic, demographic, and social factors; and/or does not address how it might increase its retention rate.

☺ Tip: Sites should clearly connect the patterns or trend in the analysis to the items in the plan.

3. Offer services voluntarily and use positive, persistent outreach efforts to build family trust			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
3-1.A Voluntary Policy	The voluntary nature of services and how families are made aware that services are voluntary	Submit Policy	**Interview:** * Program Manager * Supervisors * Assessment Workers * Home Visitors * Families **Review:** * Materials/Forms Indicating services are voluntary * Family Files for those forms * Staff Surveys
3-1.B Voluntary Practice		No additional pre-site evidence required	
3-2.A Trust Building Policy	The methods used to establish and build trusting relationships with families initially and throughout services	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Family Files * Staff Surveys
3-2.B Trust Building Practice		No additional pre-site evidence required	
3-3.A Creative Outreach Policy	The process for creative outreach services that specify the criteria indicated in the standard	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Closed Family Files
3-3.B Creative Outreach Practice		No additional pre-site evidence required	

3-4.A Measure Retention		Please submit the program's definition of family retention and method for calculating and a description of program's process for monitoring retention and minimum of 12 month retention calculation. **Please note:** programs may use the HFA Retention Spreadsheet to calculate	**Interview:** * Program Manager * Home Visitor Supervisors * Home Visitors **Review:** * Previous Retention Analyses and Plans to Increase Retention, as appropriate * Staff & Advisory Surveys
3-4.B Retention Analysis		Please submit a narrative describing how often the program conducts its retention analysis and a copy of the most recent retention rate analysis. **Please note:** programs may submit the HFA Retention Analysis Grid or program database report that includes all required elements (i.e., comprehensive, comparative and with reasons why) for 3-4.B&C.	
3-4.C Plan to Increase Retention		Please submit a copy of the most recent plan to increase the retention rate based on the analysis. When appropriate, the site should describe which aspects of the plan have been implemented.	

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

***Standard 4 Intent:* The overall intent of the standards in this section is to ensure the site is providing services intensively after the birth of the baby (weekly) and to ensure services are offered until the child is a minimum of three years and up to five years of age. Additionally, the site must have a well-thought out process for determining the intensity/frequency of home visits that is consistent with the needs and the progress of each family.**

4-1. The site offers home visiting services intensively after the birth of the baby.

4-1.A The site's policy and procedures state families are offered weekly home visits for a *minimum* of six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach.

Intent: *The first 6 months of involvement with a family, after a baby has been born, is critical for many reasons including: parent-infant relationship development, newborn care and safety, and adjustment to parenthood. While respecting the family's schedule, weekly visits during this time are essential. This standard does not require that all families receive weekly visits during this time period, but is intended to ensure weekly services are offered during this time.*

Policy regarding families being offered weekly home visits for 6 months after the birth of the baby can provide exception for isolated instances (up to 10% of active ***caseload****) due to family school and/or work restrictions. However, when families request a less frequent home visiting schedule during this timeframe, sites are encouraged to keep the family on level one, continue to offer weekly visits as the family's school and/or work situation may change. This also ensures the home visitor's* ***caseload*** *weight is safeguarded to allow for weekly home visits to resume under those circumstances. This does not mean the home visitor must continually try to schedule or engage the family into a weekly visiting schedule, but that they clearly indicate to the family the availability of this weekly schedule.*

In some situations, families may enter the site when the baby is older than 1 month, or some families may have periods of being on creative outreach during the first six months, therefore it is important to establish policy that indicates clearly that the time frame to offer weekly service is intended as a full six month period of active family engagement versus until the baby is six months old. This six month period also excludes time while on creative outreach. The HFA 4-1.B Tracking Form (or equivalent) assists site in monitoring this.

4-1.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 4-1.A.
2	-	The site's policy and procedures state the **minimum** length of time for offering weekly home visits is at least six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach.
1	-	The site's policy and procedures state the minimum length of time for offering weekly home visits is less than six months or minimum length of time for weekly visits is not indicated in site policy and procedures.

4-1.B The site ensures families remain on a weekly home visiting level for a minimum of six months after the birth of the baby, and develops strategies to improve if the rate less than 90%.4-1.B Tracking Form

Intent: *The site is expected to measure its rate of home visit intensity using the 4-1.B spreadsheet. If using a data system report instead, it must apply the same HFA methodology in its calculation. The site will need to be sure it aggregates and summarizes its data and develop improvement strategies if the rate is below 90%.*

It is important that when a family's immediate work/school schedule precludes the offer of weekly home visits, or when a family enters a level of creative outreach during the 6 month period, that their service level returns to weekly as soon as the family's schedule permits. It is not intended that families in these situations automatically be moved to Level 2, as progression to less intense services is based on indicators of increased family stability and parent-child well-being as identified in level change ***criteria*** *versus scheduling conflicts.*

4-1.B		RATING INDICATORS
3	-	At least ninety percent (90%) of families remain on a weekly home visiting level for a minimum of six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach.
2	-	Past instances may have occurred when less than 90% of families remained on a weekly home visiting level for a minimum of six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach; however, improvement strategies have been implemented and the most recent level changes from Level 1 to Level 2 (weekly to bi-weekly) indicates at least ninety percent (90%) of families remain on a weekly home visiting level for a minimum of six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach.
1	-	Less than 90% of families remain on a weekly home visiting level for a minimum of six months after the birth of the baby or six months after enrollment (whichever is longer), excluding time on creative outreach; or improvement strategies have not been developed and/or implemented.

4-2. The site has a well-thought-out system for managing the intensity/frequency of home visiting services.

4-2.A The site has policy and procedures that clearly define the levels of service (e.g., weekly visits, bi-weekly visits, monthly visits, etc.) offered by the site and the **criteria** for moving to a different level of service.

Intent: *As a* ***family-centered*** *model, HFA endorses the use of a "level system" for managing the intensity of services. A well-thought out system is sensitive to the needs of each family, the changes in family needs and competencies over time, and the responsibilities of the home visitor. Clearly defined levels reflect in measurable ways the capacity of the family, such that families with higher needs are able to receive more intensive services, while less intensive services are provided as stability and progress increases. Not only does an effective "level system" allow for individualized service delivery, it also provides sites a mechanism to monitor more effectively* ***caseload*** *capacity, thus promoting higher quality services. It is important for home visitors to know where to locate information regarding levels of service and to be familiar with the process of how a family progresses from one level to another. Typical levels and associated case weights are provided below:*

Level P = 1-2 points
Level 1 = 2 points (weekly)
Level 1SS = 3 points (weekly visits or more during temporary periods of intense crisis)
Level 2 = 1 point (every other week)
Level 3 = .5 point (monthly)
Level 4 = .25 point (quarterly)
Level X = .5 point - 2 points
(Sites are encouraged to maintain a family's case weight while on Level X equal to the family's level prior to being placed on creative outreach to ensure space is retained to move family back to that level if re-engaged)

Sites use level change forms which detail expected parent progress expectations from one level to another. In general, these expectations include:

- *demonstrating responsive, nurturing parenting practices (leading to secure attachment)*
- *engaging in child development activities with their children*
- *providing a stimulating and safe home environment*
- *screening negative for depression or being linked to appropriate mental health services*
- *working to accomplish individual/family goals*
- *managing stress effectively*
- *using nurturing and respectful discipline methods*
- *developing healthy support systems*

4-2.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 4-2.A.
2	-	The site's policy and procedures define levels of service and **criteria** for level change that include the level change criteria as detailed on level change forms.
1	-	One of the following: There is no policy and procedures; or the policy and procedures do not include the level change criteria as detailed on level change forms.

☺ Tip: When making decisions about frequency of visits prenatally, sites should keep in mind that Healthy Families research has demonstrated higher rates of positive birth outcome when visits are initiated as early in the pregnancy as possible, and no later than 32 weeks gestation with a minimum of 7 visits received prior to birth. (Lee, E., et al, 2009. *Reducing low birth weight through home visitation: A randomized controlled trial*. American Journal of Preventive Medicine 36; 2: 154-160).

☺ Tip: Prenatally enrolled families should be assigned a case weight of 2 points in the last trimester to ensure adequate space on the worker's caseload when family is moved to Level 1.

☺ Tip: Home visitor responsibilities when moving families to different levels of service should include:

- addressing issues identified during the initial assessment
- using a curriculum that promotes attachment and child development
- conducting developmental screening
- supporting parents in building healthy support systems
- reducing parental stress
- advocating for nurturing discipline techniques
- collaborating with families to develop meaningful goal plans
- conducting depression screening
- making referrals based upon family needs

- completing assessments required by the site

4-2.B Families at the various levels of service (e.g., weekly visits, bi-weekly visits, monthly visits, etc.) offered by the site receive the appropriate number of home visits, based upon the level of service to which they are assigned. 4-2.B Tracking Form

Intent: *In-home visits (taking place where the family resides) provide the opportunity to experience the family's living environment, to develop first-hand knowledge of the strengths and stresses of the home environment, to implement home safety assessments with the family, and to engage the family on "their turf". It is acknowledged that not all visits will occur in the home. At times when the home environment is overly chaotic or unstable, or when social isolation impedes the family's interaction with the larger community, occasional visits that occur outside the home can be beneficial and are permissible. However, these visits can count as a* ***home visit*** *only when the content of the visit matches the goal of a* ***home visit*** *and can be documented as such. The goal of a* ***home visit*** *is to promote positive parent-child interaction, healthy childhood growth and development, and enhance family functioning. Typically, a* ***home visit*** *lasts a minimum of an hour and the child is present.*

For those families assigned to a weekly level of service, one ***parent group meeting*** *per month may be counted as a home visit if the home visitor is present for the group meeting and the goals of a home visit are met.* ***Please note:*** *The HFA 4-2.B form (or an equivalent database report) measures home visit completion rates over a period of three months.*

The home visit completion percentages detailed in the rating indicators are designed to account for situations when staff and/or family may not be available due to illness, vacation, training, etc.

4-2.B		RATING INDICATORS
3	-	Ninety percent (90%) of families receive at least seventy-five (75%) percent of the appropriate number of home visits based upon the individual level of service to which they are assigned.
2	-	Seventy-five percent (75%) of families receive at least seventy-five (75%) percent of the appropriate number of home visits based upon the individual level of service to which they are assigned.
1	-	Less than seventy-five percent (75%) of families receive at least seventy-five (75%) percent of the appropriate number of home visits based upon the individual level of service to which they are assigned.
Note:		**This is a Sentinel Standard**

☺ Tip: Sites are encouraged to set thresholds to measure in-home home visit completion rates, and when in-home visit rates fall below the threshold, supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase completion rates. Be sure discussions are documented in supervision notes.

☺ Tip: When home visiting staff are away from the office for a period of longer than one week, families should be provided with contact information of who to contact in their absence, if needed. When extended absences occur i.e. due to family or medical leave, a more formal coverage plan should be in place, so that families receive the necessary support and services.

4-2.C The site **monitors and addresses** annually how it might increase its home visit completion rate.

Intent: *The HFA 4-2.B Tracking Form (or equivalent database report) along with supervision provides a format for monitoring home visit completion rates for each home visitor, and ultimately for the site*

as a whole. Quarterly monitoring is ongoing, so determination of patterns and trends related to home visit completion rates can be identified. A plan to improve home visit completion rates, based on information from site monitoring, is to be developed annually. This in no way precludes a site from taking earlier and more timely action when needed to correct a staffing or policy issue, or other situation requiring immediate action. ***Please note:*** *Monitors and Addresses is defined on page 12.*

4-2.C		RATING INDICATORS
3	-	Based on the most recent year of site monitoring, a plan has been implemented for increasing its home visit completion rate or all staff achieved a rate of 90% of the families receiving 75% of their home visits (no plan required).
2	-	Based on the most recent year of site monitoring, a plan that addresses how it might increase its home visit completion rate has been developed, but has not yet been implemented.
1	-	The site either has not monitored home visit completion rates; or does not have a plan for how it might increase home visit rates; or site's plan does not address a significant issue that was identified through monitoring.

4-2.D The site has policy and procedures regarding the process for reviewing progress made by families that include how the home visitor, the family, and the supervisor are involved in the level change decision.

Intent: *This standard relates to the process a site utilizes to ensure families, home visitors, and supervisors are all involved and agreeable to the level-change decision. Therefore, supervisors and home visitors are to document conversations about potential level changes during routine supervisory sessions where family progress is discussed. Likewise, home visitors and families are to have documented conversations about family progress and discussions about any formal change that might be made to home visit frequency. Sites ensure policy for level change* ***criteria*** *is based upon family progress and is not dependent solely on the age of the child nor completion of 6 months of intensive service.* ***Please Note:*** *This standard relates only to level change decisions, not to Family Goal Plan progress which is covered in standard 6-2.*

4-2.D		RATING INDICATORS
3	-	No 3 rating indicator for standard 4-2.D.
2	-	The site's policy and procedures include the process for reviewing progress made by families and clearly define how the home visitor, the family, and the supervisor are involved in the level change decision.
1	-	One of the following: There is no policy and procedures; or the policy and procedures do not address the requirements listed in the 2 rating.

4-2.E Each family's progress (as identified on level change forms) to a new level of service is reviewed by the family, home visitor, and supervisor and serves as the basis for the decision to move the family from one level of service to another. **Please note:** All parties do not have to be present at the same time to conduct this review.

Intent: *Family progress is reviewed in an ongoing fashion as often as needed (whether semi-annually, quarterly or more frequently) based on the needs of the family and the current home visit*

frequency. The decision to change to a new level of service needs to be based on family progress, which is most often outlined on level change forms. Level change decisions are not made based on site needs, personnel issues, or the age of the child.

4-2.E	RATING INDICATORS
3 -	Each family's progress (as identified on level change forms) to a new level of service is reviewed by the family, home visitor, and supervisor and serves as the basis for the decision to move the family from one level of service to another.
2 -	Past instances may have occurred when either families moved from one level of service to another in absence of a review of family progress, or the appropriate individuals (home visitor, family, and supervisor) were not involved with the level change decision; however, **recent practice** indicates the site reviews and bases level change decisions on progress made by families, and involves, the home visitor, the family, and the supervisor in the level change decision.
1 -	One of the following: evidence indicates families are moved from one level of service to another in absence of a review of family progress; reviews were not according to site policy and procedures; or appropriate individuals (home visitor, family and supervisor) were not involved with the level change decision.

4-3. The site offers services to families for a minimum of three years (or up to five years when sites are funded to do so), after the birth of the baby.

4-3.A The site has policy and procedures specifying services are offered for a minimum of three years after the birth of the baby.

4-3.A	RATING INDICATORS
3 -	No 3 rating indicator for standard 4-3.A.
2 -	The site policy and procedures specify services are offered for a minimum of three years after the birth of the baby.
1 -	One of the following: There is no policy and procedures; or the policy and procedures do not address the requirements listed in the 2 rating.

☺Tip: Sites are encouraged to continue services beyond age 3, and up to age 5, whenever family needs warrant, funding permits and transition to other services (e.g., Head Start) is not possible.

4-3.B Services are offered to families for a minimum of three years after the birth of the baby.

4-3.B	RATING INDICATORS
3 -	Services are offered for a minimum of three years after the birth of the baby.
2 -	Services are offered for a minimum of three years after the birth of the baby. Past instances may have occurred when the site did not offer services to families for at least a minimum of three years; however, **recent practice** indicates the site is offering services for a minimum of three years; or the site has not yet been in operation for 3 years.

1	-	Evidence indicates the site is not offering services for a minimum of three years.
Note:		**This is a Sentinel Standard**

4-4. The site ensures that families planning to discontinue or close from services have a well thought out transition plan.

Intent: *When a family prepares to terminate services (whether due to program completion, planned move out of the service area, etc.), transition planning efforts that involve the family, home visitor, and supervisor, will be made to ensure a successful transition.* ***Please note:*** *All parties do not have to be present at the same time to develop the plan. While the decision to develop a transition plan is based on the wishes of the family (the family may decline), the site is expected to be strongly proactive with respect to transition planning. To increase the likelihood that needed supports and services will be accessed after service closure, the site takes the initiative to explore suitable resources, contact service providers, and follow-up on the transition plan, as appropriate, when possible, and with the permission of the family, ensuring appropriate informed consents are signed.*

Whenever possible, sites are to allow for sufficient time to ensure needed services will be planned for and accessed after HFA services end. Typically, this process may take 3-6 months prior to the transition.

4-4.A The site has policy and procedures specifying the activities related to service closure and transition planning for all families who have a planned closure (circumstances leading to an unplanned or unexpected closure would not be held to the policy). The activities include the following:

- the family, the home visitor, and the supervisor are involved, though not required to be present at the same time, and sufficient time is allotted to conduct the plan,
- other collaborative service partners will be notified (when consents are in place to do so),
- resources and/or services needed or desired by the family are identified,
- steps are outlined to obtain any identified resources or services,
- prior to closure the site follows-up with identified resources to determine availability and assist with successful case closing transition.

4-4.A		RATING INDICATORS
3	-	No 3 rating indicator for 4-4.A
2	-	The site has policy and procedures specifying the process for service closure and transition planning, that includes all components identified in the standard.
1	-	One of the following: There are no policy and procedures; or the policy and procedures do not include the activities outlined in the standard.

☺Tip: Sites are encouraged to incorporate transition planning into the Family Goal Plan process if families choose to do so.

☺Tip: Program should begin transition planning with families when the child is 30 months of age (when length of program is 3 years) or 54 months (when length of program in 5 years). Following initial discussion, the topic of transition planning should be included in most discussions with the family at subsequent home visits, including identification of available resources/services that are needed or desired.

☺Tip: As it relates to families who decline a transition plan, it will be useful for the site to document or obtain a signature indicating the family has declined.

4-4.B The site utilizes transition planning to support families discharging from services.

4-4.B		RATING INDICATORS
3	-	The site conducts transition planning with families when there is a planned closure and activities include all items included in the standard.
2	-	Past instances may have occurred when transition planning activities as outlined in the standard were not conducted; however, **recent practice** indicates the site conducts transition planning according to its policy and procedures; or there have been no planned closures yet.
1	-	One of the following: there are no policy and procedures or the policy and procedures are not followed.

4. Offer services intensely (e.g., at least once a week) with well-defined criteria for increasing or decreasing intensity of service and over the long term (e.g., three to five years)			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
4-1.A Policy Offering Weekly Visits Six Months	The minimum length of time families remain on the most intensive level of service with criteria as specified in the standard	Submit Policy	**Interview:** * Supervisors and Home Visitors, if needed **Review:** * Family Files * Supervision Records
4-1.B Measuring Home Visit Intensity		Submit report showing the total number of families who have been enrolled at least six months after the birth of the baby, or six months after enrollment (whichever is longer) and the number (and percent) of those families who remained on level 1 (weekly visits) for a minimum of six months, excluding time on creative outreach. **Please Note:** The HFA 4-1.B Tracking Form may be used.	
4-2.A Level Change Policy	The program's levels of service including the level change criteria specified in the standard	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Family Files * Supervision Records * Staff Surveys
4-2.B Measure Home visit Completion *Sentinel Standard*		Submit a report showing home visit completion rates by family for each home visitor for the most recent quarter. **Please Note:** The HFA 4-2.B tracking form may be used.	
4-2.C Monitor Home Visit Completion		Submit plan to increase home visit completion including which strategies have been implemented.	
4-2.D Policy Based on Progress and Discussions	The review of progress related to level change and involvement of family, home visitor and supervisor	Submit policy and blank level change forms.	
4-2.E Level Changes Practice		No additional pre-site evidence required.	

4-3.A 3 Years Policy	The length of time families can remain in the program	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors **Review:** * Family Files * Supervision Records
4-3.B Services provided 3-5 years Practice *Sentinel Standard*		Submit a report indicating the current number of families who have been enrolled for 3 or more years. If families graduate after three years of service, provide a report indicating all families who have graduated within the last year.	
4-4.A Transition Policy	Process for service closure and transition planning including components in the standard	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors **Review:** * Family Files * Supervision Records
4-4.B Transition Planning Practice		No additional pre-site evidence required	

5. *Services are culturally sensitive such that staff understands, acknowledges, and respects cultural differences among families; staff and materials used reflect to the greatest extent possible the cultural, language, geographic, racial and ethnic diversity of the population served.*

Standard 5 Intent: *The overall intent of the standards in this section is to ensure the site is **culturally sensitive** to each family's unique characteristics. For services to be effective it is imperative that cultural context is incorporated into program design and delivery. There are two underlying assumptions to this statement: 1) that the diversity of families is of great significance to intervention programs; and 2) services may be provided by persons whose culture differs from that of the participating family. Thus, in developing home visiting programs, it is important to consider that:*

- *Family needs, health beliefs, coping mechanisms and child rearing practices vary by population - thus, interventions reflect this variation;*
- *Valuing diversity in its many forms (e.g., cultural, language, racial, religious, geographic and ethnic) allows a home visitor to establish quality relationships with families; and*
- *A home visitor's ability to establish strong relationships with families based on mutual respect and understanding will enhance the opportunity for providers and families to work together.*

*Successful home visiting programs provide **culturally sensitive** services so that new skills and ideas being shared with the family are respectful of each family's values and decision-making systems. Providing **culturally sensitive** services requires that knowledge of diversity be applied to policy and practice. Agencies and their staff observe and understand differences among families so that new skills and ideas fit within existing family behaviors and contexts. Home visitors facilitate the family's consideration of how new perspectives fit into their lives. This practice allows families and home visitors to work together to craft positive family development strategies.*

Families vary in many ways, so it is important that home visitors understand differences among them. Cultural groups may define "family" differently, which affects the audience for services. Home visitors observe cultural differences and use them as a springboard for inquiry and understanding, asking families about particular behaviors and practices. Family background and ethnicity influence value systems, how people seek and receive assistance, and communication practices (e.g., native language, slang, body-language), among other things. When home visitors express curiosity with open-ended questions and are non-judgmental in tone, families have an opportunity to reflect and share. Answers to questions provide home visitors with greater understanding and allow visitors to share alternate perspectives with families. In order to strengthen families' coping abilities and independence, visitors must respect differences among families.

☺ Tip: The HFA National Office has produced **Cultural Sensitivity: A Process of Self Awareness and Integration**; a workbook to assist sites with these standards.

5-1. The site has a description of the ***cultural characteristics*** of its current ***service population*** *that includes data (numbers and percentages) and narrative detail*.

Intent: *The description of the **service population** is specific to the families who have accepted services. The description may include features and attributes such as the ethnic heritage, race, customs, values, language, age, gender, military service, religion, sexual orientation, social class, and geographic origin among others. Additionally, sites are encouraged to look at other factors such as: domestic violence, substance abuse, mental health and cognitive abilities, criminal history, and physical disabilities as it relates to the families being served.*

5-1. RATING INDICATORS

3 - No 3 rating indicator for standard 5-1.

2 - The description (narrative with numbers and percentages) of the **cultural characteristics** of the **service population** addresses all of the following:

→ ethnic and/or racial characteristics
→ language characteristics
→ demographic characteristics and
→ other **cultural characteristics** identified by the site

1 - The site does not have a description or the description does not address all characteristics as stated above.

☺ Tip: Sites are encouraged to update the description of the cultural characteristics of the service population every time review of cultural sensitivity is completed. Ideally, sites update it annually to identify necessary training for staff as required in 5-3.

5-2. The site demonstrates **culturally sensitive** practices in all aspects of its service delivery.

5-2.A The site has the capacity to provide ***culturally sensitive*** and ***family-centered*** (e.g., photos reflective of diversity of population, materials available in ***major*** languages spoken by ***target population***, materials reflect literacy level of *families*, etc.) services to the ***major*** group(s) within the **service population**.

Intent: *Racial and ethnic minorities often face barriers in receiving adequate services within their communities. These include language barriers, marginalization, isolation, and other challenges related to socio-economic status, and encounters with service providers lacking knowledge of the family's culture. Home visitors have an opportunity to provide a voice for families who cannot speak for, or represent, themselves.*

*Sites identify strategies or practices that will ensure families feel comfortable, respected and represented in site services. It is the site's responsibility to identify major cultural groups within the **service population** and determine groups currently under-served. In addition to hiring staff who may represent the major groups (through a variety of characteristics), sites are encouraged to provide training through other community entities or other means in an effort to increase staff's ability to meet the cultural and language needs of families. This is an ongoing process for all staff.*

*It is important to keep in mind how assessment staff represents a **culturally sensitive** and **family-centered** program. Sites will also want to make sure any materials, literature; brochures (in addition to staff) are reflective of the represented diversity in the community.*

5-2.A RATING INDICATORS

3 - The site has the appropriate staff, materials (e.g., annual report, brochures, site specific materials such as curricula, etc.), and community partners to meet the cultural and language needs of the major population groups within the **service population**.

2 - While the site may not currently have all of the appropriate staff, materials (e.g., annual report, brochures, site specific materials such as curricula, etc.), and community partners to meet the cultural and language needs of the major population groups within the **service population**, it has a plan to address these needs.

1 - The site does not have the appropriate staff, materials (e.g., annual report, brochures, site specific materials such as curricula, etc.), and community partners to meet the cultural and language needs of most of the major population groups within the **service population**.

☺ Tip: Incorporate the needs identified within this standard to meet the needs of standard 5-3. Typically the unique characteristics identified as gaps in service delivery will correspond with the site providing training on culturally sensitive practice to staff at least annually.

5-2.B Ethnic, racial, language, demographic, and other **cultural characteristics** identified by the site are taken into account in overseeing staff-family interactions.

Intent: *In order to ensure staff are best equipped to connect with and relate to the unique characteristics of families, sites are encouraged to utilize training, supervision, and/or development plans, etc. to assist staff in supporting and respecting the family's cultural, racial/ethnic, and language characteristics. It is also important to support assessment staff during the oversight of staff-family interactions, because they are a family's first experience with the program and set the tone for participating in services. These activities can be linked to standards 5-2.A and 5-3.*

5-2.B RATING INDICATORS

3 - The site takes into account ethnic, racial, language, demographic, and other **cultural characteristics** identified by the site during oversight of staff-family interactions by ensuring that the worker supports and respects the family's cultural, racial/ethnic, and language characteristics.

2 - Past instances may have occurred when the site did not take into account ethnic, racial, language, demographic, and other **cultural characteristics** identified by the site during oversight of staff-family interactions by ensuring that the worker supports and respects the family's cultural, racial/ethnic, and language characteristics; however, **recent practice** indicates this is now occurring.

1 - Either the site does not take into account ethnic, racial, language, demographic, and other **cultural characteristics** identified by the site during oversight of staff-family interactions or it does not ensure the worker supports and respects ethnic, racial, language, demographic, and other **cultural characteristics** identified by the site.

☺ Tip: Supervision is the ideal opportunity to monitor home visitor-family interactions, not only during ongoing case review, but also during shadowing of home visits. It is an opportunity to ensure staff is respecting a family's cultural values and beliefs based on ethnic, racial, language, demographic, and other cultural characteristics. Additionally, through the use of the reflective practice, it provides an opportunity to support staff and strategize new ways to relate to the family based on their unique characteristics.

☺ Tip: These activities may be challenging to document and illustrate through written documentation; however, sites are encouraged to ensure staff is aware of the activities and link them back to ensuring services are culturally sensitive with regards to staff-family interaction.

5-3. The site ensures staff receives annual training designed to increase understanding and sensitivity of the unique characteristics of the **service population**. **Please Note:** During the first year of hire, standard 11-4.E. (The Role of Culture in Parenting), may be used to satisfy this standard.

Intent: *Staff is better prepared to serve and interact with families when they have increased understanding of **culturally sensitive** practices linked to the family's unique characteristics and values. Sites are encouraged to reflect on a broad definition of culture and identify training related to characteristics beyond race and ethnicity. This could include a variety of training topics such as the cultural dynamics of substance-abusing parents, or parenting in households where there is domestic violence. It could also include topics such as working with military families, immigrant families, grandparents raising grandchildren, etc. Essentially, helping staff develop and enhance skills that allow them to work most effectively with families being served.*

5-3.		RATING INDICATORS
3	-	All staff receives training related to the unique characteristics of the **service population** at least annually.
2	-	Past instances may have occurred when training related to the unique characteristics of the **service population** on an annual basis was not received; however, **recent practice** indicates the site is now ensuring all staff receives training annually.
1	-	Staff do not complete training related to the **service population** on an annual basis.

☺ Tip: Use the information gathered in 5-1 to identify training based on the unique characteristics of the service population.

5-4. The site analyzes the extent to which all aspects of its service delivery system (assessment, home visiting, and supervision) are **culturally sensitive**.

5-4.A The ***Cultural Sensitivity Review*** is completed at least every other year and it addresses the following components: materials, training and the service delivery system, and integrates input obtained from families and staff (see Standard 5-4.B).

Intent: *A **Cultural Sensitivity Review** allows a site to continually modify or tailor its system of service delivery based on the **cultural characteristics** of families being served. The review is in narrative format and includes information about the site's materials, training, and all aspects of the delivery system (assessment, home visiting and supervision). It also includes summarized input from families and staff and identify patterns and trends related to site strengths as well as areas to improve upon. **Please Note: New sites without 2 full years since home visiting services began will complete its first Cultural Sensitivity Review with one year of data instead of two.***

5-4.A		RATING INDICATORS
3	-	The **Cultural Sensitivity Review** is completed at least every other year and comprehensively addresses the following, including input obtained from families and staff: - materials, - training, and - the service delivery system (assessment, home visiting, and supervision).
2	-	The **Cultural Sensitivity Review** is completed at least every other year and addresses all the items listed in a 3 rating, but could be more comprehensive.
1	-	Any of the following: there is no **Cultural Sensitivity Review**; it does not address the components listed above; and/or it is not completed at least every two years.

☺ Tip: Sites are encouraged to reference the HFA Cultural Sensitivity Workbook for guidance on all required components of the Cultural Sensitivity Review

☺ Tip: As it relates to cultural sensitivity of supervision, sites could consider the following:

- how they assign families to staff
- how unique cultural characteristics of families and staff are taken into account
- cultural aspects of staff retention
- supervisory support for additional training on various aspects of culture
- diversity of the advisory group, etc.

5-4.B The site has obtained family and staff input regarding the site's ability to provide **culturally sensitive** services.

Intent: *The site has obtained includes feedback from both families and staff related to:*

- *the materials (brochures, flyers, curriculum, videos, etc.) used by the site,*
- *communication or language factors (language spoken and written, reading level, etc.), and*
- *culturally sensitive staff-family interaction (working 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.).*

The feedback can be gathered in various forms (e.g., surveys/questionnaires, interviews, family advisory committees, focus groups, supervision, etc.). Sites prepare a descriptive narrative that summarizes patterns and trends, strengths and areas to address, based on the feedback from families and staff.

5-4.B		RATING INDICATORS
3	-	No 3 rating indicator for standard 5-4.B.
2	-	The site has obtained direct input, within the last 2 years, from the families and staff on the following **culturally sensitive** practices: - site materials - communication or language factors and - staff-family interaction.
1	-	The site has not obtained, within the last 2 years, family and/or staff input on the areas listed in the 2 rating.

☺ Tip: Sites are encouraged to include questions on their satisfaction survey related to cultural sensitivity. Be sure to include questions that link back to the assessment process, or even referral process, if appropriate.

☺ Tip: Staff surveys should be offered to all program staff, and ideally responses should be obtained by all, protecting worker anonymity so as to encourage candid feedback without repercussion.

5-4.C The **Cultural Sensitivity Review** is reported to the advisory/governance group and strategies for growth are identified and/or discussed.

Intent: *A site continually modifies or tailors its service delivery system by integrating information learned in order to be sensitive to the **cultural characteristics** in the **service population**. It can be difficult to self-identify gaps and determine strategies. This is why it is important to seek the perspective and assistance from the site's advisory/governance group. The advisory/governance group may help to determine the necessary action to take. It is the expectation that each site will have at least one improvement strategy in order to increase the site's ability to be **culturally sensitive**.*

5-4.C		RATING INDICATORS
3	-	The **Cultural Sensitivity Review** is reported at least every other year to the advisory/governance group. Strengths and strategies for growth are identified, discussed and implemented.
2	-	The **Cultural Sensitivity Review** is reported at least every two years to the advisory/governance group. Strengths and strategies for growth are identified and discussed.
1	-	Any of the following: the **Cultural Sensitivity Review** is not reported at least every two years to the advisory/governance group; there is no Review; or strengths and strategies for growth were not identified and discussed.

5. Services should be culturally sensitive such that staff understands, acknowledges, and respects cultural differences among families; staff and materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study** **Please Note: The HFA Cultural Sensitivity Workbook: A Process of Self Awareness and Integration, may be used to assist with the development of these standards.**	**Site Visit Activities**
5-1.Service population	Policy not required **Please note:** programs may have Policy and Procedures related to these standards and may submit them for the benefit of the peer review team; however, they are not required.	Please submit a description of the program's service population as indicated in the standard.	**Interview:** * Program Manager * Staff Surveys * Advisory Group Surveys
5-2.A Appropriate staff, materials & community partnerships		If not already included in the Cultural Sensitivity Review (5-4-A), submit a narrative describing how the program ensures it has the appropriate staff, materials (e.g., annual report, brochures, program specific materials such as curricula, etc.), and community partners to meet the cultural and linguistic needs of the major population groups within the service population.	**Interview:** * Program Manager * Supervisors * Direct Service Staff * Families **Review:** * Supervision Documentation * All relevant program materials for the service and target populations, (e.g., annual report, program brochures, flyers curriculum, etc.) * Staff & Advisory Surveys
5-2.B Cultural Characteristics are taken into account when overseeing staff-family interactions		If not already included in the Cultural Sensitivity Review (5-4-A), submit a narrative describing how the program takes into account ethnic, racial, linguistic, demographic, and other cultural characteristics identified by the program in overseeing staff-family interactions.	
5-3 Training on unique characteristics		Submit a narrative describing the training offered to staff on cultural sensitive practices and the particular group(s) represented in the service population for the most recent year. Be sure to link the training to the characteristics identified in 5-1. Please submit training logs or a list of all program staff in attendance at the training(s), and date trainings were completed for the most recent year.	**Interview:** * Program Manager * Supervisors * Direct Service Staff **Review:** * Any additional training logs, if necessary * Staff Surveys

5-4.A Cultural Sensitivity Review		Submit the most recent Cultural Sensitivity Review which must include input from families and staff regarding program materials, communication or linguistic factors, and staff-family interaction. The review should be in narrative format and address at a minimum information related to materials, training, and the services delivery system (assessment, home visitation, and supervision).	**Interview:** * Program Manager * Supervisors * Direct Service Staff * Advisory Members * Families **Review:** * Staff & Advisory Surveys
5-4.B Family & Staff Input			
5-4.C Strategies for growth are identified		Please submit advisory/governing group meeting minutes to illustrate review of the Cultural Sensitivity Review and strategies that were developed with this group. If identified strategies are documented elsewhere, submit relevant supplemental documentation.	

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

Standard 6 Intent*: The overall intent of the standards in this section is to reduce risk factors and build* ***protective factors*** *ensuring site staff provide services that are* ***family-centered****, process oriented, support parents in nurturing their children and in setting meaningful goals, enhancing family functioning, and sharing child development information.*

HFA employs an ***infant mental health*** *approach in which services are relationship focused, strength-based (building on parental competencies),* ***culturally sensitive****, and are anchored to the parallel process during interactions with families. HFA home visitors develop healthy relationships with families and an alliance with parents to support them in responding sensitively in a nurturing manner with their young children.*

6-1. **Risk factors** and stressors identified from the Parent Survey/Family Stress Checklist (or other HFA approved tool) are discussed and addressed during the course of services.

6-1.A The site has policy and procedures regarding the review of each family's **risk factors** and stressors (as identified in the Parent Survey/Family Stress Checklist or other HFA approved tool) that includes how the supervisor and home visitor work together to plan activities to address these factors and how these activities will be implemented during home visits with the family, initially and during the course of services.

6-1.A		RATING INDICATORS
3	-	No 3 rating for 6-1.A.
2	-	The site has policy and procedures regarding the review of each family's **risk factors** and stressors as identified in the Parent Survey/Family Stress Checklist (or other HFA approved tool) that includes 1) the supervisor and home visitor working together to plan activities, and the timing of such, that address these factors, and 2) the home visitor and family working together on the implementation of these the activities during home visits initially and during the course of services
1	-	Any one of the following: there is no policy and procedures; or the policy and procedures do not address all the requirements listed in the 2 rating.

6-1.B The supervisor and home visitor review each family's **risk factors** and stressors as identified in the Parent Survey/Family Stress Checklist (or other HFA approved tool) and plan activities and the appropriate timing of these activities, to address all issues with families initially and during the course of services.

Intent: *Supervisors and home visitors refer back to the Parent Survey/Family Stress Checklist (or other HFA approved tools), during the course of services to clarify how the issues that place families at-risk for poor childhood outcomes are addressed over time. The frequency of this review depends on the level of service the family is on and the complexity of each family's situation.*

Additionally, the supervisor and home visitor plan how to discuss information from the Parent Survey/Family Stress Checklist (or other HFA approved tool) with families. The activities that the supervisor and the home visitor discuss are dynamic, incorporating input that home visitors receive from families and acknowledgement of changing family dynamics over time. Activities reflect a thoughtful, purposeful discussion that assists the home visitor in understanding how early childhood trauma and the stressors experienced by the family impact parenting. Discussions acknowledge and build on family strengths (protective factors) and guide the home

visitor's strategies to support the family. The content of these discussions is documented in the supervisor logs. Clear documentation of these supervision discussions assures continuation of services should there be any staff changes.

*For sites that use a screening tool to determine eligibility of home visiting services, the Parent Survey/Family Stress Checklist (or other HFA approved **assessment tool**) is conducted as part of early home visits once the family is enrolled.*

6-1.B RATING INDICATORS

3 - The supervisor and home visitor review all the **risk factors** and stressors identified in the Parent Survey/Family Stress Checklist (or other HFA approved tool), and discuss activities to address them with families initially and during the course of services.

2 - Past instances may have occurred when the supervisor and home visitor did not review all the **risk factors** and stressors identified in the Parent Survey/Family Stress Checklist (or other HFA approved tool), and/or discuss activities to address them with families initially and during the course of services; however **recent practice** indicates this is now occurring.

1 - Either the supervisor and home visitor do not review all the **risk factors** and stressors identified in the Parent Survey/Family Stress Checklist (or other HFA approved tool), and discuss activities to address them with families, or discussions do not occur initially and/or during the course of services.

☺ Tip: Activities to address risk factors can be linked to the empowerment strategies covered in the HFA Core training for home visitors along with intentional promotion of the protective factors.

6-1.C The home visitor reviews and implements with the family activities/strategies to address the **risk factors** and stressors identified in the Parent Survey/Family Stress Checklist (or other HFA approved tools), during initial home visits and over the course of services.

Intent: *The home visitor reviews and addresses with families the **risk factors** and stressors identified in the Parent Survey/Family Stress Checklist over the course of a family's enrollment in home visit services, ensuring that families are offered ongoing opportunities and support to make positive healthy changes in their lives. **Please Note:** it is not expected that a home visitor discuss all of the **risk factors** and stressors at one time, or that the home visitor "enforce" behavior-change or issue-resolution prior to a family's readiness to do so. However, evidence of implementing the activities discussed in supervision to address those issues over the course of services is present, implementation is collaborative in nature (meaning family input and changing family dynamics are incorporated), and discussions/activities are documented in the family file. Documentation of the content of these discussions in the home visit notes clearly links back to the initial assessment and the activities to support the family developed during supervision.*

6-1.C RATING INDICATORS

3 - The home visitor implements with families activities/strategies developed to address all issues identified in the Parent Survey/Family Stress Checklist (or other HFA approved tool), during the course of service.

2 - Past instances may have occurred when the home visitor did not implement with families activities/strategies to address all issues identified in the Parent Survey/Family Stress Checklist (or other approved tool), during the course of service; however, **recent practice** indicates that this is now occurring.

1 - The home visitor did not implement with families activities/strategies to address all issues identified in the Parent Survey/Family Stress Checklist (or other approved tool) during the course of services.

☺ Tip: Sites are encouraged to discuss the risk factors and stressors identified by the family and review progress as an integrated part of Family Goal Plan development.

6-2. The Family Goal Plan assists in the development of home visit activities, the identification of resources, and the successful achievements that build a family's resiliency and promote **protective factors**. The process of developing the Family Goal Plan utilizes **family-centered** practices. **Please Note:** Family Goal Plan is HFA's preferred way to reference what was previously referenced as an Individual Family Support Plan or IFSP. These terms are synonymous.

Intent: *Goal setting is designed to be a collaborative process between parents and the home visitor. Supervision supports the development and completion of goals by helping home visitors identify and resolve barriers families may be experiencing, and acknowledging progress made. The process of developing goals is an essential part of HFA's* ***infant mental health*** *approach. Supporting parents in achieving success changes the way parents view the world, increases self-efficacy, enhances internal motivation and builds* ***protective factors****. As a result families feel less like victims and more in control of their lives.*

Parents, whose needs were not met in infancy or who were raised with early childhood trauma may be more focused on survival and may have a distorted perception of what they can accomplish in their lives. This can limit their ability to think about the future and impact their feelings of self-worth. Therefore a family's ability to develop and achieve goals can be life altering. The process is more important than the product which means the role of the home visitor and the supervisor in the goal setting and achievement process is critical to family success.

6-2.A The site has policy and procedures regarding the Family Goal Plan process, such that families have at least one active goal, and includes the development of goals that are meaningful to the family; that include the timelines (target dates) for completing the plan, how the goal plans are collaboratively developed, periodically reviewed and updated, and what resources are used. Policy also addresses how strengths are identified that support goal development, and how goal planning is supported through supervision.

6-2.A		RATING INDICATORS
3	-	No 3 rating for 6-2.A.
2	-	The site has policy and procedures regarding the development and review of meaningful goal plans with families that include the timelines (target dates), how the goal plans are collaboratively developed and updated, how strengths are identified that support goal development, how goal planning is supported through supervision.
1	-	Any of the following: there is no policy and procedures; or policy and procedures do not address the requirements listed in the 2 rating.

6-2.B The home visitor and family collaborate to set meaningful goals with the family and develop specific objectives taking into consideration family needs, cultural ideologies and concerns. Once the goals are developed, the home visitor and family identify family strengths, resources, and competencies specifically related to supporting parents in accomplishing the goals and objectives developed, and build on these strengths to help overcome barriers that may arise.

Intent: *The home visitor and family work together to develop goals and break those goals into meaningful and manageable steps/objectives. There is a clear conversation and partnering between the home visitor and parent that supports growth in families. Breaking larger goals into small steps assists parents in developing problem solving skills, increases their sense of power over their situations, and supports adult brain development. Steps are incremental, measurable, and functional for the family.* ***Please Note:*** *Many sites develop goals and specific objectives/strategies for both the family and parent-child interaction/child development needs; however, from time to time the family's capacity for goal achievement and/or the complexity of the family's desired goal may warrant only one goal being worked on at a time. The focus is not so much about how many goals the families complete, but about the skills parents build in the process of developing and working on goals. The process also supports parental empowerment, enhances family functioning, and builds* ***protective factors****. The more success a family has the more they change their world view.*

Goal setting is an opportunity for the home visitor to discuss with the family issues that impact parental attachment, child development, healthy parenting and healthy lifestyle issues (e.g. issues identified in the Parent Survey/Family Stress Checklist (or other HFA approved tools), and any additional issues identified from other tools used by the site in an open, honest way. Families experience the greatest success when their home visitor clearly understands the family's values and works within a ***culturally sensitive*** *framework to assist families in developing functional goals.*

The goal setting process is designed to support competency development and growth based upon the family needs, cultural ideologies, and strengths that will support goal achievement. Therefore the identification of needs and strengths applies to both the family goals and the parent-child interaction/child development goals. Interacting with families to identify what strengths and competencies they have to address their needs develops critical thinking and problem solving skills and promotes ***protective factors****. Staff are required to complete Family Goal Plan training (see Standard 11-5.B) and can utilize the* HFA Family Goal Plan webinar and Handout Packet *for this purpose. Staff are also encouraged to access free online Protective Factors training made available by the National Alliance of Children's Trust and Prevention Funds.*

6-2.B	RATING INDICATORS
3 -	The home visitor and family collaborate to set meaningful goals and develop specific objectives taking into consideration family needs and concerns. Once the goals are developed, the home visitor and family identify family strengths, resources, and competencies specifically related to supporting parents in accomplishing the goals and objectives developed.
2 -	Past instances were found when the home visitor and family did not collaborate to set meaningful goals, develop specific objectives, and/or identify family strengths, resources, and competencies; however, **recent practice** indicates the site is now consistently applying these practices.
1 -	The home visitor and family do not collaborate to set meaningful goals, develop specific objectives and/or identify family strengths, resources, and competencies specifically related to supporting parents in accomplishing the goals and objectives developed.

☺ Tip The goal setting process takes time. Sites may use more than one tool or strategy to develop goals and specific objectives to achieve the goals.

☺ Tip: Identification of strengths and needs may be ongoing. Documentation of these conversations may be found in home visit notes, the tools each site uses to "think about" strengths and needs with families, and/or in actual Family Goal Plans. Typically, family needs are identified first with the strengths/competencies developed that are specific to those needs. Often, needs are developed into goals and strengths are used to support the parent in accomplishing the goals. Sites are encouraged to articulate in their policy and procedures how this collaboration is demonstrated and which tools are used to identify strengths and needs for both family and child goals. *Exploring the parent's values assists parents in identifying what they want for their family and increases motivation for change.*

6-2.C The home visitor and supervisor review Family Goal Plan progress on an ongoing basis.

Intent: *In order to support growth in families, supervisors and home visitors review the progress that families are making towards the achievement of their goals. The supervisor and home visitor collaborate to ensure the goals for families remain relevant, challenges to achieving goals are addressed, accomplishment of each step/objective is celebrated, and the services the home visitor provides are connected to the goals. Additionally, the supervisor brainstorms with the home visitor any barriers being faced regarding development of the Family Goal Plan with families and supports the home visitor in increasing the quality and function of the Family Goal Plan process.*

6-2.C	RATING INDICATORS
3 -	The home visitor and supervisor review Family Goal Plan progress on an ongoing basis.
2 -	Past instances were found when the home visitor and supervisor did not review Family Goal Plan progress on an ongoing basis; however, **recent practice** indicates the site now ensures this occurs.
1 -	The home visitor and supervisor do not review Family Goal Plan progress.

☺ Tip: Supervisors are encouraged to document the review of family's progress towards meeting their goals in supervisory notes. Documentation should include any discussions of progress and how the home visitor plans to use the Family Goal Plan to guide interventions and activities with families. Additionally, supervisors are encouraged to document collaboration between the supervisor and home visitor in the formal update of the Family Goal Plan wherever appropriate.

☺ Tip: Intervals for reviewing the Family Goal Plan may be adjusted based upon the level of service (i.e., weekly, biweekly, monthly or quarterly) the family is currently on.

6-2.D The Family Goal Plan is used throughout the course of services in the development of home visit activities and the identification of resources and referrals for the family.

Intent: *The Family Goal Plan process provides a framework for home visitors to ensure that families are getting what they need from site services. Home visitors use the Family Goal Plan as the guide for home visits, to design activities and provide resources and referrals that support families in accomplishing their goals. Home visitors support parents in attaining their goals through home visit activities that connect to the steps/objectives on the Family Goal Plan, celebrate the progress the parents have made on each step, and share with families how the progress they make impacts both themselves and their children. In order to support the growth in families, home visitors ensure families have a copy of their Goal Plan, review with families the progress that they are making on their specific objectives and goals. These conversations/activities support the family in addressing barriers, developing contingency plans, and celebrating the successes that they have accomplished, thereby increasing confidence and building* ***protective factors****. Celebrating the successes greatly increases a family's capacity for making positive, healthy changes and build family resiliency. There needs to always be current relevant goals (that have been agreed upon but not yet achieved) to guide service delivery. Collaboration between the home visitor and family strongly reinforces success in goal achievement and celebration of accomplishments.*

Please Note 1: *If sites utilize a checkbox, be sure to include the details of the conversation in a narrative.* ***Please Note 2:*** *the site determines how often the Family Goal Plan is re-developed or updated. The formal update, or re-development, of a Family Goal Plan should be frequent enough to ensure meaningful and relevant goals are being set. Collaboration between the supervisor and home visitor strongly reinforces success in goal achievement and celebration of accomplishments.* ***Please Note 3:*** *while families should be provided a copy of their Goal Plan, home visitors should be cautious about doing so in circumstances where IPV issues are being addressed on the goal plan.*

6-2.D		RATING INDICATORS
3	-	The Family Goal Plan is used in the development of home visit activities, and in the identification of resources, all of which help to build **protective factors**. Practice can include a variety of mechanisms such as: - continually reviewing current goals and documenting when steps are achieved - celebrating and/or affirming when steps/goals are accomplished - keeping goals current (e.g., the timeframes reflect future activities) - developing new goals when prior goals are accomplished - developing home visit activities related to the steps/goals - providing resources & referrals to families based upon steps/goals - modifying goals that are no longer meaningful to families thereby increasing opportunities for success - retiring goals that the family no longer wishes to pursue and assisting them in setting or identifying new goals - creating contingency plans that "plan for" potential barriers as appropriate - addressing barriers by building on family strengths and competencies - ensuring steps/goals for children are anchored in the family's general routines
2	-	Past instances were found when the Family Goal Plan was not used in the development of home visit activities, and the identification of resources; however, **recent practice** indicates the site is now consistently applying these practices.
1	-	The Family Goal Plan is not used in the development of home visit activities or the identification of resources.

☺ Tip: Sites are also encouraged to document home visitor/family conversations regarding the Family Goal Plan in home visit notes. Notes should detail the content of these discussions including review of current goals, any revisions to plans that may be developed and successes celebrated. As each specific objective or strategy is accomplished, home visitors are encouraged to record the "date accomplished" on the Family Goal Plan document indicating ongoing review of progress.

6-3. The site assesses, addresses, and promotes positive parent-child interaction, attachment, and bonding and the development of nurturing parent-child relationships.

Intent: *The promotion of parent-child relationships is a primary HFA goal. Many parents in HFA sites have experienced significant early childhood trauma that can impact their ability to be emotionally present for their children. Parents who themselves have experienced early childhood trauma often struggle in being responsive and available to their children, distort emotional content in their relationships with others and have a restricted ability to utilize cognitive reasoning until their own basic needs for safety and trust are met. HFA home visitors are trained to use an infant mental health approach which supports the formation of a dyadic alliance between the parents and the home visitor and provides an effective strategy to mediate successful parenting. This parent-worker alliance provides the parent with an experience of a strong and healthy relationship, and facilitates the strengthening of the parent-child relationship through the parallel process. Utilizing an* ***infant mental health*** *approach reinforces that child development occurs within the context of the parent-child relationship. Parent-child relationships and child development are different frameworks (parent-child relationships focus on attachment; child development focuses on developing cognitive, language/communication, social-emotional, fine motor, gross motor, and self-help skills).*

Sites develop clear policy and procedures for how home visitors will assess parent-child relationships and how home visitors will partner with supervisors to develop plans for increasing positive parent-child interactions that strengthen the parent-child relationship, beginning prenatally when services are initiated prior to birth. Policy and procedures include how sites plan to use the strength-based intervention tools

*introduced in HFA's role-specific **Core training** and indicate which curriculum is used and how often. It is expected that the parent-child relationship is observed each visit in which the parent and the child are both present and used for planning purposes.*

6-3.A The site has policy and procedures that require the use of **CHEEERS** and indicate how the staff will assess (either informally or formally), address, and promote positive parent-child interaction, attachment, and bonding.

6-3.A	RATING INDICATORS
3 -	No 3 rating indicator for standard 6-3.A.
2 -	The site has policy and procedures regarding the use of **CHEEERS** including when and how home visitors will assess, address and promote positive parent-child interaction.
1 -	Any of the following: the site does not have policy and procedures and/or the policy and procedures do not require the use of **CHEEERS** including when and how home visitors assess, address and promote positive parent-child interaction.

6-3.B The site assesses positive parent-child interaction, attachment, and bonding with all families, utilizing **CHEEERS** on all home visits. CHEEERS webinar and CHEEERS Helpful Prompts and How to develop interventions using CHEEERS

***Intent:** HFA requires that **CHEEERS** is used as a parent-child observation strategy during each home visit (with exception of when it is documented that the child is not present or not awake, or when a separate measurement tool is being used during that particular visit, i.e. KIPS, NCAST or PICCOLO). **CHEEERS** is also documented prenatally beginning in the 2nd trimester, as discussed in **HFA Core training for Home Visitors**. It is also expected that any group session being counted as a home visit (1/month allowed while a family is on Level 1) also include some documentation of **CHEEERS**. In both situations (prenatal and groups), not all aspects of **CHEEERS** are required to be documented. In all other situations all components of **CHEEERS** are to be observed and documented*

6-3.B	RATING INDICATORS
3 -	Home visitors assess positive parent-child interaction, attachment, and bonding with all families, utilizing **CHEEERS** on all home visits.
2 -	Past instances were found when the home visitor did not assess positive parent-child interaction, attachment and bonding with all families utilizing **CHEEERS**; however, **recent practice** indicates this is now occurring.
1 -	Home visitors do not assess positive parent-child interaction, attachment and bonding with all families utilizing **CHEEERS** on all home visits.

NOTE: This is a Sentinel Standard

☺ Tip: Promotion of the parent-child relationship begins prenatally, and the use of the HFA's *Great Beginnings Start Before Birth* prenatal training and parenting materials is encouraged.

6-3.C The site addresses and promotes positive parent-child interaction, attachment, and bonding with all families based on observations made using **CHEEERS**.

Intent: *Sites are to document observations of parent-child interaction and how they used these observations to develop and implement home visit activities and strength-based interventions that promote positive parent-child interaction. It is helpful for staff to document how they build on parental competences and promote healthy relationships in a thoughtful way using teachable moments (e.g. if parents struggle to understand what their baby is communicating to them, the home visitor might identify when they observe the parent being empathic, thereby building the parents' skills). Other sites may incorporate videotaping to promote parental sensitivity, understanding, and a secure attachment. As above, it is important to document parental competencies and struggles and what the home visitor is doing (i.e. through use of **reflective strategies**, use of curriculum activities, etc.) to promote and support the parent-child relationship.*

6-3.C		RATING INDICATORS
3	-	Home visitors address and promote positive parent-child interaction, attachment, and bonding with all families based on **CHEEERS** observations.
2	-	Past instances were found when the home visitor did not address and promote positive parent-child interaction, attachment and bonding with all families utilizing **CHEEERS**; however, **recent practice** indicates this is now occurring.
1	-	Home visitors do not address and promote positive parent-child interaction, attachment and bonding with all families utilizing **CHEEERS**.
NOTE:		**This is a Sentinel Standard**

6-4. The site promotes healthy child development, parenting skills, and health and safety practices with families.

6-4.A The site has policy and procedures, regarding the promotion of child development, parenting skills, and health and safety practices with families that specify how often this information is to be shared with families.

Intent: *Sites develop clear policy and procedures regarding how home visiting staff promote and share information regarding child development, parenting skills, and health and safety information and provide details about what activities staff might conduct. The policy and procedures also indicate how parenting skills are promoted within the context of the child's development and normal family routines. Health and safety practices focus on both preventative strategies as well as areas of concern observed in the home. Please Note: The policy and procedures include how staff observes for and address each of the issues outlined in the standard as well as what procedures staff is to follow when sharing information.*

6-4.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 6-4.A.
2	-	The site has policy and procedures regarding the promotion of child development, parenting skills, and health and safety related practices with families.
1	-	Any of the following: the site does not have policy and procedures; the policy and procedures do not cover promotion of child development, parenting skills, and health and safety related issues;

6-4.B The home visitor builds skills and shares information with families on appropriate activities designed to promote healthy child development and parenting skills.

Intent: *Home visitors observe, build skills, and share information regarding healthy child development and parenting with families based upon naturally occurring experiences as well as through curriculum and other resources. Parenting skills, such as guidance and discipline, toilet training, weaning from the breast, etc., are included as child development activities and occur within the context of parent-child interaction. A parent who has the ability to understand what their child is able to do developmentally and the intent of the baby's behavior will be much more likely to have empathy within the relationship. Child development activities are designed to promote the parent-child interaction thereby impacting the relationship established over time between the parent and child. Whenever possible, home visitors are encouraged to organize child development information into activities in which the parent is encouraged to play with the child while the home visitor shares the developmental stimulation the baby is receiving. Home visitors are encouraged to take advantage of "teachable moments" and share appropriate information with families when it is most meaningful (emergent curriculum).*

6-4.B		RATING INDICATORS
3	-	The home visitor shares information with all families on appropriate activities designed to promote healthy child development and parenting skills.
2	-	Past instances were found when the home visitor did not share information with all families on appropriate activities designed to promote healthy child development and parenting skills; however, **recent practice** indicates this is now occurring.
1	-	The home visitor does not share information with all families on appropriate activities designed to promote healthy child development and parenting skills.

☺ Tip: Sites are encouraged to document observations of child development and what information is shared with families. It is helpful for staff to document how they build on parental competencies and promote child development and parenting skills in a thoughtful way (e.g. if parents struggle to understand what their baby is communicating to them, the home visitor might ask parents what they think the baby might be communicating, explore what parents already know about their child and anchor the conversation to what children are able to do within a particular developmental age).

☺ Tip: Child development and parenting documentation should indicate not only what the child is able to do, but also how the parent responds and what the home visitor does to take advantage of teachable moments to increase parents' knowledge.

6-4.C The home visitor shares information with families designed to promote positive health and safety practices.

Intent: *Health and safety practices include sharing prevention strategies as well as addressing any health and safety issues observed in the home. Content shared with families may include smoking cessation, SIDS, "shaken baby" strategies, baby-proofing, feeding and nutrition, selection of child care providers or alternative caretakers, in addition to any culturally based safety issues. It is expected that home visitors will address any health or safety concerns that could be detrimental to parents and their children. Additionally, home visitors support the development of a healthy and stimulating home environment.*

6-4.C		RATING INDICATORS
3	-	The home visitor shares information with all families designed to promote positive health and safety practices.
2	-	Past instances were found when the home visitor did not share information with all families designed to promote positive health and safety practices; however **recent practice** indicates this is now occurring.
1	-	The home visitor does not share information with all families designed to promote positive health and safety practices.

☺ Tip: Sites will have mechanisms for insuring how home visitors use safety checklists and/or share information with families. Staff is encouraged to document the content of health and safety discussions in home visit notes.

6-5. The site selects and uses parenting curricula with families that is **evidence-informed** and that helps to cultivate and promote nurturing parent-child relationships, healthy child development, parenting skills, and includes activities for preventive health and safety.

Intent: *Curricula materials are to be used in conjunction with teachable moments, parental interest, and shared with parents using a strength-based approach building on parental capacity (i.e. emergent curriculum use). The curriculum helps home visitors provide anticipatory guidance and supports parents in thinking about what their baby's next phase of development will be, and how they can support this development.*

When a parent has endured early childhood trauma, it is important that the home visitor spend time with the parent to listen to what the parent is thinking, feeling and experiencing before presenting the curriculum. It is only when the parent feels safe and supported that he or she can begin to concentrate on handouts and curriculum activities. Including parents in the discovery of their child's development by asking parents what they have noticed about their baby as related to the specific child development topics, before teaching specific lessons or modules is highly recommended.

*The key to successful use of curriculum is tied most closely to how the materials are used with families versus what the materials are, though they should always be **culturally sensitive** and supported by research. With any choice of curriculum, sites are cautioned that the curriculum not become the primary focus of each home visit. Curriculum represents just one piece of a comprehensive approach to working with families. The primary focus of each visit is on the relationship between parents and child. Over-reliance on parenting materials distracts from this primary focus and from the ability to be fully observant, attuned and responsive to these relationship dynamics.*

Curricula will contain a variety of components which include:

- *Information on how to promote nurturing parent-child relationships (e.g., gives parents a positive sense of their new role, makes mom or dad unique to this baby, supports the development of empathy, focuses on experience versus what is "right or wrong", anchors baby's current behavior to future development, builds parental self-esteem, encourages parents to have fun playing with their baby)*
- *Child development information and how to share this in a strength-based manner (e.g., build on parental competencies, take advantage of teachable moments, engage parents' critical thinking skills, identify emerging skills, address language use and literacy, include all developmental domains, incorporates the use of developmental screens)*

- *Content that is developmental in nature*
- *Strategies that strengthen families and their relationships*
- *Health and safety information*
- *A facilitator's manual (ideally) and family materials/manual (required)*

6-5.A The site has identified curricula materials that are **evidence-informed** and promote nurturing parent-child relationships, healthy child development, positive parenting, and include preventive health and safety information. The site's policy and procedures clearly indicate when and how these materials will be used with families as well as the orientation requirements for home visitors (see Standard 10-1.A). **Please note**: Sites are encouraged to utilize supplemental curricula materials whenever needed to support the needs of particular populations**.**

6-5.A		RATING INDICATORS
3	-	No 3 rating indicator for standards 6-5.A.
2	-	The site utilizes **evidence-informed** curricula and has developed policy and procedures regarding when and how the curriculum will be used with families as well as the staff orientation requirements and how these will be met.
1	-	Any of the following: the site does not use **evidence-informed** curriculum; and/or does not have policy and procedures that include when and how the curriculum will be used with families as well as the training requirements and how these will be met.

6-5.B The site's **evidence-informed** curriculum (that promotes nurturing parent-child relationships, healthy child development, positive parenting, and includes preventive health and safety) is used by the home visitor with each family. **Please note:** More than one curriculum can be used to address the items listed in the standard.

6-5.B		RATING INDICATORS
3	-	The home visitors use the site's **evidence-informed** curriculum with each family in accordance with site policy.
2	-	Past instances have occurred when the home visitors did not use the site's **evidence informed** curriculum with each family in accordance with site policy; however, **recent practice** indicates this is now occurring.
1	-	Any of the following: the site has not identified an **evidence-informed** curriculum; or the home visitors do not use the site's identified curriculum with each family in accordance with site policy; or the site has no policy.

6-6. The site monitors the development of participating infants and children with the ASQ (Ages and Stages Questionnaire).

6-6.A The site has policy and procedures for administration of the ASQ that specifies how and when the tool is to be used with all target children participating in services, unless developmentally inappropriate, and requires that all staff who administer the tool are trained in its use.

Intent: *The policy and procedures indicates how the ASQ is used (with all target children during home visits and in accordance with established tool guidelines, allowing no more than a 30 day window on either side of the test interval, and revising the screening schedule based on prematurity), and when the tool is used (specifying which intervals the site requires staff to administer). At a minimum, sites are to screen all target children a minimum of twice per year for children under the age of three and annually for children ages three through five years. Additionally, the policy must specify instances when the site would not be administering the ASQ (i.e., developmentally inappropriate, receiving early intervention services, etc.). Because of the twice per year minimum, sites are expected to maintain Level X families on their ASQ status list (and to note time period they were on Level X), and to track receipt of ASQ during times the family is not on Level X.* ***Please Note:*** *A screening tool is used to determine the need for further assessment, typically an in depth assessment completed by a partnering community agency specializing in early intervention.*

6-6.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 6-6.A.
2	-	The site has policy and procedures for administration of the ASQ that specifies how and when the tool is to be used with all target children participating in the site, unless developmentally inappropriate. The policy and procedures require, at a minimum, screening children under the age of three twice per year, and annually for children ages three through five years. The policy also requires the training of staff on administration of the ASQ prior to first use.
1	-	Any of the following: the site does not have policy and procedures to administer the ASQ; the policy and procedures do not specify how and when the screen/tool is to be used with all target children in the site, unless developmentally inappropriate; the policy and procedures do not require screening children under the age of three twice per year, and annually for children ages three through five years, or the policy does not require the training of staff prior to first use.

☺Tip: Sites are encouraged to indicate in their policy and procedures
☺Tip: Sites are encouraged to screen more frequently than the minimum required in the standard.
☺Tip: Sites are strongly encouraged to also administer the ASQ-SE, however this tool is not currently required by HFA, and cannot be used in place of the ASQ.

6-6.B The site ensures that the ASQ (Ages and Stages Questionnaire) is used during home visits to monitor child development at specified intervals, unless developmentally inappropriate, and is administered according to the developers' instructions to ensure valid results (i.e. administered during the specified window of time). 6-6.B HFA ASQ Tracking Form

Intent: *All target children are screened for potential developmental delays according to the minimum frequency recommended by the Association for the Academy of Pediatrics. Staff are not required to screen children that are enrolled in early intervention services (special needs) and are receiving in-depth developmental assessments.*

6-6.B		RATING INDICATORS
3	-	The site uses the ASQ during a home visit at specified intervals, and ensures all target children in the site (unless developmentally inappropriate) are screened a minimum of twice per year for children under the age of three and annually for children ages three through five years.
2	-	Past instances were found when the site did not ensure all target children in the site (unless developmentally inappropriate) were screened using the ASQ a minimum of twice per year for children under the age of three and annually for children ages three through five years; however, **recent practice** indicates this is now occurring during home visits and all children have completed the most recent developmental screen.
1	-	Any of the following: the site does not use the ASQ during home visits; the site does not use the ASQ at the specified intervals to ensure all target children in the site (unless developmentally inappropriate) were screened a minimum of twice per year for children under the age of three and annually for children ages three through five years, or all children have not completed the most recent developmental screen.

Note: This is a Sentinel Standard

☺ Tip: Sites are encouraged to indicate in the family files when a child has a revised screening schedule due to premature birth or other reasons, when screens are missed due to families being on creative outreach or when families decline the opportunity to screen the child.

☺ Tip: When a child is receiving early intervention services, it is recommended that sites request a copy of the developmental assessment from the family or from the early intervention service provider with permission from the family so that the home visiting site can support the developmental activities of the early intervention team.

6-6.C Those who administer developmental screenings have been trained in the use of the tool before administering it, and supervisors also receive this training.

Intent: *Staff must be trained before administering developmental screens, and must follow its own policies regarding administration of the tool in a home visit setting. This training is conducted by an individual that understands the use of the tool in a home visit setting. When possible, this training should include information that details the critical function behind each of the developmental questions.*

6-6.C		RATING INDICATORS
3	-	All staff using the tool, and their supervisors, have been trained in its use prior to administering.
2	-	Past instances where found when training of direct service staff and supervisors was not received until after staff had administered tool, these staff have since been trained, and **recent practice** indicates the site is now ensuring that all staff receives training prior to their first administration.
1	-	Evidence exists to indicate that staff administer the tool prior to being trained and/or supervisors have not received this training.

☺ Tip: Document the first administration of the developmental screen in training logs along with the date the staff member was trained in the use of the tool. Keep content of the training in training files.

☺ Tip: Be sure to include this training in the training plan and mechanism for tracking as required by 11-1.

6-7. The site tracks target children who are suspected of having a developmental delay and follows through with appropriate referrals and follow-up, as needed.

6-7.A The site has policy and procedures which address how it tracks target children who are suspected of having a developmental delay and how it follows through with appropriate referrals and follow-up, as needed.

Intent: *Site staff knows who to refer a family to when a screen indicates the child may have a developmental delay. This determination is developed with the supervisor and may include referring the family to their primary care physician or medical provider. In most instances, sites refer to the early intervention experts within the community. Many early intervention systems are complicated with numerous requirements and a variety of agencies that provide different services to families. Families frequently have difficulty keeping track of various appointments and schedules and/or may be reluctant to access these services. The site's policy and procedures will require home visitors to track children suspected of having a developmental delay and require staff to follow-up with all referrals made. Follow-up supports the family's access to and utilization of developmental resources, services and intervention. Procedures will detail documentation requirements including the documentation of child's progress toward reaching developmentally appropriate milestones.*

6-7.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 6-7.A.
2	-	The site's policy and procedures address how it tracks target children who are suspected of having a developmental delay and how it follows through with appropriate referrals and follow-up, as needed.
1	-	The site does not have policy and procedures which address how it tracks target children who are suspected of having a developmental delay and how it follows through with appropriate referrals and follow-up, as needed.

☺ Tip: Be sure the policy and procedures are clear regarding when and how to make a referral, whom to make the referral to, how to determine the outcome of the referral, and how to participate in the process so that staff can support families and greatly facilitate the tracking process to ensure families receive appropriate services in a timely manner.

☺ Tip: Sites are encouraged to contact early intervention services in their community to assist in the development of policy and procedures regarding the referral and tracking process for children suspected of having a delay. Families that are enrolled in early intervention services will have an IFSP process. It is recommended that collaboration occur in the development of an IFSP/Family Goal Plan for both early intervention and HFA sites. Staff is encouraged to continue collaboration with early intervention services when child is dually enrolled.

6-7.B The site tracks target children suspected of having a developmental delay and follows through with appropriate referrals and follow-up, as needed.

Intent*: Sites are encouraged to collaborate with early intervention services for children who are dually enrolled in HFA and early intervention to avoid duplication of services and to encourage consistency. Early intervention services can be difficult for parents to understand. The home visitor can be a great liaison for the family into various services that are offered through early intervention. If a family declines early intervention services,*

be sure to document this in the family's file, as well as the home visitor's continuous efforts to advocate for early intervention services. Be sure to document any joint meetings attended and referrals that home visitors made to support parents.
It is critical to support parents by tracking referrals and supporting the parent in following-through with in-depth evaluations and therapy. It is recommended that screens and developmental assessments administered by early intervention services be kept in the family files (however, this is not a requirement). At the site level the program manager/supervisor is aware of any challenges with referral sources for early intervention services and assists by advocating with referral entities/partners to reduce these barriers.

6-7.B		RATING INDICATORS
3	-	Evidence indicates the site tracks target children suspected of having a delay and follows through with appropriate referrals and follow-up, as needed.
2	-	Past instances were found when the site did not track target children suspected of having a delay and follow through with appropriate referrals and follow-up, as needed; however, **recent practice** indicates this is now occurring.
1	-	Insufficient evidence to indicate that the site tracks target children suspected of having a developmental delay and follows through with appropriate referrals and follow-up, as needed.
NA	-	No children identified with a developmental delay.
Note:		**This is a Sentinel Standard**

6. Services should focus on supporting the parent(s) as well as the child by cultivating the growth of nurturing responsive parent-child relationships and promoting healthy childhood growth and development.			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
6-1.A. Policy to address risk factors identified on the Parent Survey/Family Stress Checklist.	How supervisor, home visitor & family plan to address risk factors identified in assessment and how the plans will be implemented initially and during the course of services.	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Supervisory documentation * Family Files including Family Goal Plans * Staff Surveys
6-1.B Sup HV address PS risk factors Practice		Submit samples of forms used for documentation of the discussion between the supervisor and home visitors that clearly link back to the initial assessment.	
6-1.C HV Family address PS risk factors Practice	-	Submit samples of forms used for documentation of the discussion between the home visitors and families that clearly link back to the initial assessment.	
6-2.A. Policy for development of Family Goal Plan	The development of family goal plans including timelines, how & when the goal plans are reviewed with the family, how goal plans are developed, how strengths are identified that support goal development, how goals are supported in supervision and how goals are used to build protective factors.	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Supervisory documentation * Family Files including Family Goal Plans * Staff Surveys
6-2.B. FGP Development Practice	-	Submit a blank family goal plan, tools that are used to support the development of the goal plans, blank home visitation form used by home visitors to document discussions of goal planning, and a blank form used by supervisors to document goal planning and goal updating conversations with the home visitor.	
6-2.C. Sup HV review FGP Practice	-		

6-2.D. FGP Implementation Practice	-		
6-3.A. Policy for how home visitors assess, address and promote parent-child interaction, attachment and bonding	How *& when* sites routinely assess, address, promote parent-child interaction, attachment, bonding and the development of nurturing parent-child relationships. How home visitors will partner with supervisors to develop plans for increasing positive parent-child interactions, how sites plan to use strength-based intervention tools introduced in HFA CORE training and indicate curriculum used & how often it is used. Observation of parent-child relationship is expected at each visit.	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Curriculum and materials used by the program * Family Files * Staff Surveys
6-3.B **PCI Assessed/CHEEERS used Practice** ***Sentinel Standard***		Please submit a sample of blank home visit forms indicating where CHEEERS is documented.	
6-3.C **PCI Addressed/Promoted Practice** ***Sentinel Standard***		Please submit a sample of blank home visit forms indicating where the promotion of positive parent-child interaction, attachment, and bonding with families based on CHEEERS observations are documented.	

6-4.A. Policy for the promotion of child development, parenting skills and health and safety practices	The promotion of child development, parenting skills, and health and safety practices with families that specify how often this information is to be shared with families.	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Curriculum and materials used by the program * Family Files * Supervision Records * Staff Surveys
6-4.B Promote child dev and parenting Practice		Please submit a sample of blank home visit forms indicating where the promotion of healthy child development and parenting skills with families are documented.	
6-4.C. Promote health and safety Practice		Please submit a sample of the forms used to promote health and safety and assess for safety in the home.	
6-5.A. Policy for Evidence informed curricula materials used with families	Curricula materials used, including when and how the curricula is used with families, as well as the orientation requirements for home visitors	Submit Policy (Note: Orientation requirement could be found in 10-1.A)	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Curriculum and materials used by the program * Family Files * Supervision Records * Training Logs * Staff Surveys
6-5.B. Curriculum Practice		Please submit a description/list of curricula materials used with families.	
6-6.A Policy for Administration of Developmental Screens	The administration of developmental screening with specified intervals of administration	Submit Policy Please submit a sample of developmental screening tool (only 1 interval of screen sample needed, for example, a 6-month screen will suffice for all intervals available for the tool) and a sample of form(s) used to track screening process	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:**

6-6.B Implementation of Developmental Screening Policy ***Sentinel Standard***		Please submit a report indicating which target children received at least two a developmental screens per year (unless developmentally inappropriate) for children under the age of three and at least one screen per year for children ages three through five years and which did not. Include if delay was indicated. Provide a summary of the total families (number and percent) who received the required screens divided by the total number of active families. **Please note:** Sites may submit the HFA ASQ Tracking Form or database report.	* Curriculum and materials used by the program * Family Files * Supervision Records * Tracking Form
6-6.C Staff trained on developmental screen prior to administering		Please submit a list of current staff indicating the date they were trained on the screening tool and the date they first administered it	
6-7.A Policy tracking and follow through with developmental delay	Tracking and follow-up of developmental delays	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Family Files with children suspected or confirmed of having developmental delay * Supervision records for the same files
6-7.B Developmental delays tracked and followed through Practice ***Sentinel Standard***		Please submit a sample of form(s) or system used for tracking children with suspected developmental delays and a sample of forms used to refer and monitor the interventions needed for families with a child suspected/confirmed of having a developmental delay	

7. *At a minimum, all families are linked to a medical provider to assure optimal health and development. Depending on the family's needs, they may also be linked to additional services related to: finances, food, housing assistance, school readiness, child care, job training, family support, substance abuse treatment, mental health treatment, and domestic violence resources.*

Standard 7 Intent: *The overall intent of the standards in this section is to ensure site staff link families to providers for preventative health care and timely receipt of immunizations and appropriately refer families to additional community services based on each family's unique needs.*

HFA alone may not be able to provide all the resources a family might need to become strong, so encouraging parents to access a variety of community resources is an essential part of our work. It is important to consider that many families may not have been protected by their parents, as children, which may result in parents not knowing how to protect their own children. Empowering families to take action and advocate on behalf of themselves and their children in incremental steps based on parental capacity is critically important. Staff must strike a delicate balance between doing too little and doing too much for families, lest they prevent families from learning how to successfully advocate for themselves (hence, the long standing philosophy of HFA, "Do For, Do With, Cheer On" as it relates to connecting to community resources). Additionally, staff is expected to both refer and follow-up to assure families are able to access needed services.

7-1. Participating Target Children have a **medical/health care provider** to assure optimal health and development.

7-1.A The site has policy and procedures for linking all target children to ***medical/health care provider(s)***.

Intent: *It is important for each target child to have a medical home (a partnership between the family and the child's primary health care professional) and to utilize preventative health care practices for children. The site is to have a process for informing and connecting target children to* ***medical/health care provider****(s) available within the community. Through this partnership, the primary health care professional can help the parent access and coordinate routine well-child care, sick-child care and specialty care when needed.*

7-1.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 7-1.A.
2	-	The site has policy and procedures for linking all target children to medical/health care providers and supporting parents in utilizing health care appropriately for their child(ren).
1	-	The site does not have policy and procedures to link all target children to medical/health care providers and/or policy does not include how parents will be supported in utilizing health care for their child(ren).

7-1.B Target children have a **medical/health care provider**.

Intent: *A medical home is crucial to the health and optimal development of the child. In addition to being a vital resource for ongoing preventive health and wellness guidance, and medical interventions as needed, a medical home plays a crucial role child abuse prevention as it allows another professional consistent access to the family to provide support and monitoring for the well-being of the child.*

7-1.B		RATING INDICTORS
3	-	Ninety-five percent (95%) through one hundred percent (100%) of target children have a medical/health care provider.
2	-	Eighty percent (80%) through ninety-four percent (94%) of target children have a medical/health care provider.
1	-	Less than eighty percent (80%) of target children have a medical/health care provider.

☺ Tip: For target children who currently do not have a medical/health care provider, be sure to indicate the reasons why and clearly document attempts/steps taken to link these children.

☺ Tip: It is also important to indicate if families are on Creative Outreach and current information is unavailable.

☺ Tip: Sites are also encouraged to document the current medical/health care provider for all participating family members (children other than target children and adults) – see standard 7-3.

7-2. The home visitor promotes and educates families regarding the importance of immunizing their children, tracks the receipt of immunizations, and follows-up with parents when immunization appointments are missed. Participating Target Children are up-to-date on immunizations.

7-2.A The site has policy and procedures to ensure the home visitor shares information with families designed to promote and educate families on the importance of immunizations, tracks the receipt of immunizations, and follows-up with parents when immunization appointments are missed.

Intent: *Immunizations are very important in keeping children healthy. The regular schedule recommends shots starting at birth through 24 months of age, with boosters and catch-up vaccines continuing through the teenage years and adulthood. By immunizing, children are safeguarded against the potentially devastating effects of 11 vaccine-preventable diseases plus Hepatitis A and the flu. The catastrophic effects of childhood diseases can lead to life-long illness or death.*

Vaccines help prevent infectious diseases and save lives. Childhood immunizations are responsible for the control of many infectious diseases that were once common in this country, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, and Haemophilus influenzae type b (Hib). While the US currently has near record low cases of vaccine-preventable diseases, the viruses and bacteria that cause them still exist. Vaccines prevent disease in the people who receive them and protect those who come into contact with unvaccinated individuals (aap.org).

7-2.A		RATING INDICATORS
3	-	No 3 rating indicator for 7-2.A.
2	-	The site has policy and procedures that include all of the following: -that home visitors will share information with all families designed to promote and educate families on the importance of immunizations -how home visitors will track receipt of immunizations -that home visitors will follow-up when immunization appointments are missed
1	-	The site does not have policy and procedures that includes all items listed in the 2 rating.

7-2.B The site ensures that immunizations are up-to-date for target children. **Please note:** the percentage does not include children whose permanent health conditions or family beliefs preclude immunizations; however, evidence of these exceptions must be documented in the family file.

Intent: *All children are immunized at regular health care visits, beginning at birth. Some children may be ill or have other reasons preventing them from receiving immunizations according the identified* ***immunization schedule****. Therefore, children may not necessarily receive their immunizations on time; however, it is essential to keep them up-to-date.*

Sites track immunization information differently. Some choose to collect the information from the parent/care giver and document it on the site's tracking sheets, and others solicit periodic updates from the medical providers themselves indicating whether or not the child is up-to-date or current. Therefore, sites are encouraged to clearly indicate how they receive the information used to determine if target children have up-to-date immunizations.

Please Note: *To be up to date at age one, the target child will have received all scheduled immunizations through six months of age. To be up to date at age two, the target child will have received all scheduled immunizations through 18 months of age. Because immunizations are looked at for these two intervals only, sites are expected to maintain Level X families on their immunization status list (and to note time period they were on Level X), and to track receipt of immunizations during times the family is not on Level X.*

7-2.B		RATING INDICATORS
3	-	Ninety percent (90%) through one hundred percent (100%) of target children have up-to-date immunizations at one year of age and at two years of age.
2	-	Eighty percent (80%) through eighty-nine percent (89%) of target children have up-to-date immunizations at one year of age and at two years of age.
1	-	Less than eighty percent (80%) of target children have up-to-date immunizations at one year of age and at two years of age.

☺ Tip: For target children, who are not currently up-to-date, be sure to indicate the reasons why and clearly document attempts/steps taken to obtain immunizations for these children.

☺ Tip: The Center for Disease Control has an interactive immunization scheduler available online.

7-3. Families are connected to services in the community on an as needed basis.

7-3.A The site has policy and procedures that describe how home visitors will provide information, referrals, and linkages to available health care, health care resources and community resources for all participating family members. The policy includes the follow-up mechanism to determine whether parents receive the services they were referred to.

7-3.A	RATING INDICATORS
3 -	No 3 rating for standard 7-3.A.
2 -	The site has policy and procedures that describe the process for home visitors to provide information, referrals and linkages to available health care, health care resources, and community resources for all participating family members. The policy and procedures includes follow-up mechanisms to determine whether parents receive the services they were referred to.
1 -	The site does not have policy and procedures that include the components listed in the 2 rating.

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

Intent: *Sites are encouraged to provide information, referrals and linkages for all participating family members including the target child. Information could include a variety of topics that may benefit all participating members (i.e., smoking cessation support groups, free health clinics for adults, immunization clinics, flu shots, nutritional classes, etc.). Health care information includes the importance of dental care as well as referrals linking families to preventive services for dental care, as appropriate. Additionally, home visitors share information regarding the benefits to families for spacing pregnancies. Site staff are knowledgeable of health care resources within the community and be able to appropriately provide referrals and linkages to members. It is recommended that sites only provide information, referrals and linkages when necessary, (i.e., when a pregnant mother needs assistance connecting to prenatal care, or when parents or siblings have health concerns and are without a medical care provider). Therefore if a family is currently receiving necessary services/care, there may be no need for further provision of the above-mentioned services.*

7-3.B	RATING INDICATORS
3 -	Evidence indicates that home visitors provide information, referrals and linkages to all participating family members on available health care and health care resources, when necessary.
2 -	Past instances were found when home visitors did not provide information, referrals and linkages to all participating family members on available health care and health care resources, when necessary; however, **recent practice** indicates this is occurring.
1 -	Insufficient evidence exists to suggest that home visitors are providing information, referrals and linkages to all participating family members on available health care and health care resources, when necessary.

☺ Tip: Sites may want to consider documenting health care resource referrals associated with this standard, in the same way other community resource referrals are documented for standards 7-3.C and 7-3.D.

7-3.C The site connects families to appropriate referral sources and services in the community as needed.

Intent: *Families benefit by accessing community agencies and services that can support the family in accomplishing goals or overcoming challenges they may be experiencing. Families may be reluctant to access additional services, and home visitors are one way to bridge the gap. Home visitors are familiar with the community agencies and the services they provide to be sure families are referred appropriately. Sites are encouraged to provide referrals as often as needed. Additionally, while there may be services to refer the family to within the community, it does not mean they are necessarily appropriate or needed by the family. Therefore not all families require referrals.*

7-3.C		RATING INDICATORS
3	-	Evidence indicates families are linked to additional services in the community on an as needed basis.
2	-	Past instances were found when families needing additional services were not connected to appropriate services in the community, as needed; however, recent practice indicates this is now occurring.
1	-	There is insufficient evidence to indicate families are linked to additional services in the community on an as needed basis.

7-3.D. The site tracks and follows up with the family, and/or service provider (if appropriate) to determine if the family received needed services. Follow-up with referral sources will require signed informed consent (see GA-5.C).

7-3.D		RATING INDICATORS
3	-	The site has a method for tracking and following-up on referrals of families to other community services as needed and evidence indicates the site is tracking and following up on referrals.
2	-	Past instances were found when tracking and follow-up did not occur; however, **recent practice** indicates this is now occurring.
1	-	Either the site does not have a method or the site has a method but there is insufficient evidence to indicate that tracking and follow-up is occurring.

☺ Tip: Sites are encouraged to track all of the referral resources provided and the family's utilization of those services over the course of services in one place for easy monitoring.

☺ Tip: Periodically, sites may want to review any trends pertaining to families ability to access particular services in the community. Doing so can assist with the ongoing assessment of community needs and identification of gaps in service availability.

7-4. The site has policy and procedures for strengthening families by addressing **challenging issues** such as substance abuse, intimate partner violence, developmental delay in parents, and mental health concerns, and practice indicates that this policy is being implemented.

Intent: *Healthy Families sites serve many families who are struggling with issues such as substance abuse, intimate partner violence, developmental delay in parents, depression, and other mental health challenges some of which may be caused by early childhood trauma such as child abuse, as well as other trauma, along with multiple stressors in their lives such as financial, housing, lack of education, and poor self-esteem to list a few. In order to address these challenges, site staff must form healthy relationships with parents, apply a strength-based empowerment approach that includes being honest when parents are responding to their environment in ways that may cause harm to themselves and their children, accepting families where they are, without judgment or bias, building on parental competencies and focusing on the experience versus trying to establish "right or wrong". These principles are core HFA components.*

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

- *Providing honest feedback with parents' permission*
- *Pointing out discrepancies between stated values and actual behavior*
- *Providing an atmosphere of safety and acceptance*
- *Encouraging forward thinking (i.e. assist parent in developing a vision of what they want)*
- *Providing information and referrals*
- *Using **motivational interviewing** (when trained on this technique)*
- *Utilizing reflective supervision to receive support and prevent burnout*

It is important for home visitors to help parents recognize the importance of the parent-child relationships and the impact of untreated depression and/or other mental health issues. Research clearly demonstrates that untreated disorders and past trauma can have serious consequences for early learning, social competence and lifelong health.

7-4.A The site has policy and procedures for addressing **challenging issues** including substance abuse, intimate partner violence, developmental delay in parents, and/or mental health.

Please Note: *See page 9 of the Glossary for definitions and links to additional support material, including training developed by FRIENDS NRC, which can be a useful resource, as are the protocols for working with families experiencing acute crisis outlined in this Safety Manual.*

7-4.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 7-4.A.
2	-	The site has policy and procedures that describe how the site will address **challenging issues** including substance abuse, intimate partner violence, developmental delay in parents, and mental health.
1	-	The site does not have a policy and procedures as described in the 2 rating.

☺ Tip: Often when helping families move toward "treatment readiness", the first step is to implement a screening/assessment process using the Parent Survey/Family Stress Checklist, along with depression screening tools, substance use screening tools, etc. to determine when outside services are necessary. Many sites utilize components of motivational interviewing, anchor to parents' values and dreams for their children, build on parental strengths, offer decision matrices (pros and cons regarding making decisions), and other strategies to support families in making healthy decisions about lifestyle. Staff are encouraged to also access free online Protective Factors training made available by the National Alliance of Children's Trust and Prevention Funds.

7-4.B Program staff addresses **challenging issues** such as substance abuse, intimate partner violence, developmental delay in parents, and mental health needs by actively focusing on building **protective factors**.

7-4.B		RATING INDICATORS
3	-	The site addresses **challenging issues** such as substance abuse, intimate partner violence, developmental delay in parents, and mental health by actively focusing on building **protective factors**.
2	-	Past instances were found when the site did not address **challenging issues** such as substance abuse, intimate partner violence, developmental delay in parents, and mental health by actively focusing on building **protective factors**; however, **recent practice** indicates this is now occurring.
1	-	There is insufficient evidence to indicate that the site addresses **challenging issues** as listed in the above rating indicators.

☺ Tip: Sites are encouraged to track all conversations with families that indicate staff is addressing challenging issues. Additionally, for easier monitoring, sites should document in one place all linkages/referrals to community services and the family's utilization of those services over the course of services.

☺ Tip: Sites are also encouraged to have their staff access free online Protective Factors training made available by the National Alliance of Children's Trust and Prevention Funds.

7-5. The site conducts depression screening with all families using a standardized instrument.

Intent: *Many of the items on the Family Stress Checklist/Parent Survey are precursors for depression. Add to that the extreme stress that families experience and the likelihood for depression is extremely high. When parents are depressed, there are significant impacts for the parent-child relationship such as the inability for the parent to be emotionally available to their infant, assist with physical and emotional regulation (read cues and respond in a timely and sensitive manner) and provide intellectual stimulation.*

Screening for depression both during the prenatal and postnatal period allows home visitors to assist parents in becoming aware of the depression, and determining if there are depressive issues that need to be addressed by a clinician. Administering a depression screening requires both knowledge of how to administer the screen/tool and what to do if the screen/tool has positive results. Staff training includes the following:

- *Administration guidelines*
- *Ways to talk with parents about depression*
- *Community resource information*
- *Activities home visitors can do with families to reduce stress and increase serotonin*
- *Ways to support parents in meeting their child's physical and emotional development*

Additional training opportunities include:

- *Review of the HFA online depression training module*
- *Access to the free online course through the National Child Traumatic Stress Network (Psychological First Aid – http://www.nctsn.org/sites/default/files/pfa/english/1-psyfirstaid_final_complete_manual.pdf)*

Although staff are not therapists, it is critical for home visitors to support parents in alleviating their depression while a parent is awaiting treatment or while considering treatment options. A sample of activities home visitors may engage parents in include:

- *Providing linkages and referrals to appropriate resources*
- *Providing referrals for mental health consultation (when available)*
- *Using **motivational interviewing** (when trained) to assist parents in accepting resources, treatment*
- *Utilizing supervision to assist staff in discussing depression with parents*
- *Getting parents out in the sunshine without sunglasses (sun increases serotonin)*
- *Encouraging parents to walk,, exercise, or engage in other forms of physical movement*
- *Encouraging parents to smile (even a "practice" smile increases serotonin)*
- *Encouraging parents to keep hydrated (hydration increases brain functioning)*
- *Utilizing* Protocols for Addressing Challenging Issues
- *Encouraging parents to meet their baby's physical and emotional needs*
- *And using other strategies/activities identified locally*

Extreme depression is life threatening and must be addressed by a licensed clinician.

7-5.A The site has policy and procedures for administration of a standardized depression screen/tool that specifies how and when (at least once prenatally and at least once within three months after birth) the tool is to be used with all families participating in the program and assures that all staff who administer the tool are fully trained.

7-5.A		RATING INDICATORS
3	-	No 3 rating for standard 7-5.A.
2	-	The site has policy and procedures for administration of the depression screening tool that specify how and when the tool is to be used with all families, referral and follow-up expectations with elevated screens, and activities appropriate for home visitors to do with families. The policy also includes the requirement that all staff receive training on how to administer prior to first use.
1	-	The site does not have policy and procedures for administration of a standardized depression screen/tool that specifies all of the elements in the 2 rating.

☺ Tip: Sites may choose to administer the depression screen during the assessment process.

☺ Tip: Sites are strongly encouraged to establish policy that requires the administration of depression screens for all subsequent births while the mother remains enrolled in the program, such that administration of depression screening is not exclusive to the target pregnancy/child only.

☺ Tip: Sites may consider conducting the depression screen with other caregivers, particularly fathers as research has shown that pre and postnatal depression is not exclusive to mothers. Paternal depression is of concern as well with first births and subsequent births.

7-5.B The site conducts depression screening with all enrolled mothers. If enrolled prenatally the screening will be completed at least once during the prenatal period, and for all families at a minimum of at least once postnatally before the baby is 3 months of age. 7-5.B Depression Screening Form. **Please note the following limited exception criteria**: If the mother refuses the screen, is on Level X throughout the screening period and/or the family is enrolled when the baby is older than 3 months, they are not counted within the cohort.

Intent: *Depression screening is conducted at various points is time both prenatally and postnatally. Depression screens should still be completed when families are in treatment to assure that treatment is meeting the needs of the family. If the caregiver is*

not the biological mother, depression screening may be appropriate but is not required.
Please note: *Prenatal screenings do not exempt post-natal screening.*

7-5.B	RATING INDICATORS
3 -	All mothers are screened using a standardized and validated depression screen/tool at least once prenatally (when enrolled prenatally) and at least once postnatally within 3 months of the baby's birth. The site also conducts depression screens for subsequent births after the birth of the target child.
2 -	Past instances occurred when all mothers were not screened using a standardized and validated depression screening tool at the frequency required in the standard, however, **recent practice** indicates this is now occurring with all target pregnancies/births (unless meeting exception criteria stated in the standard).
1 -	Any of the following: the site does not use the standardized depression screen/tool, and/or the standardized depression screen/tool is not used within the timeframes required in the standard; or there is no **recent practice** to demonstrate that all mothers are now being screened.

Note: This is a Sentinel Standard

☺Tip: According to several *Perinatal Care Position Statements,* depression screening is recommended to occur twice during the prenatal period (when families are enrolled in the program early in their pregnancy), and at 6 weeks, 3 months, and 1 year following the birth of the baby.

☺Tip: Ideally, if multiple providers are involved, home visitors will coordinate with others to reduce duplicate screening. In such cases, a written consent must be on file in the participant record and the program must be in receipt of a copy to show that the screening was done. Even more importantly, the site needs copy on file in order to make and track any necessary follow-up referrals/interventions for the family.

☺ Tip: Even if the site obtains copies of screens done at birth by another provider, re-screening is strongly recommended. Best practice would be to re-screen at 6 weeks and 3 months postpartum.

☺ Tip: Depression screenings are not intended to be used as formal diagnostic tools. Screening tools are used to determine the need for a more intensive evaluation by a licensed mental health clinician.

7-5.C Referral and follow-up on referrals occur for mothers, whose depression screening scores are elevated and considered to be at-risk of depression unless already involved in treatment (based on the tool's scoring **criteria**).

7-5.C	RATING INDICATORS
3 -	Mothers with an elevated depression screening score are referred (with consent) for further evaluation/treatment and follow-up unless already involved in treatment.
2 -	Past instances were found when the site did not ensure all mothers with an elevated depression screening score were referred (with consent) for further evaluation/treatment and follow-up unless already involved in treatment; however, **recent practice** indicates this is now occurring.
1 -	Any of the following: mothers with an elevated depression screening score are not referred for further evaluation/treatment and/or there is no follow-up on those who are referred.

7-5.D Those who administer the depression screen/tool have been trained in the use of the tool before administering it, including ways to talk with parents about depression, and supervisors also receive this training.

Intent: ***Please Note:*** *When a collaborative partnership results in another provider completing the depression screen and providing copy to the Healthy Families provider, the HFA site does not need to monitor training of non-HFA staff in administering the screen. However, HFA sites are required in these situations to ensure that HFA staff receive depression screen training to ensure understanding of administration guidelines and referral protocols regardless of whether they administer the screen or not, as they need to be able to interpret and act on the results.*

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7-5.D		RATING INDICATORS
3	-	All staff using the tool, and their supervisors, have been trained in its use, and in ways to talk with parents about depression before administering it, or supervising staff who are administering it.
2	-	Past instances were found when training of direct services staff and supervisors was not received until after staff had administered tool, however these staff have since been trained, and **recent practice** indicates the site is now ensuring all staff receives training prior to the first administration.
1	-	Evidence exists to indicate that staff administer the tool prior to being trained and/or supervisors have not received this training.

7. At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.) Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse and/or mental health treatment and domestic violence resources			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
7-1.A Policy Medical Providers for Target Children	Linkage of target children to medical/health care providers.	Submit Policy	**Interview if needed:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * any additional information needed
7-1.B Target Children with health care provider Practice	-	Submit a report detailing all of the target children and their current medical/health care provider, and the percent of the target children who are currently connected with a medical/health care provider.	
7-2.A Policy for Timely Receipt of Immunizations	Home visitors routinely share information designed to promote and educate families on the importance of immunizations, how immunizations are tracked and follow-up procedures	Submit Policy	**Interview if needed:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * any additional information needed
7-2.B Measure Immunization rates at 1yr and 2yr		Submit a copy of the program's immunization schedule, a report detailing all target children and whether or not they are up-to-date, and the percentage of target children whose immunizations are up-to-date.	
7-3.A Policy for provision of information, referrals & linkages to health care resources	How home visitors will provide information, referrals and linkages to available health care, health care resources and community resources as well as method for tracking and follow-up of referrals.	Submit Policy	**Interview if needed:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Family Files * Supervision Records * Staff Surveys
7-3.B Health care referrals Practice		Submit any relevant tracking documentation such as blank referral tracking forms, home visit records, etc., where this information is documented. Submit a description that clearly describes the provision of	

7-3.C Community resource referrals Practice		information, referrals, and linkages to available health care resources for all participating family members as well as other community referrals. Include follow-up mechanisms to determine whether parents receive the services they were referred to.	
7-3.D Referral follow-up Practice	-		
7-4.A Policy for addressing challenging issues	How the site will address challenging issues such as; substance abuse, intimate partner violence, developmentally delayed parents and mental health by focusing on building protective factors to strengthen families	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Family Files/Referral Tracking * Supervision Records
7-4.B Challenging Issues addressed Practice		Submit assessment tools used to assess substance abuse, intimate partner violence, mental health etc., as well as linkage/referral form used to track referrals and follow-up to referrals which clearly indicates the family's utilization or lack of utilization of those services.	
7-5.A Policy for administration of a standardized depression screen/tool	How and when the tool is to be used with families, ways to talk with parents about depression, community resource information and activities appropriate for home visitors to do with families	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Family Files/Referral Tracking * Supervision Records * Training Logs * Depression Resources/Materials
7-5.B **Screening mothers for depression** ***Sentinel Standard***		Submit copy of the standardized depression screen/tool used with families and a report listing 1) all mothers enrolled in program services, 2) date of birth of target child, 3) date of birth for subsequent children and 4) the date(s) mothers received screening for depression, and 5) outcome of the screen (+ or -). **Please Note:** Sites may use the HFA Depression Screening Tracking Form.	
7-5.C Referral and follow up for mothers with elevated screens		Please submit a list of all mothers enrolled in program services, with a positive depression screen and if referred (with permission) for further evaluation/treatment and follow up.	
7-5.D Training prior to administering		Submit a list of all staff indicating the date they were trained on the screening tool and the date they first administered it.	

8. *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 meet their unique and varying needs and to plan for future activities.*

Standard 8 Intent: ***The overall intent of the standards in this section is to ensure site staff have limited caseloads to allow them the necessary time with families to build trusting, nurturing relationships.***

8-1. Services are provided by staff with limited **caseload**s to ensure that home visitors have an adequate amount of time to spend with each family to meet their needs and plan for future activities.

8-1.A The site's policy and procedures regarding established ***caseload*** size is no more than fifteen (15) families, at the most intensive level (offered weekly visits) per full time home visitor.

8-1.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 8-1.A.
2	-	The site's policy and procedures states that **caseload** size is no more than fifteen (15) families, at the most intensive service level (offered weekly visits) per full time home visitor.
1	-	The site does not have policy and procedures or the site's policy states that **caseload** size is more than fifteen (15) families, at the most intensive service level (offered weekly visits) per full time home visitor.

☺ Tip: Circumstances may arise when staff exceed the caseload size of 15 at the most intensive level such as when a family moves from a less intensive level of services to a more intensive level of service or when a home visitor leaves and the caseload is dispersed among existing home visitors, etc. This practice should be temporary (3 months or less) and sites are encouraged to clearly document the reasons why the caseload has exceeded the limit and the duration of this deviation.

☺ Tip: Sites should prorate caseload size based on the staff person's Full Time Equivalency (e.g., a .5 FTE should not have more then 7-8 families on the most intensive level, or a .75 FTE should only have 11 families on the most intensive level).

8-1.B The site's policy regarding maximum ***caseload*** size is no more than twenty-five (25) at any combination of service levels per full-time home visitor and a maximum case weight of 30 points.

Intent: *The maximum **caseload** size is no more than 25 active families who have received at least one home visit to ensure that home visitors have sufficient time and resources to serve families most effectively. **Caseload** sizes of 25 families and a case weight of 30 points is the maximum size. Sites should set lower **caseload** expectations and serve less families when the **caseload** includes a larger composition of families that score 40 or above on the Parent Survey/Family Stress Checklist. Other reasons for **caseload** reduction include items listed in the 2 rating for standard 8-2.A. Guidance regarding assigning case weight based on level of service (frequency of home visits) can be referenced in standard 4-2.A.*

8-1.B	RATING INDICATORS
3 -	The site's policy and procedures regarding maximum **caseload** size is no more than twenty (20) families at any combination of service levels per full time home visitor and a maximum case weight of 24 points.
2 -	The site's policy and procedures regarding maximum **caseload** size is no more than twenty-five (25) families at any combination of service levels per full time home visitor and a maximum case weight of 30 points.
1 -	The site does not have policy and procedures or the site's policy regarding maximum **caseload** size exceeds twenty-five (25) families at any combination of service levels per full time home visitor and a maximum case weight of 30 points.

☺ Tip: Circumstances may arise when staff exceed caseload size (e.g., a home visitor leaves and the caseload is dispersed among existing home visitors, etc.). This practice should be temporary (3 months or less) and sites are encouraged to clearly document the reasons why the caseload has exceeded the limit and the duration of this deviation.

☺ Tip: Sites should prorate this number based on the staff person's Full Time Equivalency (e.g., a .5 FTE should not have more then 11-12 families at any combination of service levels or case weight of 15, or a .75 FTE not have more than 19 families at any combination of service levels, or case weight of 23).

8-1.C Home visitors are within the caseload ranges, as stated in standard 8-1.A and 8-1.B. Caseload Management worksheet

8-1.C	RATING INDICATORS
3 -	No home visitor exceeds the **caseload** sizes, as stated in standards 8-1.A and 8-1B.
2 -	Instances were found when home visitors exceeded the **caseload** sizes as stated in 8-1.A and 8-1.B, however any deviation was temporary (3 months or less).
1 -	Home visitors exceed the **caseload** sizes as stated in 8-1.A. and 8-1.B for periods longer than 90 days.

8-2. The site's **caseload** system ensures that home visitors have an adequate amount of time to spend with each family.

8-2.A The site has policy and procedures for managing its **caseload**s.

8-2.A	RATING INDICATORS
3 -	No 3 rating indicator for standard 8-2.A.
2 -	The site's policy and procedures include all of the following criteria: - experience and skill level of the home visitor assigned, - nature and difficulty of the problems encountered with families, - work and time required to serve each family, - number of families per service provider which involve more intensive intervention, - travel and other non-direct service time required to fulfill the service providers' responsibilities, - extent of other resources available in the community to meet family needs, and - other assigned duties.
1 -	The site does not have policy and procedures or the policy and procedures do not

include all the criteria listed above in the 2 rating indicator.

8-2.B The site uses the criteria as identified above in 8-2.A. to manage its **caseload** sizes.

8-2.B		RATING INDICATORS
3	-	The site manages its **caseload** sizes utilizing criteria identified in 8-2.A and outlined in the policy and procedures.
2	-	Past instances were found when the **caseload** sizes were not managed according to the criteria identified in 8-2.A; however, **recent practice** now indicates this is occurring.
1	-	The site does not manage its **caseload**s utilizing criteria identified in 8-2.A.

8. Services should be provided by staff with limited caseloads to assure that home visitors have and adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
8-1.A Policy for Caseload size	Caseload size for families on the most intensive service level (offered weekly visits) is no more than 15 families per full time home visitor	Submit Policy	**Interview:** * Home Visitor Supervisors * Home Visitors * Families **Review:** * Caseload documentation * Family Files * Supervision Records
8-1.B Policy for Maximum Caseload	Maximum caseload size for families at any combination of service levels is no more than 25 families or 30 points per full time home visitor	Submit Policy	
8-1.C Caseload sizes monitored		Please submit a report indicating the active caseload for all current home visitors over the past 12 months. Include each home visitor's caseload for the most recent quarter, the home visitor's full time equivalency, the number of families assigned to him or her, and the level/intensity of service each family is receiving.	
8-2.A Policy for Managing Caseloads	How caseloads are managed including all criteria listed in the standard	Submit Policy	
8-2.B Caseload Management Practice		No additional pre-site evidence required	

9. Service providers are selected because of their personal characteristics, their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

Standard 9 Intent: ***The intent of the standards in this section is to ensure staff are selected because they possess characteristics necessary to build trusting, nurturing relationships and work with families with different cultural values and beliefs than their own.***

Please Note: Program Managers and Supervisors hired prior to July 1, 2014 will need to demonstrate at least a Bachelor's degree. Criteria underlined below will be applied to staff hired July 1, 2014 or after. Also, please note that a staff development plan can be developed and implemented to support any experiential gaps at the time of hire, however it cannot compensate for education. The minimum education requirement must be met. Experiential criteria includes all items bulleted in 9-1.A-C that are not educational requirements.

9-1. Service providers and site management staff are selected because of a combination of personal characteristics, experiential, and educational qualifications.

9-1.A Screening and selection of **program manager**s includes consideration of characteristics including, but not limited to:

- A solid understanding of and experience in managing staff;
- Administrative experience in human service or related field including experience in quality assurance/improvement and site development;
- Master's degree in public health or human services administration or fields related to working with children and families, or Bachelor's degree with 3 years of relevant experience.

9-1.A		RATING INDICATORS
3	-	The site's system for screening and selection of program managers ensures that it considers all of the personal characteristics of job candidates as listed above, and site managers meet all of the criteria.
2	-	The site's system for screening and selection of program managers ensures that it considers all of the personal characteristics of job candidates as listed above; however, instances found when site managers did not meet the experiential criteria, however a **staff development plan** for managers is in place and has been acted upon.
1	-	One of the following: 1) the site does not screen for the characteristics listed above; 2) the system is not followed when hiring; 3) the site does not have a screening or selection system for hiring program managers; 4) program managers do not meet the criteria stated in the standard and there is no development plan to compensate for experiential gaps; or 5) the development plan has not been acted upon.

9-1.B Screening and selection of supervisors includes all of the following, but is not limited to:

- Master's degree in human services or fields related to working with children and families, or Bachelor's degree with 3 years of relevant experience.
- A solid understanding of and/or experience in supervising and motivating staff, as well as providing support to staff in stressful work environments
- Knowledge of infant and child development and parent-child attachment

- Experience with family services that embrace the concepts of **family-centered** and strength-based service provision
- Knowledge of maternal-infant health and dynamics of child abuse and neglect
- Experience in providing services to culturally diverse communities/families
- Experience in home visiting with a strong background in prevention services to the 0-3 age population
- Infant mental health endorsement level III or IV preferred (if available in the state)
- Experience with **reflective practice** preferred (see standard 12-2.B for more detail)

9-1.B RATING INDICATORS

3 - The site's system for screening and selection of supervisors ensures that it considers all of personal characteristics of job candidates as listed above, and supervisors meet all the criteria.

2 - The site's system for screening and selection of supervisors ensures that it considers all of personal characteristics of job candidates as listed above; however instances were found when supervisors did not meet all of the experiential criteria, however a **staff development plan** for supervisors is in place and has been acted upon.

1 - One of the following: 1) The site does not screen for the characteristics listed above; 2) the system is not followed when hiring; 3) the site does not have a screening or selection system for hiring supervisors; 4) supervisors do not meet the criteria stated in the standard and there is no **staff development plan** in place to compensate for experiential gaps, or 5) the **staff development plan** has not been acted upon.

9-1.C Screening and selection of direct service staff, volunteers, and interns (performing the same function) include consideration of personal characteristics, including but not limited to:

- Minimum of a high school diploma or equivalent
- Experience in working with or providing services to children and families
- An ability to establish trusting relationships
- Acceptance of individual differences
- Experience and willingness to work with the culturally diverse populations that are present among the site's **target population**
- Knowledge of infant and child development
- Open to **reflective practice** (i.e. has capacity for introspection, communicates awareness of self in relation to others, recognizes value of supervision, etc.)
- Infant mental health endorsement level I or II preferred

9-1.C RATING INDICATORS

3 - The site's system for screening and selection of direct service staff (and volunteers and interns performing the same direct service function), ensures that it considers all of the personal characteristics of job candidates as listed above and direct service meet all the criteria:

2 - The site's system for screening and selection of direct service staff (and volunteers and interns performing the same direct service function), ensures that it considers all of the personal characteristics of job candidates as listed above; however instances were found when direct service staff did not meet all of the experiential criteria, however a **staff development plan** for direct service staff is in place and has been acted upon.

1 - One of the following: 1) The site does not screen for the characteristics listed above; 2) the system is not followed when hiring; 3) the site does not have a screening or selection system for hiring direct service staff; 4) direct service staff and/or volunteers and interns, performing the same function, do not meet the criteria stated in the standard and there is no **staff development plan** in place to compensate for experiential gaps, or 5) the **staff development plan** has not been acted upon.

☺ Tip: Please see the glossary on page 14 and this link to interview questions when considering an applicant's **Reflective Capacity**.

9-2. The site actively recruits, employs, and promotes qualified personnel and administers its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, handicap, sexual orientation, or religion of the individual under consideration.

9-2. RATING INDICATORS

3 - The site:
- is in compliance with the Equal Opportunity Act in the United States, and communicates its equal opportunity practices in recruitment, employment, transfer and promotion of employees,
- informs staff of the equal opportunity practices
- uses recruitment materials that specify the non-discriminatory nature of the site's employment practices
- has no administrative findings or court rulings against the site in this respect, and
-no known violations of equal employment opportunity.

2 - Status is under review and pending final determination; no major difficulties have been identified in the process of a review conducted by a regulatory authority; EEO practices do not include all areas of personnel administration and there are no known violations of equal employment opportunity; the site uses limited means of communicating information on its non-discriminatory hiring practices.

1 - The site is not in compliance with the applicable law and has not begun corrective action; the site has violated its equal opportunity policy; or the site does not disseminate information internally or externally on its position on equal opportunity.

9-3. The site's recruitment and selection practices assure that its human resource needs are met.

9-3.A The site's recruitment and selection practices are in compliance with applicable law or regulation and include:

- Internal job postings of available positions before or concurrent with external recruitment,
- utilization of standard interview questions that comply with employment and labor laws and address knowledge and skills needed for the job, and
- verification of 2-3 references and/or letters of recommendation and credentials. If hired from within the organization, performance appraisals may suffice.

9-3.A		RATING INDICATORS
3	-	The site's recruitment and selection practices contain all three practices identified in the standard for both staff and volunteers.
2	-	Past instances were found where the site's recruitment and selection practices did not contain all three practices identified in the standard for both staff and volunteers; however, **recent practice** (through new hires) indicates this is now occurring.
1	-	The site's recruitment and selection practices consistently do not include all three practices identified in the standard for both staff and volunteers.

☺ Tip: Contact HFA for sample interview questions if needed.

9-3.B The agency conducts appropriate, legally permissible, and mandated inquiries (as allowed within the state or province) of state or provincial criminal history records on **all** prospective employees and volunteers who will have direct contact with children and/or access to data involving children, i.e., assessment staff, home visitors, supervisors and program managers.

Intent: *Sites must ensure the safety of the families and children it serves by conducting criminal background checks on all prospective employees who will come in contact with them, i.e., assessment staff, home visitors, supervisors and program managers. Even in cases when the State does not mandate criminal background checks for HFA staff, sites are expected to check legally permissible criminal history records. At a minimum, sites are to conduct legally permissible background checks (at any point during employment) in order to be in adherence to the standard. While inquiries made to civil child abuse and neglect registries are highly recommended, they are not always legally permissible or readily available to sites.*

Criminal history records should not be used to deny employment of qualified individuals unless the nature of the conviction is related to the specific job duties. Legal counsel should be consulted with regard to appropriate use of background checks.

The site is not required to conduct background checks for licensed staff if the site has verified that background checks are part of the licensing process, and that staff reporting to be licensed have a valid and current license.

9-3.B		RATING INDICATORS
3	-	All currently employed site staff have had legally permissible background checks completed at the time of employment including criminal background. State child abuse and neglect registries may have been checked in addition. The site is knowledgeable about what is legally permissible and usable in screening applicants. It carefully follows all mandates.
2	-	All currently employed staff have had criminal background checks completed at any point during employment and evidence indicates that any new hires have had legally permissible background checks completed at time of employment. The site conducts criminal background checks only.
1	-	The site has conducted legally permissible background checks on some but not all currently employed staff; or does not conduct mandated background checks.

Note: This is a Safety Standard

☺ Tip: Sites are encouraged to re-screen employees at various time intervals and conduct background checks not only at the time of hire but also during the course of an employment.

9-4. The site monitors personnel satisfaction and retention at least every two years and addresses how it may increase staff retention.

Intent: *A stable, qualified workforce is known to contribute to improved participant outcomes, with families more likely to be retained in services when staff are retained. Therefore, site management monitors factors associated with staff turnover. By understanding the circumstances and characteristics of staff that leave, in comparison to those that stay, strategies to increase retention can be developed (based on the data) and implemented with a greater likelihood of success. The site considers factors that have been associated with staff satisfaction and retention, including: job category, staff demographics, role clarity, acknowledgement of work performed, satisfaction with salary and benefits, reasonable workload, autonomy, opportunities for advancement and career development.* ***Please Note:*** *While the site will want to capture the reasons contributing to all staff turnover, strategies for improvement do not need to be developed when reasons pertain to personal growth opportunities that could not have been fulfilled on the job, i.e. returning to school, job promotion, etc.*

9-4.		RATING INDICATORS
3	-	The site monitors staff retention and satisfaction at least every two years, and has developed and implemented strategies to address any issues, or there has been no staff turnover in two years, in which case staff satisfaction is monitored, however turnover and strategies to address turnover do not need to be included.
2	-	The site monitors staff retention and satisfaction at least every two years, and has developed strategies to address any issues.
1	-	Any of the following: The site has not monitored staff retention and/or satisfaction at least every two years; or has not developed strategies to address issues.

9. Service providers should be selected because of their personal characteristics (e.g., non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
9-1.A Screening & selection of Program Managers	-	Please submit a description of the program's screening and selection procedures for program managers, supervisors, direct service staff (including volunteers if used), and any relevant materials used during the screening/selection procedure, such as interview guidelines, job descriptions, qualifications required at hire, etc. Also, please submit resumes all for current staff.	**Interview:** * Program Manager * Human Resources, if applicable * Other staff as needed **Review:** * Personnel Files * Staff Development Plans if needed * Staff Surveys
9-1.B Screening & selection of Supervisors	-		
9-1.C Screening & selection of direct service staff	-		
9-2 Equal Opportunity Employment	-	Please provide a narrative description of the organization's current status with regard to EOE, whether under current review, in remediation, or with a history of previous findings. Please also provide copy of any HR protocols or other descriptive documentation specific to how the organization applies EEO laws.	**Interview:** * Program Manager * Human Resources, if applicable **Review:** * Copies of dissemination materials which indicate EOE * Staff Surveys
9-3.A Job Postings, Interviews & references	-	Please submit a narrative describing the program's current process with regards to notification of available positions, utilization of standard interview questions and confirmation of reference checks.	**Interview:** * Program Manager * Human Resources, if applicable **Review:** * Personnel Files
9.3.B **Legally permissible background checks** ***Safety Standard***		Personnel files will be reviewed onsite. If peers will not have access to criminal background checks in the files, a letter authorized by the head of HR can be provided verifying current status. If providing a letter, it must include all current staff, date of hire, and the date the criminal background check was performed and results received. If utilized, also include the date of report was received from the state child abuse registry.	**Interview:** * Program Manager * Human Resources, if applicable **Review:** * Personnel Files
9-4 Staff Retention and Satisfaction	-	Please submit a narrative describing how the program monitors and addresses staff retention and satisfaction. Be sure to include corresponding data report and strategies developed to address any issues, as needed.	**Interview:** * Program Manager * Supervisors * Direct Service Staff **Review:** * Staff & Advisory Surveys

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

Standard 10 Intent: *The overall intent of the standards in this section is to ensure staff receive training specific to their role.* ***HFA Core training*** *is required for all home visitors, assessment workers, supervisors, and program managers within six months of hire. This training must be provided by a nationally certified HFA Core trainer. In addition, there are six orientation training topics required to be received by all staff prior to work with families.*

10-1. Staff (assessment workers, home visitors, supervisors and program managers), receive orientation training (separate from intensive role specific training) prior to direct work with families to familiarize them with the functions of the site. Program managers hired July 1, 2014 or later will receive orientation training within 3 months of hire. Program managers hired prior to July 1, 2014 are grandfathered and not required to document receipt of orientation topics.

Intent: *When staff are hired, they often are sent into the home to work with families prior to receiving role specific* ***HFA Core training*** *and the 6 month and 12 month wraparound trainings. Therefore, it is essential that staff have been oriented to topics that will directly impact their immediate work with families or direct service staff (for supervisors). Typically, these orientation trainings are designed and provided by the site and will reflect the resources, laws and requirements specific to the host organization, local community and/or state. Site administrators ensure that these orientation topics are comprehensive and support the staff to succeed in their roles during this early part of employment. All of these training topics must be covered prior to direct contact with participants and prior to direct supervision of staff.* ***Please note:*** *In the event that staff did not receive these trainings within the required timeframes, for accreditation purposes it is the expectation that all staff will receive the training regardless of the timeframe.* ***Please Note:*** *When a site is newly established, the program manager and/or supervisor may be involved in the writing of policy and procedure, and the development of orientation protocols for staff. These activities, with documented dates relative to each orientation topic can be referenced as completion of orientation for program managers and/or supervisors.*

10-1.A Staff (assessment workers, home visitors, supervisors and program managers) are oriented to their roles as they relate to the site's goals, services, curriculum materials, policy and operating procedures, data collection forms and processes, and philosophy of home visiting/family support prior to direct work with families or supervision of staff.

10-1.A		RATING INDICATORS
3	-	All staff are oriented to their roles as they relate to the site's goals, services, policy and operating procedures, data collection forms and processes, and philosophy of home visiting/family support prior to direct work with families or supervision of staff.
2	-	Past instances were found when staff were not oriented to their roles as they relate to the site's goals, services, curriculum materials, policy and operating procedures, data collection forms and processes, and philosophy of home visiting/family support prior to direct work with families or supervision with staff; however, **recent practice** indicates this is now occurring and all staff have received the orientation training regardless of the timeframe.
1	-	Staff are not oriented to their roles as they relate to the site's goals, services, curriculum materials, policy and operating procedures, date collection forms and processes, and philosophy of home visiting/family support prior to direct work with families or providing supervision to staff.

☺ Tip: An important element of these standards is that the training be received prior to the staff person conducting their job duties independently. If the orientation training includes shadowing, this can be done as a component, and prior to completion of the orientation training.

☺ Tip: Sites should develop a protocol for documenting the date for each staff person for 1st home visit, assessment or supervision as part of the evidence required for this standard

☺ Tip: If the site has made a recent change of practice, precedence should be given to most recently hired staff. Date of change should be included in site narrative.

10-1.B Staff (assessment workers, home visitors, supervisors and program managers) are oriented to the site's relationship with other community resources prior to direct work with families.

10-1.B		RATING INDICATORS
3	-	All staff are oriented to the site's relationship with other community resources (e.g., organizations in the community with which the site has working relationships) prior to direct work with families or supervision of staff.
2	-	Past instances were found when staff were not oriented to the site's relationship with other community resources prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff have received the orientation training regardless of the timeframe.
1	-	Staff are not oriented to the site's relationship with other community resources prior to direct work with families or supervision of staff.

10-1.C Staff (assessment workers, home visitors, supervisors and program managers) are oriented to child abuse and neglect indicators and reporting requirements prior to direct work with families.
Please note: To be accredited, sites must be sure that all staff have been oriented to child abuse and neglect indicators.

10-1.C		RATING INDICATORS
3	-	All staff are oriented to child abuse and neglect indicators and reporting requirements prior to direct work with families or supervision of staff.
2	-	Past instances were found when staff were not oriented to child abuse and neglect indicators and reporting requirements prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff have received the orientation training regardless of the timeframe.
1	-	Staff are not oriented to child abuse and neglect indicators and reporting requirements prior to direct work with families or supervision of staff.
Note:		**This is a Safety Standard**

10-1.D Staff (assessment workers, home visitors, supervisors and program managers) are oriented to issues of confidentiality prior to direct work with families.

10-1.D		RATING INDICATORS
3	-	All staff are oriented to issues of confidentiality prior to direct work with families or supervision of staff.
2	-	Past instances were found when staff were not oriented to confidentiality prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff have received the orientation training regardless of the timeframe.
1	-	Staff are not oriented to issues of confidentiality prior to direct work with families or supervision of staff.

10-1.E Staff (assessment workers, home visitors, supervisors and program managers) are oriented to issues related to boundaries prior to direct work with families.

10-1.E		RATING INDICATORS
3	-	All staff are oriented to issues related to boundaries prior to direct work with families or supervision of staff.
2	-	Past instances were found when staff were not oriented to issues related to boundaries prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff have received the orientation training regardless of the timeframe.
1	-	Staff are not oriented to issues related to boundaries prior to direct work with families or supervision of staff.

10-1.F Staff (assessment workers, home visitors, supervisors and program managers) are oriented to issues related to staff safety prior to direct work with families.

10-1.F		RATING INDICATORS
3	-	All staff are oriented to issues related to staff safety prior to direct work with families or supervision of staff.
2	-	Past instances were found when staff were not oriented to issues related to staff safety prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff have received the orientation training regardless of the timeframe.
1	-	Staff are not oriented to issues related to staff safety prior to direct work with families or supervision of staff.

10-2 Supervisors, assessment workers and home visitors who begin direct service or supervisory work prior to receipt of role-specific **HFA Core training**, must receive "stop-gap" training. Stop-gap training does not need to be conducted by a certified trainer; however it must be conducted by someone who has been intensively trained in the role they are providing stop-gap training for. Stop-gap training does not replace the requirement to attend **HFA Core training**.

Intent: *When staff begin performing in their role prior to the receipt of **HFA Core training**, the site must have policy for the provision of stop-gap training. Stop-gap training is defined as customized role-specific training (often conducted in-house or with a neighboring site) on an as-needed basis to meet an individual's urgent need for skills necessary to perform work, prior to the receipt of HFA Core training. Stop-gap training does not need to be conducted by a certified trainer; however it must be conducted by someone who has been intensively trained in the role. Stop-gap training does not replace the requirement to attend HFA Core training.*

For established sites, all new staff will complete stop-gap training in order to begin their work with families when waiting to attend HFA Core training, unless the site's policy requires that HFA Core Training is received prior to direct service. Stop gap training may be conducted by the site supervisor or program manager and includes:

- *Theoretical background of the role (general background on the importance of the role and principles, or reasons why, the role is critical to the model)*
- *Shadowing of other staff in a similar role*
- *Training on forms and form used by individuals in that role*
- ***Hands-on practice** (with observation and feedback)*
- *Inter-rater reliability related to documentation (home visitor, assessment worker, and/or supervisor)*
- *Use of a strengths-based approach when working with others*

***Please Note:** For brand new sites where there is currently no one on staff who has received HFA Core Training or there is not a neighboring site with which to connect with, the HFA National Office can provide support that allows families to begin receiving services. Please contact your HFA Regional Training Director for more details.*

10-2.A The site has policy and procedures for providing stop-gap training to staff (assessment workers, home visitors and supervisors) when they will begin their work prior to the receipt of HFA Core training to ensure that the worker has adequate understanding and knowledge of their role. The training must include the bulleted elements described in the intent.

10-2.A.		RATING INDICATORS
3	-	No 3 rating indicator for standard 10-2.A.
2	-	The site has policy and procedures for providing stop-gap training to assessment workers, home visitors and supervisors who will begin their work prior to the receipt of HFA Core training. Stop-gap training includes all bulleted elements described in the intent.
1	-	Any of the following: the site does not have policy and procedures for training assessment workers, home visitors and supervisors who will begin their work prior to the receipt of HFA Core training; the policy and procedures does not specify the training include all bulleted elements described in the intent.
NA	-	The site's policy is that all staff will receive HFA Core Training prior to providing direct service or supervision.

10-2.B Assessment workers and home visitors who administer the Parent Survey/Family Stress Checklist (or other HFA approved **assessment tool**) prior to completion of HFA Core Training, and their supervisor, have received stop-gap training to ensure that the worker has adequate understanding and knowledge of how to use the tool appropriately.

10-2.B		RATING INDICATORS
3	-	Staff receive assessment stop-gap training prior to administering the tool that includes all required elements
2	-	Past instances may have occurred when stop-gap training was not received prior to administering the tool and/or that some of the required elements were not included; however, **recent practice** indicates that the program is now ensuring all staff receive this training prior to administering the tool that training includes all elements.
1	-	Any of the following: program staff do not receive stop-gap training prior to administering the tool; or the training does not include all required elements.
NA	-	Staff completed HFA Assessment Core Training prior to administering the **assessment tool**.

☺ Tip: Be sure to include stop-gap training in the training plan and mechanism for tracking as required by 11-1.

10-2.C Home visitors who begin conducting home visits prior to completion of HFA Core Training, and their supervisor, have received stop-gap training to ensure that the worker has adequate understanding and knowledge of his/her role .

10-2.C		RATING INDICATORS
3	-	Staff receive home visitor stop-gap training prior to conducting home visits that includes all required elements.
2	-	Past instances may have occurred when stop-gap training was not received prior to conducting home visits and/or that some of the required elements were not included; however, **recent practice** indicates that the program is now ensuring all staff receive training prior to conducting home visits that includes all required elements.
1	-	Any of the following: program staff do not receive stop-gap training prior to conducting home visits; or the training does not include the required elements.
NA	-	Staff have completed HFA Home Visitor Core Training prior to beginning home visiting work.

☺ Tip: Be sure to include stop-gap training in the training plan and mechanism for tracking as required by 11-1.

10-2.D Supervisors who begin providing supervision prior to completion of HFA Core Training have received stop-gap training to ensure that the supervisor has adequate understanding and knowledge of his/her role.

10-2.D		RATING INDICATORS
3	-	Staff receive supervisor stop-gap training prior to conducting supervisor sessions that includes all required elements
2	-	Past instances may have occurred when training was not received prior to conducting supervision sessions and/or some of the required elements were not included; however, **recent practice** indicates that the program is now ensuring supervisors receive training prior to conducting supervision sessions that includes all of the required elements.
1	-	Any of the following: supervisors do not receive training prior to conducting supervision sessions; or the training does not include all of the required elements.
NA	-	All supervisors have completed HFA Supervisor Core Training prior to beginning their role.

☺ Tip: Be sure to include stop-gap training in the training plan and mechanism for tracking as required by 11-1.

10-3. Staff (program managers, assessment workers, home visitors and supervisors) receive **HFA Core training** within six months of date of hire specific to their role within the home visiting site to help them understand the essential components of their role within the site.

Intent: *Intensive training develops the knowledge and skills necessary to achieve site goals. It prepares staff to assess family needs, assist with parent-child interaction, strengthen family functioning, provide appropriate information, connect families with appropriate resources, and meet the expected standards of service delivery. Furthermore, intensive training allows staff to link theory to practice by developing and implementing practical approaches to real-life situations and to share information and experiences, and to learn from one another.*

Please Note: *Program Managers hired prior to July 1, 2014 will be "grandfathered" and not need to demonstrate evidence of receipt of HFA Core training. However, all Program Managers hired prior to July 1, 2014 are strongly encouraged to attend HFA Core training if they have not already.*

Please Note*: Supervisors hired after July 1, 2014 are required to attend both home visitor and assessment staff training to further ground them in the model, and to ensure they are able to effectively support staff to implement assessment and home visiting skills learned in training. Supervisors hired prior to July 1, 2014 must, at minimum, attend HFA Core Training for all roles they directly supervise.*

Program managers hired after July 1, 2014 must attend all HFA Core trainings.

Please note: *In the event that staff did not receive HFA Core training within the required timeframes, for accreditation purposes it is the expectation that all staff will receive the training regardless of the timeframe.*

When staff either move from one role to another (i.e., home visitor becomes assessment staff), or at some point are cross-trained (i.e., start as assessment staff and later serve as assessment and home visit staff), it is the expectation that additional core training to the new or added role will occur within 6 months from date of position change.

10-3.A All staff conducting assessments and all supervisors and program managers receive intensive ***HFA Core Assessment training***, by a certified trainer who has been trained to train others, within six months of date of hire to understand the essential components of his/her role as an assessment worker.

10-3.A		RATING INDICATORS
3	-	All staff conducting assessments, and all supervisors and program managers receive intensive role specific assessment training, by a certified trainer, on the essential components of family assessment within six months of the date of hire or position change.
2	-	Past instances were found when staff and/or supervisors and program managers did not receive intensive role specific assessment training, by a certified trainer, within six months after hire or position change; however, **recent practice** indicates this is now occurring and all assessment staff have received role specific training regardless of the timeframe.
1	-	Any of the following: staff conducting assessments and/or supervisors and program managers, do not receive intensive role specific training within specified time frame; or training was not conducted by a certified trainer.
Note:		**This is a Sentinel Standard**

☺ Tip: Post-training inter-rater reliability activities (as discussed during core training) are very important to knowledge and skill acquisition, and supervisors are strongly encouraged to have staff complete these.

10-3.B Home visitors and their supervisor and program manager have received intensive ***HFA Core*** Integrated Strategies for ***Home Visitor training***, by a certified trainer who has been trained to train others, within six months of date of hire to understand the essential components of the home visitor role. **Please Note:** Supervisors who supervise a larger centralized intake system that is responsible for completing the Parent Survey, or part of a larger site supervising a separate assessment "unit" and therefore without significant involvement in the home visiting component of

services are exempt from the requirement that all supervisors receive both tracks of HFA Core training. Supervisors with these larger assessment units are required to complete Parent Survey and recommended but not required to complete Integrated Strategies).

10-3.B		RATING INDICATORS
3	-	All home visitors and their supervisor and program manager receive intensive role specific home visitor training, by a certified trainer, on the essential components of home visiting within six months of the date of hire or position change.
2	-	Past instances were found when staff and/or supervisors and program managers did not receive intensive role specific home visitor training, by a certified trainer, within six months after hire or position change; however, **recent practice** indicates this is now occurring, and all staff have received role specific training regardless of the timeframe.
1	-	Any of the following: home visitors and/or their supervisor and program manager do not receive such training within specified time frame; or the training was not conducted by a certified trainer.
Note:		**This is a Sentinel Standard**

☺ Tip: When staff have been cross-trained, but have not performed the duties of this additional role within one year of original training, it is recommended that they receive comprehensive refresher training or retraining within 6 months of assuming these duties, should that occur. This refresher training can be conducted by a program manager or supervisor (that have completed the training) or certified trainer.

☺ Tip: Post-training certification activities (as discussed during core training) are very important to knowledge and skill acquisition, and supervisors are strongly encouraged to have staff complete these for additional certification.

10-3.C Supervisors and program managers have received intensive ***HFA Core Supervisory training***, by a certified trainer who has been trained to train others, within six months of date of hire to understand the essential components of his/her role as a supervisor, as well as the role of family assessment staff and home visitors.

10-3.C		RATING INDICATORS
3	-	All supervisors and program managers receive intensive role specific supervisory training, by a certified trainer, on the essential components of supervision, within six months of the date of hire or position change.
2	-	Past instances were found when supervisors and program managers did not receive intensive role specific supervisory training, by a certified trainer, within six months after hire or position change; however, **recent practice** indicates this is now occurring and all supervisors and program managers have now received role specific training regardless of the timeframe.
1	-	Any of the following: supervisors and /program managers do not receive training specific to their role within the specified time frame; training was not conducted by a certified trainer.
Note:		**This is a Sentinel Standard**

10. Service providers receive intensive training specific to their role to understand the essential components of family assessment, and home visiting and supervision			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
10-1.A-F Orientation Training ***10-1.C - Safety Standard***		Please submit documentation indicating the date each staff person (program manager, home visitors, assessment workers, supervisors) completed each of the orientation topics (10-1.A-F) that includes the date of hire and the date staff person began providing direct service.	**Interviews:** * As needed **Review:** ***** Training documentation as needed * Staff Surveys
10-2.A Policy for Stop-Gap Training	Providing stop-gap training to staff (assessment, home visitors and supervisors) when they will begin their work prior to receipt of HFA Core Training in accordance with the standard	Submit Policy	
10-2.B-D Stop-Gap provided when needed		Submit documentation indicating the date each staff person completed Stop-Gap training (if used) including the date of hire and the date each training topic completed, as well as the date of hire for each staff (program managers, home visitors, assessment workers, supervisors).	
10-3.A **HFA Core Assessment Training** ***Sentinel Standard***		Submit documentation indicating the date each staff person completed Core training (program managers, home visitors, assessment workers, supervisors) that includes the date of hire or submit training certificates that indicate the date training was completed, as well as the date of hire for each staff.	
10-3.B **HFA Core Home Visitor Training** ***Sentinel Standard***			
10-3.C **HFA Core Supervisor Training** ***Sentinel Standard***			

11. Service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers receive basic training in areas such as cultural competency, reporting child abuse, determining the safety of the home, managing crisis situations, responding to mental health, substance abuse, and/or domestic violence issues, drug-exposed infants, and services in their community.

Standard 11 Intent: *The overall intent of the standards in this section is to ensure staff receive the training support and have the skill set necessary to fulfill their job functions and achieve the site's goals with families. Training is geared to the unique aspects of services and is* ***culturally sensitive****, taking into account each staff member's skills and needs. Training can be received through a variety of methods including, but not limited to the following: lecture or interactive presentations by individuals with particular expertise in an area, workshops, college coursework, multi-disciplinary clinical consultations, training presentations by staff members, and self-study with supervisory follow-up.*

11-1. The site has a comprehensive training plan/policy that assures access and ongoing tracking and monitoring of required trainings in a timely manner for all staff (home visitors, assessment workers, supervisors and program managers) that includes:

- orientation (10-1.A-F)
- stop-gap training (10-2.A-D)
- intensive role specific (HFA Core) training (10-3.A-C)
- additional training within 3-months of hire (11-2.A-C)
- additional training within 6-months of hire (11-3.A-D)
- additional training within 12-months of hire (11-4.A-E)
- on-going training topics (11-5.A-D)
- cultural sensitivity (5-3)
- developmental screens (6-6.C)
- depression screens (7-5.D)
- any other evaluation tools or screening/assessment instruments used by the site

Please note: All interns and volunteers who perform the same duties as assessment workers, home visitors and supervisors receive the same type of training as paid staff.

Standard 11-1 Intent: *The training plan/policy addresses all topics and subtopics included in standard 10, as well as training required related to the administration of other site tools that are used with families (e.g., screening/****assessment tool****s, developmental screen, etc.) and annual cultural sensitivity required for standard 5-3. The plan guides the site toward achieving the training in a timely manner (by the specified timeframes) and clearly identifies how the training is provided and by whom (i.e., site manager/supervisor, community agency, HFA online training modules, video, reading materials, etc.), topics covered by each session, and the sites processes for supervisory follow-up, etc. Additionally, the site addresses how they ensure that the training provided is of high quality. Training logs include supervisory verification that the training was received. Each of the sub-topics in 11-2, 11-3, 11-4, and 11-5 needs to be designated and clearly identified.* HFA Required Training Log

11-1.		RATING INDICATORS
3	-	The site has a comprehensive training plan/policy, as well as a tracking and monitoring system that ensures timely access of training for all staff and monitoring is occurring.
2	-	The site recently developed a comprehensive training plan/policy and tracking system and recently began implementation of its tracking and monitoring system to ensure timely access to training.
1	-	Any of the following: there is no training plan/policy; the training plan/policy is not comprehensive; the plan in place and/or tracking and monitoring is not occurring, or monitoring system is not sufficient to ensure timely access to training.

☺ Tip: The tracking form should include date of hire, date of 1st direct service contact provided (home visit, assessment, supervision etc.).
☺ Tip: Sites should be sure to track training even when training was received outside of the required timeframe.
☺ Tip: It is important for sites to demonstrate how they have implemented new procedures or practices that ensure newly hired staff receive training in a timely manner.

11-2. Staff (assessment workers, home visitors, supervisors and program managers) receive training on a variety of topics necessary for effectively working with families and children within three months of hire.

Intent 11-2, 11-3, and 11-4:
Quality is determined by training that is specific and relevant to the field of home visiting and can translate to the work of HFA staff. It is intended for staff to receive training in all of the topics outlined within the rating indicators. It is a site's responsibility to establish competency of staff, and determine their need for additional training beyond the required topics outlined in these standards. The intent of training is to provide staff with the knowledge and gain the necessary skills necessary to assess issues and concerns with families and to facilitate the development of healthy families.

Several formats are acceptable to accomplish training in each of the specified areas below and can include: attendance at trainings/workshops/in-services, on-line training, formal education, certification, licensure, and competency-based testing (a tool, often paper and pencil or measured through observation of skills and abilities, which tests an individual's knowledge level on a given topic). Professional experience and previous formal education can qualify as training when coupled with competency based testing and/or supervisory follow-up to assure successful knowledge acquisition and understanding of concepts and/or materials. Formal education, previous training and previous experience must have occurred within three years prior to hire in the Healthy Families site and directly apply to the topics identified in order to be counted. Supervisors must determine how experience or education received prior to working with the site is appropriate to the staff person's work as a family assessment worker, home visitor, or supervisor and/or if additional training in this topic might be beneficial.
Please Note:
1. *Supervisors, home visitors and assessment staff hired prior to July 1, 2014 must receive at least a* ***majority*** *of the topics listed in the 11-2, 11-3 and 11-4 standards.* ***All*** *staff, including program managers, hired on or following July 1, 2014, must receive* ***all*** *of the training topics listed in the 11-2, 11-3 and 11-4 standards. Program Managers hired prior to July 1, 2014 are grandfathered and not required to show evidence that wrap-around training topics were received. It is recommended they obtain and document this training, even if received outside the required timeframes.*
2. *All staff at affiliated HFA sites may use the* ***HFA Learning Center (TLC)*** *to obtain all of the 11-2, 11-3 and 11-4 training topics online. Each online course is accompanied by a post-training assessment which must be passed successfully in order to fulfill the training requirement for the standard. Reports printed from the TLC demonstrating that all staff successfully completed each module will satisfy all evidence required for these*

standards. If not using the TLC, staff must maintain copies of course completion records and/or training agendas, certifications, etc. to demonstrate adherence.
3. *Core (role specific) training cannot be used to satisfy the 3, 6 and 12 month training requirements.*
4. *The purpose for specifying in the rating indicators a five year timeframe is to allow sites that have been in existence more than five years to demonstrate their current capacity to achieve a 3 rating, rather than being hindered by practice that may have occurred prior to its last accreditation site visit.*

☺ Tips: (for 11-2, 11-3 and 11-4):

- Sites should have mechanisms for ensuring staff training needs are being met and the trainings are of high quality.
- When circumstances prevent staff from attending a required training in a timely way it is recommended that sites document the circumstances that led to staff missing the training, so that peers can take this information into consideration when assigning a rating.
- When staff complete the TLC modules very quickly after hire, they are encouraged to revisit the TLC as a refresher at a later point once they begin to increase their experiences working with families. This will assist with the transfer of knowledge to practice, as the skills learned from a lot of training done very early may not be readily applied if they have not yet begun serving families.

11-2.A Staff have (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Infant Care within three months of the date of hire.

11-2.A		RATING INDICATORS
3-	-	All staff hired within the past five years received training on Infant Care within three months of hire. Staff hired more than five years ago have received the training but may have been later than three months after hire. Topics include: - Sleeping - Feeding/Breastfeeding - Physical care of the baby - Crying and comforting the baby
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Infant Care within three months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Infant Care topics within three months of hire; and/or there are site staff who have not received training on all the content areas identified above regardless of timeframe.

11-2.B Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Child Health and Safety within three months of the date of hire.

11-2.B		RATING INDICATORS
3	-	All staff hired within the past five years received training on all topic areas of Child Health and Safety within three months of hire. Staff hired more than five years ago have received the training but may have been later than three months after hire. Topics include: - Home safety (e.g., fire, child supervision, water temperature, pools, falls, etc.) - Shaken baby syndrome - SIDS - Seeking medical care - Well-child visits/immunizations - Seeking appropriate child care - Car seat safety - Failure to thrive
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Child Health and Safety within three months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Child Health and Safety topics within three months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of timeframe.

11-2.C Staff (assessment workers, home visitors, supervisors and program managers) have received training on all topic areas of Maternal and Family Health within three months of the date of hire.

11-2.C		RATING INDICATORS
3	-	All staff hired within the past five years received training on Maternal and Family Health within three months of hire. Staff hired more than five years ago have received the training but may have been later than three months after hire. Topics include: - Family Planning - Nutrition - Pre-natal/Post-natal healthcare - Pre-natal/Post-Partum Depression - Warning signs for when to call the doctor
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Maternal and Family Health within three months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Maternal and Family Health topics within three months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of timeframe.

11-3. Staff (assessment workers, home visitors, supervisors and program managers) receive training on a variety of topics necessary for effectively working with families and children within six-months of hire.

11-3.A Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Infant and Child Development within six months of the date of hire.

11-3.A		RATING INDICATORS
3	-	All staff hired within the past five years received training on Infant and Child Development within six months of hire. Staff hired more than five years ago have received the training but may have been later than six months after hire. Topics include: - Language and literacy development - Physical and emotional development - Identifying developmental delays - Brain development
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Infant and Child Development within six months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Child Development topics within six months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of timeframe.

11-3.B Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Supporting the Parent-Child Relationship within six months of the date of hire.

11-3.B		RATING INDICATORS
3	-	All staff hired within the past five years received training on Supporting the Parent-Child Relationship within six months of hire. Staff hired more than five years ago have received the training but may have been later than six months after hire. Topics include: - Supporting attachment - Positive parenting strategies - Discipline - Parent-Child interactions - Observing parent-child interactions - Strategies for working with difficult relationships
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Supporting the Parent-Child Relationship within six months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Supporting the Parent-Child Relationship topics within six months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of

timeframe.

11-3.C Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Staff Related Issues within six months of the date of hire.

11-3.C		RATING INDICATORS
3	-	All staff hired within the past five years received training on Staff Related Issues within six months of hire. Staff hired more than five years ago have received the training but may have been later than six months after hire. Topics include: - Stress and time management - Burnout prevention - Personal safety of staff - Ethics - Crisis intervention - Emergency protocols
2	-	Past instances were found when staff hired with the past five years did not receive training on all of the topics related to Staff Related Issues within six months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Staff Related Issues topics within six months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of timeframe.

11-3.D Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Mental Health within six months of the date of hire.

11-3.D		RATING INDICATORS
3	-	All staff hired within the past five years received training on Mental Health within six months of hire. Staff hired more than five years ago have received the training but may have been later than six months after hire. Topics include: - Promotion of positive mental health - Behavioral signs of mental health issues - Depression - Strategies for working with families with mental health issues - Referral resources for mental health
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Mental Health within six months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Mental Health topics within six months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of timeframe.

11-4. Staff (assessment workers, home visitors, supervisors and program managers) received training on a variety of topics necessary for effectively working with families and children within twelve-months of hire.

11-4.A Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Child Abuse and Neglect within twelve months of the date of hire.

11-4.A		RATING INDICATORS
3	-	All staff hired within the past five years received training on Child Abuse and Neglect within twelve months of hire. Staff hired more than five years ago have received the training but may have been later than twelve months after hire. Topics include: - Etiology of child abuse and neglect - Working with survivors of abuse
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Child Abuse and Neglect within twelve months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Child Abuse and Neglect topics within twelve months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of timeframe.

11-4.B Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Family Violence within twelve months of the date of hire.

11-4.B		RATING INDICATORS
3	-	All staff hired within the past five years received training on Family Violence within twelve months of hire. Staff hired more than five years ago have received the training but may have been later than twelve months after hire. Topics include: - Indicators of family violence - Dynamics of family violence - Intervention protocols - Strategies for working with families with family violence issues - Effects on children - Referral resources for family violence
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Family Violence within twelve months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Family Violence topics within twelve months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of timeframe.

11-4.C Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Substance Abuse within twelve months of the date of hire.

11-4.C		RATING INDICATORS
3	-	All staff hired within the past five years received training on Substance Abuse within twelve months of hire. Staff hired more than five years ago have received the training but may have been later than twelve months after hire. Topics include: - Etiology of substance abuse - Culture of drug use - Strategies for working with families with substance abuse issues - Smoking cessation - Alcohol use/abuse - Fetal Alcohol Spectrum Disorders - Street drugs - Referral resources for substance abuse
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Substance Abuse within twelve months of hire; with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Substance Abuse topics within twelve months of hire; and/or there are site staff have who not received training on all of the content areas identified above regardless of timeframe.

11-4.D Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of Family Issues within twelve months of the date of hire.

11-4.D		RATING INDICATORS
3	-	All staff hired within the past five years received training on Family Issues within twelve months of hire. Staff hired more than five years ago have received the training but may have been later than twelve months after hire. Topics include: - Life skills management - Engaging fathers - Multi-generational families - Teen parents - Relationships - HIV and AIDS
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Family Issues within twelve months of hire; however with the most recent hires, practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Family Issues topics within 12 months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of timeframe.

11-4.E Staff (assessment workers, home visitors, supervisors and program managers) received training on all topic areas of the Role of Culture in Parenting within twelve months of the date of hire.

11-4.E		RATING INDICATORS
3	-	All staff hired within the past five years have received training on the Role of Culture in Parenting within twelve months of hire. Staff hired more than five years ago have received the training but may have been later than twelve months after hire. Topics include: - Working with diverse cultures/populations (age, religion, gender, sexuality, ethnicity, poverty, dads, teens, gangs, disabled populations, etc.) - Culture of poverty - Values clarification
2	-	Past instances were found when staff hired within the past five years did not receive training on all of the topics related to Role of Culture in Parenting within twelve months of hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training on all topics regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Role of Culture topics within twelve months of hire; and/or there are site staff who have not received training on all of the content areas identified above regardless of timeframe.

☺ **TIPS FOR 11-2, 11-3, and 11-4 STANDARDS ARE LOCATED WITH STANDARD 11-2**

11-5 The site ensures that assessment staff, home visitors, supervisors and program managers receive **ongoing training** which takes into account the individual's knowledge and skill base as well receiving prenatal training, all topic areas of the Family Goal Plan process and annual child abuse and neglect training.

11-5.A The site ensures that assessment staff, home visitors, supervisors and program managers receive ***ongoing training*** which takes into account the individual's knowledge and skill base. **Please Note:** Staff who have worked for the site for less than 12 months are not required to receive ongoing training as they may have only had opportunity to attend the required training outlined in standards 10-1, 10-2, 11-2, 11-3, and 11-4.

Intent: *The worker and supervisor are to identify individual training needs, and determine what additional training topics would be most beneficial in enhancing job performance. This determination would be based upon worker knowledge, skill base and interest.*

11-5.A		RATING INDICATORS
3	-	The site ensures that staff receive ongoing training, beyond the trainings identified in the 10-1, 10-2, 11-2, 11-3 and 11-4 standards. Evidence indicates that staff are offered and participate in ongoing training.
2	-	Past instances were found when staff did not receive ongoing training, beyond the trainings identified in the 10-1, 10-2, 11-2, 11-3 and 11-4 standards; however, **recent practice** indicates this is now occurring.
1	-	The site does not ensure staff receive ongoing training or staff does not participate in ongoing training opportunities.

11-5.B Staff (assessment workers, home visitors, supervisors and program managers) receive Prenatal specific training within six months of hire when the site serves families prenatally. HFA Prenatal training webinar and Pre-Labor Conversations, and Prenatal Home Visiting Resources

Intent: *The site ensures that staff receive Prenatal Training when the site is serving prenatal families. The prenatal period affords sites the opportunity to:*

- *Improve pregnancy and birth outcomes*
- *Establish the home visitor-parent relationship*
- *Identify and address challenges earlier*
- *Promote reflective function*
- *Promote the parent-child relationship*

11-5.B		RATING INDICATORS
3	-	All staff received Prenatal Training within six months of hire when the site is serving families prenatally. Topics include: - Fetal growth & development during each trimester - Warning signs: when to call the doctor - Activities to promote the parenting role, and the parent-child relationship during pregnancy - Preparing for the baby - Promoting parental awareness of what the baby is experiencing with a connection to what the parent is doing (reflection)
2	-	Past instances were found when staff received Prenatal Training later than six months after hire; however with the most recent hire(s), practice indicates this is now occurring; and all other staff have received the training regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Prenatal topics within six months of hire; and/or there are site staff who have not received training on all of the prenatal content areas identified above regardless of the timeframe.
NA	-	The site does not serve families prenatally.

11-5.C Home visiting staff and their supervisor and program manager receive training on all topic areas of the Family Goal Plan process within twelve months of hire. HFA Family Goal Plan webinar and Handout Packet

Intent: *The purpose of the **Family Goal Plan** is to amplify parents' problem solving skills, support their ability to develop and implement options to improve their situation, and celebrate with them their successes in achieving goals and objectives. The Family Goal Plan process sets the framework for home visitors to:*

- *Offer the concept that change can happen and that the family can have an impact creating their future*
- *Help the family identify what they want to accomplish and the mechanism(s) by which the home visitor can assist*
- *Develop opportunities for the family to experience success*
- *Assist the family to identify and acknowledge their strengths*

- *Discuss with the family issues that impact healthy parenting (e.g., issues identified in the Family Stress Checklist/Parent Survey, healthy lifestyle issues, and any other issues identified from other tools used by the program) in an open, honest way as well as design goals around child development and parent-child interaction*
- *Develop a plan with families which ensure they are getting what they need from program services*
- *Work together with the family to develop goals and break those goals into meaningful steps to ensure success for each family. This includes a clear conversation and partnering between the home visitor and parent that supports growth in families*
- *Celebrate success with the family*

11-5.C		RATING INDICATORS
3	-	Home visitors, their supervisors and program manager receive training on all the topics in the Family Goal Plan process within twelve months of hire. Topics include: - Purpose and importance of the Family Goal Plan process in HFA services - Working with families to identify strengths and needs - Supporting the family's role in setting and achieving meaningful goals that assist families in taking charge of their lives - Development of Family Goal Plans based upon the home visitor's knowledge about the family, as well as tools completed with the family. - Practice writing Family Goal Plans in ways that help families create measurable goals
2	-	Past instances were found when staff received training on the Family Goal Plan later than twelve months after hire; however, **recent practice** indicates this is now occurring and all staff received the training on the topics listed in the 3 rating regardless of the timeframe.
1	-	The site's most recent hire(s) have not received all Family Goal Plan topics within twelve months of hire; and/or there are site staff who have not received training on all of the Family Goal Plan topics identified above regardless of the timeframe.

11-5.D All staff receive training annually related to child abuse and neglect in order to stay updated on current child welfare policies, practices, and trends in their community. **Please Note:** During the first year of hire, standard 11-4.A. (Child Abuse and Neglect), may be used to satisfy this standard.

Intent: *Self-study training applies for this standard with appropriate documentation (e.g., reading manuals or literature, watching videos, listening to tapes, etc.), and/or professional experience when face-to-face training is not available.*

11-5.D		RATING INDICATORS
3	-	All staff receive annual training related to child abuse and neglect that includes updates on current child welfare policies, practices, and trends in the community.
2	-	Past instances were found when staff did not receive annual training related to child abuse and neglect that includes updates on current child welfare policies, practices, and trends in the community, however, **recent practice** indicates this is now occurring and all staff received the training regardless of the timeframe.
1	-	All staff have not received annual training on all of the content areas identified

above.

11. Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers should receive basic training in areas such as cultural competency, reporting child abuse, determining safety in the home, managing crisis situations, responding to mental health, substance abuse, and/or domestic violence issues, drug-exposed infants, and services in their community			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
11-1 Training Plan/Policy	Training provided to staff, and the tracking and monitoring of training.	Please submit a copy of the program's training plan/policy. It is does not include how trainings are tracked and monitored and how the site ensures staff receive training within the required timeframes, include additional narrative to address these items. Include samples of any forms used to document and monitor training received.	**Interviews** as needed **Review** Training documentation as needed * Staff Surveys
11-2.A-C Three month wraparound training		Please submit: a list of all current staff and date of hire, training logs documenting the training current staff have received with regards to each of the topics listed in the wraparound training standards which includes the date received, the title of training and topics covered/achieved by the training. For staff utilizing formal education, previous training, and/or previous professional experience to satisfy the 3, 6 & 12 month training requirements please include a narrative indicating any competency based testing and/or supervisory follow-up to assure successful knowledge acquisition and understanding of concepts and/or materials provided to assure knowledge of the topics was satisfied. **Please note:** Sites may submit the HFA Training Log or database report.	
11-3.A-D Six month wraparound training			
11-4.A-E Twelve month wraparound training			
11-5.A Ongoing Training		Please submit a list of all staff and the ongoing training(s) completed (this can be in the form of a training log or database printout).	
11-5.B Prenatal Training within six months		If site serves families prenatally, submit list of all direct service staff (assessment workers, home visitors and supervisors) with date of hire and date staff received prenatal training.	
11-5.C Family Goal Plan/IFSP Training within 12 months		Please submit training documentation for all home visitors and supervisors with date of hire and date staff received training related to the IFSP/Goal Planning process.	
11-5.D Annual Child Abuse and Neglect Training		Please submit documentation indicating the date each staff person (home visitors, assessment workers, supervisors and program managers) completed annual child abuse and neglect training.	

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

Standard 12 Intent: *The overall intent of the standards in this section is to ensure direct service staff and supervisors collaborate effectively to facilitate healthy growth in families through the professional relationships staff have with families as well as reduce burnout and increase staff retention. A supervisor's primary role is to create an environment that encourages staff to grow and change, provide motivation and support, maintain ideals, standards, quality assurance and safety, and facilitate open, clear communication. To accomplish this, supervision is provided with protected time each week, and utilizes reflection that enables staff to increase self-awareness, identify and build on parental competencies, become more effective in their interactions with families and become more familiar with their own feelings and values and how these impact their work.*

There are three components of supervision required by supervisors within HFA programs; administrative, clinical, and reflective. Administrative supervision relates to the oversight of program policies, rules and procedures, and adherence to the Best Practice Standards. Examples of administrative supervision are:

- *Hiring*
- *Training, educating*
- *Overseeing paperwork*
- *Writing reports*
- *Monitoring productivity, and*
- *Explaining rules and policies*

Clinical supervision is focused on the family, collaborative in nature, and revolves around developing intervention or home visit activities based upon the needs of the families, the challenges families face, and builds upon family competencies. Examples of clinical supervision are:

- *Reviewing the staff members work with families*
- *Discussing the potential actions and home visit strategies used by staff*
- *Developing a plan of action*
- *Reviewing and evaluating progress, and*
- *Providing guidance and coaching*
- *Anticipating and responding to challenging situations*

Reflective supervision focuses primarily on the parallel process involving the relationships between the staff member and the parent, the parent and the baby, and the supervisor and the staff member. It includes how the interactions within each of these relationships may be impacting the work and explores the reasons behind the strong feelings that relationships elicit. Reflection also requires attending to the emotional content and how these reactions may affect the process. Examples of reflective supervision are:

- *Asking questions to encourage details about the emerging relationships between the infant, parent and staff member*
- *Listening and holding the space for/allowing inward reflection*
- *Remaining emotionally present*
- *Observing for emotional reactions, energy shifts*
- *Encouraging the staff member to explore thoughts and feelings the he/she has about the work*
- *Maintaining a balance of attention on the infant, parent, and staff member*
- *Maintain a neutral stance*

*Please note: All three components of supervision are often **integrated** and part of the same conversation on a particular topic. For example, some questions from each of the three components of supervision apply to*

*the development of family goal plans: **Administrative**: Are the family goal plans developed and reviewed during home visits? **Clinical**: How is the home visitor facilitating the family goal plan process? What tools are used (**motivational interviewing**, solution-focused questions)? How are goals broken down into achievable steps? **Reflective**: How does it impact the home visitor when families are not achieving their goals? How does the home visitor feel when families choose a goal that is not meaningful to the home visitor?*

12-1. The site ensures that direct service staff receive weekly and ongoing supervision.

Intent: *Providing weekly scheduled supervision helps direct service staff maintain perspective, evaluate their performance, encourage personal and professional development, learn new strategies to effectively work with families, and ultimately enhance the quality of services families receive. Additionally, supervision promotes both staff and site accountability and reduces staff burnout and turnover by providing much needed support. Supervisors must ensure they have adequate time to spend with each staff person, therefore the frequency and duration of supervision is monitored closely. Additionally, supervisors need to have a limited number of staff to supervisor to ensure they can fulfill the necessary activities in 12-2.*

Policy and procedures clearly define the frequency (weekly) and duration requirements for individual supervision of each full-time and part-time direct service staff. For home visiting staff, supervision is not to be split into more than two sessions per week. For family assessment staff, supervision may be split into more frequent sessions.

With regard to duration: For all full-time (1.0 FTE) and part-time staff that are .75 FTE to .99 FTE, the requirements are 1.5 to 2 hours weekly. For part-time staff that are .25 FTE to .74 FTE, the requirements are 1 hour weekly. For staff or contractors that work less than .25 FTE, supervision may be provided according to occurrence of services. For example:

1) Assessment staff discuss all of the assessments that occur in a given week; however this may not take the full hour of discussion.
2) Home visiting staff may only have three families and supervisory discussions may be utilized based on the level of service the families are on.
3) Supervisors make sure that the requirements of the 12-2 standards are being carried out throughout the shortened sessions.

For full-time staff who serve in more than one role (i.e., position is split with assessment time at 30% and home visitor time at 70%) 1.5 hours per week is the expectation to meet the supervision requirements of both roles and documentation clearly indicates both roles are being addressed.

12-1.A The site's policy states that weekly individual supervision is provided to all direct service staff (e.g., assessment and home visiting staff) and volunteers and interns (performing the same function).

Intent: *All full-time direct service staff (assessment and home visit) receive weekly individual supervision for 1.5 to 2 hours and part-time staff receive at least 1 to 1.5 hours as described above in the 12-1 intent. Supervision sessions must be received <u>individually</u> each week. **Please note**: For sites that use **reflective consultation groups**, one session per month may apply towards the weekly supervision rates, when done in accordance with the expectations outlined in standard 12-1.C.*

12-1.A		RATING INDICATORS
3	-	The site policy and procedures specify all .75-1.0 FTE direct service staff receive a minimum of 2 hours per week of scheduled individual supervision and part-time staff less than .75 FTE receive a prorated amount of supervision as defined above, and that reflective supervision groups (if used) count for 1 session per month if conducted by a qualified individual and only for direct service staff that have been in their role for at least 12 months and who have demonstrated proficiency in their role (as determined by the program and based on supervisor judgment).
2	-	The site policy and procedures specifies all .75-1.0 FTE direct service staff receive a minimum of 1 ½ hours per week of scheduled individual-supervision and part-time staff less than .75 FTE receive a prorated amount of supervision as defined above, and that reflective supervision groups (if used) counts for 1 session per month if conducted by a qualified individual and only for direct service staff that have been in their role for at least 12 months and who have demonstrated proficiency in their role (as determined by the program and based on supervisor judgment).
1	-	There is no policy; or the policy does not meet the requirements of the 2 rating.

☺ Tip: It is critical that staff have access to supervisors at all times when they are in the field. Sites must have a plan in place to cover supervision in the case of supervisor absences.

12-1.B The site ensures that weekly individual supervision is received by all direct service staff and volunteers and interns (performing the same function). 12-1.B Tracking Form

Intent: The critical importance of Supervision is emphasized in the HFA model, and particularly the role it plays in supporting the overall performance and functioning of individual staff and the program as a whole. It is understood that home visitors bring various experiences and educational backgrounds to their work, however all staff have in common the need for regular supervision to obtain guidance and support in regard to the complex challenges many families present and the impact the work has on the worker. It is therefore required that sites track and monitor in an ongoing way the receipt of weekly supervision for each staff (training or other program activities are not included in the supervisory rates). Please Note: When programs exist in rural or frontier areas, and the home visitors work in remote or off-site locations from the "main office" where the supervisor is located, the use of Skype or the telephone can suffice for weekly supervision, however at least one in-person monthly supervision is recommended.

12-1.B		RATING INDICATORS
3	-	All direct service staff receive 90% of required weekly individual supervision for a minimum of 1.5 - 2 hours. (Supervisory sessions for home visiting staff are not split into more than two scheduled meetings and less than .75 FTE staff receive a prorated amount of supervision as defined in the intent above).
2	-	All direct service staff receive **75% of** required weekly individual supervision for a minimum of 1.5 hours – 2 hours. (Supervisory sessions for home visiting staff are not split into more than two scheduled meetings and less than .75 FTE staff receive a prorated amount of supervision as defined in the intent above).
1	-	There is insufficient evidence to indicate that the site is following the acceptable guidelines as outlined in 2 rating above.
Note:		**This is a Sentinel Standard**

☺ Tip: Frequency and duration of supervisory sessions are most effective when viewed over time versus monthly to account for times when staff are in training, on vacation or for seasonal fluctuations in service delivery. Semi-annual and annual supervision rate reviews are recommended. There should always be an "acting supervisor" when staff are in the field for support and consultation. When supervisors are on leave for periods over two weeks in length, a "back-up" supervisor should be appointed or a contingency plan developed to insure the individual weekly sessions are conducted. Documentation of frequency and duration of supervision sessions also includes the reasons for cancellations and/or rescheduling.

☺ Tip: Although the individual supervisory sessions for assessment staff may be divided into more frequent sessions, supervisors are still held accountable for achieving the 12-2 standards. Assessment supervisors are encouraged to insure that at least one of the weekly supervisory sessions enables them to provide their staff with skill development and professional support.

☺ Tip**:** Sites are encouraged to use the HFA spreadsheet for 12-1.B.

☺ Tip: Volunteers and/or interns who perform direct services independently (in the role of family assessment and/or family support) must receive the same amount (frequency and duration) of supervision as required for employed staff and as outlined in the 12-1 intent. Any volunteers or interns performing in a direct service role must also receive all required trainings (see standard 10 and 11). Note: Volunteers and/or interns who perform other supportive functions to assist direct service staff (e.g. assist with parent groups, data entry, accompanying a home visitor to assist with home visit activities, etc.) are exempt from the supervision and training requirements of the standards.

12-1.C When the site provides **reflective consultation groups**, they must be implemented with the same degree of preparation, and documentation (must include who attended and content topics covered), and must be facilitated by a qualified individual.

Intent: *Typically, these sessions last two or more hours.* ***Reflective consultation groups*** *include but are not limited to:*

- *Case presentation,*
- *Focus on holding the space that encourages self-reflection and self-regulation, both physically and emotionally,*
- *Observation of the staff member's internal responses to the work including parallels between what might be going on for the worker as well as how that might impact the work,*

- *Focus on the parallel process; expanding what might be going on for the staff to what might the family and the baby might be experiencing,*
- *Considering what the supervisor might do differently for the next supervision, developing a plan with the home visitor for work going forward,*
- *Opportunities for participants in the group to reflect on the group session they just observed.*

Supervision sessions must be received individually each week for a minimum of 12 months after initial hire for all staff. Subsequent to that time, and with demonstrated staff proficiency, one reflective consultation group per month may substitute for one individual weekly supervisory session.

***Please Note:** Staff not yet with the site for at least 12 months or longer would still be encouraged to attend and benefit from group supervision (if held), however attendance cannot be counted toward the required weekly individual sessions expected of staff during that time period.*

***Please note:** that if group reflective consultation is done, there are specific qualifications that the reflective practice consultant must have (IMH Endorsement at Level III or Level IV, and/or Master's degree in counseling or related field, with two years post education, specialized work experience providing **culturally sensitive**, relationship-focused **infant mental health** services with infants and toddlers and their families, etc.). This person may be sub-contracted by the agency. If reflective consultation is conducted by a contractor, the supervisor attends.*

12-1.C		RATING INDICATORS
3	-	The site provides **reflective consultation groups** that include case presentation, and is conducted according to the guidelines listed in the intent. Group reflective consultation is counted for no more than one session per month only for staff who have demonstrated **proficiency in their role** and have been with the site for 12 months. Group reflective consultation is provided by a qualified individual.
2	-	Past instances occurred when the site provided group reflective consultation that was not conducted according to the guidelines listed in the intent; however **recent practice** indicates this is now occurring.
1	-	The site does not provide group reflective consultation according to the guidelines listed in the intent; and/or is not conducted by a qualified individual; and/or group reflective consultation is counted for more than one weekly individual supervision rate per month.
NA	-	Site does not use **reflective consultation groups**.

12-1.D The ratio of supervisors to direct service staff and volunteers and interns (performing the same function) is sufficient to allow regular, ongoing, and effective supervision to occur.

***Intent:** It is critical that supervisors have the time to prepare for supervision as well as complete all of the requirements of the site and host organization. It is estimated that each full time direct service staff member requires approximately 8 hours per week of supervisory time including the supervision session, and supervisory activities outside of the session including internal quality management activities, administrative work, and arranging training staff meetings, etc. Part time staff require nearly the same amount of supervisory time, therefore the ratio for a staff of all part time direct service providers is limited to a maximum of 8 to each full-time supervisor. It is recommended that sites, whose staff have **caseload**s largely comprised of families that score 40 or above on the Parent Survey/Family Stress Checklist maintain a 1:5 supervisor to direct service staff ratio.*

12-1.D		RATING INDICATORS
3	-	The ratio of supervisors to direct service staff is one (1) full time supervisor to five (5) full time direct service staff. Consistent evidence indicates the site is following this standard.
2	-	The ratio of supervisors to direct service staff is one (1) full time supervisor to six (6) full time direct service staff (or 8 part-time staff as indicated in the intent). Consistent evidence indicates the site is following this standard.
1	-	The site ratio of supervisors to direct service staff has more than six (6) full time direct service staff (or more than 8 part-time staff) to one (1) full time supervisor or there was insufficient evidence that the site is following the standard as outlined in 2 rating above.

☺ Tip: In the event the Supervisor is not full time in their role (i.e., is hired 75%, is a part-time assessment staff, or is a Site Manager who also serve as a supervisor, etc.) they are to indicate the amount of time spent in the supervisory role and insure the ratio of direct service staff is adjusted to the percentage of time spent in the supervisory role. For example: a supervisor who is 75% supervisor and 25% assessment staff would have a ration of .75FTE: 4.5FTE. This is calculated by taking .75 (% FTE) X 6 (as allowed in a 2 rating) and once calculated equals 4.5 FTE. This formula can be used to determine the ratio of supervisors to direct service staff regardless of the percentage of time.

12-2. Direct service staff (e.g., assessment and home visiting staff) and volunteers and interns (performing the same function) are provided with professional support and supervision that includes administrative, clinical and reflective components.

12-2.A The site has supervisory policy and procedures to assure that all direct service staff (e.g., assessment and home visiting staff) and volunteers and interns (performing the same function) are provided with professional support and supervision that includes administrative, clinical, and reflective components.

Intent: *Supervisors represent several roles in the HFA site. As an administrator, supervisors evaluate the performance of the staff and shadow assessments and home visits. In doing so, they provide feedback that encourages the staff's professional development. As the teacher/collaborator, supervisors add to the knowledge of direct service staff, discuss how to work with challenging families and enhance their abilities. Supervisors ensure that the training staff receives is incorporated into their work. Working with overburdened families is a high stress job, and as a result, supervisors have a critical role of offering guidance, emotional support and insight into the impact of the work on the worker. Ultimately providing staff with this kind of support allows for congruency between the staff person's expectations of the family and the site's expectations of the visitor, which ensures site quality. All direct service staff (assessment and home visiting) are provided with supervision that includes administrative, clinical and reflective components, are held accountable for the quality of their interactions with families on a regular and routine basis, and are provided with professional support. Sites are encouraged to develop mechanisms to measure the quality of work as well as develop strategies to provide feedback on performance measures.*

12-2.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 12-2.A.
2	-	The site has supervisory policy and procedures which assure that all direct service staff are provided with professional support and supervision which includes administrative, clinical, and reflective components in order to continuously improve the quality of their performance. Procedures include a variety of the following mechanisms: <u>Within the supervisory sessions (12-2.B practice)</u> - exploring/reflecting on of impact of the work on the worker - coaching and providing feedback on strength-based approaches, **reflective strategies**, and interventions used - assisting staff in implementing new training into practice - guiding **culturally sensitive** practice - identifying areas for growth - discussing ongoing worker safety - identifying and reflecting on potential boundary issues - sharing of information related to community resources - integrating quality assurance results that include review of all assessments and assessment records (including inter-rater reliability practices) - strengthening engagement techniques - discussing family acceptance, retention and attrition - discussing activities to address assessment issues/**risk factors** - discussing strategies aimed at building **protective factors** - supporting Parent-Child Interaction work and **CHEEERS** observations - reviewing Family Goal Plan progress and process - reviewing family progress and level changes - providing guidance on use of curriculum - integrating results of tools used (developmental screens, evaluation tools, etc.) - providing feedback on documentation <u>Outside of supervisory sessions (12-2.C practice):</u> - creating a nurturing work environment that provides opportunities for respite - shadowing home visitors and assessment staff - discussing home visit/assessment rates - reading home visit narratives & Family Stress Checklist/Parent Surveys - monitoring home visitor records, and all documentation used by the site - monitoring productivity - assuring an open door policy with supervisors - offering regular staff meetings - providing multi-disciplinary teams - assuring on-call availability to service providers - offering employee assistance program when available - acknowledging performance, - providing tools for performing job - scheduling flexibility - providing a career ladder for direct service staff
1	-	Any of the following: the site has no policy and procedures; the policy and procedures do not adequately ensure staff receive professional support and supervision which includes administrative, clinical and reflective components.

☺ Tip: Sites are encouraged to develop comprehensive internal quality management plans that include observations of assessments and home visits, building on the staff member's competencies, and integration of all tools that are used with families. Supervisors should also discuss training that staff have received and assist with implementing knowledge into practice.

12-2.B The site implements supervisory policy and procedures to assure that all direct service staff (e.g., assessment and home visiting staff) and volunteers and interns (performing the same function) are provided with supervision that includes administrative, clinical, and reflective components to continuously improve the quality of their performance.

12-2.B		RATING INDICATORS
3	-	The site implements supervisory policy and procedures which assure that all direct service staff are provided with supervision that includes administrative, clinical, and reflective components to continuously improve the quality of their performance. Practice includes the mechanisms listed in the 12-2.A standard under *Within the Supervisory Sessions*.
2	-	Past instances were found when staff did not receive supervision that included administrative, clinical, and reflective components to continuously improve the quality of their performance; however, **recent practice** indicates this is now occurring and practice includes the mechanisms listed in the 12-2.A standard under *Within the Supervisory Sessions*.
1	-	Staff do not receive supervision that includes administrative, clinical, and reflective components according to policy.
Note:		**This is a Sentinel Standard**

12-2.C The site implements supervisory policy and procedures to assure that all direct service staff (e.g., assessment and home visiting staff) and volunteers and interns (performing the same function) are provided with professional support to continuously improve the quality of their performance.

Intent: *The site's practice ensures that all direct service staff have ongoing professional support and a positive working environment that is nurturing and conducive to productivity. Many sites utilize multi-disciplinary teams to support staff in the field and these are included in the concept of professional support.*

12-2.C		RATING INDICATORS
3	-	The site implements supervisory policy and procedures to assure that all direct service staff (e.g., assessment and home visiting staff) and volunteers and interns (performing the same function) are provided with professional support to continuously improve the quality of their performance. Practice includes a variety of the mechanisms listed in the 12-2.A standard under *Outside of Supervisory Sessions.*
2	-	Past instances were found when the direct service staff did not receive professional support as outlined in the site's policy and procedures; however, **recent practice** indicates this is now occurring and practice includes a variety of the mechanisms listed in the 12-2.A standard under *Outside of Supervisory Sessions*.
1	-	The site has not implemented the supervisory procedures related to professional support. Any of the following: the site has no policy and procedures; the policy and procedures do not adequately ensure staff receives professional support; or evidence suggests the policy and procedures are not followed.

☺ Tip: Sites are encouraged to keep agendas and/or minutes of team meetings including content and who was present.

12-3. Supervisors receive regular, ongoing supervision which holds them accountable for the quality of their work and provides them with skill development and professional support.

12-3.A The site has policy and procedures to assure that supervisors are held accountable for the quality of their work, receive skill development and professional support through regular and ongoing supervision.

Intent: *Supervisors must receive professional support and skill development on a regular basis. Sites are to have clear policy and procedures regarding the frequency of supervision for supervisors, including the professional support, skill development and accountability measures in place to support supervisors Policy and procedures clearly describe which mechanisms from the items listed in the rating indicators are used by the site.*

It is recommended that supervisors receive individual supervision every other week, however the minimum requirement is monthly. Supervision of the supervisory staff can occur face-to face or via the telephone. Supervisory sessions are regularly scheduled to insure that the supervisor has the support they need to ensure quality at the staff and direct service level.

*Supervisors often carry small **caseload**s (1-3 families) or conduct occasional assessments (as a back-up to the assessment staff) in an effort to better support the direct service staff. Supervisors receive supervision related to these interactions with families. In these situations:*

- *The person providing supervision does not necessarily have to be trained as an HFA supervisor within that role.*
- *The supervision session can occur based on the frequency of contact and does not have to occur weekly.*
- *If the person providing the supervision is not trained as a supervisor in HFA, the supervisor can maintain the supervision notes based on the discussions being conducted.*

Please note: *When supervisors carry larger **caseload**s (i.e. 4 or more families), the ratio of supervisor to staff (12-1.C) is to be taken into account based on the percentage of time the supervisor is providing direct services.* Supervisors with larger **caseload**s or more routine

completion of assessments must receive supervision in accordance with the 12-1 and 12-2 standards.

12-3.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 12-3.A.
2	-	The site has supervisory policy and procedures which specify supervisors receive a minimum of once monthly individual supervision and are held accountable for the quality of their work, receive skill development and professional support. Procedures include a variety of mechanisms such as: - Addressing personnel issues, - Feedback/reflection to supervisors regarding team development and agency issues, - Review of site documentation including monthly or quarterly reports, - Site statistics (screening and initial assessment, home visit rates, content of home visits, quality assurance mechanisms, etc.), - Review of progress towards meeting site goals and objectives, - Strategies to promote professional development/growth, and - Quality oversight that could include shadowing of the supervisor.
1	-	There is no policy, or the policy does not meet the requirements specified in the 2 rating.

☺ Tip: Sites are encouraged to develop policy and procedures that address each of the mechanisms listed in the rating indicators and the frequency each mechanism is to occur.

12-3.B. The site's practice assures that supervisors receive regularly scheduled supervision, are held accountable for the quality of their work, receive skill development and professional support.

12-3.B.		RATING INDICATORS
3	-	Evidence indicates that the site is following its policy and procedures to assure supervisors receive at least monthly supervision and are held accountable for the quality of their work, receive skill development and professional support.
2	-	Past instances were found when the site was not following its policy and procedures; however, **recent practice** indicates this is now occurring.
1	-	Any of the following: There is insufficient evidence to indicate that supervision of supervisors occurs at least monthly; or there is insufficient evidence to assure supervisors are held accountable for the quality of their work, receive skill development and professional support.

☺ Tip: Supervisors document meetings with their supervisors and are encouraged to keep agendas as evidence of content of these meetings to demonstrate implementation of procedures listed above.

12-4. Program managers are held accountable for the quality of their work and are provided with skill development and professional support.

12-4.A The site has policy and procedures to assure that program managers are held accountable for the quality of their work, receive skill development and professional support.

Intent: *Program managers are provided with skill development, professional support and are held accountable for the quality of their work. This can happen through accountability with quarterly reports, annual performance reviews, regularly scheduled meetings with the program manager's Supervisor or chair of the advisory/governing board, peer supervision with a HF Program Manager from a neighboring site, and attendance at conferences or other training.*

12-4.A		RATING INDICATORS
3	-	No 3 rating indicator for standard 12-4.A.
2	-	The site has policy and procedures ensuring program managers are held accountable for the quality of their work, receive skill development and professional support.
1	-	There is no policy, or the policy does not meet the requirements specified in the 2 rating.

12-4.B The site ensures program managers are held accountable for the quality of their work, receive skill development and professional support.

12-4.B		RATING INDICATORS
3	-	Evidence indicates that the site ensures program managers are held accountable for the quality of their work, receive skill development and professional support.
2	-	Past instances were found when programs managers were not held accountable, receiving skill development and/or professional support; however, **recent practice** indicates this is now occurring.
1	-	Any of the following: There is insufficient evidence to demonstrate program managers are held accountable for the quality of their work, receive skill development and professional support.

☺ Tip: Program managers are encouraged to keep documentation of meetings with their supervisor and agendas as appropriate.

12. Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference and in order to avoid stress-related burnout			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
12-1.A Policy for Frequency & Duration	Supervision of all direct service staff that specifies frequency and duration	Submit Policy	**Interview:** * Program Manager * Supervisors * Direct Service Staff **Review:** * Supervision Logs * Staff Surveys
12-1.B **Measure supervision frequency and duration** ***Sentinel Standard***		Please submit a report that indicates the frequency and duration of the supervisory sessions for the most recent quarter. **Please note:** Sites may submit the 12-1.B HFA worksheet or equivalent database report.	
12-1.C Group Reflective Consultation		Please provide evidence of group reflective consultation sessions including date, time and content as well as evidence the group is provided by a qualified individual.	
12-1.D Ratio of Supervisors to staff		Please submit a list of each supervisor, their full time equivalency (FTE), percentage of time spent in the role, and the staff he/she supervises (with FTE for each position).	
12-2.A Policy of administrative, clinical and reflective supervision and professional support	How staff are provided with administrative, clinical and reflective supervision and professional support to continuously improve quality and are held accountable for their work	Submit Policy	**Interview:** * Supervisors * Direct Service Staff **Review:** * Supervision Logs illustrating skill development, accountability and professional support * Staff Surveys
12-2.B **Reflective, Clinical and Admin sup provided** ***Sentinel Standard***		No additional pre-site evidence required	
12-2.C Professional support provided		No additional pre-site evidence required	

12-3.A Policy for supervisor supervision	The supervision of supervisory staff and how supervisors are held accountable for the quality of their work, receive skill development and professional support	Submit Policy	**Interview:** * Supervisors of supervisors* Supervisors**Review:** * Supervision Logs illustrating skill development, accountability and professional support* Staff Surveys
12-3.B Supervisor supervision received		No additional pre-site evidence required	
12-4.A Policy for program manager accountability	Accountability, skill development and professional support processes for program managers	Submit Policy	
12-4.B Program Manager supervision received		No additional pre-site evidence required	**Interview:** * Supervisor of Program Manager * Program Manager **Review:** * Supervision documentation * Staff Surveys

GOVERNANCE AND ADMINISTRATION

The site is governed and administered in accordance with principles of effective management and of ethical practice. Please note: GA is not a Critical Element

Governance and Administration Standards Intent: *The overall intent of the standards in this section is to ensure the site has feedback and oversight mechanisms that ensure high quality services to families. These practices include effective* ***advisory group*** *operation, evaluation/review of site quality, handling of family grievances, utilization of informed consent, protection for families related to research conducted, and appropriate reporting of child abuse and neglect.*

GA-1. The site has a broadly-based, advisory/governing group which serves in an advisory and/or governing capacity in the **planning, implementation, and assessment** of site related activities.

Intent: *Advisory/governing groups serve an important function in community-based agencies in that they can be advocates for the site in the community, representing the site and agency in other venues and settings, which can bring more recognition and visibility. Community advisory/governing group members can bring to the site different skills and perspectives than might be present within site staff. Members can share with the site other ideas or strategies, brainstorming ideas that might arise and facilitate growth for sites. Additionally, members often have access to resources to strengthen the site or agency. It is important that the group has the community connections to understand the needs of the participant population. In many cases the site has two groups to report to, and that fulfill the functions outlined in the standard. The host agency governing board may have the actual responsibility in making final site decisions and financial provisions. Much of the time, this larger agency board has many other functions and does not specifically focus on the Healthy Families site in the capacity these standards require. Therefore, sites are also encouraged to have an* ***advisory group****, with the primary function of advising in the planning, implementation, and evaluation of site related activities. Ultimately, the host agency governing board will have final say, but the advisory board can provide input to the* ***program manager*** *(or other site representative) that can provide the information to the agency board.* ***Please note:*** *Frequency of meetings may vary depending on the duties assigned to the advisory/governing group, activities carried out by any subcommittees and age/longevity of the site. A minimum of quarterly meetings are maintained.*

GA-1.A The site's advisory/governing group meets at least quarterly and is an effectively organized, active body advising/governing the functions specified in GA-1.

GA-1.A		RATING INDICATORS
3	-	The site's advisory/governing group is an effectively organized, active body, which meets at least quarterly and advises/governs the activities of planning, implementation and assessment of site services.
2	-	Past instances occurred when the **advisory group** did not meet quarterly, however **recent practice** indicates this is now occurring. The site's advisory/governing group advises/governs the specified functions, but could be more active in one area of functioning.
1	-	The site's advisory/governing group meets less than quarterly; or is not active; or is ineffective in advising/governing on planning, implementation and assessment.

☺ Tip: Bylaws can serve as advisory board policy and procedures, when applicable.
☺ Tip: Advisory group involvement may be more intense during the start-up phase when community leadership is critical to the launch of the site, however well-established sites benefit tremendously from advisory group involvement as well. Over time a well-formed

advisory committee with strong member relationships is a huge asset to the continuation of a shared vision and the realization of intended program impacts.

GA-1.B The advisory/governing group has a wide range of needed skills and abilities and includes representatives with a heterogeneous mix in terms of skills, strengths, community knowledge, professions, and cultural diversity, allowing it to effectively serve the interests of the community and advocate on behalf of the diverse needs of site participants.

GA-1.B		RATING INDICATORS
3	-	The advisory/governing group has a wide range of skills, abilities, and provides a heterogeneous mix in terms of skills, strengths, community knowledge, professions and cultural characteristics (as determined by the site to represent the diverse needs of site participants).
2	-	The advisory/governing group's membership has some of the representative skills, knowledge, interests and cultural characteristics (as determined by the site to represent the diverse needs of site participants) necessary to represent the community.
1	-	The advisory/governing group's membership does not represent the skills, knowledge, interests and cultural characteristics (as determined by the site to represent the diverse needs of site participants) of the population it serves.

GA-1.C The program manager (or other site representative) and the advisory/governing group work as an effective team with information, coordination, staffing, and assistance provided by the program manager to plan and develop site policy and procedures.

GA-1.C		RATING INDICATORS
3	-	The program manager (or other site representative) and the advisory/governing group work as an effective team in planning and developing site policy and procedures.
2	-	The program manager (or other site representative) and the advisory/governing group plan and consult with one another, but the **advisory group** could be more fully involved.
1	-	The site and the advisory/governing group do not work as a team.

GA-2. Sites offer families opportunities to provide feedback to the site, through the use of formal mechanisms.

GA-2.A The site has policy and procedures regarding the mechanisms available for families to provide feedback about their experiences with services. Policy and procedures include:

- Regular survey processes used to obtain satisfaction feedback and
- Protocols for participants to file a grievance/complaint which at minimum contain:
  1. How participants/families are informed of the protocols,
  2. The specific steps for reviewing and acting on any grievances received, and
  3. The follow-up mechanisms used to address identified areas of improvement.

GA-2.A		RATING INDICATORS
3	-	No 3 rating indicator for standard GA-2.A.
2	-	The site (or the host agency) has policy and procedures regarding the mechanisms for families to provide satisfaction feedback to the site and how to file a grievance. The policy includes the items listed in the standard.
1	-	Either of the following: the site does not have policy and procedures related to the how participants provide feedback including the process for filing a grievance; or the policy and procedures do not include all items listed in the standard.

GA-2.B The site has mechanisms in place for families (e.g., past or present families) to provide formalized input into the program.

Intent: *It is critical for sites to receive and utilize feedback from families, in their efforts toward continuous quality improvement. When families provide their observations and experiences, it can illuminate areas in which staff would benefit from additional training or support, as well as highlight particular areas of strength or staff skill. Families may provide formal input into site operations through the use of satisfaction surveys, service on the advisory/governing group, family advisory committee, focus groups, etc. The information may then be shared with the site staff and full advisory/governing board in a narrative format.*

GA-2.B		RATING INDICATORS
3	-	The site has formal mechanisms for families to provide input into the program. Mechanisms used by the site include at least two of the following: participant satisfaction surveys, participant service on advisory/governing group or a family advisory committee, participant feedback through focus groups, etc.
2	-	The site has at least one mechanism for families to provide input to the program.
1	-	There are no mechanisms for families to have input into the program.

☺ Tip: Parent satisfaction surveys are most helpful when recommendations for site improvement from parents are solicited and an analysis or summary in aggregate format is shared with the advisory/governing board.

☺ Tip: Sites are encouraged to provide training and support to parents and to board members re: board operation to ensure that families are well-received and their skills used effectively (i.e., areas such as curriculum, outreach activities, cultural sensitivity, etc.).

GA-2.C The site informs all families about grievance/complaint protocols.

Intent: *In addition to having policy and procedures, sites have protocol for informing all families about the procedure for making a grievance. This protocol specifically outline the method by which the site will inform families of the steps to take should they want to make a grievance. Documentation that the grievance procedures were reviewed with families is placed in the participant file, and a copy is provided for the family to keep* so that they have the phone number or contact information.

GA-2.C		RATING INDICATORS
3	-	The site informs all families of the grievance/complaint protocols, and has followed its policy in regard to follow-up in writing on any grievances/complaints that have been received.
2	-	Past instances may have occurred when the site did not inform all families of grievance/complaint protocols or did not follow its policy to follow-up in writing on any grievances received; however **recent practice** now indicates the policy and procedures are being followed.
1	-	Any of the following: the site does not inform all families of grievance/complaint protocols; or has not followed its policy to follow-up in writing on any grievances received.

GA-3. The site monitors and evaluates quality of services.

Intent: *The site uses a variety of methods to monitor the quality of all of the services offered to families. Monitoring activities involve assessment, home visiting, and supervision. The* ***Cultural Sensitivity Review*** *(5-4 standards), family engagement/acceptance (1-2 standards) and family retention (3-4 standards) are mechanisms that can be included in evaluation of quality. Other methods include internal quality management strategies (periodic file review, shadowing of assessment, home visiting and supervision) and state or site level evaluation reports.*

GA-3.A The site annually ***reviews*** the progress towards its site goals and objectives, and has follow-up mechanisms to address identified areas of improvement.

Intent: *The site has clear written goals and objectives, and a process for monitoring and evaluating goals and addressing any identified issues. Sites use this information for continuous quality improvement. Sites are also encouraged to utilize formal state or site-specific evaluation to determine adherence to goals and recommendations for improvements.*

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GA-3.A		RATING INDICATORS
3	-	The site conducts a review of site goals and objectives annually and a follow-up mechanism to address areas of improvement has been established and implemented. This review is comprehensive.
2	-	The site conducts a review of site goals and objectives annually and a follow-up mechanism to address areas of improvement has been established, although the review could be more comprehensive.
1	-	Any of the following: the site does not conduct a review of site goals and objectives; it is not conducted on an annual basis; or no follow-up mechanism has been established.

☺ Tip: Sites should focus on their follow-up mechanisms and consider how these anchor back to the goals and their achievement. All of these efforts should be integrated into the supervision of direct service staff.

GA-3.B The site has a comprehensive **quality assurance plan** specific to the HFA program for reviewing and documenting the quality of all aspects of program implementation (assessment, home visiting and supervision) and follow-up mechanisms to address identified areas of improvement and to ensure the fidelity to the model.

Intent: *Sites will develop a **Quality Assurance plan** that will include annual shadowing of direct service staff (assessment, home visiting), satisfaction surveys, file review, reports related to program activities, etc. These activities help ensure accountability, support and skills development of site staff as outlined in the 12-2 standards. Additionally, sites will have a plan to address areas of improvement and methods of follow-up.*

GA-3.B		RATING INDICATORS
3	-	The site has a comprehensive **quality assurance plan** reviewing the quality of all aspects of implementation (assessment, home visiting and supervision) and has a follow-up mechanism to address areas of improvement. The mechanism to address areas of improvement has been implemented.
2	-	The site recently developed a comprehensive **quality assurance plan** reviewing the quality of all aspects of implementation (assessment, home visiting and supervision) and has a follow-up mechanism to address areas of improvement; however any mechanisms for improvement have not been implemented.
1	-	Any of the following: The site either does not have a quality assurance plan for reviewing the quality of its site; the mechanism for review does not include all service components (assessment, home visiting and supervision); and/or site does not have a follow-up mechanism.

☺ Tip: Additional documents to support these standards can include home visit completion rate calculations and planning (4-2.B and C), as well as acceptance analysis (1-2. B and C) and retention rate analysis (3-4. B and C).

☺ Tip: Sites are encouraged to document areas of improvement and demonstrate that improvements have been accomplished.

☺ Tip: The frequency of shadowing is encouraged to occur at least twice per year for all staff and more frequently for new staff.

☺ Tip: Program managers are also encouraged to shadow supervisors and review supervision documentation.

GA-4. The site a process for reviewing and recommending approval or denial of research proposals, whether internal or external, which involve past or present families.

GA-4A The site has policy and procedures for reviewing and recommending approval or denial of research proposals, whether internal of external, that involve past or present families. The policy and procedures includes:

- a description of the group or body of people that would conduct this review,
- protocols (or steps) for the review, and
- a timeline for completion of the process

Please Note: For individual site sites, if your stance is <u>not</u> to accept any research proposals, indicate that as the basis of your policy statement. For sites within multi-site systems, if using the central office policy please describe how the site would proceed when receiving an individual request.

Intent: *The sites policy and procedures ensure that a committee is available to make recommendations regarding the ethics of proposed or existing research, decide whether to approve research proposals, and monitor ongoing research activities. In many state systems the responsibility for the review of research proposals resides with the state entity and/or sponsoring organization, however, sites still must have policy about handling these types of requests (e.g., bring request to advisory group).* ***In cases when funder requires research as a condition of the funding, the need for policy and procedures still applies.***

GA-4.A		RATING INDICATORS
3	-	No 3 rating indicator for standard GA-4.A.
2	-	The site has policy and procedures for reviewing and recommending approval or denial on any research proposal involving past or present families or family information, and includes all items listed in the standard; or clearly states that no research proposals will be accepted for review.
1	-	Any of the following: the site does not have policy and procedures regarding the review and approval or denial of any research proposal; or the site's policy does not include all of the items listed in the standard.

GA-4B The site follows its policy and procedures for reviewing and recommending approval or denial of research proposals, whether internal of external, that involve past or present families.

GA-4.B		RATING INDICATORS
3	-	The site has followed its policy and procedures regarding the review and approval or denial of any research proposals involving past or present families or family information.
2	-	Past instances may have occurred when the site did not follow its policy, however evidence from the most recent research proposal review now demonstrates the policy and procedures are being followed.
1	-	The site's policy and procedures are not being followed.

GA-5. The site informs families of their rights and ensures confidentiality of information both during the intake process as well as during the course of services.

Intent: *HFA values a* ***family-centered*** *approach to service delivery which requires that practices reflect a profound respect for personal dignity, confidentiality and privacy. While this approach is evident throughout all service standards the standards in this section are devoted to preserving the rights and dignity of all service recipients. In addition to addressing legally protected family rights, the standards in this section also center on the professional ethics of service delivery and promote privacy, honesty and mutual respect.*

Research Note *(Client Rights: COA 8th Edition 2006): Ethics documents published by the National Association of Social Workers and the American Psychological Association both state that individuals have a right to privacy, confidentiality, and self-determination. Practitioners, while not always required by law, are ethically obligated to protect these rights for all individuals.*

GA-5.A The site has policy and procedures that informs families of their rights and confidentiality both at intake and during the course of services. Policy also includes the informed written consent by families when information is shared with an outside agency as well as the protection of participant privacy and voluntary choice.

GA-5.A		RATING INDICATORS
3	-	No 3 rating for standard GA-5.A.
2	-	The policy and procedures state the family (as defined by the site) is informed about their family rights and confidentiality before or on the first home visit. The policy and procedures also state the family is informed and signs written consent every time information is to be shared with a new external agency, and protects participant identity and privacy throughout any research project conducted by or with the cooperation of the agency and assures voluntary consent without pressure to participate.
1	-	The site does not have policy and procedures that addresses all three policies listed above (rights and confidentiality, informed consent, and participant privacy related to research projects).

GA-5.B The site ensures that all parents are notified of family rights and confidentiality at the onset of services, both verbally and in writing. At a minimum these forms include the following:

Family Rights

- the right to refuse service (**voluntary** nature)
- the right to referral, as appropriate, to other service providers
- the right to participate in the planning of services to be provided or the right to an individualized Family Goal Plan

Confidentiality

- the manner in which information is used to make reports to funders, evaluators or researchers (typically in aggregate format)
- the manner in which consent forms are signed to exchange information
- the circumstances when information would be shared without consent (i.e., need to report child abuse and neglect)

GA-5.B		RATING INDICATORS
3	-	There is evidence in family files to indicate that families are informed about their family rights and confidentiality, before or on the first home visit, both verbally and in writing.
2	-	Past instances were found in family files to indicate families were not being informed about their rights and confidentiality before or on the first home visit; however, **recent practice** indicates this is now occurring.
1	-	Any of the following: the forms do not include the criteria listed in the standard; or there is insufficient evidence in family files to indicate that families are being informed about their family rights and confidentiality before or on the first home visit.

Note: This is a Sentinel Standard

☺ Tip: While the rights and confidentiality form is required to be completed only once at the initiation of services, sites are encouraged to consider renewing it annually with families as a form

of best practice. Also, while the required elements bulleted above pertaining to family rights and confidentiality can be addressed via more than one form, sites are strongly encouraged to utilize only one form so as not to overwhelm families with excessive paperwork. Sites are also encouraged to keep language family-friendly.

GA-5.C Parents are informed and sign a new consent form every time information is to be shared with a new external source or with the same source but for a subsequent time period. The consent includes the following, but is not limited to:

- a signature from the person whose information will be released or parent/legal guardian of a person who is unable to provide authorization
- the specific information to be released
- the purpose for which the information is to be used
- the specific date the release takes effect
- the timeframe or date the release expires (not to exceed 12 months)
- the name of person/agency to whom the information is to be released
- the name of the HFA site providing the confidential information
- a statement that the person/family may withdraw their authorization at any time

Intent: *When a site receives a request for confidential information about a family, or when a release of confidential information is necessary for the provision of services, the site must obtain the family's informed, written consent prior to releasing the information.* ***Please note:*** *Consent to release information forms will only list one (1) agency per form in order to maintain confidentiality related to the various services that a family might receive. "Blanket" release of information forms, that list multiple entities on the same form, are not acceptable for use. All information on the form (including the specific information to be released, who it is being released to, the purpose for the sharing, etc.) must be filled in before parents sign the form. It is not permissible to have parents sign incomplete forms. Additionally, informed consents are time specific and do not include open-ended timeframes such as "during the course of services". Programs are to be as specific as possible about what is to be shared (e.g., home visit notes, developmental screen, assessment information, etc.) so families are very clear about what will be released. This consent may also apply to verbal sharing of information, and sufficient details about what staff may speak about must be clearly listed. Since a signed release form remains in effect for a maximum of 12 months, a new consent form will need to be signed annually when communication or sharing extends beyond the 12 month time period with the same external source.*

GA-5.C RATING INDICATORS

3 - There is evidence in family files to indicate families provide written consent every time information is to be shared with a new external source

2 - Past instances were found when families did not provide written consent for sharing of information or the consent did not include the criteria listed in the standard; however, **recent practice** indicates this is now occurring.

1 - Any of the following: Evidence in the family files indicates information is shared without the family's written consent, or the consent does not include all of the criteria listed in the standard.

Note: This is a Sentinel Standard

GA-5.D The site implements the policy related to ensuring participant privacy and voluntary choice with regard to ***research*** conducted by or in cooperation with the site.

Intent: *A site that participates in or permits **research** conducted by an outside source involving service recipients establishes the right of individuals to refuse to participate without penalty and guarantees participants' confidentiality. All research involving service recipients must be conducted in accordance with applicable legal requirements. Research includes all forms of internal or external research involving service recipients.*

GA-5.D RATING INDICATORS

3 - The site assures participant privacy and voluntary choice for all families with regard to **research**.

2 - Past instances may have occurred participant privacy and voluntary choice with regard to **research** was not assured; however, **recent practice** indicates this is now occurring.

1 - Any of the following: individual researchers follow their own plans, and potential for disclosure of identity or violation of privacy is high; or families are not provided an opportunity to refuse disclosure.

NA - No **research** is currently being conducted by or in collaboration with the site.

GA-6. The site reports suspected cases of child abuse and neglect to the appropriate authorities.

Intent: *Staff clearly understand how to identify child abuse and neglect indicators and the State's definitions of child abuse and neglect. This will assist them with knowing how and when to report. Additionally, it is important for staff to know who to contact for support when abuse or neglect is suspected. It is the intent that site leadership be notified in advance of a CPS report being made, however imminent child safety concerns are of higher priority. Therefore, staff also clearly understand that contacting Child Protective Service prior to immediate notification of the site manager and/or supervisor is appropriate ONLY IF waiting to contact site leadership may cause greater risk to the child(ren). Exceptions must be fully documented. These **criteria** and reporting procedures are clearly outlined in the orientation training staff receive prior to their work with families (10-1.C) and reviewed annually throughout employment (11-5.D).*

All direct service staff (including supervisors) should be viewed as mandated reporters and adapt a mandated reporter philosophy, even if the state does not identify them as mandated reporters. Therefore, it is also important to familiarize staff with mandated reporting laws, which places ultimate responsibility on direct service staff to report a suspicion of child abuse or neglect to Child Protective Service, without risk or jeopardy, even in situations where site leadership may not agree with the need to report.

GA-6.A The site has policy and procedures to report suspected cases of child abuse and neglect.

Intent: *The site must have policy and procedures that effectively guide staff in situations where abuse or neglect is suspected so that appropriate and timely action can be taken. Sites may choose to reiterate information from the State's Children's Code, agency-wide policy, and/or training materials that indicate child abuse and neglect **criteria** and reporting requirements. At a minimum, these materials must be referenced in policy such that staff know where to locate them.*

GA-6.A		RATING INDICATORS
3	-	No 3 rating indicator for standard GA-6.A.
2	-	The site has policy and procedures that are in accordance with all applicable laws and specify the following: - ***criteria*** used to identify and determine when to report suspected child abuse and neglect (or at a minimum, policy must indicate where these **criteria** can be found), and - immediate notification of the program manager and/or supervisor when abuse or neglect is suspected.
1	-	Any of the following: The site does not have policy and procedures that specify the **criteria** (or the location of the **criteria**) used to identify and report cases of suspected child abuse/neglect and/or, the policy and procedures do not specify immediate notification of the program manager and/or supervisor.
Note:		**This is a Safety Standard**

GA-6.B The staff uses the policy and procedures in order to report suspected cases of child abuse and neglect.

GA-6.B		RATING INDICATORS
3	-	Staff report all suspected cases of child abuse and neglect and immediate notification of site manager and/or supervisor occurs.
2	-	Past instances were found when staff did not report suspected cases of child abuse and neglect, or immediate notification of the supervisor did not occur; however **recent practice** indicates all suspected child abuse and neglect situations are reported, and immediate notification of the supervisor or site manager occurs.
1	-	The site's does not report suspected abuse and neglect, and/or immediate notification of the supervisor or site manager does not occur.
Note:		**This is a Safety Standard**

GA-7. The site responds to support families and staff in situation involving participant deaths.

GA-7.A The site has policy and procedures that specify immediate notification of the program manager and/or supervisor in cases of participant deaths (other appropriate staff/supervisors within the site are notified as needed) and specify staff are offered grief counseling when a participant death occurs, and families are offered extended support as needed.

GA-7.A	RATING INDICATORS
3 -	No 3 rating for GA-7.A.
2 -	The site's policy and procedures specify immediate notification of the site manager and/or supervisor, and that staff are offered grief counseling when a death occurs, and extended support is offered to the family.
1 -	Any of the following: the site does not have policy and procedures; the site's policy and procedures do not specify immediate notification of site manager and/or supervisor; or policy and procedures do not indicate that staff are not offered counseling when a death occurs or do not indicate that the family is offered extended support as needed.

GA-7.B The site responds in situations involving participant death to support family members and staff as needed. Program manager and/or supervisor is notified immediately.

Intent: *This standard assures both staff and family members are supported through the grief process. This could include additional reflective supervision, short-term transitional home visits with the family, the offer of grief counseling when these resources are available, etc. A death creates a deep sense of loss for families as well as staff, including home visitors, supervisors and family assessment staff with whom the family member had a relationship. At a minimum, reporting would occur if there is a death of a participating child or participating parent.*

GA-7.B	RATING INDICATORS
3 -	In situations involving participant death of a parent or target child, immediate notification of the site manager and/or supervisor occurs. Evidence indicates that support is provided to families and staff when a death occurs.
2 -	Past instances were found when notification of site manager and/or supervisor did not occur immediately or staff and/or families were not offered support; however, **recent practice** indicates this is now occurring; or there have been no recent participant deaths to illustrate implementation and follow-through.
1 -	Site manager and/or supervisor have not been notified immediately; or staff and/or families are not offered support when a death occurs.

GA-8. The site's Policy and Procedures Manual is used to guide staff in the delivery of services.

Intent: *It is critical for all staff to know and understand the policies and procedures which guide their work. It is not necessary for staff to have the Policy and Procedures manual memorized, but they will, at a minimum, know where to look when they have a policy or procedure question and view it as a common support to practice (especially for new hires).* ***Please Note:*** *Orientation to policy and procedures is required before contact with families as per standard 10-1.A. For additional guidance see* Policy and Procedure Checklist and Sample Policy and Procedure Template/Guide

GA-8.		RATING INDICATORS
3	-	The site has a Policy and Procedures Manual. There is sufficient evidence to indicate that the site uses the manual as a guide in the provision of services, particularly for newer employees.
2	-	The site has a Policy and Procedures Manual. Past instances were found when the site staff did not use the manual as a guide in the provision of services, but **recent practice** indicates that the Policy and Procedures Manual is now being utilized by staff.
1	-	Any one of the following: the site does not have a Policy and Procedures Manual; or there is insufficient evidence to indicate that the site uses the manual as a guide in the provision of services; or the site does not have a well-developed policy and procedures evidenced by missing polices associated with previous standards where policies were required.

☺ Tip: The agency in which the Healthy Families site is housed may also have a Policy and Procedures Manual. Sites are encouraged to develop policies focused on the HFA Best Practice Standards. It is helpful to design the Policy and Procedures Manual around the critical elements for both ease of use and for encouraging familiarity with the standards.

GA-9. The site ensures its HFAST (Healthy Families America Site Tracker) data is up-to-date.

Intent: *The HFAST system is used to maintain accurate demographic and programmatic details regarding all HFA sites. In order to accurately and effectively represent the entire HFA network it is imperative that sites update the information stored on HFAST at least annually (more often when there are staffing changes).*

GA-9.		RATING INDICATORS
3	-	No 3 rating for GA-9.
2	-	The site's information entered into the HFAST system is up-to-date consistent with HFA requirements for all affiliated sites.
1	-	The site does not currently have information up-to-date in the HFAST data system as required of all HFA affiliates.

Note: This is a Sentinel Standard

GA-10. The site is up-to-date with all fees owed to the HFA National Office.

Intent: *Sites must have any outstanding fees paid in full prior to accreditation.*

GA-10.		RATING INDICATORS
3	-	No 3 rating for GA-10.
2	-	The site has no outstanding fees owed to the National Office or has now paid any fees previously owed.
1	-	The site currently has fees that are overdue and not yet paid.

Note: This is a Sentinel Standard

GA - The program is governed and administered in accordance with principles of effective management and of ethical practice			
Standard	**Required Policy and Procedures**	**Additional Pre-Site Evidence in Self Study**	**Site Visit Activities**
GA-1.A Organization of Advisory Group	Policy not required **Please note:** programs may have Policy and Procedures related to these standards and may submit them for the benefit of the peer review team; however, they are not required.	Please submit a narrative (could be policy or bylaws) describing the advisory committee's role in advising programs staff with regards to planning, implementation, and evaluation of program related activities.	**Interview:** * Advisory/governing group members * Program Manager **Review:** * Board Meeting Minutes from Past Year * Advisory Group Surveys
GA-1.B Wide Range of Skills & Knowledge		Please submit a board roster with affiliation and summary of board skills, strengths, community knowledge, professions, and cultural diversity (as defined by the program); which qualify them to effectively serve the interests of the community and advocate on behalf of the participants.	
GA-1.C Program Manager & Advisory Group work as Team		Please submit a narrative describing how the program manager and advisory/governing group work as an effective team with information, coordination, staffing, and assistance provided by the program manager to plan and develop program policy and procedures.	
GA-2.A Policy for Formalized Input from Families and Grievance	How families provide feedback about their experiences with services and steps to file a grievance and steps for reviewing and acting on any grievances received	Submit Policy	**Interview:** * Program Manager * Supervisors * Direct Service Staff * Families
GA-2.B Formalized Input from Families		Please submit a narrative describing how the program obtains input regarding program services from families and a summary of results in a narrative format from all mechanisms.	
GA-2.C Implements Grievance Practice	-	Please submit a narrative describing the grievance procedure, the mechanism for informing families, and a description of any grievances received during the past year and a copy of any related forms if utilized.	

GA-3.A Review of Progress Program Goals & Objectives		Please submit a copy of the program's evaluation reports, and/or work plan illustrating the program's review of program goals and objectives and a follow-up mechanism to address areas of improvement.	**Interview:** * Program Manager* Supervisor* Direct Service Staff**Review:** * Completed QA forms/documentation - evidence may include: shadowing of staff, family file reviews, supervision reviews, review of evaluation results, etc.
GA-3.B Quality Assurance Plan		Please submit a copy of the program's Quality Assurance Plan.	
GA-4 Policy & Procedure Research Proposals	Reviewing and recommending approval or denial of research proposals, whether internal or external, which involve past or present families.	Please submit policy and if not including in the policy, submit a narrative regarding program protocol for handling of research proposals (i.e., group composition, how decision is made, communication protocols with person/group making request, etc.), and brief narrative describing any recent proposal and outcome of request.	**Interviews** if necessary
GA-5.A Policy and Procedures regarding Family Rights & Confidentiality, Release of Information and privacy is it relates to research	How families are informed about their right to confidentiality before or on the first home visit. Policy and procedures also state how families are informed and sign written consent every time information is to be shared with a new external source and when conducting research projects, as well as assuring voluntary participation.	Submit Policy	**Interview:** * Program Manager * Supervisor * Direct Service Staff * Families **Review:** * Family Files
GA-5.B Family Rights & Confidentiality *Sentinel Standard*	-	Please submit copies of relevant forms related to confidentiality and informing families of their rights.	
GA-5.C Informed & Signed Consent *Sentinel Standard*	-	Please submit copies of relevant forms related to informed consent when sharing information with other external sources (e.g., consent forms).	

GA-5.D Participant Privacy & Voluntary Choice		Please submit copies of relevant forms related to protection of participant identity and privacy and the option not to participate.	
GA-6.A Policy for criteria to identify Child Abuse & Neglect ***Safety Standard***	Immediate notification of program manager and/or supervisor when reporting suspected cases of child abuse and neglect, and the criteria for reporting Child Abuse and Neglect clearly outlined or referenced	Please submit policy	**Interview:** * Program Manager * Supervisor * Direct Service Staff **Review:** * Any Relevant Documentation * Staff Surveys
GA-6.B Implementation of Child Abuse Reporting *Safety Standard*		Submit narrative (if not outlined in program policy & procedures), describing the program's process for identifying and reporting child abuse and neglect and describe any reports that have occurred within the past year.	
GA-7.A Participant Death & Grief Counseling Policy	Immediate notification of program manager and/or supervisor in the instance of a participant death, and provision of support to staff and family.	Submit Policy	**Interview:** * Program Manager * Supervisor * Direct Service Staff **Review:** * Any Relevant Documentation
GA-7.B Participant Death & Grief Counseling Practice			
GA-8 Policy & Procedure Manual		No additional pre-site evidence required	**Interview:** * Program Manager * Supervisor * Direct Service Staff **Review:** * Any Relevant Documentation * Staff & Advisory Surveys
GA-9 HFAST up-to-date		No additional pre-site evidence required	**National Office staff to Review:** * HFAST status * Payment status
GA-10 HFA fees paid/up-to-date		No additional pre-site evidence required	

END OF HFA BEST PRACTICE STANDARDS