8TH EDITION

HEALTHY FAMILIES AMERICA

BEST PRACTICE STANDARDS

Healthy Families America®

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INTRODUCTION & GLOSSARY

HFA BEST PRACTICE STANDARDS:

A **best practice** is a method or technique that sets the standard by consistently resulting in outcomes superior to those achieved by other means. Serving as an alternative to mandatory legislated standards, best practices are used to formulate self-assessments and benchmarks as a mechanism to maintain quality. [1] Best practices define a standard way of operating across multiple organizations. Not intended to be stagnant and immovable, best practices can and do evolve to become better as improvements are discovered.

The **HFA Best Practice Standards (BPS)** describe expectations for fidelity to the Healthy Families America model. Herein referred to as the *Standards*, they are structured around the twelve research-based critical elements upon which the Healthy Families America (HFA) model was designed. The critical elements serve as the overarching 'big ideas' defining the Healthy Families America model. The *Standards* also include a section on Governance and Administration which articulates expectations for effective site management.

The policies, procedures and practices within each critical element are defined specifically so that HFA sites have clear direction on how to implement the HFA model. Sites utilize the Standards to engage in a process of continuous quality improvement while striving to meet model fidelity expectations. In order to ensure that all families being served through the HFA model receive high quality services, all HFA sites regularly participate in HFA's Accreditation process, which evaluates the site's current degree of model implementation and fidelity.

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

QUALITY ASSURANCE AND ACCREDITATION:

Sites implementing HFA commit to provide high quality home visiting services and demonstrate model fidelity through ongoing quality assurance (QA), quality improvement (QI) and Accreditation site visits. The *Standards* serve as the site's guide to model implementation and are used to evaluate the site's status toward achieving model fidelity. 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 yet meet).

Read more about the *Structure of the HFA Best Practice Standards* (next section) in order to understand how they are rated.

The Accreditation process is divided into three steps. Each of these steps allows the site to modify or tailor its current policies, procedures, or practices. While the Accreditation process is required every four years (five years for HFA multi-site systems), sites are encouraged to embrace a philosophy of continuous quality improvement by making the *Standards* a part of every day practices and ongoing quality assurance (e.g., referencing standards and intents in team meetings, supervision, training, etc.).

Step 1 - The Self-Study

The initial step in the 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 engage in a process of internal review as they pull together the information necessary to illustrate implementation of 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 acknowledges and reinforces the standards that a site is already implementing to fidelity.

Step 2 - The Site Visit

The second step in the 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 review the site's self-study to familiarize themselves with the site's processes during the weeks leading up to the site visit and identify areas requiring further clarification. Onsite, the peer team completes a review of family files and other documentation (e.g., 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 is assigned to a standard, peer teams are required to provide detailed information to indicate the basis for the rating and to guide the site on what areas need to be strengthened. The peer team's rating for each of the standards is provided in the Accreditation Site Visit Report (SVR). In some limited circumstances, sites may undergo a Fidelity Assessment instead of an Accreditation Site Visit.

Step 3 - Response Period

The final step in the Accreditation process requires sites to address the standards rated out of adherence (1 rating) as outlined in the SVR when the site does not yet meet the threshold to be awarded accredited status. Sites submit detailed narratives along with documentation of implementation to the HFA National Office and to the HFA Accreditation Panel (the Panel). Upon review of the materials, it is determined whether the site has shown sufficient improvement and now meets the threshold for accreditation. 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 or practice that has been determined either through research or consensus from the field, as a demonstration of quality. The *Standards* are broadly organized by the first order standards (the critical elements) and a section on governance and administration. The first order standard (e.g., Standard 1, Standard 2, Standard 3, etc.) 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., within Standard 1 are second order standards 1-1, 1-2, 1-3 and 1-4). While the second order standards provide more detail and specificity than the first order standards, their main purpose is to provide further context to guide implementation. Some second order standards are unsupported or stand-alone, meaning they are not broken down any further into third order standards. These include 9-2, 9-4, 10-1, 10-5 and GA-6. However, most second order standards are further broken down into a series of third order standards (e.g., within second order 1-1, are third order standards 1-1.A, 1-1.B, and 1-1.C). The third order standards and the stand-alone second order standards allow for the formation of strong programmatic practice and are the most specific standards with which the site needs to show documentation of implementation.

Found with each third order standard and stand-alone second order 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 yet meet). Read more about rating indicators below.

Rating Indicators:

Rating indicators are provided for every third order and stand-alone second order standard in the *Standards*. They were developed to help sites measure their own level of quality and model fidelity, and to ensure 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 areas in need of further improvement. 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).

ALL RATING INDICATORS ARE IN TEAL WITH A TEAL GRADIENT SCALE.

Standards that are specific to policy expectations are rated as a 2 or 1 rating only, owing to the fact that policy is either in adherence or not. However, there are a few exceptions to this rule. For standard 2-1.A regarding a site's policy on the administration of the FROG scale sites will be acknowledged with a 3 rating if their policy states that the tool will be completed on or before the second home visit, or a 2 rating if the policy states that the tool will be completed on or before the fourth home visit with a family. This also applies to supervision policy standards 12-1.A and 12-3.A, where sites can receive a 3 rating if they have established policy that meets the added expectation about supervision duration for direct service staff (12-1.A) and frequency of reflective supervision for supervisors (12-3.A).

It is also important to note that while most practice related standards will hold the site accountable to the standard, there are some standards that will hold the site to their policy, even if the site's policy expectation is more rigorous than the standard. It is useful for sites to keep this in mind when establishing policy for standards 2-1.B, 2-1.C, and GA-3.D.

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 critical elements.

ALL 1ST ORDER INTENT STATEMENTS ARE BOLD IN BLUE.

2nd Order and 3rd Order Standards Intent

Intent has also been added to many of the 2nd and 3rd order standards to further clarify what is expected, or the purpose of the standards, as it relates to best practices. The intent focuses on providing more detail on the "why" behind the standards.

ALL 2ND AND 3RD ORDER INTENTS ARE BLUE

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.

TIPS CAN BE FOUND IN BLUE BOXES MARKED WITH A GREEN ICON

Safety Standards:

These are standards that **must be met** in order to be accredited as they impact the safety of the children and families being served and the staff serving them. Safety standards include personnel background checks (9-3.B), orienting staff on child abuse and neglect indicators, role as a mandated reporter, and reporting requirements (10-2.D), supervision of direct service staff (12-1.B), site practices related to informed consent when sharing family information (GA-3.C) and child abuse and neglect policy and procedures that include reporting criteria, definitions and practice (GA-4.A, GA-4.B). Each of these standards is identified as a safety standard in its respective rating indicator box.

Essential Standards:

Essential Standards are standards determined to be especially significant to the HFA model, as they embody the essence of what it means to implement HFA. The existence of Essential Standards within the BPS is not to suggest that the other standards are non-essential, but to bring additional emphasis to this set of standards as a representation of what it means to embrace the HFA Advantage. HFA's Essential Standards set HFA sites and systems apart from other family support or case management approaches and they stand out as essential in helping direct service staff meet the goals of Healthy Families America.

The Essential Standards are:

- 2-1.B: The administration of the FROG scale to learn about family strengths and challenges.
- 3-3.B: The use of Creative Outreach as a trauma-informed strategy to build trust and re-engage families who have missed visits.
- 4-2.C: The use of HFA Level Change Forms to review family progress and decrease the frequency of home visits.
- 5-4.B: The development of an Equity Plan to support the site in achieving greater equity in all facets of its work.
- 6-1.C: The implementation of the Service Plan, the intentional work of the FSS to respond to concerns that families have shared.
- 6-2.B: The supports that FSSs provide around setting and achieving goals with families.
- 6-3.B, C, and E: The use of CHEERS to observe, partner with and support families in developing nurturing parent child relationships, and the supervisor support to staff around this important aspect of their work.
- 9-1.D: The processes for hiring HFA direct service staff.
- 10-4.A,B,C: The Core trainings required of staff within certain timeframes.
- 12-2.B: The provision of weekly reflective supervision to all direct service staff.
- GA-3.A: Policies and forms related to family rights and confidentiality.
- GA-3.B: The practice of informing families of their rights and about the processes around confidentiality at the start of HFA services.

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 documentation of implementation.

Note: Safety and Essential Standards will be indicated in BOLD font at the bottom of the rating indicator box.

National Office Requirements:

In order to be accredited, sites must also demonstrate that they are in good standing and upholding responsibilities as an HFA affiliate pursuant to the HFA Affiliation and Licensing agreement. These are described in GA-7 and include providing HFA required data, having HFA fees paid and up-to-date, using the HFA logo, name and graphics appropriately, following the HFA Site Research Policy, and reporting any critical incidents to the National Office.

Tables of Documentation:

At the end of each Critical Element and the Governance and Administration section is a Table of Documentation. This table is intended for sites preparing for accreditation as it indicates the policy, procedures, and other documentation needed to demonstrate adherence to each standard. Details are provided about how a site should prepare this information, whether it needs to be included in the self-study (which is sent to the peer reviewers 6 weeks prior to the site visit) or if it is part of what peers will review in files and/or during interviews on site. Sites should utilize the Tables of Documentation as a checklist when preparing their self-study, and when preparing materials that will be made available to the peer team when they arrive for the site visit.

Use of HFA Tools and Spreadsheets:

For certain standards, forms and spreadsheets have been created to support sites in measuring data consistent with HFA expectations and presenting documentation in a concise and manageable format. These forms should be used if the site does not have a current data system to present the information, or if the data system does not provide reports on any of these standards. If sites provide their own tracking reports they should ensure they include the same fields of information outlined in the HFA tools.

All tracking forms can be found here.

When using the HFA spreadsheets be sure to look carefully at all worksheets contained within (tabs at the bottom of each spreadsheet). This includes reading the tabbed worksheet that gives instructions on the correct use of the spreadsheet. Sites should ensure that in addition to entering data that data is also analyzed and interpreted with narrative in the space provided, along with a plan for improvement. Additionally, be sure that all data is compiled for the entire time period and use all tabs on the analyses spreadsheets. If the site works across multiple counties or with multiple partner agencies in the delivery of HFA services, the data from all counties or all partner agencies must be combined and reported collectively as one site.

ADAPTATIONS AND ENHANCEMENTS TO THE HFA MODEL:

The HFA National Office views an adaptation as an actual adjustment or modification to the specific best practices related 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 Essential standard will not be approved.

Adaptations, which seek to change some aspect of the model, are not to be confused with Enhancements, which supplement the model. For example, sites that use Doulas in addition to Family Support Specialists during the prenatal and newborn period, or sites that augment services with clinical staff to provide therapy for mental health or substance use issues. Enhancements are encouraged and do not require permission from the model to implement.

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

ACCELERATED:

An option for HFA service delivery available to sites that serve families identified at low risk (less than 10) on the FROG Scale. Families remaining at low-risk generally move through the various levels of service at a more rapid pace and may complete services in less than three years when criteria for successful completion of program (see HFA Level Change forms) have been met. Families who do not remain at low-risk, i.e., when additional family concerns and stresses are shared subsequent to administration of the FROG Scale that would have resulted in the family scoring 10 or higher.

ASSESS, ADDRESS, PROMOTE:

The complete process of identifying and utilizing CHEERS to support nurturing Parent-Child Interactions during visits with families. **Assess** refers to the factual parent-child interactions that are seen or heard during visits and documented on the visit record by the Family Support Specialist (FSS). Once the FSS has an opportunity to assess the parent-child interactions for CHEERS, this information is used to identify what to address and what to promote during the current visit or during future visits. **Address** refers to any CHEERS domains identified as opportunities for improvement or concerns that are addressed with the parent by the FSS through the use of HFA Reflective Strategies, visit activities, and/or parenting materials. **Promote** refers to any CHEERS domains identified as strengths, skills, or emerging strengths and skills that are promoted with the parent by the FSS using Accentuate the Positive, Strategic Accentuate the Positive, other affirmations, and celebratory visit activities.

CASELOAD:

The total number of families assigned to a direct service staff person, and not to exceed the maximum case weight of 30 points.

CENTRALIZED or COORDINATED INTAKE SYSTEMS:

Sites can choose to use a centralized intake system for referrals into their program. This system needs to have a solid understanding of the site's eligibility criteria so the site receives referrals from the intake system that reflect the families the site intends to serve.

CHALLENGING ISSUES:
Standard 6-1 uses terminology of challenging issues, which in this case refers to parent behaviors or life circumstances which can place children at especially high risk. These include parental substance use, mental illness, cognitive disability, and intimate partner violence. Support from a supervisor, use of reflective consultation groups (where available), and additional training are critical, as are procedures for worker safety and addressing family safety concerns. The procedures outlined in this HFA Procedures for Working with Families in Acute Crisis can be a useful resource. The focus of this manual is to provide general guidelines to enhance understanding and awareness of supporting families who may be experiencing challenging issues and identifying safety practices for direct service staff.

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 or expanded to address the specific concerns of each location or situation. Supervision 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 direct service staff fears for their safety. The safety of staff is of utmost importance.

CHEERS:
An acronym to support Family Support Specialists and parents 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, Rhythmicity/Reciprocity, and Smiles. These observations are expected to be made during each home visit as specified in the standard and intent. Training on CHEERS is also a significant part of HFA Core (Foundations for Family Support) training.

CHEERS CHECK-IN:
The CHEERS Check-In is a validated measurement tool developed by HFA and used to assess parent-child interaction at least twice annually and up to quarterly. Web-based training (required) and support on the use of this tool is provided by HFA.

CHILD WELFARE PROTOCOLS:
An option for HFA service delivery available to support sites with maintaining model fidelity while working with child welfare referred families. Affiliated sites seeking to implement CWP will submit a written implementation plan. Sites will establish relationships with their local child welfare office before seeking approval for implementation. Families enrolled through CWP must be referred by an agency within the child welfare system and the first home visit must be completed within 24 months of birth (see Standard 1-3). Sites implementing CWP are expected to establish a formal Memorandum of Agreement with the local child welfare office (see Standard 1-1.B) and code family data in a way that allows it to be analyzed and reported separately from families enrolled through traditional HFA protocols. Families are offered voluntary services for three years from the date of enrollment regardless of age at intake.

COMMENSURATE HFA EXPERIENCE:
During the new hire recruitment process, applicants for HFA site level positions are screened based on a variety of factors. Individuals who themselves participated in HFA services and/or worked in other HFA roles (e.g. an FSS, FRS or team lead now applying for a supervisor position) bring highly valuable attributes from their HFA experience and lived expertise. When considering whether the level of HFA experience is commensurate with an educational degree, this will be decided on a case-by-case basis by the hiring team, factoring the length of their previous experience (though there is not an automatic 1:1 ratio where for example a 4-year degree is met by having 4 years HFA experience), and more importantly how the individual themselves describes the impact of HFA involvement on their readiness to take on a new role.

COMMUNITY ADVISORY BOARD:
An organized voluntary group with responsibilities to advise on the planning, implementation, and evaluation of the HFA site operations. The functions and responsibilities of this group may include making recommendations to the HFA site and the organization's governing group regarding site policy, operations, fiscal needs, community needs, etc. Community Advisory Board members are a diverse group of individuals who represent the interests of the community as guided by the critical elements.

COMPLAINT:
HFA requires that all families be informed about how to file a grievance or a complaint. The site also needs to have a policy that describes how the family will be notified and what to do when they have a complaint. The site needs to have steps to follow if they receive a complaint, and the follow-up mechanisms to address the areas identified in the complaint. The family files need to have documentation that the complaint policy was reviewed with the family and a copy should be provided to the family.

CONTEXTUAL DECISION-MAKING:

On a site visit, the peer reviewers may see mixed information pertaining to a standard (e.g., an FSS has a first home visit with a prenatal family, and the Focus Child is born before the second visit. Because of this, the family is no longer prenatal, and the FSS was unable to complete a prenatal depression screen). In situations like this, where there may be extenuating circumstances, peer reviewers are trained to use contextual decision making to rate a standard, which means they must ensure the site is operating from best practice. For example, in the situation above, if the missed prenatal depression screen was because the baby was born shortly after the first home visit, the site could be rated in adherence even though not all prenatal families received a prenatal depression screen. Or, in another example, if the site had a new staff signed up for Core training, however she missed it because she was out unexpectedly for 3 months on FMLA, but as soon as she returned from FMLA she went to Core, the site was operating from best practice so therefore this would be taken into account to rate the standard in adherence vs out of adherence. This means sites should document the reasons for variances when they arise, which allows peers to have the information they need to use contextual decision making.

CORE TRAINING:

Intensive model-specific training that addresses some or all of the core components of the model, including FROG Scale, Foundations, Supervision and Implementation training.

CULTURAL CHARACTERISTICS:

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

CULTURAL HUMILITY:

Originating in the health care field, the concept of "cultural humility" was developed as an alternative to the idea that we can become "competent" in the cultures of others. Cultural humility is a lifelong commitment to self-awareness, to addressing power imbalances and to developing partnerships with people and groups who advocate for others.[2] In HFA, we embrace cultural humility in our approach to working with families from a place of self-awareness, understanding that each family has a unique culture and that our own culture and values can impact our interactions with families. It is our responsibility to continuously evaluate our interactions, interpretations and assumptions and to be committed to lifelong learning about ourselves and others. We reflect on our interactions with others and seek to understand how real or perceived power imbalances can influence our effectiveness. We align ourselves with other people or groups that advocate for others as we build authentic relationships with the families we serve. A culturally humble approach to our work ensures that we are successful in creating healthy relationships across the parallel process in alignment with the HFA Advantage.

CRITERIA:

Rules upon which judgment or decisions are based.

DEPRESSION SCREENING TOOL:

HFA requires that sites select a standardized screening tool to screen the primary caregiver in each family for depression at least once prenatally and once within three months of birth or 3 months of enrollment (when enrolled after birth), and at least once within 3 months of all subsequent births. While HFA does not specify a particular tool, the tools most commonly used by sites are the Edinburgh (EPDS) and the PHQ-9. The PHQ-2 may be used as a pre-screening followed by the PHQ-9 when indicated. The CES-D and Beck are also used by some sites, though much less frequently. Tools like the EPDS have been used with both parents.

DIRECT SERVICE STAFF:

Staff at an HFA site who carry a caseload of enrolled families to whom they provide HFA home visits and/or staff who administer the FROG scale with families.

EARLY COMPLETION:

A family enrolled and remaining as HFA Accelerated is eligible for early completion when able to sustain Level 3 accomplishments to move to Level 4 for a minimum of 6 months (or 180 days). Families enrolled in traditional HFA services, who choose to discontinue service early may potentially be regarded as early completers when they also meet and sustain for a minimum of six months accomplishments associated with moving from Level 3 to Level 4. In both cases, the Level 3-4 Completion form must be completed and signed.

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. Sites will determine the best way to identify eligible families, based on funder guidance, community need, and their own description of the families they intend to serve. HFA recognizes that in most situations, a well-developed screen will meet site needs for eligibility determination. Some sites may choose to use the FROG Scale to determine eligibility for service.

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[2] *Tervalon & Murray-Garcia (1998)*

ELIGIBILITY 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. In most cases, sites determine eligibility for services using a screening tool. In some cases, sites may use the FROG Scale to determine eligibility.

ENGAGED FAMILIES:
Families, including caregivers (e.g., mother, father, significant other, grandparents, etc.) 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.

EQUITY PLAN:
An Equity Plan results from the site's intentional, honest, critical and reflective look inward (site self-assessment) that also integrates feedback received from families and staff. This level of exploration allows sites to assess their capacity to 1) provide families with equitable access to culturally respectful and responsive services, 2) create a diverse, inclusive and supportive work culture for staff, and 3) operate within the context of the community and in partnership with parents and other providers to strengthen services. Based on what the site learns, activities are applied to promote equity and advance the current level of cultural humility at the family, staff and/or community level. The Equity Plan also includes recommendations/suggestions from its community advisory board.

EVIDENCE-INFORMED PARENTING MATERIALS:
The information that sites staff share with families must be evidence-informed, meaning that the information is based on scientific knowledge or research. Strategies employed may also be grounded in scientific research (e.g., 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, factual, relevant, and credible information versus materials that are opinion-based or outdated and no longer accurate. Sites may choose to use a formal parenting curriculum that is designed for home visiting or parent support, or sites may identify other evidence-based sources of parenting materials.

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

FAMILY RESOURCE SPECIALIST (FRS):
Typically, HFA sites use the title Family Resource Specialist to represent a direct service staff member with responsibilities related to the engagement and enrollment of new families. This role may include activities such as managing referrals, outreach to families referred, determining eligibility for services, offering HFA services, connecting families to additional resources in the community, and maintaining relationships with referral sources. Because of the variability in how this role is defined across sites, and because some sites divide these responsibilities across all direct service staff, HFA does not provide a role-specific training for the FRS. Find information about the role of direct service staff on Network Resources.

FAMILY SUPPORT SPECIALIST (FSS):
HFA home visitors are referred to in HFA training materials, the BPS, and other HFA produced documents as Family Support Specialists. This title conveys to families the purpose of the role in a way that families can relate to. FSS are responsible for building and maintaining an ongoing supportive relationship with families enrolled in home visiting services. Sites are welcome use this title or to continue titling this role in a way that best fits within their organization. Find information about the role of direct service staff on Network Resources.

FIDELITY ASSESSMENT:
A process to affirm model fidelity and support CQI activities at sites. HFA National Office staff conduct Fidelity Assessments with new provisional (not yet accredited) sites and, in very limited situations, as an alternative to a full reaccreditation site visit, including when conditions are such that site visits cannot be safely conducted. A Fidelity Assessment includes the review of site documentation related to all Essential and Safety Standards, the development of a Self-Study by the site, and a 6-month response period for sites to demonstrate improved practice. Sites successfully completing a Fidelity Assessment will have their accreditation expiration date extended for up to 3 years from the date of the Fidelity Assessment.

FIRST HOME VISIT:
The first visit completed by the assigned Family Support Specialist after eligibility has been determined, where rights and confidentiality forms are signed (unless already signed), where CHEERS is typically observed, and at least one focus area (see glossary for home visit definition) occurs.

FOCUS CHILD:

Eligibility is determined early for HFA families, ideally during the prenatal period. Healthy Families services are centered on the focus child (or children in the case of multiples), who is the prenatal child at enrollment, or child most recently born to a newly enrolled family.

FOUNDATIONS TRAINING:

Foundations training is an in-depth, formalized training required for all direct service staff, supervisors, and program managers. The training outlines the duties of the direct service staff in their role within HFA. Topics include but are not limited to: trauma-informed practice; communication skills; assessing, addressing, and promoting nurturing and sensitive parent-child relationships; creating a trusting partnership with families; goal setting; and strategies to enhance family functioning, address challenging situations, ensure healthy childhood development, and support healthy relationships. The training is facilitated by a trainer who has completed an extensive training program and is certified by the HFA National Office.

FROG SCALE:

The FROG (Family Resilience and Opportunities for Growth) Scale is the psychosocial assessment tool used by HFA sites at the onset of services to gather information about each family's unique strengths (protective factors) and challenges (risks for child maltreatment). HFA sites use the FROG Scale as the foundation for the family's Service Plan which guides ongoing services. Some sites use the FROG Scale to determine eligibility for HFA. The FROG Scale is administered with families in conversational style, respectful of what families feel comfortable sharing. While staff will continue to learn about families throughout the course of services, early completion of the FROG Scale supports relationship building by:

- immediately offering services that are responsive to the concerns and interests of each family
- building on family strengths to address concerns or challenges
- sending a clear message that this is a safe place to share difficult experiences

Each of the protective factors and potential risks identified below are measured on a continuum from strength to risk, with low scores in each area reflecting significant strengths and high scores reflecting significant risk.

- parent's childhood experiences
- experiences with substances or other potentially addictive behaviors
- mental illness
- experience with child welfare
- coping skills and supports
- stressors (housing, finances, childcare, employment, etc.)
- relationship with partner (including level of support and history or current intimate partner violence)
- knowledge of child development
- plans for discipline methods
- perception of baby/child
- physical and emotional availability of parent

FROG TRAINING:

FROG Scale training is an in-depth, formalized training for all direct service staff who will use the FROG Scale with families and their supervisors. The training includes but is not limited to: understanding the importance of telling one's story; using the framework of the FROG Scale to identify families' strengths and concerns; engaging families through conversation; documenting in narrative form; and using the FROG Scale scoring guide. The training is facilitated by a trainer who has completed an extensive training program and is certified by the HFA National Office.

FULL TIME EQUIVALENCY (FTE):

The calculation of full-time equivalent (FTE) is an employee's scheduled hours divided by the employer's hours for a full-time workweek. When an employer has a 40-hour workweek, employees who are scheduled to work 40 hours per week are 1.0 FTEs. Employees scheduled to work 20 hours per week are 0.5 FTEs. Family Support Specialists caseload maximums are determined by their FTE. This caseload expectation needs to be adjusted if the Family Support Specialist is less than 1 FTE. For example, sites will prorate a .5 FTE (1/2-time employee) so that their caseload does not exceed 15 points and that staff have an adequate amount of time to work with each family. Learn more about calculating FTE.

GRADUATE:

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

HANDS-ON PRACTICE:
Actual utilization of a tool during training or orientation to a new role, which may include role play, videotaping assessments or portions of home visits, or scoring a videotaped or shadowed FROG Scale.

HOME VISIT:
A face-to-face interaction that occurs between the family and the Family Support Specialist. The goal of the home visit is to promote nurturing parent-child interaction, support 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. Circumstances may occur where visits take place outside the home, are of slightly shorter duration than an hour, or occur with the child not present. These may be counted as a home visit if the overall goals of a home visit and some of the focus areas (listed below) have been addressed.

Also, when engagement challenges are present or special situations such as severe weather, natural disaster or community safety advisory impedes the ability to conduct an in-person visit with a family, a virtual home visit (via phone or preferably video platform), can be counted when documented on a home visit record and the goals of a home visit are met, including some of the focus areas (below).

Sites are permitted to count one group meeting per month as a home visit while families are on Level 1 or 1P; however, to do so requires that a Family Support Specialist be present during the group meeting and that the group meeting be documented on a home visit note, including some aspects of CHEERS for that particular family (when the group includes parent-child interaction time). The site may also count one visit per month conducted by a multi-disciplinary team member (if with documentation to demonstrate the staff person received HFA Foundations for Family Support training and receives supervision consistent with 12-1 and 12-2 standards. The focus areas during home visits may include, but are not limited to:

Promotion of nurturing 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.
- PCI screening and assessment

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
- health and development screening

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
- family functioning screening and assessment
- 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. However, if the state's schedule is used and it is without specific age requirements for immunizations between birth and 24 months, then the site will want to use the AAP or CDC schedule in order to calculate up-to-date status at 12 and 24 months in accordance with standards 7-2.B and C. Additionally, sites should be aware that, in some states, the ability for families to withdraw from immunizations due to personal beliefs may only be allowable until the child reaches school age, at which time all immunizations are required. Site staff will want to make parents aware if this is the case.

IMPLEMENTATION TRAINING:

In-depth, formalized training designed to prepare Program Managers and other Healthy Families America leaders for their important work. Implementation Training is an opportunity to become intensely immersed in HFA, the expectations of the model, and the responsibilities of HFA leaders, all while developing relationships with National Office staff and a network of support from other HFA colleagues throughout the country. Learners receive resources aimed at making implementation of the HFA model easier, gain familiarity with the HFA Best Practice Standards and have opportunities to consider the implementation of these standards within local sites or systems. This training is provided online by HFA National Office Staff.

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"[3].

LEVEL CHANGE FORMS:

HFA has developed and requires that sites utilize HFA Level Change forms. These forms provide the criteria for making decisions about a family's readiness to move to less frequent visits. The process allows the Family Support Specialist the opportunity to acknowledge family achievements throughout the course of services and to have a way to determine when a family has successfully completed services. While sites cannot subtract from the criteria outlined on the HFA Level Change forms, they may be permitted to add criteria. A site wishing to do so will submit any proposed modification to the HFA National Office for approval. HFA Level Change Forms and Documents.

LIVED EXPERTISE:

HFA staff are often more effective in supporting families and achieving program outcomes if they have experience within the community, apart from the formal educational attainment that is commonly included in hiring standards. Staff with knowledge of the culture of the people that the site intends to serve, and self-awareness around their own place within the community will be more successful in building trusting working relationships with the families that come into contact with the HFA site. Focusing on lived expertise also increases opportunities for diverse representation, equitable access to positions, and elevation of family voice within the services the program provides.

MEDICAL/HEALTH CARE PROVIDER:

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

MONITOR:

To keep track of through the ongoing collection of available information. The extent of the information collected for tracking and monitoring purposes will vary and is a less rigorous process than compiling data for an analysis.

Monitoring is not limited to review of data and reporting. Sites may find that they are able to learn more about the processes and outcomes that they are monitoring through the review of notes in family files, individual screening tool results or survey responses. For example, in monitoring well-child visit completion, sites may find that they are able to identify trends by reviewing a report of all families and the dates of their well child visits, but that they may learn more about site performance in this area through conversations in team meetings. For monitoring the systems related to referral relationships, sites may combine data related to the number and success of referrals from specific partners with informal information about provider relationships from direct service staff.

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[3] *World Assn. IMH*

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.[4] The spirit of Motivational Interviewing is a significant part of *HFA Advanced Family Support: Facilitating Change* training.

MULTI-DISCIPLINARY TEAM MEMBER(S):
An employed or contracted member of the local HFA site providing supplemental support to HFA staff and/or families (e.g., doulas, therapists, child development specialists, etc.). When providing services to families, these staff work in conjunction with the assigned FSS, and therefore are not considered to carry an HFA caseload. If the site chooses to have a visit from a multi-disciplinary team member count as an HFA home visit, the multi-disciplinary team member must 1) have received HFA Foundations training, 2) document the visit, including CHEERS observations, on an HFA home visit record and 3) receive supervision consistent with HFA standards for direct service staff. If the site is not counting visits from multi-disciplinary members as an HFA home visit, items 1-3 above are not required.

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.

PARALLEL PROCESS:
A key component of reflective practice, the parallel process encompasses all the relationships within the delivery of the HFA Services and focuses each person's ability to develop and promote a nurturing relationship. This includes an awareness of how focusing on the ways in which we are present and emotionally available for another creates a nurturing environment within all other relationships within the parallel process: Parent and Baby, Direct Service Staff and Parent, Supervisor and Direct Service Staff, and Program Manager and Supervisor. This is summed up in the Platinum Rule: "Do unto others as you would have others do unto others." Jeree Pawl.

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 focus child.

PARENT GROUP:
HFA sites are encouraged to hold regular parent groups to build informal support systems and reduce social isolation for participant families. For those families assigned to a weekly level of service, one HFA site-hosted parent group meeting per month may be counted as a home visit, if it is documented on a home visit record (by someone who has received HFA Foundations for Family Support Core and at least one goal of a home visit (see home visit definition) is met.

PARTNERING WITH PARENTS AROUND CHEERS:
HFA Family Support Specialists support families and promote nurturing parent-child relationships using CHEERS observations. In addition to the documentation of CHEERS to assess, address and promote attachment, FSSs support the parent-child relationship by discussing the domains of CHEERS with families through the use of reflective strategies, visit activities, and parenting materials. The more that parents become familiar with and reflect on concepts related to secure attachment, the more that they are able to make parenting choices that align with their family culture and build healthy relationships with their children. CHEERS is not something that is "done to" families, but an opportunity to come alongside families and create a shared language to talk about attachment and parent-child interaction.

PLANNING, IMPLEMENTATION, AND CONTINUOUS QUALITY IMPROVEMENT (ADVISORY GROUP ROLE):
Planning refers to the planning of events, additional referral sources, and integration of services between agencies serving families, etc. Implementation applies to supporting any implementation challenges the site faces, such as striving for early enrollment, engaging fathers, etc. Continuous quality improvement relates to feedback from the group related to the analyses and strategies aimed at strengthening site services.

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

[4] *William Miller, Steve Rollnick, 2012*

PRIMARY CAREGIVER:

HFA embraces a family-centered approach and allows the family to define who the child's family is. The primary caregiver is the individual with whom the baby lives and receives primary care from. This individual is generally, though not always, a parent, and is the primary point of contact for the Family Support Specialist when conducting home visits and observing PCI. In co-parenting or multi-generational parenting families, one person will be identified within the system as the primary caregiver. Depression screens are only required to be administered with this person.

PROCEDURE:

The step-by-step methods by which 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:

Each site has a designated Program Manager (PM) that is responsible for the day-to-day, hands-on management of the site, and is involved in planning, budgeting, staffing, training, quality assurance, and evaluation. PMs are also responsible for ongoing collaboration with community/state partners, public relations, and 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 direct service staff in a dual role as Supervisor (see Supervisor definition). Find information about the role of program manager on Network Resources.

PROTECTIVE FACTORS:

- parental resilience
- social connections
- concrete supports in times of need
- knowledge of parenting and child development
- social and emotional competence

Additional information and training can be found online. Learn more.

QUALITY ASSURANCE PLAN:

A plan to monitor and track quality and implementation to model fidelity that includes all aspects of the service delivery system, i.e., initial engagement, home visiting, supervision and management. Quality assurance can be monitored via satisfaction surveys, case file reviews, shadowing, quality assurance phone calls, supervision rates, etc. A sample Quality Assurance Plan is available.

QUALITY IMPROVEMENT PLAN:

A plan that incorporates specific, measurable, attainable, realistic, and time-oriented improvement goals carried out by the entire team with an intent to test small changes and their impact on process and/or outcomes. Download sample Quality Improvement Plan.

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 the three most recent consecutive months, though there may be certain circumstances when additional time is necessary to illustrate implementation.

RE-ENROLLMENT:

A family that enrolls in HFA services may later choose to discontinue services prior to program completion. This may be due to any number of situations, such as the family needing time to "warm" to the idea of home visiting, especially when existing stresses and past history complicate how the parent views the helping profession. Or it may be related to a move out of the service area but then the family later returns to the area. A parent who is closed to services may decide weeks or months later that they would like to re-enroll with the existing focus child. When sites have capacity to do so, they are encouraged to accept re-enrollments, and should do so at the site's discretion. If a site re-enrolls a family, that family will not be counted in the 1-3.B measurement standard. A family that discontinues services but requests to re-enter the program with a subsequent focus child is considered a new enrollment. A family that is enrolled and making progress toward successful completion of the program should not be re-enrolled with a subsequent birth. This space should be reserved for new families that have not had any opportunity to participate in services.

REFERRAL:

HFA sites are encouraged to provide linkages for families to community resources on an as-needed basis. HFA staff need to be knowledgeable of resources within their communities and help families connect to these resources. HFA requires a signed consent to release information on all referrals to external agencies when the staff member is sharing information about the family. Referrals to services that are housed within the same agency as the HFA site do not require a signed consent, though this is recommended, as is documentation of these connections to additional services as referrals.

REFLECTIVE CAPACITY:

The capacity to exercise introspection and the willingness to learn more about the fundamental nature, purpose, and essence of how humans experience this world and how our own world-view is impacted by that experience. HFA staff with reflective capacity are able to consider multiple points of view, have awareness of their own biases and feelings, can tolerate ambiguity and are able to recognize their own dysregulation. It is important 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 generally last 1.5-2 or more hours and are conducted by an individual with advanced training 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 direct service staff for work going forward
- opportunities for participants in the group to reflect on the group session they just observed.

REFLECTIVE STRATEGIES:

The HFA Reflective Strategies are specifically designed intervention tools that create an environment of increased self-awareness and self-efficacy sustained within healthy helping relationships. The reflective strategies are in alignment with the trauma-informed approach and utilized by all HFA staff regardless of role. Each strategy has a unique purpose as follows:

- Mindful Self-Regulation encourages self-awareness and promotes self-regulatory, self-care practices.
- Accentuate the Positive builds self-esteem and confidence by promoting specific skills and strengths along with the impacts and benefits of the identified skills and strengths.
- Strategic Accentuate the Positive increases the frequency of healthy, safe, and nurturing behaviors that also builds self-esteem and confidence.
- Feel, Name, & Tame supports a persons' capacity to recognize and regulate their feelings.
- Explore & Wonder builds awareness, empathy, and sensitive responses to missed cues and the feelings of others.
- Problem Talk encourages creative thinking and problem solving by clarifying and learning more about a concern, problem, or situation.
- Normalizing addresses concerns related to dangerous or harmful beliefs, behaviors, and practices while offering alternative healthy and safe options for consideration and further exploration.

The HFA Foundations for Family Support Core and Supervisor Core training include detailed descriptions, discussions, examples, handouts, and practice opportunities on all the HFA Reflective Strategies.

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:

A systematic examination of information to answer a question and advance knowledge and any activity, including program evaluation and/or quality improvement activities, (i) that would, according to Federal regulations, require review by an Institutional Review Board, or (ii) that could be expected to yield generalizable knowledge that could be shared publicly with the professional, academic and/or lay communities. 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 or quality improvement is not considered Research.

SAFER SLEEP:

HFA sites share information with families about infant sleep to reduce the risk of sleep related infant death. Sites provide information about evidence-based safe sleep practices and engage in conversations with families related to things that parents and caregivers can do to keep babies safe. For families whose choices around infant sleep may include co-sleeping or other culturally specific sleep practices, HFA staff may choose to take a harm reduction approach and share information with families about how to increase the safety of these practices.

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 Documentation (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 PLAN:
HFA requires sites to develop a Service Plan for each family. The Service Plan is a Supervisor's tool that brings collaboration and intentionality to the forefront of our work. A well-constructed Service Plan is the cornerstone of services that are effectively organized, coordinated, and based on each family's unique strengths and areas of concerns. A Service Plan operationalizes the family story into a road map that supports Family Support Specialists in their ongoing and long-term work with the family and is the mechanism by which Supervisors document their clinical support to staff that is specific to each family.

Sites may adapt or develop their own Service Plan document if it meets the expectation of the 6-1 standard. The HFA National Office is happy to review and advise on any modified forms. Download HFA Service Plan Materials.

SERVICE POPULATION:
The individuals currently enrolled and receiving services.

SERVICES:
When referenced in the Standards, services include the activities offered to families by Healthy Families direct service staff at enrollment and during home visits and does not include Healthy Families service enhancements (e.g., groups, augmented support from clinicians, or other programs housed at the agency).

SITE:
The term used to describe an HFA affiliate. Additional information about defining an HFA Site can be found in HFA Site Definition documents.

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 has 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. When experiential gaps exist at the time of hire, the staff member and supervisor develop a plan to support staff development and the acquisition of new knowledge and experience.

Download Sample Staff Development Plan for Program Managers, Supervisors, and Direct Service Staff.

SUPERVISION TRAINING:
In-depth, formalized training that outlines the specific duties of the supervisor's role within Healthy Families and covers topics including, but not limited to: the role of direct service staff, the importance of reflective supervision, supervision session structure and content for all staff, reflective strategies for supervisors, supervision of staff using the FROG Scale, sample tools and forms to use for continuous quality improvement, etc. The trainer is certified by the HFA National Office.

SUPERVISOR:
Supervisors provide weekly individualized supervision to the direct service staff within a Healthy Families site. The supervisor ensures 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. Find information about the role of supervisor on Network Resources.

TRANSFER FAMILIES:

When families move from one location to another, HFA encourages sites to ask families if they would be interested in continuing with HFA home visiting services in their new location. The HFA website has a Site Finder feature that sites can use to locate an HFA site close to where the family is relocating and to determine if the site can provide services for this transitioning family. In addition, new HFA affiliates who are transitioning from a previous home visiting model to HFA will transfer families from previous services to HFA when possible.

When families transfer from one HFA site to a new HFA site, we recommend the Family Support Specialist at the original site review with the family what information would be helpful to share with the new site so that families can make an informed decision about their consent to share this information. For continuity of service, the new site my find the following information helpful:

- Initial FROG scale
- Current Service Plan (including documentation of any additional concerns identified by the site over the course of services, including potential developmental delays, parental depression or concerns related to the parent-child relationship)
- Current Family Goal
- Family Transition Plan (if developed by the original site ahead of the close of services)
- Current family Level of Service
- Signed release of information from the family

Sites must follow all HFA policies related to informed consent when transferring families. Families transferred into an HFA site should be tracked in the same way as other referrals and included in acceptance and retention data tracking.

If the initial FROG scale completed with the family at the original site has not been shared with the new HFA site, the new FSS should complete the FROG scale early in services with transfer families to begin the process of learning more about their strengths and opportunities for growth.

Families transferring into an HFA site will be offered weekly visits at the onset of services, until progress criteria is met for moving to less frequent visits. While families may have been receiving less frequent visits at their previous site, all families benefit from increased frequency of initial visits after a transfer, allowing for staff and families to learn more about each other and to begin the process of trust-building. The life transitions and circumstances related to a move to a new community may have created additional stress in the family and weekly visits ensure families receive adequate support during this time. Sites will assess the progress of transfer families using HFA Level Change forms and will reduce frequency of visits as progress criteria are met.

Transfer families are included in HFA data collection, though they may be excluded from some calculations.

- Sites do not have to include transfer families in the calculation of families' receipt of the initial home visit before three months of age. (1-3.B)
- Transfer families are exempt from the requirement to be offered three years of service from the date of enrollment, but sites should plan to serve transfer families until the focus child reaches three years of age at a minimum. (4-3.B)
- For standards related to completion of screening tools with children and families, (6-3.D, 6-5.B, 6-5.C,) sites should note transfer status of families in data reporting in cases where the timing of the transfer to the new HFA site precludes the ability of the site to complete screenings as described in the standards. This information can be used for contextual decision-making by peer reviewers or the Panel.
- Sites will follow their policies related to depression screening, administering screens to primary caregivers within 3 months of enrollment, including transfer families.

TRAUMA-INFORMED:

One component of the HFA Advantage is HFA's trauma-informed approach. Being trauma-informed requires an awareness of the impact that trauma has had on the lives of families, an awareness of behaviors and responses that might trigger re-traumatization, and an openness to understanding how current behaviors are often adaptations to past abuses. Trauma-informed support includes ensuring safety, emphasizing autonomy and a collaborative strength-based approach. The trauma-informed approach applies to all families, and across the parallel process to include site staff, and does not rely on specific knowledge of anyone's trauma experiences or require disclosure on the part of any individuals. Because trauma is a common experience, being trauma-informed does not mean that we treat certain individuals differently based on their trauma history, but instead we provide trauma-informed support to everyone. HFA sites and systems build successful working relationships with all families and staff that provide safety, predictability, comfort and joy and result in improved outcomes for all families.

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).

WAITLIST:

When a local site is at capacity and unable to offer services to new families, the site may be inclined to put the family on a wait list. HFA discourages this practice, given that wait-listing a family gives the family false hope that they may soon access HFA services when this may not be possible. More concerning is that particularly vulnerable families should be connected to alternative resources in the community before existing risks become further amplified. This may also pose increased liability to the site if something were to happen to the family while on a wait list.

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

HFA ACCEPTANCE RATE:

The methodology for tracking the percentage of families who accept HFA home visiting services during a particular time period. Many factors may impact the acceptance rate. For example, numerous HFA sites have found that the narrower the window of time between initial referral to HFA and the offer of services, the higher the acceptance rate.

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.

Measuring Acceptance Rates:

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

1. Count the total number of potential families who, during a specified time period, were offered services after being determined eligible at the time of the initial screen/assessment (whichever is used to determine eligibility). This number will be your denominator.
2. Of the families who were offered services within that specified period of time, count how many completed a first home visit. This is your numerator.
3. Divide the number of those who had a first home visit by those who were offered services.

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, 2019, to December 31, 2019 (can be a calendar year or fiscal year).
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 defined in step 2 (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 2019 could not be counted as retained for one year until December 2020.

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

NOTE: To ensure uniformity in measurement of retention rates, HFA requires that retention calculations use first and last home visit dates, even if sites define enrollment and termination differently. As described above, the first home visit is defined as the first visit from a Family Support Specialist that is completed and documented subsequent to the offer of HFA services. The last home visit applies only to families that have been closed to services. It is defined as the most recent date that a Family Support Specialist completed and documented a home visit with the family prior to closure (regardless of level at that time). Families that are still considered "active" or "open" will not have a last home visit reflected until they have been closed. 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 will 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 numbers and percentages) that depicts analysis factors selected, along with reasons why families refuse/drop-out of service
2. a narrative that reflects anecdotal findings from discussions with staff in team meetings, supervision sessions, advisory board conversations, etc.
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, e.g., those who 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 regard 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.

Sites are strongly encouraged to choose factors that will allow them to uncover potential equity issues related to acceptance and retention in the program. In addition, the inclusion of at least one factor related to how the program operates allows the site to learn more about how adjustments to policies and practices may improve family experiences.

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

- relationships with partner agencies or other community providers
- referral sources
- staffing issues (patterns & trends among direct service staff)
- number of days between referral and assessment
- screening or assessment timeframe (e.g., prenatal, at birth within two weeks, more than two weeks)
- if a re-enrolled or transferred family
- training of staff

Programmatic Factors to consider for Retention Analysis

- enrollment timeframe (e.g., enrolled prenatally, at birth, or at a later period)
- if a re-enrolled of transfer family
- staffing issues (patterns and trends among direct service staff--depending on site size, staffing trends can be evaluated by individual, by team, and by satellite
- current service level
- length of time in services
- age of focus child(ren) at enrollment
- how policies impact what happens with families and site outcomes
- relationships with partner agencies or other community providers
- training of staff

PARENT AND FAMILY FACTORS:

- gender identity
- age
- race & ethnicity
- marital status
- education level (last grade completed)
- primary language
- sexual orientation
- employment Status (not employed, employed part-time, full-time, or seasonally)
- socioeconomic status
- location: urban, suburban, rural
- families experiencing systematic oppression
- city/zip code
- FROG Scale score
- work or school issues (barriers to engaging or retaining due to HS or college schedule, work hours, significant commute, works night shift, etc.)
- family or friend support
- teen parent(s) living independently or with parents
- grandparents raising focus child
- linkages to other community resources
- religious affiliation
- domestic/family violence
- families with disabled parents or children
- families impacted by substance use
- families impacted by mental health
- families impacted by violence or over-policing

INFORMATION USED IN ANALYSES:

Sites are required to consider formal data and other information related to analysis factors to identify patterns or trends in family acceptance or retention. Formal data refers to information that can be numerically recorded, often regarded as "hard data," or quantitative data. Factors related to program processes and activities, and factors related to family or individual parent characteristics can all be reported as formal data using both numbers and percentages. Anecdotal information, often regarded as qualitative data, gathered from site staff, advisory board members and parents related to the analysis factors helps complete the story of what is impacting family acceptance or retention. Anecdotal information may be collected in staff meetings, individual supervision, parent focus groups or community advisory board meetings.

REASONS WHY:

Staff will 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 (e.g., a family said yes to the initial 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. Sites will summarize reasons why in their narrative and utilize this information when planning to improve acceptance or retention.

COMPREHENSIVE ANALYSIS:

A comprehensive analysis is a thoughtful and intentional selection and examination of key programmatic, and Parent and Family 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, including any patterns or trends. Data and conclusions from the analysis are used to develop and apply strategies aimed at improving site services in the site's Comprehensive Quality Improvement Plan.

Summary and Guidance for Data Collection Timeframes

The Tables of Documentation provide a complete list of data requirements in the HFA Best Practice Standards (BPS). Also included is a column with recommended timeframes for ongoing monitoring and adherence to the standards, as it is helpful to have routine monitoring, measurement, and documentation of these activities support your site's Quality Assurance Plan (GA-2.A). These recommended timeframes may also be helpful as you develop and follow-up on your site's Quality Improvement Plan (Standard GA-2.B). When a site finds that any of these QA activities are following below expectations stated in the standards the site is also encouraged to include these items on their site Quality Improvement Plan for ongoing monitoring and improvement.

Measuring/Monitoring/Reporting Timeframes

- Annual - Site selects the most recent 12 months, most recent calendar year, or most recent fiscal year

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

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
1-1.C Tracking Referrals and Site Capacity	Quarterly	Submit report reflecting all families referred to your site in the most recent quarter: 1. Number of families referred by each referral source 2. Their eligibility status Include most recent plan with strategies to fill available slots or reduce gaps in service availability. Indicate which have been applied.	HFA Spreadsheet or local data report and strategies.	Update Monthly
1-2.B Initial Engagement Process	Annual	Submit a narrative about how the site monitors its initial engagement process and activities reflecting all families referred in the most recent year. A data report may be submitted in combination with a narrative regarding engagement activities. HFA's spreadsheet includes: 1. The length of time from referral to initial contact 2. The length of time from initial contact to offer of services 3. Whether able to establish initial contact or not. 4. Whether services were offered or not. Reasons why if services not offered.	HFA Spreadsheet or local data report and strategies.	Update Quarterly or more frequently, depending on number of referrals received
1-3.B Initial Engagement Process	Annual	Submit a report reflecting all families who received a first home visit in the most recent year. 1. Count number with a first home visit 2. Count number with first home visit either prenatally or within 3 months of birth 3. Calculate: #2 (number with first home visit prenatally or within 3 months) divided by #1 (number who had a first home visit) For sites enrolling families through Child Welfare Protocols (CWP), remove CWP families from the calculation above to calculate CWP families separately, 1. Count CWP number with a first home visit 2. Count CWP number with first home visit within 24 months of birth 3. Calculate: 2. (number with first home visit within 24 months) divided by 1. (number with a first home visit) Sites will include the signed MOU with CWP partners in their accreditation self-study.	HFA Spreadsheet or local data report. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
1-4.A Measure Acceptance	Annual	Submit a narrative describing the site's definition of acceptance rate and method for calculation (unless using HFA spreadsheet) and the current acceptance rate for all families offered services in the most recent year. Also describe the site's process (how and when) acceptance rate is reviewed or reference the site's current QA Plan if the site has included a review of its acceptance rate there. 1. Count number offered HFA home visiting services 2. Count number with a first home visit 3. Calculate: #2 (number with a first home visit) divided by #1 (number offered services).	HFA Spreadsheet or Acceptance Rate and description of methodology, if not using HFA spreadsheets.	Update Every Six Months
1-4.B Acceptance Analysis	Every other year	Analyze the data from all families who were offered services during at least the most recent year. Analyze both formally and informally: 1. Families who refused services in comparison to families who accept services. 2. Includes at least one analysis factor 3. The reasons why families decline. For smaller sites with less than 50 families offered services over a two-year period, the site is required at a minimum to submit a narrative including: 1. The number of families offered services within the two-year period. 2. Informal data about families who refuse services or accepts services 3. Reasons why families are not accepting services If at least ninety percent (90%) of families offered services over a two-year timeframe accepted services by receiving a first home visit, an analysis is not required. New sites not yet in operation for two full years with an acceptance rate of 90% during the first year are also exempt from completing an analysis.	HFA Spreadsheet or Acceptance Analysis for at least one cohort year. For sites not required to complete Acceptance Analysis, submit a narrative defining reason for exemption. Please see glossary for more information on analysis.	Update Annually

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
3-4.A Measure Retention	Annual	Submit the site's definition of family retention and method for calculating (unless using HFA spreadsheet) and retention calculation for families enrolled within at least one cohort year. HFA methodology for calculating a site's retention rate is: 1. Select a specified time frame (i.e., January 1, 2020 to December 31, 2020). This can be a 12-month period, a calendar year, or fiscal year. 2. Count the number of families who received a first home visit during this time frame. 3. Count the number of families in this group who remained in services at specified intervals (i.e., the number from this group remaining in services 6 months or longer, 12 months or longer, two years or more, etc.); 4. Divide #3 (totals remaining for 6 months, 12 months, etc.) by the number of families in step #2 (that received a first home visit during the time frame. 5. When selecting a time frame, it helps keep in mind the last day of your time frame will determine which intervals you can measure. A family who might have enrolled on the last day of that time frame could only be counted as retained or not for 6 months if at least 6 months have passed since they enrolled. Example: I have selected 1/1/2020-12/31/2020 and today is 1/1/2022, so any family that might have enrolled on the last day of that year has had the opportunity to be in the program for 1year and 1 day. For all the families who enrolled during that year, I can measure how many were still enrolled at the 6-month interval and the 12-month interval. I can't measure the 2-year interval yet because not all families who enrolled in that year (specifically, a family that might have enrolled on the last day) have had the opportunity to make it to the 2-year mark.	HFA Spreadsheet or Retention Rate and description of methodology, if not using HFA spreadsheets.	Update Every Six Months
3-4.B Retention Analysis	Every other year	For all families who enrolled within at least one cohort year, analyze both formally (numbers and percentages) and informally (anecdotal information from staff and advisory members) 1. Families who remain in services in comparison to families who leave. 2. Includes at least one analysis factor 3. The reason why families leave. For sites with less than 50 enrolled families at any one time over a two-year period, submit a narrative including: 1. The maximum number of families that were enrolled at any one time. 2. Informal data about families who leave service or are retained 3. Reasons why families are leaving services If at least ninety percent (90%) of families enrolled in services over a two-year timeframe remained in services, an analysis is not required. New sites not yet in operation for two full years with a retention rate of 90% during the first year are also exempt from completing an analysis.	HFA Spreadsheet or Retention Analysis for at least one cohort year. For sites not required to complete Retention Analysis, submit a narrative describing the reason for exemption. Please see glossary for more information on analysis.	Update Annually

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
4-2.B Home Visit Completion	Quarterly	Submit home visit completion report for the most recent quarter which includes: All active families by FSS including level of service, level changes that quarter, number of expected home visits that quarter and number of completed home visits that quarter. To calculate home visit completion: 1. Determine for each family over the course of a quarter the expected number of home visits (based on level of service alone). 2. Count the number of completed visits (while family is on active service level) for each family during the quarter. 3. For each family calculate: #2 (completed visits) divided by #1 (expected visits). 4. Count the total number of active families. 5. Subtract from #4 (total active families) the number of families who were on creative outreach for the entire quarter. 6. Count the number of active families who received at least 75% of expected home visits. 7. Program HVC rate is calculated by taking #6 (number of active families who received at least 75% of visits) divided by #5 (active families - minus CO entire quarter).	HFA Spreadsheet or local Home Visit completion reports by FSS and rolled-up by site for the most recent 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 FSSs.* This is a threshold standard, meaning to be in adherence a minimum threshold has been established (75% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Quarterly
4-3.B Services minimum of three years	Annual	Local data.	Report indicating 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.	Update Annually
5-4.A Staff & Family Input	Every Year	Narrative Summary	Submit a narrative summary of most recent efforts to obtain meaningful feedback from parents/caregivers and staff (current and former). Include a summary of findings: summarize patterns and trends, strengths and challenges.	Update Annually
5-4.B Equity Plan **Essential Standard**	Every Year	Submit site's Equity Plan	Please submit the most recent site equity plan. Please note: Sample of organizational self-assessments available	Update Annually

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
6-3.D CHEERS Check-In	Annual	Submit a report of all enrolled focus children (including multiples) that includes: 1. Child's date of birth 2. CCI administration dates 3. Documentation of declined screening by primary caregiver Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children.	HFA Spreadsheet or CHEERS Check-In tracking report. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Annually
6-5.B ASQ Development Screening	Ongoing- All Active Focus Children	Submit a report of all enrolled focus children that includes: 1. Child's date of birth 2. Enrollment date 3. ASQ-3 administration dates 4. Documentation of a. Indication of delay and if a referral was made b. Not screened due to involvement of early intervention services c. Revised screening schedule (prematurity or other reason) d. If the timing of re-enrolling, transferring into services, or Child Welfare Protocol enrollment precludes availability of 2 remaining intervals in a given year for contextual decision-making by Peer Reviewers or Panel. Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children.	HFA Spreadsheet or ASQ-3 Tracking Report including explanation of any missed screens. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly
6-5.C ASQ:SE Social Emotional Screening	Ongoing- All Active Focus Children	Submit a report of all enrolled focus children that includes: 1. Child's date of birth 2. Enrollment date 3. ASQ:SE administration dates since 1/1/2018 4. Documentation of a. Indication of delay b. Not screened when developmentally inappropriate Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children.	HFA Spreadsheet or ASQ-SE-2 Tracking Report including explanation of any missed screens. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly
7-1.B Medical/ Health Care Provider	Ongoing- All Active Focus Children	Submit a report reflecting: 1. List and count all active focus children 2. List and count all active focus children w/medical provider, include provider Calculate: #2 (focus children w/medical provider) divided by #1 (total number of focus children)	HFA Spreadsheet or report detailing all active focus children and their current medical/health care provider, including percent of children with a provider. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recs
7-2.B Measure Immunization Rates at 1 yr	Ongoing-All Active Focus Children	Please submit the site's immunization schedule. Also submit a report reflecting immunization rates for all enrolled focus children ages 12-23 months (including those on Creative Outreach). 1. Count number of focus children currently between 12-23 months 2. Subtract from #1 (focus children between 12-23 months) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step #2), count how many are fully up to date with all immunizations expected through 6 months 4. Report number and calculate: #3 (those up to date) divided by #2 (number between 12-23 months minus those excluded from count) Children served through CWP who are enrolled between 6-12 months of age may be excluded from the Standard 7-2.B measurement if not up to date with immunizations at one year of age. Children served through CWP who are enrolled before 6 months of age will be included in all immunization data cohorts as described in the standard (see Standard 7-2).	HFA Spreadsheet or local data report and site's immunization schedule, including immunization rate. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Every 6 Months
7-2.C Measure Immunization Rates at 2yr	Ongoing-All Active Focus Children	Submit a report reflecting immunization rates for all active focus children 24 months and older (including those on creative outreach). 1. Count number of focus children currently older than 24 months 2. Subtract from #1 (focus children 24 months and older) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step #2), count how many are fully up to date with all immunizations expected through 18 months 4. Report number and calculate: #3 (those up to date) divided by #2 (number 24 months and older minus those excluded from count) Children served through CWP who are enrolled between 18-24 months of age may be excluded from the Standard 7-C.B measurement if not up to date with immunizations at two years of age. Children served through CWP who are enrolled before 6 months of age will be included in all immunization data cohorts as described in the standard (see Standard 7-2).* Sites will include the signed MOU with CWP partners in their accreditation self-study.	HFA Spreadsheet or local data report, including immunization rate. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Every 6 Months
7-4.B Prenatal Screening Primary Care Giver for Depression	Ongoing-All Active Focus Families	Submit a report of all current primary caregivers enrolled prenatally in the past 12 months. Include: 1. enrollment date 2. date of birth of focus child 3. Prenatal screening date(s) 4. Provide an explanation of any missed screens To calculate percent screened prenatally: 1. Count number enrolled prenatally 2. Count number screened prenatally Divide #3 (screened prenatally) by #2 (enrolled prenatally).	HFA Spreadsheet or local data report, including percent screened prenatally. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
7-4.C Postnatal Screening Primary Care Giver for Depression	Ongoing-All Active Families	Submit a report of all current primary caregivers enrolled in the past 12 months. Include: 1. Enrollment date 2. Date of birth of focus child 3. Postnatal screening date(s) 4. Provide an explanation of any missed screens To calculate percent of primary caregivers screened within 3 months: 1. Count number enrolled 2. Count number screened a. For prenatal enrollments, count if received within 3 months of the child's birth b. For postnatal enrollments, count if received within 3 months of enrollment c. Add these counts together (a + b) 3. Divide #2 (screened) by #1 (enrolled) for percent screened To calculate percent of primary caregivers screened within 6 months: 1. Count number enrolled 2. Count number screened: a. For prenatal enrollments, count if received within 6 months of the child's birth b. For postnatal enrollments, count if received within 6 months of enrollment c. Add these counts together (a + b). 3. Divide #2 (screened) by #1 (enrolled) for percent screened	HFA Spreadsheet or local data report, including percent of primary caregivers screened within 3 months and within 6 months. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	Update Monthly
7-4.D Subsequent Birth Depression Screen	Ongoing-All Active Families	Submit a report of all current primary caregivers with a subsequent birth in the most recent 12 months. Include: 1. date of birth of subsequent child 2. Postnatal screening date(s) 3. Provide an explanation of any missed screens To calculate percent of primary caregivers screened: 1. Count number who had a subsequent birth 2. Count number screened within 3 months of the subsequent birth 3. Divide #2 (screened) by #1 (number with a subsequent birth) for percent screened	HFA Spreadsheet or local data report, including percent of subsequent births screened within 3 months. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.	
8-1.B Caseload monitoring	Ongoing-All Active Families	Report indicating the active caseload for all current FSS over the past 12 months. Include each FSS's full time equivalency, the number of families assigned to them, and the level/intensity of service each family is receiving.	HFA Spreadsheet or local data report.	Update Monthly

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
9-4. Staff Satisfaction and Retention	Every other year	Submit: 1. For staff retention Include staff (by position title) who left during the timeframe (12 months for new sites, 24 months for all others), their hire date, termination date, reason why they left; and any other pertinent characteristics. 2. For staff satisfaction include a summary of staff satisfaction input in regard to work conditions that contribute both negatively and positively to job satisfaction (typically aggregated survey results) for those currently employed with the HFA site. Agency-wide staff satisfaction surveys, if used, must be filtered and reported for HFA staff only. Include strategies developed for staff retention based on what was learned from retention and satisfaction data.	Narrative reflecting factors associated with staff turnover along with satisfaction feedback from existing HFA staff utilized to develop staff retention strategies, improve diversity and inclusion, and promote equity. Include which strategies have been implemented. Please note: Sample Surveys available	Update Annually
10-2. Orientation Training	Ongoing-All Current Staff	Training Logs indicate the date of hire and the date staff person began providing direct service or supervision, along with the date each staff person (direct service staff, supervisors, and program managers) completed each of the orientation topics (10-2.A-H). Also include the date the program manager's supervisor completed 10-2.A.	HFA Training Log or local training report.	Update Monthly
10-3. Stop-Gap Training	Ongoing-All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (direct service staff, supervisors, and program managers).	HFA Training Log or local training report.	Update Monthly
10-4. HFA Core Training **Essential Standards**	Ongoing-All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (direct service staff, supervisors, and program managers).	HFA Training Log or local training report.	Update Monthly
10-5. Implementation Training	Ongoing-All Current Staff	Training Logs including hire date and date of all training topics received for program manager.	HFA Training Log or local training report.	
10-6. Screening Tools Training	Ongoing-All Current Staff	Training Logs including hire date, date of all trainings received, and date of first tool administration (or tool supervision) for all current HFA staff and supervisors who are responsible for the administration of the screening tools or supervising the use of the screening tools.	HFA Training Log or local training report.	

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
11-1. through 11.3 Wrap Around Training	Ongoing- All Current Staff	Training Logs including hire date and date of training topics received for current HFA supervisors & direct service staff. All staff at affiliated HFA sites may use the online trainings developed by HFA (or other training resources provided by the National Office) to complete the 11-1, 11-2, and 11-3 training topics. If sites use something other than HFA's recommended online wraparound training, the training will comprehensively address each of the overall topics with a variety of relevant subtopics critical for preparing staff to do this work. Program Managers will have documentation of training topics related to diversity and equity (11-1.D,11-2.G,11-3.E).	HFA Training Log or local training report.	Update Monthly
11-4. Ongoing Training	Ongoing- All Current Staff	Training Logs including hire date and date of all training topics received for all current HFA staff (direct service staff, supervisors, and program managers).	HFA Training Log or local training report.	Update Monthly
12-1.B Frequency and Duration of Supervision	Quarterly	Please submit a report indicating the frequency and duration of supervision sessions for the most recent quarter. 1. Determine needed frequency and duration of supervision per FTE guidelines within BPS for each direct service staff 2. Determine number of expected supervision sessions for each staff member for one quarter 3. Subtract from #2 (expected sessions) any excused sessions per guidelines provided by BPS 4. Count number of supervision sessions that occurred within proper timeframes and for expected duration 5. Divide #4 (number of supervision sessions at required duration) by #3 (expected sessions minus those excused) 6. Create report to communicate findings for each staff member	HFA Spreadsheet or local data report.	Update Monthly

Summary and Guidance for Data Collection Timeframes

Standard	Required Timeframe	How to Measure Please Note: HFA Spreadsheets are available	What to report for Accreditation (see also Tables of Documentation by Standard)	Ongoing QA Recommendations
GA-2.A Quality Assurance Plan	Annually	Site's Quality Assurance Plan	Please submit the site's Quality Assurance Plan including QA activities related to all aspects of site implementation (initial engagement, home visiting, supervision and management). Indicate how these activities have been implemented and follow-up mechanisms developed and implemented to address areas of improvement. Sample Quality Assurance Plan Template Available.	Update Quarterly
GA-2.B Quality Improvement Plan	Annually	Site's Quality Improvement Plan	Please submit site Quality Improvement Plan including improvement goals, improvement strategies and annual progress review. Sample Quality Improvement Plan Template Available	Update Quarterly

STANDARD 1

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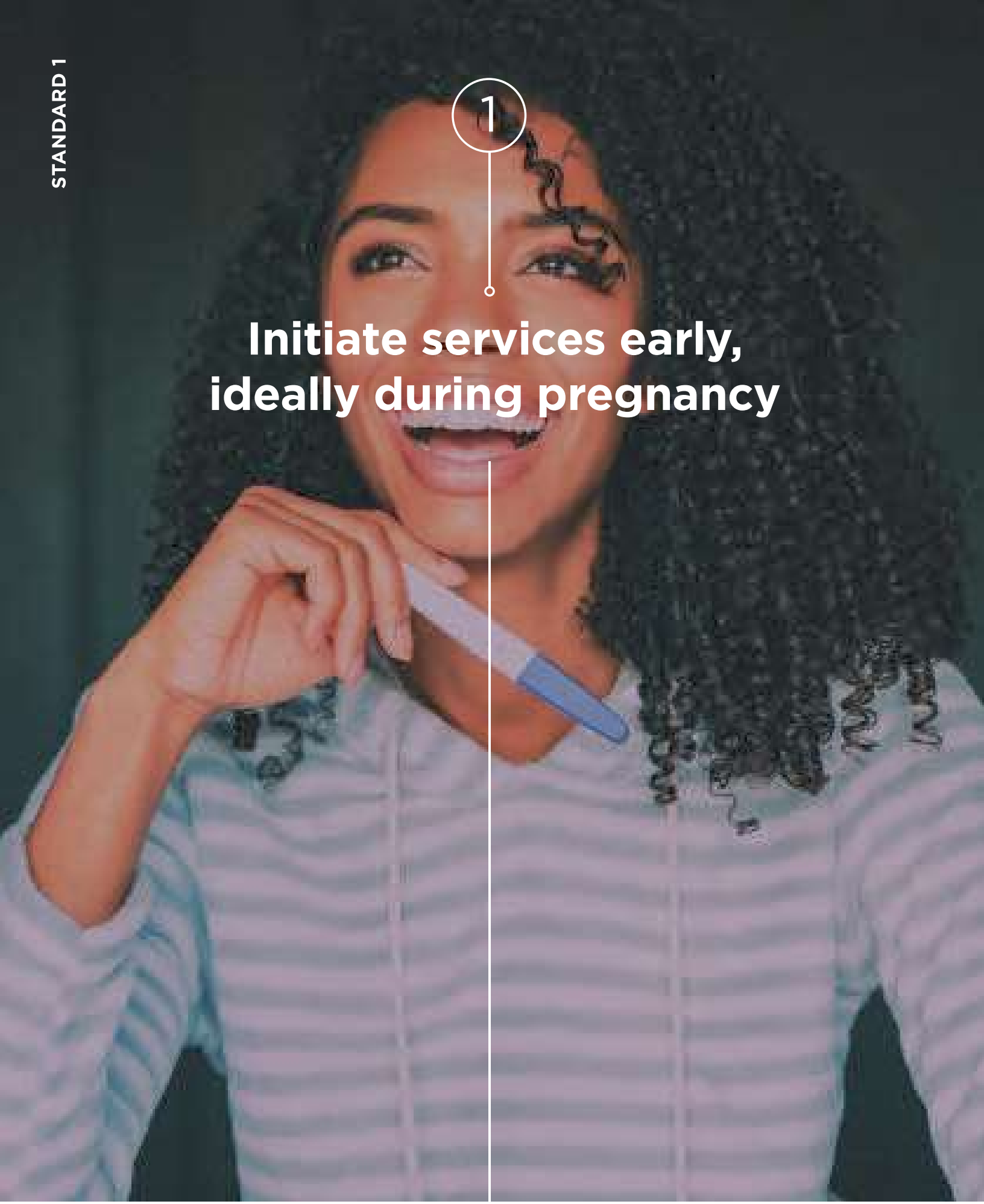
Initiate services early, ideally during pregnancy



Standard 1 Intent is to ensure the site has a well-thought out mechanism for the early identification and engagement of families who could benefit from services. The earlier families are enrolled during pregnancy the greater the opportunity to support healthy practices during pregnancy which can lead to improved birth outcomes (Lee, E., et al, 2009) and longer term parent and infant health.

When enrolled in the newborn period (0-3 months), parents can be supported with consistent, responsive, nurturing caregiving practices early in the infant's development, helping to ensure a secure attachment relationship. This timing is pivotal and research demonstrates it can increase resilience and buffer the child from later adversity (Hambrick, Brawn & Perry, 2017). Children who are securely attached as infants tend to develop stronger self-esteem and better self-reliance as they grow older and also tend to be more independent, perform better in school, have successful social relationships, and experience less depression and anxiety (Young, Simpson, Griskevicius, Huelsnitz, & Fleck, 2019).

1-1. The site has a description of its eligibility criteria and the community relationships in place to identify and initiate services during pregnancy or within three months of birth. *Please Note*: See glossary for limited exception and approval process related to HFA's Child Welfare Protocols.

1-1.A The site has a description of: 1) its eligibility criteria 2) how these criteria were selected, 3) the defined service area, and 4) the number of families the site has capacity to serve. Eligibility criteria are determined based on data collected from one or more sources, e.g., a community needs assessment, kidscount.org, state rankings, vital records, census.gov, etc., and are reviewed by the site's community advisory board at least once every four years.

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 in partnership with parents of infants and young children. It is important for the site to focus on creating equitable access to services for families experiencing barriers to resources and to base its eligibility criteria on community data, ensuring a systematic process for identifying families is in place.

The site's eligibility criteria are reviewed at least once every four years and updated as changes in funding, site infrastructure, or community demographics warrant. When the site is approved to implement HFA's Child Welfare protocols for families referred from child welfare, this must be referenced in the site's eligibility criteria description.

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For example, I work with my community advisory board and we determine teen parents are the eligibility criteria we will use, because teen parents are an underserved demographic in our area and there are very few existing services in our community to support them. We know from the Kids Count Data Center (kidscount.org), in the most recent year data is available, a total of 1,000 women under the age of 20 gave birth in our area. We also know 780 women under the age of 20 gave birth in our city's largest birthing hospital last year. We therefore define our eligibility criteria as pregnant or parenting teens (with an infant less than 3 months old), who reside in Babyville County. We have ten full-time Family Support Specialists able to serve a total of 200 families each year.

1-1.A RATING INDICATORS

3 The site has a description of 1) its eligibility criteria 2) community data (include source and year) used in deciding on these criteria, 3) the geographic service area, and 4) the total number of families projected annually to be served based on site capacity. The description and data utilized have been reviewed by the site's community advisory board **within the last two years,** and adjusted as needed based on changing community demographics or program infrastructure.

2 The site has a description of 1) its eligibility criteria 2) community data (include source and year) used in deciding on these criteria, 3) the geographic service area, and 4) the total number of families projected annually to be served based on site capacity. Both the description and data utilized have been reviewed by the site's community advisory board **within the last four years** and adjusted as needed based on changing community demographics or program infrastructure.

1 The site does not yet have a description of its eligibility criteria; or any of the following are not yet included: community data (source and year), service area, or total number of families projected annually to be served; or it has been four years or more since the community advisory board last reviewed.

TIP: Sites are encouraged to be realistic when identifying eligibility criteria. For example, while it is commendable to want to reach all families giving birth, fiscal capacity or limited staffing may make this goal unrealistic.

TIP: Eligibility criteria may include factors such as: parent age, Medicaid eligibility, geographical area, first time pregnancy, a particular number of positive screen factors, a certain score or higher on the Family Resilience and Opportunities for Growth (FROG) Scale, etc.

1-1.B The site establishes organizational relationships with community providers for purposes of identifying families and receiving referrals (e.g., local hospitals, prenatal clinics, high schools, centralized intake systems, etc.). Please Note: for sites approved to use HFA's Child Welfare Protocols, a formal Memorandum of Understanding (MOU) between the HFA site and local child welfare office is required. HFA has a sample MOU.

Intent: In addition to the site's description of its eligibility criteria and process for determining eligibility, the site will indicate the community providers who identify and refer families to HFA services. In order for sites to engage families, it is essential to create relationships with community entities who come into contact with families. In some cases these community partnerships may require formal Memorandums of Understanding/Agreement (MOU/MOA), and in other cases these relationships may be verbal agreements or informal in nature. In either case, it is important these relationships allow site staff to initially engage with families. The site will decide if a formal agreement would be beneficial with some of its referral sources. Some sites may have only formal agreements in place, while others will have only informal (verbal) agreements in place, and others still may have a mix of both formal and informal.

i

Continuing with the example in 1-1.A for Babyville County, the HFA site there reaches out to the largest birthing hospital where 780 births to women under the age of 20 occurred last year. We establish a Memorandum of Agreement with the hospital's social work department to identify and refer teen parents to our HFA site. We invite the hospital's Social Work Department director to participate on our Community Advisory Board to ensure ongoing communication, and we coordinate in-service meetings with key hospital unit staff to provide them with materials and information about our HFA services, including how to describe HFA services to families. Similarly, we engage our local WIC provider, though in a less formal way (without an MOA) so they too are aware and can refer teen parents who meet our criteria (pregnant or with a newborn, and living in Babyville County). We track each month how many referrals are coming in from each referral partner and from any other sources.

1-1.B RATING INDICATORS

3 No 3 rating indicator for 1-1.B.

2 The site identifies organizations within the community where families can be referred from, and agreements (either formal or informal) are in place. Sites approved by the National Office to implement HFA's Child Welfare Protocols have an MOU established with the local child welfare office.

1 The site does not yet identify organizations within the community where families can be referred from, or the site has not yet initiated relationships with identified referral organizations; or if approved to use HFA's Child Welfare Protocols, does not have an MOU established with the local child welfare office.

1-1.C The site tracks the number of families identified or referred by referral source, and their eligibility status. The site implements strategies to help maximize existing program capacity and support family needs in the community. *Please Note:* An HFA Spreadsheet is available for this standard.

Intent: Tracking the number of families identified or referred allows the site to utilize data effectively to advocate for families in the community whose needs may go unmet. For example, there may be many more potential families than can be served owing to the site's current capacity. This data provides the site with valuable information to maximize existing staff capacity, allowing the site to determine what dynamics might be getting in the way of engaging families in services.

Monitoring the system of organizational relationships is a key component to understanding how families are identified or referred. The site will use this data to develop strategies to improve its identification and referral processes (e.g., form new community provider relationships, strengthen existing provider relationships, provide in-service training for referral agencies including how to describe services in ways that may be more appealing to families, create more effective ways to identify families in the service area, etc.).

i

For example, over the past four quarters, the Babyville HFA site received a total of 350 referrals, with 210 referrals from the birthing hospital, 90 from WIC, 46 from a local food pantry, and 4 self-referrals; however, 100 of these referrals were duplicates or did not meet eligibility criteria because they either resided outside the county or were not teens. As a result 250 referrals received in the past year met eligibility criteria. With ten full-time Family Support Specialists, we have capacity to serve 200 families at any given time, and have remained at capacity each of the last four quarters. One hundred twenty (120) of the 250 referrals could not be served given current capacity limitations. Since we have seen similar trends over the past two years, Babyville's community advisory board has helped identify potential funding sources to support an additional 1-2 Family Support Specialists. We are in the process of applying for these funds.

1-1.C RATING INDICATORS

3 The site tracks at least quarterly all families identified or referred to Healthy Families services, indicating whether the family was eligible or not, and the source of each referral. The site, in conjunction with its community advisory board, uses this data to monitor program capacity and apply strategies to fill available slots when not yet at full capacity, and, when at capacity, to reduce gaps in service availability. The site discusses with its community advisory board opportunities for improvement at least once annually.

2 The site tracks at least quarterly all families identified or referred to Healthy Families services, indicating whether the family was eligible or not, and the source of each referral. Past instances may have occurred when the site did not track data quarterly or use this data to apply strategies to fill available slots or reduce gaps in service availability, however **recent practice** indicates this is now occurring. The site discusses with its community advisory board opportunities for improvement at least once annually.

1 Any of the following: the site has not yet tracked at least quarterly all families identified or referred; or does not yet identify the referral source; or has not yet applied strategies to increase capacity, or in conjunction with its community advisory board, discussed opportunities for improvement at least once annually.

TIP: When working in partnership with an external entity providing centralized intake, it will be important to have a formal agreement in place allowing reciprocal sharing of aggregate data. This includes how many families are being identified and referred to HFA by centralized intake and how many of these referrals are engaging in services. When partnering with centralized intake entities, it is important to periodically review criteria prompting referral to Healthy Families to ensure it is neither too broad nor too restrictive.

1-2. The site ensures all referrals into the HFA site are tracked and monitored from receipt of referral to the offer of services.

1-2.A The site has policy and procedures regarding initial engagement processes and mechanisms (from referral to offer of services) to ensure timely determination of eligibility and offer of service. Policy and procedures include each step of the process for all referrals, from receipt of referral to offer of service, the site's tracking and monitoring requirements, and documentation of reasons why when families are not offered services.

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:

- Activities and expected timeframe between receipt of referral and initial contact with family
- Activities and expected timeframe between initial contact with family and offer of services
- How and when eligibility is determined
- Mechanisms to track and monitor each step of the initial engagement process, whether able to establish initial contact or not, whether services were offered or not, and the timeliness of these activities
- Documentation of reasons why if families are not offered services

1 The site does not yet have policy and procedures; or the policy and procedures do not yet include the requirements listed in the 2 rating.

TIP: Things to consider 1) how do you receive referrals? 2) what eligibility criteria do you use? 3) what happens if a family does not meet these criteria?

TIP: Throughout the process, what are the points of contact with families? Which staff are responsible for these points of contact, and what is the goal for each step in the process? How quickly should this process move?

What is documented along the way (and where)? Is follow-up with the referral sources expected?

Are the policies and procedures detailed enough so someone unfamiliar with your site's process can carry out initial engagement by reading the policy?

TIP: It is recommended sites utilize the following timeframes, which help demonstrate to the family the site's responsiveness and the site's genuine care and concern for the family. A shorter window between referral and contact with the family has been demonstrated to increase the likelihood of successful engagement in services (unless site is at full capacity):

- Ideally less than five business days between receipt of referral and initial (actual or attempted) contact with family
- Ideally less than five additional business days between initial contact (actual) and offer of services

1-2.B The site monitors its initial engagement process, tracking the timeliness from receipt of referral to offer of service, whether able to establish initial contact or not, whether services are offered or not, and reasons why if families were not offered services.

Intent: Many families miss the opportunity to participate in services because site staff is unable, for a variety of reasons, to establish or maintain contact with them subsequent to the initial referral. Therefore, sites monitor closely the initial engagement process.

Please Note: For sites working with a centralized intake system that offers HFA services to families, the site will consider the offer of services to occur after the site receives the referral and contacts the family themselves to offer services.

Please Note: During times when HFA caseloads are at capacity, sites are discouraged from maintaining families on a waitlist. Telling eligible families they are on a waitlist conveys a promise of eventual enrollment, which may not be possible. It may be several months before an opening occurs and urgent or immediate needs the family has would go unattended, potentially at dire consequence to the family or child, bringing a liability risk to the HFA host agency. In such situations, a referral to other community services is preferred to wait-listing the family (unless a known opening is about to occur). Most often, the reason sites use a waitlist is to ensure caseload capacity can be maintained should a family leave services early. While this may be in service to the agency to demonstrate consistent capacity levels, it is not in service to the family. It also undermines the ability to initiate services as early as possible.

1-2.B RATING INDICATORS

3 The site monitors its initial engagement process. For each family referred, the site tracks the length of time from referral to offer of services, whether able to establish initial contact or not, whether services were offered or not, and when services are not offered to the family, reasons why are documented.

2 The site monitors its initial engagement process. Past instances may have occurred when the site did not track each family referred, including the length of time from referral to offer of service, whether able to establish initial contact or not, whether services were offered or not, and when services were not offered to the family, reasons why were not documented, however **recent practice** indicates this is now occurring.

1 The site does not yet monitor its initial engagement process; or track the timeliness of its initial engagement process from referral to offer of service; or, when services are not offered, the reasons why are not yet being documented.

1-2.C The site develops strategies, based on its data from 1-2.B, to strengthen its initial engagement process with families, aiming to reduce barriers and provide equitable access to HFA services.

Intent: The intention behind all data collection should be the opportunity to monitor quality and to guide continuous quality improvement efforts. With data the site collects for standard 1-2.B, it will develop strategies for increasing the capacity of the site to connect with families and improve initial engagement.

1-2.C RATING INDICATORS

3 The site has **applied strategies** to improve the initial engagement process or 90% of families referred received initial contact and were offered services, in which case strategies do not need to be applied.

2 The site has **developed strategies** to improve the initial engagement process.

1 The site has not yet developed strategies to improve the initial engagement process.

TIP: Sites are encouraged to follow-up with referring entities (assuming referring organization has a signed consent in place for information sharing) to provide information regarding the outcome of their referral(s), including when the initial contact with the family is not completed.

1-3. The first home visit occurs within three months after the birth of the baby for at least 80% of families; for sites approved to use HFA's Child Welfare Protocols, the first home visit occurs within twenty-four months for at least 80% of families referred from child welfare.

See glossary for limited exception and approval process related to HFA's Child Welfare Protocols.

Intent: HFA research, as well as significant anecdotal evidence, demonstrate the model'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 sensitive period
- the patterns of the parent-infant relationship, including parental responsiveness and interpretation of infant behavior, begin during this period, and strategies employed by Family Support Specialists can promote healthier bonding and attachment
- families with limited exposure to healthy, trusting relationships gain the ability to form a trusting relationship with a Family Support Specialist over time

The earlier the alliance between Family Support Specialist and parent is formed, the greater the likelihood of increased family engagement and retention, and improved outcomes.

1-3.A The site has policy and procedures describing activities to ensure at least 80% of families receive a first home visit prenatally or within the first three months after the birth of the baby (i.e., up until the baby turns 3 months of age), or within 24 months for families referred from child welfare (when approved by the National Office to use HFA's Child Welfare Protocols).

1-3.A RATING INDICATORS

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

2 The site's policy and procedures describe the site's activities to ensure: the first home visit occurs prenatally or within the first three months after the birth of the baby for at least 80% of families; or for sites approved to use HFA's Child Welfare Protocols, within twenty-four months for at least 80% of families referred from child welfare.

1 The site does not yet have policy and procedures, or the policy and procedures do not yet address the requirements listed in the 2 rating.

1-3.B The site's practices ensure, for families who accept services, the first home visit occurs prenatally or within the first three months of the birth of the baby, or within 24 months of birth for sites approved to use HFA's Child Welfare Protocols, for at least 80% of families initiating services in a given year.

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 and will be exempted from the requirements of this standard.

Please Note: Sites approved to implement HFA's Child Welfare Protocols will calculate separately the percentage of families referred from child welfare with at least 80% or more of first home visits by 24 months of age.

Please Note: Sites are encouraged to accept transfers from other sites whenever appropriate and to re-enroll families with the same focus child when previously closed from services. Any transfers or re-enrollments when the child is already 3 months old or older will be exempted from this calculation. Re-enrollment of graduate or soon-to-graduate families (on Level 3) with a new focus child (based on a subsequent pregnancy) is discouraged, given the progress the family has already demonstrated, and to ensure space is available to enroll brand new families.

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, and within twenty-four months after the birth of the baby for families referred from child welfare (when site has been approved to use HFA's Child Welfare Protocols).

2 **Eighty percent (80%) through ninety-four percent (94%)** of first home visits occur within the timeframes described in the 3 rating.

1 Less than eighty percent (80%) of first home visits occur within the timeframes described in the 3 rating.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% threshold, and supervision time is used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

1-4. The site measures the acceptance rate of families offered services on an annual basis and in a consistent manner and, at least once every two years, analyzes its data associated with family acceptance to better understand the underlying issues associated with families choosing to accept services or not.

1-4.A The site measures annually (12 consecutive months of data whether calendar or fiscal year) the acceptance rate of families offered services, using HFA methodology (based on receipt of first home visit and using both numbers and percentages). When measuring and analyzing, sites can use the An HFA Spreadsheet is available for this standard.

Intent: Calculating the site's acceptance rate is a critical quality improvement measure. Sites look at the total number of families offered services over the course of a year and what number and percentage 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. Please Note: As stated in the glossary, the first home visit is the first visit completed by the assigned Family Support Specialist after eligibility has been determined, where rights and confidentiality forms are signed (unless already signed), CHEERS is observed, and at least one focus area of a home visit (see glossary for home visit definition) occurs. The visit is documented on a home visit record.

1-4.A RATING INDICATORS

3 The site measures its acceptance rate of families (using HFA methodology) into services and acceptance rates are being **measured more than once a year.**

2 The site measures its acceptance rate of families (using HFA methodology) into services and acceptance rates are being **measured annually.**

1 The site is not yet measuring its acceptance rate using HFA methodology at least annually.

1-4.B For sites with 50 or more families offered Healthy Families services over a two-year period, the site analyzes its data, to identify to identify possible reasons for changes in the site's acceptance rate, comparing data for families who accept services to those who decline services (including the reasons why families decline services). Please see glossary for common terms associated with analyses. An HFA Spreadsheet is available for this standard.

For smaller sites with less than 50 families offered services over a two-year period, the site will at a minimum review anecdotal information from staff about any patterns associated with acceptance and reasons why families are not accepting services, at least once every two years. The site will do a more thorough analysis when the sample size over a two-year period is 50 or more.

Intent: Sites conduct a thorough acceptance analysis at least once every two years to determine possible reasons for changes in the site's acceptance rate. The analysis examines various factors of those who accept services (demonstrated by completion of a first home visit) compared with those, during the same time period, who were offered services yet never received a first home visit. The site will determine which factors it analyzes based on trends or patterns it has observed. The intent is to ensure the analysis can yield meaningful results that lead to activities to address underlying causes and increase acceptance as a result (see GA-2.B) *Please Note*: Sites can analyze data more frequently than every other year if beneficial to the site. *Please Note*: Brand new sites will complete a first analysis with one year of data instead of two. If the site is both new and small (fewer than 25 families offered services over one year; or less than 50 over two years), they will report on informal information and reasons why for families who declined services.

1-4.B RATING INDICATORS

3 The site uses formal data (numbers and percentages) and anecdotal information from staff to analyze, at least once every two years, families who declined services and why. The analysis examines data to identify and better understand possible reasons for changes in the site's acceptance rates. The analysis **includes at least three (3)** factors in its comparison of those who accepted and those who declined during the same time period

OR at least ninety percent (90%) of families offered services over a two-year timeframe accepted services by receiving a first home visit, in which case an analysis is not required. New sites not yet in operation for two full years with an acceptance rate of 90% during the first year are also exempt from completing an analysis.

2 The site uses formal (numbers and percentages) and anecdotal information from staff to analyze, at least once every two years, families who declined services and why. The analysis examines data to better understand possible reasons for changes in the site's acceptance rates. The analysis **includes one or two factors** in its comparison of those who accepted and those who declined during the same time period.

Sites with fewer than 50 families offered services over a two-year period have collected informal data and reasons why families are not accepting services

1 Any one of the following:

1) the site does not yet have an analysis of who declined services and why

2) the analysis does not yet include both formal data and anecdotal information

3) the analysis does not yet include a comparison of any factors of those who accepted and those who declined during the same time period

4) the analysis is not yet conducted at least once every two years

5) if a smaller site, the site has not yet, at a minimum, collected informal data and reasons why families are not accepting

NA The site did not offer HFA services to any families in the last two years, or there were less than 10 families who declined service during the two-year period to determine any patterns.

TIP: While sites choose which factors to include in their acceptance analysis it is recommended sites consider the role race and ethnicity may have on acceptance. In addition it is recommended that sites consider the impact of factors related to the program (such as staffing issues, or policy issues) may have on family acceptance. Sites are encouraged to reflect on any trends observed from the last acceptance analysis to the present one, and any lessons to be learned.

Tables of Documentation

*Note: Submit Self Study Face Sheet with Self Study

1. Initiate services early, ideally during pregnancy.

Standard	Pre-Site Documentation to include in Self Study
1-1.A | Eligibility Criteria	Submit a narrative description of: 1) Site eligibility criteria 2) how these criteria were selected, 3) the defined service area, and 4) the number of families the site has capacity to serve. Eligibility criteria are determined based on data collected from one or more sources and reviewed at least once every four years.
1-1.B | Referring Organizations	Submit a narrative identifying organizations within the community where families can be referred from, and the formal/informal agreements in place. Sites approved by the national office to implement HFA's Child Welfare Protocols have an MOU established with the local child welfare office. Sample MOU available.
1-1.C | Tracking Referrals and Site Capacity	Submit report reflecting all families referred in the most recent quarter: 1. Number of families referred by each referral source 2. Their eligibility status 3. Include most recent plan with strategies to fill available slots or reduce gaps in service availability and indicate which have been applied Please note: An HFA Spreadsheet is available for data elements of this standard
1-2.A | Policy – Initial Engagement Process	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
1-2.B | Initial Engagement Process	Submit a narrative about how the site monitors its initial engagement process and activities reflecting all families referred in the most recent year. A data report may be submitted in combination with a narrative regarding engagement activities. HFA's spreadsheet includes: 1. The length of time from referral to initial contact 2. The length of time from initial contact to offer of services 3. Whether able to establish initial contact or not 4. Whether services were offered or not 5. Reasons why if services not offered Please note: An HFA Spreadsheet is available for this standard.
1-2.C | Initial Engagement Process - Developed Strategies	Submit a narrative of developed strategies (based on data from 1-2.B) to improve the initial engagement process with families reducing barriers to ensure equitable access to HFA services.
1-3.A | Policy - First Home Visit Within 3 Months or Within 24 Months if Approved To Use CWP	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available

Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
1-3.B | First Home Visit Within 3 Months	Submit a report reflecting all families who received a first home visit in the most recent year. 1. Count number with a first home visit 2. Count number with first home visit either prenatally or within 3 months of birth 3. Calculate: #2 (number with first home visit prenatally or within 3 months) divided by #1 (number who had a first home visit) For sites enrolling families through Child Welfare Protocols (CWP), remove CWP families from the calculation above to calculate CWP families separately, 1. Count CWP number with a first home visit 2. Count CWP number with first home visit within 24 months of birth 3. Calculate: 2. (number with first home visit within 24 months) divided by 1. (number with a first home visit) Please note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
1-4.A | Measure Acceptance Rate	Submit a narrative describing the site's definition of acceptance rate and method for calculation (unless using HFA spreadsheet) and the current acceptance rate for all families offered services in the most recent year. 1. Count number offered HFA home visiting services 2. Count number with a first home visit 3. Calculate: #2 (number with a first home visit) divided by #1 (number offered services) Please note: An HFA Spreadsheet is available for this standard.
1-4.B | Acceptance Analysis	Analyze the data from all families who were offered services during at least the most recent year. Analyze both formally and informally: 1. Families who refused services in comparison to families who accept services 2. Includes at least one analysis factor 3. The reasons why families decline Please note: An HFA Spreadsheet is available for formal analysis. Please see glossary for more information on analysis. For smaller sites with less than 50 families offered services over a two-year period, the site is required at a minimum to submit a narrative including: 1. The number of families offered services within the two-year period 2. Informal data about families who refuse services or accepts services 3. Reasons why families are not accepting services For sites not required to complete Acceptance Analysis, submit a narrative describing the reason for exemption: If at least ninety percent (90%) of families offered services over a two-year timeframe accepted services by receiving a first home visit, an analysis is not required. New sites not yet in operation for two full years with an acceptance rate of 90% during the first year are also exempt from completing an analysis.

STANDARD 2

2

Sites use the validated Family Resilience and Opportunities for Growth (FROG) Scale to identify family strengths and concerns at the start of services.

Standard 2 Intent is to ensure the site has an objective process for learning about each family's strengths and concerns at the start of services. The FROG Scale is a family-centered tool used to identify the presence of both protective factors that promote resilience and factors associated with increased risk for child maltreatment or other adverse childhood experiences. It is used at the start of services to guide initial service planning and ongoing support services for the family throughout the course of services based on their identified strengths and needs.

2-1. The site is required to use the FROG Scale at the start of services to provide the family an opportunity to tell their story, to identify the presence of protective factors as well as factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences, and to support the development of a service plan to support the unique needs of each family.

Intent: Parents/caregivers represent a broad variety of backgrounds, experiences, values, and cultural norms, and these are combined in unique ways in each individual family. What may appear as a risk factor in one family may be mediated by nurturing relationships and/or significant protective factors in another. By completing the Family Resilience and Opportunities for Growth (FROG) Scale, staff learn about each family's strengths and concerns and are better able to plan services and resources that will be of most interest and benefit to the family.

2-1.A The site has policy and procedures requiring the FROG Scale be administered to identify risk and protective factors that could contribute to or mediate the risk for child maltreatment or other adverse childhood experiences. The policy and procedures also require documentation of these risk and protective factors be completed in narrative format that fully describes the concerns/needs and strengths expressed by the parent(s) during the FROG Scale conversation, and all items are scored in accordance with the guidelines of the tool. The policy and procedures identify who is responsible for administering the tool and the timeframe for completing the narrative, including supervisor review.

Intent: Site policy and procedures ensure the FROG Scale is administered objectively and reliably, and in a relationship-building, conversational style. Using a conversational style allows parents to share their story in a way that makes sense to them and enables staff to follow up for greater understanding of the family's experiences. When parents are able to tell their story at the onset of service (or as soon as possible thereafter), the parent feels heard and valued. The intent with the FROG Scale is for staff to explore all areas while understanding parents are only expected to share as much as they are comfortable sharing. Doing so conveys the respect all families deserve, and sets the stage for a genuinely attentive and responsive relationship.

Site policy also includes expectations for the documentation of the FROG Scale narrative to ensure it conveys accurately what each family shared in regard to strengths, risk factors, questions, and concerns. Consistent documentation in this way ensures accurate scoring of the tool and provides Family Support Specialists with an understanding of each family and an opportunity to provide individualized service planning based upon each family's unique strengths and concerns.

The FROG Scale is completed in as timely a way possible, i.e., no later than the fourth home visit (ideally within 30 days of enrollment though the fourth home visit may extend beyond 30 days if parents are not immediately receptive to weekly home visits).

Please Note: Some sites choose to use the FROG Scale to determine eligibility, in which case it will be completed prior to the first home visit.

2-1.A RATING INDICATORS

3 The site policy and procedures require:

1) The FROG Scale is completed **on or before the first or second home visit (ideally within a single visit and no later than within 15 days from enrollment).**
2) The FROG Scale is documented in narrative format detailing the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences. Any area not yet documented is identified for later conversation and inclusion in the service plan when needs warrant (the same is true for any updated information a family shares at a later time).
3) Responses from parents (or partner/significant other) present at the FROG visit are scored (0-4 or UR) in all domains the parent shared information for. When staff do not explore a particular area of the FROG, the reason is documented.
4) The timeframe for completing the narrative documentation and scoring is identified.
5) The process and timeframe for supervisor review and feedback are identified.

2 The site policy and procedures require:

1) The FROG Scale is completed **by the third or fourth home visit (ideally within a single visit and no later than 30 days from enrollment).**
2) The FROG Scale is documented in narrative format detailing the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences. Any area not yet documented is identified for later conversation and inclusion in the service plan when needs warrant (the same is true for any updated information a family shares at a later time).
3) Responses from parents (or partner/significant other) present at the FROG visit are scored (as 0-4 or UR) in all domains the parent shared information. When staff do not explore a particular area of the FROG, the reason is documented.
4) The timeframe for completing the narrative documentation and scoring is identified.
5) The process and timeframe for supervisor review and feedback are identified.

1 The site does not yet have policy and procedures including the detail listed in the 2 rating.

2-1.B The FROG Scale is administered and documented uniformly and in accordance with site policy and procedures.

2-1.B RATING INDICATORS

3 The FROG Scale is administered and documented in accordance with site policy and procedures.

2 Past instances may have occurred when the site did not administer and document the FROG Scale in accordance with site policy and procedures; however, **recent practice** indicates this is now occurring.

1 The site does not yet administer and document the FROG Scale in accordance with site policy and procedures.

Note: This is an Essential Standard.

TIP: Sites are encouraged to highlight/document specific conversations indicating 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," or "I am not going to use a belt to discipline my baby"). Statements like these assist FSSs in identifying potential starting points for home visit activities and can facilitate connections with families.

TIP: Information gathered on the FROG Scale is used throughout the time a family is enrolled in HFA for ongoing service planning and is the basis for standards 6-1.A, 6-1.B, and 6-1.C.

2-1.C The FROG Scale is administered within the timeframe identified in the site's policy and procedures.

2-1.C RATING INDICATORS

3 The FROG Scale is administered within the timeframe identified in the site's policy and procedures (by the 2nd visit or the 4th visit).

2 Past instances may have occurred when the site did not administer the FROG Scale within the timeframe identified in the site's policy and procedures (by the 2nd visit or the 4th visit); however, **recent practice** indicates this is now occurring.

1 The site does not yet administer the FROG Scale within the timeframe identified in its policy and procedures.

2-1.D Supervisors provide support and skill building to staff such that FROG conversations are done in a manner that is respectful, culturally responsive, and strength-based. Supervisors review and provide feedback to staff who administer the FROG Scale to ensure consistent quality of scoring and documentation.

2-1.D RATING INDICATORS

3 Supervisors review and provide feedback to staff each time the tool is administered to ensure documentation is complete, scoring is accurate, and staff are supported over time in the way they engage families in the FROG Scale conversation.

2 Past instances may have occurred when the supervisor did not review and provide feedback to staff each time the tool is administered or support staff over time in the way they engage families in the FROG Scale conversation; however, **recent practice** indicates this is now occurring.

1 Supervisors do not yet review, provide feedback, and support staff each time the FROG Scale is administered.

TIP: When supervisors attend FROG Scale training, they are encouraged to complete post-training feedback activities with their trainer. Doing so helps to develop a process supervisors can use with their staff for ongoing review and feedback.

TIP: At the time of a site visit, a supervisor's initials or signature on the FROG Scale, along with notes in the staff Supervision binder can be used to indicate the review and feedback process and demonstrate that staff are receiving support and skill building over time in the way they engage families in the FROG conversation. Supervisors may choose to save the initial draft of the FROG Scale narrative, with comments they provided or suggestions for alternate scoring, though that is not required.

TIP: Supervisors are strongly encouraged to review the FROG Scale within five business days of administration (allowing staff 1-3 business days to complete documentation and the supervisor an additional 1-2 business days to review after receiving it from staff). This helps ensure the family's immediate concerns can be addressed promptly and service planning can begin in as timely a way as possible.

Tables of Documentation

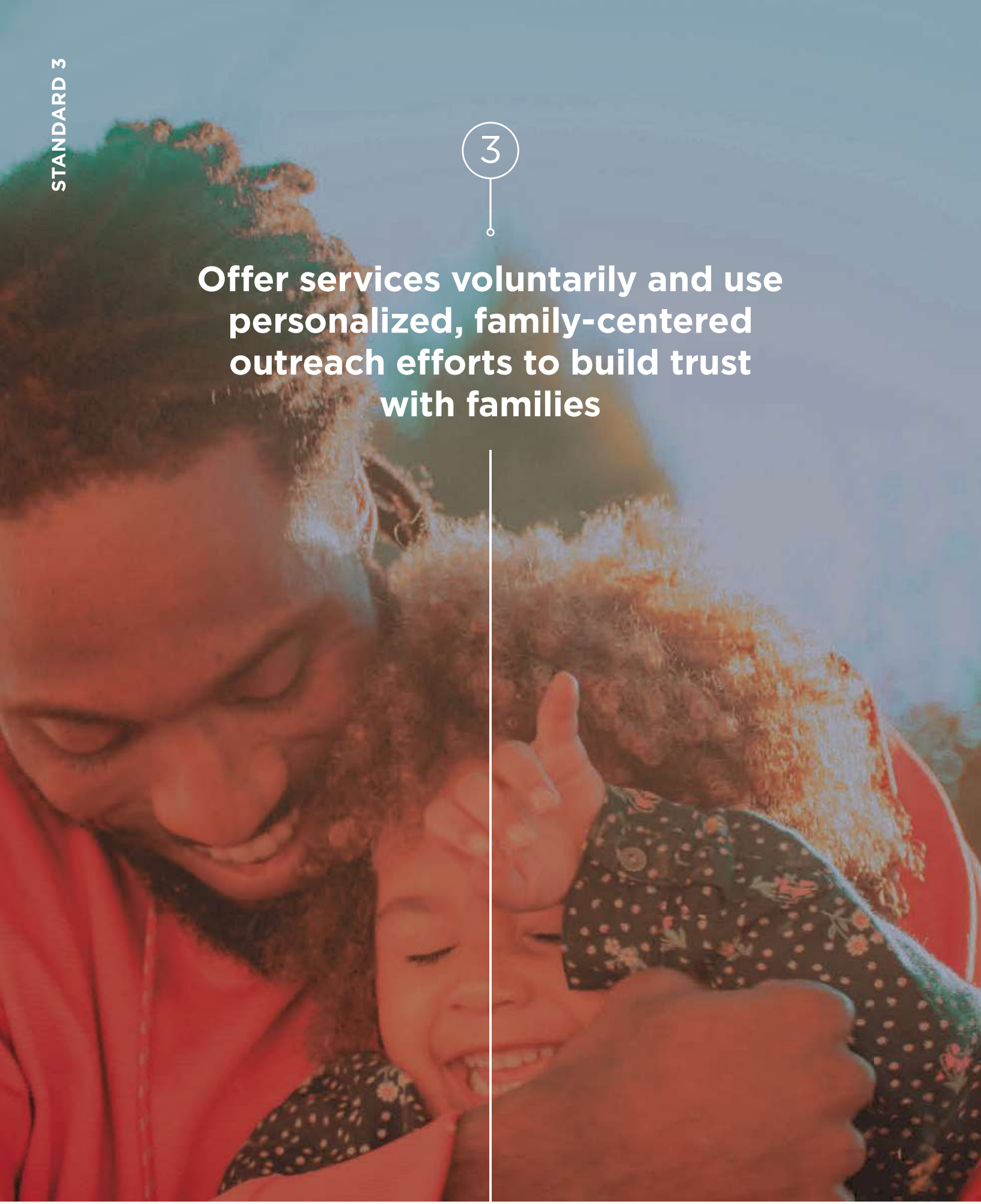
2. Sites use the validated Family Resilience and Opportunities for Growth (FROG) Scale to identify family strengths and concerns at the start of services.

Standard	Pre-Site Documentation to include in Self Study
2-1.A | Policy - FROG Scale	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
2-1.B | FROG Scale Uniformity **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
2-1.C | FROG Scale Timeframes	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
2-1.D | FROG Scale Supervision	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

STANDARD 3

3

Offer services voluntarily and use personalized, family-centered outreach efforts to build trust with families



Standard 3 Intent is to ensure the site has an equitable process for reaching out to and engaging families initially as well as throughout the time families choose to remain enrolled. HFA's emphasis on trust-building informs the HFA Advantage–a relationship-focused and trauma-informed approach to working with families. Staff interact with families utilizing the components of secure attachment–safety, predictability, comfort, and pleasure–to develop trust. Providing outreach in this way reflects our commitment to families and demonstrates our understanding of the impact that institutional and generational mistrust and misuse of power have created. The HFA approach to outreach seeks to address some of the power imbalances that can be found in helping relationships by putting parents in control and engaging with them in partnership.

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 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 stating services are voluntary and including how this information is shared with families. Please Note: See Standard GA-3.B 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 decline 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 yet have policy and procedures regarding the voluntary nature of services, including 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: HFA is very clear about services to families being offered voluntarily; however, there may be some external agencies who require HFA as part of mandated treatment (e.g., child welfare, court systems, substance abuse treatment facilities, etc.). HFA does not have authority to prevent this type of referral: however, sites should remind referral entities of such and clarify with families that regardless of the intent of the referral entity, HFA services are voluntary and families may end services at any time. Doing so helps to reduce stigma and fear, and establishes for parents a greater sense of personal power and control.

Additionally, when the site enrolls families already open and active with child welfare (CPS), whether referred directly from CPS or not, and whether the site is approved to implement HFA's Child Welfare Protocols or not, HFA staff are not to monitor family's progress on behalf of CPS or the court. Sharing of family service information with child welfare or the court system is bound by HFA's confidentiality requirements and informed consent process (GA-3) (unless subpoenaed or directed by statute) which is authorized by the parent and 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 services are now offered to families solely on a voluntary basis.

1 There are instances in which services are not yet provided voluntarily.

3-2. Staff utilizes positive pre-enrollment outreach methods to build family trust and engage new families.

3-2.A The site has policy and procedures specifying a variety of positive methods to build family trust when engaging new families in services.

Intent: This standard reflects the need for staff to reach out to families and utilize trust-building methods and tools, including supervision support, when establishing relationships with families. When parents have experienced unresolved early childhood trauma, or been marginalized by society, their sense of whether people are safe, predictable, and pleasurable may be compromised. As a result, families may be reluctant to accept services and may struggle to develop healthy, trusting relationships. Therefore, site staff must identify positive ways to establish a relationship with a family. Utilizing a family-centered approach allows staff to focus on what is important to the family. Supervision is an excellent place to strategize ways to build trust and engage families. *Please Note*: This standard applies to families who have not yet enrolled or received a first home visit (i.e.,, subsequent to the site offering services), and is not to be confused with creative outreach expectations, which occur after the family is enrolled and has received a first home visit (Standard 3-3).

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 to build family trust when engaging new families to enroll in services.

1 The site does not yet have policy and procedures or the policy and procedures do not yet address the requirements in a 2 rating.

TIP: Pre-enrollment outreach methods are best when personalized and may include:

- warm telephone calls focused on the family's well being
- creative and upbeat notes which encourage parents to want to participate
- drop-by visits (exercising safety) and leaving a card when families are not home
- texting brief messages to let a parent know you are thinking about them
- anchoring conversations based on family's interests
- encouraging self-care practices

TIP: While there is no requirement for the amount of time staff will spend trying to initially engage families, it is recommended the pre-enrollment outreach (outreach services provided prior to the first home visit) concludes within 30-45 days of the first attempted contact with the family subsequent to their verbal acceptance. For early prenatal referrals or when sites are working to build caseloads, pre-enrollment outreach may extend longer.

3-2.B Staff utilize positive methods to build family trust when engaging them to enroll in services.

Intent: Staff utilize a variety of strategies to engage and enroll families in services. Research indicates 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 direct service staff (Fraiberg, 1975). Staff will develop unique ways to connect with families.

Please Note: If there are safety concerns based upon the initial screen or assessment, supervisors and direct service staff use caution when considering unplanned visits.

3-2.B RATING INDICATORS

3 Site staff use positive methods to build family trust when enrolling families in services.

2 Past instances may have occurred when positive methods were not used; however, **recent practice** indicates the site now uses positive methods to build family trust when enrolling families in services.

1 The site does not yet use positive methods to build family trust when enrolling families in services.

3-3. For families that have had at least one home visit, the site offers post-enrollment outreach (level CO) for a minimum of three months before discontinuing services (or for a cumulative three-month period over six consecutive months). Families remain at the case weight of the level they were on prior to moving to CO.

3-3.A The site policy and procedures specify when families are placed on a post-enrollment outreach level and the activities to be carried out (and documented) while the family is on outreach. The site maintains the case weight at the level prior to CO and all post-enrollment outreach levels are continued for three months (or for a cumulative three-month period over six consecutive months). Creative Outreach is only concluded prior to three months when families have engaged in services, declined services, moved from the area, or closed due to other allowable reasons (bolded below in the intent).

Families who are assigned a permanent worker from Level TR or returned to the service area from Level TO, but who are unable to be engaged on an active service level, will be moved to Level CO. In these situations, the cumulative time on TR or TO plus CO will be for a minimum of 90 days.

Intent: It is the site's responsibility to reach out to families who have received a first home visit, yet for a variety of reasons may not be comfortable receiving ongoing home visits in a consistent manner. Often families who have experienced trauma in their own childhood, or have been marginalized or oppressed, will find it difficult to trust others. Additionally, families currently in crisis may find it difficult to continue participation due to a variety of factors.

Creative outreach activities are uniquely tailored to the individual family and are focused on demonstrating to the family that the Family Support Specialist is genuinely interested in them and wanting to continue to offer services. Creative outreach activities occur consistently and at the frequency associated with their previous level throughout the three-month time period. Sites are advised to avoid correspondence demanding the family contact the site or threatening termination from services. While services may end up being terminated after the three-month timeframe, correspondence indicating such will likely add to the feelings of alienation and lack of trust families have. Repeated, positive attempts at interaction through personalized notes and texts may be more effective in establishing a trusting relationship.

Site policy will include criteria for closing prior to three months only if the family re-engages in service, declines services, moves out of the service area, or other allowable reasons for ending services **(parent no longer has custody, pregnancy terminated or ended in miscarriage, focus child or primary care provider is deceased, significant staff safety issues, or transferred to another program).**

Please Note: Use of outreach level change forms can be helpful to keep track of dates when changes in service level occurred but are not required if start and end dates of outreach are maintained in a data system. Only levels that require progress criteria be met for movement to less frequent visits are required to be maintained in the family record.

3-3.A RATING INDICATORS

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

2 The policy and procedures specify:
- when families will be placed on a post-enrollment outreach level (CO)
- the activities to be carried out and documented during the course of outreach
- outreach is continued for 3 months and the case weight from the family's previous level is maintained during this time
- CO is only concluded prior to 3 months (whether 3 consecutive months or 3 cumulative months during a consecutive 6-month period) when families have engaged in services, declined services, moved from the service area, other allowable reasons (parent no longer has custody, pregnancy is terminated or ends in miscarriage, focus child or primary care provider is deceased, significant staff safety issues, or transferred to another program), or permanent staff assignment has been reestablished.

1 The site does not yet have policy and procedures; or the policy and procedures do not yet address all points required in the 2 rating.

TIP: Post-enrollment outreach methods are best when personalized and may include:

- warm telephone calls focused on the family's well being
- creative and upbeat notes which encourage parents to want to participate
- drop-by visits (exercising safety) and leaving a card when families are not home
- texting brief messages to let a parent know you are thinking about them
- anchoring conversations based on family's interests
- encouraging self-care practices

TIP: It is common for families to go on and off creative outreach several times, particularly when the parent has a history of past relationships that have been unsafe, unstable, or unpredictable. Reluctance to engage may be a form of self- and family protection to avoid repeating a pattern of being hurt or victimized by others. Reluctance to engage might be one of few mechanisms a parent feels able to use in order to establish some amount of control over their lives. When the Family Support Specialist offers positive, attentive creative outreach activities, it demonstrates to the parent our genuine caring for the family.

TIP: Some of the most poignant and powerful stories of family outcomes are with families who were initially very hard to engage and were on and off creative outreach. Some sites have reported as many as 40-60% of families engage from creative outreach, which is tremendous. When considering the high-risk circumstances of families' lives and the vulnerability of babies, re-engaging just one family is a huge success.

TIP: It is recommended the Family Support Specialist check in with families regularly to obtain new or additional emergency contacts. Having updated secondary contact information, and consent from the parent to use if unable to locate, can make a significant difference in maintaining connections with families over the course of service delivery.

3-3.B Families disengaging from services are placed on post-enrollment outreach (level CO) and outreach activities are continued for at least three months (or for a cumulative three month period over six consecutive months), only concluding outreach prior to three months when families have engaged in services, declined services, moved from the area, or other allowable reasons as stated in the 3-3.A intent.

3-3.B RATING INDICATORS

3 The site places families disengaging from services on outreach appropriately, conducts activities while on outreach to engage the family, and continues creative outreach for at least three months. The only instances found when outreach was concluded prior to three months occurred when the family engaged in services, declined services, moved from the area, for other allowable reasons (parent no longer has custody, pregnancy ended in miscarriage, focus child or primary care provider is deceased, significant staff safety issues, or transferred to another program), or permanent staff assignment has been established.

2 Past instances may have occurred when families were not placed on outreach when disengaging from services; however, **recent practice** indicates the site places families on outreach, conducts activities while on outreach to engage the family, and continues outreach for at least three months. The only instances found when creative outreach was concluded prior to three months occurred when the family engaged in services, declined services, moved from the area, for other allowable reasons (parent no longer has custody, pregnancy ended in miscarriage, focus child or primary care provider is deceased, significant staff safety issues, or transferred to another program), or permanent staff assignment has been established.

1 Any of the following: the site does not yet place families on creative outreach when disengaging from services; does not yet conduct activities while on outreach to engage the family; or does not yet continue outreach services for at least three months.

Note: This is an Essential Standard.

TIP: Sites may place a family on creative outreach when a scheduled visit results in a cancelled visit without notice, followed by a consecutive rescheduled visit also resulting in a cancelled visit without notice, or an unsuccessful attempt to reschedule (i.e., parent cannot be located). The date of the first cancelled without notice visit can be used as the date CO began.

TIP: When returning a family to their previous service level, to avoid frequent back-and- forth placement from Level CO to an active service level, it may be beneficial to wait until the family has received more than half of expected visits over a one-to-three- month period based on level, i.e., a family returning to level 1 receives over half of expected visits, or at least 3 visits, in one month, a family returning to level 2 receives over half, or at least 4 visits, in two months, and a family returning to level 3 receives over half, or at least 2 visits, in three months.

TIP: Supervisors use discretion to determine family situations warranting a creative outreach period longer than three months, generally when engagement is imminent. This should be documented in supervision notes. Due to potential safety and liability concerns, caution should be exercised when families remain on outreach longer than three months if there has been no visual contact with the family.

3-4. The site measures the retention rate of families on an annual basis and in a consistent manner, and analyzes data associated with family retention at least once every two years to better understand why some families choose to leave services and others choose to stay.

3-4.A The site measures its retention rate using HFA approved methodology—first and last home visit of all who enrolled in a particular calendar or fiscal year (please see measuring retention rates in the glossary). Other methodologies may be used in addition. Sites can use the HFA Spreadsheet available for this standard.

Intent: Calculating the site's retention rate is a critical quality improvement measure. Sites look at the length of time families remain in services and identify patterns and trends associated with families leaving services at specified intervals. Comparing retention rates across various years (e.g., all families enrolled in 2018 with all families enrolled in 2019) allows sites to determine if improvement strategies employed one year are having impact the next, or if there have been significant demographic or programmatic shifts that have impacted retention from year to year. ***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 annually measures its retention rate (using HFA methodology) for families enrolled in multiple years (e.g., **families enrolled the previous two fiscal or calendar years**) at multiple intervals (e.g., families enrolled in both of the previous two years have 6-month, 12-month, 18-month, etc., retention rates measured).

2 The site annually measures its retention rate (using HFA methodology) for **families enrolled during a single one-year period** at multiple intervals (e.g., measuring 6- month and 12-month retention rates).

1 The site is not yet measuring its retention rate using HFA methodology at least annually.

i

For example, if you want to measure retention for families that enrolled two years ago, you will first record each family that enrolled during the twelve-month period you selected with the date of each family's first home visit. And then, for any of these families that have left services, you will also record the date of their last home visit. Families that remain open (including those still on creative outreach) will only have the first home visit date recorded.

To calculate a valid six-month retention rate, you must wait until at least 6 months after the last day of the enrollment year you selected and then look at the percentage of families who remain in services as of that date. Similarly, twelve months after the last day of the enrollment period, you are able to calculate a valid 12-month retention rate looking at the percentage of families remaining in services out of all those enrolled. And twenty-four months after the last day of the enrollment period you will be able to calculate a valid 2-year retention rate.

Calculating retention at multiple intervals for one enrollment year will result in a 2 rating for this standard. Calculating retention at multiple intervals for two different enrollment years will result in 3 rating.

3-4.B For sites with 50 or more active families at any one time over the last two years, the site analyzes its data, to better understand why some families are choosing to leave and others are choosing to stay in services, comparing data for families no longer receiving services to data of families remaining in services (including reasons why families leave services). Please see glossary for common terms associated with analyses. Sites can use the HFA Spreadsheet available for this standard.

Intent: Sites conduct a thorough retention analysis at least once every two years to better understand why some families are choosing to leave and others are choosing to stay in services. The analysis examines various factors of those who remain enrolled with those, during the same time period, who are no longer enrolled. The site will determine which factors it analyzes based on trends or patterns it has observed. The intent is to ensure the analysis can yield meaningful results that lead to activities to address underlying causes and increase retention as a result (see GA-2.B).

For smaller sites with less than 50 active families in services at any one time over a two- year period, the site will at a minimum review anecdotal information from staff about any patterns associated with retention and reasons why families are leaving services, and to do a more comprehensive analysis when active families at any one time exceeds 50 or more over a two-year period.

Please Note: When a site completes this analysis every other year, sites may include two years of families (e.g., instead of choosing to analyze families that enroll over a one-year period, sites could choose to analyze families that enroll over two years combined). In this case, the annual measurement (3-4.A) and the analysis (3-4.B) will reflect different data sets and this is perfectly acceptable.

Please Note: Sites or multi-site systems with capacity and desire to conduct a more rigorous or more frequent retention analysis are welcome to do so.

Please Note: New sites with less than two full years of home visiting services will complete a first analysis with one year of data instead of two. If the site is both new and small (less than 25 active families at any time in one year, or less than 50 over two years), they will also use one year of data and only analyze informal data and reasons why for families who have left services.

3-4.B RATING INDICATORS

3 The site uses data (numbers and percentages) and anecdotal information from staff to analyze, at least once every two years, families who leave services and reasons why. The analysis examines data to identify and better understand why some families are choosing to leave and other choosing to stay. The analysis **includes at least three (3) factors** in its comparison of those who remained in services and those who left during the same time period.

OR at least ninety percent (90%) of families enrolled in services over a two-year timeframe remained in services, in which case an analysis is not required. New sites not yet in operation for two full years with a retention rate of 90% during the first year are also exempt from completing an analysis.

2 The site uses data (numbers and percentages) and anecdotal information from staff to analyze, at least once every two years, families who leave services and reasons why. The analysis examines data to better identify and understand why some families are choosing to leave and others choosing to stay in services. The analysis includes **one or two factors** in its comparison of those who remained and those who left during the same time period.

Sites with fewer than 50 families active in services at any one time over a two-year period (or for new sites without two years of data, fewer than 25 active families over one year), have collected informal data and reasons why families left services.

1 Any of the following:
1) the site does not yet have an analysis of families who left services and reasons why
2) the analysis does not yet include data and anecdotal information from staff
3) the analysis does not yet include a comparison of any factors of those who remained in service with those who left during the same time period
4) the analysis is not yet conducted at least once every two years
5) if a smaller site, the site has not yet, at a minimum, collected informal data and reasons why families have left services

NA There were less than 10 families who left service during the two-year period to determine any patterns.

TIP: Sites whose 12-month retention rate has remained 90% or more over a two-year period (3 rating) are encouraged to collect informal data, along with reasons why, for families leaving services.

TIP: While sites choose which factors to include in their retention analysis it is recommended sites consider the role race and ethnicity may have on retention. In addition it is recommended that sites consider the impact of factors related to the program (such as staffing issues, or policy issues) may have on family retention. Sites are encouraged to reflect on any trends observed from the last retention analysis to the present one, and any lessons to be learned.

Tables of Documentation

3. Offer services voluntarily and use personalized, family-centered outreach efforts to build trust with families.

Standard	Pre-Site Documentation to include in Self Study
3-1.A | Policy - Voluntary Services	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
3-1.B | Services are Voluntary	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
3-2.A | Policy - Trust Building (Pre-Enrollment)	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
3-2.B | Trust Building (Pre-Enrollment)	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
3-3.A | Policy - Creative Outreach (Post-Enrollment)	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
3-3.B | Creative Outreach (Post-Enrollment) **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
3-4.A | Measure Retention	Submit the site's definition of family retention and method for calculating (unless using HFA spreadsheet) and retention calculation for families enrolled within at least one cohort year. HFA methodology for calculating a site's retention rate is: 1. Select a specified time frame (i.e., January 1, 2020 to December 31, 2020). This can be a 12-month period, a calendar year, or fiscal year. 2. Count the number of families who received a first home visit during this time frame. 3. Count the number of families in this group who remained in services at specified intervals (i.e., the number from this group remaining in services 6 months or longer, 12 months or longer, two years or more, etc.); 4. Divide #3 (totals remaining for 6 months, 12 months, etc.) by the number of families in step #2 (that received a first home visit during the time frame); 5. When selecting a time frame, it helps keep in mind the last day of your time frame will determine which intervals you can measure. A family who might have enrolled on the last day of that time frame could only be counted as retained or not for 6 months if at least 6 months have passed since they enrolled. Example: I have selected 1/1/2020-12/31/2020 and today is 1/1/2022, so any family that might have enrolled on the last day of that year has had the opportunity to be in the program for 1year and 1 day. For all the families who enrolled during that year, I can measure how many were still enrolled at the 6-month interval and the 12-month interval. I can't measure the 2-year interval yet because not all families who enrolled in that year (specifically, a family that might have enrolled on the last day) have had the opportunity to make it to the 2-year mark. Please note: An HFA Spreadsheet is available for this standard.
3-4.B | Retention Analysis	For all families who enrolled within at least one cohort year, analyze both formally (numbers and percentages) and informally (anecdotal information from staff and advisory members) 1. Families who remain in services in comparison to families who leave. 2. Includes at least one analysis factor 3. The reason why families leave. Please note: An HFA Spreadsheet is available for formal analysis Please see glossary for more information on analysis. For sites with less than 50 enrolled families at any one time over a two-year period, submit a narrative including: 1. The maximum number of families that were enrolled at any one time. 2. Informal data about families who leave service or are retained 3. Reasons why families are leaving services For sites with less than 50 enrolled families at any one time over a two-year period, submit a narrative of informal data and reasons why families are leaving services. Include the maximum number of families that have been enrolled at any one time. For sites not required to complete Retention Analysis, submit a narrative describing the reason for exemption. If at least ninety percent (90%) of families enrolled in services over a two-year timeframe remained in services, an analysis is not required. New sites not yet in operation for two full years with a retention rate of 90% during the first year are also exempt from completing an analysis.

STANDARD 4

4

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

Standard 4 Intent is to ensure sites offer services intensely at the onset of services to support relationship building between the FSS and the parent(s), and attachment and bonding between parents and child, through repeated positive experiences. This reflects the parallel process. HFA services are offered for a minimum of three years and up to five years, subsequent to the birth of the focus child or date of enrollment, whichever is later. Additionally, sites utilize HFA's Level Change process for determining the frequency of home visits consistent with the progress of each family.

4-1. The site offers weekly home visiting services at the onset of services.

4-1.A The site's policy and procedures state families are offered weekly home visits at the start of services until the family meets progress criteria to support moving to every- other-week visits.

Please Note: Families experiencing significant challenge(s), i.e., with elevated FROG Scale score, will likely continue with weekly visits for at least six months and often much longer before progress criteria are met and the family moves to every-other-week visits. Occasionally, families will remain at the most intense level for the full three-five year service length owing to the severity of the issues being faced.

Intent: The first several months of involvement with a family are critical for many reasons, i.e., building a trusting partnership with the parent(s), helping develop a strong parent-infant relationship, supporting infant care and safety, assisting with the adjustment to parenthood, and addressing immediate concerns.

If a family requests less frequent home visits prior to meeting progress criteria, sites will respect the family's wishes and adjust visit frequency to family request (documenting the parent's request on the home visit record when this occurs), while maintaining the family on Level 1 and continuing to offer and encourage the family's receptivity to weekly visits. This does not mean the Family Support Specialist must continually try to schedule or engage the family in weekly visits, but the family should be fully aware of the availability of weekly visits.

This ensures the FSS's caseload weight is safeguarded to allow for weekly home visits to occur until the family meets progress criteria to move to Level 2. This also ensures that movement to Level 2 is based on family progress vs family availability.

Please Note: Families whose infant is hospitalized in the NICU after birth will not be placed on Level 1 until the baby comes home from the hospital, unless the parents want weekly visits during that time. Otherwise, the family will be on level CO or TO while in the NICU and weekly visits will be offered once the baby comes home (as specified in the standard).

4-1.A RATING INDICATORS

3 No 3 rating indicator for standard 4-1.A.

2 The site's policy and procedures state families are offered weekly home visits at the start of services and continue to be offered weekly visits until the family meets progress criteria to support moving to every other week visits.

1 The site's policy and procedures do not yet state the expectation for the offer of weekly home visits as specified in the 2 rating.

4-1.B The site ensures families (with the exception of families who enroll on level 2P) are offered weekly home visits at the onset of services (including with transfer and re-enrolling families) and until progress criteria are met for moving to less frequent visits.

Intent: When families initiate services, whether new, transferred from another HFA site and re-enrolling at the same site, it is important to begin with the weekly offer of services. People have a natural tendency to like what is familiar to us (things we interact with or see repeatedly). More frequent contacts in the beginning increases familiarity and trust. When a family's immediate work/school schedule precludes the receipt of weekly home visits, home visits will continue to be offered weekly in the event the family's schedule later permits weekly visits, and until the family has met progress criteria to move to Level 2. If a family moves to creative outreach while on Level 1, their service level returns to weekly when the family engages again in services. It is not intended for families in these situations to automatically move to Level 2 since progression to less frequent home visits is based on indicators of increased family stability and parent-child well-being, as identified in level change criteria, and not based on scheduling conflicts.

Please Note: Any family that re-enrolls with the same focus child after previously being closed to services or that transfers into HFA services from another site (when the transfer or re-enrollment occurs postnatally) will be placed on Level 1 until progress criteria for movement to Level 2 have been met.

Please Note: Families enrolled as HFA Accelerated—when parent(s) score low risk on the FROG Scale—will remain on Level 1 until progress criteria for movement to Level 2 have been met.

4-1.B RATING INDICATORS

3 All families (with the exception of 2P families) are offered weekly home visits at the onset of services (including transfer and re-enrolling families).

2 Past instances may have occurred where families were not offered weekly visits at the onset of services, however **recent practice** indicates this is now occurring with all families (including transfer and re-enrolling families and excluding 2P families).

1 Families are not offered weekly visits at the onset of services.

TIP: Families who enroll early in pregnancy on level 2P may benefit from an initial offer of weekly visits for a brief period of time to support FSS-parent relationship development and family retention, rather than an immediate start of offering every other week visits.

4-2. The site utilizes a well-thought-out system for managing the intensity/frequency of home visiting services, which includes use of HFA Level Change forms for all levels requiring progress criteria to be met when moving to less frequent visits.

4-2.A The site has policy and procedures clearly defining the levels of service (i.e., visit frequency for weekly, bi-weekly, monthly, etc. and corresponding case weight at the various levels). The site's policy and procedures also include the process for reviewing progress and achievements made by families, and the involvement of parent, FSS, and supervisor in the level change decision.

Please download HFA Level Change Forms and Documents.

Intent: Sites are required to use HFA's "level system" for managing the intensity of services. This well-thought-out system is sensitive to the needs of each family, changes in family stability and competencies over time, and the responsibilities of the FSS. Clearly defined levels reflect in measurable ways the capacity of the family. Families with higher needs are able to receive more intensive services, and less frequent services are provided as stability and progress increase. Not only does an effective "level system" allow for individualized service delivery, but it also provides sites a mechanism to monitor caseload capacity more effectively, thus promoting higher quality services. It is important for the FSS to know where to locate information regarding levels of service and to be familiar with the process of how families progress from one level to another. Changes to visit frequency are based on progress, therefore the age of the child or the length of time on a particular level are not the basis for level change decisions.

HFA has the following levels and associated case weights are provided below. Supervisors may use discretion to assign higher case weight points (adding .5-1 point) on a permanent basis for families with ongoing circumstances that need extra time from the FSS to plan for and/or conduct regular visits. This includes but is not limited to: twins, triplets or other multiple birth, extensive travel to reach the family, ongoing translation needs, parents with cognitive impairment). Supervisors and FSS can also add weight on a temporary (3 month) basis by assigning the family a Special Services (SS) level - see below.

Please Note: At the time of enrollment, families are assigned to either Level 2P, Level 1P or Level 1.

Level 2P = 2 points - every other week visits when enrolled during first or second trimester of pregnancy (0-27 weeks gestation). Case weight of 2 pts ensures caseload space is retained to allow move to Level 1 at birth

Level 1P= 2 points - weekly visits when enrolled in third trimester of pregnancy (28 weeks gestation and later), or prior to 28 weeks when family needs warrant

Level 1 = 2 points - weekly visits

Level 2 = 1 point - every other week visits

Level 3 = 0.5 point - monthly visits

Level 4 = 0.25 point - quarterly visits

Level SS = additional 1 point added to Level 1, 2, or 3 weight during temporary periods of intense crisis

Level CO = 0.5 point - 2 points - creative outreach activities are carried out for 3 months when families are not engaged in regular visits. Sites maintain a family's case weight while on Level CO equal to the family's level prior to being placed on CO to ensure space is retained to move family back to that level if re-engaged.

Level TO = 0.5 point - 2 points - family plans to be temporarily out of area and unavailable for visits for up to 3 months. Sites maintain a family's case weight while on Level TO equal to the family's level prior to being placed on TO to ensure space is retained to move family back to that level if re-engaged.

Level TR = .5 point - temporary re-assignment to another staff person during extended staff leave or turnover up to 3 months. For families who are receptive and interested in receiving visits consistent with their previous level, sites should make every effort to do so, rather than using TR.

4-2.A Intent: (cont.) *Please Note*: Level change decisions based on family progress are specifically tied to when families move from one active service level to another (i.e., Level 1 to Level 2, Level 2 to Level 3, and Level 3 to Level 4) and these Level Change forms are required. It does not apply to moving families to Level CO, TO, or TR or from Level 2P to Level 1P or from Level 1P to Level 1. These levels are not based on progress and therefore these Level Change forms are optional. However, sites are required to keep track of the dates when families move from any of these levels to another, as well as documentation of activities that occur while on these levels.

Please Note: When fully completed, the Level Change form can suffice for all documentation required to demonstrate supervisor and FSS involvement in the level change decision. If sites use HFA Celebration forms (giving copy to the family and keeping a copy in the file with the date shared with the family), this will be sufficient for all documentation required to show the FSS and family discussed level change and no additional documentation in the home visit record is needed.

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
- require use of HFA Level Change forms
- describe the process for FSS, family, and supervisor to review family progress when level change decisions are made

1 The site does not yet have policy and procedures; or the policy and procedures do not yet address the requirements listed in the 2 rating.

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 31 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: When families exit services and later express interest in re-enrolling, sites can use their discretion about whether to do so, based on their knowledge of the family and whether space is available to re-enroll. When a family has been discharged for longer than 6 months, a site should consider whether a brand new service record should be established, including obtaining updates on the FROG Scale and other intake information.

4-2.B Sites measure whether families at the various levels of service (e.g., weekly visits, bi-weekly visits, monthly visits, etc.) receive the expected number of home visits, based upon the level of service to which they are assigned. An HFA Spreadsheet is available for this standard.

Intent: Home visits provide the opportunity to experience the family's living environment and gain first-hand knowledge of the strengths and stresses of the home environment, to implement home safety checks with the family, and to engage the family on "their turf." It is acknowledged not all visits will occur in the home. Visits may happen outside the home for a variety of important, necessary, and beneficial reasons. For example when transporting to medical appointments, as an activity to reduce social isolation, when privacy and confidentiality concerns warrant a location outside the home, etc. Virtual visiting (via video preferably or phone) is also allowable when direct service staff safety is at risk, when the family is not initially comfortable with a new person coming into their home, when continuity of service can only be maintained virtually, etc. These visits can count as a home visit but only when the content of the visit matches the goal of a home visit and can be documented as such, including documentation of CHEERS. The goal of a home visit is to promote nurturing parent-child interaction, healthy childhood growth and development, and enhanced family functioning. Typically, an in-person home visit lasts about an hour and the child is present. Virtual visits may function similarly though often have a different cadence, i.e., shorter and multiple segments in the same week make up a visit, with less observation of the child.

For families assigned to a weekly level of service (Level 1 and 1P), one parent group meeting per month may be counted as a home visit if documented individually on a home visit record in the family file. The home visit documentation of the group meeting must be documented by an HFA-trained staff (does not have to be the assigned Family Support Specialist) and includes CHEERS observations when the group includes parent-child interaction time.

Some sites work in collaboration with other multi-disciplinary team members, such as doulas, lactation consultants, child development specialists, mental health therapists, etc. The site may choose to count one home visit per month conducted by these team members if the provider has received HFA Foundations core training, documents the visit on the site's home visit record, includes documentation of CHEERS, and receives supervision in accordance with standards 12-1 and 12-2. This can occur for any family regardless of level.

Please Note: When conducting virtual home visits, text messaging does not count as a home visit.

Please Note: The HFA Spreadsheet (or an equivalent database report) measures home visit completion rates (per family for each FSS caseload) over a period of three consecutive months (one quarter).If the staff supporting the family changes during the quarter, home visit completion is measured only for the period covered by the currently assigned staff person. Families who are on CO, TO, or TR during the entire quarter being measured are not included in the home visit completion calculation. Families on any of these levels for a portion of the quarter are only counted in home visit completion rates for the portion while on Level P, 1, 2 3, or 4.

The home visit completion percentages detailed in the rating indicators are designed to account for situations when staff 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.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when home visit completion rates fall below the 75% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase completion rates.

TIP: When the FSS is 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 families receive necessary support and services.

TIP: Patterns and trends associated with home visit frequency and duration are supported when viewed over time. HFA recommends quarterly review, which accounts for variations associated with family and staff schedules on a weekly or even monthly basis.

4-2.C Each family's progress (as identified on completed HFA Level Change forms) to a new level of service is reviewed and agreed upon by the Family Support Specialist and Supervisor prior to moving a family from one level of service to another. *Please Note*: completed HFA Level Change forms meet all documentation needs for 4-2.C. Any edit of these forms must be approved in advance by the national office.

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 is based on family progress and is outlined on level change forms. Level change decisions are not made based on site needs, personnel issues, family availability, or the age of the child.

4-2.C RATING INDICATORS

3 Each family's progress (as identified on completed HFA Level Change forms) serves as the basis to move to a new level of service and is reviewed and agreed upon by the Family Support Specialist and supervisor prior to moving families from one level of service to another.

2 Past instances may have occurred when families moved from one level of service to another in absence of completed HFA Level Change forms or review and agreement of family progress by FSS and supervisor; however, recent practice indicates staff and supervisor base level change decisions on family progress and complete the appropriate Level Change form prior to moving families to a new service level.

1 Families are moved from one level of service to another in absence of completed HFA Level Change forms; or a review and agreement on family progress by the supervisor and staff did not occur prior to level change.

Note: This is an Essential Standard.

4-2.D Once the supervisor and FSS agree a family's progress indicates readiness for movement to a less intensive service level, the FSS discusses with the family the change to visit frequency based on progress and celebrates family progress and achievements.

Intent: The decision to change to less frequent home visits is based on family progress, as outlined on level change forms. The conversation with families when moving to less frequent visits is used to prepare families for an adjusted visit schedule and as a time to celebrate with the family their progress and achievements. HFA has sample celebration forms that can be used with families for this purpose.

4-2.D RATING INDICATORS

3 The Family Support Specialist celebrates the progress and achievements with the family and discusses the change in visit frequency based on progress when families move from one level of service to another.

2 Past instances may have occurred when families moved from one level of service to another in absence of a celebration of family progress between the Family Support Specialist and family; however, **recent practice** indicates the Family Support Specialist and family celebrate progress and discuss the change in visit frequency based on progress.

1 Families are moved from one level of service to another in absence of a celebration of family progress, or the Family Support Specialist did not discuss the change in visit frequency based on progress.

4-3. The site offers HFA services to families for a minimum of three years (or five years when sites are funded to do so), after enrollment or after the birth of the baby (with exception of families identified as eligible for HFA Accelerated based on a low risk score on the FROG in which case may successfully complete and graduate from services sooner).

Please Note: Because HFA is voluntary, families may choose to end services at any time. FSS are encouraged to use HFA's Successful Completion of Program criteria, and to acknowledge the family as such when meeting these criteria, even when choosing to leave services early.

4-3.A The site has policy and procedures specifying HFA services are offered for a minimum of three years after enrollment or after the birth of the focus child (whichever is later), with the exception of families who transfer from another program.

Please Note: Sites who enroll families in HFA Accelerated when parent(s) score low risk on the FROG Scale, and remain at low risk, may successfully complete progress criteria and conclude services prior to three years.

Families who transfer from another program will be offered services until age three (or age five when funded to do so).

4-3.A RATING INDICATORS

3 No 3 rating indicator for standard 4-3.A.

2 The site policy and procedures specify HFA services are offered for a minimum of three years after enrollment or after the birth of the focus child (whichever is later).

1 The site does not yet have policy and procedures, or the policy and procedures do not yet address the requirements listed in the 2 rating.

TIP: Service length may also be extended beyond the norm on occasions where Level 3 or 4 families nearing service completion experience a crisis warranting a temporary return to more intensive services, such as a subsequent birth adding substantial risk to the functioning of the family.

TIP: When families have demonstrated progress and moved to less frequent visits, a normative situation, like a healthy subsequent birth, is not reason to extend service length or restart services with a new focus child. The family's progress and achievements reflect their ability to provide a nurturing, safe, and stable environment for the focus child and subsequent children, and space in the program can be opened for new families.

4-3.B Services are offered to families for a minimum of three years after enrollment or after the birth of the focus child (whichever is later).

4-3.B RATING INDICATORS

3 Services are offered for a minimum of three years after enrollment or after the birth of the baby (whichever is later).

2 Past instances may have occurred when the site did not offer services to families for 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 Site is not yet offering services for a minimum of three years.

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

Intent: When a family plans to leave HFA services (due to HFA service completion, graduation, transition to a different service provider in the community, planned move out of the service area, etc.), transition-planning efforts involving the family, Family Support Specialist, 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 families who have a planned closure and provide notice of such to the Family Support Specialist at least three months prior to closure (circumstances leading to an unplanned or unexpected closure, or a planned closure with less than three months' notice would not be held to the standard, though the site is encouraged to provide as much support as possible in these situations). The activities include the following:

- documentation of a transition plan that includes reason for planned closure and date the discussion was initiated with the family (including if family declined need for a transition plan)
- the family, Family Support Specialist and Supervisor are involved, though not required to be present at the same time
- sufficient time is allotted to conduct the plan (typically 3-6 months prior to transition)
- resources 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 or family (based on family preference) 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, including all components identified in the standard.

1 The site does not yet have policy and procedures; or the policy and procedures do not yet include the components outlined in the standard.

TIP: Site should begin transition planning with families when the child is 30 months of age (when length of service is 3 years) or 54 months (when length of service is 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 needed or desired.

4-4.B The site utilizes transition planning, to support families with a planned closure from services. Download HFA Sample Transition Plan in *English* and *Spanish*.

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.

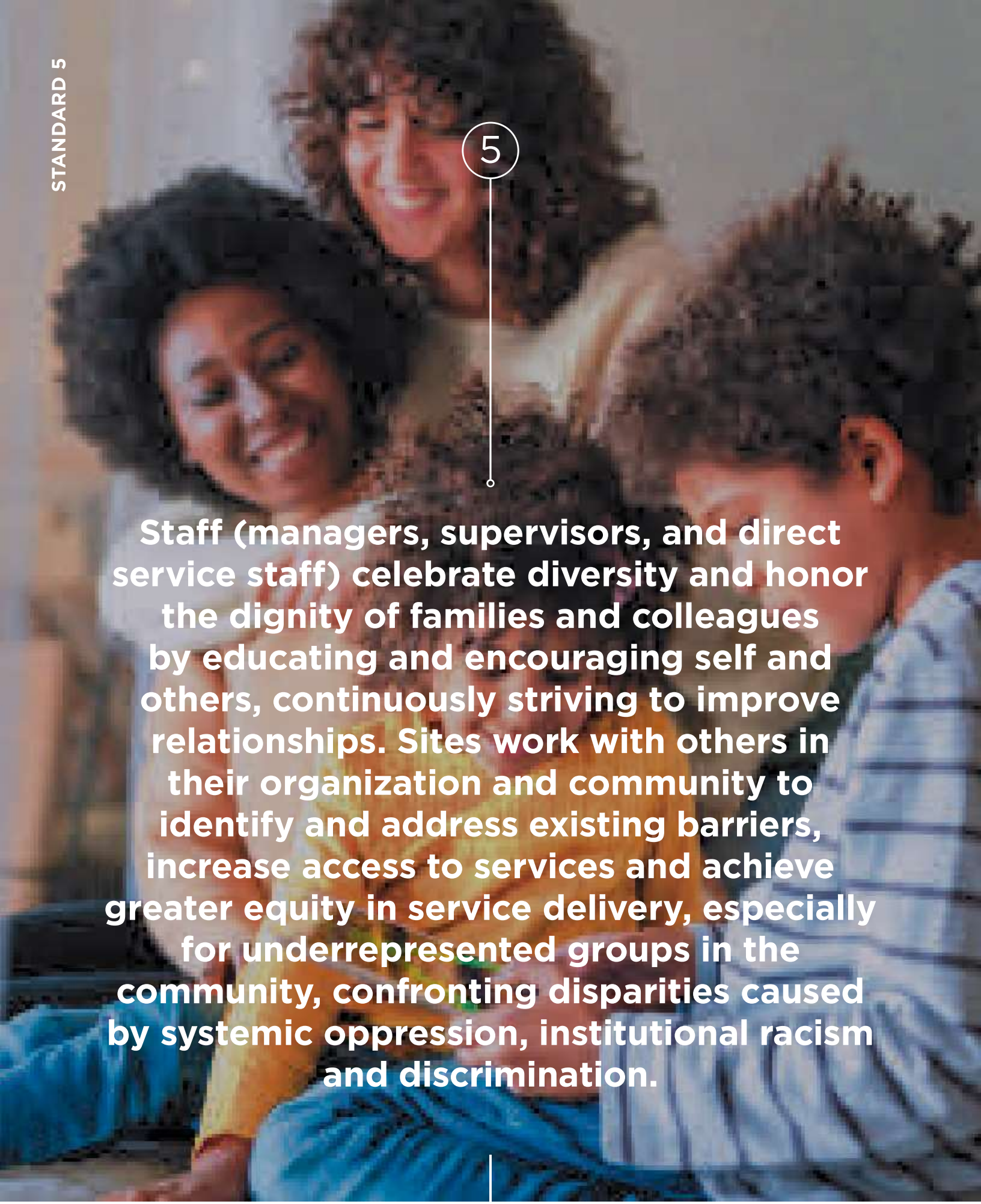
2 Past instances may have occurred when transition planning activities as outlined in the standard were not conducted; however, **recent practice** indicates the site conducts transition planning according to the standard; or there have been no planned closures yet, or families with planned closure declined a transition plan.

1 A transition plan for families with a planned closure is not yet offered or does not yet include all components identified in the standard.

Tables of Documentation

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

Standard	Pre-Site Documentation to include in Self Study
4-1.A | Policy - Weekly Visits	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
4-1.B | Weekly Visits	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
4-2.A | Policy - Levels of Service	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
4-2.B | Home Visit Completion Rate	Submit home visit completion report for the most recent quarter which includes: All active families by FSS including level of service, level changes that quarter, number of expected home visits that quarter and number of completed home visits that quarter (completed visits while on Level 1 or 1P may include one parent group per month or one multi-disciplinary team member visit per month when all requirements as stated in the intent are met). To calculate home visit completion: 1. Determine for each family over the course of a quarter the expected number of home visits (based on level of service alone). 2. Count the number of completed visits (while family is on active service level) for each family during the quarter. 3. For each family calculate: #2 (completed visits) divided by #1 (expected visits). 4. Count the total number of active families. 5. Subtract from #4 (total active families) the number of families who were on creative outreach for the entire quarter. 6. Count the number of active families who received at least 75% of expected home visits. 7. Program HVC rate is calculated by taking #6 (number of active families who received at least 75% of visits) divided by #5 (active families - minus CO entire quarter). Please Note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (75% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
4-2.C | Level Changes in Supervision Essential Standard	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
4-2.D | Level Changes with Families	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
4-3.A | Policy - Services for Minimum of Three Years	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
4-3.B | Services Provided For 3-5 Years	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, excluding any who meet criteria for HFA Accelerated and successful completion earlier than 3 years.
4-4.A | Policy - Transition Planning	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
4-4.B | Transition Planning	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.



5

Staff (managers, supervisors, and direct service staff) celebrate diversity and honor the dignity of families and colleagues by educating and encouraging self and others, continuously striving to improve relationships. Sites work with others in their organization and community to identify and address existing barriers, increase access to services and achieve greater equity in service delivery, especially for underrepresented groups in the community, confronting disparities caused by systemic oppression, institutional racism and discrimination.

Standard 5 ensures each site is intentional in its efforts to promote equity in all facets of operations with families, staff, and community. Doing so compels an honest look at existing flaws, individually and systemically, exposing and resolving blind spots previously unrecognized.

This level of intentionality allows us to listen and learn from the lived expertise of others, and to recognize how implicit bias and power imbalance impair authentic relationships. By examining and gaining greater clarity related to the causes of these and other challenges associated with long-standing health and social disparities, we are more likely to effect change through our advocacy, allyship, and meaningful dialogue with one another.

This work is hard, complicated, and at times uncomfortable. There is no quick fix and no one is exempt. It requires sustained, long-term, individual and organizational commitment. It is a unique and continuous journey we all must engage in. It involves an ongoing commitment to increasing one's self-awareness.

TIP: The policies discussed in Standard 5 may be referenced within existing policies, such as within supervision policies, training policies, personnel policies, etc., or may be standalone written guidance.

5-1. Through policy (or other written guidance) and practice, the site supports staff's ability to continually strengthen the skills required for authentic relationships, including self-awareness, self-regulation, self-reflection, skilled listening, and empathy.

Intent: Taking an honest and reflective look inward increases awareness and understanding of our biases, offering us an opportunity to be intentional in our efforts to counteract these. Being afforded safe space in supervision, team meetings, and peer-to-peer interactions enables greater likelihood for honest, respectful, and brave conversations. Recognizing the distinction between intent and impact, as well as the importance of repair, facilitates stronger relationships. These are the building blocks upon which growth and change become possible.

Sample Team Commitments / Ground Rules are available.

5-1.A The site has policy or other written guidance expressing the site's commitment to respectful staff interactions and supporting staff to continually strengthen their relational skills focused on diversity, equity, and inclusion.

5-1.A RATING INDICATORS

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

2 The site has policy and procedures, or other written guidance, including team commitments or ground rules regarding: 1) expectations for staff interactions, and 2) professional development and supervision expectations, to ensure staff have the resources needed to continually strengthen their relational skills as mentioned in standard 5-1.

1 The site does not yet have policies and procedures, or other written guidance, as stated above.

5-1.B The site's practices support a respectful team environment and staff ability to continually strengthen their relational skills.

5-1.B RATING INDICATORS

3 **All staff** are aware of the site's policies, or written guidance, and **are able to describe** efforts they have undertaken to strengthen their relational skills, and **multiple mechanisms** have been acted on to support a respectful team environment.

2 All staff are aware of the site's policies, or written guidance, and **the majority of staff are able to describe** efforts they have undertaken to strengthen their relational skills, and **at least one mechanism** has been acted on to support a respectful team environment,

1 All staff are not yet aware of the site's policies or written guidance; or a majority of staff are not yet able to describe efforts they have undertaken to strengthen their relational skills; or there have not yet been any mechanisms acted on to support a respectful team environment.

TIP: There are many mechanisms to support individual self-awareness and build team cohesiveness. Managers and supervisors play an instrumental role in creating a team culture supportive of self-learning and group exploration within a safe environment. This can happen through individual supervision, shadowing, team meetings, creating shared agreements, etc. Additionally, staff surveys, staff goal setting, and performance reviews are more formal ways to obtain staff input and support staff development.

5-2. Through policy (or other written guidance) and practice, the site supports development of a partnership with families that honors diverse family structures and the sources of strength derived from family cultures, values, beliefs, and parenting practices. Practice also recognizes the historic and current relevance of discrimination based on race, ethnicity, gender identity, sexual orientation, age, religion, and abilities and seeks inclusivity in all aspects of its work with families.

Intent: Cultural humility is not what one knows of another person's culture, though a certain level of foundational knowledge can be helpful. It is instead how we are in allowing another person to share their own story which reflects their identity, experiences, background, values, and beliefs. Allowing parents to teach us of their culture, and being observant and accepting of behaviors, attitudes, and beliefs that may be different from our own, reduces the risk of making faulty assumptions, and helps us evolve as individuals with appreciation for our common humanity.

Direct service staff 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 style among other things. When staff express curiosity with open-ended questions, are non-judgmental, refrain from imparting their own belief and value systems, and seek to repair relationships when missteps occur, families and staff have an opportunity to grow and develop.

5-2.A The site has policy or other written guidance expressing the site's commitment to interact with families in a partnership that honors diversity and inclusivity and elevates family voice.

5-2.A RATING INDICATORS

3 No 3 rating indicator for standard 5-2.A.

2 The site has policy and procedures, or other written guidance, describing the site's intention and expectations for engaging with families in a partnership that honors diverse family structures and seeks inclusivity in all aspects of its work, and elevates family voice.

1 The site does not yet have policy and procedures, or other written guidance, as stated above.

5-2.B The site's practices engage families in partnership, elevating family voice and honoring family diversity.

5-2.B RATING INDICATORS

3 **All staff** are aware of the site's policy, or written guidance, and **are able to describe** efforts they have undertaken to work together in partnership with families, elevating family voice and honoring diverse family structures, values, beliefs, and parenting practices.

2 All staff are aware of the site's policy, or written guidance, and the **majority of staff are able to describe** efforts they have undertaken to work together in partnership with families, elevating family voice and honoring diverse family structures, values, beliefs, and parenting practices.

1 All staff are not yet aware of the site's policy or written guidance; or a majority of staff are not yet able to describe efforts they have undertaken to work together in partnership with families, elevating family voice and honoring diverse family structures, values, beliefs, and parenting practices.

5-3. The site works at the community level, through policy and practice, and with guidance from its community advisory board, as a champion for families and children, advocating for just and equitable opportunities within the community, and increasing access to services and supports for those it serves and employs.

Intent: Racial and ethnic minorities, and other underrepresented groups, face barriers in accessing services within their communities. Organizations within communities have a responsibility to utilize their influence and decision-making in ways that identify and address structural inequities brought about by privilege and discrimination. This includes actions taken both internally (in support of the organization) and externally (in support of the community).

Additionally, it is the site's responsibility to identify major cultural groups within the community, determine groups currently underserved, and prioritize hiring staff who represent these groups and can provide support in the family's preferred language. Sites will also make sure that, in addition to staff, graphics and materials are representative of the community.

5-3.A The site, and/or organization, has policy or other written guidance expressing its commitment to advocating at the community level to address barriers and promote equity for those it serves and employs.

5-3.A RATING INDICATORS

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

2 The site, and/or organization, has policy and procedures, or other written guidance, reflecting how it advocates at the community level and with its community advisory board to identify and address existing barriers, increasing equitable access to services, ensuring diverse representation in staff and materials, and meeting the cultural and language needs of those it serves and employs.

1 The site does not yet have policy and procedures, or other written guidance, as stated above.

5-3.B The site's practices demonstrate its commitment to working at the community level to address barriers and promote equity for those it serves and employs.

5-3.B RATING INDICATORS

3 Site leadership and community advisory members are aware of the site's policy, or written guidance, and can **describe multiple efforts** undertaken at the community level to identify and address existing barriers, increase equitable access to services, ensure diverse representation in staff and materials, and/or meet the cultural and language needs of those it serves and employs.

2 Site leadership and community advisory members are aware of the site's policy, or written guidance, and can **describe at least one** effort they have undertaken to identify and address existing barriers, increase equitable access to services, ensure diverse representation in staff and materials, and/or meet the cultural and language needs of those it serves and employs.

1 Site leadership and/or advisory members are not yet aware of the site's policy or written guidance; or a majority of staff are not yet able to describe at least one effort undertaken to identify and address existing barriers, increase equitable access to services, ensure diverse representation in staff and materials, and/or meet the cultural and language needs of those it serves and employs.

TIP: Sites are encouraged to include questions on employee satisfaction surveys related to equitable personnel practices, including hiring, promotions or other advancement, and performance evaluations.

5-4. The site gathers information to reflect on and better understand issues impacting staff and families served and to examine the effectiveness of its equity strategies. These strategies will vary from year to year and are based on family and staff input received and what the site has learned from implementing standards 5-1, 5-2, and 5-3. Family engagement and retention data, and staff engagement and retention data may also be used.

5-4.A The site starts by gathering information, ensuring parent/caregiver voice and staff input is obtained and used to improve its ability to provide culturally respectful and responsive services as referenced in standards 5-1, 5-2 and 5-3.

Intent: It is critical for sites, in their efforts toward continuous quality improvement, to receive and utilize feedback from families and staff. When families and staff provide their observations and experiences, it can help point out areas which would benefit from additional training or support, as well as highlight particular areas of strength or staff skill, and help identify ways in which the site can advance its work to achieve greater equity in service delivery and systems change. Families and staff may provide input in a variety of ways, e.g., through the use of a satisfaction and cultural humility survey for currently enrolled families, post-service questionnaires or interviews, service on the community advisory board, family advisory committee, focus groups, etc.

5-4.A RATING INDICATORS

3 The site obtains input from **current and former** families and staff that helps the site understand how it is doing with implementation of standards 5-1, 5-2 and 5-3. Input is sought at least once annually.

2 The site obtains input from **current** families and staff that helps the site understand how it is doing with implementation of standards 5-1, 5-2 and 5-3 Input is sought at least once annually.

1 The site does not yet obtain input from current families and staff to help the site understand how it is doing with implementation of standards 5-1, 5-2 and 5-3, or the site has not yet sought input at least once annually.

TIP: Staff surveys should be offered to all site staff, and ideally responses should be obtained by all, protecting worker anonymity to encourage candid feedback without repercussion. For very small sites when anonymity can not be ensured, cross-department or organization-wide surveys may be a better option.

5-4.B The site makes meaning of the information it collects and develops an equity plan based on what the site learns about itself, from an equity perspective, in the way it supports its staff, the families it serves, and the community it works within. The equity plan sets a course for continuous improvement to achieve greater equity in all facets of its work.

Intent: Taking time to thoughtfully review the information gathered from staff and families demonstrates respect and value for what has been shared, assists the site in focusing on particular areas where there is opportunity for growth, and provides the site an opportunity to reflect on the progress it is making to promote equity. The meaningful identification of growth opportunities is the basis of the site's equity plan, which also summarizes strengths and challenges, along with any patterns or trends noted over time. The equity plan provides an opportunity to identify strategies to combat implicit bias, address barriers to equitable service delivery, and work to dismantle the causes of disparity and inequity.

5-4.B RATING INDICATORS

3 The site has an equity plan that incorporates a **summary of family and staff input obtained in 5-4.A, along with** what it learns by **completing a formal self-assessment tool related to diversity, equity, inclusion, and belonging (DEIB).** Strategies are based on what it learns from this information

2 The site has an equity plan that incorporates a **summary of family and staff** input **obtained in 5-4.A,** and strategies are based on what it learns from this information.

1 Any of the following: there is no equity plan; the equity plan does not yet incorporate a summary of family and staff input obtained in 5-4.A, or strategies are not based on family and staff input.

Note: This is an Essential Standard.

TIP: It is helpful for sites to remember that strategies to obtain information in ways that yield more meaningful lessons learned can also be an important part of an equity plan.

TIP: There are a number of DEIB focused organization self-assessment tools available to the general public. Sites will choose the one that will work best for them. HFA provides links to a few different options to consider.

5-4.C The site's equity plan is reviewed and updated at least once annually to reflect progress associated with the strategies identified in it. Revisions and new strategies are included when appropriate based on lessons learned and new input received annually from staff and families. Regular focus on the equity plan is intended to foster growth and increased capacity to promote equity.

Intent: A site continually reviews and improves its service delivery system by integrating information learned. It can be difficult to self-identify gaps and determine strategies. This is why it is important to seek the perspective and assistance from staff and families on an ongoing basis.

5-4.C RATING INDICATORS

3 The equity plan is reviewed and updated at least once annually by **site staff and the community advisory board.** Equity strategies are updated and revised based on feedback received annually from staff and families (5-4.A) and lessons learned.

2 The equity plan is reviewed and updated at least once annually by **site staff**. Equity strategies are updated and revised based on feedback received annually from staff and families (5-4.A) and lessons learned.

1 Any of the following: there is no equity plan; or the equity plan has not yet been reviewed or updated at least once annually; or equity strategies are not yet updated and revised based on feedback received annually from staff and families (5-4.A) and lessons learned.

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5. Staff (managers, supervisors, and direct service staff) celebrate diversity and honor the dignity of families and colleagues by educating and encouraging self and others, continuously striving to improve relationships. Sites work with others in their organization and community to identify and address existing barriers and increase access to services, especially for underrepresented groups in the community, confronting disparities caused by institutional racism and discrimination.

Standard	Pre-Site Documentation to include in Self Study
5-1.A | Policy – Staff Interactions	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available. Sample Team Commitments / Ground Rules are available
5-1.B | Staff Interactions	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
5-2.A | Policy - Family Partnership	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
5-2.B | Family Partnership	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
5-3.A | Policy - Community Level Advocacy	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
5-3.B | Community Level Advocacy	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
5-4.A | Family & Staff Input	Submit a narrative summary of most recent efforts to obtain meaningful feedback from parents/ caregivers and staff. Include a summary of findings: summarize patterns and trends, strengths and challenges.
5-4.B | Equity Plan **Essential Standard**	Submit the most recent organizational self-assessment and equity plan. Please note: Sample of organizational self-assessments available
5-4.C | Advisory Input Regarding Equity Plan	Submit notes to illustrate review of the Equity Plan. Please highlight updated strengths and strategies based on feedback received from staff and lessons learned. If identified strengths and 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 within a caring community.

Standard 6 Intent is to reduce risk factors and build protective factors, ensuring site staff provide services that are family-centered and growth oriented; supporting parents in nurturing their children; setting meaningful goals; and enhancing health, development, and family functioning.

HFA employs an infant mental health approach in which services are relationship-focused, strength-based (building on parental competencies), and culturally respectful and responsive, and are anchored to the parallel process.

Healthy Families sites serve many families who are struggling with issues including substance abuse, intimate partner violence, developmental delay in parents, depression, and other mental health challenges, some of which may be an effect of early childhood trauma, multiple other life stressors, and institutionalized racism and systems of oppression that have limited equitable access to financial stability, housing stability, quality education, employment opportunity, health care, transportation, and nutrition. In order to address these challenges, site staff: 1) form healthy relationships with parents, 2) apply a strength-based approach that includes being honest when parents are responding to their environment in ways that may cause harm to themselves and their children, 3) accept families where they are, without judgment or bias, 4) build on parental competencies, and 5) focus on learning about the individual's lived experience and means of coping versus judging behavior as "right or wrong." These principles are core HFA components.

6-1. Risk factors and stressors identified in the FROG Scale, as well as risk factors that emerge later in the course of services (when not disclosed or present initially), are addressed during the course of services utilizing a Service Plan. The Service Plan is developed by the supervisor and Family Support Specialist and includes a focus on building protective factors. Practice demonstrates the Service Plan is being implemented.

Download HFA Service Plan Materials. Please Note: HFA's Service Plan template can be modified by the site without approval and an alternate Service Plan format can be created if desired. It is the responsibility of the site to ensure a uniquely developed Service Plan meets the documentation requirements.

Intent: A well-constructed Service Plan is the cornerstone of home visiting services that are effectively organized and coordinated and is based on each family's unique strengths and areas of concern. The purpose of a Service Plan is to operationalize the family "story" into a "road map" that supports Family Support Specialists in their ongoing and long-term work with the family and is the mechanism by which supervisors document their clinical support to staff that is specific to each family.

A Service Plan is fluid and dynamic in order to remain relevant to the family as changes to family systems, circumstances, and dynamics occur over time. As such, service priorities also are likely change over time and a Service Plan helps to manage and "visualize" the complexity of change and the re-prioritization of activities that result. A Service Plan ensures issues identified by the family can be systematically addressed and supported in partnership with parents, without interfering or compromising the family's choice in regard to goals they are motivated to achieve. Family goal setting is a distinct and separate activity and is discussed in Standards 6-2.

6-1.A The site has policy and procedures describing the review of each family's strengths and stressors as identified in the FROG Scale, as well as parent-child interaction/attachment concerns and challenging issues identified subsequent to administration of the FROG Scale (i.e., substance abuse, intimate partner violence, parent's cognitive impairment, and mental health concerns).

Policy and procedures include the Supervisor and Family Support Specialist working together to develop an HFA Service Plan with activities to address these issues over time and to build protective factors. Procedures also include the prioritization of these activities to support them being carried out successfully without overwhelming staff or the family.

Download HFA Service Plan Materials.

Intent: Research clearly demonstrates that past trauma and untreated disorders can have serious consequences for early learning, social competence, and lifelong health. Family Support Specialists are not counselors or therapists; however, the incredibly therapeutic nature of the partnership formed with parents cannot be overstated. The most important role as it relates to supporting the challenges parents face is to listen, acknowledge, and support the parent(s). Additionally, Family Support Specialists play an important role in:

- providing an atmosphere of safety and acceptance
- keeping the baby and the parent-child relationship at the center when helping parents recognize the impact of various challenges
- providing honest feedback with parents' permission
- pointing out discrepancies between stated values and actual behavior
- encouraging forward thinking (i.e., assist parent in developing a vision of what they want)
- providing information and referrals in a way that helps parents bridge the fear or uncertainty of accessing additional services
- using motivational interviewing (when trained on this technique)

When supporting families with challenging and complex issues, a Service Plan helps staff work with intention and can help staff focus on incremental progress being made despite at times feeling "stuck."

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 FROG Scale, as well as parent(s) challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, and mental health issues) identified subsequent to the administration of the FROG Scale. Procedures include 1) the Supervisor and Family Support Specialist working together to develop a Service Plan which includes activities to address identified issues and build protective factors, 2) the prioritization/pacing of such activities, and 3) the Family Support Specialist and family working together on the implementation of these the activities during home visits initially and during the course of services.

1 The site does not yet have policy and procedures; or the policy and procedures do not yet address all the requirements listed in the 2 rating.

6-1.B At the start of services, the Supervisor and Family Support Specialist review each family's stressors and strengths as identified in the FROG Scale, as well as parent-child interaction/attachment concerns (i.e., any item rated a 4 or less on the CCI is documented on the Service Plan to be addressed), and challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale. Together the Supervisor and Family Support Specialist develop a Service Plan and update it over time prioritizing/pacing activities to address risk and build protective factors.

Intent: Supervisors and Family Support Specialists develop a Service Plan at the start of services based on the strengths and concerns identified by families during the FROG Scale conversation, plus identifying activities to support the family and build protective factors. To support the family and Family Support Specialist, there will also be planning for the appropriate prioritization and pacing of these activities.

Activities reflect a thoughtful, purposeful discussion that assists the Family Support Specialist 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 Family Support Specialist's work with the family.

6-1.B RATING INDICATORS

3 The Supervisor and Family Support Specialist review and document in a Service Plan all the risk factors and stressors identified in the FROG Scale. Challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale are also documented, in addition to the pacing and prioritization of activities to address these issues and build protective factors with families initially and during the course of services.

2 Past instances occurred when the Supervisor and Family Support Specialist did not review and document in a Service Plan all the risk factors and stressors identified in the FROG Scale, or challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale, or the pacing and prioritization of activities to address these issues and build protective factors with families initially and during the course of services; however **recent practice** indicates this is now occurring.

1 The Supervisor and Family Support Specialist do not yet review and document in a Service Plan all the risk factors and stressors identified in the FROG Scale; or documentation does not yet include challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale; or documentation does not yet include the pacing and prioritization of activities to address risk factors and build protective factors with families initially and during the course of services.

TIP: Activities to address risk factors can include use of the Reflective Strategies along with intentional promotion of the protective factors.

TIP: 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.

TIP: The FROG Scale is expected to be completed by the fourth home visit (standard 2-1.A). It is recommended the initial Service Plan be developed within 2 weeks of that visit (or sooner when the FROG is completed sooner) followed by review and update of each family's Service Plan once monthly for families on Level 1, 1P, or SS, every other month for families on Level 2, and quarterly for families on Levels 3 or 4.

6-1.C The Family Support Specialist implements with the family over the course of services, the activities identified on the HFA Service Plan in an effort to build protective factors and to address the stressors identified in the FROG Scale, as well as parent(s) challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, or mental health issues) identified subsequent to the administration of the FROG Scale.

Intent: The Family Support Specialist addresses with families the stressors identified in the FROG Scale over the course of a family's enrollment in home visiting services, ensuring families are offered ongoing opportunities and support to make positive healthy changes in their life. Utilizing a Service Plan ensures services are family driven and tailored to each family's unique strengths, concerns, stresses, and priorities articulated by the family. It is not expected a Family Support Specialist will discuss with the family all of the risk factors and stressors at one time, or that the Family Support Specialist "enforce" behavior-change or issue-resolution prior to a family's readiness to do so.

Implementation of the Service Plan is collaborative in nature, meaning family input and changing family dynamics are incorporated. Supervisors and Family Support Specialists will update the Service Plan and clarify how the issues that place families at-risk for poor childhood outcomes are addressed over time. The frequency of the update to the Service Plan depends on the complexity of each family's situation, including risk factors and challenging issues (i.e., substance abuse, intimate partner violence, cognitive impairment, and mental health issues) that may emerge subsequent to the initial administration of the FROG Scale, all of which will be incorporated into the Service Plan. Family Support Specialists will need access to or their own copy of the most updated Service Plan.

Please Note: When the Family Support Specialist implements activities outlined on the Service Plan, the date this occurred is documented on the Service Plan to ensure it is easy to reference the home visit record for the detail on what the FSS did.

Please Note: HFA has developed a document, "Procedures: Working with Families in Acute Crisis" which may be helpful in clarifying staff roles and responsibilities for supporting families experiencing challenging issues.

6-1.C RATING INDICATORS

3 The Family Support Specialist implements with families activities documented in a Service Plan.

2 Past instances may have occurred when the Family Support Specialist did not implement with families activities documented in a Service Plan; however, **recent practice** indicates this is now occurring.

1 The Family Support Specialist does not yet implement with families activities documented in a Service Plan.

Note: This is an Essential Standard.

6-2. Setting and achieving family goals builds a family's resiliency and promotes protective factors. The process of setting and accomplishing goals is family driven, and the process is more important than the product.

Intent: 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 changing. The process is more important than the product, which means the support of the Family Support Specialist and the Supervisor in the goal setting process is critical to family success.

Goal setting is a powerful activity for parents. When the activity is repeated often enough, it builds motivation and increases self-confidence and self-determination. For many, it becomes an internalized and lifelong process. That said, it is initially a new process for many families, making the encouragement from the Family Support Specialist very important.

The purpose of the **Family Goal** process 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 process allows Family Support Specialists to:

- offer the concept that change can happen and 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 Family Support Specialist can assist
- develop opportunities for the family to experience success
- assist the family to identify and acknowledge their strengths
- celebrate success with the family

6-2.A The site has policy and procedures regarding the process of helping parents develop family goals throughout the course of services, with new goals set as previous goals are accomplished or retired.

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 family goals, including:

- goal setting as an activity throughout the course of services with new goals set as previous goals are accomplished or retired
- projected dates for accomplishing the goal
- identifying family strengths to support goal achievement
- celebration of goal achievement
- FSS and supervisor support of the family goal process

1 The site does not yet have policy and procedures; or policy and procedures do not yet address the requirements listed in the 2 rating.

6-2.B The Family Support Specialist supports the family in setting and achieving goals that are meaningful to the parent.

Please Note: It may take up to 3 months after the initiation of home visiting services for a family to be ready to set a goal; however, once an initial goal has been set and achieved, families will repeat the process of setting new goals throughout the course of services.

Intent: The Family Support Specialist invites the family to develop meaningful, manageable goals. There is a clear conversation to support parents in feeling competent, capable, and hopeful in being able to make positive changes in their own lives. Breaking larger goals into small goals 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. The focus is not on how many goals families accomplish; rather, it is entirely related to the skills parents build in the process of developing and working on goals, and especially in the celebration when there is success in making progress and achieving goals.

The goal setting process is 100% family-driven based on what the parent wants, needs, or dreams about. The process supports parental self-efficacy, enhances family functioning, and builds protective factors. The more success a family has, the more they change their world view. Helping families identify the strengths and competencies they have to address the goals they set develops critical thinking and problem-solving skills and promotes protective factors.

6-2.B RATING INDICATORS

3 The Family Support Specialist supports the family to have a goal with a projected date for accomplishing the goal, and helps the family identify strengths and resources specifically related to accomplishing the goal. Family Support Specialists support families in achieving their goals, celebrate successes, and help parent(s) develop new goals when the previous goal is accomplished or when a goal may no longer be relevant to the family.

2 Past instances were found when the Family Support Specialist did not support the family to have a goal with a projected date for accomplishing the goal; or did not identify family strengths and resources; or did not support families in achieving their goals, celebrate successes, and help parent(s) develop new goals when the previous goal is accomplished or when a goal may no longer be relevant to the family; however, **recent practice** indicates the site is now consistently applying these practices.

1 Any of the following: the Family Support Specialist does not yet support the family to have a goal; or does not include a projected date for accomplishing the goal; or does not yet identify family strengths and resources specifically related to supporting parents in accomplishing the goals; or does not yet support the family in achieving their goals, celebrate successes, and help parent(s) develop new goals when previous goals are accomplished or when goals may no longer be relevant to the family.

Note: This is an Essential Standard.

TIP: The goal setting process takes time. Sites may use more than one tool or strategy to develop goals and steps to achieve the goals.

TIP: Identification of strengths and needs may be ongoing. Documentation of these conversations may be found in home visit notes, or in the tools each site uses to talk about strengths and needs with families (including tools provided in HFA Core training such as the Values Clarification activity or What I'd Like for My Child), or in actual family goal sheets. Sites are encouraged to articulate in their policy and procedures which tools are used to identify strengths. Exploring the parent's values assists parents in identifying what they want for their family and increases motivation for change. Additionally, sites offer families an opportunity to explore their strengths and consider how these strengths can support parent goals.

TIP: For families with a planned closure (see standard 4-4), the required transition plan may be accomplished on the same form used to document a family's goal. In this case the goal would be related to what the parent would like to see happen for themselves and their child subsequent to the closure.

6-2.C The Family Support Specialist and Supervisor review family goal progress on an ongoing basis.

Intent: In order to support growth in families, supervisors and Family Support Specialists review the progress families are making towards the achievement of their goals. The supervisor and Family Support Specialist collaborate to ensure the goals for families are current, challenges to achieving goals are addressed, and accomplishment of each step/objective is celebrated. Additionally, the supervisor brainstorms with the Family Support Specialist any barriers being faced regarding development of family goals with families and supports the Family Support Specialist in increasing the quality of the family goal process.

6-2.C RATING INDICATORS

3 The Family Support Specialist and supervisor review family goal progress on an ongoing basis, ensuring families have a current goal, Family Support Specialists are supported to help problem-solve any challenges, and successes are celebrated.

2 Past instances were found when the Family Support Specialist and supervisor did not review family goal progress on an ongoing basis; however, **recent practice** indicates the site now ensures this occurs, families have current goals, Family Support Specialists receive support to help problem-solve any challenges, and successes are celebrated.

1 The Family Support Specialist and supervisor do not yet review family goal progress as indicated in the 2 rating.

TIP: Intervals for reviewing the family goal progress during supervision will vary based on a variety of factors, including family needs pertaining to a particular goal, the projected date for goal completion, and/or visit frequency.

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

Intent: The promotion of parent-child relationships is a primary HFA goal. Many parents in HFA 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 Family Support Specialists are trained to use an infant mental health approach which supports the formation of a dyadic alliance between the parent(s) and the Family Support Specialist 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.

6-3.A The site has policy and procedures requiring the use of CHEERS and indicating how the staff will partner with parents to assess, address, and promote nurturing parent-child interaction (PCI), attachment, and bonding. Site policy also includes the role of supervisors to support Family Support Specialists in the use of CHEERS, and that the validated CHEERS Check-In (CCI) tool will be administered at least twice annually.

Intent: Sites develop clear policy and procedures for how Family Support Specialists will assess parent-child relationships using CHEERS. Site policy also indicates how Family Support Specialists will partner with supervisors to develop plans for increasing nurturing parent-child interactions, beginning prenatally (when services are initiated prior to birth). Policy and procedures include the use of the strength-based reflective strategies introduced in HFA's **Foundations Core training**. Policy also includes expectations related to 1) documenting CHEERS on each home visit, 2) the reflective strategies used, curriculum material shared, or visit activities completed to address concerns and promote positive PCI, and 3) use of the CCI tool at least twice annually. It is expected the parent-child relationship is observed and discussed each visit.

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 CHEERS including when and how Family Support Specialists will partner with parents to assess, address concerning parent-child interaction, and promote nurturing parent-child interaction (through use of reflective strategies, visit activities, and curriculum material). Site policy also includes the use of HFA's Cheers Check-in (CCI) tool at least twice annually, and the role of the supervisor to support Family Support Specialists with CHEERS assessments and interventions.

1 Any of the following: the site does not yet have policy and procedures; or the policy and procedures do not yet require the use of CHEERS, including when and how Family Support Specialists partner with parents to assess, address concerning parent-child interaction, and promote nurturing parent-child interaction (through use of reflective strategies and curriculum material); or the policy does not yet include the use of HFA's Cheers Check-In (CCI) tool at least twice annually; or the role of the supervisor to support Family Support Specialists with CHEERS assessments and interventions.

6-3.B The site assesses parent-child interaction, attachment, and bonding with families, utilizing CHEERS on all home visits.

Intent: HFA requires CHEERS be used as a parent-child observation strategy during each home visit, with the exception of when the FROG Scale is being administered, or when the CHEERS Check-In tool is administered. A minimum of two domains of CHEERS is documented for all home visits (including virtual visits) based on observation or parent report (the focus is on quality over quantity of domains documented). It is also expected that any group session being counted as a home visit (1 per month allowed while a family is on Level 1 or 1P) will include some documentation of CHEERS.

HFA supports the concept of the strength-based approach with families; however, because of the strong relationships staff develop with families, the intent of "strength-based" may be distorted. This can lead to only positive interactions being recorded in documentation. In addition to seeing the strengths, capacities, and resources of parents related to attachment, observations and documentation must also be honest, and reflect the experience of the full home visit. Therefore, observations and documentation through CHEERS provide factual description of parent-child interactions. Only documenting positive PCI limits the FSS's capacity to have impact on creating nurturing attachment relationships.

Supporting the use of CHEERS is analogous to supporting use of the Ages and Stages Questionnaire (ASQ-3). Staff would not record a child being able to accomplish a developmental task just because he is really trying hard or when a skill is emerging. Instead, the staff would support the parent by offering more practice, sharing child development information/curriculum, or referring for early intervention services. The same is true about parent-child interaction. When a parent is not able to respond to their child in a consistently safe, predictable, comfortable, or pleasurable manner, supporting parent-child connections by using a reflective strategy is critical. When reflective strategies are used well, parents feel supported, capable, and competent.

6-3.B RATING INDICATORS

3 Family Support Specialists partner with parents to assess parent-child interaction, attachment, and bonding with all families, utilizing CHEERS on all home visits, with the exception of when the FROG Scale or CCI tool is used on a particular visit. At least one domain of CHEERS is documented in the second trimester of pregnancy beginning at 24 weeks gestation, and at least two domains of CHEERS are documented in the third trimester and for all families throughout the time they are enrolled (with the exception of home visits where the FROG Scale or CCI tool is administered).

2 Past instances were found when the Family Support Specialist did not partner with parents to assess parent-child interaction, attachment, and bonding with all families utilizing CHEERS; however, **recent practice** indicates this is now occurring (including at least one domain of CHEERS for prenatal families in the second trimester, and at least two domains of CHEERS for prenatal families in the third trimester and for all families throughout the time they are enrolled (with the exception of home visits where the FROG Scale or CCI tool is administered).

1 Family Support Specialists do not yet partner with families to assess parent-child interaction, attachment, and bonding with all families utilizing CHEERS as specified in the 2 rating.

Note: This is an Essential Standard.

TIP: When less than all six domains of CHEERS are assessed on a home visit, the FSS is encouraged to assess different domains on subsequent visits so that over the course of a few visits, all domains are assessed.

TIP: HFA has a prenatal and postnatal tip sheet for CHEERS with helpful prompts and space to document the requirements of 6-3.B and 6-3.C.

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 concerning parent-child interaction and promotes nurturing parent-child interaction, attachment, and bonding with all families based on observations made using CHEERS.

Intent: Sites document observations of parent-child interaction and how these observations are used to develop and implement home visit activities and strength-based interventions to promote nurturing parent-child interaction. It is helpful for staff to document how they build on parental competences and promote healthy relationships in a thoughtful way (e.g., if parents struggle to understand what their baby is communicating to them, the Family Support Specialist might use Strategic Accentuate the Positive (SATP) when they observe the parent being empathic, thereby building the parents' skills). Other sites may capture video to promote parental sensitivity, understanding, and secure attachment. As above, it is important to document parental competencies and struggles and what the Family Support Specialist is doing (e.g., through use of reflective strategies, use of curriculum activities, etc.) to promote and support the parent-child relationship. Accentuate the Positive (ATP) is used for promotion of parent-child interaction; the other reflective strategies are used to address concerns in regard to parent-child interactions.

6-3.C RATING INDICATORS

3 Family Support Specialists address PCI concerns and promote nurturing parent-child interaction, attachment, and bonding with all families based on CHEERS observations.

2 Past instances were found when the Family Support Specialist did not address PCI concerns and promote nurturing parent-child interaction, attachment, and bonding with all families utilizing CHEERS; however, **recent practice** indicates this is now occurring.

1 Family Support Specialists do not yet address PCI concerns and promote nurturing parent-child interaction, attachment, and bonding with all families utilizing CHEERS.

Note: This is an Essential Standard.

6-3.D The site utilizes the CHEERS Check-In (CCI) tool at least twice annually during each year of the child's life from birth through thirty-six (36) months.

Please Note: Any item rated a 4 or less on the CCI will be documented on the Service Plan to be addressed. Items rated as 5 are to be strengthened and items rated 6 or 7 are to be promoted. All currently enrolled families, including those on levels CO, TO, and TR are included in the calculation. If the primary caregiver declines tool administration, in which case they are exempted from the calculation; however, the refusal must be documented on the tracking form. An HFA Spreadsheet is available for this standard.

Training on the CHEERS Check-In (CCI) is required for Standard 10-6.A.

6-3.D RATING INDICATORS

3 The site uses the CHEERS Check-In tool during home visits and at least **90% of all focus children** (including each child when multiples) are screened a minimum of twice per year of the child's life from birth - 36 months.

2 Past instances were found when the site did not use the CHEERS Check-In tool with at least **90% of focus children** a minimum of twice per year of the child's life from birth - 36 months; however this is now occurring during home visits and at least 90% of focus children have one CCI screen completed **in the last six months.**

1 Any of the following: the site does not yet use the CHEERS Check-In tool; or less than 90% of focus children up to age 36 months have had the CCI tool completed at least once in the last six months.

TIP: The CCI tool can be used beyond age 3. It is validated for children ages 2 months to 49 months and can also be used between 49 and 60 months if desired.

TIP: Tip: Suggested CCI intervals in the first year of life are 1) between 4-6 months and 2) between 8-10 months.

6-3.E Supervisors support Family Support Specialists to assess parent-child interaction (through use of CHEERS), address concerns, and promote secure attachment and the development of nurturing parent-child relationships.

Intent: Supervisors are critical in developing and maintaining a clear focus on parent-child interaction and attachment. It is the supervisor's role to partner with staff to ensure CHEERS is used to develop reflective strategies to increase secure attachment experiences during weekly supervision. The supervisor's documentation will reflect how they support staff's use of CHEERS. Supervisors do not need to restate the PCI observed on the visit, as this will be documented in the home visit record.

6-3.E RATING INDICATORS

3 Supervisors support staff to assess parent-child interaction, address concerns, and promote strengths of parent-child interactions with all families utilizing CHEERS.

2 Past instances were found when the supervisor did not support staff to assess parent-child interaction, address concerns, and promote the strengths of parent-child interaction with all families utilizing CHEERS; however, **recent practice** indicates this is now occurring.

1 Supervisors do not yet support staff to assess parent-child interaction, address concerns, and promote the strengths of parent-child interaction with all families utilizing CHEERS.

Note: This is an Essential Standard.

TIP: When less than all six domains of CHEERS are assessed on a home visit, the supervisor will support the FSS in assessing different domains on subsequent visits so that over the course of a few visits, all domains are assessed.

TIP: It can be supportive to Family Support Specialists for supervisors to write up CHEERS with staff immediately following a shadowed home visit, providing feedback on observations and what to include in each domain (helping to focus on the facts of the observation by discerning facts, feelings, and interpretations).

6-4. The site shares information (e.g. credible source parenting materials, evidence-informed curriculum) with parents to promote healthy child development, nurturing parent-child relationships, parenting skills, and health and safety practices with families.

Intent: Materials shared with parents are used with intentionality and a strength-based approach that builds on parental capacity and in response to parent-child interests and observations made by the FSS. Fact-based materials help Family Support Specialists 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 for the Family Support Specialist to spend time with the parent to listen to what the parent is thinking, feeling, and experiencing before presenting reading materials or activities. It is only when the parent feels safe and supported that they can begin to absorb this type of information. 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 sharing specific information, is highly recommended.

The key to successful use of handouts and activities is tied most closely to how the materials are used with families versus what materials are used. Sites use materials that are culturally respectful, supported by research, and in response to parent and child needs versus the primary focus of each home visit as they represent 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.

Parenting materials and evidence-informed curriculum contain a variety of components which include:

- information on how to promote nurturing parent-child relationships (e.g., makes parents 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, etc.)
- child development information and how to share this in a strength-based manner (e.g., build on parental competencies, engage parents' critical thinking skills, identify emerging skills, address language use and literacy, include all developmental domains, incorporate the use of developmental screens, etc.)
- content that is developmental in nature
- strategies that strengthen families and their relationships
- health and safety information such as safer sleep, breastfeeding, pre- and postnatal health care, well-child care, dental and oral health, and lead exposure

6-4.A The site has policy and procedures regarding the promotion of child development, nurturing parent-child relationships, parenting skills, and health and safety practices, and the policy specifies which evidence-informed parenting materials are used with families.

Intent: Sites develop policy and procedures regarding the Family Support Specialist's role in using evidence-informed parenting materials to promote child development, nurturing parent-child relationships, parenting skills, and health and safety.

6-4.A RATING INDICATORS

3 No 3 rating indicator for standard 6-4.A.

2 The site has policy and procedures regarding the Family Support Specialist's role in promoting child development, nurturing parent-child relationships, parenting skills, and health and safety practices with families. The policy specifies how evidence-informed parenting materials are shared with families using a strength-based approach that builds on parental capacity and in response to parent-child interests and observations made by the FSS versus as the primary focus of the visit.

1 Any of the following: the site does not yet have policy and procedures; or the policy and procedures do not yet cover promotion of child development, nurturing parent-child relationships, parenting skills, and health and safety related issues; or the policy does not yet specify how evidence-informed parenting materials are shared with families using a strength-based approach that builds on parental capacity and in response to parent-child interests and observations made by the FSS versus as the primary focus of the visit.

6-4.B Family Support Specialists build skills and share information with families on appropriate activities designed to promote healthy child development, nurturing parent-child relationships, and parenting skills.

Intent: Family Support Specialists observe, build skills, and share information regarding healthy child development, nurturing parent-child relationships, and parenting skills with families based upon naturally occurring experiences as well as through parenting materials, 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 nurturing parent-child interaction, thereby impacting the relationship established over time between the parent and child. Whenever possible, Family Support Specialists are encouraged to organize child development information into activities in which the parent is encouraged to play with the child while the Family Support Specialist shares the developmental stimulation the baby is receiving. Family Support Specialists are encouraged share information with families when it is most meaningful (in response to parent-child interests and observations made by the FSS). *Please Note*: Documentation in the home visit note includes what material/information is shared on a particular visit.

6-4.B RATING INDICATORS

3 The Family Support Specialist shares information with all families on appropriate activities designed to promote healthy child development, nurturing parent-child relationships and parenting skills.

2 Past instances were found when the Family Support Specialist did not share information with all families on appropriate activities designed to promote healthy child development, nurturing parent-child relationships and parenting skills; however, **recent practice** indicates this is now occurring.

1 The Family Support Specialist does not yet share information with all families on appropriate activities designed to promote healthy child development, nurturing parent-child relationships and parenting skills.

TIP: Sites are encouraged to document observations of child development, including not only what the child is able to do, but also how the parent responds. 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 Family Support Specialist 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).

6-4.C The Family Support Specialist shares evidence-informed parenting materials designed to promote health and safety practices based on family needs.

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, dental and oral health, and selection of childcare providers or alternative caretakers, in addition to any culturally based safety issues. It is expected Family Support Specialists will address any health or safety concerns that could be detrimental to parents and their children. Additionally, Family Support Specialists support the development of a healthy and stimulating home environment.

6-4.C RATING INDICATORS

3 The Family Support Specialist shares information with all families designed to promote evidence-informed health and safety practices.

2 Past instances were found when the Family Support Specialist did not share information with all families designed to promote evidence-informed health and safety practices; however **recent practice** indicates this is now occurring.

1 The Family Support Specialist does not yet share information with all families designed to promote evidence-informed health and safety practices.

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

6-4.D The Family Support Specialist promotes safer sleep practices with pregnant parents and families with an infant birth to twelve months of age.

Intent: Sites begin sharing safer sleep information with parents in the prenatal period, when enrolled prenatally, to support these practices occurring as soon as the baby comes home from the hospital. When enrolled postnatally, safer sleep information is shared early and as infant develops and sleep habits change over the course of the first year.

6-4.D RATING INDICATORS

3 The Family Support Specialist shares safer sleep information with all pregnant parents and families with an infant birth to twelve months of age.

2 Past instances were found when the Family Support Specialist did not share safer sleep information with all pregnant parents and families with an infant birth to twelve months of age; however **recent practice** indicates this is now occurring.

1 The Family Support Specialist does not yet share safer sleep information with all pregnant parents and families with an infant birth to twelve months of age.

6-5. The site monitors the development of participating infants and children with the ASQ (Ages and Stages Questionnaire) and ASQ:SE (Social Emotional), using current versions of both.

6-5.A The site has policy and procedures for administration of the ASQ and ASQ:SE, including the frequency these tools are to be administered with all focus children, unless developmentally inappropriate, and requires tracking of all children suspected of developmental delay, with appropriate referrals and follow-up, as needed.

Intent: The policy and procedures indicate the ASQ and ASQ:SE are used with all focus children during home visits unless developmentally inappropriate (e.g., when enrolled in Early Intervention or with permanent health condition impacting development), and in accordance with established tool guidelines, revising the screening schedule based on prematurity, and specifying which intervals the site requires staff to administer. At a minimum, sites are to screen all focus children 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. The ASQ:SE is to be administered with all focus children a minimum of once per year.

Additionally, the policy must specify instances when the site would not be administering the ASQ or ASQ:SE (i.e., developmentally inappropriate, receiving early intervention services). Sites are expected to maintain Level CO, TO, and TR families on their ASQ and ASQ:SE data reports (and to note time period they were on Level CO, TO or TR).

Site staff know who to refer a family to when the ASQ or ASQ:SE 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 or may be reluctant to access these services. The site's policy and procedures will require Family Support Specialists 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.

6-5.A RATING INDICATORS

3 No 3 rating indicator for standard 6-5.A.

2 The site has policy and procedures for administration of the ASQ and ASQ:SE that require at a minimum:

1) the ASQ and ASQ:SE are used with all focus children, unless developmentally inappropriate
2) the ASQ is administered at least twice per year each year of the child's life for children under the age of three, and annually for children ages three through five years (for sites serving ages three through five)
3) the ASQ:SE is administered at least once annually each year of the child's life
4) how it tracks focus children who are suspected of having a developmental delay and provides appropriate referrals and follow-up as needed

1 Any of the following:

1) the site does not yet have policy and procedures to administer the ASQ and ASQ:SE
2) the policy and procedures do not yet specify when the tools are to be used with all focus children, unless developmentally inappropriate
3) the policy and procedures do not yet require use of the ASQ for children under the age of three at least twice per year, and at least once annually for children ages three through five years (for sites serving children ages three through five)
4) the policy and procedures do not yet require use of annual administration of the ASQ:SE
5) the policy and procedures do not yet indicate how it tracks focus children who are suspected of having a developmental delay and how it provides appropriate referrals and follow-up as needed

TIP: Sites are encouraged to screen more frequently than the minimum required in the standard.

TIP: Supervisors are encouraged to note any concerns identified from the developmental screens on the HFA Service Plan, with planned interventions/activities to address and track progress.

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 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. It is recommended collaboration occur (with parent permission and informed consent) in the development of an IFSP with both early intervention and HFA sites. Staff is encouraged to continue collaboration with early intervention services when the child is dually enrolled.

6-5.B The site ensures 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). An HFA Spreadsheet is available for this standard.

Intent: All focus children are screened for potential developmental delays. Staff are not required to screen children who are enrolled in early intervention services (special needs) and are receiving in-depth developmental assessments. *Please Note* (was a Tip): Sites are 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.

6-5.B RATING INDICATORS

3 The site uses the ASQ during home visits and **at least 90%** of focus children (excluding those when developmentally inappropriate) are screened a minimum of twice per year of the child's life 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 use the ASQ with at least 90% of focus children (excluding those when developmentally inappropriate) a minimum of twice per year of the child's life for children under the age of three and annually for children ages three through five years; however, this is now occurring during home visits and **90% of focus children have one completed screen in the last six months.**

1 Any of the following: the site does not yet use the ASQ during home visits; or the site does not yet use the ASQ at the specified intervals to ensure all focus children in the site (excluding those when 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 less than 90% of focus children have completed ASQ screens due in the last six months.

TIP: The site is encouraged to make the ASQ tool available to parents for subsequent births. With subsequent births, the ASQ can be provided to the parent for self-administration, or it may be administered by Healthy Families staff. If administered by staff, the dates and results should be recorded in the family file.

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

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 90% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

6-5.C The site ensures the ASQ:SE (Ages and Stages Questionnaire: Social Emotional) is used during home visits, unless developmentally inappropriate, and is administered according to the developers' instructions to ensure valid results. An HFA Spreadsheet is available for this standard.

6-5.C RATING INDICATORS

3 The site uses the ASQ:SE during home visits at specified intervals and ensures **at least 90%** of focus children (excluding those when developmentally inappropriate) are screened a minimum of once per year of the child's life, for children birth to age five.

2 Past instances were found when the site did not use the ASQ:SE with at least 90% of focus children (excluding those when developmentally inappropriate) a minimum of once per year of the child's life, for children birth through age five; however, this is now occurring during home visits and **at least 90% of focus children have one completed screen in the last twelve months.**

1 Any of the following: the site does not yet use the ASQ:SE during home visits; or the site does not yet use the ASQ:SE a minimum of once per year for focus children birth to age five; or less than 90% of focus children have completed ASQ:SE screens due in the last twelve months.

TIP: The site is encouraged to make the ASQ:SE tool available to parents for subsequent births. If administered by site staff, the dates and results should be recorded in the family file.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 90% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

6-5.D The site tracks focus children suspected of having a developmental delay and provides 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 Family Support Specialist can be a great liaison for the family into various services offered through early intervention. If a family declines early intervention services, be sure to document this, as well as the Family Support Specialist's continuous efforts to advocate for early intervention services, in the family's file. Be sure to document any contacts with EI for updates, or joint meetings attended, and any referrals Family Support Specialists 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 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.

6-5.D RATING INDICATORS

3 Site tracks focus 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 focus 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 Site does not yet track focus children suspected of having a developmental delay or ensure appropriate referrals and follow-up as needed.

NA No children identified with a developmental delay.

TIP: The site is encouraged to record concerns about possible developmental delay for the focus child, along with associated referrals and activities, on the Service Plan.

TIP: The site is also encouraged to track any referrals made regarding developmental delay for non-focus children residing in the home and obtain signed consent when making the referral on behalf of the family.

Tables of 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 within a caring community.

Standard	Pre-Site Documentation to include in Self Study
6-1.A | Policy - HFA Service Plan	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
6-1.B | HFA Service Plan in Supervision	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-1.C | HFA Service Plan with Families **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-2.A | Policy - Development of Family Goals	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
6-2.B | Family Goal Development **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-2.C | Family Goals in Supervision	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-3.A | Policy - CHEERS	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
6-3.B | PCI Assessed using CHEERS **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-3.C | PCI Addressed & Promoted **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-3.D | CHEERS Check-In	Submit a report of all enrolled focus children (including multiples) that includes: 1. Child's date of birth 2. CCI administration dates 3. Documentation of declined screening by primary caregiver Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children. Please Note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
6-3.E | Supervision Support in Assessing, Addressing and Promoting PCI (Through Use of CHEERS and Validated PCI Tool) **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
6-4.A | Policy - Child Development, Parenting Skills, Health & Safety	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
6-4.B | Promote Healthy Child Development and Parenting Skills	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-4.C | Promote Health and Safety Practices	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-4.D | Promote Safer Sleep Practices	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
6-5.A | Policy - ASQ-3 and ASQ-SE-2 Screens	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
6-5.B | ASQ-3 Developmental Screening	Submit a report of all enrolled focus children that includes: 1. Child's date of birth 2. Enrollment date 3. ASQ-3 administration dates 4. Documentation of a. Indication of delay and if a referral was made b. Not screened due to involvement of early intervention services c. Revised screening schedule (prematurity or other reason) d. If the timing of re-enrolling, transferring into services, or Child Welfare Protocol enrollment precludes availability of 2 remaining intervals in a given year for contextual decision-making by Peer Reviewers or Panel. Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children. Please Note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
6-5.C | ASQ:SE-2 Social Emotional Screening	Submit a report of all enrolled focus children that includes: 1. Child's date of birth 2. Enrollment date 3. ASQ-3 administration dates since 1/1/2018 4. Documentation of a. Indication of delay b. Not screened when developmentally inappropriate Provide a summary of the total focus children (number and percent) who received the required screens divided by the total number of focus children. Please Note: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (90% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
6-5.D | Developmental Delay Tracking and Follow-Up	Submit a report the site uses to track currently enrolled focus children identified with suspected developmental delay, including referrals made and follow-up on referrals.

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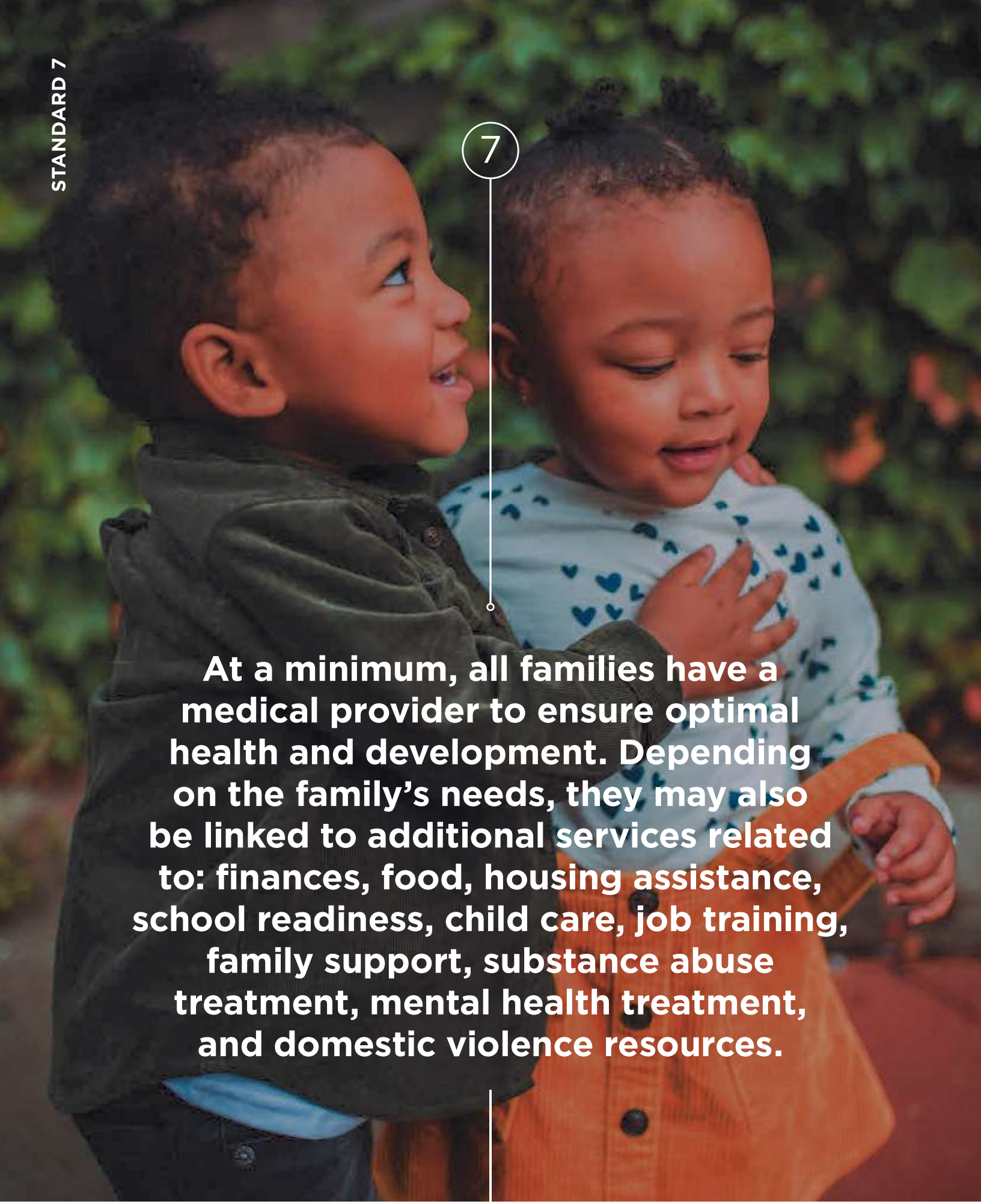


At a minimum, all families have a medical provider to ensure optimal health and development. Depending on the family's needs, they may also be linked to additional services related to: finances, food, housing assistance, school readiness, child care, job training, family support, substance abuse treatment,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

Standard 7 Intent 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 many parents may not have been protected by their parents when they were children. This may result in parents not knowing how to protect their own children. Supporting 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 longstanding 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 ensure families are able to access needed services.

7-1. Participating focus children have a medical/health care provider to ensure optimal health and development.

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

Intent: It is important for each focus 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 focus 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.

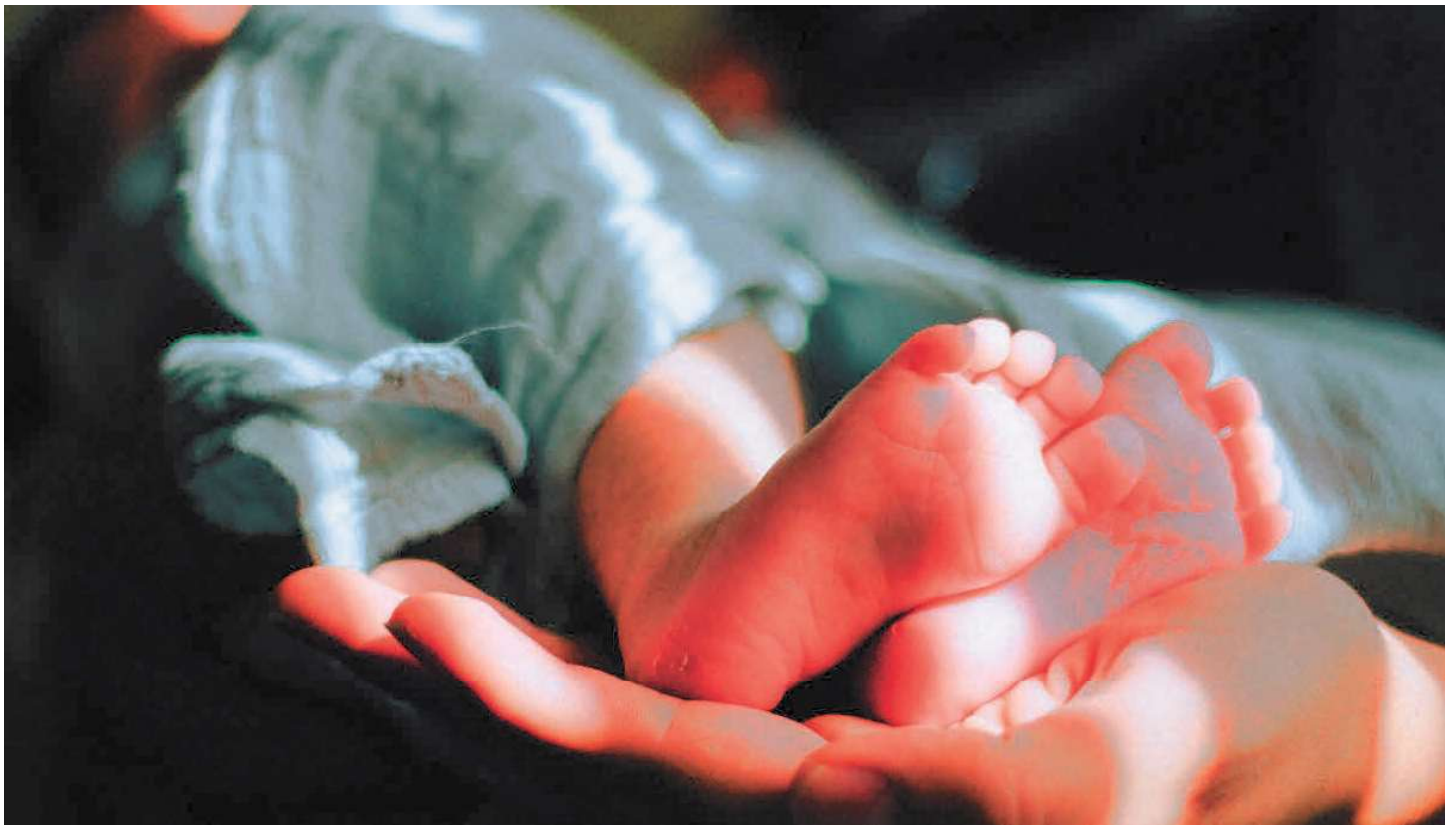
7-1.A RATING INDICATORS

3 No 3 rating indicator for standard 7-1.

2 The site has policy and procedures for linking all focus children to medical/health care providers and supporting parents in utilizing health care appropriately, including the receipt of well-child care for their child(ren).

1 The site does not yet have policy and procedures to link all focus children to medical/health care providers; or policy does not yet include how parents will be supported in utilizing health care, including well-child care, for their child(ren).

TIP: Supervisors are encouraged to note any concerns related to linkages to a medical home on a family's HFA Service Plan, with planned interventions/activities to address and track progress.



7-1.B Focus 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 in 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. An HFA Spreadsheet is available for this standard.

7-1.B RATING INDICATORS

3 Ninety-five percent **(95%) through one hundred percent (100%)** of focus children have a medical/health care provider.

2 Eighty percent **(80%) through ninety-four percent (94%)** of focus children have a medical/health care provider.

1 Less than eighty percent (80%) of focus children have a medical/health care provider.

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

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

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-1.C The site monitors the utilization of well-child care for focus children, and works to address barriers impacting access and receipt of well-child care.

Intent: Well-child visits are essential for preventive health care, to monitor growth and development, and to establish a regular connection with a medical provider. Sites track the receipt of well-child visits subsequent to enrollment in HFA and based on age of the child at the intervals recommended by the American Academy of Pediatrics (AAP) schedule (3 to 7 days, 2 to 4 weeks, 2 to 3 months, 4 to 5 months, 6 to 7 months, 9 to 10 months, 12 to 13 months, 15 to 16 months, 18 to 19 months, 2 to 2.5 years, 3 to 3.5 years, and 4 to 4.5 years). An HFA Spreadsheet is available to track the receipt of well-child visits. If the site uses a well-child visit schedule other than the AAP, a reference to it will be provided.

It is important for sites to understand what factors are impacting well-child care utilization rates. In some communities there is a documented shortage of primary care providers (HRSA, 2012). These shortages are most pervasive in urban and rural areas, in contrast to suburban areas, which generally have a larger supply of providers. In addition, accessing treatment may be difficult for some because of financial, transportation, language, or other barriers.

7-1.C RATING INDICATORS

3 The site monitors the receipt of well-child care visits for all focus children, and has **implemented** strategies to address identified barriers.

2 The site monitors the receipt of well-child care visits for all focus children; and the site has **developed** but not yet implemented strategies to address identified barriers.

1 The site does not yet monitor the receipt of well child care visits; or has not yet developed strategies to address identified barriers.

7-2. The Family Support Specialist 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 focus children are up-to-date on immunizations.

7-2.A The site has policy and procedures to ensure the Family Support Specialist 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 U.S. currently has near record low cases of vaccine-preventable diseases, the viruses and bacteria which 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 including all of the following:

- how Family Support Specialists will share information with all families designed to promote and educate families on the importance of immunizations
- how Family Support Specialists will obtain and track information regarding the receipt of immunizations
- how Family Support Specialists will follow up when immunization appointments are missed

1 The site does not yet have policy and procedures; or policy and procedures do not yet include all items listed in the 2 rating.

7-2.B The site ensures immunizations are up-to-date for focus children at one year of age. Please Note: the percentage does not include children whose permanent health conditions or family beliefs preclude immunizations; however, explanation of these exceptions must be documented in the family file. An HFA Spreadsheet is available for this standard.

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 to the identified immunization schedule (if a site does not have access to a local or state identified immunization schedule that specifies recommended immunizations for infants from birth through eighteen months, the CDC guidelines are recommended for this purpose). 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/caregiver and document it on the site's tracking sheets, and others obtain (with consent) periodic updates from the medical provider or from a statewide electronic immunization system that indicates whether or not the child is up-to-date or current. Therefore, sites are encouraged to clearly indicate how they obtain information on which immunizations have been administered to determine if focus children are up-to-date.

Please Note: When calculating up-to-date immunization rates at one year of age, the site will look at all enrolled focus children ages 12-23 months (including those on creative outreach), and the number of those children who received all immunizations recommended for infants birth through six months.

For example, if at the end of one fiscal year there are 25 enrolled focus children who are ages 12-23 months, and 20 of them received all immunizations expected through 6 months of age, the rate for this age group is 20/25 x100 = 80%.

7-2.B RATING INDICATORS

3 Ninety percent **(90%) through one hundred percent (100%)** of focus children who are currently 12-23 months of age are up-to-date with all immunizations expected by six months of age.

2 Eighty percent **(80%) through eighty-nine percent (89%)** of focus children who are currently 12-23 months of age are up-to-date with all immunizations expected by six months of age.

1 Less than eighty percent (80%) of focus children who are currently 12-23 months of age are up-to-date with all immunizations expected by six months of age.

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

TIP: The Centers for Disease Control and Prevention (CDC) have an interactive immunization scheduler available online.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-2.C The site ensures immunizations are up-to-date for focus children at two years of age. Please Note: the percentage does not include children whose permanent health conditions or family beliefs preclude immunizations; however, explanation of these exceptions must be documented in the family file. An HFA Spreadsheet is available for this standard.

Intent: See intent for 7-2.B. *Please Note*: When calculating up-to-date immunization rates at two years of age, the site will look at all enrolled focus children 24 months and older (including those on creative outreach), and the number of those children who received all immunizations expected through 18 months.

For example, if at the end of one fiscal year there are 10 enrolled focus children who are 24 months old and older and 9 of those children received all the immunizations expected for children through 18 months of age, the rate for this age group is 9/10 x 100 = 90%.

7-2.C RATING INDICATORS

3 Ninety percent **(90%) through one hundred percent (100%)** of focus children who are currently 24 months or older are up-to-date with all immunizations expected by eighteen months of age.

2 Eighty percent **(80%) through eighty-nine percent (89%)** of focus children who are currently 24 months or older are up-to-date with all immunizations expected by eighteen months of age.

1 Less than eighty percent (80%) of focus children who are currently 24 months or older are up-to-date with all immunization expected by eighteen months of age.

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

TIP: The Centers for Disease Control and Prevention (CDC) have an interactive immunization scheduler available online.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

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

7-3.A The site has policy and procedures describing how direct service staff will provide information and/or referrals to available health care and other community services for all participating family members. The policy includes follow-up mechanisms 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 describing the process for direct service staff to provide information and/or referrals to available health care and other community services 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 yet have policy and procedures; or the policy and procedures do not yet address the requirements listed in the 2 rating.

7-3.B Direct service staff provide information and referrals to 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 focus child. Information could include a variety of topics which may benefit all participating members (e.g., smoking cessation support groups, free health clinics for adults, immunization clinics, flu shots, nutritional classes, birth spacing, etc.). Health care information includes the importance of dental care as well as referrals linking families to preventive services for dental care, as appropriate. Site staff are knowledgeable about health care resources within the community and able to appropriately provide referrals and linkages to families. It is recommended sites only provide information, referrals, and linkages when necessary (e.g., 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 Direct service staff provide information and/or referrals to all participating family members on available health care and health care resources, when necessary.

2 Past instances were found when direct service staff did not provide information and/or referrals to all participating family members on available health care and health care resources, when necessary; however, **recent practice** indicates this is now occurring.

1 Direct service staff are not yet providing information and/or referrals 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 community providers for additional services when needed.

Intent: Families benefit by accessing community agencies and services to support the family in accomplishing goals or overcoming challenges they may be experiencing. Families may be reluctant to access additional services, and direct service staff are one way to bridge the gap. Site staff are familiar with the community agencies and the services they provide to ensure 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. Sites stay up-to-date on existing resources in the community so referrals can be provided appropriately when needed.

7-3.C RATING INDICATORS

3 Families are linked to additional services in the community when needed.

2 Past instances were found when families needing additional services were not connected to appropriate services (when resources exist in the community); however, **recent practice** indicates this is now occurring.

1 Families are not yet linked to additional services in the community on an as needed basis.

7-3.D The site tracks and follows up with the family or service provider (if appropriate) to determine if the family received needed services. Follow-up with these 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 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 yet have a method or the site has a method but is not yet tracking and following up.

TIP: Staff-initiated referrals related to addressing issues and activities on the Service Plan can be documented on the family's Service Plan along with follow-up on these referrals if it is helpful to keep this information in one location.

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 conducts depression screening with all families using a standardized instrument.

Intent: Many of the items on the FROG Scale are precursors for depression. Add to that the extreme stress 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 during the prenatal and postnatal periods allows Family Support Specialists to assist parents in becoming aware of the depression and determining if there are depressive issues needing to be addressed by a clinician. Administering a depression screen requires both knowledge of how to administer the screen and what to do if the screen has positive results. Staff training includes the following:

- administration guidelines
- ways to talk with parents about depression
- community resource information
- activities Family Support Specialists 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:

- 11-2.D wraparound training on mental health
- access to the free online course through the National Child Traumatic Stress Network (Psychological First Aid Field Operations Guide)

Although staff are not therapists, it is critical for Family Support Specialists to support parents in alleviating their depression while a parent is awaiting treatment or while considering treatment options. A sample of health and wellness activities Family Support Specialists may suggest 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 or treatment
- utilizing supervision to assist staff in discussing depression with parents
- getting parents out in the sunshine (which 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)
- encouraging self-care
- practicing gratitude
- using healthy strategies that have worked for the parent in the past
- utilizing Procedures for Working with Families in Acute Crisis
- encouraging parents to meet their baby's physical and emotional needs
- using other strategies/activities identified locally

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

7-4.A The site has policy and procedures for administration of a standardized depression screening tool specifying when (at least once prenatally and at least once within three months after birth, or within 3 months of enrollment if enrolled postnatally, and at least once within 3 months of all subsequent births) the tool is to be used with the primary caregiver of all enrolled families and ensures all staff who administer the tool are fully trained, and staff understand what constitutes a positive screen and steps to take when the screen is positive. As indicated in the glossary, the primary caregiver is the individual the baby lives with and receives primary care from. This individual is generally, though not always, a parent, and is the primary point of contact for the Family Support Specialist when conducting home visits and observing PCI. In co-parenting or multi-generational parenting families, one person will be identified within the system as the primary caregiver. Depression screens are only required with this person.

7-4.A RATING INDICATORS

3 No 3 rating for standard 7-4.A.

2 The site has policy and procedures for administration of the depression screening tool and specifies the following:

- is to be used with the primary caregiver of all enrolled families
- what tool is used for depression screening
- the frequency of screening: at least once prenatally and at least once within three months of birth OR within 3 months of enrollment when enrolled after birth, AND at least once within 3 months of all subsequent births (born 1/1/18 or later)
- what score constitutes a positive screen
- referral and follow-up expectations with elevated screens
- activities appropriate for Family Support Specialists to do with families
- the requirement that all staff receive training on how to administer the tool prior to first use (unless already included in the site's training plan/policy – standard 10-1).

1 The site does not yet have policy and procedures; or policy and procedures do not yet include all components in the 2 rating.

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

TIP: Sites may consider conducting the depression screen with other caregivers, in addition to the primary caregiver.

TIP: Research has shown pre- and postnatal depression is not exclusive to mothers. Paternal depression is of concern as well with first births and subsequent births.

7-4.B The site conducts depression screening with the primary caregiver of all enrolled families. If enrolled prenatally, the screening will be completed at least once during the prenatal period. Please Note the following limited exception criteria: If the primary caregiver declines the screen, they are not counted within the cohort, and the refusal must be noted on the tracking form.

Intent: Depression screening is conducted prenatally and postnatally. Depression screens are completed even when families are in treatment to ensure treatment is meeting the needs of the family. Sites are expected to include Level CO families on their depression screening data reports (and to note time period the family was on Level CO), and to track receipt of depression screening during times the family is not on Level CO.

Please Note: Sites can use the HFA Spreadsheet to track depression screens.

7-4.B RATING INDICATORS

3 **At least 95%** of active primary caregivers enrolled in the past twelve months are screened using a standardized and validated depression screening tool at least once prenatally (when enrolled prenatally).

2 **80% - 94%** of active primary caregivers enrolled in the past twelve months are screened using a standardized and validated depression screening tool at least once prenatally (when enrolled prenatally).

1 Any of the following: the site does not yet use a standardized depression screening tool; or less than 80% of active primary caregivers enrolled in the past twelve months are screened prenatally.

NA The site does not enroll families prenatally.

TIP: If another service provider is involved and has completed depression screening, the Family Support Specialists may choose to coordinate to reduce duplicate screening. When doing so, a written consent to release information must be on file in the participant record and the site must be in receipt of a copy of the depression screen to show the screening was done, and to track any necessary follow-up referrals/interventions for the family.

TIP: According to several *Perinatal Care Position Statements*, depression screening is recommended to occur twice during the prenatal period (when families are enrolled in services early in their pregnancy).

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% "on-time" threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-4.C The site conducts postnatal depression screening with the primary caregiver of all enrolled families at a minimum of at least once postnatally before the baby is 3 months of age (when enrolled prenatally) and within 3 months of enrollment (when enrolled postnatally). Please Note the following limited exception criteria: If the primary caregiver declines the screen, they are not counted within the cohort, and the refusal must be noted on the tracking form.

Intent: Depression screens are completed even when families are in treatment to ensure treatment is meeting the needs of the family. Sites are expected to include Level CO families on their depression screening data reports (and to note time period the family was on Level CO), and to track receipt of depression screening during times the family is not on Level CO.

Please Note: Sites can use the HFA Spreadsheet to track depression screens.

7-4.C RATING INDICATORS

3 **At least 95%** of active primary caregivers enrolled in the past twelve months are screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the baby's birth (for those enrolled prenatally), or within 3 months of enrollment (for those enrolled postnatally).

Families not screened within 3 months are screened at least once within 6 months postnatally or post-enrollment (unless caregiver declined the screen).

2 **80% - 94%** of active primary caregivers enrolled in the past twelve months are screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the baby's birth (for those enrolled prenatally), or within 3 months of enrollment (for those enrolled postnatally).

Families not screened within 3 months are screened at least once within 6 months postnatally or post-enrollment (unless the caregiver declined the screen).

1 Any of the following: the site does not yet use a standardized depression screening tool; or less than 80% of active primary caregivers enrolled in the past twelve months are screened within 3 months as described in the 2 rating; or less than 100% have a depression screen within 6 months of enrollment.

TIP: According to several Perinatal Care Position Statements, depression screening is recommended postnatally at 6 weeks, 3 months, and 1 year following the birth of the baby.

TIP: If another service provider is involved and has completed depression screening, the Family Support Specialists may choose to coordinate to reduce duplicate screening. When doing so, a written consent to release information must be on file in the participant record and the site must be in receipt of a copy of the depression screen to show the screening was done, and to 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: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% "on-time" threshold or the 100% within 6 months threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-4.D The site conducts postnatal depression screening with the primary caregiver of all enrolled families with a subsequent birth at a minimum of at least once postnatally within 3 months of the subsequent birth. Please Note the following limited exception criteria: If the primary caregiver declines the screen, they are not counted within the cohort, and the refusal must be noted on the tracking form.

Intent: Postpartum depression is estimated to affect more than 5 percent of all women following childbirth, making it the most common postnatal complication of childbearing. The risk of recurrence is also known to be high and, given the impact of depression on parent and child health, HFA sites are required to screen all subsequent births to ensure appropriate supports are provided when indicated.

In a study, researchers analyzed data on 457,317 women who had a first child (and subsequent births) between 1996 and 2013 and had no prior psychiatric hospital contacts or use of antidepressants. Postpartum affective disorder (which included postpartum depression) was defined as an antidepressant prescription fill or hospital contact for depression within six months after birth.

In the cohort, 0.6% of all births among women with no history of psychiatric disease led to postpartum affective disorder. A year after their first treatment, 27.9% of these women were still in treatment; after four years, that number was 5.4%. For women with a hospital contact for depression after a first birth, the risk of postpartum affective disorder recurrence was 21%; the recurrence was 15% for women who took antidepressants after a first birth. These rates mean that, compared to women without history of affective disorder, the likelihood of depression with a subsequent birth is much higher for women with postpartum affective disorder after their first birth.

Rasmussen M-LH, Strøm M, Wohlfahrt J, Videbech P, Melbye M (2017). Risk, treatment duration, and recurrence risk of postpartum affective disorder in women with no prior psychiatric history: A population-based cohort study. PLoS Med 14(9): e1002392. *Please Note*: Sites can use the HFA Spreadsheet to track depression screens.

7-4.D RATING INDICATORS

3 In the last completed reporting year, **at least 95%** of active primary caregivers with a subsequent birth were screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the birth.

2 In the last completed reporting year, **80% - 94%** of active primary caregivers with a subsequent birth were screened using a standardized and validated depression screening tool at least once postnatally within 3 months of the birth; or there have been no subsequent births.

1 Any of the following: the site does not yet use a standardized depression screening tool; or in the last completed reporting year less than 80% of active primary caregivers with a subsequent birth were screened within 3 months of the birth.

TIP: 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: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 80% "on-time" threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

7-4.E Family Support Specialists provide activities to support primary caregivers whose depression screening scores are elevated and considered to be at-risk of depression, including items listed in the intent for standard 7-4, in addition to referral and follow-up on referrals, unless already involved in treatment, or treatment resources do not exist in the community.

Please Note: When caregivers are already involved in treatment or treatment resources do not exist in the community, these situations are noted in the tracking report.

7-4.E RATING INDICATORS

3 Primary caregivers with an elevated depression screening score are supported with appropriate activities by the Family Support Specialist and are referred (with consent when needed) for further evaluation/treatment and follow-up unless already involved in treatment, or treatment resources do not exist in the community.

2 Past instances were found when the site did not ensure all primary caregivers with an elevated depression screening score were supported with appropriate activities by the Family Support Specialist and referred (with consent when needed) for further evaluation/treatment and follow-up unless already involved in treatment or treatment resources do not exist in the community; however, **recent practice** indicates this is now occurring. Or there have been no elevated depression screens for currently enrolled families.

1 Any of the following: primary caregivers with an elevated depression screening score are not yet supported with appropriate activities by the Family Support Specialists; or are not yet referred for further evaluation/treatment; or there is no follow-up on those who are referred.

TIP: Supervisors are encouraged to note any concerns identified from the depression screen on the family's HFA Service Plan, with planned interventions/activities to address and track progress.

Tables of Documentation

7. At a minimum, all families are linked to a medical provider to ensure 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	Pre-Site Documentation to include in Self Study
7-1.A | Policy - Medical Providers for Focus Children	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
7-1.B | Focus Children with Health Care Provider	Submit a report reflecting: 1. List and count all active focus children 2. List and count all active focus children w/medical provider, include provider 3. Calculate: #2 (focus children w/medical provider) divided by #1 (total number of focus children) Please Note: An HFA Spreadsheet is available for this standard. Submit HFA Spreadsheet or report detailing all active focus children and their current medical/health care provider, including percent of children with a provider. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
7-1.C | Focus Children with Well-Child Care	Submit a narrative of how the site monitors well-child care along with any strategies developed to address identified barriers. Indicate what strategies have been implemented.
7-2.A | Policy - Timely Receipt of Immunizations	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
7-2.B | Measure Immunization Rates at 1yr	Submit the site's immunization schedule. Also submit a report reflecting immunization rates for all enrolled focus children ages 12-23 months (including those on Creative Outreach). 1. Count number of focus children currently between 12-23 months 2. Subtract from #1 (focus children between 12-23 months) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step #2), count how many are fully up to date with all immunizations expected through 6 months 4. Report number and calculate: #3 (those up to date) divided by #2 (number between 12-23 months minus those excluded from count) *Please Note:* An HFA Spreadsheet is available for this standard.
7-2.C | Measure Immunization Rates at 2yr	Submit a report reflecting immunization rates for all active focus children 24 months and older (including those on creative outreach). 1. Count number of focus children currently older than 24 months 2. Subtract from #1 (focus children 24 months and older) those who are excused from receiving immunizations according to allowable reasons in BPS 3. Of these children (determined in step #2), count how many are fully up to date with all immunizations expected through 18 months 4. Report number and calculate: #3 (those up to date) divided by #2 (number 24 months and older minus those excluded from count) *Please Note*: An HFA Spreadsheet is available for this standard.
7-3.A | Policy - Health Care and Community Information and/or Referrals and Follow-up	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available

Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
7-3.B | Health Care Referrals	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
7-3.C | Community Resource Referrals	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
7-3.D | Referral Follow-up	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
7-4.A | Policy – Depression Screening	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available
7-4.B | Prenatal Depression Screening	Submit a report of all current primary caregivers enrolled prenatally in the past 12 months. Include: 1. Enrollment date 2. Date of birth of focus child 3. Prenatal screening date(s) 4. Provide an explanation of any missed screens To calculate percent screened prenatally: 1. Count number enrolled prenatally 2. Count number screened prenatally 3. Divide #3 (screened prenatally) by #2 (enrolled prenatally) *Please Note:* An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
7-4.C | Postnatal Depression Screening	Submit a report of all current primary caregivers enrolled in the past 12 months. Include: 1. Enrollment date 2. Date of birth of focus child 3. Postnatal screening date(s) 4. Provide an explanation of any missed screens To calculate percent of primary caregivers screened within 3 months: 1. Count number enrolled 2. Count number screened a. For prenatal enrollments, count if received within 3 months of the child's birth b. For postnatal enrollments, count if received within 3 months of enrollment c. Add these counts together (a + b) 3. Divide #2 (screened) by #1 (enrolled) for percent screened To calculate percent of primary caregivers screened within 6 months: 1. Count number enrolled 2. Count number screened: a. For prenatal enrollments, count if received within 6 months of the child's birth b. For postnatal enrollments, count if received within 6 months of enrollment c. Add these counts together (a + b). 3. Divide #2 (screened) by #1 (enrolled) for percent screened *Please Note*: An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.

Tables of Documentation (cont.)

Standard	Pre-Site Documentation to include in Self Study
7-4.D | Screening for Depression w/ Subsequent Births	Submit a report of all current primary caregivers with a subsequent birth in the most recent 12 months. Include: 1. Date of birth of subsequent child 2. Postnatal screening date(s) 3. Provide an explanation of any missed screens To calculate percent of primary caregivers screened: 1. Count number who had a subsequent birth 2. Count number screened within 3 months of the subsequent birth 3. Divide #2 (screened) by #1 (number with a subsequent birth) for percent screened *Please Note:* An HFA Spreadsheet is available for this standard. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (80% in this case). When the site's annual data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
7-4.E | Referral and Follow up for Primary Caregiver with Elevated Screens	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

STANDARD 8

8

Services are provided by staff in accordance with principles of ethical practice and with limited caseloads to ensure Family Support Specialists 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 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 caseloads to ensure Family Support Specialists have an adequate amount of time to spend with each family to meet their needs and plan for future activities.

Intent: The importance of a limited and manageable caseload for each Family Support Specialist cannot be emphasized enough. It ensures staff are able to work most successfully and families will be afforded the time, energy, and resources necessary to help build protective factors, reduce risk, and impact positive change.

When setting caseload size, it is important to consider staff tenure and experience, along with family complexity and service intensity. HFA's level change system assures each family is individually considered both in terms of need and in terms of progress being made. Maximum case weight of thirty points expresses the absolute ceiling, not the expected size of an FSS caseload.

In addition to guidance about assigning case weight based on level of service (standard 4-2.A), HFA allows sites to increase case weight for families when warranted (referenced in the Glossary and HFA's Level Change forms). Supervisors and FSSs will determine whether service intensity should be temporarily increased or if a more permanent increase in service intensity should be applied owing to case complexity, extensive travel, births of multiples, translation needs, etc.

8-1.A The site's policy and procedures regarding caseload size indicate full-time (40 hours/week) Family Support Specialists in their first and second year working in this role to typically carry a caseload of approximately 10-12 families, and full-time Family Support Specialists in the role for three years or more typically carry a caseload of approximately 15-20 families, with supervisors using discretion about the pace which staff build a caseload and size of each staff person's caseload, not exceeding thirty (30) case weight points.

8-1.A RATING INDICATORS

3 No 3 rating indicator for 8-1.A

2 The site's policy and procedures regarding caseload size are based on staff tenure, with full-time Family Support Specialists in their role for one-two years typically with a caseload of 10-12 families and full-time Family Support Specialists employed for three years or more typically with caseload of 15-20 families. Supervisors use discretion regarding the pace each staff person builds a caseload and, ensures regardless of time in role or number of families, caseload will not exceed thirty case weight points (prorated for staff working less and a 40 hour work week).

1 The site does not yet have policy and procedures regarding caseload size; or the site's policy states case weight exceeds the maximum allowable for full time Family Support Specialist (40 hrs/wk).

TIP: Supervisors are encouraged to monitor caseload size closely, beginning with gradual increases to an FSS caseload when staff are newly hired and trained, and setting an expectation for all staff of an average caseload size vs an expectation that all staff carry the maximum number allowed.

TIP: For sites serving families experiencing complex stressors, a tenured full-time staff person generally is maxed out with caseload of 12-16 families.

8-1.B Full-time Family Support Specialists do not exceed a case weight of thirty points.

Intent: HFA's case weight system helps to ensure the caseload of Family Support Specialists is manageable and family needs can be effectively supported. There are select circumstances when FSSs may exceed the maximum case weight of thirty points, e.g., a Family Support Specialist leaves and the caseload is temporarily dispersed among existing Family Support Specialists temporarily (3 consecutive months or less). Sites are to clearly document the reasons why the caseload has exceeded the limit, as well as the duration of this deviation.

Also, the maximum is based on a full-time schedule of 40 hours worked per week. When an organization employs full-time staff at less than 40 hours per week, and/or part-time staff, the maximum case weight will need to be prorated accordingly, and the proration calculation grid (below) can be used to determine maximum case weight.

An HFA Spreadsheet is available for this standard.

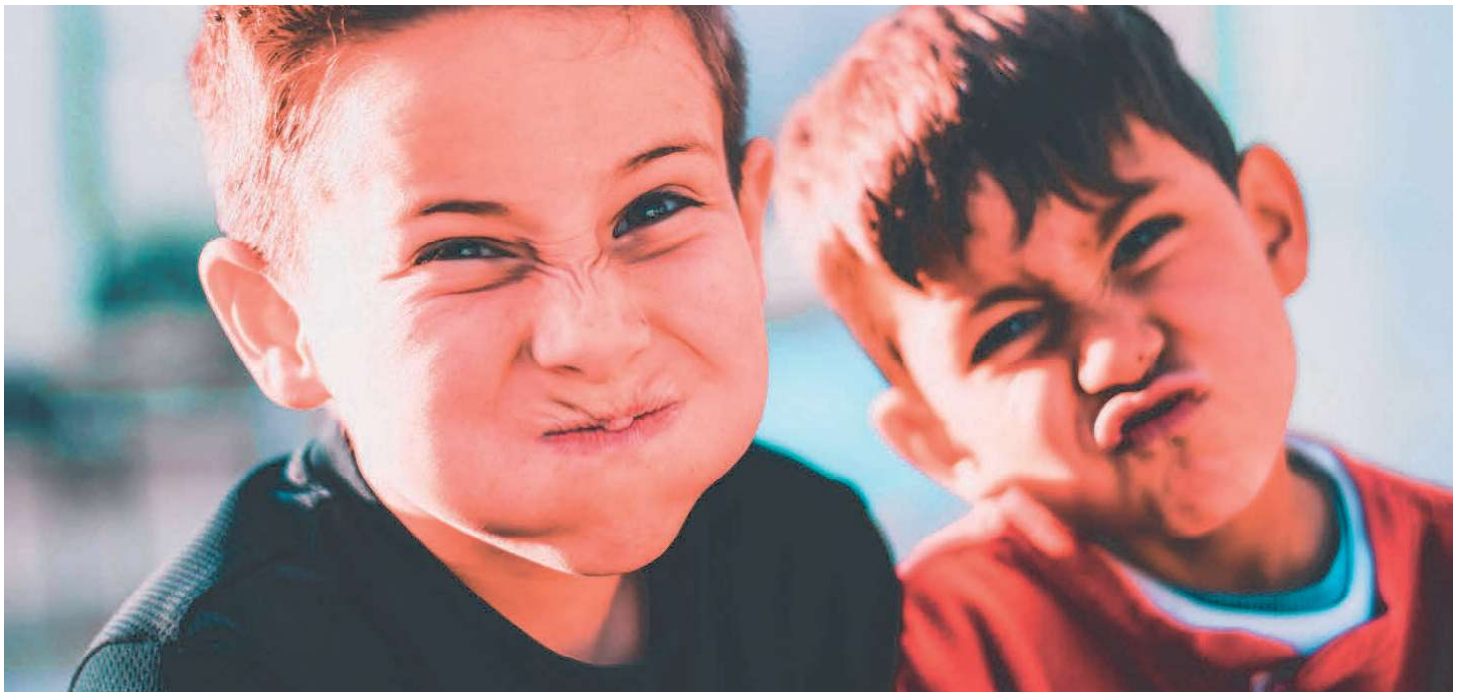
8-1.B RATING INDICATORS

3 Within the last twelve (12) months, **no Family Support Specialist exceeds the maximum case weight** of thirty points (or the prorated case weight for staff working less than 40 hour/week).

2 Instances were found when **Family Support Specialist(s) exceeded the maximum case weight of thirty points (or the prorated case weight** for staff working less than 40 hour/week); however, **any deviation in the past twelve (12) months was temporary (3 consecutive months or less).**

1 In the past twelve (12) months, Family Support Specialists have had case weights in excess of thirty points (or in excess of the prorated case weight for staff working less than 40 hour/week) for periods longer than 3 consecutive months; or data regarding case weight has not been maintained for the past 12 months.

MAXIMUM CASE WEIGHT			
Formula: 0.75 x # of hours per week			
40 HOUR WEEK	37.5 HOUR WEEK	35 HOUR WEEK	20 HOUR WEEK
30 pts	28 pts	26 pts	15 pts



8-2. The site's caseload system ensures Supervisors have procedures to apply when assigning families and when managing caseloads, including principles of ethical practice.

Intent: The primary intent of HFA's Level Change System (including case weights for each level) is focused on ensuring staff have sufficient time to support the needs of families during home visits, as well as planning time prior to home visits and documentation and follow-up time after the visit. Other circumstances also impact caseload size, such as staff who are new to HFA and who need time to integrate the essential components of HFA's approach.

Consideration when assigning families will need to factor in any potential boundary issues or conflicts to ensure staff avoid these situations. Other considerations include the length of time to travel to and from family homes, especially for rural or remote areas where travel time may exceed the norm. Considerations are also made when there are multiple births (see guidelines in HFA's Level System).

8-2.A The site has policy and procedures for assigning and managing its caseloads.

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, length of time in role, and skill level of the Family Support Specialist
- nature and difficulty of family dynamics
- work and time required to serve each family
- avoiding potential worker conflict or boundary challenge owing to an existing personal relationship
- current staff capacity
- travel and other non-direct service time required to fulfill responsibilities
- extent of other resources available in the community to meet family needs
- other assigned duties

1 The site does not yet have policy and procedures; or the policy and procedures do not yet include all the criteria listed above in the 2 rating.

TIP: Sites are encouraged to utilize a Code of Ethics, whether one established through professional organizations for nurses, social workers, early childhood professionals, or a multi-disciplinary Code of Ethics for Human Service Professionals.

TIP: Additionally, developing relationships with families who have lost their previous Family Support Specialist may require additional creative support to maintain engagement in services since there may be an additional sense of loss.

8-2.B The site uses the criteria identified in 8-2.A. to assign and manage its caseloads.

8-2.B RATING INDICATORS

3 The site assigns and manages its caseload sizes utilizing criteria identified in 8-2.A and outlined in the policy and procedures.

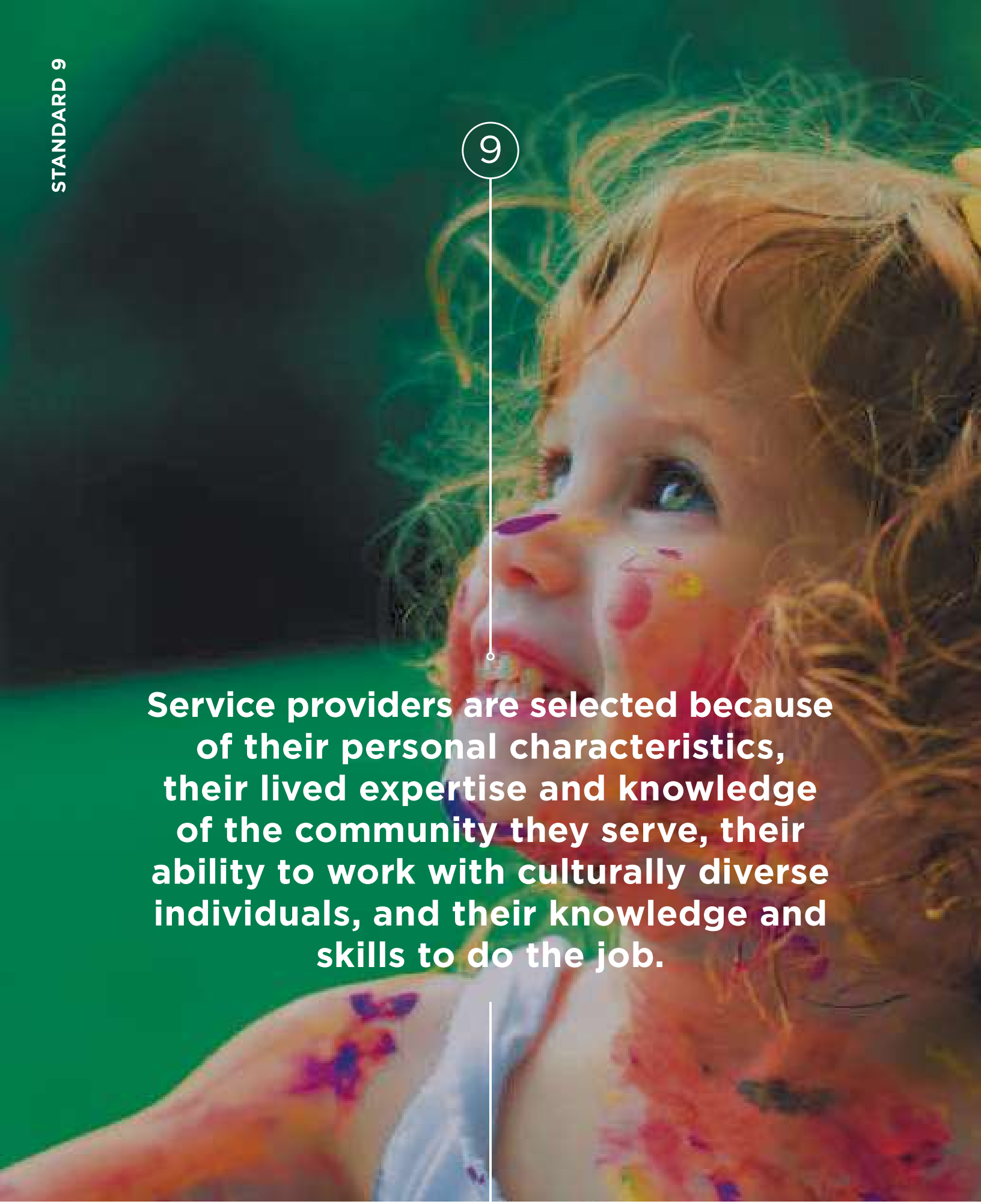
2 Past instances were found when caseloads were not assigned or managed according to the criteria identified in 8-2.A; however, **recent practice** indicates this is now occurring.

1 The site does not yet assign or manage its caseloads utilizing criteria identified in 8-2.A.

Tables of Documentation

8. Services are provided by staff in accordance with principles of ethical practice and with limited caseloads to ensure Family Support Specialists (FSS) 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	Pre-Site Documentation to include in Self Study
8-1.A | Policy - Caseload Size	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
8-1.B | Monitoring Caseloads	Submit a report indicating the monthly caseload for all current FSSs over the past 12 months. Include each FSS's full time equivalency (FTE and work hours expected per week), the number of families assigned to him or her, the level/intensity of service each family is receiving, and the case weight for each family. Please Note: An HFA Spreadsheet is available for this standard.
8-2.A | Policy - Managing Caseloads	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
8-2.B | Caseload Management	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.



9

Service providers are selected because of their personal characteristics, their lived expertise and knowledge of the community they serve, their ability to work with culturally diverse individuals, and their knowledge and skills to do the job.

Standard 9 Intent is to ensure staff are selected because they possess characteristics necessary to build trusting, nurturing relationships, and work effectively with families with different cultural values and beliefs than their own. Focusing on these characteristics also increases opportunities for diverse representation and equitable access to positions for historically and currently underrepresented individuals and groups.

Download Sample Staff Development Plan for Program Managers, Supervisors, and Direct Service Staff.

9-1. Direct service providers, managers, and supervisors are selected because of a combination of personal characteristics, experiences, and educational qualifications. The site's hiring system includes processes to ensure this can happen.

9-1.A The site's system for hiring new staff includes the following:

- job descriptions which include at least the minimum criteria indicated in standard 9-1.B-D for the positions of Program Manager, Supervisor, and direct service staff
- standardized interview questions appropriate to each role, including questions to screen for an applicant's reflective capacity
- policy requiring at least two reference checks and a criminal background check prior to hire

9-1.A RATING INDICATORS

3 No 3 rating for standard 9-1.A.

2 The site's system for screening and selection of new staff includes: 1) job descriptions with at least the minimum criteria listed for program managers, supervisors, and direct service staff (see standards 9-1.B-D), 2) standardized interview questions appropriate to each role with questions to assess each applicant's reflective capacity, and 3) policy regarding two reference checks and a criminal background check being complete prior to hire.

1 The site's system for screening and selection of new staff does not yet include all components listed in the 2 rating.

TIP: Please see the glossary definition of reflective capacity and the link to interview questions when considering an applicant's Reflective Capacity. These and other hiring tools in the HFA Supervisors Manual can be used by program and HR staff.

9-1.B Screening and selection of program managers includes consideration of characteristics including, but not limited to:

- a solid understanding of and experience in managing diverse staff with humility
- administrative experience in human service or related field including experience in quality assurance and continuous quality improvement
- master's degree in public health or human services administration or fields related to working with children and families, or bachelor's degree in these fields with 3 years of relevant experience, or less than a bachelor's degree but with commensurate HFA experience
- willingness to engage in building reflective practice (e.g., capacity for introspection, communicating awareness of self in relation to others, recognizing value of supervision, etc.)
- infant mental health endorsement preferred (if available in the state; if unsure, you can find out on the IMH website)

9-1.B RATING INDICATORS

3 The program manager, if hired after the last accreditation site visit, or if this is a first-time accreditation, **meets all of the required criteria** in the standard.

2 The program manager, if hired after the last accreditation, or if this is a first-time accreditation, **does not meet all of the criteria; however, the site documented its justification for the hiring decision and a staff development plan for the manager has been developed and implemented.**

1 The program manager, if hired after the last accreditation, or if this is a first-time accreditation, did not meet all of the criteria stated in the standard and reason for hire not documented; or a staff development plan has not yet been developed or implemented.

NA The Program Manager has worked as the Program Manager at the site prior to last accreditation site visit.

9-1.C 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 in these fields with 3 years of relevant experience, or less than a bachelor's degree but with commensurate HFA experience
- a solid understanding of or experience in supervising diverse staff with humility, 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 embraces the concepts of family-centered and strength-based service provision
- knowledge of parent-infant health and dynamics of child abuse and neglect
- experience supporting culturally diverse communities/families
- experience in home visiting with a strong background in early childhood prevention services
- willingness to engage in building reflective practice (e.g., capacity for introspection, communicating awareness of self in relation to others, recognizing value of supervision, etc.)
- infant mental health endorsement preferred (if available in the state; if unsure, you can find out on the IMH website)
- experience with reflective practice preferred (see standard 12-2.B for more detail)

9-1.C RATING INDICATORS

3 The site supervisors, if hired after the last accreditation site visit, or if this is a first-time accreditation, **meet all of the required criteria** in the standard.

2 The site supervisors, if hired after the last accreditation, or if this is a first-time accreditation, **do not meet all of the criteria; however, the site documented its justification for the hiring decision and a staff development plan for the supervisor has been developed and implemented.**

1 The site supervisors, if hired after the last accreditation, or if this is a first-time accreditation, do not meet all of the criteria stated in the standard and reason for hire not documented; or a staff development plan has not yet been developed or implemented.

NA The site supervisors have worked as supervisors at the site prior to last accreditation site visit.

9-1.D 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 humility to work with the culturally diverse families
- knowledge of infant and child development
- willing to engage in building reflective capacity (e.g., capacity for introspection, communicating awareness of self in relation to others, recognizing value of supervision, etc.)
- infant mental health endorsement preferred (if available in the state; if unsure, you can find out on the IMH website)

9-1.D RATING INDICATORS

3 The site's direct service staff, if hired after the last accreditation site visit, or if this is a first-time accreditation, **meets all of the required criteria** listed in the standard.

2 The site's direct service staff, if hired after the last accreditation, or if this is a first-time accreditation, **meets the educational criteria but at the time of hire did not meet all the experiential criteria; however, a staff development plan for direct service staff is in place and has been acted upon.**

1 Any of the following: direct service staff, if hired after the last accreditation, or if this is a first-time accreditation, do not yet meet the educational criteria stated in the standard, or do not yet meet all the experiential criteria and there is no development plan to compensate for experiential gaps; or the development plan has not yet been acted upon.

NA All direct service staff have worked as direct service staff at the site prior to last accreditation site visit.

Note: This is an Essential Standard.

9-2. The site actively recruits, employs, and promotes qualified personnel and administers its personnel practices without discrimination based upon age, sex, gender identity, sexual orientation, race, creed, color, ethnicity, religion, nationality, political affiliation, citizenship status, marital status, veteran status, disability or handicap, genetic information, pregnancy, family medical history, or any other characteristic protected by applicable federal, state, or local laws of the individual under consideration. EEOC Discrimination Types.

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 which specify the non-discriminatory nature of the site's employment practices
- **has no administrative findings or court rulings against the site in this respect**
- has 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 Any of the following: the site is not yet in compliance with the applicable law and has not yet begun corrective action; or the site has violated its equal opportunity policy; or the site does not yet disseminate information internally on its position on equal opportunity.

9-3. The site's recruitment and selection practices ensure 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:

- utilization of standardized interview questions that comply with employment and labor laws, and interview responses or summaries maintained for currently employed staff
- verification of two references or letters of recommendation; if hired from within the organization, performance appraisals can suffice

Please Note: If Human Resources policy does not permit interview responses/summary or reference checks to be maintained in personnel files, the program manager or supervisor is expected to maintain copies in their own staff files.

Please Note: Each round of recruits for a particular role will be asked the same set of questions.

9-3.A RATING INDICATORS

3 The site's recruitment and selection practices contain all 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 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 yet include all practices identified in the standard for both staff and volunteers.

TIP: It is recommended practice that all available positions are posted internally before posting externally.

TIP: HFA has sample interview questions in English and Spanish 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 employees, subcontractors, and volunteers who will have direct contact with children or access to data involving children.

Intent: Sites must ensure the safety of the families and children it serves by conducting criminal background checks on all employees who will come in contact with them, e.g., Direct service staff, 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 sought 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 or FBI fingerprinting are part of the licensing process, and staff reporting to be licensed have a valid and current license on file in the personnel record.

Please Note: If Human Resources policy does not permit criminal background checks to be maintained in personnel files, the head of Human Resources will need to provide a signed letter on agency letterhead indicating each employee's first and last name, the date of hire, and the date the criminal background check was completed.

9-3.B RATING INDICATORS

3 All currently employed site staff have had legally permissible criminal background checks completed **at the time of employment.** State child abuse and neglect registries may also have been checked.

2 All currently employed staff have had criminal background checks completed **at any point during employment**. State child abuse registries may also have been checked.

1 The site has conducted legally permissible background checks on some but not all currently employed staff; or does not yet conduct criminal 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 employment (e.g., once every five years) or if transferring within the agency.

9-4. The site evaluates and reports on staff satisfaction and retention at least once every two years and addresses how it may increase staff retention, improve staff diversity, inclusion, belonging and promote equity.

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 evaluates factors associated with staff turnover. By understanding the circumstances and characteristics of staff who leave, along with input from those who stay, strategies to increase retention can be developed (based on the data) and implemented with a greater likelihood of success. *Please Note*: While the site will want to include in their report all the reasons contributing to staff turnover, strategies for improvement do not need to be developed when reasons pertain to personal growth opportunities that could not be fulfilled on the job (e.g., returning to school, job promotion, etc.). *Please Note*: New sites without two full years since home visiting services began will monitor staff retention and satisfaction with one year of data. *Please Note*: If there has been no turnover in the last two years, the site will still monitor staff satisfaction among employed staff.

Download Sample Staff Satisfaction and Retention Template.

9-4. RATING INDICATORS

3 The site evaluates and reports on staff retention and satisfaction at least once every two years and has **implemented strategies** to address any issues identified from compiled satisfaction surveys or that impacted staff who left employment, including any issues associated with diversity, equity and inclusion.

2 The site evaluates and reports on staff retention and satisfaction at least once every two years and has developed strategies to address any issues identified from compiled satisfaction surveys or that impacted staff who left employment, including any issues associated with diversity, equity and inclusion, though **strategies have not yet been implemented.**

1 The site has not yet evaluated staff retention or satisfaction at least once every two years; or has not yet developed strategies to address issues.

TIP: When sites obtain feedback from currently employed staff related to job satisfaction and retention, they are encouraged to consider factors such as: job category, staff demographics, role clarity, acknowledgment of work performed, satisfaction with salary and benefits, reasonable workload, autonomy, and opportunities for advancement and career development.

Tables of Documentation

9. Service providers are selected because of their personal characteristics, lived expertise and knowledge of the community they serve, their ability to work with culturally diverse individuals, and their knowledge and skills to do the job

Standard	Pre-Site Documentation to include in Self Study
9-1.A | Site's System for Hiring New Staff	Staff are selected because of a combination of personal characteristics, experiential, and educational qualifications, and the site's hiring system includes processes to ensure this can happen. 1. Job descriptions with at least the minimum criteria listed for program managers, supervisors and direct service staff (see standards 9-1.B-D), 2. Standardized interview questions appropriate to each role with questions to assess each applicant's reflective capacity, 3. Policy regarding at least two reference checks and a criminal background check prior to hire
9-1.B | Screening & Selection of Program Managers **9-1.C** | Screening & Selection of Supervisors **9-1.D** | Screening & Selection of Direct Service Staff, Volunteers, and Interns **Essential Standard**	If this is a first accreditation visit, submit resumes for all current staff. If this is a reaccreditation visit, submit resumes for all staff hired since the last accreditation visit. Please also provide narrative for staff who do not meet all the criteria as outlined in the standard, including justification for the hiring decision and staff development plans that have been developed and implemented. Sample Staff Development Plan for Program Managers, Supervisors, and Direct Service Staff.
9-2. | Equal Opportunity Employment (EOE)	Please provide a narrative description of the organization's current status with regard to EOE, whether with no violations, under current review, in remediation, or with a history of previous findings. Please also provide any HR policy or protocols or other descriptive documentation specific to how the organization applies EOE laws.
9-3.A | Recruitment and Selection Practices **9-3.B** | Legally Permissible Background Checks **Safety Standard**	Personnel files will be reviewed onsite. If peers are not permitted access to personnel files, a letter on agency letterhead signed by HR director can be provided verifying internal review of personnel records. If providing a letter, it must include the first and last names of all current HFA staff, date of hire, and confirmation that each of the following exist in the personnel record: - utilization of standardized interview questions that comply with employment and labor laws and interview responses or summaries maintained for currently employed staff - verification of two reference checks or letters of recommendation. If hired from within the organization, performance appraisals can suffice, - date criminal background check was completed, - if utilized, date of state child abuse registry check. Any items not maintained by HR in the personnel file, such as interview responses/summary or reference checks, and thus unable to be verified via a letter from HR, must be provided by the program manager to be reviewed onsite.
9-4. | Staff Retention and Satisfaction	Submit narrative indicating factors associated with staff who have left along with satisfaction feedback from existing HFA staff. Also indicate how this data has been used to develop staff retention strategies, improve staff diversity and inclusion, and promote equity. Include which strategies have been implemented. 1. For staff retention, include data of staff who have left. Include staff (by position title) who left during the timeframe (12 months for new sites, 24 months for all others), their hire date, termination date, reason why they left; and any other pertinent characteristics. 2. For staff satisfaction include a summary of staff satisfaction input in regard to work conditions that contribute both negatively and positively to job satisfaction (typically aggregated survey results) for those currently employed with the HFA site. Agency-wide staff satisfaction surveys, if used, must be filtered and reported for HFA staff only. 3. Include strategies developed for staff retention based on what was learned from retention and satisfaction data. *Please note*: Sample Surveys available.

STANDARD 10

10

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

Standard 10 Intent is to ensure staff receive training specific to their role. HFA Core training is required for all direct service staff, supervisors, and program managers within six months of hire. This training must be provided by a nationally certified HFA Core trainer. Stop-gap training is provided when staff begin providing direct services prior to receiving Foundations or Supervision training. In addition, there are seven orientation training topics required to be received by staff prior to work with families.

Please Note: For training standards (10 & 11) where "recent practice" is indicated for a 2 rating, at the time of the accreditation site visit, the site's most recent hire (whose hire date has allowed sufficient time to receive training) plus any staff hired three months prior to the most recent hire, will demonstrate training was received in accordance with the standard, specific to content and timeframe requirements, unless extenuating circumstances warrant contextual decision-making.

10-1. The site has a comprehensive training policy detailing all required trainings listed below for staff (direct service staff, supervisors, and program managers), including: 1) topics, 2) the method for obtaining training, and 3) the timeframe for each.

- orientation (10-2.A-G) and 10-2.H for sites in multi-site systems
- stop-gap training (10-3.A-C) when HFA Core is received after first direct service
- intensive model specific (HFA Core) training (10-4.A-C)
- implementation training (10-5) (program managers or designee only)
- CCI, ASQ and ASQ:SE, and depression screen (10-6.A-D) for staff who administer the tool and their supervisors
- wrap-around training topics within 3 months of hire (11-1.A-D)
- wrap-around training topics within 6 months of hire (11-2.A-G)
- wrap-around training topics within 12 months of hire (11-3.A-E)
- annual ongoing training (11-4.A)
- annual training on child abuse and neglect update (11-4.B)
- annual training on diversity, equity, inclusion and belonging (11-4.C)

Please Note: All interns and volunteers who perform the same duties as direct service staff and supervisors receive the same type of training as paid staff.

Intent: The policy guides the site toward achieving all required training in a timely manner and clearly identifies:

- topics covered in each training module or session
- how the training is provided and by whom (e.g., program manager/supervisor, community agency, HFA online training modules, video, reading materials, etc.)
- the required timeframe for each training
- mechanism for tracking and supervisor verification

If the site's policy references its training log for description of all topics and the method they will be received, then a link to the log must also be provided in the policy. Training logs include date of hire to HFA, date of 1st direct service (home visit, FROG, supervision), and date of training (even when dates fall outside the required timeframe). If sites use something other than HFA's recommended online wraparound training, the training will comprehensively address each of the overall topics with a variety of relevant subtopics critical for preparing staff to do this work.

Please Note: HFA provides online training options for receipt of wrap-around training. For sites that do not use these options, the site will create a crosswalk showing each of the required topic areas, with the corresponding training title, training provider, training agenda or list of training content, and method used to cover each topic. Sites can track training using the HFA Spreadsheet available for this standard.

10-1. RATING INDICATORS

3 No 3 rating for standard 10-1.

2 The site has a comprehensive training policy, including all required trainings and the method and timeframe for receipt of all trainings.

1 Any of the following: there is no training policy; or the training plan/policy is not yet comprehensive (does not list all required topics and method for receipt of training, e.g., e-learning, LMS, onsite, etc.); or does not yet include timeframe for receipt of all training.

10-2. Staff (direct service staff, supervisors, and program managers); receive orientation training after HFA hire date and prior to direct work with families or supervision of staff to familiarize them with site responsibilities. Program managers hired prior to July 1, 2014, are not required to document receipt of orientation topics.

Intent: When staff are hired, they often begin their work with families prior to receiving **HFA Core training**. Therefore, it is essential staff have been oriented to topics which will directly impact their immediate work with families or with 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, or state. The HFA National Office makes available online orientation that sites may choose to use in addition to any organization-required orientation training. Site administrators ensure 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 staff did not receive these trainings within the required timeframes, for accreditation purposes it is expected all staff will receive the training regardless of the timeframe. *Please Note*: When a site is brand new, the program manager or supervisor may be involved in the writing of policy and procedure and the development of orientation procedures for staff. These activities, with documented dates relative to each orientation topic, can be referenced as completion of orientation for program managers or supervisors. *Please Note*: For any staff who are a re-hire to the HFA site, the expectation is to receive orientation again, if longer than three months since previously employed.

10-2.A Staff (direct service staff, supervisors, program managers, and the manager's supervisor) hired January 1, 2022 or later receive HFA Quick Start orientation training.

Orientation training prior to January 1, 2022 included: 1) the HFA goals and services, 2) the philosophy of home visiting/family support, and 3) the principles of ethical practice, subsequent to HFA hire date and prior to direct work with families or supervision of staff.

10-2.A RATING INDICATORS

3 Staff hired 01/01/22 or later receive HFA Quick Start training after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff hired 01/01/22 or later did not receive HFA Quick Start training after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required, and rated "2" if no new hires in the last five years.

1 Staff hired 01/01/22 or later do not yet receive HFA Quick Start after HFA hire date and prior to direct work with families; or supervision of staff.

TIP: Sites are encouraged to invite all Community Advisory Board (CAB) members to view HFA Quick Start orientation training at the start of their term with the CAB.

10-2.B Staff (direct service staff, supervisors, and program managers) are oriented to their roles as they relate to: 1) the site's parenting materials, curriculum, and other handouts shared with parents 2) policy and operating procedures, and 3) data collection forms and processes, after HFA hire date and prior to direct work with families or supervision of staff.

10-2.B RATING INDICATORS

3 All staff are oriented to their roles as they relate to the site's curriculum materials, policy and operating procedures, and data collection forms and processes, after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to their roles as they relate to the site's curriculum materials, policy and operating procedures, and data collection forms and processes, after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to their roles as they relate to the site's curriculum materials, policy and operating procedures, and data collection forms and processes, after HFA hire date and prior to direct work with families or supervision of staff.

10-2.C Staff (direct service staff, supervisors, and program managers) are oriented to the site's relationship with other community resources after HFA hire date and prior to direct work with families or supervision of staff.

10-2.C 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) after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to the site's relationship with other community resources after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to the site's relationship with other community resources after HFA hire date and prior to direct work with families or supervision of staff.

10-2.D Staff (direct service staff, supervisors, and program managers) are oriented to: 1) child abuse and neglect indicators, and 2) reporting requirements after HFA hire date and prior to direct work with families or supervision of staff.

10-2.D RATING INDICATORS

3 All staff are oriented to child abuse and neglect indicators and reporting requirements after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to child abuse and neglect indicators and reporting requirements after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to child abuse and neglect indicators and reporting requirements after HFA hire date and prior to direct work with families or supervision of staff.

Note: This is a Safety Standard

10-2.E Staff (direct service staff, supervisors, and program managers) are oriented to issues of confidentiality and issues of ethical practice prior to direct work with families or supervision of staff.

10-2.E RATING INDICATORS

3 All staff are oriented to issues of confidentiality and principles of ethical practice after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to confidentiality and principles of ethical practice after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the orientation training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to issues of confidentiality and principles of ethical practice after HFA hire date and prior to direct work with families or supervision of staff.

TIP: Sites are encouraged to utilize a Code of Ethics, whether one established through professional organizations for nurses, social workers, or early childhood professionals, or a multi-disciplinary Code of Ethics for Human Service Professionals.

10-2.F Staff (direct service staff, supervisors, and program managers) are oriented to issues related to boundaries after HFA hire date and prior to direct work with families or supervision of staff.

10-2.F RATING INDICATORS

3 All staff are oriented to issues related to boundaries after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received thetraining but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to issues related to boundaries after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to issues related to boundaries after HFA hire date and prior to direct work with families or supervision of staff.

10-2.G Staff (direct service staff, supervisors, and program managers) are oriented to issues related to staff safety after HFA hire date and prior to direct work with families or supervision of staff.

10-2.G RATING INDICATORS

3 All staff are oriented to issues related to staff safety after HFA hire date and prior to direct work with families or supervision of staff. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to issues related to staff safety after HFA hire date and prior to direct work with families or supervision of staff; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to issues related to staff safety after HFA hire date and prior to direct work with families or supervision of staff.

10-2.H Staff (direct service staff, supervisors, and program managers) who work at a site that is part of an HFA Multi-Site System are oriented to the Multi-Site System, including the goals, objectives, policies, and functions of the Multi-Site System and Central Administration.

10-2.H RATING INDICATORS

3 All staff are oriented to the Multi-Site System, including the goals, objectives, policies, and functions of the Multi-Site System and Central Administration, within three months of hire. For Multi-Site Systems in their first accreditation cycle, staff hired more than five years ago have received the training regardless of timeframe. For systems in a reaccreditation cycle, training data for staff hired longer than five years is not required.

2 Past instances were found when staff were not oriented to the Multi-Site System, including the goals, objectives, policies, and functions of the Multi-Site System and Central Administration, within three months of hire; however, **recent practice** indicates this is now occurring and all staff (if system is in its first accreditation cycle) have received the training regardless of the timeframe. For systems in a reaccreditation cycle, training data for staff hired longer than five years is not required.

1 Staff are not yet oriented to the Multi-Site System, including the goals, objectives, policies, and functions of the Multi-Site System and Central Administration, within three months of hire.

NA The site is not part of an HFA Multi-Site System.

10-3. Supervisors and Family Support Specialists who begin home visiting or supervision work prior to receipt of 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 home visiting or supervision work prior to the receipt of role-specific **HFA Core training**, the site must have a policy for the provision of stop-gap training. Stop-gap training is defined as: customized training provided as-needed to meet an individual's urgent need for training in the skills necessary to perform their work prior to the receipt of HFA Core training. HFA has developed a series of stop-gap training webinars to be used in conjunction with on-site activities designed to set staff on a positive trajectory for their work with families. Stop-gap on-site activities do 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 Foundations or Supervision training, unless the site's policy requires HFA Core Training is received prior to direct service. Stop-gap training, including on-site activities, have been developed by HFA and may be conducted by the site supervisor or program manager. HFA stop-gap training includes:

- a clear description of the "HFA Advantage" (what makes HFA unique, including trauma-informed practice, the power of relationships/attachment, and reflective capacity)
- shadowing of other staff in a similar role
- hands-on practice (with observation and feedback)
- training on forms used by individuals in that role and expectations for documentation
- 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, the HFA National Office can provide support allowing families to begin receiving services. Please contact your HFA Training and TA Specialist for more details.

10-3.A The site has policy and procedures for providing stop-gap training to direct service staff and supervisors of direct service staff when they begin their work prior to the receipt of HFA Core Foundations or Supervision training, to ensure staff has adequate understanding and knowledge of their role. The training must include the bulleted components described in the intent.

10-3.A RATING INDICATORS

3 No 3 rating for 10-3.A.

2 The site has policy and procedures for providing stop-gap training to direct service staff and their supervisors who will begin their work prior to the receipt of HFA Core Foundations or Supervision training. Stop-gap training includes all bulleted components described in the intent.

1 The site does not yet have policy and procedures for providing stop-gap training to direct service staff and their supervisors who will begin their work prior to the receipt of HFA Core Foundations or Supervision training; or the policy and procedures do not yet specify the training include all bulleted components described in the intent.

NA The site's policy requires that HFA Core training be received prior to providing direct service.

10-3.B Direct service staff who begin their work with families prior to completion of Intensive HFA Core Foundations training, and their supervisor, have received stop-gap training to ensure direct service staff and their supervisor have adequate understanding and knowledge of their role.

10-3.B RATING INDICATORS

3 Staff receive stop-gap training prior to their work with families and/or supervising direct service staff which includes all required components. For sites in their first accreditation cycle, staff hired more than five years ago have received training though it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired more than five years ago is not required.

2 Past instances may have occurred when stop-gap training was not received prior to beginning work with families and/or supervising direct service staff, or some of the required components were not included; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Site staff do not yet receive stop-gap training prior to beginning work with families and/or supervising direct service staff; or the training does not yet include the required components.

NA All staff have received HFA Core training prior to providing direct service.

10-3.C Supervisors who begin providing supervision prior to completion of intensive HFA Core Supervision training have received supervisor stop-gap training to ensure the supervisor has adequate understanding and knowledge of their role.

10-3.C RATING INDICATORS

3 Supervisors receive supervisor stop-gap training including all required components within four weeks of hire to HFA supervisor role. For sites in their first accreditation cycle, staff hired more than five years ago have received training though it may have occurred after first direct service. For sites in a reaccreditation cycle, training data for staff hired more than five years ago is not required.

2 Past instances may have occurred when training was not received within four weeks of hire to HFA supervisor role or some of the required components were not included; however, **recent practice** indicates this is now occurring and all supervisors (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Supervisors do not yet receive training within four weeks of hire to HFA supervisor role; or the training does not yet include all of the required components.

NA All supervisors have received HFA Core Supervisor training prior to supervising staff.

10-4. Staff (direct service staff, supervisors, and program managers) receive intensive HFA Core trainings within the following timeframes. For those administering the FROG Scale, training is received prior to first use; for Foundations and Supervision training, and FROG training for Supervisors, within six months of hire. HFA Core trainings are provided by an HFA certified trainer.

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, to share information and experiences, and to learn from one another.

Please Note: In the event staff did not receive HFA Core training within the required timeframes, it is required all staff will receive the training regardless of the timeframe.

Please Note: When a staff member who has received Core training is re-hired for the same position, whether at the same site or at a different site, re-taking of HFA Core training is required if the staff person has not worked for HFA in three or more years.

10-4.A All staff administering the FROG Scale receive intensive HFA Core FROG Scale training by an HFA certified trainer prior to first use of the tool and all supervisors receive this training within six months of hire.

10-4.A RATING INDICATORS

3 All staff using the FROG Scale and all supervisors receive intensive HFA Core FROG Scale training by an HFA certified trainer within the timeframes indicated in the standard. For sites in their first accreditation cycle, staff hired more than five years ago have received the training, though it may have been received later.

2 Past instances were found when staff using the FROG Scale or supervisors did not receive intensive HFA Core FROG Scale training by an HFA certified trainer within the timeframes indicated in the standard; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe.

1 Staff using the FROG Scale or supervisors do not yet receive intensive HFA Core FROG Scale training within the timeframes indicated; or training was not conducted by an HFA certified trainer.

Note: This is an Essential Standard.

TIP: FROG Scale training is optional for program managers who do not supervise staff administering the FROG.

10-4.B All staff (including program managers hired January 1, 2022, or later) have received intensive HFA Core Foundations training by an HFA certified trainer, within six months of date of hire, to understand key components of the HFA model. Program managers hired prior to January 1, 2022, receive the training within eighteen months of hire.

10-4.B RATING INDICATORS

3 All staff receive intensive HFA Core Foundations training by an HFA certified trainer, within six months of the date of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training, though it may have been received later than within six months of hire. For sites in a reaccreditation cycle, training data for staff hired more than five years ago is not required.

2 Past instances were found when staff did not receive intensive HFA Core Foundations training by an HFA certified trainer within six months after hire; however, **recent practice** indicates this is now occurring, and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Staff do not yet receive intensive HFA Core Foundations training within six months of hire; or the training was not conducted by an HFA certified trainer.

Note: This is an Essential Standard.

10-4.C Supervisors and program managers have received intensive HFA Core Supervision training by an HFA certified trainer within six months of date of hire, to understand the key components of supervision. This includes FROG Supervision training for those who supervise staff administering the FROG Scale. Program managers hired prior to January 1, 2022, receive the training within eighteen months of hire.

10-4.C RATING INDICATORS

3 All supervisors and program managers receive intensive HFA Core Supervision training by an HFA certified trainer, on the key components of supervision, within six months of the date of hire or position change. For sites in their first accreditation cycle, staff hired more than five years ago have received the training, though it may have been received later than within six months of hire. For sites in a reaccreditation cycle, training data for staff hired more than five years ago not required.

2 Past instances were found when supervisors and program managers did not receive intensive HFA Core Supervision training by an HFA certified trainer, within six months after hire or position change; however, **recent practice** indicates this is now occurring and all supervisors and program managers (if site is in its first accreditation cycle) have now received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Supervisors and program managers do not yet receive intensive HFA Core Supervision training within the specified time frames; or training was not conducted by an HFA certified trainer.

Note: This is an Essential Standard.

TIP: After receiving HFA Core Supervision training, all supervisors are strongly encouraged to also obtain HFA's STARS training.

TIP: FROG Supervision training is optional for program managers who do not supervise staff administering the FROG.

10-5. All Program Managers (or those in a role and fulfilling expectation of program manager as defined in the glossary) hired to HFA on or after January 1, 2018, receive intensive HFA Core Implementation training from the HFA National Office within eighteen months of date of hire, to understand the key components of implementing the HFA model. HFA Implementation training is strongly encouraged and optional for program managers hired prior to January 1, 2018.

10-5. RATING INDICATORS

3 All program managers hired to HFA on or after January 1, 2018, receive intensive HFA Core Implementation training, by National Office staff, on the key components of implementing the HFA model, **within twelve months** of the date of hire or position change; or program managers hired prior to January 1, 2018, completed HFA Implementation Training.

2 All program managers hired on or after January 1, 2018, receive intensive HFA Core Implementation training by National Office staff **within eighteen months** of hire or position change; or have a plan to attend if less than eighteen months since hire.

1 Program managers hired on or after January 1, 2018, have not yet received intensive HFA Core Implementation training from National Office staff within eighteen months of hire or position change.

NA The site's program manager was hired prior to January 1, 2018, and is exempt from completing HFA Core Implementation Training.

TIP: When possible, it is recommended the program manager's supervisor also attend HFA Core Implementation training.

10-6. Staff who are responsible for the administration of required screening tools receive trainings on these tools prior to first use, and supervisors receive these trainings within six (6) months of hire.

10-6.A Those who administer the CHEERS Check-In (CCI) tool 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 the CCI. Training can be accessed on HFA's Network Resources. CCI training received prior to HFA hire date is acceptable if the staff has been using the tool consistently (without lapse) since receipt of training.

10-6.A RATING INDICATORS

3 All staff hired in the past five years, who use the CCI, are trained in its use prior to administering the tool. Supervisors hired in the past five years receive training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred later than above. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired in the past five years did not receive training on the CCI prior to administering the tool, or for supervisors within six months of hire; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Staff administer the CCI tool prior to being trained; or supervisors have not yet received the training.

10-6.B Those who administer the ASQ have been trained in the use of the current version of the tool before administering it, and supervisors also receive this training.

Intent: Staff must be trained before administering the ASQ. Ideally, this training is conducted by an individual who understands the use of the tool in a home visit setting. When possible, this training includes information detailing the critical function behind each of the developmental questions. ASQ training received prior to HFA hire date is acceptable if the staff person has been using the tool consistently (without lapse) since receipt of training.

10-6.B RATING INDICATORS

3 All staff hired in the past five years, who use the ASQ, are trained in its use prior to administering the tool. Supervisors hired in the past five years receive training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred later than above. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired in the past five years did not receive training on the ASQ prior to administering the tool, or for supervisors within six months of hire; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Staff administer the ASQ prior to being trained; or supervisors have not yet received the training.

10-6.C Those who administer the ASQ:SE have been trained in the use of the current version of the tool before administering it, and supervisors also receive this training.

Intent: Staff must be trained before administering the ASQ:SE. Ideally, this training is conducted by an individual who understands the use of the tool in a home visit setting. When possible, this training includes information detailing the critical function behind each of the questions. ASQ:SE training received prior to HFA hire date is acceptable if there has been no gap in use of the tool.

10-6.C RATING INDICATORS

3 All staff hired in the past five years, who use the ASQ:SE, are trained in its use prior to administering the tool. Supervisors hired in the past five years receive training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred later than above. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired in the past five years did not receive training on the ASQ:SE prior to administering the tool, or for supervisors within six months of hire; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Staff administer the ASQ:SE prior to being trained; or supervisors have not yet received this training.

10-6.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: All staff who administer the depression screening tool, and their supervisors, receive training on the use of the tool prior to first use. Please Note: When a collaborative partnership results in another provider completing the depression screen and providing a 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 HFA staff receive depression screen training to ensure understanding of administration guidelines and referral procedures, regardless of whether or not they administer the screen, as they need to be able to interpret and act on the results.

10-6.D RATING INDICATORS

3 All staff hired in the past five years, who use the depression screening tool, are trained in its use prior to administering the tool. Supervisors hired in the past five years receive training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have occurred later than above. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required

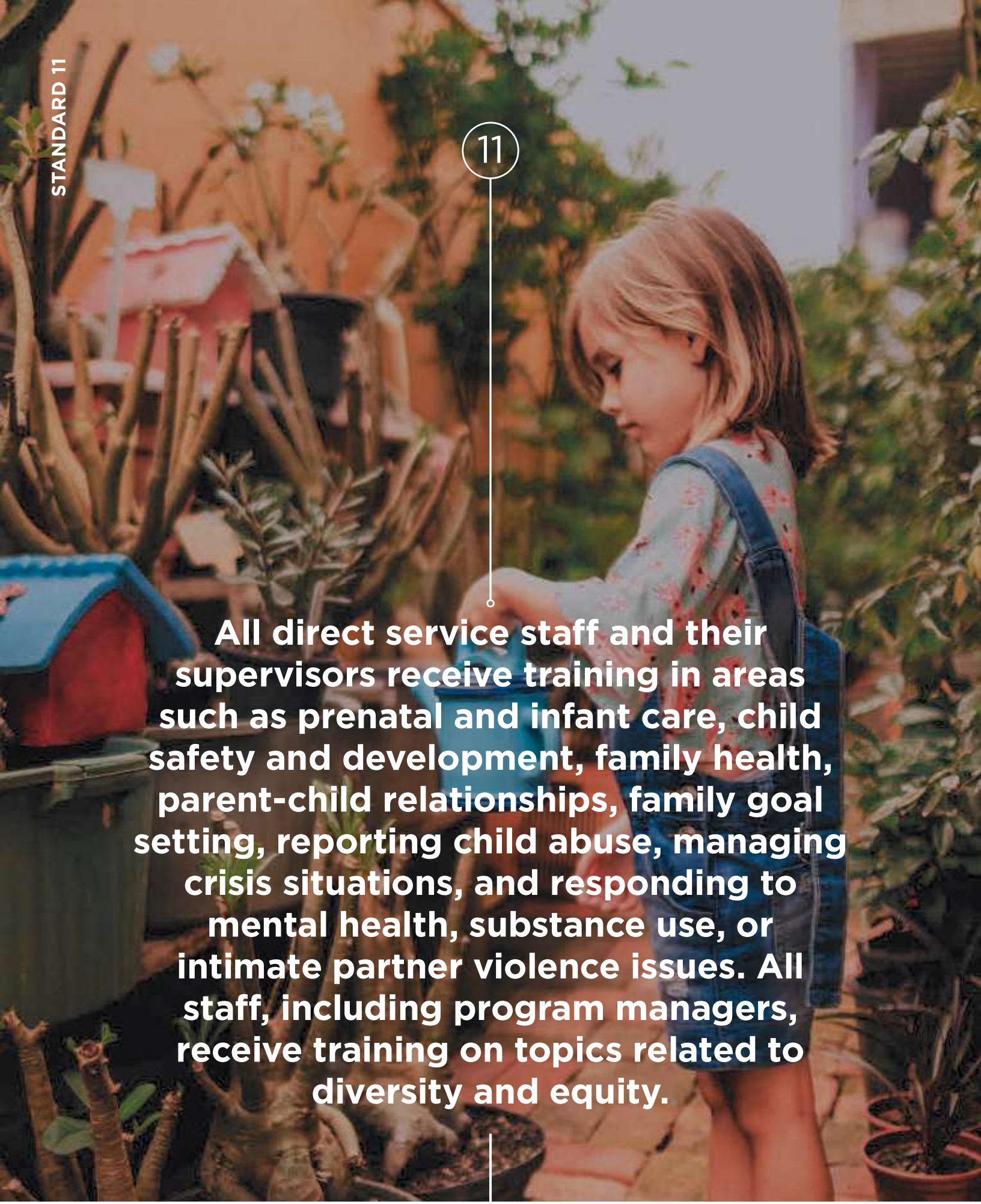
2 Past instances were found when staff hired in the past five years did not receive training on the depression screening tool prior to administering the tool, or for supervisors within six months of hire; however, **recent practice** indicates this is now occurring and all staff (if site is in its first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

1 Staff administer the tool prior to being trained; or supervisors have not yet received the training.

Tables of Documentation

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

Standard	Pre-Site Documentation to include in Self Study
10-1. | Training Plan/Policy	Submit training plan/policy for all staff (direct service staff, supervisors, and program managers) including: all required topics, method for receipt of training (i.e. e-learning, onsite, etc.); and timeframe for receipt. Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
10-2.A-H | Orientation Training **10-2.D |** Safety Standard	Submit documentation indicating the date each staff person (direct service staff, supervisors, and program managers) completed each of the orientation topics (10-2.A-H), including the date of hire and the date staff person began providing direct service or supervision. Also include the date the program manager's supervisor completed 10-2.A. Please Note: HFA Training Log available.
10-3.A | Policy for Stop-Gap Training	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
10-3.B-C | Stop-Gap provided when needed	Submit documentation indicating receipt of Stop-Gap training (if used) including the date each training topic completed, as well as the date of hire for each staff (direct service staff, supervisors, and program managers). Please Note: HFA Training Log available.
10-4.A | HFA FROG Scale Training **Essential Standard** **10-4.B |** HFA CORE Foundations Training **Essential Standard** **10-4.C |** HFA Supervisor Training **Essential Standard**	Submit documentation indicating the date each staff person completed Core training (direct service staff, supervisors, and program managers) and include the staff date of hire. Documentation can be recorded in a training log with supervisor signature, or training certificates may be submitted. Please Note: HFA Training Log available.
10-5. | HFA Implementation training for Program Managers	Submit documentation indicating the date of hire for the Program Manager (or designee) and the date HFA Implementation training was completed. Please Note: HFA Training Log available.
10-6.A-D | Tools Training	For staff who are responsible for the administration of required screening tools, and their supervisors, submit documentation indicating the date each person completed training on each of the screening tools (CCI, ASQ-3, ASQ:SE, and depression screening) and the date they first administered (or supervised use of) each tool. Please Note: HFA Training Log available.



STANDARD 11

11

All direct service staff and their supervisors receive training in areas such as prenatal and infant care, child safety and development, family health, parent-child relationships, family goal setting, reporting child abuse, managing crisis situations, and responding to mental health, substance use, or intimate partner violence issues. All staff, including program managers, receive training on topics related to diversity and equity.

Standard 11 Intent is to ensure staff receive training support and have the skill set necessary to fulfill their job functions and achieve improved outcomes with families. Training can be received through a variety of methods including, but not limited to, the following: HFA wraparound training modules, in-person or virtual attendance at lectures, interactive presentations, workshops, and college coursework.

Intent 11-1 (training within 3 months), 11-2 (training within 6 months), and 11-3 (training within 12 months): Training that is specific and relevant to the field of home visiting and can translate to the work of HFA staff is critical in the first year of employment. It is intended for staff to receive training in all of the topics outlined in the rating indicators, incorporating suggested subtopics based on relevant community dynamics and the individual learning needs of staff. It is a site's responsibility to ensure 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 skills necessary to support family well-being.

Several formats are acceptable to accomplish training in each of the specified areas below and can include: attendance at trainings/workshops/in-services, online trainings developed by HFA, other online training, formal education, certification, licensure, and competency-based testing (individual's knowledge of a topic measured by written test or through observation of skills and abilities). Previous professional experience or formal education specific to the topics identified in the standards can be used to meet the standard when received no more than three years prior to HFA hire and when coupled with competency-based testing or supervision follow-up. Follow-up with the supervisor is to ensure successful knowledge acquisition and understanding of the concepts or materials within the context of home visiting and the individual's role, and whether additional training in this topic might be beneficial.

Please Note:

1. **All staff at affiliated HFA sites may use the online trainings developed by HFA (or other training resources provided by the National Office) to complete the 11-1, 11-2, and 11-3 training topics. If sites use something other than HFA's recommended online wraparound training, the training will comprehensively address each of the overall topics with a variety of relevant subtopics critical for preparing staff to do this work.**

2. **HFA Core training (standards 10-4.B-D) cannot be used to satisfy the 3-, 6-, and 12-month training requirements.**

3. **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.**

4. **For training standards (10 & 11) where "recent practice" is indicated for a 2 rating, at the time of the accreditation site visit, the site's most recent hire (whose hire date has allowed sufficient time to receive training) plus any staff hired three months prior to the most recent hire, will demonstrate training was received in accordance with the standard, specific to content and timeframe requirements, unless extenuating circumstances warrant contextual decision-making.**

TIP: (for 11-1, 11-2 and 11-3):

- Sites should have mechanisms for ensuring staff training needs are being met and the trainings are of high quality (e.g., post-training surveys, or input obtained during supervision sessions or team meetings).
- When circumstances prevent staff from attending a required training in a timely way, it is recommended sites document the circumstances that led to staff missing the training, so peer reviewers can take this information into consideration when assigning a rating.
- When staff complete wrap-around training very quickly after hire, they are encouraged to revisit these training topics as a refresher at a later point once they begin to increase their experience working with families. This will assist with the transfer of knowledge to practice, as training done very early or too quickly may not be readily applied if they have not yet begun serving families.

11-1. Staff (direct service staff and supervisors) receive training on a variety of topics necessary for effectively working with families and children within three months of hire.

11-1.A Staff (direct service staff and supervisors) receive training on Infant Care within three months of the date of hire. HFA's online training includes these subtopics:

- infant sleep and safer sleep practices
- feeding/Breastfeeding
- failure to thrive
- physical care of the baby
- infant crying and responses to crying

11-1.A RATING INDICATORS

3 Staff hired within the past five years received training on Infant Care within three months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than three months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training 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 (if in a first accreditation cycle) have received training on this topic regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Infant Care within three months of hire; or staff hired within the past five years have not received training on this topic.

11-1.B Staff (direct service staff and supervisors) receive training on Child Health and Safety within three months of the date of hire. HFA's online training includes these subtopics:

- home safety (e.g., fire, child supervision, water temperature, pools, falls, etc.)
- abusive head trauma prevention
- sudden unexpected infant death
- seeking medical care
- well-child visits, immunizations, and oral health
- parenting children with special health needs
- community resources for child health

11-1.B RATING INDICATORS

3 Staff hired within the past five years received training on Child Health and Safety within three months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than three months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training 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 (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Child Health and Safety within three months of hire; or staff hired within the past five years have not received training on this topic.

11-1.C Staff (direct service staff and supervisors) receive training on Family Health within three months of the date of hire.
HFA's online training includes these subtopics:

- adult primary care
- family planning and reproductive justice
- disability and chronic health issues
- smoking cessation
- health equity and access to care
- community resources for adult medical care and nutrition

11-1.C RATING INDICATORS

3 Staff hired within the past five years received training on Family Health within three months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than three months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Family Health within three months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Family Health within three months of hire; or staff hired within the past five years have not received training on this topic.

11-1.D Staff (direct service staff, program managers and supervisors) receive training on Cultural Self-Awareness within three months of the date of hire.
HFA's online training includes these subtopics:

- seeking clarity on personal identity, values, and beliefs
- understanding privilege and its role in systems of oppression and racism
- how our own experiences play out in home visiting work
- implicit bias
- demonstrating compassion for self and others

11-1.D RATING INDICATORS

3 Staff hired January 2022 or later received training on Cultural Self-Awareness within three months of hire. Staff hired prior to January 2022 have received the training but it may have been later than three months after hire.

2 Past instances were found when staff hired January 2022 or later did not receive training related to Cultural Self-Awareness 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 regardless of timeframe.

1 The site's most recent hire(s) from January 2022 or later have not yet received training on Cultural Self-Awareness within three months of hire; or staff hired prior to January 2022 have not yet received training on this topic.

11-2. Staff (direct service staff and supervisors) receive training on a variety of topics necessary for effectively working with families and children within six months of hire.

11-2.A Staff (direct service staff, and supervisors) receive training on Infant and Child Development within six months of the date of hire.
HFA's online training includes these subtopics:
- brain development
- social and emotional development
- language development and early literacy
- physical development
- infant behavior (cues, states, reflexes)
- responding to developmental delays
- community resources to support children with delays

11-2.A RATING INDICATORS

3 Staff hired within the past five years received training on Infant and Child Development within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Infant and Child Development within six months of hire; however, for the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Infant and Child Development within six months of hire; or staff hired within the past five years have not received training on this topic.

11-2.B Staff (direct service staff and supervisors) receive training on Supporting the Parent-Child Relationship within six months of the date of hire.
HFA's online training includes these subtopics:
- observing parent-child interactions
- supporting attachment
- nurturing parenting strategies
- discipline

11-2.B RATING INDICATORS

3 Staff hired within the past five years received training on Supporting the Parent-Child Relationship within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training 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 (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Supporting the Parent-Child Relationship topics within six months of hire; or staff hired within the past five years have not received training on this topic.

11-2.C Staff (direct service staff and supervisors) receive training on Professional Practice within six months of the date of hire. HFA's online training includes these subtopics:

- time management
- coping with stress
- recognizing and preventing burnout
- power imbalances in professional relationships
- reflective practice

11-2.C RATING INDICATORS

3 Staff hired within the past five years received training on Professional Practice within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Professional Practice within six months of hire; however with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Professional Practice within six months of hire; or staff hired within the past five years have not received training on this topic.

TIP: Program managers are encouraged but not required to complete training on Professional Practice.

11-2.D Staff (direct service staff and supervisors) receive training on Mental Health within six months of the date of hire.
HFA's online training includes these subtopics:

- promotion of positive mental health
- behavioral signs of mental health issues
- depression
- perinatal mood disorders
- coping with loss
- strategies for working with families with mental health issues
- mental health emergencies
- referral resources for mental health

11-2.D RATING INDICATORS

3 Staff hired within the past five years received training on Mental Health within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training 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 (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Mental Health within six months of hire; or staff hired within the past five years have not received training on this topic.

11-2.E Staff (direct service staff and supervisors) receive Prenatal training within six months of hire.
HFA's online training includes these subtopics:

- 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)

11-2.E RATING INDICATORS

3 Staff have received Prenatal Training within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required.

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 (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received Prenatal training within six months of hire; or staff hired within the past five years have not received training on this topic.

TIP: HFA's Great Beginnings Start Before Birth training meets the expectations of this standard and provides a deeper dive into work with prenatal families utilizing the HFA approach. This training is strongly encouraged.

11-2.F Staff (direct service staff and supervisors) receive training on the Family Goal process within six months of hire. HFA's online training includes these subtopics:

- purpose and importance of the family goal process in HFA services
- working with families to identify strengths and needs
- supporting the family's role in setting and achieving meaningful goals to assist families in taking charge of their lives
- development of family goals based upon the Family Support Specialist's knowledge about the family, as well as tools completed with the family
- practice writing family goals in ways that help families create measurable goals

11-2.F RATING INDICATORS

3 Staff receive training on the Family Goal process within six months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than six months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff received training on the Family Goal process later than six months after hire; however, with the **most recent hire(s)** practice indicates this is now occurring and all staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on the Family Goal process within six months of hire; or staff hired within the past five years have not received training on this topic.

TIP: HFA's Family Goal webinar builds on information provided initially during HFA Core Foundations training (10-4.B), and therefore it is recommended the webinar be viewed after staff receive Core, unless Core is received so close to the 6-month due date, waiting would put staff past 6 months for receipt of 11-2.F.

11-2.G Staff (direct service staff, program managers and supervisors) receive Cultural Humility in Home Visiting training within six months of hire.

HFA's online training includes these subtopics:

- HFA's approach to culture
- honoring diverse family structures
- LGBTQIA+ parenting
- family culture as a source of family strength
- acknowledging, respecting, and celebrating cultural differences

11-2.G RATING INDICATORS

3 Staff hired January 2022 or later have received Cultural Humility in Home Visiting training within six months of hire. Staff hired prior to January 2022 have received the training but it may have been later than six months after hire.

2 Past instances were found when staff hired January 2022 or later did not receive training related to Cultural Humility in Home Visiting training 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 regardless of timeframe.

1 The site's most recent hire(s) from January 2022 or later have not yet received training on Cultural Humility in Home Visiting within six months of hire; or staff hired prior to January 2022 have not yet received training on this topic.

11-3. Staff (direct service staff, and supervisors) received training on a variety of topics necessary for effectively working with families and children within twelve months of hire.

11-3.A Staff (direct service staff and supervisors) receive training on Child Abuse and Neglect within twelve months of the date of hire.

HFA's online training includes these subtopics:

- parent and child risks for abuse and neglect
- prevention and education with families
- racial disparities in the child welfare system
- role of HFA with child welfare-involved families

11-3.A RATING INDICATORS

3 Staff hired within the past five years received training on Child Abuse and Neglect within twelve months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than twelve months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training 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 (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required, and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Child Abuse and Neglect within twelve months of hire; or staff hired within the past five years have not received training on this topic.

11-3.B Staff (direct service staff, and supervisors) receive training on Intimate Partner Violence within twelve months of the date of hire. HFA's online training includes these subtopics:

- indicators of Intimate Partner Violence
- dynamics of Intimate Partner Violence
- strategies for working with families with Intimate Partner Violence issues
- effects on children
- universal education approach to discussing healthy and unhealthy relationships with families
- the impact of racially disproportionate policing on family responses to IPV
- referral resources for family violence

11-3.B RATING INDICATORS

3 Staff hired within the past five years received training on Intimate Partner Violence within twelve months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than twelve months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Intimate Partner Violence within twelve months of hire; however, with the **most recent hire(s)**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a re-accreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Intimate Partner Violence within twelve months of hire; or staff hired within the past five years have not received training on this topic.

11-3.C Staff (direct service staff, and supervisors) received training on Substance Use within twelve months of the date of hire. HFA's online training includes these subtopics:

- causes of and risks for substance use disorders
- alcohol use and dependence
- substances prevalent in the community
- talking with families about substance and alcohol use
- strategies for working with families with substance use challenges and families in recovery
- substance use and racial disparities in the judicial system
- referral resources for substance use disorders

11-3.C RATING INDICATORS

3 Staff hired within the past five years received training on Substance Use within twelve months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than twelve months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Substance Use within twelve months of hire; however, with the **most recent hire(s),** practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Substance Use topics within twelve months of hire; or staff hired within the past five years have not received training on this topic.

11-3.D Staff (direct service staff, and supervisors) receive training on Engaging Families within twelve months of the date of hire.
HFA's online training includes these subtopics:
- engaging fathers and co-parents
- multi-generational families
- working with adolescent parents
- engaging non-binary parents
- strategies for working with families impacted by personal, historical, or generational trauma

11-3.D RATING INDICATORS

3 Staff hired within the past five years received training on Engaging Families within twelve months of hire. For sites in their first accreditation cycle, staff hired more than five years ago have received the training but it may have been later than twelve months after hire. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required.

2 Past instances were found when staff hired within the past five years did not receive training related to Engaging Families within twelve months of hire; however, with the **most recent hires**, practice indicates this is now occurring; and all other staff (if in a first accreditation cycle) have received the training regardless of the timeframe. For sites in a reaccreditation cycle, training data for staff hired in current position longer than five years is not required and rated as "2" if no new hires in the last five years.

1 The site's most recent hire(s) have not yet received training on Engaging within 12 months of hire; or staff hired within the past five years have not received training on this topic.

11-3.E Staff (direct service staff, program managers and supervisors) receive training on Inequity and Family Context within twelve months of the date of hire.
HFA's online training includes these subtopics:
- historically and currently marginalized communities
- racial wealth gap
- systemic barriers to access and accessibility
- systemic racism and social inequities
- intersectionality
- impacts of inequity on parenting and the home visiting relationship

11-3.E RATING INDICATORS

3 Staff hired January 2022 or later have received training on Inequity and Family Context within twelve months of hire. Staff hired prior to January 2022 have received the training but it may have been later than six months after hire.

2 Past instances were found when staff hired January 2022 or later did not receive training on Inequity and Family Context 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 regardless of timeframe.

1 The site's most recent hire(s) from January 2022 or later have not yet received training on Inequity and Family Context within twelve months of hire; or staff hired prior to January 2022 have not yet received training on this topic.

11-4. The site ensures direct service staff, supervisors, and program managers hired longer than twelve months receive annual training (i.e. at some time during each calendar year) that takes into account the individual's knowledge. Staff also receive annual child abuse and neglect training and annual training related to diversity, equity, inclusion, and belonging.

11-4.A The site ensures direct service staff, supervisors, and program managers hired more than twelve months ago receive ongoing training on an annual basis that takes into account the individual's knowledge and skill base, and supports ongoing professional development. Please Note: All staff do not have to attend the same training.

Intent: The worker and supervisor 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.

11-4.A RATING INDICATORS

3 The site ensures staff hired to Healthy Families for more than twelve months receive ongoing training on an annual basis, beyond the trainings identified in the 10-2, 10-3, 10-4, 11-1, 11-2, and 11-3 standards. Staff are offered and participate in ongoing training,

2 Past instances were found when staff hired more than twelve months did not receive ongoing training on an annual basis, beyond the trainings identified in the 10-2, 10-3, 10-4, 11-1, 11-2, and 11-3 standards; however, **recent practice** indicates this is now occurring.

1 The site does not yet ensure staff hired more than twelve months receive ongoing training on an annual basis; or staff does not yet participate in ongoing training opportunities.

TIP: It is recommended supervisors assist staff in identifying relevant training opportunities to meet each staff person's unique needs and all staff receive a minimum of fifteen (15) hours of ongoing training each year after the first year of hire to remain energized, enthused, and up-to-date on recent advances in the field.

TIP: Direct service staff and supervisors are encouraged to attend HFA's Facilitating Change training to meet ongoing training requirements for one year.

11-4.B All staff hired more than twelve months receive training annually related to child abuse and neglect. All staff do not have to attend the same training. Please Note: During the first year of hire, standard 11-3.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, etc.), Remote training, e.g., webinars produced by the state and updated regularly, can also be used to satisfy requirements of this standard, or professional experience when face-to-face training is not available.

11-4.B RATING INDICATORS

3 All staff hired more than twelve months receive annual training related to child abuse and neglect.

2 Past instances were found when staff hired more than twelve months did not receive annual training related to child abuse and neglect, however, **recent practice** indicates this is now occurring and all staff received the training regardless of the timeframe.

1 All staff hired more than twelve months have not yet received annual training on child abuse and neglect.

11-4.C The site ensures all staff hired more than twelve months receive annual training designed to increase awareness and understanding of concepts associated with diversity, equity, inclusion and belonging and how families, communities, home visiting services, and staff are impacted. All staff do not have to attend the same training. *Please Note*: During the first year of hire, standards 11-1.D (Cultural Self Awareness), 11-2.G (Cultural Humility in Home Visiting), and 11-3.E (Inequity and Family Context) may be used to satisfy this standard.

Intent: Staff are better prepared to serve and interact with families when they have increased awareness and understanding of diversity, equity, inclusion and belonging and how families, communities, staff, and services are impacted by social injustice, institutionalized racism, power imbalance, and implicit bias. Expanding learning opportunities in these areas on at least an annual basis clearly conveys the priority HFA places on supporting each individual's journey, and our collective effort to end racism and discriminatory practices and nurture inclusion and compassion for our common humanity.

11-4.C RATING INDICATORS

3 All staff receives, at least annually, training related to concepts associated with diversity, equity, inclusion and belonging, and how families, communities, home visiting services, and staff are impacted.

2 Past instances may have occurred when an annual training related to concepts associated with diversity, equity, inclusion, and belonging, and how families, communities, home visiting services, and staff are impacted was not received; however, **recent practice** indicates the site is now ensuring all staff receives training annually.

1 Staff do not yet complete training on an annual basis related to concepts associated with diversity, equity, inclusion and belonging, and how families, communities, home visiting services, and staff are impacted.

Tables of Documentation

11. All direct service staff and their supervisors receive basic training in areas such as prenatal and infant care, child safety and development, family health, parent-child relationships, diversity, equity, family goal setting, reporting child abuse, managing crisis situations, and responding to mental health, substance use, or intimate partner violence issues. All staff, including program managers receive training on topics related to diversity and equity.

Standard	Pre-Site Documentation to include in Self Study
11-1.A-D | Three-month wraparound training **11-2.A-G |** Six-month wraparound training **11-3.A-E |** Twelve-month wraparound training	Submit Training Logs including hire date and date of training topics received for current HFA supervisors & direct service staff. All staff at affiliated HFA sites may use the online trainings developed by HFA (or other training resources provided by the National Office) to complete the 11-1, 11-2, and 11-3 training topics. If sites use something other than HFA's recommended online wraparound training, the training will comprehensively address each of the overall topics with a variety of relevant subtopics critical for preparing staff to do this work. 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 supervision follow-up to assure successful knowledge acquisition and understanding of concepts and/or materials provided to assure knowledge of the topics was satisfied. PMs will have documentation of training topics related to diversity and equity, (11-1.D,11-2.G,11-3.E) Please Note: HFA Training Log available.
11-4.A | Ongoing Training	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). Please Note: HFA Training Log available.
11-4.B | Annual Child Abuse and Neglect Training	Submit a list of all staff and the annual child abuse and neglect training completed (this can be in the form of a training log or database printout). Please Note: HFA Training Log available.
11-4.C | Annual Diversity, Equity, and Inclusion Training	Submit a list of all staff and the annual diversity, equity, inclusion, and belonging training completed (this can be in the form of a training log or database printout). Please Note: HFA Training Log available.

STANDARD 12

12

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

Standard 12 Intent: **The field of infant mental health has identified reflective supervision as a best practice approach, and recognizes and embraces the supervisory relationship as being central to the work with families. "Over 30 years of clinical experience and empirical evidence indicates that Reflective Supervision/ Consultation (RS/C) increases the quality of infant mental health services by reducing vicarious trauma, staff turnover, and bias, while increasing practitioner knowledge and improving practice, job satisfaction, efficacy, and responsiveness. This has led to a general consensus in the multidisciplinary field of infant mental health that RS/C is inextricably both a best practice and an essential component for those providing relationship-focused prevention, intervention, and treatment" (MI-AIMH, 2017). Therefore, reflective supervision is central to the effectiveness of the Healthy Families America model. The intent of reflective supervision is to promote self-awareness, increase clarity about the work being done with a family, build confidence in staff skills, encourage intentionality, and ultimately increase the quality of services provided to families. This approach to supervision recognizes the work with families is very personal work that requires continual introspection about who we are, what we bring to the work, and how the work is impacting us. Reflective supervision is a collaborative process in which all involved (supervisor, supervisee, parent, and child) play a role, whether intentional or not.**

Reflective supervision consciously connects the experiences individuals have in the context of their relationships of others. Reflective supervision is not just about understanding how these relationships affect one other. It is also about intentionally impacting relationships. In other words, if we want parents to see, hold, respond to, and nurture their infants, they must have experienced being cared for themselves. For parents who have not been provided such caregiving through a secure, nurturing relationship, staff may provide an environment for those parents to begin to experience secure relationships. And, in order for staff to be able to provide parents with such safety and security, staff must have someone to provide a safe place for them as well. This is what we refer to as the parallel process. This work often challenges our values and worldviews in ways that result in heightened emotions that can cloud our ability to interpret family circumstances both objectively and empathetically. In work with families, direct service staff's most powerful strategy is the intentional use of self. Reflective supervisors become someone with whom staff can feel seen, held, and supported. The hope is that, as staff experience the support, compassion, respect, and feeling of being seen and heard by their supervisor, this will spill over into their work with families.

During supervision, staff are recognized for the gifts they bring to the work, such as their compassion, wisdom, patience, and ability to see all the strengths each family has to offer their children. They have an opportunity to step back from the day-to-day tasks of their work (writing notes, completing home visits, tracking data, etc.) and are invited to look at what is working well and what is not working so well in their work with families. Supervisors partner with staff in this process of reflection by allowing space and time for honest conversations about the work. They use reflective strategies and conversations as a means of increasing staff's reflective capacity (including self-awareness of the impact of their own culture, values, and beliefs on others), their ability to identify and build on parental competencies, and, ultimately, their effectiveness in their interactions with families. Supervisory sessions encourage professional and personal development by providing a safe yet challenging environment where taking initiative is nurtured and supported. Reflection is a key component of all supervisory discussions, regardless of whether those discussions are administrative or clinical (related to the family) in nature.

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

Intent: Providing weekly scheduled supervision helps direct service staff maintain perspective, evaluate their own performance, increase personal and professional development, learn and practice new strategies to effectively work with families, and develop reflective capacity, and ultimately enhances 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 must have a limited number of staff to supervise, ensuring expectations of the supervisor role can be fulfilled, and each staff person being supervised receives the support they deserve.

Policy and procedures clearly define the frequency (weekly for anyone .25 FTE and above) and duration (minimum of 1.5 hours weekly) requirements for individual supervision of each direct service staff. When needs warrant, a single weekly supervision session can be split into no more than two sessions per week.

With regard to duration: For all full-time and part-time staff who are .75 FTE to 1.0 FTE, the requirement is 1.5 to 2 hours weekly. For part-time staff who are .25 FTE to .74 FTE, the requirement is 1 hour weekly. For staff or contractors working less than .25 FTE, supervision may be provided according to occurrence of services.

For full-time staff who serve in more than one role (e.g., a position is split with Supervisor time at 30% and Family Support Specialist time at 70%, or a position that is 100% FSS also responsible for conducting the FROG Scale with their families) 1.5 hours per week is the expectation to meet the supervision requirements of both roles and functions, and documentation clearly indicates both are being addressed.

12-1.A The site's policy states individual supervision is provided to all direct service staff (e.g., Family Resource Specialists and Family Support Specialists) and volunteers and interns (performing the same function) at the frequency and duration required within the standards.

Intent: All full-time direct service staff 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 individually each week, unless excused due to the FSS or FRS being out the entire week. *Please Note*: For sites using 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 employed .25-.74 FTE receive a prorated amount of supervision as defined in the intent, and staff less than .25 receive supervision based on occurrence of service.

The site's policy also indicates:
- supervision can be divided into no more than two sessions per week
- reflective supervision groups (if used) count for 1 session per month when conducted by a qualified individual (for direct service staff who have been in their role for at least 12 months and who have demonstrated proficiency in their role as determined by the site and based on supervisor judgment)
- the ratio of supervisors to direct service staff is **1:5.**

2 The site policy and procedures specifies all .75-1.0 FTE direct service staff receive a minimum of **1.5 hours per week** of scheduled individual supervision and part-time staff employed .25-.74 FTE receive a prorated amount of supervision as defined in the intent, and staff less than .25 receive supervision based on occurrence of service.

The site's policy also indicates:
- supervision can be divided into no more than two sessions per week
- reflective supervision groups (if used) count for 1 session per month when conducted by a qualified individual (for direct service staff who have been in their role for at least 12 months and who have demonstrated proficiency in their role as determined by the site and based on supervisor judgment)
- the ratio of supervisors to direct service staff is **1:6.**

1 The site does not yet have policy and procedures; or the policy and procedures does not yet meet the requirements of the 2 rating.

12-1.B The site ensures weekly individual supervision is received by all direct service staff (Family Resource Specialists and Family Support Specialists) and any volunteers and interns who provide direct services to families independently in the role of a Family Support Specialist or Family Resource Specialist. Please Note: Volunteers or interns who perform supportive functions to assist direct service staff (e.g., assist with parent groups, data entry, accompanying a Family Support Specialist on home visits, etc.) are exempt from the supervision and training requirements of the standards. An HFA Spreadsheet is available for this standard.

Intent: It is understood that staff 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 sites track and monitor in an ongoing way the receipt of weekly supervision for each staff. *Please Note:* When circumstances warrant, (i.e. sites exist in rural or frontier areas, the Family Support Specialists work in remote or off-site locations from the "main office" where the supervisor is located, or natural disaster, severe weather or community health advisory) the use of virtual sessions via video or telephone will count for weekly supervision. *Please Note*: Direct service staff who are new to their role or are without full caseloads are still expected to receive the required amount of weekly supervision. In these situations, supervision may be more focused on skill development than family discussion. *Please Note*: When supervisors are on leave, direct service staff will have a back-up supervisor they can obtain support from. If the supervisor's leave is for two weeks or less, the back-up supervisor does not have to have received HFA Core training, though it would be preferred. However, if the Supervisor's leave is for longer than two consecutive weeks, the back-up supervisor must have received HFA Core training, as required of all supervisors. Sites may want to consider establishing a "team lead" role, as a career ladder opportunity for a direct service staff person with capacity to perform as back-up supervisor, and to have that person obtain supervision training as well.

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 (excluding weeks when direct service staff is out all week). Supervision sessions 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 1.5-2 hours (excluding weeks when direct service staff is out all week). Supervision sessions 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 The site is not yet following the guidelines as outlined in 2 rating above.

Note: This is a Safety Standard.

TIP: Frequency and duration of supervision 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 in addition to quarterly monitoring.

TIP: If providing supervision remotely by phone or video call, it is recommended the site have at least one supervision session per month as an in-person meeting, if possible.

TIP: Sites are encouraged to set goals/benchmarks (for Standard GA-2.B) when rates fall below the 75% threshold, and supervision time should be used to focus on exceptions, reasons, and problem-solving strategies to increase rates.

12-1.C A site may choose to provide once monthly reflective consultation groups in place of one weekly individual supervision session per month (for direct service staff in their role for a minimum of twelve (12) months. Documentation must include who attended and content topics covered, and must be facilitated by a qualified individual.

Intent: Typically, these sessions last approximately 1.5-2 hours. Reflective consultation groups include but are not limited to:

- family presentation
- focus on holding the space that encourages self-reflection and self-regulation for staff, 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 by expanding to what might be going on for the staff in conjunction with what the family and the baby might be experiencing
- considering what the supervisor might do differently for the next supervision
- developing a plan with staff 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 to HFA role for all staff. Subsequent to that time, and with demonstrated staff proficiency, one reflective consultation group per month may substitute for one individual weekly supervision session for .25-1.0 FTE direct service staff (.24 FTE or less may attend reflective groups; however, it cannot be used to offset individual supervision). *Please Note*: Staff not yet in their HFA role for at least 12 months are 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: If group reflective consultation is done, there are specific documented qualifications the reflective practice consultant must have:

1 IMH Endorsement or Master's degree or higher in human services related field: Master of Arts (MA), Master of Science (MS), Master of Education (MEd), Doctorate in Education (EdD), Master of Social Work (MSW), Master of Nursing (MSN), Doctor of Psychology (PsyD), Doctor of Philosophy (PhD), Medical Doctor (MD), Doctor of Osteopathy (DO) or other degree specific to one's professional focus in infant mental health; university certificate program, and/or course work in areas such as infant/very young child development, family-centered practice, cultural sensitivity, family relationships and dynamics, assessment, and intervention.

2 Two years of work experience providing culturally sensitive, relationship-focused infant mental health services with infants and toddlers and their families. This specialized work experience must be with both the infant/toddler and his/her biological, foster, or adoptive parent on behalf of the parent-infant relationship. Infant mental health services will include early relationship assessment, and parent-infant/very young child relationship-based therapies and practices. Infant mental health services include parent-infant psychotherapy, interaction guidance, and child-parent psychotherapy. These therapies and practices are intended to explicitly address issues related to attachment, separation, trauma, and unresolved losses as they affect the development, behavior, and care of the infant/very young child.

3 Previous recipient of reflective supervision. The facilitator will need to have received relationship focused, reflective supervision/consultation, individually or in a group, post-Masters, while providing services to infants, very young children, and families from a qualified professional.

4 Training or experience facilitating groups and managing group dynamics.

This person may be sub-contracted by the agency. If reflective consultation is conducted by a contractor, a site supervisor attends as a group member in order to support staff with any recommended action steps pertaining to the family discussed during group.

TIP: It is recommended reflective consultation groups establish "group rules" to protect confidentiality and promote an environment of safety between and among members. See sample group rules.

12-1.C RATING INDICATORS

3 The site provides reflective consultation groups 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 at least 12 months. Group reflective consultation is provided by a qualified individual and documentation at minimum includes individuals in attendance and content areas discussed.

2 Past instances occurred when the site provided group reflective consultation not conducted according to the guidelines listed in the intent and with documentation at minimum including individuals in attendance and content areas discussed; however, **recent practice** indicates this is now occurring.

1 Any of the following: the site does not yet provide group reflective consultation according to the guidelines listed in the intent; or it is not yet conducted by a qualified individual; or documentation of reflective consultation group meetings has not yet occurred; or group reflective consultation is counted for more than one weekly individual supervision rate per month.

NA Site does not use reflective consultation groups to offset one weekly individual supervision session per month for any of its direct service staff.

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 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 each direct service staff member requires approximately 8 hours per week of supervision time, including the actual supervision session as well as the supervision activities outside of the session including internal quality management activities, administrative work, arranging training, staff meetings, etc. *Please Note*: full-time equates to a 40-hour work week. Therefore, sites that employ staff considered full-time but working less than 40 hours per week must prorate staffing ratios accordingly. See the proration calculation tool for guidance. *Please Note*: In the event the Supervisor is not full time in their role (e.g., is hired 75%, or is hired full-time, but a portion of that time is as a part-time Family Resource Specialist, or is a Program Manager also providing supervision to direct service staff, or is full-time to the agency but only part-time to Healthy Families, etc.), they are to indicate the amount of time spent in their Healthy Families supervision role and calculate the ratio of direct service staff based on the percentage of time spent in the supervision role. For example: a supervisor who is 75% supervisor and 25% Family Support Specialist would have a ratio of .75 FTE supervisor: 4.5 FTE direct service staff. This is calculated by taking .75 (% FTE) X 6 (as allowed in a 2 rating) 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.

12-1.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. The site is consistently 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). The site is consistently following this standard. Any overage within the past twelve (12) months due to turnover or unexpected staff shortage does not exceed more than three months.

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 the site is not yet following the standard as outlined in 2 rating above.

TIP: It is recommended that sites whose staff have caseloads largely comprised of families scoring with especially elevated risk on the FROG Scale maintain a 1:5 supervisor to direct service staff ratio.

TIP: It is recommended supervisors responsible for other agency program staff maintain a similar staff to supervisor ratio in order to balance workload of the supervisor.

12-2. Direct service staff (and volunteers and interns performing the same function) receive reflective supervision pertaining to their work and are provided opportunities for skill development and professional support.

Intent: HFA Supervisors support their staff in both a mentoring and monitoring role. As a monitor, supervisors oversee the completion of activities that meet the Best Practice Standards as well as other site or agency requirements and provide strength-based feedback to nurture the staff's professional development. As the mentor, supervisors support the integration of training into the work, add to the knowledge of direct service staff, discuss how to work with families, and generally enhance their abilities. Working with families who are experiencing complex life challenges 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.

12-2.A The site has supervision policy and procedures to ensure all direct service staff (and volunteers and interns performing the same function) are provided with reflective supervision pertaining to their work and opportunities for skill development and professional support, including twice annual shadowed visits and debrief with their supervisors.

12-2.A RATING INDICATORS

3 No 3 rating indicator for standard 12-2.A.

2 The site has supervision policy and procedures which indicate supervisors are responsible for providing all direct service staff with reflective supervision and twice annual shadow visits (including debrief of shadow visits) to ensure all staff receive professional support and skill development to continuously improve the quality of their performance.

1 The site does not yet have policy and procedures; or the policy and procedures do not yet include the expectations described in the 2 rating.

TIP: In an effort to streamline supervisor documentation, supervisor activities that are clinical in nature may be documented on the HFA Service Plan for each family.

TIP: While it is not possible to engage in deep reflective conversation pertaining to each family each week, supervisors are encouraged to have in-depth reflective conversation for each Level 1, P, or SS family on a Family Support Specialist's caseload a minimum of one time per month, and a minimum of once every other month for Level 2 families.

TIP: When staff are new to their role, supervisors can demonstrate support shadowing visits more frequently than twice annually during the onboarding process.

12-2.B The site ensures all direct service staff (and volunteers and interns when performing the same function) receive reflective supervision pertaining to their work, and are provided opportunities for skill development and professional support to continuously improve the quality of their performance.

12-2.B RATING INDICATORS

3 The site ensures all direct service staff receive reflective supervision pertaining to all aspects of the work and are provided opportunities for skill development and professional support to continuously improve the quality of their performance.

2 Past instances were found when staff did not receive reflective supervision or opportunities for skill development and professional support to continuously improve the quality of their performance; however, **recent practice** indicates this is now occurring for all direct service staff.

1 Staff do not yet receive weekly reflective supervision as described in Standard 12-2.B.

Note: This is an Essential Standard.

TIP: Utilizing the Reflective Strategies as a supervisor during supervision will support staff in using Reflective Strategies effectively with families.

12-2.C The site ensures all direct service staff (and volunteers and interns performing the same function) are provided with twice annual shadow visits and debrief with their supervisor to continuously improve the quality of their performance.

Please Note: A shadow visit combined with debrief conversation between the supervisor and direct service staff counts as a weekly supervision session.

12-2.C RATING INDICATORS

3 All direct service staff (and volunteers and interns performing the same function) are provided with a minimum of twice annual shadowed visits and debrief with their supervisor.

2 Past instances were found when the direct service staff did not receive twice annual shadow visits and debrief with their supervisor; however, **recent practice within the past year** indicates this is now occurring consistently for all direct service staff.

1 Staff do not yet receive twice annual shadow visits and debrief with their supervisor.

TIP: For Family Support Specialists who administer the FROG it is recommended one of the two shadow visits per year is done on a FROG visit.

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.

Intent: According to the Best Practice Guidelines for Reflective Supervision/Consultation of the Alliance for the Advancement of Infant Mental Health, in order to maintain a reflective lens through the challenges and complexity involved in the supervisory role, it is essential that supervisors also engage in their own reflective supervision/consultation. Supervisors' experience of developing and advancing their supervisory reflective skills should include parallel dynamics to that of direct service staff's supervisory experience. The goal of supervisors' supervision should be to facilitate their ability to integrate a reflective lens into their work with direct staff and ultimately the work with families.

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. It is recommended supervisors receive individual supervision every other week; however, the minimum requirement is monthly. Supervision of the supervisors can occur face-to face or virtually (via video conferencing or phone). Supervision sessions are regularly scheduled to ensure the supervisor has the support they need to ensure quality at the staff and direct service level.

12-3.A The site has policy and procedures to ensure supervisors are held accountable for the quality of their work, receive skill development and professional support through regular and ongoing supervision, and are able to receive reflective supervision, individually or as part of a reflective group for supervisors (reflective consultation groups for supervisors are encouraged to utilize facilitators with the same qualifications as indicated in standard 12-1.C).

Intent: *Please Note*: For supervisors carrying small caseloads (one visit or less per week) on a permanent basis, or carrying a larger caseload, but on a temporary basis (i.e. when families are temporarily re-assigned due to staff leave or turnover), or occasionally administer the FROG Scale (as a back-up):

- The person providing supervision does not have to be trained as an HFA supervisor. It is preferred but not required.
- 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: For supervisors carrying larger caseloads (2 or more visits each week) on an ongoing basis), or routine administration of the FROG Scale:

- 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 must receive supervision in accordance with the 12-1 and 12-2 standards.
- The individual providing supervision to the supervisor must have received all HFA required training as outlined in Standards 10 and 11.

12-3.A RATING INDICATORS

3 Policy and procedures include a requirement that, in addition to all components of monthly administrative supervision described in the 2 rating, supervisors will receive **monthly** reflective supervision.

2 The site has policy and procedures which specify supervisors receive a minimum of **once every other month** reflective supervision (individually or as part of a reflective consultation group for supervisors) and at least monthly individual administrative supervision focused on areas such as:

- addressing personnel issues
- team development and agency issues
- review of site documentation including monthly or quarterly reports
- site statistics (screening and initial engagement, 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
- quality oversight that could include shadowing of the supervisor

1 The site does not yet have policy and procedures; or the policy does not yet meet the requirements specified in the 2 rating.

12-3.B The site's practice ensures supervisors receive individual administrative supervision and are held accountable for the quality of their work. Please Note: sites may use HFA's shadowing of supervision form.

12-3.B RATING INDICATORS

3 Site ensures supervisors receive at least monthly individual administrative supervision **and at least once annual shadowing with debrief of a supervision session**, and are held accountable for the quality of their work.

2 Past instances were found when the site did not ensure supervisors received at least monthly individual administrative supervision or were not held accountable for their work; however, **recent practice** indicates this is now occurring.

1 Individual administrative supervision of supervisors is not yet occurring at least monthly; or supervisors are not yet held accountable for the quality of their work.

12-3.C The site's practice ensures supervisors receive regularly scheduled reflective supervision.

12-3.C RATING INDICATORS

3 Site ensures supervisors receive at least monthly reflective supervision.

2 Past instances were found when the site did not ensure supervisors received at least every other month reflective supervision; however, **recent practice** indicates this is now occurring.

1 Reflective supervision for supervisors is not yet occurring at least once every other month.

TIP: Reflective consultation groups for supervisors are encouraged to utilize facilitators with the same qualifications as indicated in standard 12-1.C

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 ensure program managers are held accountable for the quality of their work and receive skill development and professional support.

Intent: The program manager role is distinct from that of program supervisor and, while both roles can be assumed by the same person, the FTE status of both roles must be delineated and protected to ensure sustainable program leadership and adequate support to staff being supervised.

Program Managers are provided with skill development and 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 (in-person or virtually) with the program manager's Supervisor or chair of the advisory/governing board, peer supervision with HFA 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 and receive skill development and professional support.

1 The site does not yet have policy and procedures; or the policy does not yet meet the requirements specified in the 2 rating.

TIP: While very small sites may be able to function with a part-time program manager, HFA recommends a full-time program manager as site size increases.

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

12-4.B RATING INDICATORS

3 Site ensures program managers are held accountable for the quality of their work and receive skill development and professional support.

2 Past instances were found when programs managers were not held accountable, receiving skill development or professional support; however, **recent practice** indicates this is now occurring.

1 Program managers are not yet held accountable for the quality of their work; or do not receive skill development or professional support.

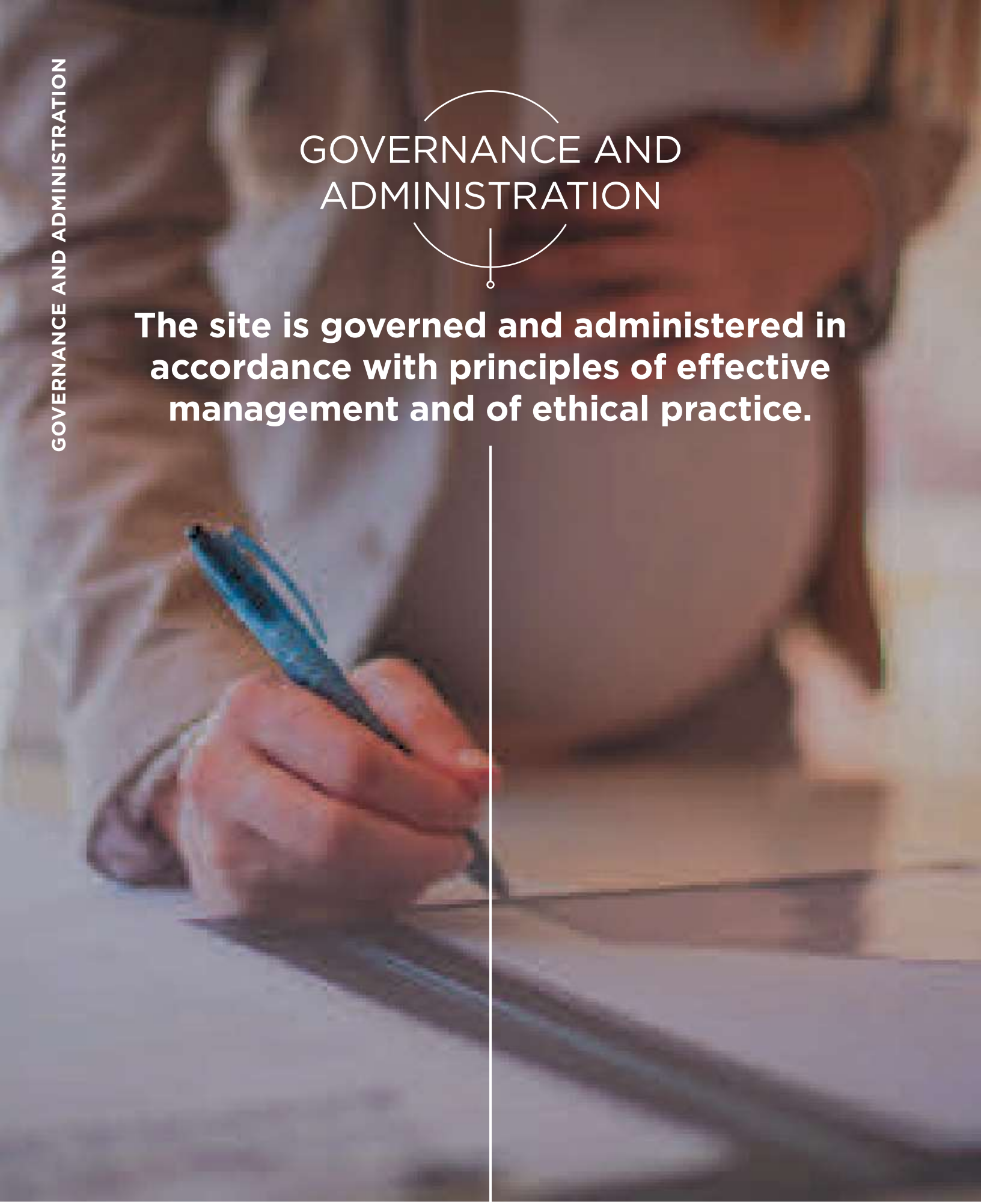
Tables of Documentation

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

Standard	Pre-Site Documentation to include in Self Study
12-1.A | Policy for Frequency & Duration	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
12-1.B | Measure supervision frequency and duration **Safety Standard**	Submit a report indicating the frequency and duration of supervision sessions for the most recent quarter. 1. Determine needed frequency and duration of supervision per FTE guidelines within BPS for each direct service staff 2. Determine number of expected supervision sessions for each staff member for one quarter 3. Subtract from #2 (expected sessions) any excused sessions per guidelines provided by BPS 4. Count number of supervision sessions that occurred within proper timeframes and for expected duration 5. Divide #4 (number of supervision sessions at required duration) by #3 (expected sessions minus those excused) 6. Create report to communicate findings for each staff member Please Note: HFA Spreadsheet available. This is a threshold standard, meaning to be in adherence a minimum threshold has been established (75% in this case). When the site's data in the self-study falls below this threshold, Peer Reviewers or Panel will request more recent data.
12-1.C | Reflective Consultation Group	Submit a report indicating the date, time and attendees of group reflective consultation groups (if utilized) for the most recent quarter, along with content areas discussed. Also, please submit the qualifications of the individual facilitating groups.
12-1.D | Ratio of Supervisors to staff	Submit the HFA Face Sheet indicating each supervisor, their full time equivalency (FTE), percentage of time spent in a supervisor role, and the staff they supervise (with FTE for each position). For any staff with multiple roles, be sure to capture FTE for each role each staff person has.
12-2.A | Policy - Administrative, Clinical and Reflective Supervision and Professional Support	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
12-2.B | Reflective, Supervision, Skill Development and Professional Support **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
12-2.C | Shadow Visits	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
12-3.A | Policy - Supervision of Supervisor	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
12-3.B | Supervision of the Supervisor Received	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
12-3.C | Supervisors Receive Reflective Supervision	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
12-4.A | Policy - Program Manager Accountability	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
12-4.B | Program Manager Supervision Received	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.

GOVERNANCE AND ADMINISTRATION

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



Governance and Administration Standards Intent is to ensure the site has feedback and oversight mechanisms to ensure high quality services to families. These practices include effective community advisory board operation, review of site quality, handling of family complaints, 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 community advisory board that serves in an advisory or governing capacity in the planning, implementation, and continuous quality improvement of site-related activities.

Intent: Community advisory boards serve an important function in community-based agencies. 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 members bring to the site different skills and perspectives than might be present within site staff. Members share strategies, brainstorming ideas and facilitating growth for the site. Additionally, members often have access to resources to strengthen the site or agency. It is important the group has the community connections to understand the needs of the families receiving HFA services.

Some HFA sites fulfill the need for the functions outlined in the Standards below by having two different groups. This happens most often when HFA sites function as part of a larger agency that has its own governing board. The agency board typically has many other functions outside of Healthy Families and usually does not have the capacity to serve in all the ways the Standards require, but it may be involved in making key decisions about the site and its financial status.

Regardless of whether or not HFA sites have this larger agency board, sites will need to create and maintain a community advisory board with the primary function of advising in the planning, implementation, and continuous quality improvement of site-related activities. Many times the host agency governing board will have final say, but the community advisory board can provide input to the Program Managers (or other representative from the local site) who can provide the information to the agency board. *Please Note*: Frequency of meetings may vary depending on the duties assigned to the advisory group and activities carried out by any subcommittees. A minimum of quarterly meetings is required.

GA-1.A The site's community advisory board meets at least quarterly and is an effectively organized, active body advising the functions specified in GA-1.

GA-1.A RATING INDICATORS

3 The site's community advisory board is an organized, active body that meets at least quarterly and advises the activities of planning, implementation, and continuous quality improvement of site services.

2 Past instances occurred when the community advisory board did not meet quarterly; however, **recent practice** indicates this is now occurring. The site's community advisory board advises the specified functions, but could be more active in one area of functioning.

1 Any of the following: the site's community advisory board meets less than quarterly; or is not yet active; or is not advising on planning, implementation, and continuous quality improvement.

TIP: Community advisory board involvement may be more intense and meet more frequently during the start-up phase. Community leadership is critical to the launch of the site, and well-established sites benefit tremendously from community advisory board involvement as well. Over time, a well-formed advisory board with strong member relationships is a huge asset to the continuation of a shared vision and the realization of intended impacts.

GA-1.B The community advisory board 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 community advisory board has a range of skills, strengths, community knowledge, and cultural characteristics (as determined by the site to represent the diverse needs of site participants). **The site does not have any identified gaps in its membership.**

2 The community advisory board's membership has a range of skills, strengths, community knowledge, and cultural characteristics (as determined by the site to represent the diverse needs of site participants). The site has **identified gaps in its membership which it is working to address.**

1 The community advisory board's membership does not yet represent the skills, strengths, community knowledge, and cultural characteristics (as determined by the site to represent the diverse needs of site participants).

TIP: When parent/caregiver representatives participate as members of the community advisory board, the site is encouraged to provide support, and education to ensure parents are well-received, their voice heard and regarded equally, and their expertise used effectively.

GA-1.C The program manager (or other representative from the local site) and the community advisory board work together effectively. The program manager provides site information for each meeting. Advisory members participate in discussion and guidance in regard to this information.

GA-1.C RATING INDICATORS

3 The program manager (or other representative from the local site) partners with the community advisory board by providing members site information needed for each meeting and engages them in advising site operations.

2 Past instances occurred when the program manager (or other representative from the local site) did not provide site information needed for each meeting to engage members to participate in advising site operations; however, **recent practice** indicates this is now occurring.

1 The program manager does not yet provide site information or engage advisory members to advise on site operations.

GA-2. The site monitors and improves the quality of its services.

Intent: The site uses a variety of methods to monitor and improve the quality of all services offered to families. Both quality assurance activities (GA-2.A) and quality improvement activities (GA-2.B) are necessary and distinguished as follows:

QUALITY ASSURANCE	QUALITY IMPROVEMENT
Defines quality	Raises quality
Relies on inspection	Emphasizes prevention
Uses a reactive approach	Uses a proactive approach
Looks at compliance with standards	Improves the process to meet standards
Requires a specific fix	Requires continuous efforts
Relies on individuals	Relies on teamwork
Examines criteria or requirements	Examines processes and outcomes
Asks, "Do we provide good services?"	Asks, "How can we provide better services?"

Scamarcia Tews, Debra, et al. Embracing Quality in Public Health. 2nd ed., www.mphiaccredandqi.org, 2012.

GA-2.A The site develops a quality assurance plan for reviewing and documenting the quality of site implementation, to increase fidelity to the model within the four components of the service delivery system (initial engagement, home visiting, supervision, and management).

Intent: Sites will develop a Quality Assurance plan that includes activities such as satisfaction surveys, annual file review, reports related to site activities, etc. These activities help ensure accountability and commitment to implementing the HFA model with fidelity. Additionally, sites will document the completion of these activities Download Sample Quality Assurance Plan.

GA-2.A RATING INDICATORS

3 The site has a current quality assurance plan including all components of the service delivery system (initial engagement, home visiting, supervision, and management) and has **implemented quality assurance activities related to all** these components to increase fidelity to the model.

2 The site has a current quality assurance plan including all components of the service delivery system (initial engagement, home visiting, supervision, and management); and quality assurance activities to increase fidelity to the model have been **implemented for at least two but not yet all** of these components.

1 Any of the following: the site either does not yet have a quality assurance plan; or the quality assurance plan does not yet include all components of the service delivery system (initial engagement, home visiting, supervision, and management); or the site has not yet initiated quality assurance activities to increase fidelity to the model.

TIP: Sites are encouraged to document areas of improvement and demonstrate improvements have been accomplished.

TIP: Sites are encouraged to discuss QA findings with its community advisory board to obtain support on strategies to increase fidelity.

GA-2.B The site establishes a comprehensive quality improvement plan, utilizing site level data related to acceptance, retention, home visit completion, etc., to develop and apply strategies aimed at strengthening site services. The plan is reviewed and updated annually.

Intent: Each year the site identifies one or more areas it wants to focus on (such as increasing home visit completion rates, or increasing participant acceptance). The site usually identifies its goals based on areas it is striving to improve, though continuous quality improvement (CQI) expectations may also be established by an oversight entity or funder. However decided, once the site has articulated its goals, it should indicate what the baseline is (e.g., home visit completion is 62% at start of the year), what the goal is (home visit completion rate will increase to 75% by year end), and a process for monitoring and evaluating progress toward meeting its goals and addressing any identified issues. Sites use this information for continuous quality improvement. Sites may use PDSA (Plan-Do-Study-Act) cycles to illustrate their efforts to achieve identified goals.

Download Quality Improvement Plan.

GA-2.B RATING INDICATORS

3 Each year the site establishes one or more quality improvement goals, applies improvement strategies, and **monitors progress** toward reaching its goals **at least quarterly**, and implements follow-up mechanisms to address areas of improvement.

2 Each year the site establishes one or more quality improvement goals, applies improvement strategies, **monitors progress** toward reaching its goals **at least annually**, and implements follow-up mechanisms to address areas of improvement.

1 Any of the following: the site does not yet establish goals; or it is not yet conducted on an annual basis; or progress is not yet monitored at least quarterly; or follow-up mechanisms have not yet been implemented.

TIP: Sites are encouraged to discuss QA findings with its community advisory board to obtain support on strategies to increase fidelity.

GA-3. The site informs families of their rights at the start of services and ensures confidentiality throughout the course of services.

Intent: HFA values a family-centered approach to service delivery, which requires site practices that reflect a profound respect for personal dignity, confidentiality, and privacy. This approach is in all services provided, and 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 an individual's 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-3.A The site has policy and procedures and appropriate forms for timely communication with families about 1) their rights and confidentiality, 2) consent procedures when family information will be shared with another entity, and 3) the process for making a complaint. The policy and procedures also indicate when forms are to be completed, and the process for addressing any complaints, if received.

Rights and confidentiality forms are written in family-friendly language and include the following:

Family Rights

- the right to be treated fairly, with courtesy and respect
- the right to decline service (voluntary nature)
- the right to be referred, as appropriate, to other service providers
- the right to participate in the planning of services to be provided
- the right to file a complaint, who to contact should the need arise (including phone number or contact information), and the process and timeframes associated with response and resolution

Confidentiality

- the manner in which information is shared, with whom, and the process for release of information forms to be signed when exchanging information
- the circumstances when information is shared with consent (e.g., for purposes of referral, or if participating in a research or evaluation study where identifying information is shared, or when data required by funders or model developer includes identifying information)
- the circumstances when information is shared without consent (e.g., need to report child abuse and neglect)

Download Sample Rights and Confidentiality form in English and Spanish.

The release of information form includes the following:

- 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

Download Sample Release of Information Form in English and Spanish.

GA-3.A RATING INDICATORS

3 No 3 rating for standard GA-3.A.

2 The policy and procedures address rights and confidentiality and the procedures for addressing any complaints, and states the family is informed about their rights and confidentiality before or on the first home visit, including the right to file a complaint. 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. Site forms currently in use include all required elements identified in the intent.

1 The site does not yet have policy and procedures addressing rights and confidentiality, on or before the first home visit, the procedures for addressing complaints, and the process for obtaining informed consent to release information, or the site's forms currently in use do not yet include all the required elements identified in the intent.

Note: This is an Essential Standard.

GA-3.B The site implements its policy and procedures ensuring all parents are notified and receive copy of family rights and confidentiality at the onset of services, both verbally and in writing. Documentation that the rights and confidentiality assurances were reviewed with families is placed in the participant file, and a copy is provided for the family to keep.

GA-3.B RATING INDICATORS

3 Families are informed and receive copy of their family rights and confidentiality, on or before the first home visit, both verbally and in writing.

2 Past instances were found when families were not being informed verbally and in writing, or provided copy of their rights and confidentiality on or before the first home visit; however, **recent practice** indicates this is now occurring.

1 Any of the following: families are not yet being informed about their family rights and confidentiality on or before the first home visit; or the site does not protect family confidentiality and privacy.

Note: This is an Essential 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 best practice. Also, while the required components 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.

GA-3.C Parents are informed and sign a new release of information form every time information is to be shared with a new external source or with the same source but for a subsequent time period.

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. All information on the form must be filled in before parents sign the form. It is not permissible to have parents sign incomplete forms. This consent may also apply to verbal sharing of information, and sufficient details about what staff may speak about must be clearly listed.

GA-3.C RATING INDICATORS

3 Families provide written consent every time information is to be shared with a new external source or with the same source but for a subsequent time period.

2 Past instances were found when families did not provide written consent for sharing of information however, **recent practice** indicates this is now occurring.

1 Information is shared without the family's written consent.

Note: This is a Safety Standard.

GA-3.D The site ensures complaints are responded to in accordance with its policy and procedures.

GA-3.D RATING INDICATORS

3 The site ensures participant complaints have been responded to in accordance with its policy and procedures.

2 Past instances may have occurred when participant complaints were not responded to in accordance with site policy and procedures; however, **recent practice** indicates this is now occurring.

1 Complaints have not been responded to in accordance with site policy.

NA No participant complaints have been received by the site in the past five years.

GA-3.E The site ensures 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 decline 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-3.E RATING INDICATORS

3 The site ensures participant privacy and voluntary choice for all families with regard to research.

2 Past instances may have occurred where participant privacy and voluntary choice with regard to research was not ensured; 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 yet provided an opportunity to decline disclosure.

NA No research is currently being conducted by or in collaboration with the site.

GA-4. The site reports all 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 Services prior to immediate notification of the site manager 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 (10-2.D) and reviewed annually throughout employment (11-4.B).

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 place ultimate responsibility on direct service staff to report a suspicion of child abuse or neglect to Child Protective Services, without risk or jeopardy, even in situations where site leadership may not agree with the need to report.

GA-4.A The site has policy and procedures to report all suspected cases of child abuse and neglect to the proper authorities.

Intent: The site must have policy and procedures to effectively guide staff in situations where abuse or neglect is suspected so appropriate and timely action can be taken. Sites may choose to reiterate information from the State's Children's Code, agency-wide policy, or training materials indicating the child abuse and neglect criteria and reporting requirements. At a minimum, these materials must be referenced in policy with a link so staff know where to locate them.

GA-4.A RATING INDICATORS

3 No 3 rating indicator for standard GA-4.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)
- expectation of all staff (managers, supervisors and direct service staff) as mandated reporters
- immediate notification of the program manager or supervisor when abuse or neglect is suspected
- the site's mechanism to track and follow-up on all children with suspected abuse and neglect

1 The site does not yet have policy and procedures specifying the items listed in the 2 rating.

Note: This is a Safety Standard.

TIP: The site's policy can reference child abuse and neglect reporting criteria from a mandated reporter document written by the agency or by a local or state child welfare office. In such cases, the site must be sure to include access to this document so staff have easy access to the reference document when needed.

GA-4.B The staff reports all suspected cases of child abuse and neglect to the proper authorities, including situations where it is believed a report has already been made by another individual or organization.

GA-4.B RATING INDICATORS

3 Staff report all suspected cases of child abuse and neglect to the proper authorities.

2 Past instances were found when staff did not report suspected cases of child abuse and neglect to the proper authorities; however, **recent practice** indicates all suspected child abuse and neglect situations are reported or, **if there have been no situations of suspected abuse and neglect to report, all currently employed staff have awareness of site's policy on how they would respond to this type of situation.**

1 There are situations within the past twelve months when staff did not report suspected abuse and neglect to the proper authorities; or staff are unfamiliar with site policy.

Note: This is a Safety Standard.

GA-4.C The staff notifies the supervisor or program manager immediately in situations where staff suspect abuse or neglect. The supervisor or program manager tracks these situations to ensure safety concerns are addressed and appropriate follow-through occurs.

GA-4.C RATING INDICATORS

3 Staff immediately notify the program manager or supervisor when abuse or neglect are suspected, and a tracking mechanism is in place to ensure safety concerns are addressed and follow-through occurs.

2 Past instances were found when staff did not immediately notify the supervisor or program manager of suspected abuse or neglect; or the site did not use a tracking mechanism; however **recent practice** indicates this is now occurring; **or currently employed staff have had no suspected abuse and neglect situations in the past year to illustrate implementation.**

1 The site's staff do not yet immediately notify the supervisor or program manager of suspected abuse and neglect; or the site is not using a mechanism to track all suspected abuse and neglect situations; or staff is unfamiliar with site policy.

TIP: The site is encouraged to document on the Service Plan when there has been suspected abuse or neglect.

GA-5. The site responds to support families and staff in situations involving participant death.

GA-5.A The site has policy and procedures specifying immediate notification of the program manager or supervisor in cases of participant death (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-5.A RATING INDICATORS

3 No 3 rating for GA-5.A.

2 The site's policy and procedures specify immediate notification of the program manager or supervisor, 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 yet have policy and procedures; or the site's policy and procedures do not yet specify immediate notification of program manager or supervisor; or policy and procedures do not yet indicate staff are offered counseling when a death occurs; or do not yet indicate the family is offered extended support as needed.

GA-5.B The site responds in situations involving participant death to support family members and staff as needed. Program manager or supervisor is notified immediately.

Intent: This standard ensures 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 direct service staff and supervisors with whom the family member had a relationship. At a minimum, reporting would occur if there were a death of a focus child or participating parent.

GA-5.B RATING INDICATORS

3 In situations involving participant death of a parent or focus child, immediate notification of the program manager or supervisor occurs. Support is provided to families and staff when a death occurs.

2 Past instances were found when notification of program manager or supervisor did not occur immediately or staff or families were not offered support; however, **recent practice** indicates this is now occurring; or if **there have been no participant deaths, all currently employed staff are aware of site policy on how they would respond to this type of situation.**

1 Program manager or supervisor have not yet been notified immediately; or staff or families are not yet offered support when a death occurs; or staff are unfamiliar with site policy.

TIP: Offering services to families after the loss of a child is crucial to supporting the grief process and services should not be closed too quickly. Sites may want to create an informal transition plan in partnership with the family to be intentional about services that will be provided after a loss. Services often continue for approximately three months when desired by the family.

GA-6. Updates to the site's Policy and Procedures Manual are communicated to all staff in a timely basis and staff have access to a copy of the Policy and Procedure Manual.

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 are able to use it as a support to practice when needed. *Please Note:* Orientation to policy and procedures is required before contact with families as per standard 10-2.A. For additional guidance see Policy and Procedure Checklist and Sample Policy and Procedure Template/Guide.

GA-6. RATING INDICATORS

3 The site has a Policy and Procedures Manual, all staff have access to it, and updates have been communicated to staff when they occur.

2 The site has a Policy and Procedures Manual. Past instances were found when the site staff did not have access to it or receive communication when updates occurred; however, all staff now have access to the Policy and Procedures Manual and **recent policy changes** were communicated to staff when they occurred.

1 Any of the following: the site does not yet have a Policy and Procedures Manual; or all staff do not yet have access to it; or staff have not yet received communication when updates to policy occur.

TIP: Staff receive orientation training to the site's policy and procedures (10-2.B). Communication with staff about policy updates can occur during supervision or team meetings with support provided to help staff understand and integrate policy changes into practice.

THIS IS THE END OF THE HFA BEST PRACTICE STANDARDS GUIDE

PRIOR TO AN ACCREDITATION OR CERTIFICATION DECISION,

the HFA National Office will confirm the following GA-7 requirements are in adherence. A site is required to remedy any that are out of adherence before the accreditation or fidelity assessment certification award can be conferred.

GA-7. In accordance with HFA's Affiliation and Licensing Agreement, which grants sites the ability to implement the model and access its intellectual property, affiliates are required to adhere to the responsibilities outlined therein, particularly those pertaining to data, fees, brand identity, and research.

GA-7.A The site ensures that all HFA required data pertaining to site staff and participants is provided as specified in the Overview of HFA Data Reporting Requirements.

Intent: HFA requires select data on sites, staff, and participants in order to accurately and effectively represent the entire HFA network and support continuous quality improvement. It is imperative that sites provide current information as defined in the Overview of HFA Data Reporting Requirements. When all site data is recorded accurately and is up-to-date, we are best able to understand, reflect on, and articulate to the field and key stakeholders and decision-makers the collective impact the HFA model has.

GA-7.A RATING INDICATORS

3 No 3 rating for GA-7.A.

2 All HFA required data, as defined in the Overview of HFA Data Reporting Requirements, is accurate and up-to-date and is consistent with expectations for all affiliated sites.

1 Data required of all HFA affiliates is not yet currently up-to-date as required of all HFA affiliates.

GA-7.B 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 or fidelity assessment certification.

GA-7.B RATING INDICATORS

3 No 3 rating for GA-7.B.

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 overdue or unpaid fees.

Note: This is a National Office Requirement.

GA-7.C The site utilizes the trademarked HFA name, logo, and brand according to HFA graphic standards.

Intent: The image and integrity of the HFA model is maintained through appropriate use of HFA graphics on all promotional materials and other documents and images shared publicly (electronically or in hard copy). Visual representation that is uniform across the HFA network conveys a stronger brand identity.

GA-7.C RATING INDICATORS

3 No 3 rating for GA-7.C.

2 The site utilizes HFA graphics (name, logo, etc.) in accordance with HFA graphic standards for site materials made available publicly.

1 The site is not yet utilizing HFA graphics (name, logo, etc.) in accordance with HFA graphic standards for site materials made available publicly.

Note: This is a National Office Requirement.

GA-7.D The site ensures that the National Office 1) is notified in advance of a site's participation in a research study involving a) the HFA model, or b) participant families, past or present, enrolled in HFA services; and 2) is provided information on the study, as described in the HFA Site Research Policy.

Intent: HFA encourages participation in research when feasible and appropriate. Notifying the National Office prior to participation and sharing information about the project 1) establishes ongoing communication between the National Office, participating site(s), and study investigators; and 2) provides the opportunity to ensure alignment with the HFA Site Research Policy, maximizing the value of study findings and their integration with existing HFA evidence and practice. *Please Note*:

- Another entity (state system or research partner) may submit the study notification and information on the site's behalf. The site ensures this information is received by HFA, as described in the HFA Site Research Policy.
- For sites not involved in any research studies, the site will indicate in writing they are not involved and indicate their understanding of HFA requirements should a request for participation in research occur at a later time.

GA-7.D RATING INDICATORS

3 No 3 rating for GA-7.D.

2 The site notifies the National Office prior to the site's participation in any research study involving 1) the HFA model, or 2) participant families, past or present, enrolled in HFA services; and receives study updates consistent with HFA's Site Research Policy. If the site is not involved in any research study, the site will provide a written statement indicating such, as described in the intent.

1 The site has not followed through with National Office requirements as listed in the 2 rating.

Note: This is a National Office Requirement.

TIP: The Research Department at the National Office is able to provide guidance and support to sites and study investigators. Sites (or the central administration when part of a Multi-Site System) are strongly encouraged to reach out to the Research Department through their Training and TA Specialist as early in the process as possible.

GA-7.E When critical incidents occur at the local site level, communication procedures are followed to ensure the national office is notified if the matter escalates to state or national level attention. This includes situations 1) involving child or caregiver death, or serious abuse incidents, which prompt local investigation or media involvement, and 2) litigation pertaining to Healthy Families work/services.

To inform the National Office, please submit this form as instructed.

Intent: Though not common, situations may arise when public relations for damage control is needed to minimize the negative effect caused by an event or series of events. Public relations is about building, improving and maintaining the public image and perception of an individual, company or organization. To ensure the most appropriate response and public communication about such events, sites are to promptly communicate critical incidents to the National Office, when the situation garners heightened media attention. Should the National Office be contacted by the media, national staff must employ its own public relations response. In each case, National Office can do effective public relations work when information of the incident has been communicated in a timely way. The National Office has a critical incident form to be used for communication purposes. *Please Note*: Sites that are part of an HFA Multi-Site System will communicate critical incidents to their Central Administration who will then report them to the National Office. Sites outside of a Multi-Site System will report directly to the National Office.

GA-7.E RATING INDICATORS

3 No 3 rating for GA-7.E.

2 Prompt communication to the National Office has occurred in the event of any critical incidents (as defined in the standard).

1 Communication to the National Office did not occur associated with a critical incident (as defined in the standard).

NA No critical incidents have occurred at the site in the last 24 months.

Tables of Documentation

GA. 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

Standard	Pre-Site Documentation to include in Self Study
GA-1.A | Organization and Function of Community Advisory Board	Submit a narrative, policy or bylaw describing the community advisory board's role in advising with regards to planning, implementation, and evaluation of site activities.
GA-1.B | Advisory with Wide Range of Skills & Knowledge	Submit a community advisory board roster which includes organization affiliation(s) and a summary of skills, knowledge and abilities to effectively serve the interest of the community.
GA-1.C | Program Manager & Community Advisory Board Work Effectively	Submit a narrative describing how the program manager (or other representative from the local site) partners with the community advisory board by providing members site information for each meeting and engages them in advising site operations.
GA-2.A | Quality Assurance Plan	Submit the site's Quality Assurance Plan. Please Note: Sample Quality Assurance Plan Template Available.
GA-2.B | Quality Improvement Plan	Submit the site's Quality Improvement Plan. Please Note: Sample Quality Improvement Plan Template Available.
GA-3.A | Policy - Family Rights & Confidentiality	Submit Policy and samples of relevant form(s) related to confidentiality, informing families of their rights and informing families of how to file complaints. Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
GA-3.B | Family Rights & Confidentiality **Essential Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
GA-3.C | Informed Consent **Safety Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
GA-3.D | Complaints Procedure Followed	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
GA-3.E | Participant Privacy & Voluntary Choice in Research	Indicate whether or not site is currently or previously involved in a research project in the past five years. Peers will review documentation and interview staff, advisory members and families onsite.
GA-4.A | Policy - Criteria to Identify Child Abuse & Neglect **Safety Standard**	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
GA-4.B | Child Abuse Reporting **Safety Standard**	No documentation required pre-site. Peers will review documentation and interview staff, advisory board members, and families on-site.
GA-4.C | Suspected Child Abuse & Neglect Immediate Notification to Supervisors and Program Managers	Submit report of currently enrolled families where child abuse and neglect was suspected and reported to the proper authorities, documenting how safety concerns are addressed and appropriate follow-through occurs. Peers will review documentation and interview staff, advisory board members, and families on-site.

Tables of Documentation

Standard	Pre-Site Documentation to include in Self Study
GA-5.A | Policy - Participant Death & Grief Counseling	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
GA-5.B | Participant Death & Grief Counseling	Submit narrative indicating any incidents of participant death that have occurred within the past year.
GA-6. | Policy & Procedure Manual	Submit Policy Please note: HFA Sample Policies and Procedures and Policy and Procedure Checklist are available.
GA-7. | National Office Requirements	No documentation required pre-site.