Healthy Families New York Site-Specific Policy and Procedures Manual

March 2021

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INTRODUCTION AND MISSION

Healthy Families New York Approach

Healthy Families New York (HFNY) is committed to relationship-based practice and recognizes the significance of the Parallel Process. Through our relationships – with families, within our program system, and in our communities – we work to decrease risk to children and families and build Protective Factors. These most basic philosophical and practical concepts underlie all HFNY training, assessment, home visiting, ongoing support and supervision, internal and external quality assurance, and program administration.

The relationship-based approach informs all the policies and procedures described in this manual. Adherence to these policies and procedures promotes fidelity to the Healthy Families America (HFA) model, which has its foundation in 12 Critical Elements.

Healthy Families America Mission Statement

The mission of the Healthy Families America is to promote child well-being and prevent the abuse and neglect of our nation's children through intensive home visiting.

Healthy Families New York Mission Statement

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

HEALTHY FAMILIES AMERICA GOALS

- Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth
- Cultivate and strengthen nurturing parent-child relationships
- Promote healthy childhood growth and development
- Enhance family functioning by reducing risk and building protective factors

HFNY PROGRAM GOALS

- Support parent child bonding and relationships
- Promote optimal child and family health, development, and safety
- Enhance parental self-sufficiency
- Prevent child abuse and neglect

GUIDE TO THE HFNY POLICIES AND PROCEDURES MANUAL

The HFNY Site-Specific Policies and Procedures Manual (PPM) is organized around the HFA Critical Elements and the HFA Accreditation Program's Best Practice Standards. It serves as a guide to orient HFNY sites toward HFA model fidelity and the practical application of the model, and compliance with HFNY expectations for practice and program management. Further, the HFNY PPM – like the model itself – supports self-awareness and self-assessment so that sites are empowered to examine their own strengths and, in collaboration with the HFNY Central Administration, strengthen areas that contribute to program improvement statewide. In addition, the PPM is a critical tool for sites' preparation for HFA Accreditation.

The PPM has been designed in close parallel to HFA Best Practice Standards, and includes all policies prescribed by HFA. In some cases, HFNY's policies are state-specific and sites are held to a higher standard than indicated by the HFA BPS; these policies are noted in the manual. Intents for each policy are shared so that sites – as well as the state system – are consciously grounded in the rationale for required policies and practices. More detail on policy and practice expectations for each policy is included where helpful.

The title of each policy includes a date indicating when it became effective. In addition, each policy that has Management Information System (MIS) evidence components or supporting forms or documentation has these elements listed at the end of the policy.

The structure of the PPM includes specific guidance to support individual sites in incorporating prescribed site-specific policy content into the manual itself, in essence adding to the state system PPM, so that sites' policy manuals can be in compliance with national and state system standards, and all policies and procedures are located together as part of a coherent, whole document. Note that for some 2nd and 3rd order standards, while specific policies are not required, providing evidence of adherence to these standards is expected.

The Appendix offers links to many items referenced in the policies. An asterisk next to the item denotes that a hard copy of the resource is provided within the Appendix. Lastly, the PPM includes a glossary of important terms to ensure universal interpretation of the meaning of key terms and concepts used in the HFA model and HFNY state system.*(Glossary currently being updated 2021)*

SCREENING AND ASSESSMENT PROCESS (EFFECTIVE 2/21/20)
HFA Best Practice Standard 1-2.A

POLICY: The site has policy and procedures regarding its screening/assessment processes and mechanisms to ensure timely determination of eligibility. Policy and procedures also include the site's tracking and monitoring requirements.

Intent: Sites have a clearly defined target area and target population and establish community relationships that support identification of and outreach to the target population so that services can begin prenatally or within three months (calculated in the MIS as 92 days) of the birth of a baby.

The site measures annually the number of families in the target population that are identified and/or referred through its system of organizational relationships, and through review and analysis of this data, develops strategies to increase the percentage identified and screened, as well as recognizing the need for services within the community.

Sites use the HFNY Screen Form to identify potential participant families and have a system for identifying families prenatally and for processing screens/referrals so that the determination of eligibility for the Parent Survey/assessment occurs prenatally.

Sites assess screened families for participation prenatally or within 14 days of the birth of the baby. Efforts are made to assess families as early as possible prenatally; at least 80% of Parent Surveys/assessments occur within 14 days of a baby's birth.

Sites systematically track, measure and analyze their efforts to reach, screen, and assess the target population in order to increase enrollment, especially early prenatal enrollment, and assess the level of need in the community, including review and analysis of stage of pregnancy at Parent Survey/assessment, families who left the process, either by actively declining or where the connection was lost after positive screens or positive Parent Surveys/assessments, and develop strategies, including community relationships and outreach materials, and a plan to increase the acceptance rate. Programs' efforts in tracking, measuring and analyzing are reflected in their Annual Service Review.

1. All sites use the HFNY Scree Form tool. Staff review screens/referrals within three days of receipt and enter information from screens/referrals into the MIS within five business days of receipt from referral sources or from families who have self-referred.
2. Sites develop and maintain effective referral relationships with community agencies to encourage as many screens/referrals as possible to be received as early as possible in the pregnancy or within the first two weeks of the infant's birth. These relationships have both informal and formal components. Formal relationships are reflected in Memoranda of Understanding (MOUs) or service agreements, which must be updated and signed annually.
3. Sites place emphasis on identifying referral sources that will help them identify potential participants early in their pregnancy.
4. Families with a positive screen are offered a comprehensive assessment using the Parent Survey/assessment to determine their strengths and needs. The Parent Survey/assessment is conducted in the family's home[1], with assessment staff making every effort to offer the Parent Survey/assessment to both parents, and within two weeks of a positive screen being entered in the MIS. If staff is unable to contact the family, they will contact the referral source to verify contact data and determine alternative means to contact the family.
5. Families where the mother, father, or their partner scores 25 or higher on the Parent Survey/assessment are eligible for intensive home visiting services. The Parent Survey/assessment process (parent survey/assessment is administered and scored, approved by program supervisor,

[1] Refer to 4.2B for out of home visit guidance.

uploaded in the MIS, and assigned to appropriate staff) should be completed within five business days. Once a staff member has been assigned, an attempt to offer home visiting services to the family should occur within 48 hours.

6. Sites give an update to the referral source within five business days of resolution of the family's enrollment status unless the referral source does not want this information.
7. Referrals/screens or other services should be offered to families who are not eligible for home visiting services (a Parent Survey/assessment score less than 25) within one week of determined ineligibility.
8. Referrals, screening, and Parent Survey/assessment outcomes are tracked by the HFNY MIS and monitored at least monthly by the program manager or designated administrative staff member, and these efforts are used to develop strategies for quality improvement.

MIS References:

Analysis/Elapsed Times Between Key Dates
Analysis/FRS Monthly Report
Analysis/Quality Assurance Report
Analysis/Screen Referral Source Summary
Analysis/Screen Referral Source Outcome Summary
Analysis/Screen/Referral Source Demographic and Outcome Analysis
Quarterly /Quarterly Pre-Assessment Engagement
Accreditation/1-2.C Assessment Information
Lists/Zip Code Report

Appendix:

HFNY Screen Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/HFNY%20Screen%20form.pdf
Quarterly Report Guidelines
https://healthyfamiliesnewyork.org/Staff/Documents/Quarterly_Report_Guideline_for_Data_Reports_final_draft022020.docx
HFNY Performance Indicators
https://www.healthyfamiliesnewyork.org/Staff/Documents/Performance%20Indicators2021.pdf

For details on the positive impacts of Healthy Families New York to share with groups, go to:
https://www.healthyfamiliesnewyork.org/Research/default.htm

Insert site-specific procedures that include:

1. The definition of the target area and description of the target population, including where the target population can be found and community relationships that have been developed to locate and engage the target population, including special efforts to reach families in the early prenatal period.
2. A description of the process for receiving referrals, conducting screens and Parent Surveys/assessments. Sites include procedures they may have for prioritizing screens/referrals.
3. A description of the mechanisms the site has in place to ensure timely determination of eligibility.
4. Timeframes between receipt of the referral or screen and contacting the family, and the timeframe from this contact to offering the Parent Survey/assessment.
5. A description of the process for tracking the process between the receipt of screens or referrals to when long-term home visiting services are offered.
6. Mechanisms for monitoring the processes and timeframes.

FIRST HOME VISIT (EFFECTIVE 9/19/19)
HFA Best Practice Standard 1-3.A

POLICY: For families that accept services, the first home visit occurs prenatally or within the first three months after the birth of the baby.

Intent: The first home visit that begins to establish a long-term home visiting relationship (i.e., after the screening and assessment process), occurs within three months (calculated in the MIS as 92 days) of a baby's birth, 95% of the time, as set by HFNY Performance Indicators. Any instance when a family's first planned home visit falls outside these parameters must be discussed with and approved by the site's OCFS program contract manager. Programs develop strategies to expand and maintain prenatal enrollment, and to address how they will achieve the HFNY Performance Indicator of at least 65% prenatal enrollment. HFNY research demonstrates if services begin prenatally, families have better outcomes. Calculating the rate of families accepting services is a critical quality improvement practice; therefore, programs systematically track, measure, and analyze their efforts annually to reach this goal. Programs' efforts in tracking, measuring, and analyzing are reflected in their Annual Service Review.

1. Once a family is determined eligible for intensive home visiting services, an attempt will be made to offer services within 48 hours, and immediately begin engagement efforts.
2. The first home visit occurs as soon as possible after a home visitor has been assigned and no later than three months (calculated in the MIS as 92 days) after the birth of the baby.
3. The family is considered to be enrolled when, during a home visit, they have signed the Service Agreement Form and Family Rights and Confidentiality Form. These indicate the family's informed consent to receive services. HFNY sets the date of signatures as the family's enrollment date.
4. A family that enrolls in HFNY 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 professions. Or, it may also 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 target child. When sites have the 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 several of the measurement standards. A family that discontinues services but requests to reenter the program with a subsequent target 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.
5. Engagement efforts and families' enrollment status are tracked in the MIS and monitored at least monthly by the program manager, and these efforts are used to develop strategies for quality improvement.

MIS References:

Quarterly /Quarterly Pre-Intake Report
Tickler/Pre-Intake Tickler
Accreditation/ 1-3.B Timing of First Home Visit Accreditation/1-4.A and B Acceptance Rate and Analysis

Appendix:

HFNY Performance Indicators
https://www.healthyfamiliesnewyork.org/Staff/Documents/Performance%20Indicators2021.pdf
Sample Service Agreement Form*
Sample Family Rights and Confidentiality Form (need HFA login)

https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/

Insert site-specific procedures that include:

1. A description of the beginning of services, i.e., that they begin prenatally, or at birth.
2. A description of the process for tracking the timing of first home visit in relation to the child's date of birth.
3. A description of the process for monitoring and adhering to this standard.
4. A description of how and when home visitors are assigned after a positive assessment.
5. A description of protocols for re-assessment.
6. If the family's first home visit falls outside of the required time frame of within the first 3 months after the birth of the baby, this family must be discussed with and approved for enrollment by the site's OCFS program contract manager.

ELIGIBILITY REQUIREMENTS (EFFECTIVE 2/20/20)
HFA Best Practice Standard 2-1.A

POLICY: Families are eligible for intensive home visiting services when they have various factors associated with increased risk for child maltreatment or other adverse childhood experiences, as determined by a score of 25 on the parent survey/assessment.

Intent: Use of standardized screening and assessment tools to systematically identify and assess families most in need of services. The parent survey is used to assess the presence of various factors associated with increased risk adverse childhood experiences.

1. Staff review screens/referrals within three business days of receipt of screen/referral from health, education and human service agencies, as well as from families who self-refer.
2. For all positive screens, a Pre-Assessment Form is completed.
3. A Screen is positive if any of the following are true about the PC1 (Primary Caretaker 1):
   a. Marital status is single, separated, divorced, widowed
   b. Late (started after the 12th week of pregnancy) or no prenatal care, poor compliance
   c. Inadequate income (TANF or Medicaid, employed without insurance or family financial concerns)
   d. Expectant/new parent is under 21 years of age at time of screen or;
   e. A Screen is also positive if the marital status, prenatal care, and income are ALL unknown.
4. Families with a positive Screen are offered a comprehensive Parent Survey/assessment to determine their eligibility for intensive home visiting services.
5. Families where either parent scores 25 or higher on the Parent Survey/assessment are eligible for intensive home visiting services.
6. Screen and Parent Survey/assessment results are documented in the site's data system and monitored by the program manager at least monthly.
7. If a family does not initially achieve a score of 25 or above, yet appears to be in need of and able to benefit from home visiting services, every effort should be made by the Family Resource Specialist to obtain additional information to add to the Parent Survey/assessment to ensure the information is complete and the scoring is accurate. In the rare cases that the family still does not achieve a score of 25 or above, the site program manager should contact their program contract manager at OCFS to discuss how to best meet the family's needs.

MIS References:

Analysis/FRS Monthly Report
Analysis/Program Synopsis
Quarterly/Quarterly Pre-Assessment Engagement
Tickler/FRS Tickler

Appendix:

HFNY Screening Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/HFNY%20Screen%20form.pdf
Pre-Assessment Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Pre-Assessment%20Activity%20Form.pdf
HFNY Parent Survey Narrative Standardized Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/PSSTANDARDIZEDFORM%20Rev.1-21.pdf

Insert site-specific procedures that include:

1. A description of the required criteria for determining eligibility for Healthy Families home visiting services.
2. Describe procedures for follow-up on assessment refusals.

ASSESSMENT NARRATIVES (EFFECTIVE 2/20/20)
HFA Best Practice Standard 2-2.A

POLICY: The Parent Survey/assessment is used to assess for the presence of factors that could contribute to increased risk for child maltreatment and/or other adverse childhood experiences and is completed within the required timeframe set forth in 1-2.A.

Intent: No single factor can predict which parents face the high levels of stress that may lead to child abuse or neglect, nor when a child is at risk for developmental delays, poor childhood outcomes or adverse childhood experiences. Therefore, HFNY sites use the Parent Survey/assessment to objectively determine family strengths and needs, identify families most in need of services, and ensure that services are offered to families the model is designed to serve.

HFNY sites must ensure that all staff involved in the Parent Survey/assessment process provide such service objectively and consistently. Sites state clear expectations for the documentation of the Parent Survey/assessment narrative to ensure it conveys accurately the depth and detail of each family's strengths, risk factors, and needs, to provide home visitors with an understanding of each family, and afford the opportunity to provide individualized service that builds upon their strengths and is specific to their unique needs.

1. Families with a positive Screen are offered a comprehensive Parent Survey/assessment, to determine their eligibility for intensive home visiting services.
2. The Parent Survey/assessment is completed prior to initiation of long-term home visiting services and preferably in one session and no more than two sessions.
3. Families with either parent having a score of 25 or higher on the Parent Survey/assessment are eligible for intensive home visiting services.
4. Every effort is made for the Parent Survey/assessment to be completed with both parents, or primary caregivers.
5. Parent Surveys/assessments are fully documented consistent with expectations outlined in HFA Parent Survey and Community Outreach (PSCO) Core training, with narrative detail for each of the ten domains for parents, or primary caregivers, using the HFNY Parent Survey Narrative standardized form.
6. Each parent or primary caregiver is rated 0, 5, 10 or Unknown in each of the ten domains of the Parent Survey/assessment using the Rating Scale.
7. The narrative includes details of the family's strengths, risk factors and needs as determined by the Parent Survey/assessment.
8. The HFNY Parent Survey Narrative standardized form is to be completed by the Family Resource Specialist within two business days of the assessment visit and submitted to the supervisor for review.
9. Family Resource Specialists (FRS) supervisors review all Parent Survey Narratives. These reviews may be completed outside of regular supervision times to ensure that the supervisor reviews them in a timely manner. Any subsequent changes are reflected in a finalized Parent Survey Narrative. The Parent survey/assessment process (Parent Survey/assessment is administered and scored, approved by the FRS supervisor, uploaded in the MIS, and assigned to appropriate staff) should be completed within 5 business days.
10. In order to ensure reliability in scoring the Parent Survey/assessment and quality of assessment practice, staff that complete assessments participate in regularly scheduled, protected supervision with their supervisor, and supervisors review and confirm scoring to assure inter-rater reliability. Supervisors observe workers conducting the Parent Survey/assessment in accordance with the HFNY Quality Assurance policy.
11. All staff with responsibility for conducting the assessment must complete intensive, role-specific training offered by a certified Healthy Families America PSCO Trainer, that includes the theoretical background of the tool, hands-on practice, and scoring and documentation procedures, prior to

offering the assessment. Those who supervise Family Resource Specialists must also receive the PSCO training.

12. HFNY does not accept stop-gap training for staff administering the Parent Survey/assessment.

MIS References:

Training/ 10-4 Intensive Role Specific Training for Staff
Accreditation/ 12-2.B Observations by Supervisor

Appendix:

HFNY Parent Survey Worksheet
https://www.healthyfamiliesnewyork.org/Staff/Documents/PSWORKSHEETpaperworksheetRev.0121.pdf
HFNY Parent Survey Narrative Standardized Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/PSSTANDARDIZEDFORM%20Rev.1-21.pdf

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Insert site-specific procedures that include:

1. A description of Parent Survey/assessment criteria.
2. The process for documenting Parent Surveys/assessments including:
- **a.** A description of who completes the narrative, including training required and the Parent Survey Narrative.
- **b.** The timeframe for completing the narrative.
- **c.** Language that supports that narratives accurately convey the detail of the families' strengths, risk factors and needs.
- **d.** Support for assessment practice that includes a description of: Routine review of assessments and timeframe for review, reflective supervision, the training required for the supervisor, practice observation for quality assurance, and inter-rater reliability practice.

VOLUNTARY NATURE OF SERVICES (EFFECTIVE 2/21/20)
HFA Best Practice Standard 3-1.A

POLICY: HFNY services are voluntary

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

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

Additionally, when the site enrolls families already open and active with child welfare cases, staff may not monitor family's progress on behalf of the referral entity nor perform the job functions required by that entity. Sharing of family service information with child welfare and/or other service systems is bound by the confidentiality requirements of HFNY and informed consent (unless subpoenaed) that indicates precisely what information is to be shared.

1. Parents are to be informed, verbally and in writing, of the voluntary nature of participating in HFNY services as early as possible and no later than when families consent to participate in services, including the Parent Survey/assessment visit.
2. The Parent Survey/assessment visit is used as the first opportunity for families to make an informed and voluntary choice about participation in services offered by the program.
3. During the Parent Survey/assessment visit, the Family Resource Specialist explains what Healthy Families is, what services are available, and the voluntary nature of services.
4. Family Resource Specialists review a consent for assessment form that indicates that services are voluntary, and the assessment proceeds after the parents have signed indicating their informed consent.
5. Family Support Specialists review a service agreement form that includes a Family Rights and Confidentiality Form that indicates that program services for enrolled families are voluntary. Sites must include at minimum (refer to GA-5B for policy on Family Rights and Confidentiality):

   Family Rights
   - The right to refuse services
   - The right to a referral, as appropriate, to other service providers
   - The right to participate in planning of services to be provided
   - The right to file a grievance/complaint and how to do so if the need arises including phone number or contact information (see GA-5A for grievance policy requirements)

   Confidentiality
   - The manner in which information is used to make reports to funders, evaluators or researchers (typically aggregate format)
   - The manner in which consent forms are signed to exchange information
   - The circumstances when information would be shared without consent (i.e., need to report child abuse and neglect).

6. Each family choosing to participate in HFNY services signs and receives a copy of the Family Rights and Confidentiality Form.
7. In the event that any entity (child welfare or the court system, for example) attempts to mandate services for a family, staff ensure that both the agency and the family know that services will be offered voluntarily and that the family is free at any time to decide whether or not to participate.

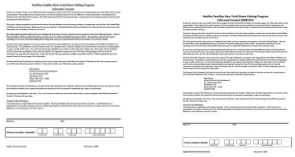
MIS References:

None

Appendix:

Sample Family Rights and Confidentiality Form (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/

Informed Consent



(MIECHV)

Insert site-specific procedures that include:

1. Statement of commitment to services that are voluntary.
2. How families are informed of voluntary nature of services and their right to refuse services and how this is documented.
3. The site's Family Rights and Confidentiality Form that clearly states the voluntary nature of services.

BUILDING TRUST AND ENGAGING FAMILIES (EFFECTIVE 2/21/20)
HFA Best Practice Standard 3-2.A

POLICY: HFNY staff use positive methods to build family trust and engage/enroll new families.

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, 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 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 has received a first home visit (Standard 3-3).

1. Home visitors are trained to plan for intentional use of reflective strategies and active listening skills to build a trusting relationship with families and encourage healthy brain development.
2. When a family is reluctant to participate in home visiting or does not appear to be available, the home visitor discusses the family in detail with their supervisor to problem-solve the engagement difficulties and develop pre-intake strategies to build trust and engage the family.
3. To build trust, staff will maintain a regular, predictable home visit schedule, always notifying the family if changes in the schedule must occur. Staff will also endeavor to always follow-through on what they say they are going to do.
4. Staff will use a variety of outreach and engagement activities including texting, phone messages, sending friendly notes, drop-by visits, invitations to parent groups and leaving small token gifts like hand sanitizer, etc. to engage families.
5. All activities to engage the family are documented in the participant file.
6. Staff continue positive outreach methods for a minimum of 30-45 days after assignment until the family has enrolled or declined services. Outreach may also be discontinued if it is learned the family has left the service area or the parent or child are no longer available (miscarriage, moving, loss of custody, etc.)

MIS References:
Pre-Intake Form

Appendix:
None

Insert site-specific procedures that include:

1. Describe how staff will begin building their relationship with the family with the first attempted contact and during the course of services.
2. Describe how outreach will be customized based on the family's needs and interests, indicating an understanding of those needs and an ability and willingness to help.
3. Describe how supervisors support staff and have ongoing discussions with staff about positive and persistent outreach and engagement methods.

Creative Outreach and Levels Temporary Re-assignment and Temporarily Out of Service
(EFFECTIVE 2/21/20)
HFA Best Practice Standard 3-3.A

POLICY: Families who have received at least one home visit are offered Creative Outreach in accordance with the HFA Level Change Forms for a minimum of three months before discontinuing services.

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 histories find it difficult to openly trust and welcome others into their homes. Additionally, families in crisis may find it difficult to continue participation due to a variety of factors.

Services are to be uniquely tailored to the individual family. Activities are to be focused on strategies that demonstrate to the family that the Family Support Specialist is genuinely interested in them and willing to continue to offer services. Creative activities designed to reach out to families occur throughout the full three-month timeframe. Sites are advised to avoid correspondence that threatens or demands the family to contact the site lest they be terminated from services. While services may in all likelihood be terminated after the three-month timeframe, correspondence indicating that plan will likely add to the feelings of alienation and lack of trust families have. Personalized, handwritten notes may be more effective in establishing a trusting relationship.

The three-month Creative Outreach timeframe applies to families who have received a first home visit subsequent to the offer and acceptance of services. Sample strategies to use with families while on Creative Outreach are similar to those identified above (3-2. B) when working to initially engage families and may include:

- Warm telephone calls focused on the family's well being
- Creative and upbeat notes encouraging parents to want to participate
- Drop by visits (exercising safety) and leaving a card when families are not home
- Texting when approved by site policy
- Anchoring conversations with families to their interests and needs
- Demonstrating joy in being with the parent(s)
- Offering playful/fun activities
- Encouraging parent's self-care
- Utilizing music and art in initial interactions, and
- Personalizing engagement efforts

Note: Families placed on Level TR (Temporary Re-assignment) during a staff leave of absence or turnover, will receive creative outreach service similar to families placed on Level CO (Creative Outreach) as described on HFA Level Change forms, until staff returns from leave or there is a permanent reassignment.

1. A family that has enrolled in the program is placed on Level CO when:
   a. The family cannot be located.
   b. The family has missed three consecutive scheduled home visits while on Level 1-Prenatal, Level 1, Level 2 or Level 1SS. The program will place the family on CO on the date of the first missed home visit.
   c. A family on Level 3 or 4 has missed one scheduled visit and there has been no communication. This does *not* include a family who calls prior to the missed visit to reschedule.

2. Level CO corresponds to the family's circumstances and not those of the home visitor or the program. For example, families may not be placed on Level CO when a home visitor is on leave of absence or vacation, or when the program is having trouble filling a vacancy. It is the program's responsibility to visit the family according to the family's current home visit level.
3. Home visitors consult with their supervisor in determining Level CO, TR or TO. The review is documented in the participant file and supervision documentation. When Level CO, TR or TO status is assigned, discussions about the outreach efforts occur regularly in supervision.
4. Creative Outreach and TR efforts include positive and persistent engagement activities such as, phone calls, text messages, drop-by home visits, use of door hangers, friendly letters, and materials that may be of special interest to the family (e.g., ASQs, job announcements, social activities, etc.).
5. A family is taken off of Level CO or TO when they have received *two consecutive home visits*. The date of the second home visit is the date of level change, and this is documented using the HFNY Change Form.
6. The family remains on Level CO status for a minimum period of 92 days, as set by HFNY Performance Indictors. The services to the family may be closed prior to 92 days *only* under the following circumstances:
   - **a.** The family has reengaged in services
   - **b.** The family has refused services
   - **c.** The family has moved from the service area
   - **d.** Neither parent has custody of the child
   - **e.** The pregnancy ended in miscarriage or termination
   - **f.** The target child is deceased
   - **g.** The primary care giver is deceased
   - **h.** There are significant safety concerns that place the home visitor's health and well-being in jeopardy
   - **i.** The family has transferred to another program
7. Level CO and TO can extend beyond 92 days if it is likely that the family will be re-engaged. Supervisors and home visitors discuss this circumstance and document this discussion. HFNY Performance Indicators set the maximum percentage of families on Level CO at 10% or lower.
8. Families are returned to their same or a higher frequency of visits when they are taken off Level CO. This decision is made based on discussions between the supervisor, home visitor and family (not necessarily at the same time).
9. If 92 days of outreach at Level CO conclude without success, a letter may be sent to the family indicating that services will be closed and inviting them to contact the program if their circumstances have changed and services as outlined in the Family Rights and Confidentiality Form.
10. Whenever appropriate, home visitors and supervisors discuss transition planning for families being discharged from the program after being enrolled and at the conclusion of outreach efforts.
11. Sites use the MIS and informal methods, such as discussions with staff and others involved in program services, to track and analyze, at least annually, the length of time families remain in services to identify patterns and trends associated with families dropping out of services, and develop strategies for improving retention. Programs use the Annual Service Review to discuss strategies for increasing retention rates based on its analysis of programmatic, demographic, social and other factors that appear to impact retention of families for at least one year.
12. New sites without 2 full years of home visiting data will complete an annual measurement of retention based on 6-month retention data.

MIS References:

Accreditation/3-3.B Use of Creative Outreach
Accreditation/3-4.A and B Retention Rate Analysis
Analysis/Program Synopsis
Lists/Supervisor case list

Appendix:

Creative Outreach Activities/Checklist*

HFA Level Change Forms (need HFA Login)
https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf
https://www.healthyfamiliesamerica.org/network-resources/?topic=level-change

Sample Family Rights and Confidentiality Form (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/

Informed Consent


(MIECHV)

Annual Service Review Guidelines *(Currently being updated 2021)*

Insert site specific procedures that include:

1. Describe when families are placed on level CO.
2. How the program will provide positive and persistent engagement activities, the frequency of CO activities, include how much, how often- specific expectations. Examples may include home visits, door hangs, materials, calls and texts. Include documentation when "safety issues" is selected as a reason to put a family on CO.
3. Describe procedures for placing families on Level TR (Temporary Reassignment) and when a family is receptive and able to continue receiving home visits.
4. Describe procedure for the use of Level TO (Temporary Out of the Service Area)
5. Describe procedures for how supervisors will oversee families on Levels TR and TO according to guidelines outlined on the HFA Level Change Form
6. Describe procedure for the length of time families remain on CO (92 days) and circumstance that level CO will conclude.
7. Describe procedure on the shared decision making between the supervisor and FSS as to when level CO is assigned and then regular reviews about outreach efforts, including the documentation of all outreach efforts.

Minimum Length of Time to Offer Weekly Home Visits (EFFECTIVE 11/27/18)
HFA Best Practice Standard 4-1.A

Policy: Families are offered weekly home visiting services for a minimum of six months (calculated in the MIS as 183 days) after the birth of the baby or after enrollment, whichever is longer, excluding any time on Creative Outreach (CO), Temporarily Out of the area (TO), and Temporary Reassignment (TO). Services are offered long term – 3 to 5 years.

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

1. At the time of the birth of a baby (when enrolled prenatally), or at the time of enrollment for postpartum women, families are placed on services Level 1 (weekly visits) or Level 1SS (more intensive).
2. All families on Level 1 (or 1SS) are offered weekly visits for a minimum of six months, excluding time on Levels CO, TR or TO.
3. Families moved to a creative outreach level from Level 1 will return to Level 1 once re-engaged until a minimum of six months on Level 1 have been completed and the family has met the criteria outlined on the Level Change Form for movement to Level 2.
4. As with all other service level changes, the movement from Level CO to Level 1 includes a discussion with the family to let them know of any changes in visit frequency.
5. The supervisor and the FSS formalize all level changes during regular supervision.

MIS References:

Intensive Home Visitation Level after Target Child is Born
Level Change History Report
Case Home Page: Basic Information tab

Appendix:

None

Insert site-specific procedures that include:

1. The requirement that families are offered weekly home visits for a minimum of six months (calculated in the MIS as 183 days) after the birth of the baby or date of enrollment, whichever is longer, excluding any time the family was on Levels CO, TR or TO.
2. The requirement that families are enrolled only prior to the baby reaching three months of age (calculated in the MIS as 92 days), except in limited circumstances, with prior OCFS approval.

Levels of Service (EFFECTIVE 11/27/18)
HFA Best Practice Standard 4-2.A

POLICY: The intensity of services is based on clearly defined levels of service and criteria for moving from one level of service to another as outlined in the HFA Level Change Forms. Progression from one service level to another is based on the progress of the family and involves the family, the home visitor and the supervisor.

Intent: As a family-centered model, HFA endorses the use of a "level system" for managing the intensity of services. A well-thought out system is sensitive to the needs of each family, the changes in family needs and competencies over time, and the responsibilities of the Family Support Specialist. Clearly defined levels reflect in measurable ways the capacity of the family, such that families with higher needs are able to receive more intensive services, while less intensive services are provided as stability and progress increases. Not only does an effective "level system" allow for individualized service delivery, it also provides sites a mechanism to monitor more effectively caseload capacity, thus promoting higher quality services. It is important for Family Support Specialists to know where to locate information regarding levels of service and to be familiar with the process of how a family progresses from one level to another. Because changes to visit frequency are based on progress, the age of the child or the length of time on a particular level is never the sole basis for level change decisions.

1. Service intensity is based on criteria on the HFA Level Change Forms.
2. When families agree to participate in intensive home visiting services:
   a. If pregnant and prior to 28 weeks gestation, they enter services at 2P and should receive bi-weekly home visits. Once the pregnancy is beyond 28 weeks, the family will move to 1P and begin receiving weekly home visits. While on Level 2P, a family can be moved to a Level 1P (weekly visits) if the supervisor, FSS and family feel weekly visits are warranted.
   b. If the family begins services when the mother is at or beyond her 28th week of pregnancy, they enter services on Level 1P with weekly visits.
   c. If the family has a new baby (target child), they begin services on Level 1. If the parent has a multiple birth, they will enter at Level M, and have an additional .5 case weight.
3. Families served prenatally move to Level 1 with the birth of the new baby and Level 1 families can move to Level 1SS when in crisis, or during a high-need time period, after discussion with supervisor. Families may be moved to Level 1SS only from Level 1. If the family is on a level with less intensive home visiting, home visitors and supervisors discuss moving the family to Level 1 first, if appropriate, then to Level 1SS if it becomes clear that they need more than one visit every seven days, and/or the home visitor must devote a great deal more time to supporting or advocating for the family. The time spent on Level 1SS should be less than 3 months. There may be situations in which Level 1SS extends beyond 3 months, such as multiple births or parental developmental disabilities. This requires the approval of the site's OCFS program contract manager (PCM).
4. Families are offered Level 1 services (including short term movement to Level 1SS) for a minimum of six months following the birth of the baby or enrollment, whichever is longer, excluding time on creative outreach.
5. After the initial six months of Level 1 services, each family's service level is reviewed to determine the family's progress based on criteria on the HFA Level Change Forms.
6. Movement from one level to another is based on the progress of the family determined by the criteria defined in the HFA Level Change Forms. Level changes are discussed between the FSS and supervisor during supervision and in discussion with the family. During home visits, the FSS discusses with the family their achievements, visit schedule, family circumstances and readiness for change in frequency of home visits. The family's receptiveness or resistance to the proposed level change is documented in the home visit records. Copies of completed Parent Celebration Certificates should be completed with every level change, this will satisfy the home visit documentation.

7. Based on the HFA Level Change Form criteria and discussion with the family, the FSS and supervisor routinely review the family's progress towards meeting criteria for a level change and make a determination about each family's service level change based on family progress. These discussions are documented in the supervision notes. Completed and signed Level Change forms also satisfy supervision documentation.
8. Each service level is assigned a weighted numerical value so FSSs and the supervisor can closely monitor when their caseload has availability or conversely is at capacity. Consistent with best practice standards, an FSS carries no more than a case weight of 30 points.

HFNY Level System

Level	Timing	Case weight	Visits expected
2P(Prenatal)	Prenatal up to 3rd trimester (old 1P)	2	1 visit every 14 days (Biweekly)
1P (Prenatal)	Prenatal, 3rd trimester to birth	2	1 visit every 7 days (Weekly)
1	Postnatal, for at least 6 months after enrollment	2	1 visit every 7 days (Weekly)
M	Postnatal, for at least 6 months after enrollment		1 visit every 7 days (Weekly)
1SS	Temporary periods of crisis	3	1+ visit every 7 days (During temporary periods of intense crisis)
2	(After 1)	1	1 visit every 14 days (Biweekly)
3	(After 2)	.5	1 visit every 28 days (Monthly)
Level 4	(After 3)	.25	1 visit every 84 days (Quarterly)
Level CO (creative outreach)	Family out of contact, or will be away **more than** 3 months	.5-2 Case weight determined by level family on prior to CO.	Creative Outreach (weekly engagement activities).
Level TO (temporarily out of area for up to 3 months)	Temporarily Out of Area, for up to 3 months	.5 – 2 Sites maintain a family's case weight while on Level TO equal to the family's level prior to being placed on creative outreach to ensure space is retained to move family back to that level if re-engaged.	N/A
*Level TR (temporary re-assignment to another staff person during extended staff leave or turnover up to 3 months when family is not receptive or able to receive visits at previous frequency.	Temporarily Resigned to other worker for light contact.	.5	As agreed upon between the FSS and the family.

*If family is receptive and able to continue receiving services at the frequency associated with previous level, then the level and case weight would not be changed to TR.

Note: One parent group meeting per month may be counted as a home visit if the assigned home visitor is involved with the group meeting and it is documented individually on the home visit record in the family file. The home visit documentation of the group meeting must be documented by the assigned Family Support Specialist and includes CHEERS observations when the group includes parent child interaction time. This can only be used for Level 1P and Level 1 families.

MIS Reports:

Supervisor Case List
FSS Case List
Program Caseload Summary
Home Visiting Completion Rate Analysis - Detail and Summary
Family Support Specialist Home Visit Record - Detail and Summary
Case Home Page, Basic Info tab

Appendix:

HFNY Sample Level Change Criteria Forms (need HFA Login)
https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf

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Insert site-specific policies and procedures that include:

1. A description of service levels and the criteria for moving families from one level to another. Procedure for monitoring that family is at their appropriate level.
2. Reference to level change forms with specific criteria for each level.

HOME VISIT COMPLETION (EFFECTIVE 9/25/20)
HFA Best Practice Standard 4-2. B

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

Intent: Home visits (taking place where the family resides) provide the opportunity to experience the family's living environment, to develop first-hand knowledge of the strengths and stresses of the home environment, to implement home safety assessments with the family, and to engage the family on 'their turf'. Certain situations could lead to visits not occurring **in** the home: unstable or chaotic environments, the need to promote participants' interaction with the larger community to reduce social isolation or when visits happen in conjunction with other services being provided to the family. Visits occurring outside the home can be beneficial and are permissible at supervisors' discretion. 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 the documentation of CHEERS. The goal of a home visit is to promote positive parent-child interaction, healthy childhood growth and development, and enhance family functioning. Typically, a home visit lasts a minimum of an hour and the child is present.

HFNY's expectations:
Out of home visits can count as a home visit if the content of the visit matches the goal of a home visit, can be documented as such, including documentation of CHEERS and have supervisory approval. Under extreme circumstances, when in-person home visits are not possible due to severe weather conditions, natural disaster, pandemic or community safety advisory **virtual visits**[2] may be conducted.

1. All home visits, which include in-home, out-of-home and virtual visits Must follow these goals:
   a. The assessment and documentation of parent-child interaction using CHEERS (provided that TC is present and/or awake).
   b. A focus on the promotion of healthy growth and development of the child.
   c. The enhancement of family functioning.
2. Out-of-home visits and virtual visits need supervisory approval in order to count toward the home visit rate.
3. Supervisors and FSSs will discuss the reasons for conducting out- of-home and virtual visits and strategies will be developed to gain the family's trust and ultimately conduct visits in the home, whenever possible.
   a. The reasons to conduct out-of-home visits might include things such as safety, home infestation, a gatekeeper in the home, refusal from PC1, the opportunity to promote positive PCI out of the home, promote a healthy childhood growth and development or to enhance family functioning.
   b. The reasons to conduct virtual visits include extreme circumstances such as a pandemic, special weather conditions, natural disaster and community safety advisory. In such circumstances, programs will follow HFNY Central Administration's protocols and procedures.
   c. When out of-home visits will occur for more than two consecutive visits, or if in home visits are refused by PC1 or unsafe, the Service Plan will be used to identify the factors that contribute to the family not permitting in- home visits and strategies will be developed to move to in-home visits if possible.
   d. When out of home visits will occur for more than two consecutive visits, the family's reasoning for out-of-home visits will be reviewed during the in-depth discussion and strategies will be developed to ultimately conduct visits in the home.

[2] Extreme circumstances such as pandemic, could lead to long-term virtual visits. In that case, programs will follow HFNY Central Administration's protocols and procedures developed for that special situation. Guidance is published and updated regularly on the HFNY Website.

   e. Programs should reach out to their program contract manager if out-of-home visits should continue for more than 3 months (for L4 families after 2 consecutive visits).
4. The FSS will discuss strategies with the family and use the Family Goal Plan in cases where the family choses to work on a goal that would lead to in-home visitation.
5. In the case of supervised out-of-home visits, the site will follow their agency's policy.

MIS References:

Home Visit Log
Supervisor Form
Home Visiting Completion Rate Analysis – Detail and Summary

Appendix:

None

Insert site-specific policies and procedures that include:

1. A description of the goals of the home visits and how you document them using the Home Visit Log.
2. How the supervisor will approve the use of out-of-home and virtual visits.
3. A description of how the site tracks out-of-home and virtual visits:
   a. the frequency permitted
   b. the location they occur
   c. the reason for out-of-home and virtual visits (i.e., using the Home Visit Log).
4. How the site will discuss families who receive out-of-home visits and the strategies used to move to in home visits and how this will be documented.
5. A description of the strategies the FSS will use to promote in home visits with families.
6. Insert your agency's policy and procedures regarding supervised visits in foster care or when PC1 is incarcerated.

Examples of such guidance are:

https://www.healthyfamiliesnewyork.org/Staff/Documents/covid19emailfromocfs.pdf
https://www.healthyfamiliesnewyork.org/Staff/Documents/CRITICAL_INCIDENT_REPORT.doc
https://www.healthyfamiliesnewyork.org/Staff/Documents/FSSGuidelinesfo%20ConductingVirtua%20HomeVisit0320.pdf
https://www.healthyfamiliesnewyork.org/Staff/Documents/FRSGuidelinesVirtualParentSurveyVisits0320.pdf
https://www.healthyfamiliesnewyork.org/Staff/Documents/CHEERSvirtualvisitsguidelines032020.pdf
https://www.healthyfamiliesnewyork.org/Staff/Documents/ConsiderationsforResumingIn-HomeVisitsFINALDRAFT.docx
https://www.healthyfamiliesamerica.org/hfa-response-to-covid-19/

DURATION OF SERVICES (EFFECTIVE 2/21/20)
HFA Best Practice Standard 4-3.A

POLICY: Intensive home visiting services are offered to families for a minimum of three years after the birth of the baby.

Intent: The sites offer traditional HFNY services to families for a minimum of three years and up to five years, after the birth of the baby.

1. HFNY services are offered to families at least until the target child reaches three years of age, and up to age five, as needed.
2. All materials indicate that services are provided prenatally through the age of five.
3. The Family Rights and Confidentiality handout used by the site, and sites' procedures ensure that families are made aware at the time of enrollment that services are provided through age five.

MIS References:

Participant in Program for at Least 3 Years as of Today
'New Levels (January 2019)' PowerPoint on MIS

Appendix:

HFA's Level Tool Guidance (need HFA login)
https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf

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Describe the timeframe for offering services to families. HFNY is designed to support families prenatally through the age of five.

Insert site-specific procedures that include:

1. A description of the time-frame for offering services to families, which must be prenatally until the age of five.
2. A discussion of the site's capacity to provide services for families with children through age five, relative to other services in the community.

NOTE: 4-3. B. is a SENTINEL STANDARD

SERVICE CLOSURE AND TRANSITION PLANNING (EFFECTIVE 2/28/20)
HFA Best Practice Standard 4-4.A

POLICY: Transition plans are developed when a family is ending services with a planned service closure (i.e., when a family is graduating from the program or is moving from the service area, or other circumstances indicate departure from the program).

Intent: As a family prepares to end services, efforts and time to plan for a smooth and successful transition should involve the family, the home visitor, and the supervisor. While the decision to develop a transition plan is based on the wishes of the family - the family may decline - sites are expected to be strongly proactive in transition planning. The site takes the initiative to explore suitable resources, contacts service providers, if the family has given their written consent, and follows-up on the transition plan.

1. Six months before completion of the program, or when the family indicates they are planning to move from the service area and have given at least three months' notice, the FSS will initiate formal transition planning by discussing with the parents their continuing goals for their child and for their family as a whole. Special care should be taken with transition plans when the family ends their engagement to the program due to loss, i.e., death of the parents, loss of pregnancy, loss of TC, etc.
2. The home visitor and supervisor review and discuss family goals, transition plan and discharge plan and keep documentation of these discussions.
3. The transition plan will include reason for closure, the date of the initial discussion regarding closure and date of planned closure.
4. The home visitor assists the family in identifying resources and /or services needed or desired by the family and any other services available to them in the community. Services might include Head Start, childcare, or other community-based early childhood education programs, or another HFA site if the family is moving. The home visitor makes referrals as needed.
5. The home visitor and family update the Family Goal Plan to incorporate any additional family goals generated by the transition. The home visitor and the family revisit the transition plan when the family's departure from the program becomes imminent and make contact with any new service providers.
6. Prior to closure, the home visitor follows-up on all referrals that have been made to determine availability of services and to assist with successful transition.
7. Whenever possible, the site conducts a family exit interview.
8. The Follow-Up Form is completed at discharge.

MIS References:

Transition Plan on HV log
MIS Goal/Transition Plan Form
Follow-Up Form

Appendix:

HFNY Transition Plan Form (in English and Spanish) (HFNY MIS)

Insert site-specific procedures that include:

1. Steps to develop and document the Transition Plan: FSS and family discuss and come up with a plan, that should include:
   a. reason for closure,
   b. the date of the initial discussion regarding closure,
   c. the planned closure date,

d. identified resources/services needed by the family and
e. an outline of steps needed to obtain any identified resources or services.

2. The discussions the FSS and supervisor have about the plan made by the FSS and the family. In addition to the feedback provided by the supervisor during regular supervisions, documented on the Supervision Form.
3. The process by which the FSS assists the family in identifying other service providers near to where they are or will be living.
4. How/where the family's written consent to referrals, will be kept.
5. How the FSS and family will update Family Goals to incorporate any additional family goals the family wishes to complete prior to closure and/or goals in relation to transitioning into other services.
6. How exit interviews will be conducted with families.
7. Finally, indicate how the site will document the plan.

PROVIDING CULTURALLY RESPECTFUL SERVICES (EFFECTIVE 1/28/21)
HFA Best Practice Standard 5

Policy: Services consider the culture of families such that staff understands, acknowledges, and respects cultural differences of families; staff and materials used by the site reflect to the greatest extent possible the cultural, language, geographic, racial and ethnic diversity of the population served.

Intent: The overall intent of this standard is to ensure that sites are culturally respectful to each family's unique characteristics and views each family's culture broadly beyond just race, ethnicity, or heritage.

Successful home visiting programs provide services with cultural humility so that new skills and ideas being shared with families are respectful of each family's values and decision-making systems. Providing services with cultural understanding and humility requires knowledge of diversity be applied to policy and practice. Home visitors facilitate the family's consideration of how new perspectives fit into their lives. The practice allows families and home visitors to work together to craft positive family development strategies.

Families vary in many ways, so it is important that home visitors, and programs as a whole, understand differences among them. Cultural groups may define "family" differently, which affects the audience for services. Home visitors observe cultural differences and use them as a springboard for inquiry and understanding, asking families about particular behaviors and practices. Family background and ethnicity influence value systems, how people seek and receive assistance, and communication practices (e.g. native language, slang, body-language) among other things. When home visitors express curiosity with open-ended questions and are non-judgmental and refrain from imparting their own beliefs and value systems, families have the opportunity to reflect and share.

Staff are better prepared to serve and interact with families when they have an increased understanding of cultural practices linked to family's unique characteristics and values. Sites are encouraged to reflect on broad definition of culture and identify training based on the unique characteristics of the service population. This could include a variety of training topics such as the cultural dynamics of substance abusing parents or parenting in households where there is intimate partner violence. It could also include topics such as working with military families, immigrant families, grandparents raising grandchildren, etc. The goal is to essentially help staff develop and enhance skills to allow them to work most effectively with families being served.

1. The site has a description of the cultural characteristics of the service population and ensures that their service population's ethnic, racial, linguistic, demographic, and cultural characteristics are identified by the site and used to inform all aspects of program practice.
2. The site completes an annual Cultural Analysis and Plan (CAP) to define their service population and ensure that the characteristics listed above are used to inform practice. The CAP includes the following elements:
   - **a.** A description of the cultural characteristics of the site's service population that includes total numbers, percentages of the population, and narrative detail.
   - **b.** A review of program policy and practice to ensure that the program's updated ethnic, racial, linguistic, demographic, and cultural characteristics are incorporated. This includes reviews of site materials, communication and language factors, interactions between staff and families, training and training materials, and all components of service delivery (e.g., initial engagement, home visiting, supervision, management, etc.).
   - **c.** A summary of how staff and family input is obtained on site materials, communication and language, and all components of service delivery and the results of that input.
   - **d.** A strategic plan for improvement is developed that incorporates the site's strengths and areas for growth. This plan should address all the above areas and include staff training and

professional development needs.

3. The site ensures that the CAP is shared with their Advisory Board and feedback is obtained to assist in strengthening any areas where opportunities for growth were identified.
4. The site ensures that all staff receive annual training designed to increase understanding of the unique characteristics of the service population and document the completion of training in the MIS on the training form.

MIS References:

Program Demographics
Culturally Sensitive Practices

Appendix:

Guidelines for Annual Service Review- Currently being updated (2021)
HFA Cultural Analysis and Plan workbook (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/cultural-analysis-and-plan-guide/

Insert site specific procedures that include:

1. Where a description of the cultural characteristics of the site's service population that includes numbers, percentages and narrative detail can be found.
2. A description of how the site ensures that ethnic, racial, linguistic, demographic and cultural characteristics are identified by the site to inform all aspects of program practice
3. A description of how the site completes the Cultural Analysis annually and addresses site materials, communication and language factors, interaction between staff and families, training and all components of service delivery (initial engagement, home visiting, supervision, and management).
4. How the site ensures the Cultural Analysis includes a summary of staff and family input on all components of service delivery.
5. A description of how the site develops a plan based on the findings of the analysis that addresses improvement opportunities.
6. A description of how the site shares the Cultural Analysis and Plan with their Advisory Board and how feedback is obtained.
7. How the site ensures that all staff receive annual training designed to increase understanding of the unique characteristics of the service population and document the training in the MIS by clicking the appropriate box (BPS 5-3 on training form).

REVIEWING AND ADDRESSING RISK FACTORS AND CHALLENGING ISSUES (EFFECTIVE 6/22/18)
HFA Best Practice Standard 6-1.A

POLICY: Supervisors and Family Support Specialist (FSS) review the risk factors and stressors identified by the Parent Survey, as well as parent/child interaction/attachment and any concerns and risk factors/challenging issues identified subsequent to the Parent Survey and address these issues during the course of services using the HFA Service Plan.

Intent: Supervisors and Family Support Specialists will develop an HFA Service Plan based on all risk factors identified in the initial assessment/Parent Survey. The Service Plan will list all risk factors plus activities to support the family and build protective factors. To support both the family and Family Support Specialist there will also be planning for the appropriate prioritization and pacing of activities. Supervision discussions are thoughtful and purposeful and assist the FSS's to understand how early childhood trauma and the stressors experienced by the family impact parenting.

1. The supervisor and FSS review the Parent Survey together at the onset of services, identifying each of the risk factors and stressors for the family.
2. Using the HFA Service Plan, the supervisor and FSS develop a plan of activities to address each of the risk factors/stressors identified, including prioritizing and determining a pace for each activity.
3. The FSS and family implement the activities from the plan throughout the course of services, building protective factors. These activities are documented in the Home Visit Log and noted during supervision on the Service Plan (placing date of home visit activity completed on the plan).
4. During supervision sessions, the supervisor and FSS routinely review the activities that have been implemented, discuss the readiness of the family to address issues, reflect on the success of the activities, and discuss next steps. These discussions are documented in the HFNY Supervision Form. The frequency of these discussions will depend on the complexity of each family's situation, including risk factors and challenging issues and should correspond with in-depth conversations regarding the family.
5. Any challenging issues identified after completion of the Parent Survey (i.e., mental health issues, substance abuse, intimate partner violence, challenges identified through the use of screening tools such as depression screens, ASQ's, Parent-Child Interaction Tools etc.) are added to the HFA Service Plan and followed up according to #3 and #4 above.
6. Progress on goals and follow-up on any recommendations for working with the family are monitored and celebrated on an ongoing basis both in supervision and with the family.

MIS References:
None

Appendix:
HFNY Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf
HFNY Service Plan (HFNY MIS)

Insert site-specific policies and procedures that include:

1. How the supervisor and FSS work together to:
   a. Review each family's risk factors and stressors identified in the Parent Survey
   b. Plan activities/strategies to address each of these factors utilizing the HFA Service Plan and prioritizing and determining the pace to address each one.

c. How often the Service Plan will be reviewed based on each individual family's needs, risk factors and challenging issues.

2. How the FSS and the family work together to implement the planned risk reduction activities/strategies during home visits both initially and during the course of services.

3. Additional risks/challenging issues (mental health, substance abuse, domestic violence and parental cognitive impairment) are added to the Service Plan.

FAMILY GOAL PLAN (EFFECTIVE 9/25/20)
HFA Best Practice Standard 6-2.A

POLICY: Family Support Specialists and families work together to develop a Family Goal Plan.

Intent: Goal setting is designed to be a collaborative process between parents and the Family Support Specialist. The process of developing goals is an essential part of HFNY's Infant Mental Health approach. 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 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. Successfully achieving a goal can change the way a parent views the world, increase a sense of self-efficacy, enhance internal motivation, and build Protective Factors. As a result, families feel less like victims and more in control of their lives.

In goal setting, the process is more important than the product; along the way, parents gain the ability to identify their goals, learn skills necessary to reach their goals, and take steady action towards achieving them. The Family Support Specialist's role is to support the family in experiencing success and all of its benefits (which even a "small" goal can provide) within a trauma-informed and culturally sensitive framework. Supervisors support the development and completion of goals by helping the Family Support Specialist identify and address a family's barriers to success and affirm the progress they have made.

1. The Family Support Specialist utilizes a collaborative and strength-based approach to create a Family Goal Plan within the first 90 days of service. This requires active participation from the family and may include information gathered during the assessment process and other screening tools. Goal setting is 100% based upon what the families want, need, or dream about.
2. The Family Support Specialist utilizes tools like the "What I'd Like for My Child" and "Family Values Cards" activity referenced at HFA Foundations for Family Support training to demonstrate collaboration in the goal setting process and is used to help identify family strengths to support goal achievement.
3. Family Goal Plans include detailed action steps for achieving the goals as well as realistic timelines for accomplishing their goals. The family and Family Support Specialist work together to identify ways to achieve goals and to identify and build upon strengths.
4. Home visit activities and identification of resources are provided as the Family Support Specialist works to assist the family in accomplishing their goals.
5. Family Goal Plans are documented in MIS on the HFNY Goals/Transition Plan form and a copy of the Family Goal Plan is given to the family. Goals are reviewed with the family and during supervision on an ongoing basis. This includes discussions regarding progress on goals, identification of strengths and barriers, addressing any family concerns and celebrating successes. These discussions with the family are documented in the home visit narrative and the goals/steps are documented in the MIS. Supervision discussions regarding progress and barriers are also documented in supervision notes.
6. Achievement of goals is celebrated via a discussion on strengths built and growth of the family. Documentation of this celebration is included in the home visit record The Family Support Specialist works with the family to modify goals as needed, to retire goals that the family is no longer interested in pursuing, and to update the Family Goal Plan with new goals as goals are accomplished. Families should always have at least one active goal that they are working on and that the Family Support Specialist is supporting.

MIS References:

MIS Goal/Transition Plan Form

Appendix:

None

Insert site-specific procedures that include:

1. The time frames and processes for developing, reviewing, and updating the Family Goal Plan that includes collaboration between the family and the home visitor, and the home visitor and supervisor.
2. The strategies and tools that ensure that the goals that are developed are meaningful to the family.
3. Tools and processes to be used to identify strengths and Protective Factors that support goal development.
4. How the Family Goal Plan process is supported in supervision.
5. How the Family Goal Plan is used to inform home visit activities and resources offered to families.
6. How achievement of goals is acknowledged and celebrated with families.
7. How the Family Goal Plan will be documented in the MIS on the HFNY Goals/Transition Plan form.
8. How a copy of the Family Goal Plan will be shared with the family.

CHEERS: Assessing Parent-Child Interaction (EFFECTIVE 5/25/19)
HFA Best Practice Standard 6-3.A

POLICY: Utilizing CHEERS, FSSs assess, parent-child interaction: FSSs address any concerning interaction and promote positive parent-child interaction, attachment and bonding.

Intent: The promotion of parent-child relationships is a primary HFA and HFNY goal. Many parents 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 use reasoning until their own basic needs for safety and trust are met. Home visitors are trained to use an Infant Mental Health (See Appendix) approach, which supports building a partnership with parents and providing a platform for exploring parent-child interaction together. It is expected that the parent-child relationship is observed during each visit where the parent and child are both present using CHEERS as the framework for observations, and these observations are documented, discussed in supervision, and used in planning subsequent visits and other services.

1. During each home visit the FSS observes parent-child interaction using CHEERS and identifies areas of strengths, needs and concerns. The FSS consistently uses teachable moments to reinforce the parent's positive interactions, to promote nurturing relationship skills and to address any concerns identified through CHEERS observation.
2. All observations are documented in the Home Visit Log. Documentation includes parent strengths, needs, and any concerns observed during parent child interactions. Each aspect of CHEERS has an example of a behavioral observation of what is seen or heard and the frequency. All components of CHEERS are to be documented unless:
   a. The child is asleep or not present for the entire visit (no CHEERS required)
   b. The mother is pregnant (at least one CHEERS aspect beginning at 24 weeks and any two CHEERS aspects at 31 weeks (frequency not required).
   c. A group is being used for that week's home visit (Level 1 families only) (some components of CHEERS required when PCI time is part of group meeting)
   d. The Parent Survey is administered during that visit or CHEERS Check-In tool is used during that particular visit.
3. The FSS supports positive interactions between parent and child by using the Reflective Strategies and helps parents practice skill building activities during home visits. This includes activities from curricula (i.e., Growing Great Kids, Partners for a Healthy Baby), which are used at a frequency planned by the supervisor and FSS for each family.
4. The FSS and supervisor discuss the parent-child relationship and parent-child interactions during supervision and develop plans to address any needs or concerns based on the observations of the FSS. These discussions are documented in supervision notes and any activities or strategies to address the concerns are added to the Service Plan.
5. The supervisor supports the home visitor in assessing parent-child interaction, addressing parent child interactions and promoting positive parent-child interaction, attachment, and bonding with all families utilizing CHEERS and the validated CHEERS Check-In and documented as outlined in the Home Visit Narrative Instructions.
6. The CHEERS Check-In is administered to each child annually (**MIECHV Programs every six months**) until discharge. The first CHEERS Check-In will be completed between five and seven months. The results of the CHEERS Check-In are reviewed in supervision and the supervisor and FSS work together to develop a plan (documented on the Service Plan) to address any concerns. Any CHEERS Check-In score below a 4, should be added to the Service Plan with strategies to address concerns.

MIS References:

Home Visit Narrative

Appendix:

Infant Mental Health
https://www.zerotothree.org/early-development/infant-and-early-childhood-mental-health
HFA CHEERS Guide for Home Visitors
https://www.healthyfamiliesnewyork.org/Staff/Documents/CHEERSGuideforHomeVisitors0819.docx
HFA CHEERS Discussion Guide for Supervisors
https://www.healthyfamiliesnewyork.org/Staff/Documents/CHEERSDiscussionGuideforSupervisors%20022020.doc
Home Visit Narrative Content Instructions
https://www.healthyfamiliesnewyork.org/Staff/Forms/ContentInstructionsNewYorksHomeVisitingProgram.pdf

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Insert site-specific procedures that include:

1. How home visitors will use CHEERS to assess parent-child relationships on all home visits where interaction is observed. If a group visit occurs for Level 1, how will home visitors be required to document CHEERS?
2. How home visitors will document parent-child interactions observed during home visits, including a commitment to objectivity and using specific examples observed.
3. How supervisors will work with home visitors to develop plans for increasing positive parent-child interactions and how discussions will be documented in supervision notes.
4. How strength-based intervention tools (i.e., the HFA Reflective Strategies) will be used to promote positive parent-child interactions.
5. How curriculum will be used to promote parent-child interaction, how it will be selected, and how often it will be used.
6. How home visitors will address any needs or concerns regarding the parent-child relationship and interactions and activities to address concerns will be added to the Service Plan.
7. How supervisors will support home visitors with CHEERS assessments and interventions and the documentation of CHEERS.
8. How home visitors will use the CHEERS Check-In at minimum of once per year beginning between five and seven months and annually *(**MIECHV Programs every six months**)* until discharge.

NOTE: 6-3. B, 6-3.C and 6-3.E are SENTINEL STANDARDS

PROMOTING CHILD DEVELOPMENT, PARENTING SKILLS, AND HEALTH AND SAFETY (EFFECTIVE 7/24/20)
HFA Best Practice Standard 6-4.A

POLICY: HFNY utilizes evidence-informed curriculum materials and promotes child development, parenting skills, and health and safety practices with families.

Intent: Curricula materials are to be used in conjunction with teachable moments, parental interests, and shared with parents using strength-based approach building on parental capacity (e.g. emergent curriculum use). The curriculum helps the Family Support Specialist provide anticipatory guidance and supports parents in thinking about what their babies next phase of development will be, and how they can support this development.

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

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

Curriculum will contain a variety of components which include;

- Information on how to promote nurturing parent-child relationships (e.g., gives parents a positive sense of their new role, makes mom or dad unique to this baby, supports the development of empathy, focuses on experience versus what is "right or wrong", anchors baby's current behavior to future development, builds parental self-esteem, encourages parents to have fun playing with their baby)
- Child development information and how to share this in a strength-based manner
- Content that is developmental in nature
- Strategies that strengthen families and their relationships
- Health and safety information such as safe sleep, breastfeeding, pre and postnatal health care, well-child care, dental and oral health and lead exposure

1. The Ages and Stages Questionnaire (ASQ) and ASQ-Social/Emotional (SE) are used to monitor child development status and as a teaching tool with parents to build knowledge and promote appropriate developmental expectations.
2. Child development and parenting skills are also promoted through the use of evidence-informed curriculum routinely during home visits with all families.
3. Sharing health and safety information that includes prevention strategies as well as areas of concern observed in the home. Concerns that can result in harm are addressed frequently until resolved.
4. Evidence informed curriculum promoting child development, parenting skills and health and safety is expected to be used in most home visits. Should the family be experiencing a challenge, the Family Support Specialist must use their judgement on the best way to meet the family's needs.

5. All curriculum and handouts provided, are documented on the Home Visit Log. Narrative. The Family Support Specialist provides detailed information in narrative form on home visits record to capture what was shared during the home visit and the family's response to the information.
6. The Service Plan will be used to document curriculum to be shared with families to address risk factors identified.
7. Additional checklists, handouts and brochures promoting positive parent child interaction, knowledge of child development and health and safety practices, that have been approved by the site, are used to supplement the use of curriculum.

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MIS References:

Home Visit Log

Appendix:

HFNY website
https://healthyfamiliesnewyork.org/default.htm
HFNY Approved Evidence Informed Curriculum
https://www.healthyfamiliesnewyork.org/Staff/curriculum.htm

Insert Site specific procedures that include:

1. How staff promote child development, including any curricula and/or tools to be used in most home visits.
2. How staff promote parenting skills, including any curricula and/or tools to be used in most home visits.
3. How staff promote health and safety related practices, including any curricula and/or tools to be used in most home visits.
4. How the Supervisor and Home Visitor will use the service plan to document curriculum used to address risk factors.
5. How staff will be documenting in the home visit log what curriculum was used in the home visit.

DEVELOPMENTAL SCREENING (EFFECTIVE 1/4/2019)
HFA Best Practice Standard 6-5.A

POLICY: HFNY monitors the development of participating infants and children with the Ages and Stages Questionnaire (ASQ-3) and the Ages and Stages Questionnaire SE (ASQ-SE2), which are standardized developmental screens.

Intent: The ASQ-3 and ASQ:SE2 screening tools are used as a means of partnering with parents in observing their child's development and to see the significance of their role in supporting that development, and to determine the need for further assessment, typically an in-depth developmental assessment by Early Intervention and/or the Committee on Preschool Education (CPSE).

1. FSSs utilize the standardized child development screening tool, ASQ-3 and ASQ- SE2 for all target children, unless developmentally inappropriate.
2. If the child is engaged in early intervention services, staff is not required to complete the ASQ during that time. Staff should coordinate services and obtain updates from Early Intervention (with signed parental consent).
3. The ASQ-3 is administered at a minimum of twice per year for children under the age of three and annually for children ages three through five years.
4. The ASQ:SE-2 is to be administered at a minimum of once per year and can be done as early as at 6 months.
5. The ASQ-3 and ASQ:SE-2 are used in partnership with parents, during the home visit and are administered in accordance with tool instructions to ensure accuracy, including adjusting for prematurity when needed and allowing no more than a 30-day window on either side of the administration due date.
6. All ASQ-3s and ASQ:SE2s are reviewed, documented and followed up by a Developmental Specialist.
7. All administration dates and scores are entered into the MIS to monitor completion for all target children, and to help track referrals to Early Intervention and/or CPSE when indicated by scores that fall below cut-off in any domain.
8. Any concerns identified from the developmental screens should be discussed at supervision and plans or interventions noted on the Service Plan.
9. If the ASQ-3 or ASQ:SE-2 schedule is revised for any reason, or the family declines the opportunity to screen their child, it is documented on the home visit log.
10. All staff who administer the ASQ-3 and the ASQ:SE-2 will complete training on the use of the tool prior to using it.

MIS References:
ASQ History Report

Appendix:
None

Insert site-specific procedures that include:

1. How your site utilizes the ASQ-3 and ASQ:SE2 as developmental screening tools with all families unless developmentally inappropriate or if the child is already receiving early intervention services.
2. Describe the timeframes for administration of the developmental screening tools.
3. Describe how ASQ-3 and ASQ:SE2 are reviewed by the Developmental Specialist and the follow up process.
4. Describe how the FSS and supervisor discussions on plans and interventions are documented.

5. Describe how staff are trained on how to administer the tool prior to using it with families.

NOTE: 6-5. B is a SENTINEL STANDARD

TRACKING DEVELOPMENTAL DELAYS (EFFECTIVE 1/14/2019)
HFA Best Practice Standard 6-6.A

POLICY: HFNY tracks child development and follows up on all children who are suspected of having a developmental delay.

Intent: It is central to the goals of HFNY that child development is observed and monitored, and that any indications of delay are discussed with parents, and parents are supported in accessing more in-depth assessment from the child's primary care provider, Early Intervention and/or Committee on Preschool Education (CPSE). Follow-up on referrals is a significant support to parents and is, therefore, expected and tracked. Ensuring families' access to services is a team effort, so the program manager and supervisor should be aware of any challenges with referral sources for early intervention services and assist by advocating with referral entities/partners to reduce these barriers. The completed ASQ-3 and ASQ:SE2 Summary Sheets indicate whether the child appears to be developing on target or has any potential developmental delays.

1. In the event an ASQ-3 or ASQ:SE-2 indicates a possible delay in one or more developmental areas, the FSS discusses the results with the parent and the supervisor. If deemed appropriate, the FSS facilitates a referral to the local Early Intervention Services, the child's primary care physician and/or CPSE, with parents' signed consent unless the family declines the service (declines should be documented in the family file and/or Case Notes).
2. If the ASQ reflects scores in the gray area only, the supervisor and FSS will discuss activities to address the gray areas and schedule to rescreen at the next age interval. If scores in the gray area persist, the FSS will discuss a referral with the parent.
3. If the ASQ reflects scores in the black area, the FSS will discuss immediately with the supervisor and discuss the referral with the parent.
4. The FSS communicates with Early Intervention Services and/or CPSE (with signed consent) to learn about services provided and how to best support the family with those services.
5. The supervisor ensures all children with a suspected developmental delay are closely monitored and tracked. The supervisor ensures necessary follow-up and that the FSS is providing appropriate resources to the family; these are documented in Supervision Notes. MIS system documents referrals, follow-up, and the utilization of developmental resources, services and intervention.

MIS References:
HFNY Case Notes

Appendix:
HFNY Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf

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Insert site-specific procedures that include:

1. Describe the process for follow-up when there is a suspected developmental delay
  a. Describe how the supervisor and FSS work together to identify when to make a referral, the referral resource to be used and how referrals are made.
2. Describe how referral outcomes are discussed and the follow-up process.
3. Describe how staff collaborate with families and service providers in the process of the family's receipt of services in a way that supports the family's access and utilization of resources, services and intervention.

NOTE: 6-6. B is a SENTINEL STANDARD

Medical/ Health Care Provider (EFFECTIVE 3/1/19)
HFA Best Practice Standard 7-1.A

POLICY: All target children will have a health care provider to assure optimal health and development, and support is provided to assist parents in using health care appropriately for their children.

Intent: It is important for each target child to have a medical home (partnership between the family and the child's primary health care professional) and to utilize preventive health care practices for children. The site is to have a process for informing and connecting target children to medical/health care providers 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.

1. Information regarding the medical/health care provider is collected and documented during the visit **in** which the Parent Survey is completed.
2. FSSs assist the parent in securing preventive health care services, understanding the importance of a medical home, and reminding parents of upcoming immunizations, well-child and/or prenatal care visits.
3. When necessary, FSSs assist in coordinating health services through direct communication with the medical provider or physician office staff (with signed consent).
4. FSSs assist families in addressing barriers to obtaining health care services.
5. FSSs track and document the receipt of immunizations and well-baby care visits according to time frames indicated by the CDC, and any other medical care, on the TC Medical Form in the MIS.

MIS References:
TC Medical Form

Appendix:
None

Insert site-specific procedures that include:

1. How sites will ensure that all target children have a medical/health care provider.
2. How FSSs will support parents in using health care appropriately for their children.
3. Specific data to be collected, time frames for collection, and where these are documented.

IMMUNIZATIONS (EFFECTIVE 3/1/19)
HFA Best Practice Standard 7-2.A

POLICY: Families receive education on the importance of immunizations, and children are up to date on their immunizations.

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

1. FSSs provide information to parents regarding the importance of immunizations and encourage timely receipt of immunizations according to the immunization schedule recommended by the American Academy of Pediatrics.
2. FSSs share an immunization schedule with parents. One example is the schedule of immunizations from the CDC individualized scheduler at http://www2a.cdc.gov/nip/kidstuff/newscheduler_le/.
3. FSSs document all scheduled immunizations and well-baby care visits on the TC Medical Form in the MIS.
4. When immunizations are missed, FSSs record the explanation on the Home Visit Narrative and work with parents to reschedule and address any barriers to getting the immunizations (i.e., transportation, language barriers, etc.)
5. FSSs document the target child's health care provider on the Target Child Identification and Birth Outcomes form in the MIS, and after that, on the Follow-Up form. Programs also document the current medical provider for the Primary Caretaker 1 on the Intake form and after that, on the Follow-Up form. There is no need to wait for a Follow-up form to be due when a family has a new doctor. This change can be documented on the Change Form and on the Medical Provider tab of the Case Home Page in the MIS.
6. Programs are required to report on Primary Caretaker 1 and Target Child having a medical provider, a HFNY Performance Target, on a quarterly basis.
7. Should a child have a medical reason for not getting immunizations or the family is declining immunizations owing to personal beliefs, this is documented in the family file and on the tracking form.

MIS References:

Quarter Performance Targets
Four Quarter Performance Targets
PC1/TC Medical Provider Listing
7-2. B/C Target Child Immunization

Appendix:

None

Insert site-specific procedures that include:

1. How parents are educated regarding the importance of immunizations
2. How receipt of immunizations is tracked per child
3. How FSSs work with parents when immunization appointments are missed

REFERRALS/ LINKAGES TO HEALTH CARE AND COMMUNITY RESOURCES (EFFECTIVE 3/1/19)
HFA Best Practice Standard 7-3.A

POLICY: Families receive information, referrals, and linkages to available health care resources and other community resources based on family need and interest, and follow-up to ensure that families receive the services to which they were referred.

Intent: Sites are encouraged to provide information, referrals and linkages for all participating family members including the target child. Information could include a variety of topics which may benefit all participating members (e.g., smoking cessation support groups, free health clinics for adults, immunization clinic, 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 of health care resources within the community and are 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 medical care provider). Therefore, if a family is receiving necessary services/care, there may be no need for further provision of the above-mentioned services.

1. During initial assessments and ongoing contact with families, FSSs assess needs and provide information and referrals to health care and other community resources as needs are identified.
2. FSSs are knowledgeable and well connected to community services that might be beneficial for families.
3. Depending on each family's capacity and comfort level, FSSs are involved in varying ways and intensity levels when making referrals. Involvement can range from solely providing referral information to the parent, to making the initial contact with referral source (with signed consent), to accompanying the family to the initial appointment.
4. When referrals are made, FSSs follow-up with the family and/or the referral source (with signed consent), as necessary, to support the connections and promote follow-through.
5. All referrals, follow-up actions, and outcomes are recorded on the Home Visit Narrative and Service Referral Form.

MIS References:

Case Filter/Site Options

- **Count of Service Referrals by Code**
- **Quarterly Service Referrals**
- **Parent Survey PC1 Issues**
- **Service Referrals Needing Follow-Up**

Appendix:

None

Insert site-specific procedures that include:

1. The process for assessing need and interest, and providing information, referrals and linkages to available health care and community resources for all participating family members.
2. The follow-up mechanisms used to determine whether parents received the services they were referred to, and how well they have met the families' needs.

DEPRESSION SCREENING (EFFECTIVE 3/1/19)
HFA Best Practice Standard 7-4.A

POLICY: FSSs conduct depression screening with the primary caregiver in each family using the PHQ-2 and the PHQ-9, standardized instruments.

Intent: With the extreme stress that many families experience, the risk of depression is high. When parents are depressed, their ability to be responsive and emotionally available to their child may be reduced, and they may negatively misinterpret their child's response to them. Screening for depression both during the prenatal and postnatal period allows home visitors to assist parents in becoming aware of the depression and determining if there are depressive issues that need to be addressed by a clinician.

Staff must receive training to administer a depression screen and be prepared to respond to the results of the screen, including developing relationships with service providers in the community.

Sites can refer to www.hfnymis.org/docs/PHQ9-procedures.pdf for guidance on timeframes and documentation for depression screening.

Staff members are not therapists, and it is critical for home visitors to support parents in alleviating their depression while a parent is awaiting treatment or while considering treatment options. They need to be prepared to: Provide referrals; use supervision for assistance in discussing depression with parents; promote stress reduction; employ Motivational Interviewing tools and strategies; encourage parents' efforts to meet their child's physical and emotional needs; and follow protocols for addressing critical situations.

PHQ-9 scores are interpreted as follows:

Total Score	Depression Severity	Action Steps
1-4	Minimal depression	Watchful waiting
5-9	Mild depression	Watchful waiting
10-14	Moderate depression	Referrals
15-19	Moderately severe depression	Referrals
20-27	Severe depression	Active Treatment- Contact with Supervisor

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

1. Home visitors conduct depression screening using the PHQ-2 and PHQ-9 Depression Screens with all primary caregivers to assess for risk of perinatal depression, in accordance with the tool developer guidelines.
2. The PHQ-2 is administered during the assessment process and is incorporated into the Parent Survey form. Screenings are documented on the Home Visit Narrative and in supervision notes. If the participant (s) score is a 3 or more, the PHQ-9 should also be given.
3. The PHQ-9 is administered:
   - Within 30 days of the first prenatal home visit (if serving the family prenatally), and documented on the Intake Form
   - Within the first three months of the baby's birth for families enrolled postnatally, and at least once within three months of all subsequent births. This is documented on the Target Child Identification and Birth Outcomes form.

4. Depression screening will also be administered any time during home visiting services if a parent is displaying or reporting depressive behaviors or symptoms. This includes fathers as determined necessary by the FSS and supervisor.
5. Families receive education on risks for, and signs and symptoms of perinatal depression during the course of home visits, and specifically when the PHQ-9 is administered. If the participant scores positive on question 9 of the PHQ-9, move to the site-specific safety protocols.
6. If a participant's score on the PHQ-9 indicates depression, they are referred to mental health resources in the community (or provider of family's choice) for a follow up mental health assessment. If a participant scores 20 or above, the home visitor must consult immediately with the supervisor for emergency treatment referrals.
7. In the instances where the depression screening is done as a part of a collaborative process with other service providers involved with the family, the site must be in receipt of a copy to show that the screen was completed on time and to make and track any necessary follow-up referrals or interventions for the family.
8. The FSS and supervisor discuss the results of depression screens and develop plans to assist the family (i.e., addressing problem solving, building positive self-esteem, building family supports, referrals, etc.) as needed.
9. FSSs promote stress reduction, and support parents to be responsive to their child's physical and emotional needs
10. FSSs share community resource information with all families when they enroll in the program. For families at risk of depression, home visitors highlight community resources that specialize in depression, and encourage and assist families to access these resources. All families are given the suicide prevention hotline number, as well as contact information for mental health clinics.
11. If a referral is needed, the FSS documents the referral, as well as the outcome of the referral on the Service Referral Form.
12. When depression screen scores are elevated or are considered at-risk of depression, FSSs use activities to support the primary caregivers, such as:
    a. Providing linkages and referrals to appropriate resources
    b. Providing referrals for mental health consultation (when available)
    c. Using motivational interviewing (when trained) to assist parents in accepting resources, treatment
    d. Utilizing supervision to assist staff in discussing depression with parents
    e. Getting parents out in the sunshine (sun increases serotonin)
    f. Encouraging parents to walk, exercise, or engage in other forms of physical movement
    g. Encouraging parents to smile (even a "practice" smile increases serotonin)
    h. Encouraging parents to keep hydrated (hydration increases brain functioning)
    i. Encouraging self-care
    j. Practicing gratitude
    k. Using healthy strategies that have worked for the parent in the past
    l. Utilizing Procedures for Working with Families in Acute Crisis
    m. Encouraging parents to meet their baby's physical and emotional needs
    n. Using other strategies/activities identified locally
13. All staff who administer the PHQ-2 and PHQ-9 will complete training on the use of the tool prior to using it.

MIS References:

Intake Form
TC ID

Appendix:

Procedures for Working with Families in Acute Crisis*
https://app.box.com/s/kd2bfdeecpqjtqjyzf9c

Insert site-specific procedures that include:

1. That the PHQ-9 is used to screen for depression.
2. How the depression screening tool is to be used
3. When the depression screening tool is to be used.
4. Community resources and information for agencies and programs that provide services to address depression.
5. Activities appropriate for home visitors to do with families to address stress and depression.
6. That staff are trained prior to administering the tool, and who administers the training.
7. Safety protocol for staff if the suicide screening question is positive.

NOTE: 7-5. B is a SENTINEL STANDARD

CASELOAD SIZE (EFFECTIVE 11/27/19)
HFA Best Practice Standard 8-1A & 8-2A

POLICY: FSSs have limited caseloads with maximum caseloads determined by the chart below according to the number of hours a full-time FSS works at a program, or using the formula included below for FSSs that work less than fulltime in that role (BPS 8-1. A). FSSs may carry a total caseload of more than the maximum families below if their case weight is 15 points or less (which can happen if an FSS caseload is largely comprised of Level 3 and 4 families). Family assignments and FSSs' caseloads are managed to ensure staff have sufficient time to support the needs of families during home visits (BPS 8-2. A). Other considerations should be considered when managing caseload sizes such as, but not limited to, potential FSS conflict or boundary challenge due to an existing personal relationship, FSS experience and skill level, and the nature and difficulty of problems encountered with families.

Intent: Services are provided by staff in accordance with principles of ethical practice and with limited caseloads. This helps assure that adequate time is spent with families to build trusting, nurturing relationships that allows home visitors to meet families' unique and varying needs and to plan for future activities.

	Max weight	Max # of families	
Maximum Caseloads by Hours Worked			
		When all families served are on level 1	When families served are at a variety of levels
40-hour week	30 max weight	15	25
37.5-hour week	28 max weight	14	23
35-hour week	26 max weight	13	21
20-hour week	15 max weight	7	12
Formula for maximum caseload for part-time workers			
	.75 x number of hours per week	.375 x #hrs./wk.	.625 x #hrs./wk.

Caseloads are limited to ensure that home visitors have sufficient time and resources to serve families most effectively. Sites may set lower caseload expectations and serve fewer families under special circumstances. Any decisions regarding case weights that are higher or lower than expected must be discussed with the OCFS program contract manager. These conversations should be documented in supervisor notes or team meeting notes, wherever most appropriate.

1. The supervisor and home visitor monitor caseload size during supervision.
2. The chart above determines a full-time home visitor's maximum number of families and maximum case weight that can be served according to the number of hours worked a week.
3. The site will prorate caseload size based on the home visitor's full-time equivalency.
4. There may be temporary periods when case weights exceed maximum size (for example, a home visitor leaves the program and the caseload is dispersed among existing home visitors until another home visitor is hired). When this occurs, the reason is clearly documented and includes the amount of time that the case weights were out of adherence with this policy, and sites ensure that the time does not exceed three months.
5. When making caseload assignments, the supervisor will take into consideration the following:
   a. Experience and skill level of the FSS assigned
   b. Nature and difficulty of the problems encountered with families
   c. Work and time required to serve each family

d. Families with multiple births count as an additional .5 weight when calculating an FSS case weight.
e. Consideration of potential worker conflict or boundary challenge owing to an existing personal relationship
f. Number of families per home visitor which involve more intensive intervention
g. Travel and other non-direct service time required to fulfill the home visitor's responsibilities
h. Extent of other resources available in the community to meet family needs
i. Other assigned duties of the FSS

MIS Reports:

FSS Case List
Enrolled Program Caseload Information
FSS Home Visit Narrative
Supervisor's Case List
Home Visiting Completion Rate Analysis

Appendix:

Home Visiting Levels Table
https://www.healthyfamiliesnewyork.org/Staff/Documents/Home%20Visiting%20Levels%20Table.pdf

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Insert site specific procedures to include:

1. Caseload size is monitored by the supervisor and FSS during supervision using the Program Caseload Summary in the HFNY Management Information System.
2. The site's caseload system including weighted points is described in Policy 4-2. A. A full time FSS will have no more than the number of families on a variety of levels, number of families on the highest level of service, and case weight according to the chart above that corresponds to the number of hours worked in a week.
3. The supervisor may use discretion in assigning more than the allowed number of families if the FSS's case weight is 15 or less (for example: carrying all Level 3 and Level 4 families).
4. If a staff person is less than full time, the caseload size will be pro-rated based on their number of hours worked per week.
5. When making caseload assignments, the supervisor will take into consideration the following:
   a. Experience and skill level of the FSS assigned
   b. Nature and difficulty of the problems encountered with families
   c. Work and time required to serve each family
   d. Families with multiple births count as an additional .5 weight when calculating an FSS case weight.
   e. Consideration of potential worker conflict or boundary challenge owing to an existing personal relationship
   f. Number of families per home visitor which involve more intensive intervention
   g. Travel and other non-direct service time required to fulfill the home visitor's responsibilities
   h. Extent of other resources available in the community to meet family needs
   i. Other assigned duties of the FSS

SELECTION OF STAFF (EFFECTIVE 7/1/19)
HFA Best Practice Standard 9-1.A

Policy: The system for hiring new staff takes into account the candidates' personal characteristics, experience, knowledge and skills.

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

1. The site maintains and utilizes job descriptions for program managers (or the equivalent title), supervisors, and all direct service staff which includes all requirements listed in the HFA Best Practice Standards as well as additional requirements set forth by host agencies.
2. The requirements of the Equal Opportunity Act are adhered to per agency policy and Equal Employment Opportunity practices are noted on materials posted throughout the agency and on employee job applications
3. The site reviews resumes to ensure that minimum educational and experiential requirements are met. **Program manager** resumes must be sent to Central Administration for review and approval to hire. Programs must submit resumes of any supervisors who do not meet the minimum qualifications to Central Administration for review and approval.
4. The site utilizes standardized interview questions with all potential applicants corresponding to the position for which they applied. These interview questions include questions to determine the applicant's Reflective Capacity and assess the applicant for all the characteristics outlined in standards 9-1. B-D of the HFA Best Practice Standards.
5. The site maintains documentation of the completed standardized interview questions for any new hire and stores them in a confidential manner.
6. The site conducts two reference checks on prospective employees prior to hire and maintains these records in the personnel file.
7. The site conducts legally permissible criminal background checks on prospective employees prior to hire and maintains these records in the personnel file. Sites may also check the State Child Abuse Maltreatment registry.

STAFF SELECTION

Screening and selection of **program managers** includes, but is not limited to:

- Master's degree in public health or human services administration or fields related to working with children and families, or bachelor's degree with 3 years of relevant experience
- A solid understanding of and experience in managing staff
- Administrative experience in human service or related field, including experience in quality assurance and improvement, and site development
- Experience with and commitment to reflective practice
- Infant mental health endorsement preferred
- Final selection for program managers **must** be approved by the HFNY Central Administration

Screening and selection of **supervisors** includes, 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 three years of relevant experience
- A solid understanding of or experience in supervising and motivating staff, as well as providing support to staff in stressful work environments
- Knowledge of infant and child development and parent-child attachment.

- Experience with family services which embrace the concepts of family-centered and strengths-based service provision
- Knowledge of maternal-infant health and dynamics of child abuse and neglect
- Experience in providing services to culturally diverse communities/families
- Experience in home visiting with a strong background in prevention services to the 0-3 age population
- Infant mental health endorsement preferred
- Experience with reflective practice preferred

** For Internal candidates, Healthy Families New York allows for selection of supervisors, a combination of education, experience, implementation of a staff development plan, and prior HFNY Central Administration approval.** Please note that this will NOT meet Healthy Families America Best Practice Standards for Accreditation.

Note regarding HFA Accreditation: Program managers and supervisors hired prior to July 1, 2014 will need to demonstrate at least a bachelor's degree. Additional criteria above will be applied to staff hired July 1, 2014 or after. Also, note that a staff development plan can be developed and implemented to support any experiential gaps at the time of hire, however it **cannot** compensate for education. The minimum education requirement must be met.

Screening and selection of **direct service staff** (including volunteers and interns performing the same function as paid staff) includes, but is not limited to:

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

Any exceptions to these staff screening and selections requirements must be discussed with and approved by HFNY Central Administration prior to hire.

STAFF RETENTION AND SATISFACTION
HFA Best Practice Standard 9-4

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.

The site evaluates and reports on personnel satisfaction and turnover at least once annually, utilizing staff satisfaction surveys. If any issues are identified from the compiled satisfaction survey responses of current staff, as well as issues that impacted staff who left employment, the site will develop strategies to address how it plans to increase staff retention.

MIS Reports:

Quarterly Worker Characteristics

Appendix:

Sample interview Questions (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/sample-interview-questions-spanish/
https://www.healthyfamiliesamerica.org/network-resources/sample-interview-questions/
Interview Rating Scale
https://www.healthyfamiliesnewyork.org/Staff/Documents/Interpersonal_Rating_Scale.pdf

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Insert site-specific procedures that include:

1. The site's system for screening and selection of all staff ensures that it considers all of the personal characteristics of job candidates as listed above, and staff meet the criteria.
2. That 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.
3. How the site actively recruits, employs, and promotes qualified personnel and administers its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, handicap, sexual orientation, or religion of the individual under consideration.
4. The site's recruitment and selection practices are in compliance with applicable law or regulation and must include:
   a. The process for internal and external recruitment.
   b. Use of standard interview questions that comply with employment and labor laws, and address knowledge and skills needed for the job, and demonstrate ability to establish and maintain a strengths-based program culture and applicant's reflective capacity.
   c. Verification of 2-3 references and/or letters of recommendation and credentials. If hired from within the organization, performance appraisals may suffice.
5. How the site will ensure that all employed site staff have had legally permissible background checks completed at the time of employment, including criminal background checks. State child abuse and neglect registries may have been checked in addition. The site is knowledgeable about what is legally permissible and usable in screening applicants, and it carefully follows all mandates. (HFA BPS 9-3. B) NOTE: This is a Safety Standard.
6. Include job positions, selection criteria and duties for other positions not listed above, such as assistant program manager, child development specialist, fatherhood advocate, or others.
7. How the site monitors and analyses staff retention and satisfaction annually, and evidence that it develops and implements strategies to address any issues discovered through this process.

TRAINING PLAN/POLICY (EFFECTIVE 9/25/20)
HFA Best Practice Standards 10 & 11

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

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

Intent: The overall intent of the standards in this section is to ensure staff receive training specific to their role. HFA Core training is required for all Family Support Specialists, Family Resource Specialists, and Supervisors, within six months of hire. Program managers hired after July 1, 2014 who supervise direct service staff are required to attend all three HFA Core trainings within six months from starting that position (one HFA direct service Core training and the Supervisor Core training within six months and the remaining Core training within 18 months if not providing supervision to direct service staff). *HFNY differs in that it requires all staff to receive Core training before they begin assessing or home visiting families and within six months of date of hire. This training must be provided by a nationally certified HFA Core trainer. In addition, there are seven orientation training topics required to be received by staff prior to work with families.

Additionally, these standards ensure staff receive the training support and have the skill set necessary to fulfill their job functions and achieve the site's goals with families. Training is geared to the unique aspects of services with which staff are engaged, and is culturally respectful, taking into account each staff member's skills and needs.

ORIENTATION TRAINING
HFA Best Practice Standard 10-2 A-G

Policy: Staff (Family Resource Specialists, Family Support Specialists, Supervisors and Program Managers), receive orientation training (separate from intensive role specific training) subsequent to HFA hire date and prior to direct work with families to familiarize them with the functions of the site.

Program Managers hired July 1, 2014 or later will receive orientation training within 3 months of hire. Program Managers hired prior to July 1, 2014 are grandfathered and not required to document receipt of orientation topics.

There are seven required orientation topics to be received by all staff prior to work with families:

1. All staff members are oriented to their roles as they relate to HFA's goals and services, the philosophy of home visiting/family support, and the principles of ethical practice subsequent to their HFA hire date and prior to direct work with families or supervision of staff. (10-2A)
2. 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 subsequent to their HFA hire date and prior to direct work with families or supervision of staff. (10-2B)
3. All staff members are oriented to the site's relationship with other community resources subsequent to their HFA hire date and prior to direct work with families or supervision of staff. (10-2C)

4. All staff members are oriented to child abuse and neglect indicators and reporting requirements subsequent to their HFA hire date and prior to direct work with families or supervision of staff. (10-2D)
5. All staff members are oriented to issues of confidentiality prior to direct work with families or supervision of staff. (10-2E)
6. All staff members are oriented to issues related to boundaries subsequent to their HFA hire date and prior to direct work with families or supervision of staff. (10-2F)
7. All staff members are oriented to issues related to staff safety subsequent to their HFA hire date and prior to direct work with families or supervision of staff. (10-2G)
8. In addition to the required orientation training topics, all staff members are required to shadow trained staff to assist new staff in becoming familiar with their role.

MIS Reports:

Training/10-2 Orientation Training
Training/Shadowing
Training/Required Topics

Appendix:

NOTE: All staff hired after 1/1/18 are oriented to their roles as they relate to HFA goals and services, the philosophy of home visiting/family support, and the principles of ethical practice subsequent to HFA hire date and prior to direct work with families or supervision of staff. For staff hired before 1/1/18, training on the principles of ethical practice is required to be completed by six months after the release of this policy. Sites are encouraged to use an established Code of Ethics, such as codes developed for nurses, social workers, early childhood professionals, or a multi-disciplinary Code of Ethics for Human Service Professionals. (https://www.nationalhumanservices.org/ethical-standards)

Insert site-specific policies and procedures that include:

A description of how orientation training is provided: when it is used, what is the content of the training, how it is delivered and by whom, and how it is documented.

STOP GAP TRAINING
HFA Best Practice Standard 10-3

Policy: All staff is required to receive training specific to their position. HFNY does not allow stop-gap training as a temporary or long-term solution to the need for role-specific training for any role but supervisor. Under extreme circumstances, when in-person trainings are not possible for an extended period of time, HFNY Central Administration may approve an exception to allow FSSs and FRSs to work in the field independently after completing an enhanced stop-gap training. This enhanced stop-gap training will require new staff to complete the HFA stop-gap training independently with the support of their supervisor and participate in enhanced sessions facilitated by PCANY. This facilitation is typically done virtually. Staff will still need to complete the full four-day core training for their role when available. For a supervisor, stop-gap training may be used only as a short-term solution and does not replace the requirement to attend Supervisor Core training.

Stop-gap needs to be conducted by someone who has been intensively trained in the role they are providing stop-gap training for. Stop-gap training may be provided to supervisors so that they can begin to support staff prior to attending Supervisor Core only if all of the following conditions are met:

1. The supervisor has attended either FSS or FRS core, or both, depending on which roles they will be supervising.
2. They have not had the opportunity to attend their role-specific training prior to the site's need for the supervisor to begin supervision practice.
3. Stop-gap training is provided by someone who has completed Supervisor Core.
4. Stop-gap training for the supervisor is required to include the following for each role the supervisor will be supervising:
   - **a.** A clear description of the "HFA Advantage" (what makes HFA unique including trauma informed practice, the power of relationships/attachment, and reflective capacity).
   - **b.** Shadowing of other supervisors
   - **c.** Training on forms used by supervisors
   - **d.** Hands-on practice, with observation and feedback
   - **e.** Inter-rater reliability and/or other documentation review as it relates to the roles that you are supervising
   - **f.** Use of a strengths-based approach when working with others
5. The supervisor attends Supervisor Core training provided by the Training and Staff Development Team within six months after they have started supervising staff.

MIS Reports:

Training/Required Topics
Training/Shadowing
Training/Data Training

Appendix:

HFA FRS Stop-Gap Training for Supervisors (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/stop-gap-supervisors-of-family-resource-specialists/

HFA FSS Stop-Gap Training for Supervisors (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/stop-gap-supervisors-of-family-support-specialists/

Insert site-specific policies and procedures that include:

A description of how stop-gap training is provided: when it is used, what is the content of the training, how it is delivered and by whom, and how it is documented.

ROLE SPECIFIC TRAINING
HFA Best Practice Standard 10-4

Policy: Staff (Family Resource Specialists, Family Support Specialists, Supervisors, and Program Managers supervising direct service staff) receive role-specific HFA Core training from a HFA certified trainer within six months of date of hire. Program managers who do not supervise any direct service staff are required to receive one HFA Core training (either FSS or FRS) and the Supervisor Core training within six months of hire and the remaining Core training within 18 months. Exceptions may be granted when the contract execution/renewal process presents a barrier and should be discussed with the program contract manager.

NOTE: THIS IS A SENTINEL STANDARD.

Intent: Intensive training fosters the knowledge and skills necessary to achieve program 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. 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.

All staff receives Core training that is provided by an HFA certified trainer.

Program Managers hired after July 1, 2014 who supervise direct service staff are required to attend all three HFA Core trainings within six months from starting that position (one HFA direct service Core training and the Supervisor Core training within six months and the remaining Core training within 18 months if not providing supervision to direct service staff), as well as attend HFNY Program Manager Orientation at the next available training date. Program managers hired prior to July 1,2014 will be "grandfathered," and do not need to demonstrate evidence of receipt of HFA Core training, unless the program manager also supervises direct service staff or supervises a supervisor carrying a caseload of 4 or more families. Even if not required, program managers are strongly encouraged to attend HFA Core trainings.

All Program managers hired on or after January 1, 2018 receive HFA Implementation training from the HFA National Office within eighteen months of date of hire, to understand the essential components of implementing the HFA model. HFA Implementation training is strongly encouraged and optional for program managers hired prior to January 1, 2018. Program managers who have attended Implementation training prior to January 1, 2018 do not need to re-take the training. Please note: In situations where the program manager's time commitment to the site is extremely limited or divided among different individuals, the program manager may designate another staff person to attend instead. This happens infrequently and so must be discussed with an HFA Implementation Specialist for approval.

Supervisors are required to complete the HFNY Supervisor Core Training within six months of starting that position. While supervisors may begin supervising staff without having attended the HFNY Supervisor Core training, HFNY policy requires that supervisors attend the role specific core training (FSS or FRS) prior to supervising staff in that role. Supervisors hired after July 1, 2014 are required to attend both FSS and FRS core trainings within six months of starting the supervisor position if they have not completed them previously to further ground them in the model, and to ensure they are able to effectively support staff to implement assessment and home visiting skills learned in training. Supervisors hired prior to July 1, 2014 are required to, at minimum, have attended HFA Core Training for all roles they directly supervise prior to providing supervision.

FRSs begin assessing families only after FRS Core training has been completed and are required to receive core training within 6 months of starting work in that role.

FSSs make home visits unaccompanied by other staff only after FSS Core training has been completed and are required to receive core training within 6 months of starting work in that role.

Cross-Trained Staff are required to receive additional core training specific to their new or added role before providing services specific to that role. Training is required to take place within 6 months of starting in the new role. In order to maintain a skilled approach, all direct service staff who have completed FRS training and are active in the role are required to complete parent surveys in accordance with the HFNY QA Policy.

Returning Staff

A training plan is developed by the program manager and the Training and Staff Development Director for each returning staff person prior to the staff person providing services to families.

Any staff person returning to the state system after an absence from HFA program practice of 3 or more years is required to attend the entire HFNY training process for new staff.

MIS Reports:

Training/10-4 Intensive Role Specific Training for Staff
Training/2-2.C Parent Survey Training
Training/ No Home Visits before FSS Core Training
Training/Required Topics

Appendix:

None

No-program specific policy and procedures required here.

WRAPAROUND TRAININGS
Best Practice Standards 11-1, 11-2, & 11-3

Policy: Staff (Family Resource Specialists, Family Support Specialists, and supervisors) receive training on a variety of topics necessary for effectively working with families. Specific trainings are required within three months of the date of hire, within six months of the date of hire, and within twelve months of the date of hire. The required topics and subtopics are outlined in the "Required Trainings" grid at the end of the training policy. Program managers are required to receive all of the trainings within eighteen months of their date of hire unless directly supervising staff.

ONGOING TRAININGS
Best Practice Standard 11-4

Policy: The site ensures Family Resource Specialists, Family Support Specialists, Supervisors and Program Managers hired more than twelve months receive ongoing training on an annual basis which takes into account the individual's knowledge and skill base. Please note: In the second year of hire and every year thereafter, all staff (Program Managers, Supervisors, Family Resource Specialists and Family Support Specialists) receive ongoing training to support ongoing professional development (all staff do not have to attend the same training).

HFNY TRAINING PLAN (CURRENT PLAN)

Intent: The training plan guides the site towards meeting training expectations in a timely manner with specified timeframes, and clearly identifies how the training is provided and by whom, topics that will be covered in each training, and the site's processes for supervisory follow-up. Additionally, the site addresses how they ensure that the training provided is of high quality.

1. The training plan addresses all topics and subtopics included in HFA Best Practice Standards 10 and 11, as well as the training that is required to administer other tools that are used with families prior to administering the tools with families: Depression screens, developmental screens, etc., as well as training on effective use of curriculum. Supervisors must receive training on all tools their staff administers.
2. Training may be provided by various qualified individuals, including program manager, supervisor, community agency, HFA online training modules, and use various modalities, including video, reading materials, self-study modules, etc.

3. Training tracking includes supervisory verification of all required training received.
4. The MIS tracking includes date of hire, date of first direct service contact or supervision of staff, and date of first administration of tools.
5. Sites track training even when training was received outside of the required timeframe.
6. Learning formats can include attendance at trainings, workshops, and in-services; on-line training; current formal education; certification; licensure; and competency-based testing.
7. There are circumstances when staff may be exempt from wrap-around trainings only, that must be documented in MIS and back-up documentation maintained for review by peer reviewers. Professional experience and previous formal education can qualify as training when coupled with competency-based testing and/or supervisory follow-up to assure successful knowledge acquisition and understanding of concepts and/or materials.
8. Returning Staff: A training plan is developed by the program manager and the HFNY Staff Development and Training Director for each returning staff person prior to them providing service to families. **Any staff person returning to the state system after an absence from HFA program practice of 3 or more years is required to attend the entire HFNY training process for new staff.*
9. Formal education, previous training, and previous experience must have occurred within three years prior to hire and apply directly to the topics identified in order to be counted.
10. Supervisors, FSSs and FRSs hired prior to July 1, 2014 are required to receive at least a majority of the topics listed in the 11-1, 11-2 and 11-3 standards.
11. All staff, including program managers, hired on or following July 1, 2014, are required to receive all of the training topics listed in the 11-1, 11-2 and 11-3 standards. Program managers hired prior to July 1, 2014 are "grandfathered" and not required to show evidence that wrap-around training topics were received, however it is recommended they obtain and document this training, even if received outside the required timeframes.
12. Role-specific Core training cannot be used to satisfy the 3, 6 and 12-month training requirements.
13. Interns and volunteers may not serve as direct service staff and are therefore not subject to the same training requirements. Interns and volunteers may only serve as a support to direct serve staff and will receive training consistent with agency requirements for their role.

Required training for all staff[3]			
All staff receive Orientation Training regarding their role, HFA goals and home visiting philosophy, the site's relationship with community resources, child abuse and neglect indicators, confidentiality, ethical practice, boundaries, and staff safety prior to direct work with families.			
Screening and assessment tools (ASQ, ASQ-SE, PHQ-2, PHQ-9, HITS, Home, Audit-C, CHEERS Check In) – prior to administration			
Within 3 months	**Within 6 months**	**Within 12 months**	**Ongoing training[4] (annually)**
• Infant care • Sleeping • Feeding/Breastfeeding • Physical care of baby • Crying and comforting baby	• Infant and child development • Language and literacy • Physical and emotional • Identifying developmental delays • Brain development	• Child abuse and neglect • Etiology of child abuse and neglect • Working with survivors of abuse	• The staff and supervisors identify training needs and determine what additional training topics would be most beneficial in enhancing job performance, and training is offered
• Child health and safety • Home safety • Shaken baby syndrome • SIDS • Seeking medical care • Well-child visits and immunizations • Seeking appropriate child care • Car seat safety • Failure to thrive	• Supporting the parent-child relationship • Supporting attachment • Positive parenting strategies • Discipline • Parent-child interactions • Observing parent-child interactions • Strategies for working with difficult relationships	• Intimate Partner Violence • Indicators of IPV • Dynamics of IPV • Intervention protocols • Strategies for working with families with IPV issues • Effects of IPV on children • Referral resources for IPV	• Annual child abuse training • Updates on child welfare policies, practices, trends in the community
• Maternal and family health • Family planning • Nutrition • Pre- and post-natal health care • Pre-natal and post-partum depression • Warning signs for when to call the doctor	• Staff related issues • Stress and time management • Burnout prevention • Personal safety of staff • Ethics • Crisis intervention • Emergency protocols	• Substance abuse • Etiology for substance abuse • Culture of drug use • Strategies for working with families with substance abuse issues • Smoking cessation • Alcohol Use/Abuse • Fetal Alcohol Spectrum Disorders • Street drugs • Referral resources for substance abuse	• Annual Cultural Sensitivity Training
• HFNY Family Goal Plan training • Purpose and importance of the FGP process • Helping families identify strengths and needs • Supporting the family to set and achieve	• Mental health • Promotion of positive mental health • Behavioral signs of mental health issues • Depression • Strategies for working with families with mental	• Family issues • Life skills management • Engaging fathers • Multi-generational families • Teen parents • Relationships • HIV and AIDS	

[3] In addition to training prescribed in 10-2 and 10-4

[4] Takes into account the staff members' knowledge and skill base, and assumes Prenatal and Family Goal Plan trainings

meaningful, measurable goals, and build independence • Development of FGPs based on the FSSs' knowledge about the family (including the Parent Survey Assessment), as well as tools completed by the family • Practice writing family goals in ways that help families create measurable goals	health issues • Referral sources for mental health		
	• HFNY Prenatal training • Fetal growth and development during each trimester • Warning Signs: When to call the doctor • Activities to promote the parenting role during pregnancy and the parent child relationship during pregnancy • Preparing for baby • Promoting parental awareness of and sensitivity to the baby's needs with a connection to what the parent is doing (reflection)	• Role of culture in parenting • Working with diverse populations (age, religion, gender, sexuality, ethnicity, poverty, fathers, teens, gangs, disabilities, etc.) • Culture of poverty • Values clarification • Multi-Site System/Central Administration • Goals, objectives, policies and functions of Multi-site system and Central Administration • (All staff hired since January 1, 2018 are required to be oriented to this.)	

Training can be received through a variety of methods including, but not limited to, the following: lecture or interactive presentations by individuals with particular expertise in an area, workshops, college coursework, multi-disciplinary clinical consultations, training presentations by staff members, and self-study with supervisory follow-up. Sites may use the HFA online trainings (TLC) in conjunction with site-based supervision/training to assure successful knowledge acquisition and understanding of concepts. If not using TLC, sites need to maintain training agendas to demonstrate adherence to the standard. Reports printed from the TLC demonstrating that all staff successfully completed each module will satisfy all evidence required for these standards.

MIS Reports:

Training/Required Topics
Training/5-3 Culturally Sensitive Practices
Training/6-5 ASQ/ASQ-SE Training
Training/7-4F PHQ 2/9 Training
Training/10-2 Orientation Training
Training/10-4 Intensive Role Specific Training for Staff
Training/11-1 Wraparound Training for All Staff by 3 months of Hire
Training/11-2 Wraparound Training for All Staff by 6 months of Hire
Training/11-3 Wraparound Training for All Staff by 12 months of Hire
Training/11-2 Prenatal Training for All Staff by 6 months of Hire
Training/11-4 Annual Child Abuse & Neglect Training for all Staff
Training/Data Training

Training/Shadowing
Training/FGP/IFSP Training
Training/Training Tickler
Training/Training Resume

Appendix:

Recommended Order of Trainings
https://www.healthyfamiliesnewyork.org/Staff/Documents/RecommendedOrderofTrainings12152020.docx
Site Training Record (HFNY MIS)

Insert site-specific procedures that include:

1. Staff discusses their annual training goals with their supervisor during their introductory period and as part of annual performance evaluations.
2. All training is documented in the MIS.
3. The site's administration monitors and approves training received to ensure timely access to and receipt of all required training.
4. Supervisors provide new staff orientation prior to direct work with families or supervision of staff.
5. Sites track training on these topics and ensure that staff receive training within required time frames.
6. If the site has received approval from Central Administration to administer additional screening and assessment tools, include expectation that staff is trained to use these tools prior to administration.
7. Site-specific procedures should reflect how the program will demonstrate how all training topics are covered, including documentation on when training took place, how it was delivered and by whom. Evidence should be available as to the content of trainings and how they cover the required topics. MIS training logs on their own are insufficient and should be supported by documentation of training content such as orientation manuals, training outlines, syllabi from training webinars or videos, etc. Core and TLC trainings do not need supporting documentation beyond proof of completion.

ON-GOING SUPERVISION FOR DIRECT SERVICE STAFF (EFFECTIVE 12/17/20)
HFA Best Practice Standard 12-1. A

POLICY: All direct service staff, FSSs and FRSs, receive regular, ongoing supervision, are provided with skill development and professional support, and are held accountable for the quality of their work.

Intent: All full-time direct service staff (Family Resource Specialist and Family Support Specialist) receive weekly individual supervision for 1.5 to 2 hours and part time staff receive at least 1 to 1.5 hours. Supervision sessions must be received individually each week, unless excused owing to the FSS or FRS not working the entire week.

1. Full-time staff and part-time staff that are at least .75 FTE participate in regular, individual supervision for a minimum of 1.5 to 2 hours a week (over a seven-day period). For part-time staff that are .25 FTE to .74 FTE, the requirements are 1-hour weekly (over a seven-day period of time). HFNY Performance Indicators set the expectation that this frequency and duration of supervision is achieved at least 75% of the time.
2. For staff that works less than .25 FTE, supervision may be provided according to role and occurrence of services.
3. Full time supervisors (35 hours a week or more), will supervise no more than five full time direct service staff. The maximum number of direct service staff a part-time supervisor can supervise is pro-rated based on the percentage of time in the supervisory role.
4. Volunteers and interns may serve as a support to direct staff, but may not assume the role of FSS or FRS.
5. Supervision is usually conducted in one session per week. Supervision must be completed in no more than two sessions per week.
6. Supervisors document the dates, duration, and content of all supervisory sessions, in MIS. This is tracked to ensure staff are receiving supervision according to the threshold established in the standard.
7. The only acceptable reason for missing a supervision session is the supervised staff person's absence for an entire "week", calculated as the 7-day period after their assigned supervision date.
8. Group reflective supervision is not officially recognized at this time as contributing to expectations for reflective supervision and will remain unrecognized until the HFNY system encompasses the Infant Mental Health Endorsement.
9. It is required that when staff are in the field, they always have access to a supervisor.

MIS Reports:

Accreditation/12-1.B Regularly Scheduled and Protected Supervision – Details and Summary
Lists/Supervisor Case list

Appendix:

Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

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Insert site-specific procedures that include:

A description of the procedures and practices that ensure that policy expectations are met.

Administrative, Clinical & Reflective Supervision and Professional Support (EFFECTIVE 12/17/19)
HFA Best Practice Standard 12-2.A

Policy: All direct service staff receive regular, ongoing supervision, are provided with skill development and professional support, and are held accountable for the quality of their work.

Intent: All direct service staff (Family Resource Specialists and Family Support Specialists) are provided with supervision including administrative, clinical and reflective components, are held accountable for the quality of their interactions with families on a regular and routine basis and are provided with professional support. Sites are encouraged to develop mechanisms to measure the quality of work as well as develop strategies to provide feedback on performance measures. Sites are to have clear policy and procedures regarding supervision including professional support, skill development and ways to demonstrate accountability for the quality of their work.

1. Supervisors utilize the HFNY Supervisor Form for each supervision session. Supervisor organizes notes within the supervisor form for any and all conversations for each family. Supervisors ensure each family on the staff's caseload is discussed. All Parent Surveys are reviewed at a frequency that provides timely administrative, clinical and reflective conversations needed to meet the family's and staff's needs.
2. Families who are on Level 1, 1P, Level SS Level 2, Level 3 must be discussed in-depth at least once a month in reflective supervision and documented. More frequent discussions are encouraged if needed and must be documented. For families on Level 4 the discussion and documentation must occur before or after each visit.
3. During supervision, staff are provided with supervision that includes administrative, clinical and reflective components, are held accountable for the quality of their interactions with families on a regular and routine basis and are provided with professional support (as noted in 12.1B). Supervisors focus on various areas including:

Within supervision sessions

Any activity engaged in by a supervisor with staff can and probably will have aspects of administrative, clinical, and reflective supervision. These supervision tasks have been grouped by the type of supervision most often, but not exclusively associated with each task:

Administrative Tasks
- integrating quality assurance results that include review of all assessments and assessment records (including inter-rater reliability practices)
- monitoring due dates for screenings and measurement tools
- discussing family acceptance, retention and attrition
- providing feedback on documentation
- assisting staff in implementing new training or new policy into practice
- sharing of information related to community resources

Clinical
- discussing activities to address assessment issues/risk factors
- developing the Service Plan
- supporting Parent-Child Interaction work and CHEERS observations
- guiding culturally sensitive practice
- providing guidance on use of curriculum
- integrating results of tools used (developmental screens, evaluation tools, etc.)
- identifying areas for growth
- strengthening engagement techniques

- discussing strategies aimed at building protective factors
- reviewing Family Goal progress and process
- reviewing family progress and level changes
- integrating policy changes into practice

Reflective
- exploring/reflecting on impact of the work on the worker
- coaching and providing feedback on strength-based approaches, reflective strategies, and interventions used (e.g. motivational interviewing)
- encouraging self-care
- guiding culturally sensitive practice
- identifying areas for growth
- identifying and reflecting on role boundaries
- discussing ongoing worker safety

Outside of/Prior to Supervision sessions (12-2.C practice):

Administrative
- reading home visit narratives & Parent Surveys
- reviewing of CHEERS and CHEERS Check In
- reviewing home visit completion rate
- discussing home visit/assessment rates
- offering regular staff meetings
- monitoring Family Support Specialist records, and all documentation used by the site
- monitoring productivity
- providing tools for performing job
- scheduling flexibility
- offering employee assistance program when available
- providing a career ladder for direct service staff
- acknowledging performance

Clinical
- observing Family Support Specialists and Family Resource Specialists according to HFNY QA Policy
- Providing multi-disciplinary teams (holding team meetings for specific professional development purposes or building areas of expertise)
- assuring on-call availability is provided to support workers in the field

Reflective
- Creating a nurturing work environment that provides opportunities for respite
- Assuring an open-door policy with supervisors to support growth and professional development the following:
  - **a.** All FSSs and FRSs are provided with feedback on the results of quality assurance reports
  - **b.** Family files are reviewed, and feedback is provided in accordance with the HFNY QA Policy
  - **c.** Home visit observations are conducted in accordance with the HFNY QA Policy
  - **d.** Parent Survey observations are conducted in accordance with the HFNY QA Policy

MIS References:

Accreditation/12-2. B Home Visit Observation by Supervisor
Accreditation/12-2. B Parent Survey Observation by Supervisor
Accreditation/12-2. B Summary of Supervision Activities

Appendix:

Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf
Supporting Home Visitor Supervision (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/supporting-fsss-in-supervision/
Supporting Parent Survey Supervision (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/supporting-frss-in-supervision/

Insert site-specific procedures that include:

1. The site's supervision policy and procedures which ensure supervisors are responsible for providing all direct service staff with professional support and supervision which includes administrative components, clinical components, reflective components in order to continuously improve the quality of their performance. The site's procedures include the mechanisms for quality improvement and tasks in each of the three components listed above.
2. Frequency of supervision for workers
3. How workers are held accountable for the quality of their work (i.e., using information gathered through MIS reports and forms).
4. How workers are provided skill development and professional support and include procedures mentioned in addressing topics above (clinical, administrative and reflective)

SUPERVISION OF SUPERVISORS (EFFECTIVE 12/1/19)
HFA Best Practice Standard 12-3.A

POLICY: Supervisors receive regular ongoing supervision, are provided with skill development, professional support and are held accountable for the quality of their work.

Intent: Sites are to have clear policy and procedures regarding the frequency of supervision of supervisors including professional support, skill development and ways to demonstrate accountability for the quality of their work.

1. Supervisors receive individual, regularly scheduled, comprehensive reflective supervision (discussions will include administrative, clinical and reflective elements) from the program manager or designee for at least ninety minutes per month (sixty minutes if supervisor is less than .49 FTE). Supervisions can be broken up into shorter sessions with one expected to be at least 45 minutes. Additional supervision is strongly recommended, as needed for skill development especially with new supervisors. Additional supervision time can be either individual or group sessions.
2. The program manager or designee conducting the supervision documents the topics discussed and strategies developed on the HFNY Supervision Form.
   Topics may include but are not limited to:
   - **a.** Addressing personnel topics
   - **b.** Feedback/reflection to supervisors regarding team development/dynamics and agency topics.
   - **c.** Review of documentation including supervisor notes, family documentation, site goals, quarterly reports, other statistics and reports.
   - **d.** QA feedback from QA activities i.e., participant satisfaction surveys, staff observations (external and internal).
   - **e.** Feedback from Supervisor Observation
   - **f.** Strategies to promote professional development and growth.
   - **g.** Use of and support of reflective strategies, discussion of protective factors, integration of Service Plan, etc.
   - **h.** Clinical support related to families in the program.
3. If the supervisor serves four or more families on a permanent basis (for more than 3 months), the supervisor will receive supervision according to the policies related to Standard 12-1 and 12-2 for their direct service.
4. For supervisors carrying caseloads between 1-3 families on a permanent basis (for more than 3 months) or carry a larger caseload but on a temporary basis or conduct occasional assessments as a back-up the supervision session can occur based on the frequency of contact and does not have to occur weekly.

MIS Reports:

12-3 Supervision of Supervisors Report (new on MIS)

Appendix:

Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf
Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

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Insert site-specific procedures that include:

1. Frequency of supervision for supervisors not carrying a caseload: at least 90 minutes per month, that can be divided into 2 sessions of 45 minutes. (60 minutes for part time, less than .49 FTE) Additional supervision is strongly recommended and can be individual or in group.

2. Frequency of supervision for supervisors carrying a caseload.
3. How supervisors are held accountable for the quality of their work (i.e., use MIS Supervision Form; Pre-Planning Session to document all discussions had outside of scheduled supervision)
4. How supervisors are provided skill development and professional support and include procedures for:
   a. Addressing personnel topics
   b. Feedback/reflection to supervisors regarding team development/dynamics and agency topics.
   c. Review of documentation including supervisor notes, family documentation, site goals, quarterly reports, other statistics and reports.
   d. QA feedback from QA activities i.e. participant satisfaction surveys, staff observations (external and internal).
   e. Feedback from Supervisor Observation
   f. Strategies to promote professional development and growth.
   g. Use of and support of reflective strategies, discussion of protective factors, integration of Service Plan, etc.
   h. Clinical support related to families in the program.
5. How Supervisors are in receipt of reflective supervision and how they provide feedback about the supervision received.

SUPERVISION OF PROGRAM MANAGERS (EFFECTIVE 11/26/19)
HFA Best Practice Standard 12-4. A

POLICY: Program managers receive regular, ongoing supervision, are provided with skill development and professional support, and are held accountable for the quality of their work.

Intent: Program managers are provided with skill development, professional support and are held accountable for their work. Accountability can be addressed through quarterly reports, Annual Service Reports, Annual Performance reviews, regularly scheduled meetings with the program manager's supervisor or chair of the advisory/governing board, peer supervision with a HF program manager from a neighboring site and attendance at conferences or other trainings.

1. The program manager receives regular ongoing support from their direct supervisor at least monthly.
2. The program manager maintains documentation indicating dates of these meetings and topics discussed. Topics may include:
   - **a.** Personnel issues
   - **b.** Review of progress on QA plan
   - **c.** Review of site goals and mechanisms to address goal issues
   - **d.** Input and recommendations from the advisory board.
   - **e.** Advocacy, marketing, system building and outreach.
   - **f.** Implementation challenges (i.e., accessing target population, accessing training, data issues, etc.)
   - **g.** Supervision of supervisors
   - **h.** Skill development in program development and management.
   - **i.** Strategies developed during supervision to address any concerns
3. Accountability of the program manager can be addressed through quarterly reports, Annual Service Reports, annual performance reviews, regularly scheduled meetings with the program manager's supervisor.

Note: The program manager role is distinct from that of the program supervisor, and while both roles can be assumed by the same person, status of both roles must be protected to ensure sustainable program leadership and adequate support to staff being supervised. If these roles are assumed by the same person, supervision must include support in each role that meets the Best Practice Standards.

MIS Reports:
None

Appendix:
None

Insert site-specific procedures that include:

1. That the program manager receives supervision at least once a month, who provides their supervision, and how their supervision is documented.
2. How the program manager is held accountable for the quality of his or her work.
3. How the program manager is provided skill development and professional support.
4. For program managers that also assume the supervisor role, describe how support is provided in the supervisor role and how this is documented.

FAMILY SATISFACTION FEEDBACK (EFFECTIVE 7/24/20)
HFA Best Practice Standard GA-2.A

POLICY: Families are given the opportunity to provide formalized input through satisfaction surveys

Intent: When families provide sites with their observations and experiences, it can highlight particular areas of strength or staff skill and illuminate areas in which staff would benefit from additional training or support.

1. Each family is given the opportunity to provide input on the program annually by completing a satisfaction survey. This survey is in addition to the feedback solicited from families by supervisors as part of regular, ongoing QA activities.
2. The results of all returned surveys are compiled in a summary report.
3. Additional opportunities for parent input are encouraged, including service on the Advisory group, being interviewed as participating families at site visits, participation in focus groups and/or other survey opportunities.
4. Recommendations for action based on family feedback are discussed at least annually as a team and with the Advisory Group to develop strategies to improve quality of services.

MIS Reports:
None

Appendix:
None

Insert site-specific procedures that include:

1. A description of the mechanisms used to obtain feedback from families (i.e., surveys, supervisor phone calls to parents, at FSS shadowing opportunities, from parent participation on advisory groups, being interviewed as participating families at site visits, and participation in focus groups and/or other survey opportunities).
2. How feedback from families is compiled and used.
3. How recommendations for actions based on family feedback are discussed at least annually as a team and with the advisory group. This also includes how feedback from families related to site materials, communications with staff and staff/family interactions are included in the Cultural Analysis and Plan (CAP). (Note: *the CAP requires the summarized input from families and staff as well as to identify patterns and trends related to site strengths as well as areas to improve upon).*

QUALITY ASSURANCE (EFFECTIVE 12/1/20)
HFA Best Practice Standard GA-3

POLICY: The site annually establishes goals/benchmarks, monitors the progress toward its goals/benchmarks, and develops follow-up mechanisms to address identified areas of improvement. The site develops and implements a comprehensive quality assurance plan for reviewing and documenting the quality of all aspects of site implementation (initial engagement, home visiting, supervision, and management) and implements follow-up mechanisms to address identified areas of improvement and to ensure fidelity to the model.

Intent: Each year the site identifies one or more benchmarks or goals it wants to focus on (such as increasing home visitation rates or increasing the number of children receiving at least two developmental screens each year). The site usually identifies its goals based on areas it is striving to improve, though continuous quality improvement expectations may also be established by Healthy Families New York Central Administration, funders, and contractual obligations. However decided, once the site has articulated its goals, it should indicate what the baseline is (e.g. home visit completion is 42% at the 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 goals and addressing any identified issues. Sites use this information for continuous quality improvement. Site may use PDSA (Plan Do Study Act) cycles to illustrate their efforts to achieve identified goals/benchmarks.

Sites will develop a Quality Assurance plan that will include activities such as shadowing of direct service staff (assessment, home visiting), satisfaction surveys, file reviews, reports related to site activities, etc. These activities help ensure accountability and support skills development of site staff as outlined in the 12-2 standards. Additionally, sites will document the completion of these activities and will implement strategies to address identified areas of improvement.

1. Sites use a variety of methods to monitor the quality of all of the services offered to families, as detailed in the Quality Assurance Table.
2. The state system's goals and objectives are monitored through ~~in~~ the HFNY Performance Indicators (every 6 months) and HFNY Performance Targets (quarterly).
3. The QA plan has specific internal quality assurance strategies, and includes monitoring initial engagement, home visiting, supervision practice, and management according to the HFNY Performance Indicators and HFNY Performance Targets.
4. The QA plan includes working with the Center for Human Services Research to monitor quality and completeness of the data.
5. The Quality Assurance Plan includes:
   a. Cultural Analysis and Plan (5-4 standards)
   b. Analysis of family engagement/acceptance (1-2 standards), family retention (3-4 standards), and prenatal enrollment
   c. Analysis of sites' Performance Targets and Performance Indicators are included in evaluation of quality.
6. Sites use information gathered through all QA activities to continue effective practices and develop follow-up mechanisms to identify and address areas for improvement. Annually, sites will identify one or two goals/benchmarks they are striving to improve, analyze data and conditions, develop and implement a plan, and review results. The efforts throughout the year will be reported in Quarterly Reports, the Annual Service Review, and Program Improvement Plans, when applicable.

HFNY QUALITY ASSURANCE TABLE

<table>
<tr><th colspan="4">Sites' Internal QA Activities</th></tr>
<tr><td colspan="4">MIS data completion</td></tr>
<tr><td colspan="4">Quarterly narrative and data reports (also regularly reviewed and addressed by OCFS Contract Managers)</td></tr>
<tr><td colspan="4">Annual program-wide participant satisfaction survey</td></tr>
<tr><td colspan="4">Every 2 years staff satisfaction and retention survey</td></tr>
<tr><td colspan="4">Quarterly Performance Targets</td></tr>
<tr><td colspan="4">Performance Indicators – twice per year</td></tr>
<tr><td>Practice QA:
All practice QA activities are reviewed in supervision to acknowledge practice strengths and support practice improvement.
All QA follow-up is documented by the supervisor.</td><td>FSS
▪ One home visit observation per quarter in the first year and each year thereafter
▪ One participant file review per quarter
▪ Two participant surveys per quarter via phone or in person (Program manager should review all participant satisfaction surveys that are conducted by the supervisor)
▪ Annual performance review and professional development plan</td><td>FRS
▪ One assessment observation per quarter in the first year of FRS practice, then twice per year, including "inter-rater reliability" of the observed assessments
▪ One Assessment refusal call or observation of assessment calls per quarter
▪ Annual performance review and professional development plan</td><td>Supervisor
▪ One supervision observation of each supervisor per quarter by PM or approved designee
▪ One review of supervisor binder/notes by supervisor of supervisors per quarter
▪ Annual performance review and professional development plan</td></tr>
<tr><td colspan="4">Dual Role Staff- Staff regularly performing both the role of FSS and FRS will have two home visit observations and one assessment observation annually. QA activities such as participant surveys and assessment refusal calls/call observations will be conducted in proportion to the staff's time allotment in each role.</td></tr>
<tr><td colspan="4">Annual Service Review (ASR) The ASR represents the culmination of all of the site's QA activities, and is shared with the site's advisory board and funder. The ASR is studied by the site and used as a tool to develop a specific plan for program enhancement and improvement.</td></tr>
<tr><th colspan="4">External QA Activities</th></tr>
<tr><td>PCANY Quality Assurance visits</td><td colspan="2">FSS: Observation of program practice, including at least one supervisor observation *see PCANY QA Protocol. Additional role specific support, training, and/or technical assistance may be offered as follow-up to QA activities.

Occur every 24 months, and follow PCANY protocols for planning, expectations, and follow-up for the visit</td><td>FRS: Observation of program practice, including at least one supervisor observation *see PCANY QA Protocol. Additional role specific support, training, and/or technical assistance may be offered as follow-up to QA activities.

Occur every 24 months, and follow PCANY protocols for planning, expectations, and follow-up for the visit</td></tr>
<tr><td>Technical Assistance Visits</td><td colspan="3">Scheduled as needed and offered by one or more Central Administration partner in accordance with HFNY TA protocol.</td></tr>
<tr><td>OCFS site visits</td><td colspan="3">OCFS Program Contract Managers visit sites approximately every 12 months (at least twice a year for new programs). PCMs provide follow-up documentation and support sites in developing</td></tr>
</table>

	specific plans and timelines for quality improvement.
HFA Accreditation	While HFA accreditation occurs every 5 years, sites will begin to update their Self-Assessment Tool 24 months prior to accreditation.

MIS Reports:

Quarterlies /Quarterly 4 Quarter Performance Targets
Accreditation/3-4 A and B Retention Rate Analysis
Accreditation/1-2 C Assessment Information
Accreditation/1-3 B Timing of First Home Visit
Analysis/Quality Assurance Report
Training/10-2 Orientation, 10-4 Intensive Role Specific Training for Staff, Shadowing,11-2 E Prenatal, and 11-2F FGP/ IFSP
Training/11-1 Wraparound 3 months, 11-2 Wraparound 6 months and 11-3 Wraparound 12-month reports
Accreditation/4-2 B. HFA Home Visiting Completion Rate Analysis – Summary
Accreditation/12-2 B. Observations by Supervisor
Accreditation/12-3 B. Supervision of Supervisors
Quarterlies/Quarterly Program Information for 8 quarters
Accreditation/ 12-1 B. Regularly Scheduled and Protected Supervision – Summary

Appendix:

Annual Service Review Guidelines- *(Currently being updated 2021)*
PCANY QA Protocols
https://www.healthyfamiliesnewyork.org/Staff/support.htm
OCFS Quarterly Report
https://healthyfamiliesnewyork.org/Staff/Documents/Quarterly_Report_Guideline_for_Data_Reports_final_draft022020.docx
OCFS Site Visit Tool
https://www.healthyfamiliesnewyork.org/Staff/support.htm
Performance Indicators
https://healthyfamiliesnewyork.org/Staff/Documents/PIdetails4-1-17to9-30-17.pdf
Quarterly Performance Targets

Sample Participant Survey
https://www.healthyfamiliesamerica.org/network-resources/5-4-family-satisfaction-survey-english/
https://www.healthyfamiliesamerica.org/network-resources/5-4-family-satisfaction-survey-spanish/
QA Quarterly Activities Calendar
https://www.healthyfamiliesnewyork.org/Staff/Documents/QA_quarterlyactivitiescalendar_PMs_and_Sups032021_not%20MIECHV.pdf
https://www.healthyfamiliesnewyork.org/Staff/Documents/QA_quarterlyactivitiescalendar_PMs_and_Sups032021_MIECHV%20(1).pdf (MIECHV)
Guidelines for Supervision Notes
https://healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

Insert site-specific policies and procedures that include:

1. Details on how the site will implement the HFNY quality assurance plan.
2. Details on how the site will follow-up on quality assurance activities to address identified areas of improvement and to ensure fidelity to the model.
3. Details on how participant file reviews are done, documented, and how feedback is given.
4. Details on how supervision note reviews are done, documented, and how feedback is given.
5. Details on how sites will monitor the practice of supervisors who regularly conduct home visits and/or parent surveys and how feedback is given.
6. Details on how the site will determine approved designees for performing supervision observations. At a minimum, designees will have demonstrated a comprehensive knowledge of reflective supervision and must be approved by the site's Program Contract Manager.

RESEARCH PROPOSALS (EFFECTIVE 7/24/20)
HFA Best Practice Standard GA-4

POLICY: The site has a process for reviewing and recommending approval or denial of research proposals, whether internal or external, which involve past or present families. The policy and procedures include:

- A description of the group or body of people who could conduct this review
- Procedures (or steps) for the review
- A timeline for completion of the process, and if approved/accepted
- Steps to ensure participant privacy and voluntary choice
- Communication with the National Office (via the Healthy Families America (HFA)
- Implementation Specialist) regarding summary of research design and contact information for principal investigator.

Intent: The site's policy and procedures ensure a committee or defined group of people is available to make recommendations regarding ethics of proposed or existing research, decide whether to approve research proposals, and monitor ongoing research activities including procedures to protect family privacy and voluntary choice. In HFNY, the responsibility for the review of research proposals resides with HFNY Central Administration (CA), followed by review and approval by the NYS Office of Children and Family Services. However, sites must also have policy and procedures for handling these types of requests prior to their submission to HFNY CA for review. In cases when a funder requires research as a condition of the funding, the need for policy and procedures still exists.

Only bona fide researchers may conduct research involving past or present families served by HFNY programs. To be eligible to conduct research, the researcher must be a faculty member or graduate student at an accredited institution of higher education or hold a research position at a reputable research organization or government agency.

1. When approached to participate in a research study, the program manager should contact their OCFS program contract manager to discuss the study and data collection requirements. If there are questions about whether a funder is conducting research versus collecting data on program services to monitor performance or improve services as a condition of funding, this should be discussed. The OCFS program contract manager may request assistance from OCFS researchers as necessary to determine whether the project is a research study[3].
2. Programs should follow their own agency policy and procedures regarding whether they will allow bona fide researchers (other than HFNY system researchers) to engage in research activities with past or present families receiving services from HFNY programs.
3. If the agency agrees to allow the researcher to use their program for research purposes, the agency must provide the researcher with a letter of support to indicate their willingness to participate in the research study.
4. Prospective researchers must submit a proposal that meets all the requirements of the OCFS Research Proposal Application, which includes obtaining letters of support from participating programs and Institutional Review Board approval, to the HFNY Program Supervisor who will put the research proposal on the agenda for review at the next HFNY CA meeting. These meetings occur at least six times per year and include partners from OCFS, PCANY, and CHSR. Review by the full group allows multiple aspects of impact to be considered.

[3] If the primary purpose of the data being collected or requested is to contribute to monitoring, oversight, or improvement of the program and the requestor is affiliated with the program as a stakeholder, employee, funder, etc., then the study may not need to follow these procedures. When in doubt, reach out to the OCFS program contract manager for assistance.

5. The HFNY CA will have up to 90 days to review the proposal based on the following standards: 1) relevance to the HFNY mission or contribution to the body of literature in the field; 2) methodological adequacy; 3) procedures for ensuring participant privacy, confidentiality, and voluntary choice; 4) potential risks and benefits to participants; 5) impact on HFNY or program operations; and 6) support from involved parties. HFNY CA will also assess the extent to which the program is providing services with fidelity to the HFNY model. In order to ensure that any research results are relevant to the state system, the program in which the research will be conducted must be meeting state performance standards. Exceptions may be allowed if the research is being conducted to specifically address areas in which the program is not yet meeting standards. Researchers should be sure to address the following questions within their proposals:
   - What is the added value to families involved in the research study over and above the services provided by HFNY?
   - Can the results of the study be generalized to other HFNY programs?
6. Once HFNY CA has reviewed the research proposal, the OCFS researcher and the program's OCFS contract manager will contact the researcher to address any concerns that were expressed by HFNY CA or told that their study is conditionally approved pending review by the OCFS Bureau of Research, Evaluation, and Performance Analytics (BREPA). If the researcher is unable to address all the concerns raised by HFNY CA, the study will be rejected. After all concerns are addressed to the satisfaction of HFNY CA, the HFNY Program Supervisor will provide a letter of support indicating conditional approval of the research study by HFNY.
7. Upon receipt of the letter of support from the HFNY Program Supervisor, the researcher may proceed with the OCFS Research Approval process and should submit a complete research proposal to:

   OCFS Research Proposal Review Team
   Bureau of Research, Evaluation, and Performance Analytics
   NYS Office of Children and Family Services
   e-mail: ocfs.sm.ResearchProposal@ocfs.ny.gov

Please note in your email that this is an HFNY research proposal.

8. HFNY CA will abide by OCFS timeframes for review of all research proposals. Currently, the BREPA review of the research proposal is conducted by researchers who are also members of HFNY CA which expedites the initial stages of the OCFS review.
9. Once OCFS approval of the research proposal has been received, the OCFS researcher will notify HFNY CA and send a summary of the approved research design and contact information for the Principal Investigator to the HFA National Office (via the HFA Implementation Specialist).
10. HFNY programs that participate in a research study will need to add a filter in the HFNY MIS for the study. This filter should be selected for each family participating in the study. The Active Enrolled Cases report in the HFNY MIS can be run with the filter selected to track participation. A copy of the research study's informed consent form should be kept in each participant's file. Participant files will be reviewed to make sure the consent form is included during the annual site visit.
11. If a participant involved in a research study at one program site transfers to a new program site, the program manager should notify their OCFS program manager. The participant's continued participation in the research study will be addressed on a case by case basis via consultation between the research study principal investigator/project director, the OCFS program contract manager, and the OCFS HFNY researchers.
12. Any concerns about the research study (e.g., participant feedback, changes to the approved plan, etc.) should be communicated to the program's OCFS program contract manager within 5 business days.
13. Any final reports or findings should be shared with OCFS and HFNY prior to dissemination so that OCFS and HFNY may confirm that the safety and privacy of families or program staff has been protected and so that OCFS and HFNY may benefit from the research results. Up to 20 business

days shall be required to review and approve draft posters, presentations, journal abstracts, and manuscripts. Researchers should also notify OCFS and HFNY in advance of any media, publicity, or other public presentation related to the research study.

MIS Reports:

Active Enrolled Cases Report

Appendix:

NYS OCFS Research Proposal Application Process

Double click to open embedded document.

Insert site specific procedures that include:

1. The program's own agency and/or program policies and procedures regarding whether they will allow bona fide researchers (other than HFNY system researchers) to engage in research activities with past or present families. The procedures should specify:
   - **a.** Whether the program will allow researchers who otherwise meet the requirements to conduct research within their program;
   - **b.** The name of the contact person for the agency/program who should be approached regarding participation in a research study;
   - **c.** Other individuals at the agency/program who will need to be contacted to review the request to participate;
   - **d.** Who will make the decision to participate; and
   - **e.** Who will provide a letter of support to the prospective researcher for inclusion in their application to HFNY CA and OCFS.
2. The location where informed consent forms for participants included in research studies are stored (e.g., secured paper files, electronically in MIS, etc.).

FAMILY RIGHTS AND CONFIDENTIALITY AND PARTICIPANT GRIEVANCE (EFFECTIVE 7/27/20)
HFA Best Practice Standards GA-5. A, GA-5. B, GA-5C

POLICY: Families are informed of their rights and ensured confidentiality of information both during the intake process as well as during the course of services.

Intent: A family-centered approach to service delivery requires that practices reflect a profound respect for personal dignity, confidentiality and privacy. When a request for confidential information about a family is received, or when a release of confidential information is necessary for the provision of services, sites must obtain the family's informed, written consent prior to releasing the information. Informed consents are time specific.

1. All families enrolled in HFNY have the right to be treated with dignity and respect and to know the scope and limitations of the services offered. Any information shared between the family and staff must be protected and treated in a confidential manner. Home visitors inform families of their rights and confidentiality and provide them with the **Family's Rights and Confidentiality Form** before or on the first home visit. The form includes:
   a. The right to refuse services (voluntary nature of the program).
   b. The right to referral, as appropriate, to other service providers.
   c. The right to participate in the planning of the services they will receive.
   d. The right to file a grievance/complaint and how to do so should the need arise.
      - Specific steps for reviewing and acting on any grievances received.
      - The timeframe for addressing any grievances.
      - The follow-up mechanisms used to address identified areas of improvement.

2. Confidentiality is an essential part of the agency's services. Every family has the right to private and confidential interaction with staff. The only exception to this right occurs when the law mandates report of illegal or potentially life-threatening behavior. The home visitors inform families of their confidentiality using the **Family's Rights and Confidentiality Form** before or on the first home visit. The form includes:
   a. The manner in which information is used to make reports to funders, evaluators, Central Administration and/or researchers (in aggregate format).
   b. The manner in which consent forms are signed to exchange information with other providers.
   c. The circumstances when information would be shared without consent such as the need to report child abuse and neglect.

3. All HFNY sites adhere to the following confidentiality standards:
   a. All HFNY staff sign a confidentiality agreement to keep participant information confidential including the acceptable use of HFNY MIS. Staff keep their MIS password confidential.
   b. All family files are stored in locked file cabinets or electronically on the MIS or other computer-based filing system (encrypted and password protected).
   c. Files are not left open on staff's desk.
   d. Staff log off MIS when leaving the desk or office.
   e. In case of staff leaving the job, the site must inform CHSR within 24 hours using the ticket system.
   f. FSSs and FRSs discuss information related to families only with site staff, administration, funders, OCFS, HFNY Central Administration and HFA. (If site were to participate in any outside evaluation project –see GA-4)
   g. A family's information cannot be discussed with an outside provider unless Consent for the Release of Information form has been signed. Consent to release information forms will only list one agency per form in order to maintain confidentiality related to the various services that a family might receive. Consent forms must include:
      - A signature of the person whose information will be released or parent or 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. * No release agreement can exceed 12 months.
- The name of the person/agency to whom the information is to be released.
- The name of the HFNY site providing the confidential information.
- A statement that the person/family may withdraw their authorization at any time.

h. Staff do not talk about the families being served with friends or family members.

i. Staff do not use the name of the family member (or any identifying information) in any public area.

j. Staff who breach confidentiality commitments face disciplinary action up to and including dismissal.

4. All families are asked to participate in the HFNY evaluation at enrollment and sign the Informed Consent. They are informed of the scope and intent of the evaluation, the voluntary nature of their participation, that they have the right to refuse participation without it having effect on the services they receive and that all evaluation results will be presented in aggregate form. (For participation in any outside evaluation project –see GA-4).

5. Families are informed of the grievance process on the first home visit as part of the process of reviewing the **Family's Rights and Confidentiality Form** and provided with a business card with the Program Manager or Supervisor's information for them to contact if they have any concerns with the services.

6. The grievance process within the **Family's Rights and Confidentiality Form** includes:

a. Any grievances received are immediately discussed with program management, agency leadership, and/or OCFS and appropriate action is taken including contact with the family, to ensure there is clear understanding of the family's concern. Follow-up needed will be determined within five business days of receiving the grievance. The local Advisory Group may be called upon to help resolve grievances.

b. The family will be made aware of the resolution strategy and steps as soon as they have been determined.

c. The family has the right to appeal any decision they believe does not adequately resolve their grievance by applying to the Agency Director and the Advisory Group.

d. Families may request a change in FSS at any time. The site honors these requests whenever possible.

e. Staff members are removed from work with families immediately, pending resolution of a grievance involving allegations that, if true, would endanger families' safety and well-being.

f. The site works with staff named in grievances through coaching in supervision and takes any additional personnel actions needed.

MIS Reports:

None

Appendix:

Family's Rights and Confidentiality Form including Grievance Policy
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/
MIS User Agreement
https://www.healthyfamiliesnewyork.org/Staff/Documents/HFMISUserAgreement.pdf
HFNY Data Request Needing OCFS Approval Form (MIS Paper forms)
MIECHV Informed Consent (HFNY MIS)

Sample Consent to Share Information with External Source (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-c-release-of-information-english/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-c-release-of-information-spanish/

Insert site-specific procedures that include:

1. How families will be informed of their rights at enrollment, both verbally and in writing (how it will be documented on the Home Visit Log) regarding:
   - The right to refuse services.
   - The right to referral.
   - The right to participate in the planning of services.
   - The right to file a grievance/complaint and the specific steps for reviewing and acting on any grievance received and how grievances will be documented and kept regarding:
     - Discussion with supervisor and/or program management.
     - Contact with the family to ensure there is clear understanding of the family's concern.
     - The timeframe for addressing any grievances.
     - The follow-up mechanisms used to address identified areas of improvement.
2. How your site adheres to confidentiality and how you share this with families including:
   - The manner in which information is used to make reports to funders, evaluators or researchers.
   - The manner in which staff are oriented to the MIS and sign the User Agreement.
   - The manner in which files are protected (in family binders or electronic files: locked cabinets, password protection, encryption)
   - The manner in which consent forms are signed, and the family is informed every time information is shared with a new external agency.
   - The manner in which information is protected and kept confidential when there are multiple participants in the same household or dwelling.
   - The circumstances when information would be shared without consent (i.e., need to report child abuse and neglect).
3. How will families be informed of any additional data requests and the approval process that follows (i.e., Informed Consent).

REPORTING CHILD ABUSE AND NEGLECT (EFFECTIVE 12/20/19)
HFA Best Practice Standard GA-6

POLICY: All suspected cases of child abuse and neglect are reported to the appropriate authorities and the program manager and/or supervisor are notified immediately.

Intent: A clear understanding of child abuse and neglect indicators and the state's definitions of child abuse and neglect will assist staff with knowing how and when to report it. It is important for staff to know whom to contact for support when abuse or neglect is suspected. It is the intent that site leadership is notified in advance of a CPS report being made, however imminent child safety concerns are a higher priority. Therefore, Sstaff clearly understand that contacting the police or State Central Register prior to the immediate notification of the site manager or supervisor is appropriate ONLY IF waiting to contact the authorities (police or SCR) may cause greater risk to the child (ren).

All direct service staff (including supervisors) should be viewed as mandated reporters and adapt a mandated reporter philosophy, even if the state does not identify them as mandated reporters. Therefore, it is also important to familiarize staff with mandated reporting laws, which places ultimate responsibility on direct service staff to report a suspicion of child abuse or neglect to the New York State Central Register (SCR) without risk or jeopardy, even in situations where site leadership may not agree with the need to report.

1. Home visitors are not considered mandated reporters under section 413 of New York State Social Service Law. In order to meet the HFA Best Practice Standards, home visitors, supervisors, and program managers are required to make a report to the NYS Central Register when they suspect child abuse or maltreatment.
2. Families are informed of the limits of confidentiality at intake, including the requirement to report to the SCR if needed.
3. If staff suspects abuse or neglect, they should immediately speak with their supervisor and make a report to the SCR. If imminent danger is threatened, the home visitor is to call 911 prior to calling the supervisor or SCR.
4. Supervisors should provide support and guidance regarding the staff member's observations and concerns. The supervisor should not attempt to dissuade the FSS or FRS from making a report. It should be noted that proof of abuse or maltreatment is not necessary to call the SCR. If program staff are unsure whether a report should be made, the SCR will be called. The SCR staff will make the determination as to whether a report will be registered.
5. All program managers, FRS and FSS supervisors, FSS and FRS, interns and volunteers receive orientation prior to direct services with families or supervision of staff. This orientation, BPS 10-2. D, must ensure that staff clearly understands how to identify child abuse and neglect indicators, fully understands the State's definition of child abuse and neglect, and is aware of the legal limits of confidentiality. Additionally, as per BPS 11-4. B, all staff receive annual training related to child abuse and neglect in order to stay updated on current child welfare policies, practices, and trends in their community.
6. A report to the State Central Register must be made if a staff member suspects
   that a child has experienced one of the following types of Abuse or Maltreatment (includes neglect) including but not limited to failure to exercise a minimum degree of care or sexual/physical abuse against the child or allowing sexual/physical abuse to be committed.

Definition of Maltreatment: A child's physical, mental or emotional condition has been impaired, or placed in imminent danger of impairment by the failure of the child's parent or other person legally responsible to exercise a minimum degree of care.

Definition of Abuse: Abuse encompasses the most serious injuries and/or risk of serious injuries to children by their caregivers. When a child whose parent or other person legally responsible for his or her care inflicts

serious physical injury or commits a sex offense against the child. Abuse also includes situations where a parent or other person legally responsible knowingly allows someone else to inflict such harm on a child.

Indicators of Maltreatment and Abuse:

1. Indicators of maltreatment can include but are not limited to:
   a. Failing to provide the child with food, clothing, shelter, education, medical or surgical care, though financially able to do so or offered financial or other reasonable means to do so.
   b. Failing to Provide a child with proper supervision or guardianship.
   c. Unreasonably inflicting, or allowing to be inflicted, harm or substantial risk thereof, including but limited to the infliction of excessive corporal punishment.
   d. The misuse of drugs or alcohol to the extent of loss of control.
   e. By abandoning the child.
2. Indicators of sexual abuse can include but are not limited to:
   a. Injury to genital area.
   b. Symptoms of sexually transmitted diseases.
   c. Sexually suggestive, inappropriate, or promiscuous behavior or verbalization.
   d. Expressing age in-appropriate knowledge of sexual relations.
   e. Sexual victimization of other children.
3. Indicators of physical abuse can include but are not limited to:
   a. Injuries to the eyes or both sides of the head or body.
   b. Frequent injuries of any kind. These may appear in distinctive patterns such as grab marks, human bite marks, cigarette burns, or impressions with other instruments.
   c. Destructive, aggressive, or disruptive behaviors.
   d. Passive, withdrawn, or emotionless behavior.
   e. Fear of going home
4. Whenever possible, home visitors should inform the family that a report is going to be made. When circumstances make informing the family, either prior to or after calling the SCR, unsafe for family members or staff, it is up to the supervisor and home visitor to determine how to handle the incident and move forward to preserve the family.

MIS Reports:

None

Appendix:

Child Abuse Maltreatment Policy Presentation GA-6
https://www.healthyfamiliesnewyork.org/Staff/programmanager.htm

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Insert site specific procedures that include:

1. The program will use the above criteria to make a report of suspected child abuse and neglect.
2. Requirement that the program manager and/or supervisor must be notified immediately when abuse or neglect is suspected.
3. How all observations of suspected abuse and neglect, and any next steps are documented.
4. How the family will be informed of any report made to the State Central Register. Include when the family may not be informed.
5. Any other program requirements.

GA-6. A and GA-6. B are Safety Standards

Critical Incident Policy (EFFECTIVE 7/24/20)
HFA Best Practice Standard GA-7

POLICY: Home visitors must immediately notify the program manager and/or supervisor in the event of a participant or participant's household member's death, critical injury, serious abuse incidents which prompt local investigation or media involvement, as well as litigation pertaining to Healthy Families work or services, **or other critical incident. The OCFS program contract manager (PCM) must be notified within 24 hours. Affected participants and staff are offered counseling when a participant death or critical incident occurs.** Programs are also required to report any misuse of funds as a critical incident.

Intent: Critical incidents that affect the program staff and participant families, including the death or critical injury of a program participant, serious abuse incidents which prompt local investigation or media involvement, as well as litigation pertaining to HFNY work or services, staff witnessing a violent incident, an assault of program staff, threats against the program or program staff, and natural disasters, may create a deep sense of loss for the families and staff. This policy assures that both staff and family members are supported through the grief/loss process, or to address their sense of safety. 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.

1. In the event of critical incident, including the death or critical injury of a participant household member, serious abuse incidents which prompt local investigation or media involvement, as well as litigation pertaining to HFNY work or services, threats against the program or program staff, serious injury of staff on duty, the staff that becomes the first one aware of the incident immediately informs the program manager and/or supervisor. The OCFS PCM should be notified as soon as possible by phone or email, but within a maximum of 24 hours of the program becoming aware of the incident. This notification is to include preliminary information such as name and age of the participant and a brief description of the incident.
2. Support is offered to the family, including services for grief counseling or other therapeutic services, if desired by the family, and short-term transitional home visits in the case of the death of the target child.
3. Appropriate support should also be provided to the home visitor(s) and supervisor, including additional reflective supervision, and counseling or access to an Employee Assistance Program (EAP).
4. If the program staff suspect that death or critical injury of the target child or other child in the home may be the result of child abuse or neglect, staff follow the agency's procedures consistent with the child abuse reporting policy and cooperates fully with any investigation.
5. Critical Incidents are documented on the OCFS Critical Incident Report forms. (see Appendix).
6. If a report is made to the State Central Register concerning the death or critical injury, documentation on the OCFS Critical Incident Report includes: who made the initial report to the Statewide Central Register, if known; the contact information for the CPS worker or supervisor, if known; the notifications that followed the initial report; whether follow-up HFNY services will be provided to the remaining household members, and length of time they will be provided. Programs should refer to the GA-6A Policy for reporting of Child Abuse and Maltreatment.
7. Healthy Families New York programs funded through contracts with the New York State Office of Children and Family Services and are required to report any misuse of such funding to the Office of Children and Family Services.
8. A preliminary written report of the critical incident, with available information, will be made to OCFS using the OCFS Critical Incident Report within 72 hours of the

program becoming aware of the incident at most. A final OCFS Critical Incident Report, with all required information included, is submitted to the OCFS PCM with updates weekly as necessary.

MIS Reports:

None

Appendix:

Critical Incident Report*

Insert site-specific procedures that include:

1. Immediate notification of the program manager and or supervisor when a critical incident occurs. For subcontractors, this would also include notifying the contract manager of the contract holder.
2. Staff is offered grief counseling when a death or critical injury occurs.
3. The support that will be offered to the family who has experienced loss.
4. Protocol for notifying OCFS program contract manager when a critical incident occurs.
5. Requirements for completing the necessary documentation when a critical incident occurs and that a report will be made to the State Central Register when required.
6. Protocols for when multiple participating families are impacted by a critical incident.
7. Protocols for when there is an incident of media involvement concerning a critical incident the program is involved in.
8. Protocols surrounding the misuse of funds and the notification to OCFS PCM.

Appendix

1-2.A Screening and Assessment Process
HFNY Screen Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/HFNY%20Screen%20form.pdf
Quarterly Report Guidelines
https://healthyfamiliesnewyork.org/Staff/Documents/Quarterly_Report_Guideline_for_Data_Reports_final_draft022020.docx
Annual Service Review Guidelines- Currently being updated (2021)
HFNY Performance Indicators
https://www.healthyfamiliesnewyork.org/Staff/Documents/Performance%20Indicators2021.pdf

1-3.A First Home Visit
HFNY Performance Indicators
https://www.healthyfamiliesnewyork.org/Staff/Documents/Performance%20Indicators2021.pdf
Sample Service Agreement Form*
Sample Family Rights and Confidentiality Form (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/

2-1.A Eligibility Requirements
HFNY Screening Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/HFNY%20Screen%20form.pdf
Pre-Assessment Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Pre-Assessment%20Activity%20Form.pdf
HFNY Parent Survey Narrative Standardized Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/PSSTANDARDIZEDFORM%20Rev.1-21.pdf

2-2.A Assessment Narratives
HFNY Parent Survey Worksheet
https://www.healthyfamiliesnewyork.org/Staff/Documents/PSWORKSHEETpaperworksheetRev.0121.pdf
HFNY Parent Survey Narrative Standardized Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/PSSTANDARDIZEDFORM%20Rev.1-21.pdf

3-1.A Voluntary Nature of Services
Sample Family Rights and Confidentiality Form (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/
Informed Consent

(MIECHV)

3-2.A Building Trust and Engaging Families
None

3-3.A Creative Outreach
Creative Outreach Activities/Checklist*
HFA Level Change Forms (need HFA Login)
https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf
https://www.healthyfamiliesamerica.org/network-resources/?topic=level-change

Sample Family Rights and Confidentiality Form (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-spanish/
Informed Consent


(MIECHV)

Annual Service Review Guidelines- Currently being updated (2021)

4-1.A Minimum Length of Time to Offer Weekly Home Visits
None

4-2.A Levels of Service
HFNY Sample Level Change Criteria Forms (need HFA Login)
https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf

4-2.B Home Visit Completion
None

4-3.A Duration of Service
HFA's Level Tool Guidance (need HFA login)
https://www.healthyfamiliesamerica.org/hfa-restricted.php?file=Level-Change-Packet-6.18.pdf

4-4.A Services Closure/Transition Planning
HFNY Transition Plan Form (in English and Spanish) (HFNY MIS)

5 Providing Culturally Respectful Services
Guidelines for Annual Service Review- Currently being updated (2021)
HFA Cultural Analysis and Plan workbook (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/cultural-analysis-and-plan-guide/

6-1.A Reviewing and Addressing Risk Factors and Challenging Issues
HFNY Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf
HFNY Service Plan (HFNY MIS

6-2.A Family Goal Plan
None

6-3.A CHEERS: Assessing Parent-Child Interaction
Infant Mental Health
https://www.zerotothree.org/early-development/infant-and-early-childhood-mental-health
HFA CHEERS Guide for Home Visitors
https://www.healthyfamiliesnewyork.org/Staff/Documents/CHEERSGuideforHomeVisitors0819.docx
HFA CHEERS Discussion Guide for Supervisors
https://www.healthyfamiliesnewyork.org/Staff/Documents/CHEERSDiscussionGuideforSupervisors%20022020.doc
Home Visit Narrative Content Instructions
https://www.healthyfamiliesnewyork.org/Staff/Forms/ContentInstructionsNewYorksHomeVisitingProgram.pdf

6-4.A Promoting Child Development, Parenting Skills, Health and Safety
HFNY website
https://healthyfamiliesnewyork.org/default.htm
HFNY Approved Evidence Informed Curriculum
https://www.healthyfamiliesnewyork.org/Staff/curriculum.htm

6-5.A Policy: Developmental Screening
None

6-6.A Tracking Developmental Delays
HFNY Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf

7-1.A Medical/Health Care Provider
None

7-2.A Immunizations
None

7-3.A Referrals/ Linkages to Health Care and Community Resources
None

7-4.A Depression Screening
Procedures for Working with Families in Acute Crisis*
https://app.box.com/s/kd2bfdeecpqjtqjyzf9c

8-1.A and 8-2.A Caseload Size and Caseload Management
Home Visiting Levels Table
https://www.healthyfamiliesnewyork.org/Staff/Documents/Home%20Visiting%20Levels%20Table.pdf

9-1.A and 9-4.A Selection of Staff
Sample interview Questions (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/sample-interview-questions-spanish/
https://www.healthyfamiliesamerica.org/network-resources/sample-interview-questions/
Interview Rating Scale
https://www.healthyfamiliesnewyork.org/Staff/Documents/Interpersonal_Rating_Scale.pdf

10 and 11 Training Plan/ Policy
HFA FRS Stop-Gap Training for Supervisors (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/stop-gap-supervisors-of-family-resource-specialists/
HFA FSS Stop-Gap Training for Supervisors (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/stop-gap-supervisors-of-family-support-specialists/
Recommended Order of Trainings
https://www.healthyfamiliesnewyork.org/Staff/Documents/RecommendedOrderofTrainings12152020.docx
Site Training Record (HFNY MIS)

12-1.A Ongoing Supervision for Direct Service Staff
Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

12-2.A Administrative, Clinical and Reflective Supervision and Professional Support
Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf
Supporting Home Visitor Supervision (need HFA login)

https://www.healthyfamiliesamerica.org/network-resources/supporting-fsss-in-supervision/
Supporting Parent Survey Supervision (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/supporting-frss-in-supervision/

12-3.A Supervision of the Supervisor
Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/Supervision%20Paper%20Form%202.0.pdf
Guidance for Using the Healthy Families New York Supervision Form
https://www.healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

12-4.A Supervision of the Program Manager
None

GA-2.A Family Satisfaction Feedback
None

GA-3 Quality Assurance
Annual Service Review Guidelines- *(Currently being updated 2021)*
PCANY QA Protocols
https://www.healthyfamiliesnewyork.org/Staff/support.htm
OCFS Quarterly Report
https://healthyfamiliesnewyork.org/Staff/Documents/Quarterly_Report_Guideline_for_Data_Reports_final_draft022020.docx
OCFS Site Visit Tool
https://www.healthyfamiliesnewyork.org/Staff/support.htm
Performance Indicators
https://healthyfamiliesnewyork.org/Staff/Documents/PIdetails4-1-17to9-30-17.pdf
Quarterly Performance Targets

Sample Participant Survey
https://www.healthyfamiliesamerica.org/network-resources/5-4-family-satisfaction-survey-english/
https://www.healthyfamiliesamerica.org/network-resources/5-4-family-satisfaction-survey-spanish/
QA Quarterly Activities Calendar
https://www.healthyfamiliesnewyork.org/Staff/Documents/QA_quarterlyactivitiescalendar_PMs_and_Sups032021_not%20MIECHV.pdf
https://www.healthyfamiliesnewyork.org/Staff/Documents/QA_quarterlyactivitiescalendar_PMs_and_Sups032021_MIECHV%20(1).pdf (MIECHV)
Guidelines for Supervision Notes
https://healthyfamiliesnewyork.org/Staff/Documents/SupervisorNoteGuidelines819.pdf

GA-4 Policy: Research Proposals
NYS OCFS Research Proposal Application Process*
Available upon request: ocfs.sm.ResearchProposal@ocfs.ny.gov
Double click to open embedded document.

GA-5.A, GA-5.B, GA-5.C Family Rights and Confidentiality, Informed Consent, Participant Grievance
Family's Rights and Confidentiality Form including Grievance Policy*
https://www.healthyfamiliesamerica.org/network-resources/ga-5-b-rights-and-confidentiality-english-2/
MIS User Agreement
https://www.healthyfamiliesnewyork.org/Staff/Documents/HFMISUserAgreement.pdf
HFNY Data Request Needing OCFS Approval Form (MIS Paper forms)
MIECHV Informed Consent (HFNY MIS)

Sample Consent to Share Information with External Source (need HFA login)
https://www.healthyfamiliesamerica.org/network-resources/ga-5-c-release-of-information-english/
https://www.healthyfamiliesamerica.org/network-resources/ga-5-c-release-of-information-spanish/

GA-6 Reporting Child Abuse and Neglect
Child Abuse Maltreatment Policy Presentation GA-6
https://www.healthyfamiliesnewyork.org/Staff/programmanager.htm

GA-7 Critical Incident
Critical Incident Report*

FAMILY RIGHTS AND RESPONSIBILITIES

I, _____ hereby agree to participate in the Healthy Families (insert Program Name), Home Visiting Program. I understand that; I have the right to give or refuse written signed consent if information is to be released. I understand that any information about me is otherwise private and confidential. The only exception to this right occurs when the law mandates reports of illegal or potentially life-threatening behavior. Additional rights include the following:

- The right to refuse services
- The right to services without regard to race, color, gender, religion, age, handicap, marital status, national or ethnic origin, including sexual orientation.
- The right to ongoing participation in the planning of services to be provided and in the development and periodic revision of my service plan.
- The right to file a grievance/complaint.

The grievance policy was reviewed with me (us) on: Date: _____

Healthy Families services are available to me for up to five years; or for 3 years if my child starts a Head Start program and no longer require services.

I further understand that a Family Support Specialist will be required to make regular visits to my home in order to ensure that the health and educational needs of myself and/or my child(ren) are being met. To achieve this goal, I must take the responsibility of doing the following if applicable.

- ♥ *Being cooperative in maintaining home visit appointments (I will contact my Family Support Specialist to cancel/reschedule whenever a change of plans is necessary).*
- ♥ *Following up with **referrals** provided by my Family Support Specialist.*
- ♥ *Keeping medical appointments (i.e. Prenatal Visits, Well Baby Visits, Immunizations)*

If I choose to do so, I know that I can discontinue services with Healthy Families Brookdale at any time. I may also contact the Supervisor_____(ext_____), or Program Director, (insert name), with any questions or concerns about my Support Specialist or the program services.

Parent's Signature_____ Date_____

FSS Signature_____ Date_____

Grievance Policy and Procedure:

Families are informed of the grievance process, provided with a "Report of Complaint" form**,** and with contact information for the Program Director and Supervisor on the first home visit as part of the process of reviewing the **Family's Rights and Responsibility Form.**

The grievance process includes the following:

1. Any grievances received are immediately (or within 24 business hours) discussed with program management (i.e. Supervisor, Coordinator and Program Director) and appropriate action is taken including contact with the family to ensure there is a clear understanding of the family's concerns.

2. The family will be made aware of the resolution strategy and steps as soon as they have been determined.

3. Families may request a change in Family Support Specialist at any time. The site honors these requests whenever possible.

4. Staff members are removed from work with families immediately, pending resolution of a grievance involving allegations that, if true, would endanger families' safety and well-being.

5. The site works with staff named in grievances through coaching in supervision and takes any additional personnel actions needed.

6. Documented grievances and provided to the Program Director to be stored electronically or in a locked file cabinet.

Family: _____ **Home Visitor:** _____

OUTREACH AND ENGAGEMENT FORM

(Check Outreach Stage Below & Insert Date Outreach Level Began)

☐PRE-ASSESSMENT: _____ **☐PRE-INTAKE:**_____ **☐LEVEL CO:** _____

Phone Calls/TEXTS:

- Pre-Assessment – Time frame to be determined based on engagement
- pre-intake – Weekly (for 30-45 days/ or 6 weeks)
- level CO – every other week (for 92 days/ or 13 weeks)

	List Dates		List Dates		List Dates
WEEK 1		WEEK 6		WEEK 11	
WEEK 2		WEEK 7		WEEK 12	
WEEK 3		WEEK 8		WEEK 13	
WEEK 4		WEEK 9		WEEK 14	
WEEK 5		WEEK 10		WEEK 15	

LETTERS:

- **pre-assessment - MAIL LETTER MONThly**
- **Pre-intake - Mail letter bi-weekly**
- **Level Co - MAIL LETTER MONTHLY**

	List Date(s)
OUTREACH LETTER(S)	
PRE-CLOSING LETTER	
CLOSING LETTER WITH REFERRALS: (SEND ON CLOSING DATE)	

Attempted visits: (ATTEMPTED VISIT monthly on Level CO only)

	List Date(s)
MONTH 1	
MONTH 2	
MONTH 3	

OTHER CREATIVE OUTREACH ACTIVITIES (AS NEEDED):

	List Date(s)		List Date(s)
REACH OUT TO REFERRAL SOURCE		SEND FAMILY A SPECIAL NOTE/ MAGNET OR CARD	
CALL/EMAIL EMERGENCY CONTACT		MAIL CURRICULUM OR ASQ/ASQ-SE2	
INVITE FAMILY TO PROGRAM/COMMUNITY EVENT		PROVIDE A REFERRAL	
PROVIDE A GIFT		OTHER (SPECIFY):	

Invite family to multiple program events to build trust

Share some of your knowledge around child health and development

Emphasize the program's voluntary nature and committment to partnering with families to raise happy healthy children

Demonstrate your interest in the family by exploring their interests and needs and providing relevant referrals

Focus on the relationship by reaching out in between visits & remembering info. previously shared by family

Engage the father BEFORE the assessment is scheduled

Call 24-48 hours after receiving the referral

Show genuine care and concern

Get help from your team

BE PERSISTENT!

Healthy Families America

PROTOCOLS: Working with Families Experiencing Acute Crisis

On occasion, you may encounter a family who is experiencing an acute crisis related to one or more social issues, such as mental illness, substance abuse, or domestic violence. Regardless of educational background or experience, it is not the home visitor's responsibility to provide clinical intervention/treatment to home visiting participants. Your first priority will be your safety, the safety of the individual in crisis, and the safety of their child(ren). This means gathering information while *avoiding* provocative questions or making statements that minimize or exacerbate the situation, such as "It is not so bad" or "Why would you say that?" "You don't mean that" or "Everything will be fine." Always consult with your supervisor as soon as possible when such situations arise. **ALL SITES MUST HAVE SPECIFIC WRITTEN PLANS FOR COVERAGE WHEN A SUPERVISOR IS NOT READILY AVAILABLE.**

Assessment staff should report any of the following situations or suspected situations to their supervisor as "red flags" to be passed on to the home visitor. Personal safety procedures should be followed at all times.

GENERAL PRACTICES FOR IMMEDIATE SAFETY:

IF YOU BELIEVE YOU OR SOMEONE ELSE IS IN DANGER DURING A HOME VISIT:

1. **LEAVE IMMEDIATELY.** If you need a way to more safely remove yourself from the setting, claim an emergency has come up that you need to go and address, say you left something in your car and need to go out to get it, claim that you are ill and need to reschedule.
2. Call 9-1-1 (or local emergency number)
3. Call your supervisor to advise him or her of the situation.
4. Call child protective services (CPS) if children are in danger.
5. Contact the family as safety permits (in consultation with your supervisor) to ensure that everyone is safe. Assure the parents that you will continue to work with them, if possible, within program guidelines.
6. Document all activities, consultations (including with your supervisor), and the outcomes of each.

IF YOU BELIEVE SOMEONE IS IN DANGER DURING A TELEPHONE CONTACT:

1. Get as much information about her/his location as possible.
2. Tell the person you are calling 9-1-1, unless you fear that doing so might exacerbate the situation or cause the caller to hang up. Try to keep the person on the line.
3. Enlist the assistance of a third party (i.e. your supervisor, a coworker) to make the 9-1-1 call.
4. Consult with your supervisor immediately.
5. Stay in touch with the family as safety permits.
6. Document all activities, consultations (including with your supervisor), and the outcomes of each.

IF YOU ARE IN DOUBT ABOUT OR UNCOMFORTABLE WITH ANY UNUSUAL SITUATION, CONSULT YOUR SUPERVISOR IMMEDIATELY. FOR THE SAFETY OF ALL INVOLVED, *DO NOT* TRANSPORT ANY INDIVIDUAL WHO IS INVOLVED IN THE CRISIS (VICTIM, CHILD, OR PERPETRATOR).

The following are specific situations that *may* arise with families including the definition, assessment, and specific procedures for each. Your site may have additional requirements.

A. MENTAL ILLNESS/PYSCHIATRIC EMERGENCIES

Definition: Being in a home with one or more family members who exhibit behaviors related to a mental illness or has scored positive using a *depression screening tool*; and when the mood represents a change from previous functioning. Mental illness may include, but not be limited to:

- depression
- post-partum depression
- schizophrenia
- bipolar disorder
- borderline personality disorder

Assessment:

1. Observe for physical symptoms such as:
   - **a.** Sleep disturbances (too much or too little sleep)
   - **b.** Appetite disturbances (over or under eating)
   - **c.** Unexplained aches and/or pains
2. Non-physical symptoms of depression:
   - **a.** Feeling sad and/or crying
   - **b.** Avoiding pleasurable experiences
   - **c.** Withdrawing from family and/or friends
   - **d.** Loss of interest in daily activities
   - **e.** Feeling guilty, hopeless, helpless, irritable, angry
   - **f.** Having trouble concentrating, memory problems
   - **g.** Having thoughts of suicide (*see suicidal ideation)*
3. Determine if there is an immediate danger to you, the child(ren), or any adult in the home, including the person with the mental illness considering the following *signs/symptoms* of acute mental instability and possible risk:
   - **a.** Suicidal ideation, threats, attempts
   - **b.** Homicidal ideation, threats, attempts
   - **c.** Hallucinations: auditory, visual, or tactile (voices, visions, or sensations that are internal only, but perceived as coming from an external source)
   - **d.** Delusions (unshakeable, persistent belief that something is true even in the face of evidence that it is not true, or even impossible)
   - **e.** Severely disorganized or bizarre behavior
   - **f.** Extreme lethargy, catatonic state (unresponsive)
   - **g.** Severe deterioration in day-to-day hygiene and functioning
   - **h.** Severely disorganized or bizarre speech, incoherence, pressured speech
   - **i.** Very rapid mood changes and extremes of mood (e.g. excessive crying or excessively giddy)
   - **j.** Dangerous or severely risky behavior
   - **k.** Aggressive behavior, angry outbursts
   - **l.** Self-injurious behavior, such as cutting, pulling hair out, burning oneself
   - **m.** Self-medication with drugs, alcohol, prescription medications not prescribed to him/her, or over use of prescribed medications
   - **n.** Stopping medications without prescribing physician knowledge or approval

- Some of the above symptoms may be present as regular symptoms of the illness; but if they are ***new, worse*****, or in any way *frightening*,** follow the stated procedures to assure safety listed on pages 1 and 2.

Procedure:

- **IF YOU BELIEVE THERE IS RISK OF IMMEDIATE DANGER TO YOU OR ANY OTHER PERSON, FOLLOW THE STEPS OUTLINED ON PAGE 1 and 2.**

- If you do not feel comfortable making a judgment regarding the person's safety, request a police officer and/or mental health specialist be sent out to do a welfare check.

- If there is no immediate danger, but mental illness is suspected:
  1. When depression is suspected, administer the *depression screening tool* selected by your program.
  2. If not known from the Parent Survey, explore whether the parent has ever been diagnosed with a mental illness; and, if so, whether s/he is currently receiving any kind of treatment for the disorder.
  3. Offer intervention and treatment referrals, including psychiatrists, therapists, and/or support groups or services.
  4. Assist the parent in completing any forms/paperwork/calls required to access services, as needed. Always comply with confidentiality restrictions and secure written consent when making calls for the parent. Use a *Do for, do with, cheer on* approach.
  5. Follow-up with the parent in a timely manner on referrals, and assist in overcoming any barriers to accessing services.
  6. *Only with written consent*, inform the treating physician and/or therapist of current symptomology.
  7. See safety plan section on page 13.
  8. Immediately inform your supervisor of your concerns.
  9. Document all activities, consultations (including with your supervisor), and the outcomes of each.

- Routine activities that can be helpful:
  - When first becoming aware of a parent's mental illness, attempt to secure consent to talk with the treating physician and/or therapist regarding the individual's illness, risks, symptoms, medicines, etc.
  - Provide educational materials related to the identified disorder.
  - Support the parent in complying with treatment and regular communication with the physician/therapist when questions arise.
  - Continue to support the parent in identifying self-care activities, postive social supports, and stress reduction strategies.
  - If the mother is using psychotropic medications, encourage her to speak with the treating physician about the safety of continued use during pregnancy and/or breastfeeding.

- Self-care activities can be done to manage mild depression (while awaiting treatment or encouraging a parent to get to treatment). These may include the following:
  - Encourage the parent to spend time outside in the sunshine (without sunglasses). The sun increases seratonin levels, which help reduce depressed mood.
  - Encourage outdoor activities as weather allows (walking, going to the park, trips to the library, etc.).
  - Encourage positive social support (support groups, parenting classes, positive acitivities with supportive friends/family).

- Reference materials staff can use:
  - Community mental health clinics/hospitals
  - Some curricula have information on depression

- Resources:
  - Online resources:
    - www.nami.org
    - www.nimh.nih.gov
    - www.samsha.gov

        - www.guideline.gov
        - www.mayoclinic.com
        - www.apa.org.
    - Online support groups for individuals living with mental health disorders

- Add your site's local community resources for mental illness here:

B. SUICIDAL IDEATION OR ATTEMPT

Definition: Thoughts or comments about committing suicide, an attempt to do so, or statements about wishing to be dead.

Assessment: In most cases, a person will not come right out and state that they are considering suicide. It is important to be aware of and follow up on subtle hints or signs:

1. The person may make a vague statement such as: "sometimes I don't want to be here anymore," or "The world would be better off without me."
2. They may also exhibit a sudden change in their feelings or behavior. This could include a sudden lack of concern about things that had previously been upsetting to them.
3. The person may give away prized belongings.
4. Do not ignore vague statements, as these may be the person's way of testing the waters. Use solution-focused questions (*Problem Talk*) directly towards any statements made.
5. **Do not assume the responsibility of assessing the genuineness or level of intent of suicidal statements - treat all statements with equal concern.**
6. Observe for and ask about:
    a. Family history of suicide, current trauma, various mental disorders, familial support (both at the time of Parent Survey and throughout the course of services)
    b. Talking in a negative manner ("I am worthless, there is no hope," "I hate everyone, I hate myself," "Everyone would be better off if I just never existed," etc.)
    c. Destructive/high-risk behaviors (cutting; hypersexual activity; racing, theft, or other illegal behaviors not typical of the person; sudden excessive spending).

Asking someone if they are thinking about suicide does NOT put the idea in their head, increase their risk, or lead them to an attempt.

Procedure:

- **IF YOU BELIEVE THERE IS IMMEDIATE DANGER, REMOVE YOURSELF FROM THE SITUATION AND USE THE SAFETY PROCEDURES DESCRIBED ON PAGE 1 and 2.**

- For suicide *attempt*:
    1. Call 9-1-1 (or other local emergency number)
    2. Apply first aid, as appropriate and safe (for you and the victim)
    3. Ensure safety of children
    4. Consult with supervisor immediately
    5. Document all activities, consultations (including with your supervisor), and the outcomes of each.
- For suicidal *ideation:*
    1. Ask the person if they are considering killing themselves, their children, or someone else. Remember asking about suicide does not make someone more likely to do it.
    2. If the person indicates that they feel like killing themselves, ask if they have a plan.
    3. Once they tell you their plan, explore whether or not the means is available to carry it out (i.e. Does someone planning to shoot themselves own or have access to a gun and ammunition?).

   a. **If they report a plan and means to carry it out, call 9-1-1 immediately. Remove yourself from the site if you feel at risk of potential harm.**
   b. Request a police officer and/or mental health specialist be sent out to do a welfare check.
   c. When possible, stay with the person until help arrives.
   d. If the interraction is by phone, enlist someone else to assist in calling 9-1-1 while you keep talking to the suicidal person. Try to keep her or him on the telephone until help arrives at the location of the person.
   e. Call your supervisor immediately for futher direction.
4. If the person does not have a specific plan or the means available to carry out a plan, talk to the person about making a safety plan, including a verbal or written "contract" not to harm themselves while you support them in getting assistance *(see safety plan oon page 13).*
5. If person has a mental health provider, have the person contact the provider immediately and tell him or her about the currernt suicidal ideation.
6. If the person has no therapist or psychiatrist, discuss the importance of this and offer referrals.
7. The home visitor may offer to be present while the parent shares his or her ideation with others residing in the home who may provide an additional source of support and monitoring.
8. The home visitor may offer to make contact with other support figures, such as family members, friends, etc. outside of the home who may provide added monitoring or other assistance - again, *always in keeping with confidentiality regulations*.
9. Consult supervisor immediately to discuss the situation.
10. Document all activities, consultations (including with your supervisor), and the outcomes of each.

- Add your site's local community resources for suicidal ideation or attempt here:

C. HOMICIDAL IDEATION OR ATTEMPT

Definition: Thoughts or comments about committing homicide (killing another person), an attempt to do so, or statements about wishing another person was dead.

Procedure:

- **IF YOU BELIEVE THERE IS IMMEDIATE DANGER, REMOVE YOURSELF FROM THE SITUATION AND USE THE SAFETY PROCEDURES DESCRIBED ON PAGES 1 and 2.**

- For *homicidal ideation:*
  1. If a person indicates that they feel like killing another person, ask them if they have a plan to do so.
     a. If s/he indicates a plan, explore whether or not they have the means to carry out the plan (i.e. If they are planning to shoot someone, do they own or have access to a gun and ammunition?).
     b. **If they report a plan and have realistic means, call 9-1-1 immediately after you have removed yourself from the situation.**
     c. Request that a police officer and/or mental health specialist be sent out to do a welfare check.
     d. If the interraction is by phone, enlist someone else to assist in calling 9-1-1 while you keep talking to the homicidal person. Try to keep her or him on the telephone until help arrives at the location of the person.
     e. Call your supervisor immediately for futher direction.
     f. Contact CPS if a child is in danger.

g. Document all activities, consultations (including with your supervisor), and the outcomes of each.

2. If no plan, *and if person has a mental health provider*, have person contact the provider immediately and inform the provider about the homicidal ideation.

a. If person has no therapist, discuss the importance of this and offer referrals.

b. Consult supervisor immediately to discuss the situation.

c. Document all activities, consultations (including with your supervisor), and the outcomes of each.

- Routine activities that can be helpful
  - Follow-up with parent to determine if she has contacted her physician/therapist.
  - Obtain written consent to speak with the physician/therapist(s).
  - Provide referrals to support groups in the community or access an approved on-line support group.
  - Provide educational materials related to the identified disorder.
  - Support the parent in complying with recommended treatment and regular communication with the physician/therapist when questions arise.
  - Continue to support parent in identifying self-care activities, postive social supports, and stress reduction strategies.
  - Ask your supervisor and/or coworkers for agency-approved articles related to topic and relay information to the parent.

- Resources:
  - Online resources include:
    - www.suicidepreventionlifeline.org
    - www.samsha.gov
    - www.guideline.gov
    - www.aca.org
    - www.nimh.nih.gov
  - 1-800-273-TALK (8255)
-
- Add your site's local community resources for homicidal ideation or attempt here:

D. DOMESTIC VIOLENCE

Definition: Working with a family in which there is a violent or abusive relationship; and/or one characterized by power and control tactics, with one person being victimized by the other. (This may consist of a man controlling a woman, a woman controlling a man, or one person controlling another of the same gender; occasionally, there is mutual battering or violence.)

Assessment:

1. Determine if there is *immediate danger* to you or any member of the household.

2. Observe for behaviors and indicators that violence may be present:

a. Raised voices

b. Walls with holes/damage or other broken items in the home

c. Anxious behavior (hypervigilance, nervousness, distraction, etc.)

d. Unexplained or poorly explained bruises or injuries

3. Be familiar with the *power and control tactics* characteristic of domestic violence:

a. Emotional abuse: verbal assaults, name calling, criticisms, blaming.

b. Intimidation: scaring a person with frightening looks, gestures, or body language; smashing and throwing things; punching walls; harming pets; displaying weapons in a threatening manner.

c. Use of Coercion and Threats: verbal threats to harm or leave the partner, harm or take the children, commit suicide or homicide, or make the partner participate in illegal activiity.

d. Isolation: controlling what a partner does, where a partner goes, who the partner sees and talks to; limiting outside involvement; using jealousy as an excuse to justify isolation.

e. Using Children: making the partner feel guilty about the children; using children to relay messages; using visits to harass the partner; threats to take children away.

f. Economic Abuse: controlling expenditures; giving an allowance; making a partner ask for money; preventing the partner from getting or keeping a job; not letting the partner know about or have access to family income.

g. Using Male/Female Privilege: treating a partner like servant; acting like "master of the castle"; defining male and female roles; making all the "big" decisions.

h. Minimizing, Denying, and Blaming: making light of the abuse and not taking the partner's concerns seriously; denying the abuse happened; shifting responsibility for the abuse; blaming the partner for causing the abuse.

i. Physical and Sexual Abuse: hitting, slapping, punching, pinching, beating, choking; forcing a partner to perform involuntary sexual acts; having sex after a beating; marital rape; affairs with others.

Procedure:

- **IF YOU BELIEVE THERE IS RISK OF IMMEDIATE DANGER TO YOU OR ANY OTHER PERSON, FOLLOW THE STEPS OUTLINED ON PAGE 1 and 2.**

- **If there is no immediate danger**, but domestic violence is detected:
  1. Explore the situation fully, and listen first for safety issues for child, parent, and staff. Use open-ended questions to identify discrepencies and ambivalence.
  2. Use solution-focused questions (The reflective strategy*, Problem Talk,* is especially effective for exploring with parent.).
  3. Discuss with the participant the power and control tactics that you observe or learn of from descriptions given by the victim. Advocate counseling for the parent. Address this as an advocacy issue affecting the victim and the child(ren).
  4. Develop a basic safety plan as outlined on page 13.
  5. Use reflective strategies to help the victim consider the impact of the domestic disruption upon the child(ren).
  6. Encourage the parent to contact local community resources: (be aware of local resources and requirements for those resources) to get counseling, legal assistance, shelter, court order for protection, etc. Do *not* transport families to shelters.
  7. If the abuser admits to the problem and wants help, assist with referrals to treatment programs for abusers (be aware of local treatment options).
  8. Consult with your supervisor.
  9. Continue to provide support, regardless of whether the abused parent stays, leaves, or returns to the home after leaving.
  10. Be aware that first time violence and exacerbation of frequency in already violent relationships are at higher risk during the prenatal period, as perpetrators try to gain control over any out-of-control situation.
  11. Remember that a parent experiencing intimate partner violence is at greatest risk of death when trying to leave – 75% of intimate partner homicides occur after the victim leaves the relationship, so do not pressure her/him to leave before that person feels ready. A PERSON EXPERIENCING INTIMATE PARTNER VIOLENCE LEAVES AN AVERAGE OF 7 TIMES BEFORE FINALLY ENDING A RELATIONSHIP.

- Routine activities that can be helpful:
  - Maintain a supportive, healthy relationship with the family

- Find a common interest to build and maintain the relationship (think of ways to make home visits fun)
- Use motivational interviewing and values clarification, when appropriate

- Resources:
  - Some curricula include content and ways to interact with families related to violence in the home
  - Online resources include:
    - www.mayoclinic.org
    - www.apa.org (search 'anger management' in each)
    - www.thehotline.org
    - http://www.ovw.usdoj.gov/domviolence.htm
      www.nlm.nih.gov/medlineplus/domesticviolence.html

- Add your site's local community resources for domestic violence here:

HELPING PARENTS CREATE A SAFETY PLAN

- Each agency should have a basic safety plan, which can be individually tailored.
- Always carry extra safety plans when going on home visits.
- The safety plan should include:
  - Numbers for:
    - Primary Care Physician
    - Counselor/Therapist/Psychologist/Psychiatrist
    - 3 friends or family members the person may contact in acute emergency
    - Number to the national and/or local suicide prevention hotline
  - A reminder of 9-1-1 and 2-1-1 (if available in state)
  - Strategies for care and protection of the children in an emergency
  - List of positive ways to cope
  - Self-care activities
  - Referrals (names, addresses, phone numbers) to a counselor and/or psychiatrist, if needed, along with other community resources that have been noted in earlier sections
  - Helplines with 24 hour support via telephone or internet.
  - Scheduled date for the next home visit.
  - A schedule of dates and times for phone check-ins by the home visitor

PARTICIPANT CRITICAL INCIDENT REPORT
Policy- GA-7A
TO BE COMPLETED BY PROGRAM MANAGER

Program/Site Name:Click or tap here to enter text.

Child Name: *Click or tap here to enter text .*D.O.B.*Click or tap here to enter text*. Sex: ☐ M ☐ F

Incident Occurrence Date:Click or tap to enter a date. Time: ☐ AM ☐ PM

Notified Contract Manager Date:Click or tap to enter a date.

PARTICPANT

Identification Number: Click or tap here to enter text.

Relationship to Child: Click or tap here to enter text.

Service Level: ☐ Level 1P ☐ Level 2P ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4
☐ Level CO ☐ Level TO ☐ Level TR

STAFF

Family Support Specialist Name: Click or tap here to enter text.

Supervisor Name: Click or tap here to enter text.

Type of Incident *(please check all that apply):*
☐ household members death ☐ critical injury ☐ serious abuse
☐ litigation pertaining to a particular participant ☐ participant threat against a staff member
☐ other *(which would include any information regarding a non-participant that would warrant a report)*

Description of the incident: Give a brief summary here and attach a detailed narrative if necessary. Specific information to include: Description of Incident- Include the following information, if applicable: Names of individuals involved in incident(1) Details leading up to the incident; (2) brief family history; (3) service history (number of visits, referrals made); (4) Criminal charges/report to Statewide Central Register, if any.
Click or tap here to enter text.

HFNY Critical Incident Report, Cont.

Describe Action Taken- Include the following information, if applicable: (1) Authorities notified, such as Child Abuse Hotline, police, Child Protective Services (2) name and location of hospital, as well as cause of death, diagnosis of illness or injury: (3) Notification of lead agency Director, OCFS Contract Manager, or any other pertinent parties; (4) Referrals/services provided to family and staff since the incident.

Click or tap here to enter text.

Initial Report by name: Click or tap here to enter text. Title:Click or tap here to enter text.

Report Date: Click or tap to enter a date. Time: ☐ AM ☐ PM ☐ Oral ☐ Written

Report to Name: Click or tap here to enter text. Title: Click or tap here to enter text.

Was this incident reported to the NY Statewide Central Register *(if applicable)*? ☐ No ☐ Yes

If yes, register call ID number: Click or tap here to enter text.

If no, please explain:Click or tap here to enter text.

FOR OCFS USE ONLY

Date initial notification received:Click or tap to enter a date.

VIA ☐ Email ☐ Voicemail ☐ Phone Call ☐ In-Person

By: Click or tap here to enter text. To: Click or tap here to enter text.

Date form received: Click or tap to enter a date. Initials: Click or tap to enter a date.

Litigation ☐ No ☐ Yes Media Coverage: ☐ State ☐ Local ☐ National ☐ N/A

HFA Notification Date: Click or tap to enter a date.

Updates since initial report:

Program Critical Incident Report
Incidents involving a Healthy Families NY Program
Policy- GA-7A
TO BE COMPLETED BY PROGRAM STAFF

Program/Site Name: Click or tap here to enter text.

Name of staff making the report: Click or tap here to enter text.

Role of the staff making the report: Click or tap here to enter text.

Incident Date: Click or tap to enter a date. Time: ☐ AM ☐PM

Notified Contract Manager Date: Click or tap to enter a date.

Type of Incident *(please check all that apply):*

☐ Natural disaster ☐ Serious injury to staff ☐ Threats against the program
☐ Media Involvement ☐ State ☐ Local ☐ National
☐ Litigation against program ☐ Misuse of funds ☐ Other

Description of the incident: Description of the incident should include- Name(s) of program staff involved ,what led up to the incident, what are the details regarding the incident including whether there is media attention, details regarding any litigation against the program, specifics regarding misuse of funds, what impact the incident has had on services to families, the nature of the natural disaster, if staff has been threatened action taken to protect the staff, (such as order of protection), if there was a serious injury to staff, the nature, cause, and extent.

HFNY Critical Incident Report, Cont.

Describe Action Taken-
Include the following information, if applicable:(1) Authorities notified, such Law Enforcement, Child Abuse Maltreatment Hotline (2) if injury to staff, extent of injury and treatment received (3) Notification of lead agency Director, OCFS Contract Manager, or any other pertinent parties; (4) Support provided to staff since the incident.

Initial Report by name: Click or tap here to enter text. Title: Click or tap here to enter text.

Report Date: Click or tap to enter a date. Time: ☐ AM ☐ PM ☐ Oral ☐ Written

Report to Name: Click or tap here to enter text. Title: Click or tap here to enter text.

FOR OCFS USE ONLY

Date initial notification received:Click or tap to enter a date.

VIA ☐ Email ☐ Voicemail ☐ Phone Call ☐ In-Person

By: Click or tap here to enter text.To: Click or tap here to enter text.

Date form received:Click or tap to enter a date. Initials: Click or tap here to enter text.

Litigation: ☐ No ☐ Yes Media Coverage: ☐ State ☐ Local ☐ National ☐ N/A

Was HFA notified? ☐ No ☐Yes Date: Click or tap to enter a date.

Updates since initial report: