

# Healthy Start~Healthy Families Oregon POLICIES & PROCEDURES MANUAL

Umatilla-Morrow Head Start, Inc.

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August 2011



Oregon Commission on Children and Families  
530 Center Street NE, Suite 100 • Salem, Oregon 97301  
503.373.1283 • [www.ccf.state.or.us](http://www.ccf.state.or.us)

This Manual Belongs To:

Name: \_\_\_\_\_

Date: \_\_\_\_\_

I have read these policies and procedures, and am aware of how to access the policy online at [http://www.umchs.org/umchsresources/administration/pandp/pandp.html#healthy\\_start](http://www.umchs.org/umchsresources/administration/pandp/pandp.html#healthy_start). I acknowledge a hard copy is available at the Main Office, Main Office Annex and Hawthorne sites as well.

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## INTRODUCTION:

This Program Policies and Procedures Manual (PPPM) follows the standards and numbering system in the 2008-2010 Healthy Families America (HFA) Site Self Assessment Tool. Oregon specific policies follow the HFA standards in each section. Local policies are to be inserted following state policies as needed and desired, using the guidance for local programs written in blue italics.

HFA has identified 10 standards as critical to accreditation, and has designated them as Safety and Sentinel Standards. These standards are described below and marked in this manual with an identifying symbol. These standards are described below.

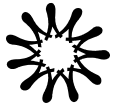
**SAFETY STANDARDS:** These standards must be met in order for programs and state systems to be accredited as they impact the safety of the families being served. There are three safety standards:

- 9-3.B. Personnel background checks.
- 10-2.C. Staff orientation training on child abuse/neglect indicators and reporting requirements.
- G-12.C. Policies and procedures around child abuse/neglect reporting criteria and definitions.



**SENTINEL STANDARDS:** These standards are considered to be especially significant in assuring program quality. While adherence to each of these standards is not required in order to receive HFA accreditation, a program with any of these standards rated out of adherence will be required to prepare and submit an improvement plan that clearly indicates how the program intends to bring the standard into compliance, coupled with evidence of implementation. There are seven sentinel standards:

- 6-4.B. and 6-6.B. Developmental screening of program children and follow-up of suspected delays.
- 6-7.A. and 6-7.B. Notifying families of their rights, of confidentiality practices, and obtaining informed consent before information is shared with others.
- 11-1.B. Supervision time, skill development and accountability, and professional
- 11-2.A. & 11-2.B. Support for direct service staff.



# Healthy Start~Healthy Families Oregon Program Policies and Procedures Manual August 2011

Umatilla-Morrow Head Start, Inc.

## Mission Statement

Healthy Start~Healthy Families Oregon promotes and supports positive parenting and healthy growth and development for all Oregon families expecting or parenting first born children.

Umatilla-Morrow Head Start is a caring, innovative network of quality individuals working in partnership with others to strengthen families and communities.

- We are committed to providing a quality comprehensive educational program to all families and children through the communities we serve.
- We believe the educational process begins at home and we will assist parents in working with their children to understand developmentally appropriate practices.
- We are neighbors working together to strengthen families free of drug and alcohol abuse, promoting communities in which children are Free to Grow.
- We will empower staff and families to identify needs and develop strengths, values and dreams by building confidence and respect.

## Program Goals

Healthy Start~Healthy Families seeks to ensure healthy, thriving children and nurturing caring families in all of Oregon's communities. By enhancing family functioning and supporting positive parenting practices, Healthy Start~Healthy Families contributes to several Oregon Early Childhood Benchmarks, including:

- Increasing school readiness,
- Improving health outcomes for children and families, and
- Reducing the incidence of child abuse and neglect.

Healthy Start~Healthy Families promotes positive parent-child relationships, supports healthy childhood growth and development and enhances family functioning by:

- Building trusting, nurturing relationships,
- Teaching parents to identify strengths and utilize problem solving skills, and
- Improving the family's support system through linkages and appropriate referrals to community services.

## Home Visitation Program Description

Healthy Start~Healthy Families was created by the Oregon Legislature in 1993. It is a statewide program in Oregon's system of supports and services for families with young children. Healthy Start~Healthy Families promotes wellness for Oregon families with first-born newborns by offering universal, accessible and non-stigmatizing services tailored to the family's unique situation.

Healthy Start~Healthy Families offers consenting first-birth families universal access to screening and personalized referrals to community services. Families may also receive a Welcome Baby gift packet filled with information about parenting and child development. Families determined to be at higher risk for adverse childhood outcomes (through the use of a standardized research-based screening tool) are offered ongoing home visiting services.

Home visiting services may continue for as long as the family wants to remain engaged, for at least three and up to five years in some situations, depending on local program policy. Visits assist families in achieving goals around parenting and improved family functioning by building on family strengths.

Today, Healthy Start~Healthy Families is a vital link in a network of integrated early childhood services.

Umatilla-Morrow Head Start, Inc. (UMCHS) is a private non profit which provides services to children and families in seven counties in Northeastern Oregon – Umatilla, Morrow, Grant, Wallowa, Gilliam, Wheeler, and Sherman. UMCHS is the grantee for Head Start/Oregon Prekindergarten , Early Head Start, Women, Infants & Children Nutrition Program (WIC), Child Care Resource & Referral (CCR&R), Family Support & Connections, Healthy Start and Court Appointed Special Advocates (CASA).

## **Governing Legislation**

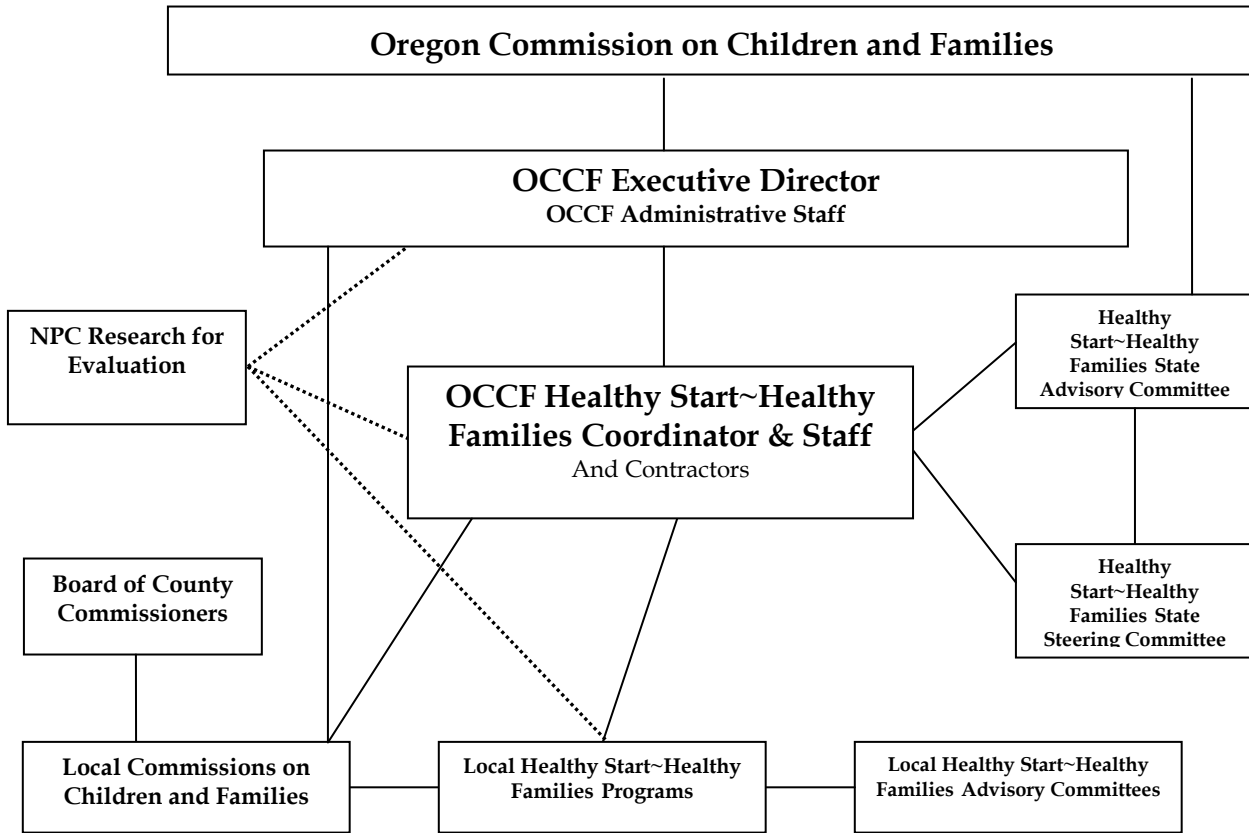
The Oregon Revised Statutes (ORS 417.795) pertaining to Healthy Start~Healthy Families (HS~HF) can be found in Appendix E.

The Oregon Administrative Rules (Division 45 423-045-0005-ff) pertaining to HS~HF can be found online at [http://arcweb.sos.state.or.us/rules/OARS\\_400/OAR\\_423/423\\_045.html](http://arcweb.sos.state.or.us/rules/OARS_400/OAR_423/423_045.html).

## **Program Policies and Procedures Manual**

This manual describes statewide program policies and procedures that all local programs must follow. Local programs insert specific policies and procedures within the document, describing local practices in detail so staff clearly understand expectations around their work. Local policies must not conflict with or substitute for state policies. See section GA-8.

### State System Organization



Note: Dotted line signifies Independent Contractor.

## 1. **CRITICAL ELEMENT #1: Initiate Healthy Start~Healthy Families (HS~HF) Services** prenatally or at birth.

**1-1. Policy:** The program ensures it identifies and initiates home visiting services with families in the target population for services either while mother is pregnant and/or at the birth of the baby.

**Performance Goal:** 60% or more first births screened.

**Minimum Performance Standard:** 50% or more first births screened.

**Performance Goal:** 80% of screenings occur prenatally or within 14 days after the baby's birth.

**Minimum Performance Standard:** 70% or more of screenings occur prenatally or within 14 days after the baby's birth.

**Performance Goal:** 90% or more new families receive their first home visit prenatally or within 3 months of the baby's birth.

**Minimum Performance Standard:** 80% or more new families receive their first home visit prenatally or within 3 months of the baby's birth.

### Procedures

**1-1.A.** First birth families are the target population for HS~HF. First birth families are defined as those having their first parenting experience (see Glossary). Local programs have a description of the demographic characteristics of first birth families residing in their service area, and identify where the families can be found.

#### [Healthy Start Critical Element #1](#)

**1-1.B.** Written agreements with hospitals and/or other appropriate entities provide access to first birth families. Organizational relationships with other community entities allow all first-birth families to be offered screening to establish eligibility for services. Programs identify strategies to increase the percentage of families screened/identified. The screening process includes giving parents information about newborn health and safety, community resources for families, parenting and child development information, and individualized referrals to appropriate services.

#### [Healthy Start Critical Element #1 Referral Policy](#)

**1-1.C.** The program monitors and addresses families who screen positive on the New Baby Questionnaire (NBQ) and were not offered home visiting services. Programs ask all eligible families if they would be interested in intensive services, informing them about the voluntary nature of the program and giving a brief description of the services that may be available. Families are asked to indicate whether they would be interested if services are available. When "interested if services are available" is selected on the NBQ, and then services are not offered, the reason is documented and entered into the Family Manager Database.

**1-1.D.** Screening using the NBQ is conducted prenatally or within 14 days after the baby's birth.

### Healthy Start Critical Element #1

- 1-1.E.** The program monitors and addresses families who verbally declined intensive home visiting services following a positive screen. The reason for decline is documented on the NBQ and entered into Family Manager database. Programs analyze data and develop strategies to address issues identified.
- 1-1.F** HS~HF provides intensive home visiting services for consenting families screened as eligible (using scoring procedures identified in the Evaluation Manual “Red Book”) for intensive services as program capacity allows. Intensive service begins with the first home visit which occurs prenatally or within the first 90 days after the baby’s birth. See Glossary for definition of “first home visit”.

### Healthy Start Critical Element #1

- 1-1.G.** Intensive services follow the target child, and may be offered to first-time substitute care providers.
- 1-1.H.** Families with babies up to 90 days of age are eligible for program entry.
- 1-1.I.** Programs may choose to offer additional services (e.g., Welcome Baby or Introductory Visits in the home) to families screened at lower risk but these services cannot be supported by HS~HF general fund or Medicaid reimbursement dollars.

### Healthy Start Critical Element #1

- 1-2. Policy:** The program measures, analyzes and addresses how it might increase the acceptance rate into intensive services in a consistent manner and on a regular basis.

#### **Procedures**

- 1-2.A.** The program manager or designee assures appropriate data collection and procedures are in place to measure the acceptance rate of families into intensive service based on receipt of first home visit. Acceptance rates are monitored at least annually.
- 1-2.B.** The program manager, supervisor or designee analyzes at least every two years (both formally and informally) among those determined to be eligible, who refuses the program and why. Information from the statewide evaluation, local program and other appropriate sources are utilized. The analysis addresses programmatic, demographic, social and other factors as well as a comparison of those who accept and those who decline.

### Healthy Start Critical Element #1

- 1-2.C.** Based on the analysis, the program manager, supervisor or designee develops and implements a plan for increasing the acceptance rate among individuals who are not currently choosing to participate in the program. The plan addresses programmatic, demographic, social and other factors.

[Healthy Start Critical Element #1](#)

2. **CRITICAL ELEMENT #2: Use a standardized assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes.**

**2-1. Policy:** The program uses the New Baby Questionnaire (NBQ), a standardized risk screening tool, to systematically identify families at risk for poor childhood outcomes.

#### **Procedures**

- 2-1.A.** Healthy Start~Healthy Families (HS~HF) programs define a process to identify all first birth families (OAR 423-045-0015). Programs screen consenting families using the NBQ to identify families at risk of poor child outcomes. Families residing in another county will be asked what program to complete a “consent to contact” form and send it to the program in the county of residence within three (3) working days of completion to be outreached for screening.
- 2-1.B.** Program eligibility criteria are found in the HS~HF Evaluation Manual “Red Book.” Families found to be at higher risk through NBQ screening are offered intensive home visiting services where program capacity allows. Because families receive their first home visit within 90 days after birth, keeping families on wait lists beyond this period is not an acceptable practice.

#### **Healthy Start Critical Element #2**

- 2-1.C.** Programs ensure the NBQ is administered uniformly with the target population. To ensure uniformity and objectivity, parent self report is reflected. A “clinical positive” determination for eligibility can be made by a program manager based on information derived from other sources. This determination is noted on the top of the NBQ in large print letters.

#### **Healthy Start Critical Element #2**

- 2-1.D.** All families must give express written consent for screening. Consent is obtained using language the family understands (using a translated version of the form and/or interpretation services). Consent documentation is kept on record at the program site.

#### **Healthy Start Critical Element #2**

- 2-1.E.** HS~HF programs record screening information in the confidential OCCF Family Manager database. Before data entry, consenting families must be provided with information regarding privacy practices to meet requirements of the Health Information Portability and Accountability Act (HIPAA) in a language they can understand or with appropriate interpretation services provided.

#### **Healthy Start Critical Element #2**

- 2-1.F.** Families may be screened over the telephone. The interviewer notes “telephone consent given”, signs and dates the consent form. The family is informed that they will receive a consent form and HIPAA information by mail. They are asked to sign and return the form to the program at their earliest convenience. Programs keep a record of the mailing including the date sent.

[Healthy Start Critical Element #2](#)

- 2-1.G.** Local programs establish policies for contacting families with positive NBQ screens to offer intensive home visiting services.

[Healthy Start Critical Element #2](#)

- 2-1.H.** If a family is found to be at higher risk, desires services, and there is no room in the program, every effort is made to link the family with other appropriate resources.

[Healthy Start Critical Element #2](#)

- 2-1.I.** Neighboring programs establish Memoranda of Understandings (MOUs) for transmitting information from consenting screened families to the program in the county where the family resides.

[Memorandum of Agreement Healthy Start~Healthy Families and Good Shepherd](#)  
[Memorandum of Agreement Healthy Start~Healthy Families and Health Department](#)  
[Memorandum of Agreement Healthy Start~Healthy Families and Mirasol Family Health Center](#)  
[Memorandum of Agreement Healthy Start~Healthy Families and OCDC](#)  
[Memorandum of Agreement Healthy Start~Healthy Families and St. Anthony Hospital](#)  
[Memorandum of Agreement Healthy Start~Healthy Families and Yellowhawk Tribal Health Center WIC Program](#)

- 2-1.J.** Families who move into the service area with babies under the age of 90 days are considered eligible for screening and intensive services.

- 2-2. Policy:** Staff and volunteers who use the screening tool have been trained in its use prior to administering it.

### Procedures

- 2-2.A.** Training for screeners includes information on the HS~HF program and the theoretical background of the screening tool. Trainees must have hands-on practice obtaining written informed consent and conducting the NBQ prior to use. Programs may use training exercises in the *QuickStart* to accomplish these objectives.

[Healthy Start Critical Element #2](#)

- 2-2.B.** Programs assure staff and volunteers providing screening services have adequate knowledge and understanding in the use of the NBQ screening tool prior to work with families. Instructions on scoring the NBQ and Talking Points for obtaining informed consent are given in the Evaluation Manual “Red Book” as well as in *QuickStart*.

[Healthy Start Critical Element #2](#)

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

**3-1. Policy:** Healthy Start~Healthy Families (HS~HF) services are offered to families on a voluntary basis and cannot be mandated. Families may choose to discontinue services at any time.

#### **Procedures**

**3-1.A.** By law (Appendix E), HS~HF services are voluntary and cannot be a part of any mandated plan. OCCF establishes memoranda of understanding with state agencies to ensure the voluntary participation of families with no adverse consequences for families who choose not to participate.

**3-1.B.** Families are informed of their right to confidentiality and give informed written consent to participate in program services using the HS~HF Rights and Confidentiality form on or before the first home visit. Consent is obtained in language the family understands, through use of a translated form and/or an approved interpreter. **(HFA Sentinel Standard)** (See also Policy GA-5.A.)



#### **[Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust](#)**

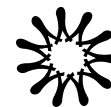
**3-1.C.** Programs follow established state protocols for working with local agencies to ensure the voluntary participation of families. Programs develop local program policies for working with families involved with the Department of Human Services Child Welfare and Self Sufficiency. Families who are receiving services from DHS Child Welfare at the time of enrollment are eligible for intensive home visiting services. (See also Policy G-12.D)

#### **[Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust](#)**

**3-1.D.** Families who choose not to participate in the statewide evaluation system are eligible to receive HS~HF services. Demographic information is recorded on the OCCF Family Manager database and is not shared with the evaluators. Any additional family records are maintained locally on site.

#### **[Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust](#)**

**3-1.E.** Families participating in intensive home visiting services read and sign the HS~HF Release of Information (ROI) form (in a language they can understand or with interpretation provided) every time information is to be shared with another agency or provider (except in the case of mandatory reporting of abuse or neglect). The Department of Human Services (DHS) Release of Information form may also be used (in a language the family can understand or with translation provided). (See also Policy GA-5.B.) **(HFA Sentinel Standard)**



#### **[Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust](#)**

- 3-1.F.** Intensive service families are defined as those who have received their first home visit and have signed the HS~HF Family Rights and Confidentiality Form.
- 3-1.G.** Supervisors assign postnatal families to Home Visitors within six working days of receiving screening information. Prenatal families may be “held” until after the birth of the baby to begin home visiting services if the program does not provide prenatal home visits.

**Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust**

- 3-1.H.** Prior to the first home visit, the program conducts engagement activities using a variety of positive methods to build family trust (i.e., phone calls, incentives, mailings, etc.) This type of engagement activity for families who have not received a first home visit is not being extended beyond 90 days after the baby’s birth.

**Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust**

- 3-1.I** A Family Intake form is submitted to NPC Research for each new family.

**3-2. Policy:** Program staff uses a variety of positive methods to engage newly enrolled intensive service families, build family trust, and maintain family involvement in the program.

**Performance Goal:** 90% or more families stay engaged in intensive services for 90 days or longer.

**Minimum Performance Standard:** 80% or more families stay engaged in intensive services for 90 days or longer.

**Procedures**

- 3-2.A.** Programs develop local guidelines for a variety of positive methods to engage newly enrolled intensive service families, and to build their trust and maintain their involvement in the program (including but not limited to, activities such as notes, phone calls, and mailings).

**Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust**

- 3-2.B.** Home Visitors use positive methods and supervisory support to establish trusting relationships and keep families interested and connected over time.

**Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust**

**3-3. Policy:** Program staff use Creative Outreach methods for 90 days before discontinuing intensive services to a family.

**Procedures**

- 3-3.A.** Families who neither actively participate in home visiting, nor decline services, are placed on Creative Outreach for a minimum of 90 days. Efforts to contact the family to re-engage them in services are documented in the family file and in supervision notes.

**3-3.A.i.** Families may be placed on Creative Outreach when they have missed at least one home visit followed by at least 10 working days of unsuccessful attempts to reschedule, or after at least one month of unsuccessful attempts to schedule a home visit. Beyond this minimum requirement, programs may use their discretion placing families on Creative Outreach.

**3-3.A.ii.** Families may also be placed on Creative Outreach immediately upon telling the program that they will not be available for visits for at least 30 days. (i.e., they will be out of the area for at least a month). (See also Policy 8-1.F)

**3-3.A.iii.** Families may not be placed on Creative Outreach due to program issues, i.e., staff turnover or absences, training, agency closures, etc.

#### Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust

**3-3.B.** Programs may conclude Creative Outreach prior to 90 days if parents (re)engage in intensive services, request to exit the program or move leaving no way to make further contact.

**3-3.C.** Families who move out of the area and give consent for transfer are referred to the local program in their new county of residence by the HOME VISITOR or supervisor.

**3-3.D.** Program participants who have exited intensive services and later request re-entry may resume intensive services through the third birthday (see policy 4-3) at the discretion of the program manager.

#### Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust

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

**Performance Goal:** 75% or more families remain in intensive services for 12 months or longer.  
**Minimum Performance Standard:** 50% or more families remain in intensive services for 12 months or longer.

#### **Procedures**

**3-4.A.** The program manager or designee ensures appropriate data collection and monitors the retention rate of families receiving intensive services at least annually.

#### Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust

**3-4.B.** The program manager or designee conducts an analysis of the retention at least every two years. This analysis is comprehensive including who drops out of the program and why, in comparison to families who remain in the program. Both formal and informal methods are utilized. Formal analysis is conducted utilizing information from the Family Manager Database and statewide evaluation. Informal analysis includes local data review, discussions with staff and others involved in program services. This analysis includes programmatic, demographic, social and other factors.

#### Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust

- 3-4.C.** Based on the analysis, programs develop and implement a plan to increase the retention rate that addresses programmatic, demographic, social, and other factors. Both formal and informal methods are utilized.

### Healthy Start Critical Element #3 - Voluntary Services that Build Family Trust

4. CRITICAL ELEMENT #4: Offer services intensely with well defined criteria for increasing or decreasing intensity of service over the long term.

**4-1. Policy:** The program offers home visitation services intensely after the birth of the baby.

#### **Procedures**

- 4-1.A.** Families are offered weekly home visits for a minimum of 180 days after the birth of the baby or a minimum of 180 days after a post-natal first home visit (whichever is longer), excluding time on Creative Outreach. Prenatal visits are not included in this 180 days of weekly visits.

### Home Visit Policy

- 4-1.B.** The program ensures that families remain on a weekly home visitation level for a minimum of 180 days. During this time, families are not assigned to a less intense level of services.

### Home Visit Policy

**4-2. Policy:** The program has a well-thought-out system for managing the intensity and frequency of Home Visitor services.

**Performance Goal:** 75% or more intensive service families receive at least 75% of the appropriate number of home visits based on the level of service to which they are assigned.

**Minimum Performance Standard:** At least 65% of intensive service families receive at least 75% of the appropriate number of home visits based on the level of service to which they are assigned.

#### **Procedures**

- 4-2.A.** Levels of service offered by the program and criteria for level change are clearly defined as follows: (1) Level change criteria are found on the standardized and required Service Level Assignment Forms and (2) The levels of service are as follows:

- Level P-1,2,3,4 Prenatal, weekly to quarterly home visits
- NOTE: The first month of prenatal services is typically weekly to establish a relationship, complete needed referrals and intake paperwork. After the first month, frequency is based on family need during the prenatal period.**
- Level 1: Weekly home visits
  - Level 1SS: Weekly (or more frequently), high needs
  - Level 2: Every other week home visits
  - Level 3: Monthly home visits
  - Level 4: Quarterly home visits
  - Level X: Creative Outreach, weekly to monthly contact  
(See Policy 8-1.B. for the caseload weights of the various service levels)

- 4-2.B.** Programs ensure that families at the various levels of service (weekly visits, bi-weekly visits, monthly, or quarterly visits) receive the appropriate number of home visits, based upon the level of service to which they are assigned.

#### Home Visit Policy

- 4-2.C.** Monthly home visits for the program as a whole is entered into Family Manager and monitored by the program manager on a monthly basis.. Supervisors provide individual coaching to address performance issues with home visitors in order to raise home visit completion rates. Home visitors and supervisors increase their home visiting rates by taking a team approach and by working to minimize programmatic barriers to home visit completion. The program develops, implements, and monitors progress on a plan for increasing home visit completion rates at least annually.

#### Home Visit Policy

- 4-2.D.** Family progress is the basis for deciding to move the family from one level of service to another. Progress is reviewed by the family, Home Visitor, and supervisor prior to changing service levels. All parties do not have to be present at the same time to conduct this review. Discussions about level changes are documented in the Home Visit Record and supervisory notes. When level changes are made, they are recorded on the Level Assignment Forms.

#### Family Partnership Plan Policy

#### Family Development and Intensive Case Management

- 4-2.E.** Service levels are not changed in response to barriers to full participation, unless 80% of the criteria for level change outlined on the Level Assignment Forms are also met. (These barriers may include the need for early morning, evening, or weekend visits, the need for translation at each visit, staffing issues, etc.)
- 4-2.F.** A home visit is a face-to-face interaction that occurs between the parent(s) or primary caregiver(s) and Home Visitor. Home visits last for approximately one hour and the child typically must be present. Occasional visits may occur outside the home but these visits count as a home visit only when the content matches the definition of a home visit and can be documented as such. (See Glossary for the complete definition of a “home visit.”)
- 4-2.G.** Home visits are documented using the Home Visit Record. Documentation of all additional contacts is required (e.g., phone calls and letters) using an appropriate form. No more than one home visit per day is documented per family.

#### Home Visit Policy

- 4-2.H.** For families on Level 1, a parent group meeting may substitute for one home visit per month. Groups may substitute for home visits for families on other service levels at the discretion of the home visitor and supervisor. Groups may count as home visits if:
- A person trained as a home visitor is present,

- The interaction at the group meeting meets the definition of a home visit (see Glossary),
- The staff member interacts with each family individually as well as in the group,
- The group meeting is documented on a Home Visit Record for each family attending, and
- Individual parent-child and group interactions is recorded on the Home Visit Record.

### Policy and Procedure for Social Support Groups Policy for Parent Education

- 4-2.I.** All Home Visit Records and/or additional contact documentation (Contact Logs, etc.) are written within 48 hours of contact with families.

- 4-3. Policy:** Families may choose to remain enrolled in the program for a minimum of three years and a maximum of five years after the baby's birth based on family needs and available community and program resources.

#### **Procedure**

- 4-3.A.** The program encourages family participation for the full duration of program services by continuing to promote engagement, build family trust, celebrate the completion of family goals, and encourage the development of new ones, and providing information and support that is considered useful by the family.

### Home Visit Policy

- 4-3.B.** The home visitor and supervisor work with the family to build their system of formal and informal supports. Efforts are made to decrease the frequency of visits over time as the criteria for level changes are met to avoid fostering dependence. These efforts are documented in the Home Visit Record, Home Visitor Plan, and supervision notes.
- 4-3.C.** Transition planning begins well in advance of the target child reaching the age limit for the program (at least 180 days before the birthday). This includes gradually reducing the level of service and assuring the family has other resources in place. Referrals are made and linkages tracked. Efforts to prepare for transition out of the program are documented on the Home Visit Record, the Referral Tracking Form, and in supervisory notes.

### Transition Policy

- 4-3.D.** Exit/Re-entry data is entered in the Family Manager database within a month of case closure or re-entry including reasons for exit.
- 4-3.E.** Families exit Healthy Start intensive services when:
- The target child has reached the age limit defined by the program and so "graduates" from Healthy Start services,
  - The family has been on Creative Outreach for 90 days or more and has not re-engaged,
  - The family requests discontinuation of services,
  - The family moves out of the program's service area (and does not transfer to another Healthy Start program),
  - The target child is no longer in the home, or

- The Home Visitor's safety is at risk.

**5. CRITICAL ELEMENT #5: Services are culturally competent such that staff understands, acknowledges and respects cultural differences among families. Staff and materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served.**

**5-1. Policy:** The program has a description of the cultural characteristics of its current service population that includes ethnic, racial, linguistic, demographic, and other characteristics.

**Procedures**

**5-1.A.** The description of the diversity of the current service population includes a variety of characteristics, features, and attributes such as:

- Ethnic heritage and/or race,
- Customs and values,
- Language,
- Age,
- Gender,
- Religion,
- Sexual orientation,
- Social class,
- Geographic origin, and
- Factors such as domestic violence, substance abuse, mental health and cognitive abilities as related to families served.

**See-Community Assessment under Program Planning Policy**

**5-1.B.** The description of the current service population is updated every two years in order to assure that the program remains current in its ability to meet the needs of its service population and that program materials and staff training are appropriate to the population served.

**Program Planning Policy**

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

**Procedures**

**5-2.A.** Appropriate staff, curricula, other materials, and community partnerships are available to meet the cultural and linguistic needs of the major population groups within the service population.

**Holiday and Special Events Policy**

**Home Visit Policy**

**Community Partnerships**

**Comprehensive Literacy Policy**

**5-2.B.** Cultural, ethnic, racial, linguistic and other characteristics are considered when matching families to service providers. Supervisors monitor staff-family interactions through a variety of means, including ongoing case review and periodic shadowing of home visits to ensure that family cultural values and

beliefs are respected. These considerations and observations are documented in supervision notes.

#### Healthy Start Communication

- 5-2.C.** Monolingual families are assigned to a home visitor who speaks their language. If this is not possible, skilled interpreters are provided.

#### Healthy Start Communication

- 5-2.D.** Materials for families are culturally sensitive and written in their native language whenever possible. Written materials reflect literacy levels of parents.

#### Healthy Start Communication

- 5-3. Policy:** All staff receive training on an annual basis that is designed to increase understanding and sensitivity of the unique characteristics of the service population.

#### UMCHS Training Plan

#### Staff Training Program - Career Ladders

- 5-4. Policy:** The program analyzes the extent to which all components of its service delivery system are culturally sensitive.

#### **Procedures**

- 5-4.A.** Programs complete a Cultural Sensitivity Review (Report) at least every two years that addresses the following components:
- Materials,
  - Training, and
  - Service delivery system (screening, home visitation, supervision, etc.).

The Review in its final version summarizes the strengths and needs for improvement in all areas of the service delivery system. It also identifies recommendations/suggestions for how the program might advance its current level of cultural sensitivity.

#### Program Planning Policy

- 5-4.B.** The Cultural Sensitivity Review includes family and staff input regarding the program's ability to provide culturally sensitive services. Staff and families can be offered a variety of culturally sensitive input options such as one-on-one oral interview in the language they speak, anonymous surveys, and/or focus groups. The Review summarizes patterns and trends, strengths and areas to address based on the feedback from families and staff.

#### Program Planning Policy

- 5-4.C.** The Review is reported to the program's Advisory Group requesting feedback and input in the development of strategies for areas of growth. Actions are taken to address identified areas of growth.

#### Program Planning Policy

6. **CRITICAL ELEMENT #6:** Services focus on supporting the parent(s) as well as supporting the parent-child interaction and child development. This support includes discussing issues identified at the initial assessment, collaboration with families to identify, develop and achieve goals, sharing parenting and child development information, and ensuring children are developmentally on target.

**6-1. Policy:** Home Visitors conduct a Family Assessment Interview (FAI) using the Family Stress Checklist within the first three home visits. Issues identified by the family in the Family Assessment Interview are discussed and reviewed during the course of home visiting services.

**Performance Goal:** 65% or more parents report reduced parenting stress.

**Minimum Performance Standard:** 50% or more parents report reduced parenting stress.

### Procedures

- 6-1.A.** The home visitor and the supervisor discuss and review the information identified by the family during the Family Assessment Interview (FAI) in order to plan the initial approach to the family and guide the provision of services over time. Documentation of the initial review, including stressors, strengths, concerns and the initial approach is captured on the Home Visitor Plan (see 6-1 C).
- 6-1.B.** The home visitor and family discuss and review the information given by the family in the FAI and the general FAI topics early in the service delivery and over the course of a family's enrollment in the program. Documentation of these conversations is included on the Home Visit Record. Documentation demonstrates clear follow-up on concerns and needed resources identified in the FAI.

[Home Visit Policy](#)

[Family Partnership Plan Policy](#)

- 6-1.C.** The Home Visitor (HVP) Plan (formerly Home Visitor Goal Plan) is a strategic planning tool that guides supervision and home visiting services by addressing Family Assessment Interview topics in order to strengthen families and remove barriers to meeting HFA goals. Development of the HVP is collaborative, beginning in supervision with a review of the FAI, including family strengths and concerns and the development of an initial approach (typically within the 4<sup>th</sup> week of service). Additional goal(s) are established after the home visitor has spent more time with the family, with at least one additional goal set within 75 days of service. The HVP is kept in the supervisor file and is informed by the FAI, home visitor observations, the Family Goal Plan (FGP), Parent Survey responses, individual family values and other sources as a framework for supervision. The HVP is a fluid document that is reviewed, revised and updated regularly during supervision.

[Home Visit Policy](#)

[Family Partnership Plan Policy](#)

- 6-1.D.** Staff administering the assessment tool (Family Stress Checklist) during the FAI are trained in its use prior to conducting the interview with families. Staff supervising those who administer the FAI are similarly trained and certified in its use. (See also Policy 10-3.) Training in the FAI consists of:
- Initial training given on-site, and documented in training records.
  - Core FAI Training completed within 180 days of hire
  - Certification in the FAI within 180 days of completing Core FAI Training, following the FAI Certification protocol. Extension of this timeline may be granted with written approval of the FAI Trainer.

### [Family Partnership Plan Policy](#)

- 6-2. Policy:** Delivery of services to families is guided by the Family Goal Plan (FGP) and the process of developing the plan uses family-centered practices.

#### **Procedures**

- 6-2.A.** The home visitor and family collaborate to identify family strengths/competencies, values, concerns and needs as well as the services desired to address those needs. The home visitor initiates activities that assist families in identifying these areas through the use of a Family Concerns and Referrals form, Family Values Activity and Wishes for My Child/Child Qualities Activities. The Family Concerns and Referrals form is completed with the family to identify concerns and needs within the first three home visits, as part of the FAI process. The Family Values Activity occurs within the first 30 days of service (or the 4<sup>th</sup> home visit). The Wishes for My Child/Child Qualities Activity occurs within the first 45 days of service (or within the 6<sup>th</sup> home visit). Programs may choose to incorporate the Parent Qualities and What I Want for Myself/My Family activities and may choose to use either cards such as Reachables along with the provided forms. Through these activities, the home visitor and family work together to identify what is important to the family as preparation for the Family Goal Plan. These discussions are documented on the activity forms and Home Visit Record and are revisited over the course of service.

### [Home Visit Policy](#)

### [Family Partnership Plan Policy](#)

- 6-2.B.** Based on what is most important to the family, the home visitor and family collaborate to develop a FGP within 45 days of the first home visit. The FGP contains specific objectives and strategies for achieving goals, while taking into consideration family strengths, needs and concerns. The FGP typically has one or two goals at a time that may include personal, family and parenting goals. Home visitors use motivational interviewing to assist parents in choosing a goal with the greatest meaning to them. Larger goals are broken down into smaller achievable steps, objectives or strategies. Each step or strategy is incremental, measureable and functional for the family. The FGP is a working document and serves as a guide for ongoing delivery of services. Discussion of FGP goals is documented on the Home Visit Record at least monthly and additionally as needed in the family file.

- 6-2.C.** The home visitor and the supervisor review FGP progress regularly to ensure that goals for families remain relevant, challenges to achieving goals are addressed, successes for steps/objectives are celebrated, and that the services the home visitor provides are connected to the family goals. These discussions are ongoing and review of progress is documented in supervision notes at least every 60 days.
- 6-2.D.** The FGP serves as the guide for delivering services. This is documented in the family file and can include a variety of activities such as:
- Continually reviewing goals to ensure they remain current and documenting when steps are achieved,
  - Ensuring resources and referrals are provided to families based on steps/goals,
  - Celebrating and/or affirming when steps/goals are accomplished,
  - Developing new goals when goals are accomplished,
  - Ensuring staff's activities and interventions are related to steps/goals,
  - Modifying or retiring goals that are no longer meaningful to families, or the family no longer wishes to pursue,
  - Creating contingency plans that "plan for" potential barriers,
  - Addressing barriers the family may be experiencing in reaching their goals, and
  - Ensuring steps/goals for children are anchored in the family's general routines.

[Home Visit Policy](#)

[Family Partnership Plan Policy](#)

**6-3. Policy:** The program promotes positive parent-child interaction, child development skills, and health and safety in work with families.

**Performance Goal:** 85% or more parents report reading to their child three times per week or more.

**Minimum Performance Standard:** 70% or more parents report reading to their child three times per week or more.

**Performance Goal:** 85% or more parents report positive parent child interactions.

**Minimum Performance Standard:** 70% or more parents report positive parent child interactions.

### Procedures

- 6-3.A.** Home visits include the use of evidenced based curricula to promote positive parent-child interaction, positive parenting skills, knowledge of child development, health, and safety issues. This information is routinely shared with families unless there are documented mitigating circumstances.

[Home Visit Policy](#)

**6-3.A.i.** All health and safety materials given to parents are in accordance with the recommendations of the American Academy of Pediatrics.

**6-3.A.ii.** Curricula are selected and used to meet the individual needs of the family, with attention paid to cultural, linguistic, cognitive factors, and the interests of the family.

**6-3.A.iii.** Additional curricula and materials used in home visitation are approved by the supervisor prior to use with families.

### Home Visit Policy

**6-3.B.** Home visitors build skills and share information with families on appropriate activities designed to promote positive parent-child interaction and child development skills at each visit unless there are documented mitigating circumstances. Home visitors encourage parents to do the activities with their child verses the home visitor doing the activity with the child. Observations, interactions, activities and how curriculum was used are documented on the Home Visit Record.

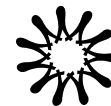
**6-3.C.** Home visitors share information with families designed to promote positive health and safety practices including prevention strategies and any issues observed in the home. This occurs and is documented on the Home Visit Record at intake and at least monthly on levels 1 and 2 and every other visit on levels 3 or 4.

**6-4. Policy:** The program monitors the development of all participating children using a standardized developmental screening tool.

### **Procedures**

**6-4.A.** The ASQ (Ages and Stages Questionnaire) and ASQ-SE (Ages and Stages Questionnaire – Social Emotional) are used to monitor child development. Screening is administered by trained staff in accordance with ASQ and ASQ-SE guidelines following a standard screening schedule (see 6-4-B). If a family is on a revised screening schedule, the reason for the adjustment is documented in the Family File.

**6-4.B.** Unless developmentally inappropriate, ASQ screening is done at: 4, 8, 12, 18, 24, 30, 36, 48, and 60 months. The ASQ-SE is used every six months for the first three years and after that once a year. The 2 month ASQ is now available and optional. The Data Tracking Form is used for tracking when these are due. **(HFA Sentinel Standard)**



**6-4.C.** The ASQ is adjusted for babies born 36 weeks + 6 days or less. For example, if a baby is born at 36 weeks gestational age, the ASQ is administered four weeks later than the baby's chronological age.

**6-4.D.** The ASQ and the ASQ-SE must be administered within 30 days before or after the due date to ensure validity. Information on results is submitted to the evaluation using the Family Update form and entered in Family Manager.

- 6-5. Policy:** All staff must be trained prior to using the ASQ or ASQ-SE. Training on the instruments includes reading the manuals, watching the training videos, observing another qualified staff member administering the tools, being observed administering the tools, and orientation to local Early Intervention services to facilitate referral.

[Developmental Screening](#)

[ASQ-SE Info Pages](#)

[Identification of Social Emotional Concerns](#)

[Staff Qualifications](#)

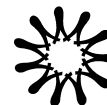
- 6-6. Policy:** The program tracks target children who are suspected of having a developmental delay utilizing the Referral Tracking Form and follow through with appropriate referrals and follow-up. Discussions are documented in supervision records.

## Procedures

- 6-6.A.** The supervisor and Home Visitor determine when a child should be referred for developmental concerns based upon the ASQ, the ASQ-SE, and other observations made during home visits.

[Referral Policy](#)  
[Developmental Screening](#)  
[ASQ-SE Info Pages](#)

- 6-6.B.** The Home Visitor tracks children suspected of having a developmental delay and follows through with appropriate referrals and follow-up as needed to assist families in obtaining appropriate early intervention/early childhood special education services. **(HFA Sentinel Standard)**



[Student-Client Records Policy](#)  
[Referral Policy](#)

- 6-6.C.** The Home Visitor integrates services between Early Intervention and Healthy Start~Healthy Families (HS~HF) when children are dually enrolled. Integrated services include attending therapy services, joint FGPs and documentation of referrals made and accomplished. The continued use of the ASQ by HS~HF is determined on a case-by-case basis jointly by the agencies serving the family.
- 6-6.D.** When families decline Early Intervention services, discussions and efforts to share information about Early Intervention services are documented in the Home Visit Record, Referral Tracking Form, and supervisory notes.

[Student-Client Records Policy](#)

- 6-6.E.** When children do not meet eligibility criteria for Early Intervention services, the Home Visitor encourages the family to stimulate the child's development, continues to conduct developmental screenings using the ASQ and ASQ SE, and documents these activities on the Home Visit Record. Discussions of the child's developmental status occur regularly in supervision and are recorded in supervision notes.
- 6-6.F.** When families are served through multiple programs conducting developmental screenings, the Home Visitor documents efforts to coordinate services and obtains copies of developmental screenings conducted by other professionals for the family's file (with a signed ROI giving permission).

7. **CRITICAL ELEMENT #7: At a minimum, all families are linked to a medical provider to assure optimal health and development. Depending upon the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family resource centers, substance abuse treatment programs, and domestic violence shelters.**

**7-1. Policy:** Participating target children in Healthy Start~Healthy Families (HS~HF) are linked to a primary medical/health care provider to assure optimal health and development.

**Performance Goal:** 80% or more of children are linked to a Primary Care Provider (PCP).

**Minimum Performance Standard:** 70% or more of children are linked to a PCP.

#### **Procedures**

- 7-1.A. Programs have established procedures for providing information and connecting families to medical/health care providers.

#### **Physical & Dental Exam Policy**

- 7-1.B. Staff support families to establish a primary medical/health care provider (PCP) for the target child and document the PCP name in the family file.

#### **Physical & Dental Exam Policy**

**7-2. Policy:** The program ensures that immunizations are up-to-date for target children.

**Performance Goal:** 80% or more of children are up-to-date with immunizations.

**Minimum Performance Standard:** 70% or more of children are up-to-date with immunizations.

#### **Procedures**

- 7-2.A. Staff support intensive service children in receiving timely immunizations according to current recommendations from Centers for Disease Control and Prevention (CDC).

- 7-2.B. Staff record immunizations and well-baby checks in the family file and report these to the evaluators using the Family Update Form.

#### **Immunization Policy**

- 7-2.C. Staff provide families with preventative child health and safety information based on American Academy of Pediatrics recommendations.

- 7-2.D. When families' beliefs preclude immunizations for their children, this is documented in the family file.

#### **Immunization Policy**

**7-3. Policy:** Home Visitors provide information, referrals, and linkages to available health care resources for all participating family members.

#### **Physical & Dental Exam Policy**

**7-4. Policy:** Families are connected to additional services in the community as needed.

**Performance Goal:** 80% or more parents report HS~HF helped with Social Support.

**Minimum Performance Standard:** 70% or more parents report HS~HF helped with Social Support.

- 7-4.A. Home Visitors make appropriate referrals for community services based on: information gathered in the FAI, needs and desires expressed by the family during home visits and the development of the FGP, and information received (with family consent) from other service providers.

[Family Partnership Plan Policy](#)  
[Umatilla-Morrow County Resource Directory](#)  
[Referral Policy](#)

- 7-4.B. The Home Visitor documents all referrals on the Referral Tracking Form.
- 7-4.C. The Home Visitor follows up on referrals, documenting the outcome, and any reasons the referral was not accomplished. If referrals are not successful, the Home Visitor works with the family to access alternate resources.

[Family Partnership Plan Policy](#)

- 7-4.D. Referrals and follow-up are discussed in regular supervisory sessions and discussion is documented on supervision notes.

7-5. **Policy:** The program endeavors to build and maintain positive working relationships with local public health departments and other medical providers serving HS~HF families.

#### Procedures

- 7-5.A. The program ensures that public and private health care systems and providers are informed and kept up-to-date on HS~HF services and operations.

[Healthy Start Communication](#)

- 7-5.B. Public and private health care systems and providers have an advisory role within the program.

[Health Advisory Committee Policy](#)

- 7-5.C. The local program works with local public health department home visitation services to coordinate efforts.

[Healthy Start Communication](#)

[Memorandum of Agreement Healthy Start and Good Shepherd](#)

[Memorandum of Agreement Healthy Start and Health Department](#)

[Memorandum of Agreement Healthy Start and Mirasol Family Health Center](#)

[Memorandum of Agreement Healthy Start and OCDC](#)

[Memorandum of Agreement Healthy Start and St. Anthony Hospital](#)

[Memorandum of Agreement Healthy Start and Yellowhawk Tribal Health Center WIC Program](#)

7-6. **Policy:** The program ensures HS~HF services are coordinated with other service providers who may be working with the family.

#### Procedures

- 7-6.A. If the Home Visitor learns that another home visitation program, community service, or medical program is providing services to the family, efforts are made to arrange a joint staffing meeting or telephone conversation between the two programs (with the written consent of the family) in order to avoid duplication of services. A lead program is identified and roles are clarified.

[Healthy Start Communication](#)

[Memorandum of Agreement Healthy Start and Good Shepherd](#)

[Memorandum of Agreement Healthy Start and Health Department](#)

[Memorandum of Agreement Healthy Start and Mirasol Family Health Center](#)

[Memorandum of Agreement Healthy Start and OCDC](#)

[Memorandum of Agreement Healthy Start and St. Anthony Hospital](#)

[Memorandum of Agreement Healthy Start and Yellowhawk Tribal Health Center WIC Program](#)

[Healthy Start Communication](#)

- 7-6.C. Documentation of ongoing coordination of services is maintained by the Home Visitor in the family file and by the supervisor in supervision notes.

[Healthy Start Communication](#)

**8. CRITICAL ELEMENT #8: Services are provided by staff with limited caseloads to assure that Home Visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities.**

**8-1. Policy:** Services are provided by staff with limited caseloads to assure that Home Visitors have an adequate amount of time to spend with each family to meet their needs and plan for future activities.

**Performance Goal: 25-30** average caseload points per 1.0 FTE Home Visitor.

**Minimum Performance Standard: 18-24** average caseload points per 1.0 FTE Home Visitor

**Procedures**

- 8-1.A. Full time Home Visitors carry no more than 15 families at the most intensive levels (e.g., Level 1: weekly visits or Level 1SS). Programs prorate caseloads for part-time Home Visitors based on their Full Time Equivalency (e.g., a .5 FTE should have no more than 7-8 families or a .75 FTE should have no more than 11 families on the most intensive level).

- 8-1.B. Full time Home Visitors carry no more than 25 families at various service levels, or no more than a maximum total weighted caseload of 30 points at any one time. Programs prorate caseload size for part time Home Visitors (see example above). Caseloads are weighted in the following manner:

<b>Level P-1, 2, 3, 4:</b>	0.5 - 2 points	Weekly to quarterly visits (optional)
<b>Level 1:</b>	2 points	Weekly home visits
<b>Level 1SS:</b>	3 points	Weekly (or more) home visits (high needs)
<b>Level 2:</b>	1 point	Every other week home visits
<b>Level 3:</b>	0.5 point	Monthly home visits
<b>Level 4:</b>	0.25 point	Quarterly home visits
<b>Level X:</b>	0.5 point	Weekly to monthly contact (Creative Outreach)

**8-1.C.** Level P- 1, 2, 3, 4: These are optional prenatal home visiting service levels. The first month of prenatal services is typically weekly to establish a relationship, complete needed referrals and intake paperwork. After the first month, frequency is based on family need during the prenatal period. The Home Visitor and supervisor determine the frequency of home visits with the family's input. Factors considered in determining the Prenatal Level include:

- The severity and complexity of issues needing attention prior to the birth of the baby,
- Other home visitation services the family is receiving, and
- The parents' availability for visits.

Discussions about the level of prenatal service with the family, Home Visitor, and supervisor are documented in the supervision notes and the Home Visit Record. The Prenatal Level Assignment form is completed stating the assigned level, and the Home Visitor's caseload reflects the proper weight for the prenatal level assigned.

### Home Visit Policy

**8-1.D.** Prenatal families are assigned to Level 1 after the birth of the baby.

**8-1.E.** Level 1SS: Families on Level 1 may receive additional caseload weighting for special services for the following:

- In crisis,
- Who live beyond the program's usual travel area/time,
- With parents who have cognitive limitations or are illiterate,
- Who need an interpreter, and
- Who require intensive case management.

For families placed on Level 1SS due to temporary factors, the appropriateness of their continuation on Level 1SS is reviewed in supervision at least every 30 days and documented in the supervision notes.

### Home Visit Policy

**8-1.F.** Level X (Creative Outreach): Families who neither actively participate in home visiting, nor decline services, are placed on Level X for a minimum of 90 days. Efforts to contact the family to re-engage them in services are documented in the family file and in supervision notes.

**8-1.F.i.** Families may not be placed on Level X unless they have missed at least one home visit followed by at least 10 working days of unsuccessful attempts to reschedule, or after at least one month of unsuccessful attempts to schedule a home visit. Beyond this minimum requirement, programs may use their discretion as to if and when they place families on Level X.

**8-1.F.ii** Families may also be placed on Level X immediately upon telling the program that they will not be available for visits for at least 30 days. (i.e., they will be out of the area for at least a month).

**8-1.F.iii:** Level X, like all levels, is based on the family's situation and so is not appropriately used to address programmatic issues like staff turnover, absences, training, program closures, etc.

## Home Visit Policy

**8-2. Policy:** Programs assign cases within the framework of the weighted caseload management procedure to ensure that home visitors have an adequate amount of time to spend with each family.

### **Procedures**

- 8-2.A.** Programs establish criteria for managing caseloads and assigning families to home visitors. Criteria may include:
- Experience and skill level,
  - Nature and difficulty of the problems encountered,
  - Work and time required to serve each family,
  - Multiple births (twins, triplets, etc.),
  - Number of families that involve more intensive intervention,
  - Distance and travel time,
  - Culture, ethnicity, language,
  - Extent of other resources available in the community,
  - Caseload limitations, and
  - HOME VISITOR flexibility when family has many scheduling limitations.

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

**9-1. Policy:** The program ensures that service providers and program management staff are selected because of a combination of personal characteristics, experiential, and educational qualifications.

### **Procedures**

- 9-1.A.** Screening and selection of program managers considers characteristics including, but not limited to:
- A solid understanding of and experience in managing staff,
  - Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development, and
  - A Bachelor's degree in human services administration or related field or an equivalent combination of education and experience is required (Master's degree preferred).

## Staff Qualifications

- 9-1.B.** Screening and selection of supervisors considers characteristics including, but not limited to:
- A solid understanding of and experience in supervising and motivating staff, as well as providing support to staff in stressful work environments,
  - Knowledge of infant and child development and parent-child attachment,

- Experience with family services that embrace the concepts of family centered and strength-based service provision,
- Knowledge of maternal-infant health and dynamics of child abuse and neglect,
- Experience in providing services to culturally diverse communities/families,
- Experience in home visitation with a strong background in prevention services to the 0-3 age population, and
- A Bachelor's degree and experience in human services, supervision, or related fields or an equivalent combination of education and experience are required (Master's degree preferred).

#### Family Development Manager Staff Qualifications

- 9-1.C.** Screening and selection of direct service staff and volunteers/interns (if performing the same function as direct service staff) considers characteristics including, but not limited to:
- Experience in working with or providing services to children and families,
  - Ability to establish trusting relationships,
  - Acceptance of individual differences,
  - Experiences and willingness to work with the diverse population(s) present among the program's target population,
  - Knowledge of infant and child development, and
  - A high school diploma or GED (AA degree or Bachelor's degree preferred) and a combination of experience or qualifications as required by agency or program site.

#### Healthy Start~Healthy Families Family Advocate Healthy Start Advocate EHS Outreach Staff Qualifications

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

#### Employment Policies

- 9-3. Policy:** The program's recruitment and selection practices assure that its human resource needs are met.

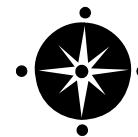
#### **Procedures**

- 9-3.A.** Recruitment and selection practices are in compliance with applicable law or regulation and include:
- Notification of its personnel of available positions before or concurrent with recruitment elsewhere,
  - Utilization of standard interview questions that comply with employment and labor laws, and

- Verification of two to three references and credentials.

### Employment Policies Hiring Procedure

- 9-3.B.** All Healthy Start~Healthy Families (HS~HF) staff and volunteers who will have responsibilities relating to families or their files must have a criminal background check before contact with families, following the policies of their employing agency for staff doing similar work with families. Staff may participate in home visits with another already cleared staff member pending the criminal background check. **(HFA Safety Standard)**



### Hiring Procedure

- 9-3.C.** Hiring of HS~HF parents: Programs may hire people previously enrolled in the program using the following guidelines:
- At least one year has past since the applicant participated in HS~HF,
  - Standard hiring procedures are followed, and
  - The applicant's family file is not utilized during the hiring process and/or during the duration of employment. The file is kept locked and inaccessible to all staff.

**9-4. Policy:** Monitor and analyze staff retention, including personnel turnover and satisfaction every two years and take action to correct identified problems.

### **Procedures**

- 9-4.A.** Programs encourage staff that are leaving the program to complete the Exit Survey provided by the statewide evaluation contractors (available at [www.npcresearch.com](http://www.npcresearch.com)).
- 9-4.B.** Programs are required to offer optional exit interviews to all staff.

### Employment Policies Exit Interview Questions

- 9-4.C.** Staff turnover rates are examined at least every two years by specific job categories and in the context of measures of job satisfaction. Local programs must have a mechanism to measure context of job satisfaction such as, staff satisfaction surveys and focus groups allowing a comparison of staff that leave with staff that stay. Anonymity on surveys is encouraged whenever possible.

### Exit Interview Questions

**10. CRITICAL ELEMENT #10**

**10a.** Service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers receive basic training in areas such as cultural competency, substance abuse, reporting child abuse and neglect, domestic violence, drug-exposed infants, and services in their community.

**10b.** Service providers receive intensive training specific to their role to understand the essential components of family assessment and home visitation.

**10b.** Service providers receive intensive training specific to their role to understand the essential components of family assessment and home visitation.

**10-1. Policy:** The program has a comprehensive training plan that assures access and ongoing tracking and monitoring of required trainings in a timely manner for all staff.

**Procedures**

**10-1.A.** OCCF reviews the statewide training plan (Appendix A) at least every two years. Local programs may adopt this state training plan and add local training needs. All programs maintain training backup documentation records for each staff member including:

- Orientation,
- Core training,
- Training within 6-months of hire,
- Training within 12-months of hire,
- On-going training topics,
- Training for screeners, and
- Cultural sensitivity.

[Staff Qualifications](#)

[UMCHS Training Plan](#)

[Staff Performance Appraisals Procedure](#)

[Training Request Form](#)

**10-1.B.** Program managers or designees ensure that training activities are entered in the OCCF Training Tracker database within 30 days of receiving training.

**10-1.C.** Staff, volunteers, interns, or partner agency staff performing screening receive training specific to their role.

[Staff Qualifications](#)

**10-1.D.** HFA Certified state trainers provide Core Training for home visitors, supervisors, and program managers. Trainings are held at least two times per year. Additional trainings are scheduled as needed. Core Training cannot be used to satisfy any other training topic requirements.

**10-1.E.** The following training materials are provided through Central Administration:

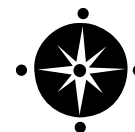
- *Quick Start*: Orientation for Healthy Start~Healthy Families Staff,
- Healthy Start~Healthy Families Family Assessment Interview Training Manual,
- Healthy Families America Training Manual,

- Medicaid Administrative Claiming Training and MOTT (Medicaid Online Time Tracker) System DVD and training materials,
- ASQ/ASQ-SE Manuals and Videos,
- The “*Red Book*” Evaluation Manual and Evaluation Training DVD,
- Program Managers Quick Reference Guide, and
- Healthy Families America Site Self Assessment Tool.

**10-2. Policy:** All staff receive orientation (separate from Core Training) prior to direct work with children and families to familiarize them with the functions of the program. Programs use *QuickStart: Orientation for Healthy Start~Healthy Families Staff* for this training. Programs ensure that orientation training is entered into the Training Tracker database.

### Procedures

- 10-2.A.** Staff receive orientation to their roles as these relate to the program’s goals, services, policies and operating procedures (including forms, evaluation tools, and data collection), and the philosophy of home visiting/family support prior to direct work with children and families or supervision of staff.
- 10-2.B.** Staff are oriented to the program’s relationship with other community resources prior to direct work with children and families.
- 10-2.C.** Staff are oriented to child abuse and neglect indicators and reporting requirements prior to direct work with children and families. **(HFA Safety Standard)**
- 10-2.D.** Staff are oriented to issues of confidentiality prior to direct work with children and families.
- 10-2.E.** Staff are oriented to issues related to boundaries prior to direct work with children and families.
- 10-2.F.** Staff receive additional training, where appropriate, prior to performing specific functions and within six months of hire as follows:
- Training on the ASQ/ASQ-SE instruments prior to using them,
  - Medicaid training prior to participation in random time studies and annually thereafter, and
  - Training on Evaluation reporting forms described in the “*Red Book*” and demonstration of competency with their supervisor prior to submitting forms to the evaluation.



[Hiring Procedure](#)  
[UMCHS Training Plan](#)

**10-3. Policy:** All staff receive intensive role-specific training (Core Training) within six months of the date of hire that is specific to their program role to help them understand its essential components. OCCF staff enter Core Training into the Training Tracker database.

#### **Procedures**

- 10-3.A.** All home visitors (including staff from collaborative partnerships, volunteers, and interns functioning as home visitors) conducting the Family Assessment Interview (FAI) receive FAI Training (given by a certified trainer who has been trained to train others) within six months of hire date. All trainees follow up by completing the requirements for FAI certification within six months of the training (See also Policy 6-1.D).
- 10-3.B.** All home visitors (including staff from collaborative partnerships, volunteers, and interns functioning as home visitor) complete home visitor Core Training (given by a certified trainer) within six months of hire date.
- 10-3.C.** Supervisors attend Core Supervisor, Core Home Visitor and Core FAI Training within six months of hire.
- 10-3.D.** Program managers attend Core Program Manager Training within six months of hire and are encouraged to attend all Core Trainings.
- 10-3.E.** OCCF utilizes a cost sharing model for training and travel related expenses. OCCF offers Core Trainings a minimum of two times per year at no cost to programs. Programs are responsible for all related travel and lodging expenses.

**10-4. Policy:** Supervisors and home visitors receive training on a variety of topics necessary for effectively working with families and children within six months of hire. On-line HFA training modules are available for all six month topics. Programs ensure that trainings are entered into the Training Tracker database (see Glossary for acceptable means of achieving training).

#### **Procedures**

- 10-4.A.** Home Visitors and supervisors receive training on Infant Care within six months of the date of hire that includes a majority the following topics:
- Sleeping,
  - Feeding/breastfeeding,
  - Physical care of the baby, and
  - Crying and comforting the baby.
- 10-4.B.** Home Visitors and supervisors receive training on Child Health and Safety within six months of the date of hire that includes a majority of the following topics:
- Home safety,
  - Shaken baby syndrome and Sudden Infant Death Syndrome (SIDS),

- Seeking medical care,
  - Well-child visits and immunizations,
  - Seeking appropriate child care,
  - Car seat safety, and
  - Failure to thrive.
- 10-4.C.** Home Visitors and supervisors receive training on Maternal and Family Health within six months of the date of hire that includes a majority of the following topics:
- Family planning,
  - Nutrition,
  - Pre-natal/post-natal healthcare, and
  - Pre-natal/post-natal depression.
- 10-4.D.** Home Visitors and supervisors receive training on Infant and Child Development within six months of the date of hire that includes a majority of the following topics:
- Language and literacy development,
  - Physical and emotional development,
  - Identifying developmental delays, and
  - Brain development.
- 10-4.E.** Home Visitors and supervisors receive training on Role of Culture in Parenting within six months of the date of hire that includes a majority of the following topics:
- Working with diverse cultures/populations (age, religion, gender, sexuality, ethnicity, poverty, dads, teens, gangs, disabled, etc.),
  - Culture of poverty, and
  - Values clarification.
- 10-4.F.** Home Visitors and supervisors receive training on Supporting the Parent-Child Interaction within six months of the date of hire that includes a majority of the following topics:
- Supporting attachment,
  - Positive parenting strategies,
  - Discipline,
  - Parent-child interactions,
  - Observing parent-child interactions, and
  - Strategies for working with difficult relationships.

**10-5. Policy:** Staff receive training on a variety of topics necessary for effectively working with families and children within twelve months of hire. On-line HFA training modules are available for all 12 month topics. Programs ensure that trainings are entered into the Training Tracker database (see Glossary for acceptable means of achieving training).

### Procedures

**10-5.A.** Home Visitors and supervisors receive training on Child Abuse and Neglect that includes a majority of the following topics within twelve months of hire. Topics include:

- Etiology of child abuse and neglect, and
- Working with survivors of abuse.

**10-5.B.** Home Visitors and supervisors receive training on Family Violence that includes a majority of the following topics within twelve months of hire. Topics include:

- Indicators and dynamics of family violence,
- Intervention protocols,
- Strategies for working with families with family violence issues,
- Referral resources for domestic violence,
- Effects on children, and
- Gangs.

**10-5.C.** Home Visitors and supervisors receive training on Substance Abuse that includes a majority of the following topics within twelve months of hire. Topics include:

- Etiology of substance abuse,
- Culture of drug use,
- Strategies for working with families with substance abuse issues,
- Smoking cessation,
- Alcohol use/abuse,
- Fetal alcohol syndrome,
- Street drugs, and
- Referral resources for substance abuse.

**10-5.D.** Home Visitors and supervisors receive training on Staff Related Issues that includes a majority of the following topics within twelve months of hire. Topics include:

- Stress and time management,
- Burnout prevention,
- Personal safety of staff,
- Ethics,
- Crisis management, and
- Emergency protocols.

- 10-5.E.** Home Visitors and supervisors receive training on Family Issues that includes a majority of the following topics within twelve months of hire. Topics include:
- Life skills management,
  - Engaging fathers,
  - Multi-generational families,
  - Teen parents,
  - Relationships, and
  - HIV and AIDS.
- 10-5.F.** Home Visitors and supervisors receive training on Mental Health that includes a majority of the following topics within twelve months of hire. Topics include:
- Promotion of positive mental health,
  - Behavioral signs of mental health issues,
  - Depression,
  - Strategies for working with families with mental health issues, and
  - Referral resources for mental health.

**10-6. Policy:** All staff receive ongoing training that takes into account the worker's knowledge and skill base. Programs ensure that trainings are entered into the Training Tracker database.

### Procedures

- 10-6.A.** Programs have Individual Training Plans for each staff member. These plans address knowledge and skill base, professional development, changes in roles, needs of the program, and personal interests. Individual training plans for staff moving from one local HS~HF program to another consider previous training.

#### [Staff Performance Appraisals Procedure](#) [Professional Development Plan](#)

- 10-6.B.** Staff who have worked for the program less than 12 months are not required to participate in ongoing training. They receive training as outlined in Policies 10-2 through 10-5 and Policy 10-6.A.
- 10-6.C.** All staff receive annual training in cultural sensitivity. (See Policy 5-3.)
- 10-6.D.** All staff receive training annually and prior to participation in Medicaid Administrative Claiming (MAC) and using the Medicaid Online Time Tracker (MOTT) System. (See Medicaid Administrative Claiming Policy 5.)

**11. CRITICAL ELEMENT #11: Service providers should receive ongoing effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so they can see that they are making a difference and in order to avoid stress-related burnout.**

**11-1. Policy:** The program ensures that home visitation staff (i.e., HOME VISITORS and any volunteers/interns) receive regular and ongoing supervision.

### Procedures

**11-1.A.** Programs provide regularly scheduled individual supervision for each home visitor for a minimum of 1.5 hours (2 hours preferred) per week. At least one hour per week of individual supervision is provided for home visitors who work 20 or less hours per week. Scheduled supervision is not split into more than two regular sessions. A supervisor must be available to debrief at all times a home visitor is working with families.

Supervision of home visitors who are not housed in the same location as their supervisor shall be conducted weekly and may be in person, by phone or by webcam. Home Visitor safety is a priority. A face-to-face supervision session must be conducted at least monthly. On-site staff support (not funded by Healthy Start~Healthy Families (HS~HF) General Fund if not HS~HF Core position) is required for staff safety, and immediate debriefing support. **Note:** The intent of this policy is for rural areas where the distance between supervisor and home visitor may be significant.

### Staff Qualifications

**11-1.B.** All home visitation staff receive weekly individual supervision as outlined above. This time is regularly scheduled. The frequency and duration of supervision sessions is documented in the supervisory notes. **(HFA Sentinel Standard)**



### Staff Qualifications

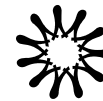
**11-1.C.** The program maintains a ratio of one supervisor (with responsibilities only for supervision in the HS~HF program) for up to six FTE direct service staff (and/or volunteers/interns who perform the same function), not to exceed nine staff members. If the supervisor is less than full-time or if the supervisor is also the program manager or has other duties besides HS~HF supervision, the FTE of direct service staff is adjusted to the percentage of time spent in the supervisory role to maintain an overall ratio of 1:6. (See Glossary for calculation methodology.)

### **The Family Services Manager supervises the 2.5 FTE Healthy Start Family Advocates.**

**11-2. Policy:** Direct service staff (home visitation staff and volunteers/interns performing the same function) are provided with skill development and professional support and held accountable for the quality of their work.

## Procedures

- 11-2.A.** Through supervision, all direct service staff are provided with the necessary skill development to continuously improve the quality of their performance and are held accountable for the quality of their work. The content of supervision is recorded in supervisory notes. **(HFA Sentinel Standard)**



Skill development in supervision includes, but is not limited to the following:

- Coaching and providing feedback on strength-based approaches and interventions used (e.g., problem-solving, crisis intervention), including regular review of the HV goal plan.
- Shadowing one home visit per home visitor at least annually, in addition to quality assurance activities in 11-2.C,
- Shadowing one assessment visit per home visitor at least annually,
- Reviewing FGP progress and process,
- Reviewing family progress and level changes,
- Discussing family retention and attrition,
- Providing feedback on documentation and integrating use of tools used (e.g., developmental screens, evaluation tools),
- Integrating quality assurance results including regular and routine review of assessments and assessment records, home visit records, and all documentation used by program,
- Coaching regarding home visit completion rates,
- Discussing putting new training into practice,
- Supporting cultural sensitivity and practices,
- Providing guidance on use of curricula,
- Providing reflection on techniques and approaches,
- Identifying areas for growth,
- Identifying and reflecting on potential and actual boundary issues, and
- Sharing information on community resources.

### [Staff Qualifications](#) [Healthy Start Forms](#)

- 11-2.B.** Through supervision, direct service staff are provided with the necessary professional support to continuously improve the quality of their performance. Content of supervision in this area is documented in supervisory notes. **(HFA Sentinel Standard)**



Supports include, but are not limited to:

- Regular staff meetings,
- Multi-disciplinary teams,
- On-call availability of supervisor or designee to service providers,
- Exploration/reflection of impact of the work on the worker,
- Employee assistance program,
- Clinical supervision,
- Acknowledgment of performance,
- Provision of tools for performing job,
- Creating a nurturing work environment with opportunities for respite,

- Scheduling flexibility, and
- Providing a career ladder for direct service staff.

[Staff Qualifications](#)

[Employment Policies](#)

[Staff Training Program - Career Ladders](#)

[2011-2012 Staff Calendar](#)

### 11-2.C Quality Assurance Activities

- *Family Assessment Interview (FAI) Review.* The Supervisor or designee reviews each assessment to verify that each home visitor is acquiring appropriate information, making appropriate referrals, scoring correctly and using the Assessment Interview as a basis for service delivery and case planning. The supervisor observes each home visitor conduct an FAI assessment at least annually and more frequently for Home Visitors new to conducting the family interview. The supervisor will ensure reliability by completing the inter-rater reliability tool at least every 180 days. In order to assure ongoing competence in the FAI, if an home visitor does not conduct a FAI for 180 days, s/he enacts a role play of the FAI and submits a written assessment to the supervisor for review.
- *Home Visit Review.* The Supervisor or designee reviews the Home Visit Records and discusses them with the Family Support Worker to ensure appropriateness of support activities for family, including referrals, parent-child activities, and the timeliness and thoroughness of documentation. Frequency and duration of home visits are analyzed for each home visitor and addressed throughout supervision. All aspects of service, including service intensity, FGP and HV Goal Plan, referrals and follow-up, and ASQ, ASQ-SE, and immunizations are monitored.
- *Home Visit Completion Rate Review: Home Visit and Caseload Management Review:* The home visit completion rate for program families is regularly reviewed, and a team approach is taken to assure adequate numbers of visits are made. The home visit completion rate for each home visitor is reviewed during supervision. Problem-solving to improve the home visit completion rate occurs regularly during supervision and team meetings.
- *Caseload Review.* The Supervisor and home visitor routinely review each family's file during supervision to determine the appropriate level of service. The supervisor ensures that each home visitor carries no more than the maximum total weighted caseload for the home visitor's full-time equivalency (FTE). Supervisors encourage appropriate use of the level system, to avoid dependence while providing adequate support for families. Supervisors encourage transition planning for families approaching graduation.
- *Family Retention Review.* Annually, the Supervisor or designee reviews family retention rates for each home visitor s/he supervises and together with the home visitor, develops and implements a plan to address retention.
- *File Review.* The Supervisor completely reviews every family's file annually and at closing to ensure that all paperwork is completed correctly. Ongoing file review is done through supervision and through spot checks, peer file reviews by the home visitor team, and other methods assure complete and thorough documentation. Training and support on documentation is provided by the program to its staff.

- *Evaluation Paperwork Review:* The Supervisor is responsible for the complete and timely submission of all necessary evaluation forms (Family Intake, Family Update, HOME, Parent Survey I, IIA&B) to NPC Research. The program is responsible for the accuracy and completeness of the data submitted to NPC and entered into Family Manager.
  - *Telephone Surveys.* The Supervisor contacts two families per Family Support Worker every 180 days (total of four families per year per home visitor) to determine parent satisfaction. These surveys may be completed in person, at parent meetings, or via telephone. The Supervisor develops and implements a plan to address problems identified by parent input.
- 11-2.D.** Supervisors maintain written documentation of the content of supervision sessions. General topics are captured on the General HOME VISITOR Supervision form. Supervisory content related to families is documented on the Family Progress Review form in the supervision notes and the HV Goal Plan. Further documentation of supervision in the family file is demonstrated by signed Home Visit Records, FGPs, and Level Assignment forms.

**11-3. Policy:** Supervisors receive regular, on-going supervision which holds them accountable for the quality of their work and provides them with skill development and professional support.

### Procedures

- 11-3.A.** Supervisors receive regular and on-going supervision that, at a minimum, occurs every 30 days.

### Staff Qualifications

- 11-3.B.** Supervisors are held accountable for the quality of their work, receiving both skill development and professional support. Procedures may include but are not limited to the following:
- Addressing personnel issues,
  - Feedback/reflection to supervisors regarding the team,
  - Agency issues,
  - Review of program documentation such as monthly or quarterly reports, program statistics, and quality assurance mechanisms,
  - Review of progress towards meeting program goals and objectives,
  - Strategies to promote professional development/growth, and
  - Quality oversight that could include shadowing of supervisor.

### Staff Qualifications

**11-4. Policy:** Program managers are held accountable for the quality of their work and are provided with skill development and professional support.

**11-4.A.** Program Managers are provided with professional support and receive supervision holding them accountable for their work. Meetings documenting accountability occur at least quarterly. Some elements of accountability could be derived from quarterly reports, annual performance reviews, as well as regularly scheduled meetings with supervisor of program manager, chair of the advisory group, or a peer program manager.

#### [Staff Qualifications](#)

**11-4.B.** Program Managers are held accountable for the quality of their work, receiving both skill development and professional support. Expectations in local policy, procedures and practice must include but are not limited to the following:

- Strive to meet Oregon Performance Indicators and maintain HFA Standards,
- Write local Healthy Start Program Policies and Procedures Manual and update the manual annually,
- Analyze and develop plans required by HFA regarding Acceptance, Retention, Home Visit Completion, Cultural Sensitivity, and Staff Retention and Satisfaction,
- Monitor screening, program acceptance, and home visit completion data,
- Develop, implement and monitor comprehensive Program Training Plan; update as appropriate,
- Establish Memorandum(s) of Agreement with hospitals and/or other appropriate entities to provide access to first time parents,
- Maintain and enhance relationships with volunteers providing donations for program,
- Liaison with local CCF, early childhood team, appropriate community agencies and community partners,
- Liaison with Central Administration HS staff and attend semi-annual PM/Supervisor Training,
- Work with Local Advisory Committee to promote and support program,
- Develop and monitor program budget, including monitor expenditures, Medicaid Administrative Claiming, leveraging community contributions and other additional revenue,
- Research opportunities for leveraged resources, alternative funding sources, cash contributions, in-kind services, and grant prospects,
- Prepare for and follow up on annual site visit by OCCF and LCCF, and
- Review Family Manager Reports to be sure that the program is on track in screening, family service, and outcome measurements, and that all data is accurate and complete.

**11-4.C.** Each local program must have one primary contact designated as the program manager. The minimum FTE for the role of Program Manager is .10 FTE or four hours per week.

**11-4.D.** Program managers (a minimum of one representative per program) participate in the state HS~HF Manager meetings/training held semi annually.

**11-5. Staff Health and Safety.** The health and safety of each worker in the HS~HF program is of utmost importance.

**11-5.A.** Each local HS~HF program has written procedures to address the health and safety of all staff and volunteers. These procedures address precautions that must be taken to ensure the safety of all staff and volunteers and must include identifying situations when:

- It is unsafe to travel to make a home visit,
- The Home Visitor must not enter a home because of safety reasons,
- The Home Visitor must leave the home immediately, and
- It is appropriate only to visit the home with another person (the supervisor, another staff member, and a collaborating partner such as a nurse or mental health specialist).
- Supervision of home visitors who are not housed in the same location as their supervisor shall be conducted weekly and may be in person, by phone or by webcam. Home Visitor safety is a priority. A face-to-face supervision session must be conducted at least monthly. On-site staff support (not funded by HS~HF General Fund if not HS~HF Core position) is required for staff safety, and immediate debriefing support. Note: The intent of this policy is for rural areas where the distance between supervisor and home visitor is significant.

#### [Safety Manual for Home Visitors](#)

- 11-5.B.** All home visiting staff receive initial training in home visiting safety prior to visiting families. This training is reinforced ongoing through supervision. Discussions of Home Visitor safety are documented in supervision notes.

#### [Safety Manual for Home Visitors](#)

- 11-5.C.** The local program has communication systems in place that ensure staff safety (i.e., requiring cell phones and/or pagers while in the field, sign out boards, etc.).

#### [Safety Manual for Home Visitors](#)

- 11-5.D.** Supervisors or their designees are available in the office or by phone at all times when Home Visitors are in the field.

#### [Safety Manual for Home Visitors](#)

- 11-5.E.** Local procedures outline a process for staff to receive crisis/grief counseling as needed to help them deal with issues they encounter in their work with families.

#### [Safety Manual for Home Visitors](#)

**GOVERNANCE AND ADMINISTRATION: The program is governed and administered in accordance with principles of effective management and of ethical practices.**

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

#### **Procedures**

**GA-1.A.** Each local Healthy Start~Healthy Families (HS~HF) program has an Advisory Group. The local HS~HF Advisory Group has bylaws and/or written operating procedures.

#### **Health Advisory Committee Policy**

**GA-1.A.i.** Roles and functions of the local HS~HF Advisory Group:

- Advises the local program, reports to the LCCF,
- Makes recommendations for planning, implementation, and policies of its local HS~HF program,
- Works to support HS~HF' role in the local community's early childhood system of supports and services,
- Promotes and advocates for the local program,
- Takes an active role in resource development for the program, including the 25% (5% cash or cash equivalent) local community match required for HS~HF funds,
- Serves as a forum for communication and resource sharing among community partners, and as a venue for building collaboration, and
- Forms subcommittees as needed to address specific issues and areas of interest,
- Assures the development and implementation of a local Program Support Action Plan that is consistent with the state Program Support Action Plan (Appendix F). This plan is reviewed and updated as needed.

#### **Health Advisory Committee Policy**

**GA-1.A.ii.** The local HS~HF Advisory Group keeps and makes public minutes/notes of all meetings and a current membership roster.

#### **Health Advisory Committee Policy**

**GA-1.B.** HS~HF local Advisory Group Membership:

- The local HS~HF Advisory Group has a wide range of skills and abilities and provides a heterogeneous mix of skills, strengths, community knowledge, professions, age, race, sex, gender, and ethnicity,
- Membership includes representation by community members (members of service groups, advocacy groups for young children, the business, public relations, arts, and recreation communities, etc.) and present or former program participants,
- Partner agencies in the community are represented, including DHS, Relief Nurseries (if present), health and mental health, education, and childcare,
- Members select a chair and a vice-chair who work with the program manager to prepare the agenda,
- HS~HF providers/contractors/staff are non voting members who may attend meetings to provide information and expertise.

**[Health Advisory Committee Policy](#)**

**GA-1.C.** The local program manager and the advisory group work as an effective team with information, coordination, staffing, and assistance provided by program manager to plan and develop program policies and procedures. The program manager is responsible for keeping members informed and actively involved.

**[Health Advisory Committee Policy](#)**

**GA-2. Policy:** Families are offered opportunities to provide feedback to the program, through the use of formal mechanisms

**GA-2.A.** Each local HS~HF program ensures families have an opportunity for input by providing the Parent Survey 2 every 180 days during the first year of service and annually thereafter.

**[How are we Doing? \(Survey\)  
Parent Involvement Survey](#)**

**GA-2.A.i.** The supervisor makes telephone calls to participants and shadows Home Visitors periodically as a part of the Quality Assurance Plan, following the format given in the *Program Managers and Supervisors Reference Guide*.

**[Staff Qualifications](#)**

**GA-2.A.ii** Additional opportunities for parent input are encouraged, including service on the advisory group, being interviewed as program participant at site visits, participation in focus groups and/or other survey opportunities.

**[Parent Involvement Survey](#)**

**GA-2.B.** Each local HS~HF program has procedures regarding participant grievances, which include the following: how the participant/families are informed of the policy, the programs process for reviewing any grievances received and the follow-up mechanisms used to address identified areas of improvement. These procedures ensure that grievances are addressed in a timely manner by an objective person or body. The LCCF director or designee and/or the local HS~HF Advisory Committee may be called upon to help resolve grievances.

### Complaint Policy

**GA-2.B.i. Participant Grievances:** Participant grievances are addressed by the supervisor and/or program manager in a timely manner and appropriate action is taken.

- Participants may request a change in home visitor at any time. The program honors these requests whenever possible,
- Staff members are removed from work with families immediately pending resolution of a grievance involving allegations that, if true, would endanger program participants' safety and well-being, and
- The program works with staff named in grievances through coaching in supervision and takes any additional personnel actions needed

### Complaint Policy

**GA-2.B.ii Staff Grievances:** Staff grievances are addressed through personnel policies of the employing agency in a timely manner.

### Employment Policies

**GA-3. Policy: The program monitors and evaluates quality of services. Quality Assurance and Program Improvement.**

**GA-3.A.** All programs follow the State Quality Assurance Plan (Appendix B) developed by members of the Advisory Committee (formerly State Steering Committee). Quality assurance materials provided to programs include the HS~HF Program Managers and Supervisors Reference Guide, the LCCF Directors Reference Guide, the HFA Site Self-Assessment Tool, The Program Policies and Procedures Manual, the Program Forms Manual and other tools made available to programs by OCCF. All programs:

- Engage in continuous quality improvement with ongoing monitoring of their service quality including Oregon performance indicators,
- Maintain adherence to the Healthy Families America Best Practice Standards for home visiting,
- Comply with the current HS~HF Program Policies and Procedures Manual, and
- Receive ongoing technical assistance from OCCF HS~HF staff and contractors as requested.

**GA-3.B.** Each program receives a site visit every calendar year. Site visits will have a quality assurance focus one year of the biennium and a technical assistance focus the other year.

**GA-3.C. Local Quality Assurance Plan:** Following a quality assurance site visit, programs develop or update the Program Goal Plan (PGP) which is then submitted to the LCCF and OCCF within 45 days of receiving the site visit report. The PGP addresses any challenges meeting the Performance Indicators and other issues identified in the site visit report. In years with a technical assistance focused site visit, programs update the PGP and identify additional strategies as needed. OCCF provides technical assistance in the development of the PGP and supporting programs to achieve identified goals to meet Performance Indicators and HFA standards when requested. The PGP is updated at least annually.

**GA-3.D. Quality Improvement Plan:** If needed, programs receive specific written feedback about major concerns regarding the successful implementation of the PGP or other issues regarding program quality from OCCF HS~HF staff and/or the LCCF. The program prepares a written response within 30 days, providing additional information to clarify the situation and alleviate the concerns. If the concerns still stand, OCCF and the LCCF notify the program within 30 days that a Quality Improvement Plan is required.

**GA-3.D.i** Concerns leading to a Quality Improvement Plan include:

- Review of data collection process and data quality,
- Issues with meeting Performance Indicators,
- Non-adherence to the HFA standards (program performance that falls below the threshold for maintaining HFA credentialing),
- Significant non-adherence to the HS~HF Program Policies and Procedures Manual, and/or
- Other areas of concern identified by the LCCF, OCCF staff, parents, and/or the local program Advisory Board.

**GA-3.D.ii** The written Quality Improvement Plan is prepared by the local program in collaboration with the LCCF and OCCF HS~HF staff within 60 days of the notification of identified concerns. This plan addresses the each identified area of concern with specific action steps and timelines for accomplishment.

**GA-3.D.iii** OCCF HS~HF staff, the LCCF, and the program are given copies of the Quality Improvement Plan. OCCF HS~HF staff and members of the evaluation team provide technical assistance to help with the implementation of the Quality Improvement Plan.

**GA-3.D.iv** A follow-up site visit is conducted by the LCCF and OCCF HS~HF staff within 90 days of the implementation of the Quality Improvement Plan to assess progress. OCCF HS~HF staff provide additional support and technical assistance as appropriate. OCCF staff provide the local program and LCCF with a written report after the follow-up site visit, addressing progress in all of the areas identified in the Quality Improvement Plan.

**GA-3.E. Corrective Action Plan:** If the steps to effectively address the issues in the Quality Improvement Plan are not in place 60 days after receiving the follow-up site visit report, the LCCF, in collaboration with OCCF HS~HF staff, will write a Corrective Action Plan with a maximum completion time of 90 days after the plan is signed. Signatures on the Corrective Action Plan are required from the local program manager and/or supervisor, LCCF director, Chair of the Local Commission, and OCCF HS~HF Coordinator. The OCCF Executive Director receives a copy of the Corrective Action Plan.

**GA-3.E.i** OCCF HS~HF staff provides follow-up phone contact to determine progress a minimum of once every 30 days during the 90 days of implementation of the Corrective Action Plan. The LCCF receives copies of all communication between the local program and OCCF.

**GA-3.E.ii** If the Corrective Action Plan is not successfully implemented within 90 days, the LCCF Director notifies the OCCF HS~HF Coordinator and OCCF Executive Director. The LCCF Director, OCCF HS~HF Coordinator, and OCCF Executive Director analyze the program's willingness and/or ability to comply with the Corrective Action Plan. OCCF staff prepare a written report which is sent to the LCCF and the program.

**GA-3.E.iii** A written analysis and history of the entire quality assurance process engaged with the program to date is prepared by OCCF staff and presented to the state HS~HF Advisory Committee which may decide:

- To continue with the corrective action plan with specific timeframes for effective implementation,
- To recommend that the LCCF change the local HS~HF provider, or
- To disaffiliate the program from the state system.

### **GA-3.F. Affiliation**

**GA-3.F.i** Residents of each county in Oregon have potential access to HS~HF services through a HS~HF program that meets the best practice guidelines outlined by HFA and which functions as part of a unified and consistent quality early childhood system. HS~HF programs may be administered through regional partnerships, entered into by LCCFs and their contracting agencies, or through individual county programs.

**GA-3.F.ii** Each HS~HF program site that participates in all aspects of the statewide system is affiliated with Oregon's HFA Multi-site credential. Participation is defined as providing service delivery in

adherence to the HFA Critical Elements and the current state HS~HF Program Policies and Procedures Manual.

### **GA-3.G. Change of Provider/Temporary Affiliation**

**GA-3.G.i** There are occasions when a LCCF chooses to enter into a contract with a new local HS~HF provider, including:

- Failure of the program provider to provide quality cost effective services,
- Voluntary withdrawal of the current provider,
- Desire of the local community to change the format of HS~HF service delivery in order to more effectively or efficiently meet the needs of their population,
- Other compelling reasons that may arise, and
- Before making the decision to change providers, the LCCF carefully considers the impact of the change on families.

**GA-3.G.ii** If, for any reason, a current HS~HF provider stops providing contracted services prior to the end of their contract, the LCCF will notify OCCF 45 days prior to signing a contract with the new provider so that state HS~HF staff can provide program specific training and technical assistance. The LCCF and OCCF may mutually agree to a notice period of less than 45 days if necessitated by specific circumstances.

**GA-3.G.iii** When changing HS~HF providers, the LCCF is responsible for ensuring timely transfer of program and participant files and HS~HF equipment. The LCCF enters into a transition plan with the new and the old provider to assure continuity of services for families. OCCF HS~HF staff provide support and technical assistance through this process.

**GA-3.G.iv** The new HS~HF provider prepares and submits a program budget to the LCCF and to OCCF. This budget demonstrates adherence to the HFA Critical Elements, willingness and ability to comply with the HS~HF Program Policies and Procedures, and capacity to successfully meet the HS~HF performance indicators.

**GA-3.G.v** The new provider receives a site visit by the state HS~HF staff within 90 days of initiation of the contract. The site visit includes training and technical assistance as needed to assure the effective implementation of the program model. When OCCF HS~HF staff are assured of the program's compliance with HFA standards and the state Policies and Procedures Manual, temporary affiliation with the state system is granted.

**GA-3.G.vi** Full affiliation is granted to a new program provider after one full year of service delivery, with an annual site visit review that

demonstrates adherence to the HFA Critical Elements and compliance with HS~HF Program Policies and Procedures.

**GA-3.G.vii** Affiliation of Sites or Programs Funded Through Other Resources: County programs funded by other sources may use the HS~HF name if these programs adhere to the HFA standards and HS~HF Program Policies and Procedures. Programs request affiliation by establishing interagency agreements with LCCF and OCCF that include provisions for oversight and/or quality assurance of these programs.

### **GA-3.H. Disaffiliation**

**GA-3.H.i** Disaffiliation may occur when a program has not improved through the Quality Assurance process. In this case, the program does not adhere to the HFA Critical Elements, and/or the state Program Policies and Procedures Manual, or meet the Oregon Performance Indicators.

**GA-3.H.ii** Disaffiliation results in discontinuation of OCCF HS~HF funding to the LCCF for program services. Funding resumes when HS~HF is again operational in that county with a program that meets the criteria to become eligible to receive temporary affiliation.

**GA-3.H.iii** A recommendation for disaffiliation of a program from the state HS~HF Advisory Committee is referred to the OCCF state staff for action. (See OAR 423-101-0017 (9) (A), (C), (D) 2004 Revisions.)

**GA-3.H.iv** Within 10 working days of the recommendation for disaffiliation, the OCCF Executive Director provides written notice to the LCCF of intent to discontinue HS~HF state funding to the county.

**GA-3.H.v** Funding is discontinued after 60 days. The LCCF provides notice to the HS~HF program of the intent to discontinue funding 30 days prior to de-funding. The LCCF ensures the safe retention of all program and participant records and HS~HF equipment and materials.

**GA-3.H.vi** Funds to provide HS~HF services in that county are held by OCCF until a program that meets the criteria for temporary affiliation is in place in that county.

**GA-3.H.vii** If the funds are held for more than 90 days, they are pro-rated in order to avoid overpayment. The appropriate amount to provide services for the time remaining is sent to the LCCF for distribution to the new provider. The remainder is held by OCCF for distribution to functioning HS~HF programs through the LCCFs or

is used by OCCF for the HS~HF statewide system by providing additional training or materials to all programs statewide.

**GA-3.I. Conflict Resolution and Appeals Process:**

Efforts are made to avoid conflict between the state system and local programs through open communication, ongoing technical assistance, and utilization of the LCCF as a mediating partner.

**GA-3.I.i** Efforts are made to resolve matters at the level of the parties immediately involved. After these efforts fail to reach resolution, the following procedures are used to resolve the matter.

**GA-3.I.ii** In the event that a conflict arises between local programs and the central state administration that cannot be resolved through open communication among OCCF HS~HF staff, program, and the LCCF staff, a skilled mediator agreed upon by all parties is called in to facilitate up to two sessions among the parties.

**GA-3.I.iii** If mediation fails to resolve the matter, both parties submit a written statement describing their positions to the HS~HF State Advisory Committee for review. Copies are sent to the LCCF and the OCCF Executive Director. The Advisory Committee decides the proper resolution of the matter.

**GA-3.I.iv** If the county program does not agree with this decision, it may make an appeal requesting the State Advisory Committee review the matter. The OCCF staff involved, local program staff, and the Advisory Committee each submit written documentation of their positions to the Advisory Committee. The Advisory Committee decides the matter. There are no further appeals.

**GA-3.J Disciplinary Procedures:** Each local HS~HF program ensures that the program has disciplinary procedures for all program employees. These procedures must provide appropriate disciplinary actions for all staff and volunteers who violate federal or state law or policies of the program.

**Employment Policies**

**GA-3.K Program Name:** The name “Healthy Start~Healthy Families” must be included in each program’s name to support public recognition and marketing efforts of HS~HF statewide.

## Healthy Start/Health Families of Umatilla County

### GA-4. Program Evaluation and Research

**GA-4.A** The program has policy and procedures for reviewing and recommending approval or denial of research proposals, whether internal or external, which involve past or present families.

**Grant Funded Opportunities**

- GA-4.B.** OCCF provides for regular and ongoing evaluation of HS~HF through a qualified evaluator. The contracted evaluator prepares statewide and program specific reports as agreed in their contract.
- GA-4.C.** The contracted evaluator has a formal written plan that addresses program implementation, participant satisfaction, and participant outcomes.
- The plan is developed through active collaboration among the evaluators, state OCCF staff, local programs, LCCF staff, and includes confidentiality assurances,
  - The evaluation plan is reviewed on an annual basis by the state Advisory Committee to ensure that it is of sufficient scope to accurately describe progress toward identified implementation and outcome goals.
- GA-4.D.** Each local HS~HF program participates in the statewide HS~HF evaluation and ensures that all families participating in any HS~HF service (screening, and/or home visiting services) sign a consent form indicating their express written consent to participate (or not) in the HS~HF evaluation and what that participation entails.
- GA-4.E.** Evaluation data is shared only in the form of aggregated results. Local programs use a state identification number on all materials sent to the state evaluators.
- GA-4.F.** Each local HS~HF program ensures that each staff member has appropriate training in data collection, data entry and submission to the evaluation.

**[UMCHS Job Descriptions – Social Services](#)**

**[UMCHS Job Descriptions – Managers](#)**

**[Staff Qualifications](#)**

- GA-4.G.** Each program is responsible for the collection and entry of complete and accurate data on each participating family within the time parameters set by the evaluation. The program manager assures that staff are completing, entering and/or submitting all required forms in a timely manner.

**[UMCHS Job Descriptions – Social Services](#)**

**[UMCHS Job Descriptions – Managers](#)**

**[Staff Qualifications](#)**

**[Program Planning Policy](#)**

- GA-4.H.** Local programs are responsible to cooperate with the evaluation to ensure the accuracy of the data reported, and to monitor their data through ongoing review of Family Manager reports and semi-annual reports. Programs must contact the evaluation team immediately to resolve any data discrepancies as soon as these are noted through review of the semi-annual reports or other data sets.

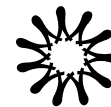
**[UMCHS Job Descriptions – Managers](#)**

**[Staff Qualifications](#)**

**[Program Planning Policy](#)**

**GA-5. Policy:** Families are informed of their rights and confidentiality of information is assured both during the intake process as well as during the course of services.

**GA-5.A.** Families are informed of their right to confidentiality at the onset of services, both verbally and in writing. Families give informed written consent to participate in program services using the HS~HF Rights and Confidentiality form on or before the first home visit. Consent is obtained in language the family understands, through use of a translated form and/or an approved interpreter. **(HFA Sentinel Standard)**



**GA-5.B.** Families participating in intensive home visiting services read and sign the HS~HF Release of Information (ROI) form (in a language they can understand or with interpretation provided) every time information is to be shared with another agency or provider (except in the case of mandatory reporting of abuse or neglect). The Department of Human Services (DHS) Release of Information form may also be used (in a language the family can understand or with translation provided). **(HFA Sentinel Standard)**



**GA-5.C** Programs assure family privacy and voluntary choice with regard to research conducted by or in cooperation with the program.

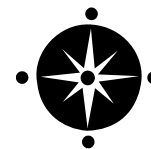
**GA-5.D.** Parent(s) have access to review and receive copies of their records as provided by law.

#### [Student-Client Records Policy](#)

**GA-5.E.** HS~HF records of adolescent parents are confidential and are not shared with anyone, including the parents of the adolescent, unless the adolescent signs a release or the release of information is otherwise required by law.

**GA-6. Policy:** The program reports suspected cases of child abuse and neglect to the appropriate authorities.

**GA-6.A.** Each local HS~HF program has written procedures for reporting suspected child abuse. These procedures will include protocols for immediate notification of program manager and/or supervisor and reporting to local Department of Human Services Child Welfare. **(HFA Safety Standard)**



#### [Child Abuse & Neglect Policy & Procedure](#)

**GA-6.B.** All local HS~HF paid and unpaid staff are mandated to report suspected child abuse and neglect according to the specifications of Oregon law. Local programs ensure paid and unpaid staff receive appropriate and timely training about state reporting laws and local procedures, including annual updates.

#### [Child Abuse & Neglect Policy & Procedure](#)

**GA-6.C.** All local HS~HF staff receive support from supervisors in their role as mandatory reporters, including immediate assistance with problem-solving in cases of suspected abuse and neglect, support in making reports to Department of Human Services Child Welfare, opportunities to debrief, and ongoing support through regular scheduled supervision sessions.

[Child Abuse & Neglect Policy & Procedure](#)

**GA-6.D.** Programs develop local program policies for working with families involved with the Department of Human Services Child Welfare and Self Sufficiency. By law, HS~HF services are voluntary and cannot specifically be a part of any mandated plan for families. Families who are receiving services from DHS Child Welfare at the time of enrollment are eligible for intensive home visiting services.

[Child Abuse & Neglect Policy & Procedure](#)

**GA-7. Policy:** Each local HS~HF program has written procedures for reporting critical incidents including reporting participant deaths (child, parent, or other immediate family member), major health and safety issues, and any significant unusual occurrence affecting the integrity and reputation of the program. These procedures include protocols for immediate notification of supervisors, program manager, and LCCF director or designee.

**GA-7.A.** Local program staff or LCCF staff immediately notify OCCF HS~HF staff of participant deaths, criminal allegations involving program staff, and any other incidents deemed important that could affect the integrity and reputation of the program statewide. Staff are offered grief counseling when a death occurs through the agency's provided Employee Assistance Plan.

**GA-8. Policy:** The HS~HF Policies and Procedures Manual is used to guide service providers in the delivery of services.

**GA-8.A.** All HS~HF Programs follow the state Program Policies and Procedures Manual (PPPM) as written.

**GA-8.B.** Local Commission on Children and Families (LCCF) and HS~HF programs are asked for input for revisions annually. Changes to the PPPM are reviewed annually by the HS~HF State Advisory Committee. This review ensures policies and procedures are comprehensive, up-to-date, and consistent with evidence-based practices.

**GA-8.C.** Proposed suggestions for changes to the PPPM may be made at any time and are submitted electronically or in hard copy to the state Advisory Committee through OCCF staff.

**GA-8.D.** After revisions, the PPPM is approved by the OCCF Director or designee.

**GA-8.E.** Program managers/supervisors and LCCF directors are notified of the approved changes to the PPPM. The state PPPM on the OCCF website is updated within 30 working days of the approved changes.

**GA-8.F.** All programs are required to have a Local Policies and Procedures Manual (PPPM) that is in accord with the state PPPM.

**GA-8.F.i.** Local PPPM are reviewed annually and revised as needed. Policy changes are approved by the local HS~HF Advisory Group and/or other bodies as locally specified. LCCF staff and members are involved in this process.

**GA-8.F.ii.** The LCCF receives a copy of the local PPPM within 30 days of its adoption.

**GA-8.F.iii.** Local PPPMs are submitted to OCCF within 90 days the final state PPPM being released.

**GA-9. Policy: All local programs have a written budget and monitors expenditures to manage financial resources and support program activities, and the budget is reviewed and approved prior to the beginning of the fiscal year.**

**Minimum Performance Standard:** 25% match, with at least 5% cash or cash equivalent.

**GA-9.A.** Each local program has an annual budget as a part of their contract. The budget demonstrates the use of HS~HF General Funds (HSGF) and HS~HF Medicaid (HSM) funds to provide HS~HF core services according to the HFA program model and HS~HF Fiscal Guidelines (Appendix D).

#### [Program Planning Policy](#)

**GA-9.B.** HSGF and HSM may only be used to provide services to higher risk families. These services are defined as HS~HF Core Services, and include:

- Screening to identify higher risk families (including resource referral and providing parenting information),
- Home visiting services following the HFA model for higher risk families, and
- Materials and supplies, administrative costs, staff training, etc., as needed to support these services.

#### [Program Planning Policy](#)

**GA-9.C.** To the extent that a local community wishes to provide additional services to lower risk families, funding other than HSGF or HSM must be used. These activities for lower risk families are clearly distinguished from HS~HF core services.

#### [Program Planning Policy](#)

**GA-9.D.** The program budget is reviewed by the LCCF annually and at specified intervals throughout the year. The LCCF is responsible for assuring that the program budget allocates funds to provide cost effective services that can

meet HFA program model standards and the HS~HF performance indicators. Technical assistance and information from OCCF assists the LCCF in reviewing the budget.

**GA-9.E.** The LCCF presents the program budget to the Board of County Commissioners for approval at the beginning of each fiscal period (biennially) or whenever significant changes (such as a change of provider) occur.

**GA-9.F.** A copy of the program budget is provided to OCCF annually.

**GA-9.G.** The LCCF and local HS~HF provider seek diversification in funding. All programs are funded by at a minimum State HS~HF General Funds (HSGF), Medicaid Administrative Claiming (MAC, or HSM), and must also generate a local match contribution equaling 25% of HSGF. A minimum of 5% must be cash or cash equivalent. The balance can be in-kind. Proactive efforts to secure additional resources for funding are encouraged.

#### Program Planning Policy

**GA-9.H.** The LCCF partners with the local program to develop additional resources for funding and may direct other OCCF funds received locally to the HS~HF program. The LCCF reports other forms of leverage it generates that benefit the HS~HF program but do not qualify as match (i.e., funds obtained to provide additional complementary services to HS~HF families and others such as playgroups or local services to lower risk families).

#### Program Planning Policy

**GA-9.I.** Local HS~HF programs demonstrate at least a 25% (5% minimum cash or cash equivalent) local match as part of the base operating budget of their program.

- Match goes to provide HS~HF Core Services only,
- Match is reported to the OCCF at the specified intervals,
- At least 25% of HSGF is matched,
- This match may be made up of: cash contributions, grants, county general funds, in-kind contributions, volunteer hours, and the value of donated materials.

**GA-10. Policy:** The program makes available to the community an annual report or fiscal, statistical, and service data regarding the program.

**GA-11. Policy:** The program is audited annually by a certified public accountant.

**GA-11.A.** Agencies providing local HS~HF services are audited annually by a certified public accountant and is made available to the community.

#### Program Planning Policy

**GA-OR-1. MEDICAID ADMINISTRATIVE CLAIMING (MAC): All HS~HF programs are required by ORS (Appendix E) to participate in federal Medicaid (Title XIX) Administrative Claiming, following procedures provided by OCCF.**

- GA-OR-1.A.** OCCF manages the Title XIX Medicaid Administrative Claiming (MAC) program in accordance with all state and federal rules and regulations.
- GA-OR-1.B.** Medicaid earnings, except as described in OAR 423-010-0023(3), must be used to maintain or expand HS~HF program core services as defined in this HS~HF Program Policies and Procedures Manual and Fiscal Guidelines. Any Medicaid funds from other Medicaid programs (i.e., Targeted Case Management or Maternity Case Management) that are generated by staff paid by HS~HF, must be reinvested in HS~HF program core services. Participation in MAC by program managers and administrative staff is not required and should be handled on a case by case basis with OCCF.
- GA-OR-1.C.** Local programs report on the use of their Medicaid funds (HSM) to OCCF biennially through their LCCF. Use of HSM is recorded in the annual program budget which is reviewed by the LCCF and OCCF.
- GA-OR-1.D.** OCCF staff provides annual training and ongoing technical assistance in the implementation of MAC. Training includes:
- The MAC coding system as it relates to HS~HF work,
  - Use of the OCCF data system and Medicaid Online Time Tracker (MOTT),
  - The LCCF role in the administration of MAC funds, and
  - Appropriate uses of MAC funds in program budgets.
- GA-OR-1.E.** All local HS~HF staff receive local training on MAC and MOTT using materials provided by OCCF prior to their participating in MAC.

[SDC Plan](#)

[UMCHS Training Plan](#)

**GA-OR-2. The Role of State Commission on Children and Families/Children's Collaborative**

- GA-OR-2.A.** The State Commission on Children and Families/Children's Collaborative (SS/CC) exercises fiduciary authority for the use of granted HS~HF funds, including contract responsibility. The HS~HF Advisory Committee is appointed by the SC/CC, and keeps them updated on the HS~HF program, bringing them reports on the program's successes, challenges, and requests for advice from the SC/CC when requested.

**GA-OR-3. The Role of the HS~HF State Advisory Committee (Advisory Committee of the State Commission on Children and Families)**

- GA-OR-3.A.** The HS~HF State Advisory Committee is responsible to and advocates for the HS~HF program and its goals.

**GA-OR-3.B.** The HS~HF Advisory Committee roles and functions:

- Operates under State Commission on Children and Families Bylaws as an appointed Advisory Committee, advisory to the State Commission on Children and Families,
- Reports its findings and recommendations to the State Commission when requested
- Brings a broad perspective and vision to advise the effective implementation of HS~HF to achieve program mission and goals,
- Serves as a venue for communication among persons representing various aspects of the state system of supports and services for early childhood. The focus is on supporting HS~HF as an integral part of that system,
- Takes the lead in developing and updating the HS~HF Strategic Plan,
- Makes recommendations to OCCF Staff regarding the implementation of the strategic plan, and the effective implementation of the program in order to achieve its overall mission and goals,
- Takes an advocacy role in promoting the HS~HF program and services and supports for families with young children overall,
- Forms ad-hoc sub-committees to work on specific issues as needed. Sub-committees report on their work to the entire Committee at meetings, and through email, and
- Leads the efforts of the Building Program Support Task Force.

**GA-OR-3.C.** Advisory Committee members represent a wide range of skills and abilities and a heterogeneous mix in terms of skills, strengths, community knowledge, professions, age, race, sex, nationality, or ethnicity.

- The State Commission on Children and Families appoints members of the HS~HF Advisory Committee. At least one member of the Advisory Committee is a State Commission Member. A Vice-Chair is selected by the members.
- Recommendations for appointment to the Advisory Committee can be made by OCCF staff, LCCFs, and local HS~HF programs,
- Members of LCCFs, Early Childhood Teams, HS~HF Advisory Committees, current or former HS~HF participants, and representatives of other aspects of the community (including health care, mental health, education, academia, business, social services, and citizen groups interested in the well-being of young children) are eligible for membership. Every effort is made to recruit members from varied ethnic, racial, age, sex, and geographic areas,
- Advisory Committee members commit to active participation. They familiarize themselves with the HS~HF Program through reading orientation materials provided by OCCF staff, attend the majority of meetings in person or by phone, communicate by email, and serve on subcommittees, and
- When members are unable to participate actively, the Chair, Vice Chair, and/or OCCF staff consult with them regarding their continued membership.

- GA-OR-3.D.** OCCF staff support the Advisory Committee Chair and Vice Chair in developing agendas, facilitating communication, and recording minutes. Minutes of the HS~HF Advisory Committee are sent via email to members, and are posted on First Class. OCCF HS~HF staff attend all meetings of the Advisory Committee. Additional OCCF staff may attend in order to facilitate communication and bring information on their areas of expertise such as fiscal and resource development.
- GA-OR-3.E.** The HS~HF Advisory Committee meets every 90 days.

#### **GA-OR-5. The Role of State OCCF Staff**

- GA-OR-5.A.** OCCF staff is responsible for communication with all local HS~HF programs and LCCFs in order to keep them up to date on program goals, policies, and procedures.
- GA-OR-5.B.** OCCF staff ensures Core Training is available for all new HS~HF HOME VISITORS and all program Supervisors/Managers.
- GA-OR-5.C.** OCCF staff provides on-site training to all new program providers and new program managers in the philosophy, goals, program policies, and procedures of the HS~HF program. New programs receive “start up technical assistance” and mentoring from state HS~HF staff.
- GA-OR-5.D.** OCCF staff monitors training for local HS~HF staff to ensure adherence to HFA training standards using the Training Tracker data system and additional training records.
- GA-OR-5.E.** OCCF staff provide technical assistance based upon local HS~HF program need, information gathered during site reviews, or through program evaluation reports.
- GA-OR-5.F.** OCCF staff ensures regular ongoing evaluation of HS~HF through a qualified evaluator. The contracted evaluator prepares statewide reports as agreed in the contract.
- GA-OR-5.G.** OCCF staff maintains appropriate safeguards for all HS~HF data. Confidentiality Agreements are signed and kept on file for all HS~HF state staff, contracted employees, and HS~HF Committee members who have access to confidential information.
- GA-OR-5.H.** OCCF will conduct a Request for Application process each biennium with the LCCFs. The application will indicate the LCCF’s commitment to assure that contracted providers will meet each of the 12 Critical Elements and associated HS~HF Performance Indicators.
- GA-OR-5.I.** OCCF staff maintain standards for HFA Multi-Site Accreditation including fulfilling requirements of the HFA Multi-site addendum and supporting programs through technical assistance, training, quality assurance, evaluation, and central administration so that the statewide network maintains accreditation through HFA.

**GA-OR-6. The Role of Board of County Commissioners**

The Board of County Commissioners (BOCC) in each county exercises fiduciary authority for the use of granted HS~HF funds, including contract responsibility.

**GA-OR-7. The Role of Local Commission on Children and Families**

- GA-OR-7.A.** The Local Commission on Children and Families (LCCF) disseminates HS~HF state general funds and Medicaid reinvestment funds based on statutory and contract authority.
- GA-OR-7.B.** The LCCF made recommendations to the BOCC regarding HS~HF services in the county. The LCCF enters into an agreement for services either through contract or intergovernmental agreement. The LCCF ensures that legislative intent and the PPPM guide service delivery, and that the provider has the ability to achieve HS~HF' performance indicators.
- GA-OR-7.C.** LCCF's are not required to engage in competitive bidding processes to select providers for HS~HF services. [See OAR 423-045-0015(1) (d).]
- GA-OR-7.D.** LCCFs are required to submit an application to OCCF each biennium indicating the LCCF's commitment to assure that contracted providers will meet each of the 12 Critical Elements and associated HS~HF Performance Indicators.
- GA-OR-7.E.** LCCF's monitor HS~HF contracts as required by the State Commission on Children and Families. In addition, LCCFs receive and review semi annual program data received from the Evaluation.
- GA-OR-7.F.** The LCCF provides support and technical assistance to the local HS~HF Program in order to develop and maintain strong partnerships with the local early childhood system of services and supports. The program is represented on the local Early Childhood Team.
- GA-OR-7.G.** The LCCF partners with OCCF to conduct a site visit each biennium to the HS~HF provider(s) as outlined in the Annual Quality Assurance Plan. Review team members include LCCF staff, OCCF HS~HF staff, and/or any designated contractors. The review team may also include peer reviewers from other local programs, members of the local HS~HF Advisory Group, and/or local commission members.
- GA-OR-7.H.** The LCCF works with OCCF HS~HF staff to provide technical assistance to address issues identified in the program review.
- GA-OR-7.I.** The LCCF is responsible for submitting an annual Medicaid Reinvestment Plan to the OCCF as outlined in OCCF Policy CTY-110.

## GLOSSARY

**ACCEPTANCE OF INTENSIVE SERVICE:** *Participants* who voluntarily agree to participate in home visiting services after initial identification through screening, have received a first home visit have accepted intensive services.

**ACCEPTANCE RATE:** The mechanism for tracking the percent of *participants* who voluntarily agree to participate after the offer of program services and receive a first home visit. In order to measure this rate more accurately, programs monitor the **acceptance rate** of *participants* after each component of the recruitment process (e.g., screening, initial acceptance and final acceptance of intensive service). Rates are calculated through the evaluation and presented annually in the Status Report.

Initial acceptance rate for intensive service is calculated by:

- Counting the total number of *participants* with a positive NBQ who indicated they were interested in intensive service (if available) during the fiscal year (July 1 – June 30), and
- Dividing by the total number of *participants* with a positive NBQ who were asked if they were interested in intensive service (if available) during that same time period..

Final acceptance rate for intensive service is calculated by:

- Counting the total number of *participants* who receive a first home visit in the fiscal year (July 1 – June 30), and
- Dividing by the total number of potential *participants* with a positive NBQ who indicated they were interested in intensive services (if available) during that same time period.

**ACRONYMS:** Words used in Healthy Start~Healthy Families (HS~HF) that are formed from the initial letters of a phrase or title. Common acronyms include:

<b>Administration</b>		<b>Families</b>	
AKA	Also Known As	apt.	Apartment
ASQ	Ages and Stages Questionnaire	Appt.	Appointment
ASQ-SE	Ages and Stages Questionnaire, Social- Emotional	ASAP	As Soon As Possible
FAI	Family Assessment Interview	BA	Baby
HFA	Healthy Families America	c	with
HSGF	HS~HF General Fund	CD	Child Development
FSC	Family Stress Checklist	CPS	Child Protective Services
LCCF	Local Commission on Children and Families	DOB	Date of birth
OCCF	State Commission on Children and Families	Dx	Diagnosis
MAC	Medicaid Administrative Claiming	FOB	Father of the baby
MOTT	Medicaid Online Time Tracker	HV	Home Visit
MOA	Memorandum of Agreement	Hx	History of...
NBQ	New Baby Questionnaire, screening tool	MGM	Maternal grandmother
PM	Program Manager	MGF	Maternal grandfather
PPPM	Program Policies & Procedures Manual	MH	Mental Health
Rx	Prescription	MOB	Mother of the baby
SSAT	Site Self-Assessment Tool (HFA)	NICU	Neonatal Intensive Care Unit
TANF	Temporary Assistance to Needy Families	PCI	Parent Child Interaction
Unk	Unknown	PCP	Primary Care Provider
WIC	Women, Infants and Children – Food Program	PGM	Paternal grandmother
		PGF	Paternal grandfather
		SO	Significant other

**ADMINISTRATION:** The *personnel/staff* with responsibility for leadership and oversight of the program including service delivery, accountability, data management, and managing the program's resources (fiscal and personnel).

**ADVISORY COMMITTEE:** An organized voluntary group that advises HS~HF program operations. The functions and responsibilities of this group may include making recommendations to the HS~HF program and the organization's *governing group* (if different from the *advisory group*) regarding program policy, operations, finances, community needs, etc. Typically *advisory group* members are a diverse group of individuals who represent the interests of the community as guided by the critical elements.

**ANALYSIS:** A detailed study and reporting of program trends and patterns. Typically this would include *demographic, social, programmatic*, and other *factors* which impact services to families.

**ANNUAL STATUS REPORT:** A comprehensive document prepared by the HS~HF evaluation team that describes and summarizes program activities and services and is available to the community. This document includes an overview of services provided in the past year, demographic profiles of program *participants*, and a summary of outcomes achieved during the year.

**ASSESSMENT:** A measurement and/or report of the status (including strengths and needs) of an individual, a group, or the broader community.

**BYLAWS:** *Guidelines* adopted by the program (or its host agency, collaborative, community partners, *advisory/governing group*, etc.) for the regulation of its operations.

**CASELOAD:** The total number of families and caseload points assigned to a direct service staff person.

**CENTRAL ADMINISTRATION:** The Oregon Commission on Children and Families. State staff assure the quality of each site as well as the entire system through training, technical assistance, and evaluation services. These functions may be provided either directly by the Central Administration staff or through a *subcontractor*.

**CHARACTERISTICS:** Distinguishing features, attributes, and/or qualities.

**CRITERIA:** Standards and/or expectations on which judgments or decisions are based (i.e., criteria for moving *participants* from one level to the next).

**COMPETENCY BASED TESTING:** A tool, often paper and pencil, which tests an individual's knowledge level on a given topic. Subject area competencies can also be measured through observation of skills and abilities.

**CONTRACT:** A formal written legal agreement between two or more parties that specifies the services, people, space, or products to be provided in exchange for some form of compensation.

**CULTURE:** Behaviors, habits/patterns, values and beliefs, language, customs/traditions, religious beliefs, arts, institutions, and all other products of human work and thought considered to be the expression of a particular population or group of people.

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

**CULTURAL SENSITIVITY:** The degree to which the program continually modifies or tailors its system of service delivery to the *cultural characteristics* in its *service population* including *personnel/staff* selection, training and development, *assessment*, service planning and implementation, program evaluation, and *participant* care monitoring.

**DATA MANAGEMENT SYSTEM:** A systematic and standardized way of collecting and organizing information that allows for accurate monitoring of program activities and timely reporting of program statistics.

**DEMOGRAPHIC FACTORS:** General population characteristics such as gender, age, race, ethnicity, marital status, education, linguistics, employment, income level, etc.

**ELIGIBLE FOR SERVICES:** A process by which a program determines who meets specific *criteria* for receiving services. HS~HF screens the New Baby Questionnaire (NBQ) to determine eligibility for intensive home visiting services.

**EQUAL OPPORTUNITY POLICY:** An employer's written statement which describes how it ensures that all current and prospective employees are afforded equal employment opportunities and how it overcomes any effects of past discrimination.

**FAMILY ASSESSMENT INTERVIEW (FAI):** An assessment of family strengths and stresses that is conducted by the Home Visitor within the first three home visits.

**FAMILY ASSESSMENT INTERVIEW TRAINING:** In-depth three-day training that outlines the assessment process including interviewing skills, conducting and scoring the assessment, and completing necessary paperwork and documentation. The trainer is certified and has been trained to train others.

**FAMILY FILE:** A written compilation of information that describes and documents services given to participating families.

**FAMILY GOAL PLAN (FGP) -** The FGP is a working document and serves as a guide for ongoing delivery of services. The HOME VISITOR and parent(s) collaborate to develop the FGP including both personal and parenting goals that relate to identified strengths and needs.

**FINANCIAL AUDIT:** An independent review by a certified public accountant which certifies that an agency's financial report fairly reflects its financial status.

**FIRST BIRTH FAMILY:** Any family parenting for the first time. This include families with first born children for either parent, families whose firstborns were placed with adoptive or foster parents at or soon after birth, families whose firstborns died in early infancy, etc.

**FIRST HOME VISIT:** The first home visit when a family has accepted home visiting services and signed a Rights and Confidentiality form.

**GOVERNING GROUP:** An organized voluntary group with the legal authority and responsibility to set *policy* and oversee the operation of an agency. Generally the governing group is a group such as the Board of Directors.

**GUIDELINES:** Written statements of *procedure* directing program *personnel/staff* on the most appropriate course of action.

**HEALTHY FAMILIES AMERICA (HFA):** The program model on which HS~HF is based and which provides accreditation for programs and Multi-Site systems that adhere to its research-based critical elements.

**HEALTHY START~HEALTHY FAMILIES PROGRAM POLICIES AND PROCEDURES MANUAL:** This manual specifies policies and procedures for HS~HF of Oregon to assure that programs meet HFA accreditation standards as specified in the 2007 HFA Site Self-Assessment Tool. All programs follow the HS~HF Program Policies and Procedures Manual as written.

**HOME VISIT:** A face-to-face interaction that occurs between the *participant(s)* and Home Visitor. The goal of the home visit is to promote positive parent-child interaction, healthy childhood growth and development, and enhance family functioning. Typically home visits occur in the home and last a minimum of an hour and the child is present. Only one home visit per day is eligible to be counted as a home visit. The focus during home visits may include, but are not limited to:

**Promotion of positive parent-child interaction:**

- Support of attachment,
- Social-emotional relationship,
- Support for parent role as child's first teacher (language & emergent literacy),
- Parent-child play activities,
- Support for parent-child goals, etc.

**Promotion of healthy childhood growth & development:**

- Child development milestones,
- Child health & safety,
- Nutrition,
- Access to health care (well-child check-ups, immunizations),
- Linkage to appropriate early intervention services,
- Advocacy, etc.

**Enhancement of family functioning:**

- Trust-building,
- Strength-based strategies to support family well-being,
- Family goals,
- Assessment tools,
- Coping & problem-solving skills,
- Stress management & self-care,
- Home management & life skills,
- Linkage to appropriate community resources (e.g., food stamps, employment, education),
- Access to health care,
- Reduction of self-defeating behaviors (e.g., substance abuse, domestic violence),
- Reduction of social isolation,
- Crisis management,
- Advocacy, etc.

**HOME VISITOR PLAN:** A Home Visitor Plan is developed between home visitor and Supervisor. The Family Assessment Interview, FGP, home visit observations, parent surveys and other information can be used to inform the Home Visitor Plan. It identifies program goals and steps to meet these goals. These goals are targeted to high priority needs and/or issues that may or may not have been identified by the family, but relate to HS~HF program goals around family function, parent child relationships and child development.

**IMMUNIZATION SCHEDULE:** Immunization schedules follow the current recommendations of The American Academy of Pediatrics. These recommendations (found at <http://www.aap.org/>) specify which immunizations a child should have and at what age.

**IMMUNIZATION RATE:** The percentage of *target children* who are up-to-date with immunizations at a certain point in time (i.e., when the target child is nine months old, 12 months old, two years old, etc.). The percentage does not include children whose family beliefs preclude immunizations. In order to not count these families, the program requests a written statement from the parents to be kept on file.

**INTENSIVE SERVICE FAMILY:** Families who have received their first home visit and have signed the HS~HF Family Rights and Confidentiality Form.

**ISOLATED INSTANCES:** An instance that does not lend itself to a pattern and typically is considered to occur less than 10% of the time.

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

**MEMORANDA OF UNDERSTANDING (MOU):** A written agreement between two organizations or entities that outlines the scope, nature, and extent of services provided by each. Each HS~HF program has MOUs with hospitals or other appropriate entities to provide access to first birth families. Other MOUs may be helpful as well to formalize relationships between the program and other entities.

**MONITORS & ADDRESSES: Monitors:** to keep track of through the ongoing collection of available information. The extent of the information collected for tracking/monitoring purposes will vary and is a less rigorous process than compiling data for an analysis. In some situations, available data will be minimal, such as when tracking missed screens, in which case the program may not be able to determine much more than the total number missed and possibly referral source. In other situations, such as when monitoring families that assessed positive yet, verbally declined further involvement, the program will have more data available that it can use based on the amount of information that has been gathered from the family up to that point.

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

**MULTI-SITE SYSTEM:** Oregon is a multi-site state system with multiple sites providing direct HS~HF services (i.e., assessment, home visitation, and supervision). These sites all follow the HS~HF Program Policies and Procedures Manual. The *Central Administration* ensures the quality of each site and the entire system through *quality assurance*, training, technical assistance, and evaluation services. These functions are provided either directly by the *Central Administration* at OCCF and/or through a *subcontractor*.

**NARRATIVE:** A narrative is a written description of program practice. It is not as formal as a *policy* or *procedure*.

**NEW BABY QUESTIONNAIRE (NBQ):** A 12-item research-based screening tool adapted from the Hawaii Risk Indicators Inventory for use by Oregon's HS~HF program. It is designed to be an easily administered screening tool to measure families' level of risk for negative family and child outcomes

**PARTICIPANTS:** As defined by the program, participants include the individuals/family members enrolled in services.

**PARTICIPANT-CENTERED:** An approach to service delivery that is individualized and tailored to the unique strengths and needs of each family.

**PERFORMANCE INDICATOR:** A measure of program success in reaching a desired result. Performance indicators are identified for both service delivery and family outcomes and monitored through the Annual Status Report.

**PERSONNEL/STAFF:** The body of employees, consultants, and/or volunteers which carry out the tasks of the program performing under the program's administration and/or supervision.

**POLICIES:** Written statements of principles and positions that guide program operation and services, which are reviewed and approved by the OCCF Executive Director, in the case of state policies, and the local Advisory Committee, and/or other appropriate administrative group for local policies.

**PROCEDURES:** The step-by-step methods by which broad policies are implemented and program operations are carried out are written in a manual.

**PROGRAM:** A term used to describe a system of services offered by an agency. Sometimes the word "program" is used interchangeably with the word "service" or to describe specific programs under a broader service.

**PROGRAM MANAGEMENT SYSTEM:** An operational system for managing all aspects of the local program and/or multi-site system including assessment, home visitation, supervision and staff support, quality assurance, and contract compliance and maintenance.

**PROGRAMMATIC FACTORS:** General program elements that impact service planning and delivery which may include, but are not limited to staffing issues (administrative/direct service level), approaches to service delivery and evaluation of these approaches, how policies impact what happens with families and program outcomes, relationships with other agencies or community providers, training of staff, adherence to the critical elements, support received from the advisory/governing group, and program funding, etc.

**QUALITY ASSURANCE:** A systematic and objective approach to monitoring and evaluating the appropriateness and quality of program implementation in order to identify and resolve any problems and to improve performance. A written and comprehensive plan establishes and coordinates the Quality Assurance process. Programs follow the annual HS~HF State Quality Assurance Plan, and also develop local plans that add specificity to the state plan.

**RATIO CALCULATION:** The maximum ratio of supervisors to direct staff is one full-time supervisor for six full-time staff. If the supervisor is part time, the full-time equivalency (FTE) is multiplied by six. For example, a supervisor who is .75 FTE could supervise 4.5 FTE staff (no more than five individuals) or .75 FTE times six.

**REFUSED SERVICES:** Potential participants who have been offered services and decline to participate, and former participants who tell the program they no longer wish to continue services are said to have refused services.

**REGULAR/REGULARLY:** This term implies ongoing scheduled activities that take place at specified intervals.

**RELEASE OF INFORMATION:** A form which must be signed before any information is released about the family to another agency or person. The signed form is kept in the family file. Exceptions are made in the case of mandatory reporting of abuse and neglect.

**RETENTION RATE:** This term refers to the percent of *participants* who remain in the program after program acceptance. Retention *rates* are based on the time period between the first and last home visit *and are calculated by:*

- counting the total number of intensive service families who had a first and last home visit during a given period and dividing by
- the total number of intensive services families who had a first home visit (may or may not have had a last home visit) during the same period..

The Annual Status Report provides information on retention rates for 3, 6, 12, 18 and 24 month periods for *participants* enrolled in previous fiscal years who have had the opportunity to be enrolled for at least 12 months.

**ROUTINE/ROUTINELY:** This term, as it is used in the HFA site self-assessment tool, refers to a pattern of program implementation.

**SAFETY STANDARD:** Must be met in order to be credentialed as they impact the safety of the families being served. There are three safety standards:

- 9-3.B. Personnel background checks
- 10-2.C. Orienting staff on child abuse/neglect indicators and reporting requirements
- G-12.C. Child abuse/neglect reporting criteria, definitions and policies and procedures

**SCREEN:** A process of early identification of potential program participants based on risk assessment. HS~HF uses the New Baby Questionnaire (NBQ) to identify risks associated with poor child and family outcomes and qualifies families to receive intensive home visiting services.

**SCREENING RATE:** The mechanism for tracking the percent of *participants* who voluntarily agree to complete the New Baby Questionnaire. The screening rate is calculated by:

- Counting the total number of *participants* who completed the New Baby Questionnaire after the offer of program services in the fiscal year (July 1 – June 30), and
- Dividing by the total number of potential *participants* in the target population (first births).

**SELF-STUDY TRAINING:** This type of training includes reading articles, books, manuals, watching DVDs, listening to tapes, etc., followed by individual activities (i.e., writing, discussing, and giving presentations) and supervisory follow-up to assure that knowledge on the topic was gained.

**SENTINEL STANDARD:** Determined to be especially significant in the review of the HS~HF program quality. While adherence to each of these standards is not required in order to receive the HFA credential, a program with any of these standards rated out of adherence will be required to prepare and submit an improvement plan that clearly indicates how the program intends to bring the standard into compliance, coupled with evidence of implementation. There are seven sentinel standards:

- |                                  |  |
|----------------------------------|--|
| 6-4.B. and 6-6.B.                | Developmental screening and follow-up of suspected delays.   |
| 6-7.A. and 6-7.B.                | Notifying families of their rights, of confidentiality practices, and obtaining informed consent when information is to be shared with others (GA 5.A & GA 5.B in the 2006 HFA Standards). |
| 11-1.B., 11-2.A.,<br>and 11-2.B. | Supervision time, skill development, accountability, and professional support.   |

**SERVICE POPULATION:** Members of the target population who receive program services.

**SOCIAL FACTORS:** The set of characteristics linked to a family's formal and informal support network that may include friends, family members, neighbors and connections to religious groups, school or community agencies, and services that may contribute and/or influence human development, relationships, way of life, group dynamics, etc.

**STAFF DEVELOPMENT:** Knowledge and skill building activities intended to improve the ability of personnel/staff to perform their assigned tasks, to assume higher levels of responsibility, and to serve better the needs of program participants.

**STATISTICS:** Various program statistics are required throughout the Self-Assessment Tool. Data is available through the Family Manager database and the HS~HF evaluation. Local programs also keep statistical data on site.

**SUBCONTRACTOR:** A legally binding relationship between two entities (individuals or organizations) the purpose of which is to procure services or products consistent with an existing contract held by one of the parties for those services or products.

**SUPERVISION:** The process for providing oversight, guidance, and support to others in such a way to ensure accountability and professional development.

**TARGET CHILD(REN):** The child or children that determined the families' eligibility to receive HS~HF services.

**TARGET POPULATION:** Members of a group which the program is designed to serve. The boundaries of the designated target population may be set by a variety of factors such as specific social problems, age, and/or community needs. HS~HF's target population is first birth families.

**TRAINING:** A defined period of time during which an individual with expertise in the specified content area (i.e., has been trained to train others in the identified material) teaches or otherwise shares the information with staff. Training may be acquired in a variety of ways including attendance at trainings, formal education, certification, licensure, self-study, and/or competency-based testing. Self-study, professional experience/licensure, and previous formal education count as training when coupled with supervisory follow-up. Formal education, previous training, and previous experience must have occurred within three years prior to hire in HS~HF in order to meet the training requirements. Supervisors and staff work together to determine which training topic areas are fulfilled through the training received.

The following are the specific areas of training required by Healthy Start/HFA:

**Orientation Training.** Addresses the essential components of the job and may include program goals, services, policies, operating procedures, child abuse and neglect reporting requirements, history and philosophy of home visiting, and enrollment of families and confidentiality. Staff are oriented to the program's relationship with other community resources. This training is given before a staff person begins performing their duties or early in their employment. In Multi-Site state systems, orientation to the functions of the Multi-Site system is included as orientation training for new program managers. See Section 10-2.

**Intensive Role Specific Training.** In-depth formalized training which outlines the specific duties of the individual's role within HS~HF (i.e., home visitation, supervision, etc.). This training must be provided within the first six months of employment. In order to qualify as intensive role specific training, it should be provided by an individual who has been trained to train others in the intensive components of their role within the home visitation program. See Section 10-3.

**Additional Training within Six-months of Hire.** The topics and underlying content areas identified in Section 10-4. that include Infant Care, Child Health and Safety, Maternal and Family Health, Infant and Child Development, Role of Culture, and Supporting the Parent-Child Relationship that must be completed within six months of date of hire.

**Additional Training within 12-months of Hire.** The topics and underlying content areas identified in Section 10-5. that include Child Abuse and Neglect, Family Violence, Substance Abuse, Staff Related Issues, Family Issues, and Mental Health that must be completed within twelve months of date of hire.

**On-Going Training.** Supportive and regularly scheduled training provided to staff based upon the specific program needs and issues of families within the community served. Topics may include, but are not limited to: child development, infant care, culture, language development, substance abuse, family systems, and other staff related subjects. See Section 10-6.

**TRAINING TRACKER:** A web-based data management system to record staff training in required areas including on-going training. Programs are responsible for ensuring that staff enter training in a timely fashion. On-site training records should also be kept for professional development and supervision purposes.

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

## APPENDIX A

**Healthy Start~Healthy Families Oregon Training Plan****Purpose**

The purpose of this Training Plan is to assure staff in all programs are trained to provide effective, high quality home visiting services for families and children to reach the Oregon Benchmarks of reduced child abuse and neglect, improved childhood health and development, and increased school readiness.

**Factors considered in the development of this plan are:**

- a. The Healthy Families America (HFA) Standards around training
- b. Written evaluations of trainings provided in 2009
- c. Training requests received by OCCF staff
- d. New resources available: HFA 6 and 12 month training modules, available technology and experience in distance training
- e. Budgetary limitations

The HFA standards require staff receive several types of trainings at specific times in their employment. Oregon's central administration shares responsibility for these trainings with local programs by providing resources, conducting trainings, and monitoring and tracking trainings received statewide.

**Types of Trainings:**

1. Orientation Training is provided by:
  - a. *QuickStart for Healthy Start~Healthy Families of Oregon*
  - b. Site and program specific orientation (orientation to local program and agency policies and procedures, local training requirements)
  - c. ASQ and ASQ SE training as outlined in section 6-5 of the PPPM.
2. Introductory training about the multi-site system is provided by:
  - a. *QuickStart for Healthy Start~Healthy Families of Oregon*
  - b. Evaluation training through NPC Research's training DVD and the "Red Book"
  - c. Medicaid Administrative Claiming training DVD and on-site training
  - d. Program Policy and Procedure Manual
3. Role specific training is provided by HFA Certified Trainers through OCCF at least every 6 months or more often if needed. In 2010, the HFA Certified Core Trainers will receive re-certification training by HFA.

OCCF provides the following role specific trainings:

- o Home Visitor Core Training (Integrated Strategies for Home Visiting)
- o Family Intake Interview (FAI) Core Training
- o Supervisor Core Training
- o Program Manager Training

**Home Visitor Core:**

- o Incorporate new materials, agendas and training techniques from HFA re-certification training.
- o Utilization of Integrated Strategies for Home Visiting Curriculum

**Family Assessment Interview Core:**

- o Incorporate new materials, agendas and training techniques from HFA re-certification training.

- Revise the training manual to include information about motivational interviewing.

**Supervisor Core:**

- Continue to provide supervisor core training as developed in 2009, incorporating feedback from participants' evaluations
- Incorporate new information from HFA re-certification training
- Update training materials as needed

**Program Manager Core:**

- Continue to provide specific program manager core training as developed in 2009, incorporating feedback from participants' evaluations.
- Update training materials as needed.
- Utilize HFA's program manager core training as an additional resource when it becomes available.
- Invite local commissions to participate.

4. 6 month, 12 month required training is available through local training and/or the HFA Learning Center on-line training modules.
5. The Central Administration supports programs in assuring their staff receive training in required areas of knowledge within their first six and twelve months of service in the following ways:
  - a. Maximize the effective use of Training Tracker. Train program managers and supervisors to use the Training Tracker web application effectively so they can monitor their staff's training needs and accomplishments through:
    - Provide a webinar or video conference on the HFA Training standards including a section on Training Tracker.
    - Provide individualized training upon request-- face to face, by telephone, or online.
    - Update written and online "Help" manuals on Training Tracker
  - b. Provide access to all program supervisors to 6 and 12 month training modules from HFA.
  - c. Inform all program staff of opportunities specific topic training via email.
5. The Central Administration supports programs in assuring their staff receive at least 20 hours per year of ongoing training (continuing education) in the following ways:
  - Provide training through monthly webinars or video conferences during 2010. All 12 Critical Elements will be addressed throughout the year. Target audience: program managers and other staff as appropriate to the topic areas.
  - Provide required semi-annual Program Manager Meeting/Training face-to-face and/or via video conference.
  - Inform all program staff of ongoing training opportunities through email.

## APPENDIX B

**Healthy Start~Healthy Families Oregon Quality Assurance Plan**

**Purpose:** This plan is designed to ensure that all Healthy Start~Healthy Families (HS~HF) programs in Oregon provide effective, comprehensive, high quality home visiting services to support families and allow children to develop to their fullest potential.

**Goal:** Ensure that HS~HF programs throughout Oregon provide quality service to families following the Healthy Families America (HFA) best practice standards identified in the HFA Site Self Assessment Tool (SSAT), leading to the achievement of adequate or better performance measured by the HS~HF Performance Indicators for service delivery and family outcomes.

**Objective 1.** Continue to monitor the State policies and procedures manual for adherence to Healthy Families America's best practice standards. Review and update policies and procedures as needed. (See Policy GA-8 for details)

**Objective 2:** Implement and monitor a system of internal quality assurance procedures at each of the HS~HF program sites. (See Policy GA-3 for details)

***Local Commissions on Children and Families (LCCFs), Semi-annual Reports:*** The LCCF Director or designee reviews the Semi-annual Reports from NPC Research and Family Manager database and communicates with the program manager should issues be noted. (See Policy GA-OR-7 for details)

Programs submit Quality Assurance Checklist and related documents to OCCF annually for review. Checklist and Documents include:

- Trainer Tracker entry up to date
- Annual Forms revision implementation
- Annual screening plan (1-1 C & 1-1 E)
- Annual plan to increase the HVC rate
- Acceptance Analysis and Plan (every two years)
- Retention Analysis and Plan (every two years)
- Cultural Sensitivity Review and Plan (every two years)
- Staff Retention Analysis and Plan (every two years)
- Advisory group input received
- Program Policy and Procedure Manual
- Program Goal Plan (Quality Improvement Strategies)

**Objective 3.** Annual site visits to monitor quality management processes.

The LCCF Director or designees together with OCCF HS~HF Staff and contractors organize a team of reviewers and conduct an annual site visit to the local program to assess key quality assurance indicators and quality management processes. (See Policy GA-3 for details)

**Objective 4.** Ensure that programs receive technical assistance and monitoring necessary to implement a quality home visiting program. State OCCF staff provide technical assistance based upon local HS~HF program need, information gathered during annual site reviews, Family Manager reports and through program evaluation. (See Policy GA-3 for details)

***Objective 5.*** OCCF Staff and Advisory Committee (when appropriate) reviews the following on a yearly basis in order to inform the annual State Program Goal Plan, Training and Technical Assistance Plan and Strategic Plan:

- Performance Indicators
- Training and Technical Assistance Survey data (every two years)
- Evaluations from State provided training
- Local program site visit reports
- Local Program Goal Plans
- Local program Cultural Sensitivity Reviews (every two years)

**APPENDIX C**  
**Healthy Start~Healthy Families Oregon Performance Indicators**

**Final 2009-11 Performance Indicators**

Approved by State Commission on Children & Families on September 10, 2009

<b>Service Delivery Indicators</b>	<b>Exceeds HFA or OR Standard if:</b>	<b>Adequate if:</b>	<b>Below OR Standard if:</b>	<b>Data Sources</b>
1. Percentage of expected first births screened, based on OCCF Service Expectations* determined according to funding	60% or more screened	50%-59% screened	Fewer than 50% screened	OR vital statistics & NBQ screens data during fiscal year *Note 2009-11 screening expectation is based on first birth population
2. Percentage of screenings occurring prenatally or within the first 2 weeks of the child's birth	80% or more screened prenatally or within 2 weeks of birth	70-79% screened within 2 weeks	Fewer than 70% screened within 2 weeks	NBQ: Screen date and baby's birthdate
3. New Indicator: Percentage of new Intensive Service families receiving their first home visit prenatally or within 3 months of the baby's birth.	90%	80-89%	Fewer than 80%	Baby's birth date (NBQ or Family Intake); Family Intake (first home visit)
4. Percentage of families receiving 75% of expected visits based on assigned service level.	75% or more receive 75% of expected visits	65-74% receive 75% of expected visits	Fewer than 65% receive 75% of expected visits	Home Visit Completion / Caseload Management Tracking Forms
5. Percentage of IS families engaged in Intensive Services for 90 days or longer (early engagement).	90% or more	75-89% engaged	Fewer than 75% engaged	Family Intake Form (first home visit) & Exit/Re-Entry Form (exit date)
6. Percentage of families remaining in Intensive Services for 12 months or longer	65% or more	50%-64% remained	Fewer than 50% remained	Family Intake Form (first home visit) & Exit/Re-Entry Form (exit date)
7. Percentage of Expected Average Caseload Capacity.	25 -30 average caseload points per 1.0 FTE HOME VISITOR	18-24 average caseload points per 1.0 FTE HOME VISITOR	Less than 18 average caseload points per 1.0 FTE HOME VISITOR	Home Visit Completion / Caseload Management Tracking Forms
8. Match Expectations Met. Programs currently expected to have 25% match, of which 5% must be cash.	NA	25% match, with at least 5% cash	<25% total match or < 5% cash match	OCCF Local Resources Database (entered by Local Commissions)

Outcome Indicators	Exceeds HFA or OR Standard if:	Adequate if:	Below OR Standard if:	Data Sources
1. Percentage of Children with Primary Care Provider	80% or higher	70%-79%	less than 70%	Percentage of IS children with a primary medical care provider, as reported by HOME VISITOR on most recent Family Update
2. Percentage of Children with Up-to-Date Immunizations	80% or higher	70%-79%	less than 70%	Percentage of IS children with up-to-date immunizations, as reported by HOME VISITOR on most recent Family Update
3. Percentage of Parents Reading to Child 3x/week or more	85% or higher	70%-84%	less than 70%	Percentage of IS children whose parents report reading to them 3 times per week or more, as reported on the most recent Parent Survey
4. Percentage of Parents Reporting Positive Parent-Child Interactions	85% or higher	70%-84%	less than 70%	Percentage of IS children whose parents report engaging in developmentally appropriate interactions 3 times per week or more (singing, playing, etc) as reported on the most recent Parent Survey.
5. Percentage of Parents Reporting Reduced Parenting Stress	65% or higher	50%-64%	less than 50%	Percentage change in the average level of parenting stress (measured by Abidin's Parenting Stress Index) reported by parents from their baseline Parent Survey to the 6-month Parent Survey.
6. Percentage of Parents Reporting that Healthy Start~Healthy Families Helped with Social Support	85% or higher	70%-84%	less than 70%	Percentage of parents reporting that Healthy Start~Healthy Families helped them either a little or a lot to improve their social ties with family and friends, as reported on the most recent Parent Survey.

**APPENDIX D**  
**OCCF Healthy Start~Healthy Families Fiscal Guidelines**  
Effective October 1, 2009

### Use of Healthy Start~Healthy Families (HS~HF) State General Funds

HS~HF General Funds (HSGF) are allocated for the sole purpose of providing HS~HF Program Core Services.

The State Commission requires that HS~HF Programs provide Core Services in the most cost effective manner possible, following the Healthy Families America (HFA) program model. Full compliance with these approved uses is expected.

Core Services are defined as those activities that identify and serve high risk families following the HFA best practice model for home visiting. At least annually a program budget is submitted by the Local Commission to the Oregon Commission on Children & Families (OCCF) which includes all elements of these guidelines.

HSGF allocations are intended for purchase of HS~HF Core Services. HS~HF Core Services are:

- Home visiting services, i.e. direct service staff, supervisors, parenting curricula, and other materials needed to educate, support, and engage high risk families in services,
- Parent groups, classes and activities when used as a supplement to home visits,
- Screening to identify high risk families most in need of services,
- Program management, staff training, supervision and administrative costs needed to provide services in adherence to the HFA best practice standards, and
- Core Services do not include any services given after families are screened and found to be lower risk (or if they decline services).

The following are appropriate uses of HSGF resources in HS~HF programs and reflect common costs of Core services following the HFA model:

#### Staffing:

The following Core staff positions may be paid for with HSGF:

- Program Manager
- Program Supervisor OR Combined Program Manager/Supervisor
- Home Visitor (HV)

Additionally, the following *optional* staff positions may be paid for with HSGF. Programs describe the role and function of these staff positions in their contracts with local commissions, clarifying the role of each position in relation to Core Services for high risk families.

- Assistant Manager (in large programs)
- Screener
- Administrative Assistant
- Volunteer Coordinator – only when used for screening and outreach services to identify and serve high risk families

The following staff positions **may not** be paid for with HSGF:

- Additional on-site program managers or site coordinators at individual provider agencies within large programs.
- Additional professional staff (i.e. nurses, early childhood specialists, mental health consultants, etc.) These roles are additions to Core Services in the HFA model, provided through referrals and collaborative partnerships.
- Additional staff performing functions or providing services that are not considered Core Services following the HFA model (i.e., car seat technician, or family resource/clothing closet coordinator).

- The costs of indirect support to the program by staff of a parent organization or a separate agency (i.e. receptionists, bookkeepers, IT support, etc). These may be included within indirect or administrative costs charged by the parent organization, but are not paid as *specific FTE* dedicated to Healthy Start.
- Volunteer Coordinator staff when used for services other than screening and outreach (see above).

### Screening and Outreach Services:

Screening costs are limited to 10-15% of the overall HSGF allocation. Contracts with local commissions reflect this percentage.

Costs of screening should be kept as low as possible through the use of community partners and the utilization of volunteers, AmeriCorps etc. Screening may be conducted in a variety of settings and through a variety of partnerships. Local commissions monitor screening rates and costs to assure appropriate use of State HSGF.

The following expenses related to the screening and referral process may be paid for with HSGF:

- Community outreach to engage screening partners and referral sources,
- Obtaining consent to contact families (the "pre-consent" to screening),
- Materials for basic information and referral packets,
- Coordination, training, and supervision of screening volunteers, and
- Screening using the New Baby Questionnaire (NBQ):
  - Obtaining consent
  - Completing screen (approximately 20-30 minutes per screen)
  - Data entry
  - Making referrals.

The following services **may not** be paid for with HS General Funds:

- Services such as Welcome Baby home visits for low risk families,
- Welcome Baby gifts, and
- Program incentives.

### Intensive Services:

The bulk of HSGF should be used to provide Core Intensive Services to high risk families in the most efficient and cost effective manner following the HFA best practice model.

Home visiting is the primary method of service delivery in Healthy Start. Parent groups, classes, and activities may be added to supplement the home visiting services for high risk families.

Services use a variety of evidence based curricula. Curricula and other educational materials may be purchased using HSGF.

### Training:

Local programs may use HSGF to pay for required training for Core staff to meet HFA requirements. Adequate funds must be budgeted to allow for staff training. These funds could come from other resources.

### Supervision of home visitors:

Supervisors of home visitors may be paid for with HSGF. Programs must ensure adequate supervisory FTE to meet the HFA standard ratio for supervisors to staff. No more than 6 Home Visitors (working 20 hours per week or more) may be supervised by a 1.0 FTE supervisor whose only role is staff supervision. This ratio is prorated for part-time supervisors, including those who perform other functions (i.e., combination Program Manager/Supervisor).

### Indirect/Administration:

Local program indirect/admin costs charged to HSGF must be maintained within "reasonable levels". These costs may include indirect support to the program by staff of a parent organization or a separate agency (i.e. receptionists, bookkeepers, IT support, etc.). These may be included within indirect/admin costs, but are not paid as specific FTE dedicated to Healthy Start. OCCF recommends that indirect/admin costs not exceed 5%. However, indirect/admin costs

paid with HSGF must be limited to a maximum of 10%. Local commissions establish appropriate percentage of indirect/admin costs in their contracting process. Additional funding sources may help pay for indirect costs.

If the Local Commission elects to utilize up to the 4% of the HS-HF General Fund allocation allowable for LCCF administration; a budget narrative must describe how these administrative dollars will be utilized by the LCCF to support the local HS-HF program and an accounting of funds spent must be provided at the end of each fiscal year.

### Use of Medicaid Administrative Claiming (MAC)

Under legislation, all HS-HF programs participate in Medicaid Administrative Claiming (MAC). Only staff members who are paid with state and local general funds or other eligible resources are eligible to claim MAC earnings. Participation in MAC by program managers and administrative staff is not required and should be handled on a case by case basis with OCCF.

Each county enters into a Medicaid Intergovernmental Agreement with OCCF. Counties may claim expenses for administering the contract up to 5% of the earnings when costs are appropriately documented and invoiced to the program.

HS-HF staff complete time studies on four days each quarter randomly selected by the state Medical Assistance Programs Division of the Department of Human Services. Time is coded according to the specific activity occurring during each time slot. Codes for each time study are entered into the Medicaid Online Time Tracker (MOTT) system. All staff must be trained in MAC and MOTT prior to entering time studies. All staff received annual Medicaid refresher trainings.

MAC funds earned by program staff must be used to maintain or expand HS-HF Core Services. Acceptable uses are staffing, staff training, materials, curriculum, parent groups and classes, and other program enhancements. MAC funded home visiting staff may submit time studies for MAC reimbursement making it possible to fund home visiting staff with MAC funds. MAC funding may vary greatly, so it is recommended to be conservative in the use of MAC funds to fund staff.

Local commissions and programs submit a MAC Reinvestment Plan to OCCF annually accounting for their use of MAC funds to support Healthy Start. The use of these funds is also included in the annual program budget.

### Use of Local Match Funds

OCCF requires a local match to HSGF of 25% of which 5% must be cash or cash equivalent from all HS-HF programs. The intent of cash match is to build community investment and increase sustainability of the local HS-HF program. Local match is used to provide HS-HF Core Services.

#### Definitions of terms:

**Cash Match** includes cash received from private and public sources that are used to purchase goods and services (including staff) directly related to the provision of HS-HF Core Services.

**Cash Equivalent** includes core services donated by private and local public sources that, if not donated, would require HSGF or other funds to purchase these goods and/or services. Examples:

1. Utilization of hospital staff, community partner staff or volunteers for screening and outreach services. The cash equivalent for screening and outreach services core service hours donated to the program is determined utilizing the Independent Sector website at [http://www.independentsector.org/programs/research/volunteer\\_time.html](http://www.independentsector.org/programs/research/volunteer_time.html). The dollar value of associated cash equivalent hours are entered into the Local Resources Database under Cash Equivalent.
2. The costs of indirect support to the program by staff of a parent organization or a separate agency (i.e. receptionists, bookkeepers, IT support, etc.) provided at no cost to the program.
3. The value of office space that is provided to the program at no cost to the program by another entity.

**In-kind Match** includes, but is not limited to, the value of in-kind goods and services that are directly related to the provision of HS-HF services.

Examples include:

1. Donation of diapers, formula, baby safety products.
2. Donation of household items, clothing, food, etc.
3. The value of volunteer time for clerical support.

*(Note: the value of Advisory Board member time is considered leverage.)*

4. The time of professionals giving service to the program in their professional capacity may be valued at their usual and customary rate and the value of such entered into the Local Resources database as In-Kind contributions. For example, if a speaker who usually is paid \$500 for 3-hour training provides training for program staff at no cost, the time is valued as \$500.

**Leverage:** All cash or in-kind resources received by a HS~HF program that are not for the provision of core services, cannot be considered local match for the purposes of meeting the HS~HF 25% match. These additional resources are considered leverage. For example: A federal grant for purposes other than core services received by the program for which HS~HF funds were used in obtaining the grant. It is important to track leverage as another measure of local support for the program, and its effectiveness in gathering resources.

<b>Cash Match</b>	
<b>Can be used as Local Match<sup>1</sup></b>	<b>Cannot be Used as Local Match</b>
Cash donations from local businesses, schools, school district(s), or service groups	State or Federal funds received from OCCF such as state General Funds, Medicaid Administrative Claiming, or Family Preservation and Support
Private cash donations	
County General Funds	General or Federal funds received from other State agencies such as DHS, Employment Division, Dept. of Justice,
Third party payment of HS~HF staff who provide core services	
Grants from foundations	Funds received that do little to contribute to sustainability of the program or do not build community support (These revenues should be reported as leverage to local commission)
Grants and/or contributions from local faith organizations	
Federal grants received directly by the local program or LCCF for the purpose of delivering HS~HF core services	

<sup>1</sup> Not to be considered as all inclusive

## Appendix E

### OREGON REVISED STATUTE - HEALTHY START PROGRAMS (2009)

**417.795 Healthy Start Family Support Services programs; standards; coordination.** (1) The State Commission on Children and Families established under ORS 417.730 shall establish Healthy Start Family Support Services programs through contracts entered into by local commissions on children and families in all counties of this state as funding becomes available.

(2) These programs shall be nonstigmatizing, voluntary and designed to achieve the appropriate early childhood benchmarks and shall:

(a) Ensure that express written consent is obtained from the family prior to any release of information that is protected by federal or state law and before the family receives any services;

(b) Ensure that services are voluntary and that, if a family chooses not to accept services or ends services, there are no adverse consequences for those decisions;

(c) Offer a voluntary comprehensive screening and risk assessment of all newly born children and their families;

(d) Ensure that the disclosure of information gathered in conjunction with the voluntary comprehensive screening and risk assessment of children and their families is limited pursuant to ORS 417.728 (6) to the following purposes:

(A) Providing services under the programs to children and families who give their express written consent;

(B) Providing statistical data that are not personally identifiable;

(C) Accomplishing other purposes for which the family has given express written consent; and

(D) Meeting the requirements of mandatory state and federal disclosure laws;

(e) Ensure that risk factors used in the risk assessment are limited to those risk factors that have been shown by research to be associated with poor outcomes for children and families;

(f) Identify, as early as possible, families that would benefit most from the programs;

(g) Provide parenting education and support services, including but not limited to community-based home visiting services and primary health care services;

(h) Provide other supports, including but not limited to referral to and linking of community and public services for children and families such as mental health services, alcohol and drug treatment programs that meet the standards promulgated by the Oregon Health Authority pursuant to ORS 430.357, child care, food, housing and transportation;

(i) Coordinate services for children consistent with the voluntary local early childhood system plan developed pursuant to ORS 417.777;

(j) Provide follow-up services and supports from birth through five years of age;

(k) Integrate data with any common data system for early childhood programs implemented pursuant to section 7, chapter 831, Oregon Laws 2001;

(L) Be included in a statewide independent evaluation to document:

(A) Level of screening and assessment;

(B) Incidence of child abuse and neglect;

(C) Change in parenting skills; and

(D) Rate of child development;

(m) Be included in a statewide training program in the dynamics of the skills needed to provide early childhood services, such as assessment and home visiting; and

(n) Meet voluntary statewide and local early childhood system quality assurance and quality improvement standards.

(3) The Healthy Start Family Support Services programs, local health departments and other providers of prenatal and perinatal services in counties, as part of the voluntary local early childhood system, shall:

(a) Identify existing services and describe and prioritize additional services necessary for a voluntary home visit system;

(b) Build on existing programs;

(c) Maximize the use of volunteers and other community resources that support all families;

(d) Target, at a minimum, all first birth families in the county; and

(e) Ensure that home visiting services provided by local health departments for children and pregnant women support and are coordinated with local Healthy Start Family Support Services programs.

(4) Through a Healthy Start Family Support Services program, a trained family support worker or nurse shall be assigned to each family assessed as at risk that consents to receive services through the worker or nurse. The worker or nurse shall conduct home visits and assist the family in gaining access to needed services.

(5) The services required by this section shall be provided by hospitals, public or private entities or organizations, or any combination thereof, capable of providing all or part of the family risk assessment and the follow-up services. In granting a contract, a local commission may utilize collaborative contracting or requests for proposals and shall take into consideration the most effective and consistent service delivery system.

(6) The family risk assessment and follow-up services for families at risk shall be provided by trained family support workers or nurses organized in teams supervised by a manager and including a family services coordinator who is available to consult.

(7) Each Healthy Start Family Support Services program shall adopt disciplinary procedures for family support workers, nurses and other employees of the program. The procedures shall provide appropriate disciplinary actions for family support workers, nurses and other employees who violate federal or state law or the policies of the program. [1993 c.677 §1; 1999 c.1053 §21; 2001 c.831 §14; 2003 c.14 §209; 2005 c.271 §3; 2009 c.595 §362]

**Appendix F**  
**Healthy Start~Healthy Families Oregon**  
**BUILDING PROGRAM SUPPORT ACTION PLAN**

<b>OVERALL</b>	
1. Establish Building Support Taskforce	<ul style="list-style-type: none"> <li>a. Establish an on-going Building Program Support Taskforce (BPST) to enact this Action Plan (as a sub-group of the State Advisory Committee) as part of the Healthy Start Redesign Implementation Package</li> <li>b. Recruit members, set meetings coordinated with Advisory Committee to enact (and modify as needed) the Action Plan</li> </ul>
2. Build "Healthy Start Champions"—both State and Local	<ul style="list-style-type: none"> <li>a. Identify and arrange visits with elected officials as potential Champions</li> <li>b. Identify and visit with potential Champions among other leaders (physicians, private sector, funders, law enforcement, etc.)</li> <li>c. Arrange home visits and visits to programs for potential champions</li> <li>d. Strategically recruit for HS Advisory Committee. Refer to HFA matrix for desired representation</li> <li>e. Train local Program Managers (PMs), LCCF to develop a plan and build local Champions</li> <li>f. State Advisory members &amp; others identify and access Champions for local programs using their networks</li> </ul>
<b>BUILDING DIVERSIFIED FUNDING</b>	
1. Strategically plan to build diversified funding at the state and local level	<ul style="list-style-type: none"> <li>a. Assess local database reports on match and leverage</li> <li>b. Further develop Action Plan to increase diversified funding over the next biennium</li> </ul>
2. Engage in resource development at state level	<ul style="list-style-type: none"> <li>a. Seek grants to support statewide HS needs (evaluation, staff training, quality assurance work, etc.)</li> <li>b. Seek grants for underserved populations statewide or regionally (i.e., military families, tribal families, prenatal services, etc.)</li> <li>c. Explore corporate sponsorships (businesses, banks, etc.)</li> <li>d. Hold at least one major fundraising event each year for Healthy Start. Honor Champions, programs, staff, participating families, etc.</li> <li>e. Support ongoing Local grant writing efforts</li> </ul>
3. Train and support HS Program Managers (PMs) in resource development and fundraising	<ul style="list-style-type: none"> <li>a. Develop "Fundraising Tips" (including ideas like Baby Clubs tied to cost per family per year, "for \$<u>X</u>, you can supply a family with <u>X</u>")</li> <li>b. Develop and provide fundraising training for PMs and Local Commissions</li> <li>c. Ongoing technical assistance (TA) for PMs and Local Commissions on fundraising strategies</li> <li>d. Provide TA for programs and Local Commissions writing grants</li> </ul>
4. Train program staff to maximize Medicaid Administrative Claiming (MAC)	<ul style="list-style-type: none"> <li>a. Monitor reports &amp; provide program specific training on the MAC Codes</li> </ul>

5. Monitor progress on 25% match (including 5% cash)	<ul style="list-style-type: none"> <li>a. Review semi-annual leverage reports</li> <li>b. Provide specific TA to Local Commissions and programs to address challenges meeting match requirements</li> </ul>
6. Access other federal funding sources	<ul style="list-style-type: none"> <li>a. Explore possible access to federal mental health education dollars</li> <li>c. Federal Home Visiting legislation—monitor legislation, and access portion of funding for Oregon as it becomes available</li> <li>a. Other federal opportunities (Race to the Top, Early Learning Challenge Grants, etc.)</li> </ul>
<b>BUILDING MARKETING AND COMMUNITY RELATIONS</b>	
1. Require use of Healthy Start-Healthy Families Oregon name on all materials (used in combination with local name)	<ul style="list-style-type: none"> <li>a. Include in RFA</li> <li>b. Include in Program Policies (&amp; enforce)</li> </ul>
2. Make full use of existing marketing materials. Once these are used, re-order using Healthy Start/ Healthy Families	<ul style="list-style-type: none"> <li>a. Check that all local programs have all OCCF developed resources</li> <li>b. Train program staff in use of marketing materials</li> <li>c. Update, re-order, add to these as needed</li> </ul>
3. Give all programs links to national resources	<ul style="list-style-type: none"> <li>a. Provide info on resources through: Prevent Child Abuse America, Healthy Families America, Zero to Three, Home Visiting Network, etc.</li> </ul>
4. Further develop HS message	<ul style="list-style-type: none"> <li>a. Identify focus: wellness- "a healthy start for your baby" and/or "infant mental health" (e.g., attachment, positive parenting, etc.)</li> <li>b. Define what's unique about HS compared to "all the other starts" &amp; why it's needed</li> <li>c. Choose and use agreed upon slogan -- "Healthy Start—It Works!" or "Healthy Start—Because Babies Don't Come with Directions", or "Healthy Start—Changing Communities One Baby at a Time"</li> </ul>
5. Provide marketing training for PMs and all HS staff, Local Commissions	<ul style="list-style-type: none"> <li>a. Teach how to deliver consistent, accurate, intentional messages about program &amp; their work                             <ul style="list-style-type: none"> <li>o Coach to see "marketing" as part of every encounter they have as HS staff</li> <li>o Provide materials/review use of materials they already have</li> <li>o Develop sample presentations, etc.</li> </ul> </li> <li>b. Successful programs share strategies, successes</li> </ul>
<b>BUILDING ADVOCACY</b>	
1. Develop network of state and local Champions	<ul style="list-style-type: none"> <li>a. See Overall Strategies, Building Champions</li> <li>b. Build advocacy Champions—"elder statesmen", i.e., Sen. Avril Gordly, Govs Roberts and Atiyeh, etc.</li> </ul>
2. Align with existing groups	<ul style="list-style-type: none"> <li>a. Build relationships with advocacy groups that are natural allies on state and national levels</li> <li>b. Build relationships with local advocacy groups</li> <li>c. Build relationships with professional organizations supporting Healthy Start's mission such as medical, law enforcement, professional, business communities, etc.</li> <li>d. Build relationships with early childhood advocates, early childhood</li> </ul>

	<p>partner programs &amp; agencies—advocate together for a comprehensive Early Childhood Agenda</p> <p>e. Build relationships with foundations, potential funders and develop specific “asks” and deliverables</p>
<p>3. Invite dialog about HS—learn perceptions and beliefs so can address proactively to build support.</p>	<p>a. Actively solicit input about perceptions of Healthy Start</p> <p>b. Address concerns-- make changes or change inaccurate perceptions</p>
<b>BUILDING COLLABORATIONS</b>	
<p>1. Strategically recruit for State Advisory Committee to build collaboration (using HFA Matrix to assure diverse representation)</p>	<p>a. Recruit medical, health, business, law enforcement, professionals, community leaders for Advisory Committee</p> <p>b. Recruit elected officials for Advisory Committee</p> <p>c. Increase representation of diverse stakeholders on Advisory Committee using HFA criteria for board representation</p>
<p>2. Build screening partnerships</p>	<p>a. Work with Early Childhood Council to develop Universal Screening for psychosocial risks as a priority</p> <p>b. Work with statewide groups of health and medical community, etc. to promote screening system as benefit for families, other partner services</p> <p>c. Support local Early Childhood Teams to link HS screening with other local work</p>
<p>3. Collaboratively convene an educational event once a biennium to address at least one of Healthy Start’s core missions— prevention of child abuse and neglect, promotion of attachment, healthy growth and development and readiness to learn</p>	<p>a. Plan educational event internally and with early childhood partners</p> <p>b. Consider linking to annual Healthy Start fundraising event</p>