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INTRODUCTION
This Program Policies and Procedures Manual (PPPM) follows the standards and numbering system in the 2014-2016 Healthy Families America (HFA) Best Practice Standards. 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 sites written in blue italics.

HFA has identified 15 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 sites 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
- **10-1.C** Staff orientation training on child abuse/neglect indicators and reporting requirements
- **GA-6.A and GA-6.B** Policies and procedures around child abuse/neglect reporting criteria, definitions, and practice

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

- **4-2.B** Families at various levels of service receive the appropriate number of home visits based on level of service
- **4-3.B** Services are offered to families for a minimum of three years after birth
- **6-3.B** Site routinely assesses, addresses, and promotes positive parent-child interaction, attachment and bonding during home visits using the CHEEERS framework
- **6-6.B and 6-7.B** Site conducts developmental screening with parent(s) and child, and follows up on suspected delays
- **7-5.B** Site conducts depression screening with all enrolled mothers prenatally at least once and once postnatally before the baby is three months of age; paternal screening is encouraged
- **10-3.A, B** All home visitors, supervisors and program managers receive intensive HFA Core Assessment and HFA Core Home Visitor training given by certified HFA trainers
- **10-3.C** All supervisors and program managers receive intensive HFA Core Supervisory training given by a certified HFA trainer
- **12-1.B** Site ensures that weekly individual supervision is received by all .75 – 1.00 FTE direct service staff for a minimum of 1.5-2 hours, and all other FTE direct service staff per policy requirements.
- **12-2.B** Site ensures that all direct service staff are provided with supervision that includes administrative, clinical and reflective components
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Healthy Families Oregon
Program Policies and Procedures Manual
2014

*(Insert Local Site Name here)*

**Mission Statement**
Healthy Families Oregon promotes and supports positive parenting and healthy growth and development for all Oregon families expecting or parenting newborns that need and accept extra support. *May add local Mission Statement here.*

**Program Goals**
Healthy Families seeks to ensure that all of Oregon’s communities have nurturing, caring families where children are healthy and thriving. Healthy Families Oregon achieves this goal by enhancing family functioning and promotes positive parent-child relationships during home visits. This work contributes to several of Oregon’s Early Childhood Benchmarks:

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

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

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

**Home Visitation Program Description**
Healthy Families, formerly known as Healthy Start, 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 Families promotes wellness for Oregon families who need extra support during a pregnancy and at the time of birth by offering accessible and non-stigmatizing services tailored to the family’s unique situation.

Healthy Families offers consenting families access to screening and personalized referrals to community services. Families may 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 site policy. Visits assist families in achieving goals around parenting and improved family functioning by building on family strengths.

Today, Healthy Families Oregon is a vital link in a network of integrated early childhood services. *Add local site description here.*
Healthy Families Oregon Program Policies and Procedures Manual

Governing Legislation

The Oregon Revised Statues (ORS 417.795) pertaining to Healthy Families Oregon (HFO) can be found in Appendix E.

The Oregon Administrative Rules (Division 45 423-045-0005-ff) pertaining to HFO are available by request from HFO Central Administration staff at the Early Learning Division (ELD), Oregon Department of Education.

Program Policies and Procedures Manual

This manual describes the statewide program policies and procedures for Healthy Families Oregon that all local sites must follow. Local sites insert specific policies and procedures within the document, describing local practices in detail so staff clearly understands expectations around their work. *Local policies must not conflict with or substitute for state policies.*

State System Organization

- Oregon Department of Education, Early Learning Division
- Healthy Families Oregon Central Administration Office
  - Board of County Commissioners/ Early Learning Hubs
  - Healthy Families Oregon State Advisory Committee
  - Local Healthy Families Oregon Sites
  - Local Healthy Families Advisory Committees

*Note:* Dotted line signifies Independent Contractor
CRITICAL ELEMENT 1: Initiate Healthy Families services prenatally or at birth.

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

1-1.A. In accordance with Oregon Revised Statute 417.705-417.797, HFO has mechanisms for timely identification of families so home visiting services can begin prenatally or as early as possible within the first 90 days after the birth of the baby. All sites use the New Baby Questionnaire to identify potential participants. Families are eligible for services when they meet the scoring criteria on the New Baby Questionnaire (see 2-1A).

Each HFO site provides a comprehensive description of its target population including demographics that depict the issues the community is facing. The description includes the number of live births per year and the racial/ethnic/cultural/linguistic makeup of the population within the identified program’s geographic service area. Details include how the local site coordinates with other local early childhood services to ensure duplication of services does not occur.

In accordance with HFA Best Practice Standards, sites have a system to identify the target population and develop strategies to increase the number of families identified within the target population. It is NOT an expectation that all families in the target population be identified or screened by HFO sites. HFO Central Administration Office at the ELD within the Oregon Department of Education encourages HFO sites to actively seek outreach opportunities to identify expectant parents and parents of infants (0-3 months) as indicated by local need taking into consideration the following statewide priorities:

- High child abuse rates
- High infant mortality rates
- High rates of homelessness
- High rates of teen or single parents

NOTE – In communities when it is available, using the population giving birth within the program’s geographic boundaries encouraged.

Insert local comprehensive description of the target population, including demographics, or reference where they can be found. Be sure to include explicit details for the above statewide priorities.
Insert details of other available early childhood services within your service area, their target populations and how services are coordinated to ensure no duplication of services occurs.

1-1.B. Each site identifies community partners where their target population is found. Sites have established organizational relationships with these agencies for purposes of obtaining referrals, identifying and screening families.

Organizational relationships with other community entities allow families in the target population to be offered screening to establish eligibility for services. Sites will pursue written (formal Memorandums of Understanding/Agreements), verbal and/or informal agreements with appropriate entities to provide access to the site’s target population for screening. 

List organizations/community partners in your community where your target population is found. Describe the formal and informal agreements that are in place for each of these organizations/community partners.

Explain how your site ensures continued positive relationships with these agencies, including the strategies used.

1-1.C. Sites regularly monitor their screening process and coordination of organizational relationships. Sites will identify strengths and gaps, and develop strategies to increase the percentage of families that are screened. The site measures the screening rate at least annually using the Annual Review of Screening.

Insert local procedures indicating how you regularly monitor screening process, rates and organizational relationships. Describe your process for developing strategies to increase the percentage screened using the Annual Review of Screening. Please Note: If sites are able to screen/identify 90% or more of potential families, strategies to increase the percentage do not need to be identified.

1-2. Sites ensure that screening processes are regularly tracked and monitored.

1-2.A. The screening process includes completing the New Baby Questionnaire, giving parents information about newborn health and safety, community resources for families, parenting and child development information, and individualized referrals to appropriate services.

Describe, in detail, your screening process for your site. Include who screens families (i.e. screener, community partner, volunteer, etc.).

Describe your site’s policy and procedure ensuring timely determination of eligibility and the timeframes between the receipt of screens to the completion of contact to offer services.

Describe how your site tracks and monitors the above.
Describe what resource information is shared with families during screening. Examples of resource information distributed include: SIDS, shaken baby syndrome, smoking cessation and breastfeeding support information. Describe how these resources are distributed.

1-2.C. Sites will screen using the New Baby Questionnaire. Screening is conducted prenatally or within 14 days after the baby’s birth.

Insert local procedures that ensure screens are completed prenatally or within 14 days of birth.

1-2.D. Sites monitor and address families who screen positive on the New Baby Questionnaire and were not offered home visiting services. Sites ask all eligible families if they would be interested in home visiting services, informing them about the voluntary nature of the program services and giving a brief description of what 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 New Baby Questionnaire, and services are not offered, the reason is documented on the Exit Form and entered into the Family Manager database.

Describe your site’s process for monitoring and addressing families who screen positive and were not offered home visiting services.

1-2.E. Sites monitor and address families who verbally declined home visiting services following a positive screen. The reason for decline is documented on the New Baby Questionnaire and entered into Family Manager. Sites analyze data and develop strategies to address issues identified at least annually using the Annual Review of Screening.

1-3. Home Visiting services begin with the first home visit that occurs prenatally or within the first 90 days after the baby’s birth.

1-3.A. HFO provides intensive services for consenting families screened as eligible (using scoring procedures identified in 2-1.A) for home visiting services as program capacity allows. These services begin with the first home visit that occurs prenatally or within the first 90 days after the baby’s birth. Programs are encouraged to begin home visiting services with families during the prenatal period. Sites analyze data and develop strategies to address challenges at least annually using the Annual Review of Screening.

Insert local procedures ensuring the first visit occurs within 90 days of birth as stated in 1-3.A.

Insert how your site monitors and tracks families from the time they are screened until the first home visit.

Families with babies up to 90 days of age are eligible for home visiting services.
Home visiting services can follow the target child, and may be offered to substitute care providers. Examples of a substitute care provider might include foster parents or grandparents. This does not include childcare providers or supervised visitation. For example: A child is removed from a parent’s home and placed in foster care while the mother completes drug treatment. If the treatment is short-term and the mother is to be back within 90 days, Creative Outreach would be used in this situation to keep in contact with the mother and services would resume when she returned home with the child. If the duration of the separation is unknown and the child is placed at another care provider long-term, then the services would follow the child.

“Re-enrollment” of a family does not occur when a new baby is born during the provision of services and programs do not change the target child to the new baby. Services continue to follow the original target child.

If a family has been previously exited from HFO services, and screens eligible for services during a subsequent pregnancy, the program must follow local prioritization criteria as defined in 2-1B to determine if services will be offered.

Sites 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 HFO general fund or Medicaid reimbursement dollars.

If this type of service for lower risk families is offered; describe what services are offered and how it is funded. (Note: this policy does not refer to higher risk families who cannot receive intensive service due to site capacity)

Describe whether your site begins home visiting prenatally or at birth. If it varies, indicate how the decision is made for each family.

1-4. Each site measures, analyzes and addresses how it might increase the acceptance rate into home visiting services in a consistent manner and on a regular basis.

1-4.A. The program manager or designee assures appropriate data collection including the use of HFO’s Annual Status Report 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.

1-4.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 Family Manager Database, the statewide evaluation, the local site 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.

Insert local procedures for conducting this analysis. Indicate what sources of information are used besides Family Manager and NPC Semi-annual Reports as well as what formal and informal methods are used.
1-4.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 site. The plan addresses programmatic, demographic, social and other factors.

*Insert local procedures including how and when this plan is developed and updated. Also indicate how staff and your advisory group are involved in the development of this plan.*
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 adverse childhood experiences.

2-1. The site uses the New Baby Questionnaire (NBQ), a standardized risk screening tool, to systematically identify families at risk for other adverse childhood experiences.

2-1.A. Healthy Families Oregon (HFO) defines the process to identify families who are eligible for home visiting services for all sites in the state (OAR 423-045-0015). Sites screen consenting families using the New Baby Questionnaire to identify families at risk of poor child outcomes. Families residing in another county will be asked by the screener to complete a “consent to contact” form and send it to the site in the county of residence within three (3) working days of completion, to be outreached for screening.

Families are eligible for Healthy Families Services if:

1. They have depression (“YES” to #19A & 19B), or
2. They have drinking/drug use issues (“YES” to #21), or
3. They have any two or more risk factors

All families must give express written consent for screening using the Welcome to Healthy Families form. Consent is obtained using language the family understands (using a translated version of the form and/or interpretation services in a language the family can understand). Consent documentation is kept on record at the local site.

Insert local procedures for obtaining written consent for the New Baby Questionnaire in languages that families can understand (Central Administration provides forms in several languages).

HFO sites record screening information in the confidential Central Administration 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.

Insert local procedures for HIPAA process including what languages HIPAA forms are available in and how translation or interpretation is assured in other languages. Attach document used to notify families of HIPPA privacy practices in Appendix G.

Families may be screened over the telephone. The interviewer notes, “telephone consent given”, signs and dates the Welcome to Healthy Families 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 site at their earliest convenience. Sites keep a record of the mailing including the date sent.
Neighboring sites establish Memoranda of Understandings (MOUs) for transmitting information from consenting screened families to the site serving the area where the family resides.

List MOUs in place with other HFO sites. Note: Sites can share screening information without MOUs (families give consent to HFO services on the New Baby Questionnaire consent); however, it is helpful to have specific MOUs with HFO sites frequently sharing screening information.

Once families are identified and screened as eligible for home visiting services based on the New Baby Questionnaire criteria, local sites utilize clearly defined criteria to prioritize families when capacity does not allow services to all eligible families. Possible research based criteria may include:

- Families with two or more children under the age of five
- Teen parents
- Number of risk factors on NBQ
- Parent Survey score (if previously enrolled in HFO services under a different birth)

Insert local criteria to prioritize families when capacity does not allow services to all eligible families.

Local sites establish procedures for contacting families with positive New Baby Questionnaire screens to offer home visiting services.

Insert local procedures for contacting families with positive NBQ.

If a family is found to be at higher risk, desires services, and there is not capacity at the site, every effort is made to link the family with other appropriate resources in the community. Sites work collaboratively with other early childhood service providers and their Early Learning Hub to assure that families receive available timely services that meet their needs.

Insert local procedures describing how HFO eligible families not served with home visits are linked with other resources.

2-2.Staff and volunteers who use the New Baby Questionnaire screening tool to assess for the presence of factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences have been trained in its use prior to administering it and the New Baby Questionnaire is administered uniformly.
2-2.A Local site program management must coordinate training for all screeners that includes a review of information on Healthy Families Oregon services and the theoretical background of the screening tool. Local site program management must also coordinate opportunities for new screeners to receive hands-on practice in obtaining written informed consent and conducting the New Baby Questionnaire prior to use. Instructions on scoring the New Baby Questionnaire and talking points for obtaining informed consent (Welcome to Healthy Families form) are given in the Program Evaluation and Forms Manual (Redbook).

*Insert local procedures identifying the site’s screeners (HFO staff, community volunteers, community partners, etc...). Include the system for training screeners, keeping screeners connected with the site and how their work is monitored for quality assurance purposes.*

2-2.B Sites ensure the New Baby Questionnaire 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 site’s program manager based on information derived from other sources. This determination is noted on the top of the New Baby Questionnaire in large print letters, and indicated as a positive screen in Family Manager. The source of the information is also documented on the top of the New Baby Questionnaire for the site’s record.

*Insert local procedures ensuring the NBQ is administered uniformly.*
CRITICAL ELEMENT 3: Offer services voluntarily and use positive, persistent outreach efforts to build family trust.

3-1. Healthy Families Oregon (HFO) services are offered to families on a voluntary basis and cannot be mandated. Families may choose to discontinue services at any time.

3-1.A. By law (Appendix E), HFO services are voluntary and cannot be a part of any mandated plan.

3-1.B Sites follow established state protocols for working with local agencies to ensure the voluntary participation of families. Sites develop local policies for working with families involved with the local Department of Human Services (DHS). Families who are receiving services from DHS at the time of enrollment are eligible for voluntary home visiting services. HFO staff will not monitor the enrolled family on behalf of DHS or any other agency. Sharing information with these agencies, except in a child abuse or neglect report, is bound by HFO confidentiality requirements and only allowable if a family gives consent via the HFO Release of Information form.

Insert local procedures for assuring services are voluntary and are not offered as part of any mandated plan. Document your relationship, formal or informal, with the local DHS.

Insert local procedures for serving DHS involved families, including procedures around obtaining a Release of Information when communicating with the agency.

A note about the program evaluation: Families who choose not to participate in the statewide evaluation system are eligible to receive HFO home visiting services. Demographic information is recorded on the Central Administration Family Manager database and is not shared with the evaluators. Any additional family records are maintained locally on site.

3-2. Site staff uses a variety of positive methods to engage newly enrolled families, build family trust, and maintain family involvement in home visiting services.

3-2.A. Sites develop local guidelines for a variety of positive methods to initially engage families and to build their trust and maintain their involvement in home visiting services. This includes, but is not limited to, activities such as friendly notes, supportive phone calls, and mailings that are welcoming in nature.

Insert local procedures to engage families to build family trust in the initial engagement period (i.e., before the first home visit).
3-2.B. Home Visitors use positive methods and supervisory support to establish trusting relationships and keep families interested and connected over time.

Insert local procedures ensuring home visitors use the policy to build long-term retention with families over time such as anchoring conversations with families to their interest and needs, demonstrating joy in being with the parent(s), offering playful/fun activities to do with their baby etc.

3-3. Site staff offer creative outreach under specified circumstances for a minimum of three months (90 days) for each family before discontinuing services.

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

Families may be placed on Creative Outreach when they have missed at least one home visit followed by at least 10 working days of non-response by the family to reschedule, or after at least 30 days of unsuccessful attempts to schedule a home visit. Beyond this minimum requirement, sites may use their discretion when placing families on Creative Outreach.

Families may also be placed on Creative Outreach immediately upon telling the site that they will not be available for visits for at least 30 calendar days. (i.e., they will be out of the area for at least a month). Families may not be placed on Creative Outreach due to site issues (i.e., staff turnover or absences, training, agency closures, etc.).

Sites may conclude Creative Outreach prior to 90 calendar days only if parents (re)engage in intensive services, request to exit the services or move leaving no way to make further contact.

Insert your site’s Creative Outreach procedures describing the types of activities done during the Creative Outreach period, how progress is assessed, the frequency of contacts, and how decisions about this are made. Please include efforts to personalize communication and support each family individually. Efforts may be weekly to monthly. Central Administration recommends weekly the first month, bi-weekly the second month and at least one handwritten letter including a date the family will be exited from program services in the third month.

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

3-4.A. The site’s program manager or designee ensures appropriate data collection and monitors the retention rate of families receiving home visiting services at least annually following the HFA approved methodology as detailed in the HFO 2 Year Family Retention Analysis and Plan.
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 the statewide evaluation. Informal analysis includes local data review, discussions with staff and others involved in site services. This analysis includes programmatic, demographic, social and other factors.

Insert local site’s procedures for ensuring appropriate data collection.

3-4.C. Based on the analysis, sites 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.

Insert local procedures including sources of information used for completing the 2 Year Family Retention Analysis and Plan.

Insert local procedures describing how this plan is developed and who is involved (staff, advisory group, etc...) in developing strategies for increasing retention. Include how effective implementation is monitored.
CRITICAL ELEMENT 4: Offer services intensely and over the long term, with well-defined criteria for increasing or decreasing intensity of services.

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

4-1.A. Families are offered weekly home visits for a minimum of six months after the birth of the baby starting at the first postnatal home visit, excluding time on Creative Outreach. Prenatal visits are not included in these six months of weekly visits.

Families will remain on a weekly home visitation level for a minimum of six months after the birth of the baby. During this time, families are not assigned to less intense levels of service.

Insert local procedures including the strategies that your site uses to present this information to new families and strategies used to ensure weekly visits occur for the full six months of active family engagement.

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 approximately one hour and the child is typically 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.”) 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.

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

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:

- The 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
• Individual parent-child and group interactions is recorded on the Home Visit Record, including documentation of the items within the CHEERES assessment that were observed.

*Insert local policy/procedures for working with parent groups. Note: Groups can be formal or informal, and may be as small and simple as a “joint home visit” or “play date” with one or more home visitors present. Supervisors or program managers who are fully trained in home visitor duties and have received all current core training content may serve as home visitors in the group setting.*

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

4-2.A. Levels of service offered by the site 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 P1 (2 points):** Prenatal: weekly home visits
- **Level P2 (1 point):** Prenatal: every other week home visits
- **Level P3 (.5 point):** Prenatal: monthly home visits
- **Level 1SS (3 points):** Weekly or more frequent home visits
- **Level 1 (2 points):** Weekly home visits
- **Level 2 (1 point):** Every other week home visits
- **Level 3 (.5 point):** Monthly home visits
- **Level 4 (.25 points):** Quarterly home visits
- **Level X (.5 points):** Creative Outreach (weekly to monthly contact)

**Prenatal Levels:**
Level P- 1, 2, 3: These are optional prenatal home visiting service levels. If early in a pregnancy (1\textsuperscript{st} and 2\textsuperscript{nd} trimester), the first month of prenatal services should include weekly visits to establish a relationship and complete needed referrals and intake paperwork. After the first month, frequency is based on family need. The home visitor and supervisor determine the frequency of home visits with the family’s input during this time. Factors considered in determining the prenatal level of service include:

- The severity and complexity of issues needing attention prior to birth
- Other supportive services the family may be receiving

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 Level Assignment form is completed stating the assigned level, and the home visitor’s caseload reflects the proper weight for the prenatal level assigned. Prenatal families are assigned to Level 1 after the birth of the baby.

**During the last trimester of pregnancy, it is recommended that families receive weekly home visits to ensure adequate space on the home visitor’s caseload when the family is moved to Level 1 after the birth of the baby.**
Insert local procedures around prenatal service intensity, including any additional information of how level decisions are made.

Level 1SS:
Families on Level 1SS may receive additional caseload weighting for special services for the following:
- Families in temporary, extreme crisis
- Families that live beyond the program’s usual travel area/time
- Parents who have cognitive limitations
- Families using an interpreter
- Families that 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. Level 1SS is at the discretion of the program manager.

Insert additional local procedures with specific guidelines for Level 1SS for your site.

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.
- 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.
- 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).
- 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.
Sites 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.

- All home visits are entered into Family Manager on a monthly basis by each site
- Home Visit Completion reports are created each month and reviewed by the home visitor, supervisor and program manager

Insert local procedures describing when and who enters home visit completion data and when you review the reports with staff.

Home visits for the site as a whole are entered in 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 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 at least yearly on the Annual Plan to Increase Home Visit Completion Rate.

Insert local procedures for monitoring home visit completion, and how your site ensures that families receive the appropriate number of visits based on their service level, addressing individual home visitors, the team and the site.

Describe how the Annual Plan to Increase Home Visit Completion Rate is developed, implemented and what month it is completed within.

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 family progress that dictate level changes are documented clearly in the Home Visit Record and supervisory notes. When level changes are made, they are recorded on the Level Assignment Form.

Family progress is reviewed on an ongoing basis to determine if a family should move from one level of service to another. Service levels are not changed in response to barriers to full participation. These barriers may include the need for early morning, evening, or weekend visits, the need for translation at each visit, staffing issues, etc. Level change decisions are not made based on site needs, personnel issues or the age of the child.

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:

- The 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
• Individual parent-child and group interactions are recorded on the Home Visit Record, including documentation of the items within the CHEEERS assessment that were observed.

4-3. The site offers services to families for a minimum of three years after the birth of the baby.

4-3.A. Home visiting services are offered for a minimum of three years, and may include several months of transitional services as needed while the family is connected to other appropriate supports. Transitional service provision is at the discretion of the program manager.

*Insert your site's age limit for Healthy Families participants.*

4-3.B. Services are offered through the child’s third birthday year. The home visitor and supervisor work with the family to build their system of formal and informal supports during this time. 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.

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

4-4.A. Transition planning begins well in advance of the target child reaching the age limit for the program (no later than 6 months before the child’s graduation date, if applicable). This provides sufficient time to plan the transition with the family. Activities during this transition planning include:

- The family, home visitor, and the supervisor being involved in the transition planning, though not required to be present at the same time
- Collaborative partners notified of transition (with consent in place)
- Resources and/or services needed or desired by family are identified
- Steps are outlined to obtain identified resources/services, on the Home Visitor Plan and all transition planning activities completed during home visits are documented on each Home Visit Record by the home visitor. This can also be documented on the Family Goal Plan if the family desires.
- Follow up by site to assist with successful transition at program exit
- Steps are documented on the Home Visit Record, Home Visitor Plan, and in supervision notes including any decline of services and/or referrals

Some circumstances leading to an unplanned discharge will not be held to the policy:

- 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 Families Oregon site)
• The target child is no longer in the home
• The home visitor’s safety is at risk

When a participating family declines participation in a transition plan, home visitors will obtain a signature indicating the family has declined.
CRITICAL ELEMENT 5: Services are culturally sensitive such that staff understands, acknowledges and respects cultural differences among families. Staff and materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served.

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

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, criminal history, and cognitive abilities as related to families served.

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

*Insert a description of the cultural characteristics of your site’s service population including ethnic, racial, language, demographic and other characteristics. This is specific to the families who have accepted services.*

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

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

*Describe staff, curricula, materials, community partners, etc. that reflect and relate to the major groups within your service population. Also identify strategies or practices that ensure families feel comfortable, respected and represented in your site’s services.*

Monolingual families are assigned to a home visitor who speaks their language. If this is not possible, skilled interpreters are used whenever available.
Insert local policy/procedures describing the site’s procedures for using translators and/or interpreters, and indicating which languages are provided directly by home visitors.

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 review of families assigned to each home visitor and periodic shadowing of home visits to ensure that family cultural values and beliefs are respected. Reflective supervision is utilized to provide staff an opportunity to think about and strategize new ways to relate to the family based on their unique characteristics. These considerations, observations, and activities are documented in supervision notes.

Insert local procedures describing how this is done.

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

All HFO staff receives access to annual training on cultural sensitivity from the ELD’s Equity Specialist via webinar.

Insert local policy/procedures describing additional annual cultural sensitivity training for staff that is geared to your site’s target population.

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

5-4.A. Sites complete a Cultural Sensitivity Review at least every two years that addresses all of the following components:

- Materials
- Training
- Service delivery system (screening, home visitation, supervision, etc.)

Specific to supervision, sites are encouraged to consider the following:

- How they assign families to staff
- How unique cultural characteristics of families and staff are taken into account
- Cultural aspects of staff retention
- Program manager/supervisor support for additional training on various aspects of culture,
- Diversity of the advisory group, etc.

The Cultural Sensitivity 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 site might advance its current level of cultural sensitivity.
5-4.B. The Cultural Sensitivity Review includes family and staff input regarding the site’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 interviews in the language they speak, anonymous surveys, and/or focus groups. This Review summarizes patterns and trends, strengths and areas to address based on the feedback from families and staff.

Insert how your site and incorporates staff and family input regarding culturally sensitive services.

5-4.C. The Cultural Sensitivity Review is reported to the site’s Advisory Group that provides feedback and input for the development of strategies to address identified areas of growth in the review. At least one strategy to address identified areas of growth is required to increase the site’s ability to be culturally sensitive. Actions are taken by the site to implement the strategy (ies).

Insert your site’s procedures indicating what month this Review is reported to the Advisory Group.
CRITICAL ELEMENT 6: Services focus on supporting the parent(s) as well as the child by cultivating the growth of nurturing, responsive parent-child relationships and promoting healthy childhood growth and development.

6-1. Home visitors conduct the Parent Survey within the first three home visits. Risk factors and stressors identified from the Parent Survey are discussed and addressed initially and during the course of home visiting services.

6-1.A. The home visitor and the supervisor review the Parent Survey initially and over the course of services, planning how to address all of the risk factors and stressors with the family. The frequency of these discussions and reviews depend on what level of service the family is on and intensity of family issues that the family is displaying. Supervisors and home visitors discuss building on the family’s strengths, changing dynamics in the home, impact of childhood trauma and stressors that may be influencing parenting, etc. Activities and strategies discussed and implemented may include, but are not limited to:

- Use of Action Tools
- Motivational Interviewing
- Use of specific curriculum
- Parent-child activities that create focus on the child and bring joy to the parent
- Healthy coping activities
- Collaborating with other supportive agencies that are involved
- Referrals to appropriate community agencies
- Wishes for My Child, Family Values Activity connections

At the onset of services the home visitor and supervisor discuss the Parent Survey assessment and work together to plan activities, discuss strategies to address the strengths, risk factors and stressors identified in order to plan and implement an initial approach with the family. Initial planning, discussions, and follow up are incorporated on the Home Visitor Plan – Initial Approach (typically completed within the 4th week of service) and in supervision notes under the specific family using the Family Progress Review form. The Home Visitor Plan – Initial Approach form is kept in the supervision notebook.

The regular, ongoing discussions, after the initial approach, are documented in supervision notes under the specific family in the supervision notebook using the Family Progress Review form. Additionally, the Home Visitor Plan – Ongoing is recommended to guide discussions between supervisors and home visitors around activities and strategies related to the Parent Survey with families that have more complex family situations over the course of services.
Home visitors review and discuss all risk factors and stressors that were identified on the Parent Survey and Home Visitor Plan (initial and ongoing) regularly with each family throughout the course of their enrollment in the program.

Home visitors implement the activities and strategies during initial home visits and over the course of a family’s enrollment that were developed during supervision (as noted on the initial and ongoing Home Visitor Plan) with all families to address risk factors and stressors identified. Documentation is included on the Home Visit Record and clearly demonstrates implementation of activities, strategies and follow-up.

Staff administering the Parent Survey is trained in its use prior to conducting the assessment with families. Staff supervising those who administer the Parent Survey are similarly trained in its use (See Critical Element 10 for details on training).

6-2. The Family Goal Plan (FGP) assists in the development of home visit activities, the identification of resources, and the successful achievements that build a family’s resiliency and promote protective factors using family-centered practices.

6-2.A. The home visitor and family collaborate to set meaningful goals to help parents increase problem-solving skills, empower them and experience success in the process of developing and working on goals. During this process, families are encouraged to identify family strengths, resources, and protective factors, values, concerns and 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 Activity.

The Family Concerns and Referrals form is completed with the family to identify their concerns and needs within the first three home visits, as part of the Parent Survey process. The Family Values Activity occurs within the first 30 days of service (or the 4th home visit) and helps the family identify strengths and think about what they want for their family.

The Wishes for My Child Activity occurs within the first 45 days of service (or within the 6th home visit) and helps the family think about what they want for their child.
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. In addition to these activities, home visitors will also take this opportunity to discuss issues that were discussed in the Parent Survey using an honest, nurturing, and open approach. These discussions are documented on the aforementioned forms as appropriate when completing them with the family and on the Home Visit Record. The content of each of these activities/forms continue to be discussed and revisited over the course of services by the home visitor and supervisor and by the home visitor and family.

*Insert local procedures describing and/or listing methods used to involve parents in the FGP process, (i.e. using the forms mentioned above or others, etc.)*

**Based on what is most important to the family:** the home visitor and family collaborate to develop the Family Goal Plan within 60 days of the first home visit. The Family Goal Plan process contains opportunities for families to develop/increase creative thinking and problem solving skills, and takes into consideration family strengths, needs and concerns. The Family Goal Plan typically encompasses one goal at a time that may include personal, family and parenting goals as identified by the family. Home visitors use the following mechanisms to help family’s create a goal:

- Use motivational interviewing to assist parents in choosing goals with the greatest meaning to the family
- Breaking down larger goals into smaller, achievable steps, objectives or strategies
- Help family create mini-steps or strategies to achieve goal that are incremental, measureable and functional for the family
- Use the Family Goal Plan as a working document and as a guide for ongoing delivery of services.

Home visitors assist the family in identifying their own strengths that will specifically help them to accomplish their identified goal(s). Home visitors will use Action Tools, including but not limited to Problem Talk and Accentuating the Positives/Strategic Accentuating the Positives, to support this process.

Family Goal Plan discussions between the home visitor and family are documented on the Home Visit Record at least monthly. Progress, changes in mini-steps or goals, meeting and celebrating goals are documented and **updated on the Family Goal Plan** as well.

The home visitor and supervisor review the progress of each family in regard to their Family Goal Plan 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 30 days.**
Insert local procedure for reviewing FGP’s in supervision.

6-2.D. The Family Goal Plan is used throughout a family’s enrollment in development of activities and identifying resources and referrals. This is documented on the Home Visit Record and in supervision notes, and practice includes a variety of mechanisms 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 home visit activities related to the steps/goals
- Developing new goals when prior goals are accomplished
- 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 by building on family strengths and competencies
- Ensuring steps/goals for children are anchored in the family’s general routines.

May insert local procedures adding specifics about how this is done.

6-3. Each HFO site utilizes CHEEERS and Action Tools to assess, address, and promote positive parent-child interaction, attachment and bonding and the development of nurturing parent-child relationships.

6-3.A. Home visitor utilize CHEEERS as an objective parent-child observation strategy during each home visit. CHEEERS observations are documented on the home visit record using an objective, factual method. CHEEERS is documented in prenatal visits as well in response to promoting and encouraging a strong attachment with the parent(s).

Home visitors use Action Tools as a strength-based intervention during home visits to address the areas identified in CHEEERS as needing support or where the parent is successful. Action Tools are used to acknowledge, address and promote positive parent-child interactions, enhance/strengthen/reinforce attachment and bonding to encourage the development of nurturing parent-child relationships. Home visitors document Action Tools utilized to address CHEEERS observations on the Home Visit Record.

Supervisors support home visitors in using an objective method of documenting CHEEERS and using Action Tools as a way to support families to enhance/strengthen and reinforce positive, nurturing relationships.

Home visitors and supervisors use the CHEEERS observations as ground work for planning purposes and ongoing development of plans that include strategies, activities to do with the family, and use of Action Tools throughout the family’s
enrollment in the program to promote positive parent-child interaction. Planning and development include discussing CHEEERS observations for each family during supervision and documenting discussions on the Family Progress Review form, as well as documenting any strategies reviewed during supervision.

6-3.B. Insert how your ensures the practice of policy 6-3.A.

6-4. Each Healthy Families Oregon site regularly shares information with parents on child development, parenting skills and health and safety practices, including prevention.

6-4.A. Home visits include the promotion of 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 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 look for “teachable moments” and set up home visits so that the parent is engaged in the activity with their child. Observations, interactions, activities and how the curriculum was used are documented on the Home Visit Record.

Some of the most common evidence-informed curricula include:

- Growing Great Kids
- Parents as Teachers
- Partners for a Healthy Baby
- Nurturing Parents
- PIPE

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. All health and safety materials given to parents are in accordance with the recommendations of the American Academy of Pediatrics.

Insert local procedures indicating how home visitors observe for and address each of the above items and how they share the information with all families to promote healthy child development and parenting skills. Note: Sites must make decisions about how they present information to address cultural factors and individual family situations. Indicate how parenting skills are promoted within the context of the child’s development. Include how staff observe for and address these issues as well as follow through procedures.
Insert local procedure ensuring that home visitors **routinely** share information with families designed to promote positive health and safety practices, including prevention as stated in 6-4.A.

6-5. Sites use evidence-informed curriculum with families that helps to cultivate and promote nurturing parent-child relationships, healthy child development, parenting skills, and includes activities for preventive health and safety.

6-5.A. All HFO sites have a primary evidence-informed curriculum for use with families in the program. This curriculum promotes nurturing parent-child relationships, healthy child development, positive parenting, and includes preventive health and safety information.

Curriculum selected and used will meet the individual needs of families, with attention paid to cultural, linguistic, cognitive factors, and the interests of the family. Supplemental curriculum and materials used in home visitation are approved by the supervisor prior to use with families.

Home visitors and supervisors will be trained on the use of the primary, evidence-informed curriculum prior to its use in home visits or prior to supervising staff using the curriculum according to the requirements of the curriculum developers. The training will be documented on the *Healthy Families Oregon Training Log* and in the Training Tracker module of the database.

*List the primary curriculum that your site uses. Note: Distinguish between curriculum and other materials—here you list curriculum only.*

*Insert local procedures for incorporating supplementary curriculum and materials. Note: This refers to other curriculum used and the use of information found on the Internet, or other materials that staff may discover, regarding parenting, health and safety and child development. The supervisor must be aware of new materials being considered, and assess appropriateness for use with families.*

*Insert local procedures for training home visitors and supervisors in the primary curriculum according the curriculum developer’s requirements before using it with families as stated in 6-5.A.*

6-6. All HFO sites monitor the development of all participating infants and children using a standardized developmental screening tool.

6-6.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. If a family is on a revised screening schedule, the reason for the adjustment is documented on the Home Visit Record and Family File (*Data Tracking Sheet*).
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.

The ASQ is adjusted for babies born 36 weeks + 6 days or less. Age adjustments for the ASQ will continue until the child is 2 years of age. 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 until the baby is 2 years old.

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 program evaluation using the Family Update form and entered in the Family Manager database.

6-6.B. Insert local policy/procedures describing how you ensure that the ASQ and ASQ/SE are utilized as stated in 6-6.A. (unless developmentally inappropriate).

6-6.C. 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, one on one training by staff that understands the use of the tool in a home visiting setting, observing another qualified staff member administering the tools, being observed administering the tools, and orientation to local Early Intervention services to facilitate referral. ASQ and ASQ/SE training is documented on the Healthy Families Training Log.

Insert local policy/procedures describing on-site training of new staff in the ASQ and ASQ SE and how it is documented.

In the instances where the ASQ and ASQ-SE are done as a part of a collaborative process with other service providers involved with the family, the site must be in receipt of a copy of the complete results of each tool to show that the tools were completed on time and to make and track any necessary follow-up referrals/interventions for the family.

Insert your local policy for who you are partnering with, indicate what type of formal agreement is in place to support the partnership, and how you ensure that the ASQ and ASQ-SE are completed by the partner program/provider on time according to the above policy. Indicate how you receive a complete copy of the results of the screen from the partner program/provider.

Sites are required to ensure that all staff understand the administration guidelines and referral protocol regardless of whether they administer the screen or not, as they need to be able to interpret and act appropriately on the results of the screen.
6-7. The site tracks target children who are suspected of having a developmental delay and follows through with appropriate referrals and follow-up, as needed.

6-7.A. The home visitor, in coordination with the supervisor, 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.

The supervisor and home visitor determine when a child should be referred for developmental concerns based upon the ASQ and/or the ASQ-SE scores, and other observations made during home visits. Home Visitors document ASQ results and discussions with parent(s) about concerns on the Home Visit Record (HVR) and/or the Data Tracking Sheet in the family file. Supervisors document discussions with home visitor about the scores and concerns on the individual family’s Family Progress Review in the supervision notebook.

The home visitor integrates services between Early Intervention and Healthy Families when children are dually enrolled. Integrated services include attending therapy services, joint FGP’s and documentation of referrals made and accomplished. The continued use of the ASQ by the local Healthy Families site is determined on a case-by-case basis jointly by the agencies serving the family. Discussions are documented in Home Visit Records, Progress Notes and in supervision notes.

When families decline Early Intervention services, discussions and efforts to share information about Early Intervention services are documented in the Home Visit Record and supervisory notes.

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. When families are served through multiple sites 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).

6-7.B. Insert local procedures to ensure that this is done as stated in 6-7.A., including when and how referrals are made, to whom, and how staff support families to ensure referral to appropriate services in a timely manner.

Insert local procedures describing the local tracking system, including the local EI services that families are referred to.
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 related to: finances, food, and housing assistance, school readiness, child care, job training, family support, substance abuse treatment, mental health treatment and domestic violence resources.

7-1. Participating target children in Healthy Families Oregon (HFO) are linked to a primary medical/health care provider to assure optimal health and development.

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

Insert local procedures for providing information and connecting families to a provider.

Staff supports families to establish a primary medical/health care provider (PCP) for the target child and document the Primary Care Physician’s name in the family file. Home visitors also document information that is shared about medical/health providers on the home visit record.

Insert local procedures describing where this is documented in the family file and in the home visit record.

7-2. Sites ensure that home visitors promote and educate families regarding the importance of immunizing children, track the receipt of immunizations, and follow-up with parents when immunization appointments are missed. Target children are up-to-date on immunizations.

7-2.A. Home visitors routinely share information with families concerning the importance of immunizations and support them to receive timely immunizations for their children according to current recommendations from Centers for Disease Control and Prevention (CDC). Home Visitors will track receipt of immunizations and follow up with the family and document when immunization appointments are missed.

7-2.B. Home visitors record immunizations and well baby checks in the family file, print out a child’s individual immunizations from the alert system, or document on the home visit record. Up-to-date immunizations are reported to the program evaluators using the Family Update Form.

Home visitors also provide families with preventative child health and safety information based on American Academy of Pediatrics recommendations.

When families’ beliefs preclude immunizations for their children, it is documented on the data tracking form in the family file and the home visit record.

Insert your site’s procedures describing how and where this is documented.
7-3. Home visitors connect families to services in the community on an as needed basis.

7-3.A. Describe your local process that home visitors use to provide information, referral and linkages to health care, health care resources, and community resources for all participating family members.

7-3.D. Each site uses the Home Visit Record and/or the blue Referral Tracking Form to document referrals and follow up with families. Referrals and follow-up are discussed in regular supervisory sessions and discussion is documented on supervision notes.

Describe your local process for documenting referrals and subsequent follow-up with families, specifically which documentation method you use (HVR or Referral Tracking Form).

The local site works with local public health department home visitation services to coordinate efforts. It is recommended that sites ensure that public and private health care systems and providers are informed and kept up-to-date on HFO services and operations.

If the home visitor learns that another home visitation site, community service, or medical site is providing services to the family; efforts are made to arrange a joint staffing meeting or telephone conversation between the two sites (with the written consent of the family) in order to avoid duplication of services. A lead site is identified and roles are clarified. Documentation of ongoing coordination of services is maintained by the home visitor in the home visit record and by the supervisor in supervision notes.

7-4. Sites address challenging issues such as substance abuse, depression and mental health challenges, and intimate partner violence with families using a strength-based empowerment approach to build protective factors.

7-4.A. Home visitors address challenging issues to strengthen families by:

- Building a healthy, safe relationship with the parent(s) based on acceptance so that they can provide honest feedback with the parent’s permission,
- Using Action Tools, motivational interviewing,
- Encouraging forward thinking by assisting the parent in developing a vision of what they want
- Providing information and referrals
- Pointing out discrepancies between stated values and actual behaviors and
- Utilizing reflective supervision to receive support and prevent burnout.
The focus of the home visitor is to build a family’s protective factors and reduce risks such as untreated disorders, unresolved trauma, and substance abuse. Information regarding these risks can be gathered during the Parent Survey, from the needs and desires expressed by the family during home visits, from maternal depression screens and during the development of the Family Goal Plan, Wishes for My Child and Family Values Activity. Home visitors document these discussions on the home visit record.

*Insert any additional local procedures for addressing the above issues. Please include specific strategies that home visitors use in this process of building protective factors and reducing risk.*

7-5. Sites conduct depression screening with all families using a standardized instrument.

7-5.A. Home visitors conduct depression screening using the PHQ9 Depression Screening or the Edinburgh Depression Scale with all families in accordance with the tool developer guidelines. Depression screening is done within 30 days of the first prenatal home visit (if serving the family prenatally) and postnatally, within the first three months of the baby’s birth. Depression screening will also be completed any time during home visiting services if a parent is displaying or reports depressive behavior or symptoms. This includes fathers as determined necessary by the home visitor and supervisor. Screenings for each subsequent pregnancy/birth that a family has while receiving home visiting services is highly encouraged. Screenings are documented on the Home Visit Record and in supervision notes.

In the instances where the depression screening is done as a part of a collaborative process with other service providers involved with the family, the site must be in receipt of a copy to show that the screen was completed on time and to make and track any necessary follow-up referrals/interventions for the family.

*Insert your local policy for who you are partnering with, indicate what type of formal agreement is in place to support the partnership, and how you ensure that screens are completed by the partner program/provider on time according to the above policy. Indicate how you receive a complete copy of the results of the screen from the partner program/provider.*

Sites are required to ensure that all staff understand the administration guidelines and referral protocol regardless of if they administer the screen or not, as they need to be able to interpret and act appropriately on the results of the screen.

Home visitors will support parent(s) who are at risk for or who are displaying symptoms of depression by engaging in the following activities as appropriate:

- Providing linkages and referrals to appropriate resources
- Providing referrals for mental health consultation (when available)
- Utilizing supervision to assist staff in discussing depression with parents
- Getting parents out into the sunshine without sunglasses (sun increases serotonin) for visits
- Encouraging parents to walk, exercise, or engage in other forms of physical movement
- Encouraging parents to smile (even a “practice smile” increases serotonin)
- Encouraging parents to keep hydrated (hydration increases brain functioning)
- Encouraging parents to draw on healthy coping skills that they are interested in doing/trying
- Help parents recognize the impact of depression on the parent-child relationship and encouraging them to meet their baby’s physical and emotional needs
- Using strategies such as action tools and motivational interviewing to assist them in moving forward, increase awareness

*Insert the specific depression screening tool used for your site, when you administer it, and how you ensure that depression screenings are conducted.*

*Insert specific strategies and community resources that staff use locally to support parents with this challenge. Discuss how you meet the needs of families who refuse the screening.*

7-5.B. *Insert how your site ensures that depression screening occurs as stated in 7-5.A.*

7-5.C. Sites offer referrals and follow-up on referrals for parent(s) whose depression screening scores are elevated and considered to be at-risk for depression (based on the tool’s screening criteria) unless they are already involved in treatment. All referrals and follow-up are documented on the home visit record and/or blue referral tracking sheet and in supervision notes.

*Insert local procedure for offering referrals/follow-up on referrals for parents whose depression screenings scores are elevated and where you document the information.*

7-5.D. Staff who administer the site’s depression screening tool are trained in the use of the tool prior to administering it. Supervisors also receive the training prior to supervising staff that are administering it. Training is documented on the Healthy Families Training Log and entered into Training Tracker in the HFO web applications database within 30 days of training.

*Insert your site’s procedure for training staff on the depression screening tool, including where you will access the training.*
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. 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.

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 pro-rate 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. Sites will set lower caseload expectations and serve less families when a home visitor’s caseload includes a larger composition of families that score 40 or above on the Parent Survey. Programs pro-rate caseload size for part time home visitors (see example above).

8-1.C. Sites ensure that home visitors are within the caseload ranges, as stated in standard 8-1.A. and 8-1.B.

Insert local procedures around how your site ensures that home visitors have limited caseloads and how supervisors are monitoring the amount of families on a home visitor’s caseloads with scores over 40 on the Parent Survey.

8-2. The sites 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.

8-2.A. Sites use all of the following criteria for managing caseloads and assigning families to home visitors. Criteria include:
- Experience and skill level of the assigned home visitor
- Nature and difficulty of the problems encountered with families
- 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
- Home visitor flexibility when family has many scheduling limitations

Insert local procedures around how your site ensures that the criteria above are used to manage caseloads and assign families.
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. The site ensures that service providers and program management staff are selected because of a combination of personal characteristics, experiential, and educational qualifications.

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 field including experience in quality assurance/improvement and site development
- Master’s degree in public health or human services administration or fields related to working with children and families, or Bachelor’s degree with 3 years of relevant experience

For program managers hired before July 1, 2014 that do not meet the criteria, a staff development plan that addresses all components listed above excluding the formal educational degree is in place at the site and has been acted upon.

Insert local policy/procedures stating local requirements and actions related to any necessary staff development plans as outlined above.

9-1.B. Screening and selection of supervisors including, but not limited to:

- Master’s degree in human services or fields related to working with children and families, or Bachelor’s degree with 3 years relevant experience
- A solid understanding of and/or experience in supervising and motivating staff, as well as providing support to staff in stressful work environments
- Knowledge of infant and child development and parent-child attachment
- Experience with family services that embrace the concepts of family centered and strength-based service provision
- Knowledge of maternal-infant health and dynamics of child abuse and neglect
- Experience in providing services to culturally diverse communities/families
- Experience in home visitation with a strong background in prevention services to the 0-3 age population
- Infant mental health endorsement level III or IV preferred (if available in the state)
- Experience with reflective practice preferred (see standard 12-2.B for more detail)

For supervisors hired before July 1, 2014 that do not meet the criteria, a staff development plan that addresses all components listed above excluding the formal educational degree is in place at the site and has been acted upon.
Insert local policy/procedures stating local requirements and actions related to any necessary staff development plans as outlined above.

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:
- Minimum of 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 site
- 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 site’s target population
- Knowledge of infant and child development
- Open to reflective practice (i.e. has capacity for introspection communicates awareness of self in relation to others, recognizes value of supervision, etc.)
- Infant Mental Health endorsement level I or II preferred

Insert local policy/procedures stating local requirements.

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

Insert reference to host agency’s policies.

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

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 address knowledge and skills needed for the job, and
- Verification of 2-3 references and/or letters of recommendation and credentials. If hired from within the organization, performance appraisals may suffice.

Insert local procedures here.

9-3.B. All Healthy Families Oregon staff and volunteers who have responsibilities relating to families or their files must have a legally permissible criminal background check before contact with families or their information, 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.

Hiring of past participants in Healthy Families Oregon: Sites may hire people previously enrolled in the program using the following guidelines:

- At least one year has passed since the applicant participated in Healthy Families
- Standard hiring procedures are followed, including screening and selection criteria as outlined in 9-1C
- 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. The site monitors personnel satisfaction and retention at least every two years by completing the Staff Retention Analysis and Plan and addresses how it may increase staff retention. Action is taken to correct identified problems.

Sites encourage staff that is leaving the program to complete the Exit Survey provided by the statewide evaluation contractors (available at www.npcresearch.com). Programs are required to offer optional exit interviews to all staff.

*Insert your site’s procedure describing how exit surveys are done.*

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

*Insert your site’s procedure, including local method utilized to capture measure of job satisfaction, for those staff that stay.*
CRITICAL ELEMENT 10: Staff receive intensive training specific to their role to understand the essential components of family assessment, home visitation and supervision.

10-1. All staff receive orientation training (separate from intensive role specific training) prior to direct work with families to familiarize themselves with the functions of Healthy Families and their local site. Program managers will receive orientation training within 3 months of hire.

10-1.A. All staff receive orientation training prior to conducting their job duties independently that includes the site’s goals, services, policy and procedures, Healthy Families Oregon program evaluation forms and processes, and philosophy of home visiting/family support prior to direct work with families or supervision of staff using the QuickStart Manual and the Forms and Evaluation Manual. These trainings are documented on the Healthy Families Training Log and entered into Training Tracker in the HFO web applications database within 30 days of the training.

10-1.B. All staff is oriented to the site’s relationship with other community resources using the QuickStart Manual and local community information from the site. Direct service staff must be oriented prior to work with families. This training is documented on the Healthy Families Training Log and entered into Training Tracker in the HFO web applications database within 30 days of the training.

10-1.C. All staff is oriented to child abuse and neglect indicators and reporting requirements. Direct service staff must be oriented prior to work with families. This training is documented on the Healthy Families Training Log and entered into Training Tracker in the HFO web applications database within 30 days of the training. Note: To be accredited, all staff must have been oriented to child abuse and neglect indicators.

10-1.D. All staff is oriented to issues of confidentiality using the QuickStart Manual. Direct service staff must be oriented prior to work with families. This training is documented on the Healthy Families Training Log and entered into Training Tracker in the HFO web applications database within 30 days of the training.

10-1.E. All staff is oriented to boundaries using the QuickStart Manual. Direct service staff must be oriented prior to work with families. This training is documented on the Healthy Families Training Log and entered into Training Tracker in the HFO web applications database within 30 days of the training.

10-1.F. All staff is oriented to staff safety using the QuickStart Manual and the host site’s safety policies. Direct service staff must be oriented prior to work with families. This training is documented on the Healthy Families Training Log and entered into Training Tracker in the HFO web applications database within 30 days of the training.
Each local HFO site 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 HFO General Fund if not an HFO 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.

Insert local policy/procedures for the health and safety of staff here. Note: This is very important! Think hard about this, and get input from home visitors, families, and advisory board.

The local site 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.).

Insert local policy/procedures indicating how supervisors know which home each home visitor is scheduled to be visiting at all times.

Supervisors or their designees are available in the office or by phone at all times when home visitors are in the field.

Insert local policy/procedures.

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.

Insert local policy/procedures.

10-2. Home visitors and supervisors who begin work prior to having the role-specific HFA Core training, will receive “stop-gap” training. It does not need to be conducted by a certified trainer; but must be done by someone who has been intensively trained in the role they are providing stop-gap training for. This does not replace the required HFA Core training.
10-2.A. All home visitors and supervisors receive stop-gap training within one month of hire date (if they have not received the HFA Core training) and prior to direct work with families to ensure that staff has a thorough understanding of their role within Healthy Families. This includes staff from collaborative partnerships, volunteers, and interns functioning as home visitors. The training is conducted by staff that has been intensively trained in that role. The stop-gap training includes:

- The theoretical background of their role
- Shadowing other staff in like positions
- Training on forms and HFO program evaluation
- Use of strength-based approached and action tools
- Hands-on practice

10-2.B. All home visitors conducting the Parent Survey and their supervisors receive stop-gap training within one month of hire date (if they have not received the HFA Core Assessment Training) and prior to completing a Parent Survey assessment to ensure adequate understanding of how the tool is used. This includes staff from collaborative partnerships, volunteers, and interns functioning as home visitors. The stop-gap training includes:

- The theoretical background of their role
- Hands-on practice conducting and documenting the Parent Survey

10-2.C. All home visitors who begin providing home visits prior to completing the HFA Home Visitor Core Training, and their supervisor, receive stop-gap training within one month of hire date to ensure that staff has adequate understanding and knowledge of their role. Training includes:

- The theoretical background of home visiting
- Shadowing on home visits
- Use of strength-based approached and action tools
- Hands-on practice
- CHEEERS documentation

10-2.D. All supervisors who begin providing supervision prior to completing the HFA Core training receive stop-gap training within one month of hire date to ensure that the supervisor has adequate understanding and knowledge of their role. This training is to be completed before supervisor conducts supervisory sessions with staff.

Insert local procedures to ensure stop-gap training for all staff including who is responsible for providing it within the timeframes and when support from the Central Administration office might be needed (during times of program management transitions only).
### 10-3. Program managers, supervisors, and home visitors will receive HFA Core Training within six months of the date of hire that is specific to their site role to help them understand the essential components of their position. Central Administration staffs enter the HFA Core Training into training tracker in the HFO web applications database.

| **10-3.A.** | All staff conducting the Parent Survey, their supervisor and program manager will complete the HFA Core Assessment Training (given by a certified trainer who has been trained to train others) within six months of hire date. |
| **10-3.B.** | All home visitors and their supervisor and program manager will complete HFA Core Home Visitor Training (given by a certified trainer who has been trained to train others) within six months of hire date. This includes staff from collaborative partnerships, volunteers, and interns functioning as home visitors. |
| **10-3.C.** | Supervisors and program managers will complete intensive HFA Core Supervisory Training (given by a certified trainer who has been trained to train others) within six months of hire. |

Core training requirements for program managers will be “grandfathered” in for those hired prior to July 1, 2014. All program managers hired on or after July 1, 2014 will be required to adhere to the policies for core training (home visitor, parent survey, and supervisor) attendance as outlined above.

Central Administration utilizes a cost-sharing model for training and travel related expenses. Central Administration offers Core Trainings a minimum of two times per year at no cost to sites. Sites are responsible for all related travel and lodging expenses.
CRITICAL ELEMENT 11: Service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers receive basic training in areas such as cultural competency, substance abuse, reporting child abuse and neglect, domestic violence, drug-exposed infants, and services in their community.

11.1. Healthy Families Oregon has a comprehensive training plan that assures access and ongoing tracking and monitoring of required trainings in a timely manner for all staff. HFA’s The Learning Center online training modules will be utilized by each site in training new staff. Each site ensures that trainings are entered in Training Tracker in the HFO web applications database and an HFA Learning Center report is printed and retained to show successful completion of all training topics.

Central Administration 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. The completed Healthy Families Oregon Training Log is required for new staff. All programs maintain training backup documentation records for each staff member. Backup documentation includes:

- Orientation (10-1.A-F)
- Stop-gap training (10-2.A-D)
- Intensive role specific training (10-3.A-C)
- Additional training within 3 month of hire (11-2.A-C)
- Additional training within 6 months of hire (11-3.A-D)
- Additional training within 12 months of hire (11-4.A-E)
- On-going training topics (11-5.A-D)
- Cultural sensitivity (5-3)
- Developmental screening (6-6.C)
- Depression screening (7-5.D)
- Prenatal Training (11-6.B)
- Primary Curriculum Training (6-5.C.)
- Medicaid Administrative Claiming Training (GA-OR-1)

Insert local program Training Plan or indicate where it can be found. Include on-site record keeping system for staff training including the use of the Healthy Families Training Log (SR) for new hires.

Note: Local training records should include: For training classes - training certificates, brochures and/or agendas that describe the content of the training, and information about trainer qualifications. For self-study: documentation of what was studied, the author or producer of the materials, what was learned, how learning was assessed, i.e., through discussion in supervision, presentation to other staff on the topic, writing a report or completing the Documentation of Learning Through Training form, self-tests, etc. For other training credit methods (professional licensure or experience, college courses, etc.) maintain similar documentation.
Program managers or designees ensure that training activities are entered in Training Tracker in the HFO web applications database within 30 days of receiving training.

Staff, volunteers, interns, or partner agency staff performing screening receive training specific to their role.

HFA certified 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.

The following training materials are provided through Central Administration:

- QuickStart Manual
- Healthy Families Assessment Interview Training Manual
- HFA The Learning Center Online Training Modules
- Medicaid Administrative Claiming Training Manual and MOTT Webinar
- ASQ/ASQ-SE Manual and Video
- Forms and Program Evaluation Manual (Red Book)
- Program Evaluation Training DVD
- Prenatal Training Recorded Webinar
- Family Goal Plan Recorded Webinar from HFA National
- Program Manager/Supervisor Reference Guide
- Healthy Families America Best Practice Standards

11-2. Home visitors, supervisors and program managers complete the HFA on-line training modules for all three-month topics necessary for effectively working with families and children. Sites ensure that trainings are entered into training tracker.

11-2.A. Home visitors, supervisors and program managers complete the HFA on-line training module on **Infant Care** within three months of the date of hire. Topics include:

- Sleeping
- Feeding/breastfeeding
- Physical care of the baby
- Crying and comforting the baby

11-2.B. Home visitors, supervisors and program managers complete the HFA on-line training module on **Child Health and Safety** within three months of the date of hire. Topics include:

- Home safety
- Shaken baby syndrome
- Sudden Infant Death Syndrome (SIDS)
- Seeking medical care
- Well-child visits and immunizations
- Seeking appropriate child care
• Car seat safety
• Failure to thrive

11-2.C. Home visitors, supervisors and program managers complete the HFA on-line training module on Maternal and Family Health within three months of the date of hire. Topics include:
  • Family planning
  • Nutrition
  • Pre-natal/Post-natal healthcare
  • Pre-natal/Post-Partum depression
  • Warning signs for when to call the doctor

11-3. Home visitors, supervisors and program managers complete the HFA on-line training modules for all six-month topics necessary for effectively working with families and children. Sites ensure that trainings are entered into training tracker.

11-3.A. Home visitors, supervisors and program managers complete the HFA on-line training module on Infant and Child Development within six months of the date of hire. Topics include:
  • Language and literacy development
  • Physical and emotional development
  • Identifying developmental delays and
  • Brain development

11-3.B. Home visitors, supervisors and program managers complete the HFA on-line training module on Supporting the Parent-Child Relationship within six months of the date of hire. Topics include:
  • Supporting attachment
  • Positive parenting strategies
  • Discipline
  • Parent-child interactions
  • Observing parent-child interactions
  • Strategies for working with difficult relationships

11-3.C. Home visitors, supervisors and program managers complete the HFA on-line training module on Staff Related Issues within six months of hire. Topics include:
  • Stress and time management
  • Burnout prevention
  • Personal safety of staff
  • Ethics
  • Crisis management
  • Emergency protocols

11-3.D. Home visitors, supervisors and program managers complete the HFA on-line training module on Mental Health six month of the date 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
• Referral resources for mental health

11-4. Home visitors, supervisors and program managers complete the HFA on-line training modules for all 12-month topics necessary for effectively working with families and children. Sites ensure that trainings are entered into training.

11-4.A. Home visitors, supervisors and program managers complete the HFA on-line training module on **Child Abuse and Neglect** within 12 months of the date of hire. Topics include:

• Etiology of child abuse and neglect
• Working with survivors of abuse

11-4.B. Home visitors, supervisors and program managers complete the HFA on-line training module on **Family Violence** within 12 months of the date 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

11-4.C. Home visitors, supervisors and program managers complete the HFA on-line training module on **Substance Abuse** within 12 months of the date 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
• Referral resources for substance abuse

11-4.D. Home visitors, supervisors and program managers complete the HFA on-line training module on **Family Issues** within twelve months of hire. Topics include:

• Life skills management
• Engaging fathers
• Multi-generational families
• Teen parents
• Relationships
• HIV and AIDS
11-4.E. Home visitors, supervisors and program managers complete the HFA on-line training module on **Role of Culture in Parenting** within twelve months of hire. Topics include:

- Working with diverse cultures/populations (age, religion, gender, sexuality, ethnicity, poverty, dads, teens, gangs, disabled, etc.),
- Culture of poverty
- Values clarification

11-5. All staff receive training that takes into account the worker’s knowledge and skill base. Ongoing training must include annual cultural sensitivity training, annual child abuse and neglect training and annual Medicaid/MOTT training. Self-study may not be utilized to meet these training requirements. Prenatal Training and Family Goal Plan Training requirements may be met with appropriate self-study documentation. Sites ensure that trainings are entered into Training Tracker within 30 days of the training.

11-5.A. Sites have Individual Training Plans for each staff member. These plans address ongoing training in relation to knowledge and skill base, professional development, changes in roles, needs of the site, and personal interests. Individual training plans for staff moving from one local HFO site to another consider previous training.

Staff who have worked for Healthy Families less than 12 months are not required to participate in ongoing training.

*Insert local procedures for ongoing training and development of Individual Training Plans. Please specify how your site documents ongoing training (especially for seasoned staff).*

11-5.B. Home visitors, supervisors, and program managers receive **Prenatal Training** within six months of hire when the site serves families prenatally. Central Administration makes training available via webinar using content developed and presented by HFA National. Topics include:

- Fetal growth and development during each trimester
- Warning signs: when to call the doctor
- Activities to promote the parenting role, and the parent-child relationship during pregnancy
- Preparing for the baby
- Promoting parental awareness of what the baby is experiencing with connection to what the parent is doing (reflection)

*Insert local procedures for staff to complete Prenatal Specific Training.*

11-5.C. Home visitors and their supervisors receive **Family Goal Plan** within 12 months of hire to ensure that staff understands the process and framework of the Family Goal Plan (FGP). Training is made available by Central Administration via webinar using content developed and presented by HFA National. Topics include:
• Purpose and importance of the FGP process in HFA services
• Process that supports a family’s role in determining that meaningful goals are set that assist families in taking charge of their lives
• Identification of family’s strengths, needs and concerns
• Development of and practice writing FGP’s based upon the home visitor’s knowledge about the family, as well as information from the Family Values Activity, Wishes for My Child and the Referrals and Concerns Form
• Helping families write measurable and attainable goals

Insert local procedures for staff to complete FGP training on all topic areas.

11-5.D. All HFO site staff receive annual training related to Child Abuse and Neglect in order to stay updated on current child welfare policies, practices, and trends within the site’s community.

All HFO site staff receive annual training in cultural sensitivity.

All HFO staff receive training annually and prior to participation in Medicaid Administrative Claiming (MAC) and using the Medicaid Online Time Tracker (MOTT) System.

Insert local procedures for staff to complete the required annual trainings.
CRITICAL ELEMENT 12: Service providers receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families.

12-1. The site ensures that home visitation staff receive regular and ongoing supervision. This includes home visitors and any volunteers/interns in a home visitor role.

12-1.A. Sites provide regularly scheduled individual supervision for each home visitor for a minimum of 1.5 to 2 hours per week for staff that are .75 to 1 FTE. Part-time staff that are .25 to .74 FTE receive 1 hour per week. Staff that are less than .25 FTE can have variable supervision duration based on their workload and schedule. Scheduled supervision is not split into more than two regular sessions. A supervisor or “acting supervisor” must be available at all times a home visitor is working with families for support and consultation.

Insert local procedure describing the supervision process, including duration and frequency. If utilizing distance supervision, local policy must indicate how often in-person supervision occurs and how support and staff safety are addressed.

12-1.B. Sites ensure that weekly, individual supervision is received by all home visitation staff, including volunteers and/or interns who perform direct service or the same function) according to the FTE/duration policy above. Frequency and duration of supervision is documented on the Supervision Log and percentage is calculated quarterly. Documentation includes the reason for missing supervision, cancellations and/or rescheduling. Supervision Logs are reviewed semi-annually by the site. Every effort is made to set a specific time weekly for supervision.

The content of weekly supervision is documented on the General Weekly Supervision Form and includes administrative, clinical, and reflective components.

Supervision of home visitors who are not housed in the same location as their supervisor is 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 Families State General Fund if not HFO 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).

Insert any other local procedures to ensure that supervisory sessions are received by staff.

12-1.C. Sites may conduct reflective consultation groups. The groups must be implemented with the same degree of preparation and documentation as individual supervision (attendees, topics covered), and must be facilitated by a qualified individual. These groups include:
• Consultant with Infant Mental Health (IMH) Endorsement and/or Master’s degree in counseling or related field with two years’ post education, specialized work experience providing culturally sensitive, relationship-focused infant mental health services with infants and toddlers and their families.

• Time frame of two or more hours

• Case presentation

• Encouraging self-reflection and self-regulation, both physically and emotionally

• Observation of the staff member’s internal responses to the work including parallels between what might be going on for the home visitor as well as how that might impact the work

• Focus on the parallel process; expanding what might be going on for the staff to what might the family and the baby be experiencing

• Consider changes for next supervision, if needed, developing a plan for the work going forward

• Opportunity for participants to reflect on the group session they just experienced

One reflective consultation group per month may substitute for a weekly supervision, with the exception of new hires, which must receive weekly, individual supervision for a minimum of 12 months after initial hire date before they are eligible to count the reflective consultation group towards weekly supervision requirements.

12-1.D. The site maintains a ratio of one supervisor (with responsibilities only for supervision of the local HFO site) for up to six FTE direct service staff (and/or volunteers/interns who perform the same function), not to exceed eight staff members for a staff of all part time direct service providers. If the supervisor is less than full-time or if the supervisor is also the site manager or has other duties besides HFO supervision, the FTE of direct service staff FTE 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.)

*Insert local staffing ratio, including current FTE for each HFO staff.*

12-2. 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.

12-2.A. Supervisors provide professional support and supervision that includes administrative, clinical, and reflective components. Procedures include a variety of the following, but not limited to:

**Within supervisory sessions (12-2.B. practice):**

• Exploring/reflecting on the impact of the work on the worker
• Coaching and providing feedback on strength-based approaches and interventions used (action tools, problem-solving, crisis intervention, etc)
• Supporting Parent-Child Interaction work and CHEEERS observations
• Guiding the practice of cultural sensitivity
• Identifying areas for growth/acknowledging strengths
• Identifying and reflecting on potential boundary issues
• Sharing community resource information
• Acknowledging or strengthening engagement techniques
• Reviewing FGP progress and process
• Reviewing family progress and level changes
• Discussing family acceptance, retention and attrition
• Providing feedback on documentation and integrating use of tools used (developmental screens, evaluation tools)
• Integrating quality assurance results that include review of assessments and inter-rater reliability practices, shadowing visits, and phone calls to families
• Coaching/acknowledging/problem-solving home visit completion rates
• Discussing putting new training into practice
• Supporting cultural sensitivity and practices
• Providing guidance on use of curriculum
• Providing feedback on documentation

**Outside supervisory sessions (12-2.C. practice):**

• Creating a positive, nurturing work environment that provides opportunities for respite
• Reading home visit records and Parent Surveys
• Monitoring home visit records, all other required documentation
• Monitoring productivity
• Assuring an open door policy
• Offering regular staff meetings
• Assuring on-call availability to direct service workers
• Acknowledging performance
• Providing tools for performing the job
• Shadowing one home visit per home visitor at least annually
• Shadowing one assessment visit per home visitor at least annually
• Completing four quality assurance calls per home visitor every year
• Providing a career ladder for direct service staff

Describe the content of a typical supervision session at your site, including preparation for and focus on the balance of administrative, clinical and reflective practice and components. Include the procedure for documentation of supervision.

**Required Site Quality Assurance Activities**

• **Parent Survey Review:** The Supervisor or designee reviews each Parent Survey assessment to verify that the home visitor is acquiring appropriate
information, making appropriate referrals, scoring correctly and using the Parent Survey as a basis to get to know the family’s strengths, protective factors, and needs. The supervisor observes each home visitor conduct a Parent Survey at least annually and more frequently for home visitors who may need more support in this area. The supervisor will ensure reliability by completing the *Parent Survey Inter-rater Reliability* form at least every 180 days. In order to assure ongoing competence in completing the Parent Survey. If a home visitor does not conduct a Parent Survey for 180 days, s/he enacts a role-play and submits a written assessment to the supervisor for review.

- **Home Visit Record Review**: The Supervisor or designee reviews Home Visit Records before supervisory sessions. Review includes ensuring home visitor is addressing Parent Survey needs and concerns, strengths and protective factors of family, including use of action tools, providing 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 Home Visitor Goal Plan, referrals and follow-up, and ASQ, ASQ-SE, maternal depression screening and immunizations are monitored.

- **Home Visit Completion Rate Review**: Each home visitor’s home visit completion rate is regularly reviewed, and a team approach is taken to assure adequate numbers of visits are made. Rates are reviewed during supervisory sessions as well. Acknowledging success and problem solving to improve the home visit completion rate occurs regularly during supervision and team meetings.

- **Caseload Review**: The supervisor and home visitor routinely discuss family progress during supervision to assure 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 ensure appropriate use of the level system, to avoid dependence while providing adequate support for families.

- **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 at least 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 site 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, My Parenting Experience I, II A&B) to NPC Research. The site is responsible for the accuracy and completeness of the data submitted to NPC and entered in Family Manager.

• **Telephone Survey**: The Supervisor contacts two families per home visitor 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 acknowledges positive feedback from parent with home visitor and also develops and implements a plan to support home visitor if challenges were identified by parent input.

• Supervisors maintain written documentation of the content of supervision sessions. General topics are captured on the *General Weekly 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, Family Goal Plans, and Level Assignment forms.

**12-2.B.**

*Describe how your site ensures that supervision is implemented as stated above in 12-2.A. Also describe how your site ensures that staff have ongoing professional support and a positive working environment that is nurturing and conducive to productivity.*

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

**12-3.A.** Supervisors receive regular and on-going supervision that occurs at a minimum, every 30 days, with a recommendation that it occurs every other week. Procedures may include but are not limited to the following:

- Addressing personnel issues
- Feedback/reflection to supervisors regarding the team
- Agency issues
- Review of site documentation such as monthly or quarterly reports, site statistics, and quality assurance mechanisms
- Review of progress towards meeting site goals and objectives
- Strategies to promote professional development/growth
- Quality oversight that could include shadowing of supervisor

*Insert local policy for supervision of supervisors including frequency, by whom, and how it is documented.*
Program managers are held accountable for the quality of their work and are provided with skill development and professional support.

12-4.A. 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 policies and procedures and update the PPPM annually
- Analyze and develop plans required by HFA regarding Acceptance, Retention, Home Visit Completion, Cultural Sensitivity, and Staff Retention and Satisfaction
- Monitor screening, site acceptance, and home visit completion data,
- Develop, implement and monitor comprehensive Site Training Plan and update as appropriate
- Establish Memorandum(s) of Agreement with hospitals and/or other appropriate entities to provide access to the target population
- Maintain and enhance relationships with volunteers providing donations for site
- Liaison and with the Early Learning Hub in their local community Liaison with Central Administration staff and attend semi-annual PM meeting
- Work with Local Advisory Group to promote and support site
- Develop and monitor site budget, including monitoring of expenditures
- Manage all Medicaid Administrative Claiming and MOTT reporting leveraging community contributions and other additional revenue for match requirements
- 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 Central Administration
- Review Family Manager reports and NPC Semi-Annual Reports to be sure that the site is on track in screening, family service, and outcome measurements, and that all data is accurate and complete

Each local site must have one primary contact designated as the program manager. The minimum FTE for the role of Site Manager is .10 FTE or four hours per week.

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 site manager, chair of the advisory group, or a peer site manager.
Insert local policy/procedure for the supervision of the program manager including frequency, by whom, and how it is documented.
GOVERNANCE AND ADMINISTRATION: The site is governed and administered in accordance with principles of effective management and of ethical practices.

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

GA-1.A. Each local Healthy Families site has an Advisory Group. The local Healthy Families Advisory Group has bylaws and/or written operating procedures.

Roles and functions of the local Healthy Families Advisory Group:
- Advises the local site
- Meets at least quarterly, but as needed to support the site
- Regularly assesses the site’s services
- Makes recommendations for planning, implementation, and policies of its local site
- Works to support Healthy Families role in the local community’s early childhood system of supports and services
- Promotes and advocates for the local site
- Takes an active role in resource development for the site, including the 25% (5% cash or cash equivalent) local community match required for Healthy Families Oregon funds
- Serves as a forum for communication and resource sharing among community partners, and as a venue for building collaboration
- Forms subcommittees as needed to address specific issues and areas of interest
- Assures the development and implementation of a local Site Support Action Plan that is consistent with the state Site Support Action Plan (Appendix F). This plan is reviewed and updated as needed.

Describe the local advisory group including how often it meets, its bylaws and the makeup of the group.

The local HFO Advisory Group keeps and makes public minutes/notes of all meetings and a current membership roster.

Insert local procedures describing who does this and how.

GA-1.B. Healthy Families local Advisory Group Membership:
- The local Healthy Families 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 site 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,
• Healthy Families Oregon providers/contractors/staff are non-voting members who attend meetings to provide information and expertise.

*Insert local Advisory Group information.*

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

*Insert local procedures that the program manager uses to ensure that the Advisory Group works as an effective team.*

GA-2. Families are offered opportunities to provide feedback to the site, through the use of formal mechanisms

**GA-2.A - B.** Each local Healthy Families site ensures families have an opportunity for input by providing the My Parenting Experience II to participants in Healthy Families every 6 months.

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 Manager and Supervisor Reference Guide* to ensure that families have a chance to inform the site of what they like/don’t like about the program and/or home visitor.

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

**Participant Grievances:** All families are notified of the participant grievance procedure on the first home visit. Each local Healthy Families site has procedures regarding participant grievances, which include the following: how the participant/families are informed of the policy, the sites 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 program manager or designee and/or the local Advisory Group may be called upon to help resolve grievances.

The supervisor and/or program manager addresses participant grievances in a timely manner and appropriate action is taken.

• Participants may request a change in home visitor at any time. The site 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 site participants’ safety and well-being, and
• The site works with staff named in grievances through coaching in supervision and takes any additional personnel actions needed.

Insert local procedures for participant grievances here.

Staff Grievances: Staff grievances are addressed through personnel policies of the employing agency in a timely manner.

Insert local procedure for staff grievances here.

GA-3. The site monitors and evaluates quality of services.

GA-3.A. All sites follow the State Quality Assurance Plan (Appendix B) developed by members of the Healthy Families Oregon Advisory Committee. Quality assurance materials provided to the sites include:

• Program Managers and Supervisor Reference Guide
• HFA Best Practice Standards
• Healthy Families Oregon Program Policies and Procedures Manual
• Forms and Program Evaluation Manual (Redbook)
• and other tools made available to sites by Central Administration

All sites:

• 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 Healthy Families Oregon Program Policies and Procedures Manual
• Receive ongoing technical assistance from Healthy Families Oregon Central Administration staff and contractors as requested

Each site 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.B. Local Quality Assurance Plan:
Following a quality assurance site visit, sites develop or update the Program Goal Plan, which is then submitted, to Healthy Families Central Administration within 45 days of receiving the site visit report. The Program Goal Plan addresses site strengths as well as any challenges meeting the Performance Indicators and other issues identified in the site visit report. In years with a technical assistance focused site visit, sites update the Program Goal Plan and identify additional strategies as needed. Central Administration provides
technical assistance in the development of the Program Goal Plan and supporting sites to achieve identified goals to meet Performance Indicators and HFA standards when requested. The Program Goal Plan is updated at least annually.

**Quality Improvement Plan:**

If needed, sites receive specific written feedback about major concerns regarding the successful implementation of the Program Goal Plan or other issues regarding site quality from Central Administration staff. The site prepares a written response within 30 days, providing additional information to clarify the situation and alleviate the concerns. If the concerns still stand, Central Administration will notify the site within 30 days that a Quality Improvement Plan is required.

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 (site performance that falls below the threshold for maintaining HFA credentialing)
- Significant non-adherence to the HFO Program Policies and Procedures Manual
- Other areas of concern identified by Central Administration staff, parents, and/or the local site Advisory Board

The written Quality Improvement Plan is prepared by the local site in collaboration with Central Administration staff within 60 days of the notification of identified concerns. This plan addresses each identified area of concern with specific action steps and timelines for accomplishment.

Central Administration staff and the site are given copies of the Quality Improvement Plan. Central Administration and members of the evaluation team provide technical assistance to help with the implementation of the Quality Improvement Plan.

A follow-up site visit is conducted by Central Administration staff within 90 days of the implementation of the Quality Improvement Plan to assess progress. Central Administration provides additional support and technical assistance as appropriate. Central Administration staff provide the local site with a written report after the follow-up site visit, addressing progress in all of the areas identified in the Quality Improvement Plan.

**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, Central Administration 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 site manager and/or supervisor, Site Director, Early Learning Hub Leadership, and Central Administration HFO.
Coordinator. Central Administration receives a copy of the Corrective Action Plan.

Central Administration 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.

If the Corrective Action Plan is not successfully implemented within 90 days, the program manager notifies the Healthy Families Oregon Central Administration Coordinator and Early Learning Division Director. The program manager, Central Administration Coordinator, and Early Learning Division Director analyze the site’s willingness and/or ability to comply with the Corrective Action Plan. Central Administration staffs prepare a written report that is sent to the site.

A written analysis and history of the entire quality assurance process engaged with the site to date is prepared by Central Administration staff and presented to the state HFO Advisory Committee which may decide:

- To continue with the corrective action plan with specific timeframes for effective implementation,
- To recommend local Healthy Families provider changes, or
- To disaffiliate the site from the state system.

**Affiliation:**
Residents of each county in Oregon have potential access to Healthy Families Oregon services through a local Healthy Families site that meets the best practice guidelines outlined by HFA and which functions as part of a unified and consistent quality early childhood system. Healthy Families sites may be administered through regional partnerships, and their contracting agencies, or through individual county-based sites in alignment with the community’s Early Learning Hub.

Each local 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 HFO Program Policies and Procedures Manual.

**Change of Provider/Temporary Affiliation:**
There are occasions when a county chooses to enter into a contract with a new local HFO provider, including:

- Failure of the site provider to provide quality cost effective services,
- Voluntary withdrawal of the current provider,
- Desire of the local community to change the format of service delivery in order to more effectively or efficiently meet the needs of their population, and
- Other compelling reasons that may arise.

Before making the decision to change providers, the county carefully considers the impact of the change on families.
If, for any reason, a current local Healthy Families provider stops providing contracted services prior to the end of their contract, the county will notify Central Administration 45 days prior to signing a contract with the new provider so that Central Administration staff can provide site-specific training and technical assistance. The county and Central Administration may mutually agree to a notice period of less than 45 days if necessitated by specific circumstances.

Central Administration staff provides support and technical assistance through the process of changing providers.

The new local Healthy Families provider prepares and submits a site budget to Central Administration via their community’s Early Learning Hub. This budget demonstrates adherence to the HFA Critical Elements, willingness and ability to comply with the HFO Site Policies and Procedures, and capacity to successfully meet the Healthy Families Oregon Performance Indicators.

The new provider receives a site visit by Central Administration 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 site model. When Central Administration HFO staffs are assured of the site’s compliance with HFA standards and the Program Policies and Procedures Manual, temporary affiliation with the state system is granted.

Full affiliation is granted to a new site 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 HFO Site Policies and Procedures.

Affiliation of Sites or Sites Funded through Other Resources: Sites funded by other sources may use the HFO name if these sites adhere to the HFA standards and HFO Site Policies and Procedures. Sites request affiliation by establishing interagency agreements with Central Administration that include provisions for oversight and/or quality assurance of these sites.

**Disaffiliation:**
Disaffiliation may occur when a site has not improved through the Quality Assurance process. In this case, the site does not adhere to the HFA Critical Elements, and/or the HFO Program Policies and Procedures Manual, or meet the Oregon Performance Indicators.

Disaffiliation results in discontinuation of Central Administration HFO funding to the site for services. Funding resumes when HFO is again operational with a site that meets the criteria to become eligible to receive temporary affiliation.

A recommendation for disaffiliation of a site from the state HFO Advisory Committee is referred to the Central Administration state staff for action. (See OAR 423-101-0017 (9) (A), (C), (D) 2004 Revisions.)
Within 10 working days of the recommendation for disaffiliation, the ELD Director provides written notice to the site of intent to discontinue HFO state funding to the county and funding is discontinued after 60 days.

Funds to provide HFO services are held by Central Administration until a site that meets the criteria for temporary affiliation is in place.

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 Early Learning Hub for distribution to the new provider. The remainder is held by Central Administration for distribution to functioning HFO sites or is used by Central Administration for the HFO statewide system by providing additional training or materials to all sites statewide.

**Conflict Resolution and Appeals Process:**
Efforts are made to avoid conflict between the state system and local sites through open communication and ongoing technical assistance.

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.

In the event that a conflict arises between local sites and Central Administration that cannot be resolved through open communication among Central Administration staff, site, a skilled mediator agreed upon by all parties is called in to facilitate up to two sessions among the parties.

If mediation fails to resolve the matter, both parties submit a written statement describing their positions to the HFO State Advisory Committee for review. Copies are sent to the Early Learning Division Director. The Advisory Committee decides the proper resolution of the matter.

If the county site does not agree with this decision, it may make an appeal requesting the State Advisory Committee review the matter. The Central Administration staff involved, local site 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.

**Disciplinary Procedures:**
Each local HFO site ensures that the site has disciplinary procedures for all site employees. These procedures must provide appropriate disciplinary actions for all staff and volunteers who violate federal or state law or policies of the site.

*Insert local procedure here.*

**Site Name:**
The name “Healthy Families” must be included in each site’s name to support public recognition and marketing efforts of Healthy Families Oregon statewide.
GA-4. Healthy Families Oregon has policy and procedures at the state and local level for reviewing and recommending approval or denial of research proposals, whether internal or external, which involve past or present families.

All state level research proposals are considered by Central Administration and then taken to the State Advisory Committee for approval or denial. If approved, the State Advisory Committee determines scope (required for all sites, selected sites, or optional for site participation) and receives updates from the evaluator throughout the life of the research project. Local level proposals are taken to the local Advisory Committee for approval or denial. Central Administration is informed of all research projects that local sites are participating in.

*Insert your local site’s procedure for reviewing and recommending approval or denial of research proposals.*

Central Administration provides for regular and ongoing program evaluation of Healthy Families Oregon through a qualified evaluator. The contracted evaluator prepares statewide and site specific reports as agreed in their contract.

The contracted evaluator has a formal written plan that addresses site implementation, participant satisfaction, and participant outcomes:

- The plan is developed through active collaboration among the evaluators, state Central Administration staff, local sites, 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

Each local site participates in the statewide HFO evaluation and ensures that all families participating in any Healthy Families service (screening, and/or home visiting services) sign a consent form indicating their express written consent to participate (or not) in the HFO evaluation and what that participation entails.

Evaluation data is shared only in the form of aggregated results. Local sites use a state identification number on all materials sent to the state evaluators.

Each local HFO site ensures that each staff member has appropriate training in data collection, data entry and submission to the evaluation.

*Insert local procedure for training staff on evaluation here.*
Each site 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 site manager assures that staff are completing, entering and/or submitting all required forms in a timely manner.

*Insert local policy/procedures here. How do you make sure data is entered in Family Manager or sent to NPC on time, accurately done, and is as complete as possible?*

Local sites are responsible to cooperate with the evaluation to ensure accuracy of the data reported, and to monitor their data through ongoing review of Family Manager reports and semi-annual reports. Sites 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.
GA-5. 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 site services using the *Healthy Families Oregon Family 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.

Families participating in intensive home visiting services read and sign the *Healthy Families Oregon Release of Information* (ROI) form (in a language they can understand or with interpretation provided) every time information is to be shared with family members, DHS, another agency or provider (except in the case of mandatory reporting of abuse or neglect).

GA-5.B. Insert how families are notified of their right to confidentiality at the onset of services, both verbally and in writing and local procedures assuring that the *Healthy Families Oregon Rights and Confidentiality* form is signed on or before the first home visit. Indicate which languages these forms are available in, and how translation and/or interpretation services are approved and provided.

GA-5.C. Insert local procedure regarding signing the ROI every time information is shared with an outside source, and which languages are available on site. Include procedures for arranging translation and/or interpreting services as well as local policy/procedures assuring the form is signed before any information is released.

The ROI form does not include open-ended time frames such as “during the course of services” and timeframes or dates when the release expires do not exceed 12 months. ROI’s are as specific as possible about what is to be shared.

Parent(s) have access to review and receive copies of their records as provided by law.

*Insert local procedures for families to review records here.*

HFO records of adolescent parents are confidential and are not shared with anyone, including the parents of the adolescent, unless the adolescent signs an ROI or the release of information is otherwise required by law.
GA-6. The site reports suspected cases of child abuse and neglect to the appropriate authorities.

GA-6.A. Each local Healthy Families site has written procedures for reporting suspected child abuse. The criteria used to identify and determine when to report suspected child abuse and neglect is found in the Mandatory Reporting Manual from Oregon Department of Human Services.

These procedures include protocols for immediate notification of the program manager and/or supervisor and reporting to local Department of Human Services Child Welfare. Contacting the local Department of Human Services Child Welfare prior to immediate notification of the site manager and/or supervisor is appropriate ONLY IF waiting to contact site leadership may cause greater risk to the child(ren). Situations in which this occurs will be fully documented in the family file.

Insert local procedures here.

GA-6.B. All local HFO paid and unpaid staff is mandated to report suspected child abuse and neglect according to the specifications of Oregon law. Local sites ensure paid and unpaid staff receives appropriate and timely training about state reporting laws and local procedures, including annual training or updates.

Insert local procedures describing how this is done.

All local HFO 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.

Insert local procedures describing how this is done

Sites develop local site policies for working with families involved with the Department of Human Services Child Welfare and Self Sufficiency. By law, HFO 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.

Insert local policy/procedures here describing the process for serving DHS involved families.
GA-7. Each local Healthy Families site 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 site. These procedures include protocols for immediate notification of supervisors, program manager, and Site Director or designee.

*Insert local procedures for reporting critical incidents, including reporting participant deaths, major health and safety issues. Please include above protocols and any forms specific to your site.*

Local site staff immediately notifies the Healthy Families State Coordinator of participant deaths, criminal allegations involving site staff, and any other incidents deemed important that could affect the integrity and reputation of the site statewide. Staff is offered grief counseling when a death occurs.

*Insert local procedures for notification of state staff and ensuring counseling is offered [i.e. Employee Assistance Site (EAP)].*

GA-8. The HFO Program Policies and Procedures Manual is used to guide service providers in the delivery of services.

All HFO Sites follow the Healthy Families Oregon Program Policies and Procedures Manual (PPPM) as written.

The HFO State Advisory Committee reviews changes to the PPPM annually. This review ensures policies and procedures are comprehensive, up-to-date, and consistent with evidence-based practices.

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 Central Administration staff.

Program managers/supervisors and Site Directors are notified of the approved changes to the PPPM. The state PPPM on the Central Administration website is updated within 30 working days of the approved changes.

All sites are required to have their approved local PPPM that is in accord with the state PPPM to guide services.

Local PPPM are reviewed annually and revised as needed. The local HFO ADVISORY GROUP and/or other bodies as locally specified approve policy changes.

The local PPPM is submitted to Central Administration within 90 days the final state PPPM being released.

GA-9. All local sites have a written budget and monitors expenditures to manage financial resources and support site activities, and the budget is reviewed and approved prior to the beginning of the fiscal year.
GA-9.A. Each local site has an annual budget as a part of their contract. The budget demonstrates the use of HFO General Funds (HFGF) and HFO Medicaid (HSM) funds to provide HFO core services according to the HFA site model and HFO Fiscal Guidelines (Appendix D).

*Insert local policy/procedures describing the local budget process, including who develops the site budget and when and how this budget will be shared with the Early Learning Hub in your community for submission to HFO Central Administration.*

GA-9.B. HFGF and HSM may only be used to provide services to higher risk families. These services are defined as HFO 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.

*Insert local policy/procedures for your site’s HFO Core Services.*

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

*Insert local policy/procedures regarding other services your program may provide to lower risk families and how you will distinguish those services from HFO core services.*

GA-9.D. The site budget is reviewed by the Early Learning Hub annually and at specified intervals throughout the year. The Early Learning Hub is responsible for assuring that the site budget allocates funds to provide cost effective services that can meet HFA site model standards and the HFO Performance Indicators. Technical assistance and information from Central Administration assists the Early Learning Hub in reviewing the budget.

GA-9.F. A copy of the site budget, that includes all administrative dollars held back by the Early Learning Hub, is provided to Central Administration annually.

GA-9.G. The Early Learning Hub and local HFO provider seek diversification in funding. All sites are funded by at a minimum State HFO General Funds (HFGF), Medicaid Administrative Claiming (MAC, or HSM), and must also generate a local match contribution equaling 25% of HFGF. A minimum of 5% must be cash or cash equivalent. The balance can be in-kind. Match is reported to the Central Administration office annually. Proactive efforts to secure additional resources for funding are encouraged.

*Insert local policy/procedures describing local match and fundraising efforts here.*
**GA-9.H.** The Early Learning Hub partners with the local site to develop additional resources for funding and may direct other Central Administration funds received locally to the HFO site. The Early Learning Hub reports other forms of leverage it generates that benefit the HFO site but do not qualify as match (i.e., funds obtained to provide additional complementary services to HFO families and others such as playgroups or local services to lower risk families).

*Insert local policy/procedures describing local reporting process here.*

**GA-OR-1. MEDICAID ADMINISTRATIVE CLAIMING (MAC):** All HFO sites are required by ORS (Appendix E) to participate in federal Medicaid (Title XIX) Administrative Claiming, following procedures provided by Central Administration.

**GA-OR-1.A.** Central Administration manages the Title XIX Medicaid Administrative Claiming (MAC) site 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 HFO site core services as defined in this HFO Program Policies and Procedures Manual and Fiscal Guidelines. Any Medicaid funds from other Medicaid sites (i.e., Targeted Case Management or Maternity Case Management) that are generated by staff paid by HFO must be reinvested in HFO site 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 Central Administration.

**GA-OR-1.C.** Local sites report on the use of their Medicaid funds (HSM) to Central Administration biennially. Use of HSM is recorded in the annual site budget that is reviewed by the Early Learning Hub and Central Administration.

**GA-OR-1.D.** Central Administration staff provides annual training and ongoing technical assistance in the implementation of MAC. Training includes:

- The MAC coding system as it relates to HFO work
- Use of the Central Administration data system and Medicaid Online Time Tracker (MOTT)
- Appropriate uses of MAC funds in site budgets

**GA-OR-1.E.** All local HFO staff receives local training on MAC and MOTT using materials provided by Central Administration prior to participating in MAC.

**GA-OR-2. The Role of Early Learning Council**

The Early Learning Council (ELC) exercises fiduciary authority for the use of granted HFO funds, including contract responsibility. The HFO Advisory Committee is appointed by the ELC, and keeps them updated on the HFO program, submitting reports on HFO’s successes, challenges, and responds to requests for advice from the ELC when requested.
GA-OR-3. The Role of the HFO State Advisory Committee

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

GA-OR-3.B. The HFO Advisory Committee roles and functions:
- Reports its findings and recommendations to the Early Learning Council when requested
- Brings a broad perspective and vision to advise the effective implementation of HFO to achieve its 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, focusing on supporting HFO as an integral part of that system
- Takes the lead in developing and updating the HFO Strategic Plan
- Makes recommendations to Central Administration staff regarding the implementation of the strategic plan, and the effective implementation of the site in order to achieve its overall mission and goals
- Takes an advocacy role in promoting the HFO site and services and supports for families with young children overall
- Forms ad-hoc sub-committees to work on specific issues as needed and the sub-committees report on their work to the entire Committee at meetings, and through email
- Leads the efforts of the Building Program Support Task Force

GA-OR-3.C. HFO 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 Early Learning Council appoints members of the HFO Advisory Committee. The members select a Chair and Vice-Chair
- Recommendations for appointment to the Advisory Committee can be made by Central Administration staff, and local HFO sites
- HFO Advisory Committees, current or former HFO 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 HFO through reading orientation materials provided by Central Administration staff, attend the majority of meetings in person or by phone, communicate by email, and serve on subcommittees
- When members are unable to participate actively, the Chair, Vice Chair, and/or Central Administration staff consults with them regarding their continued membership
Central Administration staff support the Advisory Committee Chair and Vice Chair in developing agendas, facilitating communication, and recording minutes. Minutes of the HFO Advisory Committee are sent via email to members. HFO staffs attend all meetings of the Advisory Committee. Additional Central Administration staff may attend in order to facilitate communication and bring information on their areas of expertise such as fiscal and resource development.

The HFO Advisory Committee schedules meetings every other month.

**GA-OR-5. The Role of Central Administration Staff**

- **GA-OR-5.A.** Central Administration staff is responsible for communication with all local HFO sites in order to keep them up to date on program goals, policies, and procedures.

- **GA-OR-5.B.** Central Administration staff ensures Core Training is available for all new HFO home visitors and all site supervisors and program managers.

- **GA-OR-5.C.** Central Administration staff provides on-site training to all new site providers and new site managers in the philosophy, goals, site policies, and procedures of the HFO site. New sites receive “start up technical assistance” and mentoring from state HFO staff.

- **GA-OR-5.D.** Central Administration staff monitors training for local HFO staff to ensure adherence to HFA training standards using the Training Tracker data system and additional training records.

- **GA-OR-5.E.** Central Administration staff provides technical assistance based upon local HFO site need, information gathered during site reviews, or through Family Manager reports or site evaluation reports.

- **GA-OR-5.F.** Central Administration staff ensures regular ongoing evaluation of HFO through a qualified evaluator. The contracted evaluator prepares statewide reports as agreed in the contract.

- **GA-OR-5.G.** Central Administration staff maintains appropriate safeguards for all HFO data, files, reports, etc. Computers are password protected; file cabinets are locked and accessible only to appropriate employees. Confidentiality Agreements are signed and kept on file for all HFO state staff, and contracted employees who have access to confidential information.

- **GA-OR-5.H.** Central Administration staff maintain standards for HFA Multi-Site Accreditation including fulfilling requirements of the HFA Multi-site addendum and supporting sites 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 Early Learning Hubs

The Early Learning Hubs disperse HFO state general funds and Medicaid reinvestment funds based on statutory and contract authority.

The Early Learning Hubs enter into an agreement for services either through contract or intergovernmental agreement. The Early Learning Hub ensures that legislative intent and the PPPM guide service delivery, and that the provider has the ability to achieve HFO performance indicators.

The Early Learning Hubs are not required to engage in competitive bidding processes to select providers for HFO services [OAR 423-045-0015 (1) (d).]

The Early Learning Hubs monitor HFO contracts as required by the Early Learning Division, Oregon Department of Education. In addition, the Early Learning Hubs receive and review semi-annual program data received from the evaluation of HFO.

The Early Learning Hub provides support and technical assistance to the HFO site in order to develop and maintain strong partnerships with the local early childhood system of services and supports. The site is represented in the advisory structure of the Early Learning Hub.

The Early Learning Hub works with HFO staff to support technical assistance to address issues identified during site visits and/or program reviews.

The Early Learning Hub is responsible for submitting an annual Medicaid Reinvestment Plan to the Central Administration as outline in Policy CTY-110.

GA-OR-7. The Role of Board of County Commissioners

The Board of County Commissioners (BOCC) in each county exercises interim fiduciary authority for the use of granted HFO funds, including contract responsibility, when a given county is not included in the service area for an Early Learning Hub.
GLOSSARY

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

ACCEPTANCE RATE: The mechanism for tracking the percent of participants who voluntarily agree to participate after the offer of site services and receive a first home visit. In order to measure this rate more accurately, sites 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 bi-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 Families Oregon (HFO) that are formed from the initial letters of a phrase or title. Common acronyms include:

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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.

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

ADVISORY GROUP: An organized voluntary group that advises HFO site operations. The functions and responsibilities of this group may include making recommendations to the HFO site and the organization’s governing group (if different from the advisory group) regarding site 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 site trends and patterns. Typically this would include demographic, social, systemic, and other factors that impact services to families.

ASSESSMENT: A standardized process conducted by staff trained in the use of a valid measurement tool designed to more thoroughly explore family strengths and needs. An assessment is done face-to-face and most often is completed in the home during the prenatal-newborn period. The assessment is always completed at the start of services to support the development on individualized plans. HFA requires the use of the Parent Survey as the assessment tool used for service planning.

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

BYLAWS: Guidelines adopted by the site (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 ELD, Oregon Department of Education staff that 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 and/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 site 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, site evaluation, and participant care monitoring.

DATA MANAGEMENT SYSTEM: A systematic and standardized way of collecting and organizing information that allows for accurate monitoring of site activities and timely reporting of site 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 site determines who meets specific criteria for receiving services. HFO screens the New Baby Questionnaire (NBQ) to determine eligibility for intensive home visiting services.

EQUAL OPPORTUNITY POLICY: An employer’s written statement that 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 FILE: A confidential, 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 and identify strengths that will support the family in reaching their goal(s). The FGP is used by the home visitor to design activities for visits and provide resources and referrals that support families in accomplishing their goals.

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 site personnel/staff on the most appropriate course of action.

HEALTHY FAMILIES AMERICA (HFA): The site model on which HFO is based and which provides accreditation for sites and Multi-Site systems that adhere to its research-based critical elements.

Healthy Families Oregon PROGRAM POLICIES AND PROCEDURES MANUAL: This manual specifies policies and procedures for Healthy Families Oregon to assure that sites meet HFA accreditation standards as specified in the Best Practice Standards (2014-16). All local sites follow the HFO Program Policies and Procedures Manual and local policies and procedures as written.

HOME VISIT: A face-to-face interaction that occurs between the family and the home visitor. The goal of the home visit is to promote positive parent-child interaction, healthy childhood growth and development, and enhance family functioning. Typically home visits occur in the home 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:
	- Development of healthy relationships with parent(s), social-emotional relationship
	- Support of parental attachment to child(ren)
	- Support of parent-child attachment
	- Parent-child play activities
	- Support for parent-child goals, etc.

Enhancement of family functioning:
	- Trust-building and relationship development
	- Strength-based strategies to support family well-being and improved self-sufficiency
	- Identifying parental capacity and building on it
	- Family Goals
	- Building protective factors
	- Assessment tools
	- Coping & problem-solving skills, stress management and self-care
	- Stress management & self-care
	- Home management & life skills
	- Linkage to appropriate community resources (e.g., food stamps, employment, education),
	- Access to health care
	- Reduction of challenging issues (substance abuse, domestic violence)
	- Reduction of social isolation
	- Crisis management
	- Advocacy, 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
	- Parenting skills (discipline, weaning, etc.)

HOME VISITOR PLAN: A Home Visitor Plan (Initial or Ongoing) is developed between home visitor and supervisor. The Parent Survey, FGP, home visit observations, and other information can be used to inform the Home Visitor Plan (See 6-1. for detailed information).

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

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 site requests a written statement from the parents to be kept on file.

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.

MEMORANDUM OF UNDERSTANDING (MOU): A written agreement between two organizations or entities that outlines the scope, nature, and extent of services provided by each. Each HFO site 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 site and other entities.
MONITORING: Monitoring is to keep track of through the ongoing collection of available information. The extent of the information collected for tracking/monitoring purposes will vary and is a less rigorous process than compiling data for an analysis. In some situations, available data will be minimal, such as when tracking missed screens, in which case the site may not be able to determine much more than the total number missed and possibly referral source. In other situations, such as when monitoring families that assessed positive yet, verbally declined further involvement, the site will have more data available that it can use based on the amount of information that has been gathered from the family up to that point.

MULTI-SITE SYSTEM: Oregon is a multi-site state system with multiple sites providing direct HFO services (i.e., assessment, home visitation, and supervision). These sites all follow the HFO 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 the Early Learning Division, Oregon Department of Education and/or through a subcontractor.

NARRATIVE: A narrative is a written description of site 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 HFO site. It is designed to be an easily administered screening tool to measure families' level of risk for negative family and child outcomes

PARENT SURVEY: An assessment of family strengths and stresses that is conducted by the home visitor within the first three home visits.

PARENT SURVEY 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.

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

PERFORMANCE INDICATOR: A measure of site 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 that carry out the tasks of the site performing under the site’s administration and/or supervision.

POLICIES: Written statements of principles and positions that guide site operation and services, which are reviewed and approved by the Early Learning Council, 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 site operations are carried out are written in a manual.

PROTECTIVE FACTORS: Parental resilience, social connections, concrete supports in times of need, knowledge of parenting and child development, nurturing and attachment (children’s social and emotional competence).

QUALITY ASSURANCE: A systematic and objective approach to monitoring and evaluating the appropriateness and quality of site 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. Sites follow the annual HFO 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, not to exceed eight staff members for a staff of all part time direct service providers. 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.

REFLECTIVE PRACTICE: A safe place (where trust is established) for a regularly schedules meeting to collaboratively examine thoughts and feelings about an experience. The practice includes active listening and thoughtful questioning of both parties to gain a better understanding of the reasons for the thoughts and feelings and thus determining the best interventions for moving forward.

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

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

RELEASE OF INFORMATION: A form that 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 site after site 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 site implementation.

SAFETY STANDARD: Must be met in order 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-I.C. Orienting staff on child abuse/neglect indicators and reporting requirements
GA-6A &6B. Child abuse/neglect reporting criteria, definitions and policies and procedures

SCREENING: A process of early identification of potential site participants based on risk assessment. HFO 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 site services in the fiscal year (July 1 – June 30), and dividing by the total number of potential participants in the target population.

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 HFO site quality. While adherence to each of these standards is not required in order to receive the HFA credential, a site with any of these standards rated out of adherence will be required to prepare and submit an improvement plan that clearly indicates how the site intends to bring the standard into compliance, coupled with evidence of implementation.
Families at various levels of service receive the appropriate number of home visits based on level of service.

Services are offered to families for a minimum of three years after birth.

Site routinely assesses, addresses, and promotes positive parent-child interaction, attachment and bonding during home visits using the CHEEERS framework.

Site conducts developmental screening with parent(s) and child, and follow-up on suspected delays.

Site conducts depression screening with all enrolled mothers prenatally at least once and once postnatal before the baby is three months of age; paternal screening is encouraged.

All home visitors, supervisors and program managers receive intensive HFA Core Assessment and HFA Core Home Visitor training by certified HFA trainers.

All supervisors and program managers receive intensive HFA Core Supervisory training by a certified HFA trainer.

Site ensures that weekly individual supervision is received by all direct service staff for a minimum of 1.5-2 hours.

Site ensures that all direct service staff are provided with supervision that includes administrative, clinical and reflective components.

Site ensures all parents are notified of family rights and confidentiality at the onset of services both verbally and in writing.

Site ensures that parents are informed and sign a new consent form every time confidential information about a family is to be shared with a new source.

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

**SITE:** A term used to describe a system of services offered by an agency. Sometimes the word “site” is used interchangeably with the word “service” or to describe specific sites under a broader service.

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

**SITEMATIC FACTORS:** General site 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 site outcomes, relationships with other agencies or community providers, training of staff, adherence to the critical elements, support received from the advisory/governing group, and site funding, etc.

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

**STATISTICS:** Various site statistics are required throughout the Self-Assessment Tool. Data is available through the Family Manager database and the HFO Evaluation. Local sites also keep statistical data.
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.

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

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 HFO services.

TARGET POPULATION: Members of a group that the site 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.

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 HFO 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 Families/HFA:

**Orientation Training:** Addresses the essential components of the job and may include site goals, services, policies, operating procedures, child abuse and neglect reporting requirements, history and philosophy of home visiting, and enrollment of families and confidentiality. Staffs are oriented to the site’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 additional training for new program managers.

**Intensive Role Specific Training:** In-depth formalized training which outlines the specific duties of the individual’s role within HFO (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 certified by HFA national to train others in the curriculum specifically designed for the intensive components of their role within the home visitation site.

**On-Going Training:** Supportive and regularly scheduled training provided to staff based upon the specific site 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. It is required for all staff to have cultural sensitivity training, Medicaid training, and child abuse and neglect reporting training annually.

**Stop-Gap Training:** Stop-gap training is defined as customized role-specific training (often conducted in-house on an as-needed basis to meet an individual’s urgent need for skills necessary to perform work, prior to the receipt of HFA Intensive Role Specific Training. It does not need to be conducted by a certified trainer; however it must be conducted by someone who has been intensively trained in the role. Stop-gap training does not replace the requirement to attend Intensive Role Specific Training.
TRAINING TRACKER: A web-based data management system to record staff training in required areas including on-going training. Sites are responsible for ensuring that staffs 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 Families Oregon Training Plan

Purpose
The purpose of this Training Plan is to assure staff in all sites is trained to provide effective, high quality home visiting services for families and children improve childhood health and development, increased school readiness and reduce child abuse and neglect.

Factors considered in the development of this plan are:

a. The Healthy Families America (HFA) Best Practice Standards around training
b. Written evaluations of trainings
c. Training requests received by Central Administration staff
d. HFA Learning Center 3, 6 and 12 month training modules
e. Budgetary limitations

The HFA standards require staff (paid, volunteer, or intern) performing the duties of home visitors and supervisors to receive several types of trainings at specific times in their employment. Oregon’s Central Administration shares responsibility for these trainings with local sites by providing resources, conducting trainings, and monitoring and tracking trainings received statewide through the use of the statewide database’s module Training Tracker.

Types of Trainings:

1. Orientation Training is provided by:
   a. QuickStart Manual
   b. HFO program and site specific orientation (orientation to local site and agency policies and procedures, local training requirements, child abuse and neglect indicators and reporting requirements, staff safety, etc.)
   c. ASQ and ASQ SE training
d. Maternal depression screen training
e. Medicaid Administrative Claiming Training Manual and MOTT Webinar

2. Introductory training about the multi-site system is provided by:
   a. QuickStart Manual
   b. Evaluation training through NPC Research’s training DVD and the Forms and Program Evaluation Manual (Red Book), including other evaluation tools such as the HOME etc.
   c. Medicaid Administrative Claiming training Webinar and on-site training
d. HFO Program Policy and Procedure Manual

3. Role specific training is provided by HFA Certified Trainers through Central Administration at least every 6 months or more often if needed.
   Central Administration provides the following role specific trainings:
   o Home Visitor Core Training
   o Assessment Core Training
   o Supervisor Core Training
   o Program Manager Core Training
4. 3, 6, and 12-month required training is available through the HFA Learning Center on-line training modules and includes all required sub-topics.

5. The Central Administration supports sites in assuring their staff receive training in required areas of knowledge within their first three, 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:
      - A webinar or video conference detailing 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 home visitors, supervisors and program managers to 3, 6 and 12-month training modules from HFA.
   c. Inform all program staff of opportunities for specific topic training via email.

6. The Central Administration supports sites in assuring their staff receives at least 20 hours per year of ongoing training (continuing education) in the following ways:
   - Provide training through monthly webinars or video conferences. Provide required annual Program Manager Meeting/Training face-to-face.
   - Inform all staff of ongoing training opportunities through email.
   - Provision of annual cultural sensitivity training webinar delivered by the ELD’s Equity Specialist
   - Provision of Medicaid (MAC) and MOTT training tools

7. Curriculum training is provided by local sites for each new staff according to the curriculum developer’s requirements.

8. Stop-gap training is provided by local program managers and/or supervisors prior to staff providing direct service or supervision while waiting to attend core trainings. Topics are included as follows:
   - Theoretical background of staff’s role
   - Shadowing of other staff in a similar role (this may be done at another site if parallel positions are not available at the site)
   - Training on forms and form use
   - Hands on-practice (with observation and feedback, including an actual home visit)
   - Inter-rater reliability related to documentation (home visit documentation, parent survey summaries and scores and/or supervision documentation)
   - Use of the strength-based tools and interviewing techniques (i.e.: Explore and Wonder, Problem Talk, Normalizing, Feel Felt Found, Accentuating the Positives and Strategic Accentuating the Positives)

9. Family Goal Plan Training is available from Central Administration via recorded webinar from HFA National.

10. Prenatal Training is available from Central Administration via recorded webinar from HFA National.
Healthy Families Oregon Program Policies and Procedures Manual

APPENDIX B

Healthy Families Oregon Quality Assurance Plan

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

**Goal:** Ensure that all local HFO sites provide quality service to families following the Healthy Families America (HFA) Best Practice Standards leading to the achievement of adequate or better performance measured by the HFO Performance Indicators for service delivery and family outcomes.

**Objective 1.** Continue to monitor the HFO Program Policies and Procedures Manual for adherence to Healthy Families America’s Best Practice Standards. Review and update policies and procedures annually as needed. (See Policy GA-8 for details)

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

Semi-annual Reports: The Program Director or designee reviews 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)

Sites submit Quality Assurance Checklist and related documents to Central Administration annually for review. Checklist and Documents include:
- Training Tracker entry up to date
- Annual Forms revision implementation
- Annual Screening Plan
- 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
- Local Policy and Procedure Manual revisions
- Local Program Goal Plan (Quality Improvement Strategies) following annual site visit

**Objective 3.** Annual site visits to monitor quality management processes.
The program manager, together with Central Administration staff and contractors, organize and conduct an annual site visit to the local site to assess key quality assurance indicators and quality management processes. (See Policy GA-3 for details)

**Objective 4.** Ensure that sites receive technical assistance and monitoring necessary to implement a quality home visiting site. State Central Administration staffs provide technical assistance based upon local HFO site needs, information gathered during annual site reviews, Family Manager and through site evaluation. (See Policy GA-3 for details)
Objective 5. Central Administration staff and Advisory Committee (when appropriate) review the following on a yearly basis in order to inform annual state planning:

- Performance Indicators
- Training and Technical Assistance survey data (every two years)
- Evaluations from state provided training
- Local Site Visit Reports
- Local Site Program Goal Plans
- Local site Cultural Sensitivity Reviews (every two years)
### Service Delivery Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Exceeds HFA or Oregon Standard (Target)</th>
<th>Adequate</th>
<th>Below Oregon Standard</th>
<th>Enter Program Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of screenings occurring prenatally or within the first 2 weeks of the child's birth</td>
<td>80% or more screened prenatally or within 2 weeks of birth</td>
<td>70-79% screened within 2 weeks</td>
<td>Fewer than 70% screened within 2 weeks</td>
<td>______</td>
</tr>
<tr>
<td>2. Percentage of new Intensive Service families receiving their first home visit prenatally or within 3 months of the baby's birth.</td>
<td>90%</td>
<td>80-89%</td>
<td>Fewer than 80%</td>
<td>______</td>
</tr>
<tr>
<td>3. Percentage of families receiving 75% of expected visits based on assigned service level.</td>
<td>75% or more receive 75% of expected visits</td>
<td>65-74% receive 75% of expected visits</td>
<td>Fewer than 65% receive 75% of expected visits</td>
<td>______</td>
</tr>
<tr>
<td>4. Percentage of IS families engaged in Intensive Services for 90 days or longer (early engagement).</td>
<td>90% or more</td>
<td>75-89% engaged</td>
<td>Fewer than 75% engaged</td>
<td>______</td>
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<tr>
<td>5. Percentage of families remaining in Intensive Services for 12 months or longer</td>
<td>65% or more</td>
<td>50%-64% remained</td>
<td>Fewer than 50% remained</td>
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<tr>
<td>6. Percentage of Expected Average Caseload Capacity.</td>
<td>25 -30 average caseload points per 1.0 FTE FSW</td>
<td>18-24 average caseload points per 1.0 FTE FSW</td>
<td>Less than 18 average caseload points per 1.0 FTE FSW</td>
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<tr>
<td>7. Match Expectations Met. Programs currently expected to have 25% match, of which 5% must be cash.</td>
<td>NA</td>
<td>25% match, with at least 5% cash</td>
<td>&lt;25% total match or &lt; 5% cash match</td>
<td>______</td>
</tr>
<tr>
<td>8. Percentage of IS children with at least one on-time developmental screen in the past year*</td>
<td>75%</td>
<td>65%-74%</td>
<td>Fewer than 65%</td>
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</tbody>
</table>

### Outcome Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>90% or higher</th>
<th>80%-89%</th>
<th>less than 80%</th>
<th>______</th>
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</thead>
<tbody>
<tr>
<td>1. Percentage of Children with Primary Care Provider</td>
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<tr>
<td>2. Percentage of Children with Up-to-Date Immunizations</td>
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<tr>
<td>3. Percentage of Parents Reading to Child 3x/week or more</td>
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<tr>
<td>4. Percentage of Parents Reporting Positive Parent-Child Interactions</td>
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<tr>
<td>5. Percentage of Parents Reporting Reduced Parenting Stress</td>
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<tr>
<td>6. Percentage of Parents Reporting that Healthy Start Helped with Social Support</td>
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</table>
APPENDIX D
Healthy Families Oregon Fiscal Guidelines

Use of Healthy Families State General Funds (HFGF)
HFO General Funds (HFGF) are allocated for the sole purpose of providing HFO Site Core Services.

The Early Learning Division, Oregon Department of Education requires that HFO Sites provide Core Services in the most cost effective manner possible, following the Healthy Families America (HFA) site 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 site budget is submitted by the Early Learning Hubs to HFO Central Administration that includes all elements of these guidelines.

HSGF allocations are intended for purchase of HFO Core Services. HFO 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 in accordance with the HFA model to serve as a home visit,
- Screening to identify high risk families most in need of services,
- Site 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 HFGF resources in HFO sites and reflect common costs of Core services following the HFA model:

Staffing:

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

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

Additionally, the following optional staff positions may be paid for with HFGF. Sites describe the role and function of these staff positions in their contracts with Early Learning Hubs, clarifying the role of each position in relation to Core Services for high-risk families.

- Assistant Manager (in large sites)
- Screener
- Administrative Assistant/Data Specialist
- 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 HFGF:

- Additional on-site program managers or program coordinators at individual provider agencies within large sites.
- 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 site 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 Families.
• 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 HFGF allocation. Contracts with Early Learning Hubs 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. Early Learning Hubs monitor screening rates and costs to assure appropriate use of State HFGF.

The following expenses related to the screening and referral process may be paid for with HFGF:
• 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):
  o Obtaining consent
  o Completing screen (approximately 20-30 minutes per screen)
  o Data entry
  o Making referrals.

The following services may not be paid for with HFGF:
• Services such as Welcome Baby home visits for low risk families,
• Welcome Baby gifts, and
• Site incentives.

Intensive Services:
The bulk of HFGF 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 intensive service delivery in Healthy Families. Parent groups, classes, and activities may be added to supplement the home visiting services for high-risk families as allowed by the HFA evidence-based model.

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

Training:
Local sites may use HFGF 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.

Supervisors of home visitors:
Supervisors of home visitors may be paid for with HFGF. Sites 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 site indirect/admin costs charged to HFGF must be maintained within “reasonable levels”. These costs may include indirect support to the site 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 Families. Central Administration recommends that indirect/admin costs not exceed 5%. However, indirect/admin costs paid
with HFGF must be limited to a maximum of 10%. Early Learning Hubs establish appropriate percentage of indirect/admin costs in their contracting process. Additional funding sources may help pay for indirect costs.

If the Early Learning Hub elects to utilize up to the 4% of the HFO General Fund allocation allowable for Early Learning Hub administration; a budget narrative must describe how these administrative dollars will be utilized by the Early Learning Hub to support the local HFO site 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 sites receiving HFGF 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 site managers and administrative staff is not required and should be handled on a case-by-case basis with Central Administration.

Each Early Learning Hub enters into a Medicaid Intergovernmental Agreement with the ELD, Oregon Department of Education, and HFO Central Administration. Early Learning Hubs may claim expenses for administering the contract up to 5% of the earnings when costs are appropriately documented and invoiced to the site.

HFO staff complete time studies on four days each quarter randomly selected by the state Medical Assistance Sites 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 must receive annual Medicaid refresher trainings.

MAC funds earned by site staff must be used to maintain or expand HFO Core Services. Acceptable uses are staffing, staff training, materials, curriculum, parent groups and classes as allowed by the HFA evidence-based model, and other site 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.

Early Learning Hubs and sites submit a MAC Reinvestment Plan to Central Administration annually accounting for their use of MAC funds to support Healthy Families. The use of these funds is also included in the annual site budget.

**Use of Local Match Funds**

Central Administration requires a local match to HFGF of 25% of which 5% must be cash or cash equivalent from all HFO sites. The intent of cash match is to build community investment and increase sustainability of the local HFO site. Local match is used to provide HFO 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 HFO Core Services.

- **Cash Equivalent** includes core services donated by private and local public sources that, if not donated, would require HFGF 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 site is determined utilizing the Independent Sector website at [http://www.independentsector.org/sites/research/volunteer_time.html](http://www.independentsector.org/sites/research/volunteer_time.html). The dollar value of associated cash equivalent hours is entered into the Local Resources Database under Cash Equivalent.
  2. The costs of indirect support to the site by staff of a parent organization or a separate agency (i.e. receptionists, bookkeepers, IT support, etc.) provided at no cost to the site.
  3. The value of office space that is provided to the site at no cost to the site 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 HFO 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 site in their professional capacity may be valued at their usual and customary rate and the value of such services. For example: A speaker who usually is paid $500 for a 3-hour training provides training for site staff at no cost, the time is valued as $500.

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

<table>
<thead>
<tr>
<th>Cash Match</th>
<th>Can be used as Local Match¹</th>
<th>Cannot be Used as Local Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash donations from local businesses, schools, school district(s), or service groups</td>
<td>State or Federal funds received from the ELD, Oregon Department of Education such as state General Funds, Medicaid Administrative Claiming, or Family Support Title IV-B2 funds.</td>
<td>General or Federal funds received from other State agencies such as DHS, Employment Division, Dept. of Justice,</td>
</tr>
<tr>
<td>Private cash donations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County General Funds</td>
<td></td>
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<tr>
<td>Third party payment of HFO staff who provide core services</td>
<td></td>
<td></td>
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<tr>
<td>Grants from foundations</td>
<td></td>
<td></td>
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<tr>
<td>Grants and/or contributions from local faith organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal grants received directly by the local site or Early Learning Hub for the purpose of delivering HFO core services</td>
<td></td>
<td>Funds received that do little to contribute to sustainability of the site or do not build community support.</td>
</tr>
</tbody>
</table>

¹ Not to be considered as all inclusive
OREGON REVISED STATUTE – SITES (2013)

417.795 Healthy Families Oregon programs; standards; coordination.
(1) The Early Learning Division shall establish Healthy Families Oregon programs in all counties of this state as funding becomes available.
(2) These programs shall be non-stigmatizing, 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 risk assessment of all children, from zero through three years of age, and their families in coordination with voluntary statewide early learning system screening and referral efforts;
(d) Ensure that the disclosure of information gathered in conjunction with the voluntary comprehensive risk assessment of children and their families is limited pursuant to ORS 417.728 (8) 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 screen 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;
(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 under ORS 430.357, child care, food, housing and transportation;
(i) Coordinate services for children consistent with other services provided through the Oregon Early Learning System;
(j) Integrate data with any common data system for early childhood programs;
(k) 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;
(l) 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
(m) Meet statewide quality assurance and quality improvement standards.
(3) The Healthy Families Oregon programs, in coordination with statewide home visiting partners, 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 prenatal families and families with children less than three months of age and provide services through at least the child’s third birthday; and
(e) Ensure that home visiting services provided by local home visiting partners for children and pregnant women support and are coordinated with local Healthy Families Oregon programs.
(4) Through a Healthy Families Oregon program, a trained home visitor shall be assigned to each family assessed as at risk that consents to receive services through the trained home visitor. The trained home visitor 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, collaborative contracting or requests for proposals may be used and must include 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 home visitors organized in teams supervised by a manager.

(7) Each Healthy Families Oregon program shall adopt disciplinary procedures for trained home visitors and other employees of the program. The procedures shall provide appropriate disciplinary actions for trained home visitors 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; 2012 c.37 §§53,95; 2013 c.624 §§32a,32b; 2013 c.728 §§5,6]
### OVERALL

1. Establish Building Support Taskforce
   - a. Establish an on-going Building Site Support Taskforce (BPST) to enact this Action Plan (as a sub-group of the State Advisory Committee)
   - b. Recruit members, set meetings coordinated with Advisory Committee to enact (and modify as needed) the Action Plan

2. Build "Healthy Families Champions"—both State and Local
   - a. Identify and arrange visits with elected officials as potential champions
   - b. Identify and visit with potential champions among other leaders (physicians, private sector, funders, law enforcement, etc.)
   - c. Arrange home visits and visits to sites for potential champions
   - d. Strategically recruit for State Advisory Committee. Refer to HFA matrix for desired representation
   - e. Train local Program Managers (PMs) to develop a plan and build local Champions
   - f. State Advisory members & others identify and access champions for local sites using their networks

### BUILDING DIVERSIFIED FUNDING

1. Strategically plan to build diversified funding at the state and local level
   - a. Assess reports on match and leverage
   - b. Further develop Action Plan to increase diversified funding for HFO services

2. Engage in resource development at state level
   - a. Seek grants to support statewide HFO needs (evaluation, staff training, quality assurance work, etc.)
   - b. Seek grants for underserved populations statewide or regionally (i.e., military families, tribal families, rural/frontier families, etc.)
   - c. Explore corporate sponsorships (businesses, banks, etc.)
   - d. Hold at least one major celebration event each biennium for Healthy Families. Honor champions, sites, staff, participating families, etc.
   - e. Support ongoing local grant writing efforts

3. Train and support Program Managers (PMs) in resource development and fundraising
   - a. Develop “Fundraising Tips” (including ideas like Baby Clubs tied to cost per family per year, “for $X, you can supply a family with X"
   - b. Develop and provide fundraising training for in partnership with Early Learning Hubs
   - c. Ongoing technical assistance (TA) for PMs and Local Commissions on fundraising strategies in partnership with Early Learning Hubs
   - d. Provide TA for sites writing grants

4. Train site staff to maximize Medicaid Administrative Claiming (MAC)
   - a. Monitor reports & provide site specific training on the MAC Codes

5. Monitor progress on 25% match (including 5% cash)
   - a. Review semi-annual leverage reports
## BUILDING MARKETING AND COMMUNITY RELATIONS

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| 1. Require use of Healthy Families Oregon name on all materials         | a. Include in RFA  
|                                                                         | b. Include in PPPM (& enforce)                                                                                                       |
| 2. Make full use of existing marketing materials.                       | a. Check that all local sites have all Central Administration developed resources  
|                                                                         | b. Train site staff in use of marketing materials  
|                                                                         | c. Update, re-order, add to these as needed                                                                                         |
| 3. Give all sites links to national resources                           | a. Provide info on resources through: Prevent Child Abuse America, Healthy Families America, Zero to Three, Home Visiting Network, etc. |
| 4. Further develop Healthy Families message                              | a. Identify focus: wellness- “for your baby” and/or “infant mental health” (e.g., attachment, positive parenting, etc.)  
|                                                                         | b. Define what's unique about Healthy Families compared to “all the other starts” & why it’s needed  
|                                                                         | c. Choose and use agreed upon slogan -- “Healthy Families—It Works!” or “Healthy Families—Because Babies Don’t Come with Directions”, or “Healthy Families—Changing Communities One Baby at a Time” |
| 5. Provide marketing training for PMs and all HFO staff                 | a. Teach how to deliver consistent, accurate, intentional messages about site & their work  
|                                                                         |   o Coach to see “marketing” as part of every encounter they have as Healthy Families staff  
|                                                                         |   o Provide materials/review use of materials they already have  
|                                                                         |   o Develop sample presentations, etc.                                                                                               |
|                                                                        | b. Support sites to share strategies that are successful                                                                             |

## BUILDING ADVOCACY

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| 1. Develop network of state and local Champions                         | a. See Overall Strategies, Building Champions  
|                                                                         | b. Build advocacy Champions—“elder statesmen and women”                                                                 |
| 2. Align with existing groups                                           | a. Build relationships with advocacy groups that are natural allies on state and national levels  
|                                                                         | b. Build relationships with local advocacy groups  
|                                                                         | c. Build relationships with professional organizations supporting Healthy Families mission such as medical, law enforcement, professional, business communities, etc.  
|                                                                         | d. Build relationships with early childhood advocates, early childhood partner sites & agencies—advocate together for a comprehensive Early Childhood Agenda |
3. Invite dialog about Healthy Families—learn perceptions and beliefs so can address proactively to build support.
   e. Build relationships with foundations, potential funders and develop specific “asks” and deliverables

   a. Actively solicit input about perceptions of HFO
   b. Address concerns-- make changes or change inaccurate perceptions

**BUILDING COLLABORATIONS**

1. Strategically recruit for State Advisory Committee to build collaboration (using HFA Matrix to assure diverse representation)
   a. Recruit medical, health, business, law enforcement, professionals, community leaders for Advisory Committee
   b. Recruit elected officials for Advisory Committee
   c. Increase representation of diverse stakeholders on Advisory Committee using HFA criteria for board representation

2. Build screening partnerships
   a. Work with Early Learning Council to develop Universal Screening for risks as a priority
   b. Work with statewide groups of health and medical community, etc. to promote screening system as benefit for families, other partner services
   c. Support local Early Learning Hubs to link screening with other local work

3. Collaboratively convene an educational event once a biennium to address at least one of Healthy Families core missions—prevention of child abuse and neglect, promotion of attachment, healthy growth and development and readiness to learn
   a. Plan educational event internally and with early childhood partners
   b. Consider linking to biennial celebration event
Appendix G

Insert a copy of the information your site shares with families regarding the HIPPA privacy practices (2-1A).