Healthy Families America® — AFFILIATE —

Site Policies & Procedures Manual

San Diego HFA Multi-Site System

April 2024

First 5 First Steps

AAP-CA3 San Diego & Imperial Counties Incorporated in California
American Academy of Pediatrics - California Chapter 3
American Academy of Pediatrics
Dedicated to the Health of All Children®

County of San Diego Health and Human Services Agency

LIVE WELL SAN DIEGO

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Acronyms

Acronym	Name
ROLES	
ONE	Office of Nursing Excellence
PHN	Public Health Nurse
SSA	Social Services Aide
PHN Sup	PHN Supervisor
Sr PHN	Senior Public Health Nurse
QAS	Quality Assurance Specialist
FTE	Full time equivalent
PHN Mgr	PHN Manager
PM	Program Manager
PROGRAMS	
AAP-CA3	American Academy of Pediatrics – California Chapter 3
F5FS	First 5 First Steps HFA
SAY San Diego	Social Advocates for Youth
Home Start	Home Start San Diego
Palomar	Palomar Health
SBCSC	South Bay Community Services
HVP	Home Visiting Program
MSS	Multi-site System
PHC	Public Health Center
HFA	Healthy Families America
MCH	Maternal Child Health
NFP	Nurse-Family Partnership
PARTNERS & FUNDING	
F5SD	First 5 Commission of San Diego
First Steps	First 5 First Steps
CHVP	California Home Visiting Program
CHVP - MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
CA-ES	California Early Start
HDS	Healthy Development Services
PCI-GC	Project Concern International- Global Communities Healthy Start
SDRC	San Diego Regional Center
BIH	Black Infant Health
NHA	Neighborhood House Association – Head Start-Services for Pregnant Women
Vista Hill PCM	Vista Hill Parent Care Perinatal Case Management
TOOLS	
ASQ-3	Ages & Stages Questionnaire, 3rd Edition
ASQ:SE-2	Ages & Stages Questionnaire - Social-Emotional, 2 Edition
CCI	CHEERS Check-In
IPV	Intimate Partner Violence
PHQ-9	Patient Health Questionnaire
PSS	Parent Satisfaction Survey
UISPP	University of Idaho Survey on Parenting Practices Modified

LEVELS	
CO (Level CO)	Creative Outreach
TO (Level TO)	Temporary Out of Area
TR (Level TR)	Temporary Re-Assignment
SS (Level SS)	Special Circumstances
FORMS & WORKSHEETS	
CalWIN	Cal-WORKs Information Network
CFWB	Child and Family Well-Being Department
COR	Contracting Officer's Representative (e.g., F5SD, County)
FPR	Family Progress Review
FSC	Family Support Connection
FSP	Family Service Plan
HIPAA	Health Insurance Portability and Accountability Act
HVCC Worksheet	Home Visit Completion & Caseloads Worksheet
HVR	Home Visit Record
PFU	Parent Follow-Up
QA Calls	Parent Experience Quality Assurance Calls
ROI	Release of information
SPS	Supervision and Professional Support
HFA FUNDAMENTALS	
ACEs	Adverse Childhood Experiences
ATP	Accentuate The Positive
BPS	Best Practice Standards
CAB	Community Advisory Board
CHEERS	Cues, Holding, Expression, Empathy, Rhythmicity/Reciprocity, & Smiles
CQI	Continuous Quality improvement
First Visit	Intake/enrollment visit
Foundations	Foundations for Family Support Core Training
FROG	Family Resilience and Opportunity for Growth
HFA	Healthy Families America
HFA RS	HFA Reflective Strategies
LMS	Learning Management System
Parent(s)	Any primary caregiver, regardless of biological relationship
PCI	Parent-Child Interaction
PT	Problem talk
TA	Technical Assistance
They/Them	Inclusive of she/her and he/him pronouns
UR	Unknown Risk (FROG)
CURRICULUM	
BT	Baby TALK
M&B	Mothers and Babies
OTHER HELPFUL ACRONYMS	
NICU	Neonatal Intensive Care Unit
EAP	Employment Assistance Programs

Purpose of this Manual

This version of the San Diego Healthy Families America (HFA) Multi-Site System (MSS) Site Policies and Procedures Manual is effective ***January 2024.*** *Additional and/or revised policies and procedures will be included in future versions.*

This manual serves to establish policies, procedures, and guidelines to ensure that standards of best practice are met by each site in our San Diego HFA MSS. The policies and procedures of the San Diego HFA MSS are based on the framework set by the HFA Twelve Critical Elements and the best practices outlined in the 8th Edition HFA *Best Practice Standards (BPS).*

Policies are organized in chronological order of service delivery. Policies corresponding to HFA BPS will reference the specific standard number in parenthesis, for example (HFA 1-1.A). Policies that address safety standards are indicated by the word "Safety," and policies that address essential standards are indicated by the word "Essential."

Structure

The San Diego HFA MSS includes sites providing voluntary family support programs that are dedicated to preventing child abuse and neglect and promoting children's optimal health (physical, mental and social) in San Diego County.

The goals of the San Diego HFA MSS:

- Promote positive parenting and strengthen family functioning
- Promote family health and well-being
- Enhance child health and development
- Increase parental knowledge of early childhood development
- Prevent child abuse and neglect
- Connect families with community supports and cultivate strong communities
- Provide early detection of developmental delays and health issues
- Increase children's school readiness and success

The system is structured so that direct service providers can focus as much as possible on pursuing those goals. For carrying out necessary quality and administrative functions, it is more efficient to develop and harmonize policies, procedures and regulations at the "upstream" or government/coordinating agency level, rather than at the individual family and provider or "downstream" level. The San Diego HFA MSS structure uses a Central Administration, the American Academy of Pediatrics-California Chapter 3 (AAP-CA3), to carry out training, technical assistance and quality assurance responsibilities.

Sites in the San Diego HFA MSS include:

- First 5 First Steps ("First Steps") – the First 5 Commission of San Diego (F5SD) contracts with four lead agencies (Home Start, Palomar Health, SAY San Diego and SBCS) to provide HFA services in four regions of the county.
- HFA Public Health Nursing ("HFA PHN") – the County of San Diego (CoSD) oversees implementation of services provided by PHN and support staff across six regions of the county. Each region is served by a Public Health Center (PHC) that functions as a hub for home visiting and other health and human services in the region.

CoSD contracts with AAP-CA3 to serve as Central Administration and provide county- wide coordination and support for the San Diego HFA MSS lead agencies.

HFA has a number of data benchmarks to assess progress for families. HFA PHN collects comprehensive information for managing the program and documenting process and outcome measures through Persimmony Electronic Case Management (ECM) system.

1. Target Population

Each site in the San Diego HFA MSS serves specific population groups based on several factors that may include but are not limited to funder requirements, geographic region, family characteristics and local data. The target population for HFA Public Health Nursing ("HFA PHN") is pregnant, postpartum, and early parenting families residing in San Diego County.

Policy on Updating Eligibility Description and Criteria (HFA 1-1.A)

Each site will have a description of 1) its eligibility criteria, 2) community data (including source and year) used in deciding on these criteria, 3) the geographic service area, and 4) the total number of families projected annually to be served based on site capacity. Eligibility criteria are determined based on data collected from one or more sources (e.g., SD County Regional and Community Data, a community needs assessment, kidscount.org, state rankings, vital records, census.gov). The site's community advisory board reviews the description and data utilized at least every four years and supports making adjustments based on changing community demographics or program infrastructure.

Referral Partners (HFA 1-1.B)

Each site identifies partners and places where families from its target population can be engaged in services. For organizations within the site's geographic boundaries, sites will initiate contact with representatives from those organizations to describe the program, its benefits, and partnering opportunities. HFA PHN referral partners will be granted access to the Persimmony Public Health Nursing Referral Portal and user support to facilitate referrals. HFA PHN maintains and updates a list of partnering organizations on file.

2. Processing Referrals

San Diego HFA MSS aims to connect families with the services that best meet their needs. HFA PHN accepts county-wide referrals from all referral partners as well as self-referrals for families residing in San Diego County.

Serving Families Outside a Site's Region

Policy

HFA PHN only serves families who reside in County of San Diego.

Procedure

If HFA PHN identifies an organization that serves families beyond the site's service area (outside of San Diego County), they will assist with outreach to home visiting programs in other counties based on the residence of families referred to HFA PHN by that organization.

Referrals from Child and Family Well-Being (CFWB)

Policy

Eligibility for CFWB (CWS) referrals consists of new cases that have been open to CFWB for a maximum of 3 months prior to HFA referral. The site will still attempt to offer three years of service to eligible families.

Procedure

1. Sites may accept referrals from CFWB with proper documentation clearly indicating the referral source. This documentation will be maintained in the family's file and/or data system record.
2. The first visit and all intake assessments must occur before the target child turns five years of age.
3. These referrals may be brought to Leadership meetings for further discussion to support all sites in the network with being informed and prepared (e.g., additional training, etc.) to provide the best services possible for families.

TIP: Consider how to strengthen and establish a cooperative relationship with CFWB. For example, a site may consider inviting a CFWB representative to join their Advisory Board, convene monthly meetings, invite to trainings, and maintain ongoing communication to support CFWB staff with understanding HFA as a voluntary support program for families.

Sending Referrals to a Different San Diego HFA MSS Site

Policy

If during screening and assessment, site staff determine that a referral is a better fit for a different site in the San Diego HFA MSS (e.g., outside of service area, eligibility, capacity, language capacity), the referral will be processed by the recipient site and sent to the HFA site that best fits the family.

Sites may continue to enroll families who meet their eligibility criteria if they have capacity. Referral should be considered for these families if the site is at capacity or if a different site will better meet their needs (e.g., language, medical concerns, location).

Procedure

For referring from a First Steps site to HFA PHN, the PM or a Supervisor from the HFA MSS site that initially received the referral will:

1. Ensure the family resides in San Diego County and has a target child under 5 years of age.
2. Submit the referral through HFA PHN's online referral portal.
3. Inform the family they can expect a phone call from an HFA PHN staff member.

For referring from HFA PHN to First Steps site, the ONE Senior PHN will:

1. Call the correct PM and inform them that a referral is coming.
2. Fax the referral form to the correct site. Actions will be documented in Persimmony ECM.

The new site will:

1. Review the referral form and contact the family.

3. Target Population

Determining Eligibility

Policy

The San Diego HFA MSS accepts referrals for families who are pregnant or have recently given birth. Sites serve families who are not eligible for other HVPs and meet the site's eligibility criteria.

HFA PHN accepts referrals through the PHN Referral Portal as well as self-referrals for pregnant, postpartum, and early parenting families (with target child up to 60 months of age) residing in San Diego County, while adhering to the HFA requirement that 80% of families have their first visit prenatally or within 3 months of birth.

HFA PHN handles all new referrals through a Centralized Referral Process detailed below. All details and dates of the initial engagement process are entered into Persimmony ECM (e.g., referral date, initial intake, contact initiated/services offered, client accepted/declined services, FROG scheduled, FROG completed, and first visit completion).

Procedure

Centralized Referral Process

Action	Responsibility	When
1. Intake is initiated with review of new referrals made through the Persimmony Referral Portal. Referrals are triaged for completeness and eligibility.	ONE Sr. PHN	Within one business day of received referral
2. Views all referrals in Persimmony and initiates contact with families to offer services. Documents outcome of contact attempts in Persimmony.	ONE SSA	Within one business day of received referral
3. After successful contact attempt and family verbally agrees to service, staff will schedule FROG visit with an SSA from the PHC in community where family resides.	ONE SSA	Appointment to be booked within 5 business days unless scheduling conflict (up to 2 weeks).
4. Persimmony Client List is reviewed for families with scheduled FROG visit and PHN is assigned based on referral details. PHN is assigned prior to FROG visit to facilitate scheduling of first home visit by SSA during FROG visit.	PHN Supervisor	Within one business day of received referral

TIP: Initial engagement is the period of services that starts with our referral partners and outreach efforts and continues with referrals, initial screening and FROG assessments. The approaches and strategies used may vary from those utilized to retain families already enrolled in services.

The FROG (HFA 2-1.A)

Policy

HFA PHN does not use the FROG to determine eligibility. HFA PHN will use the FROG to inform the development of a service plan to support the unique needs of each family. The FROG allows referred families an opportunity to tell their story. It serves to identify the presence of protective factors and factors that could contribute to increased risk for child maltreatment or other adverse childhood experiences (ACEs).

Procedure

FROG Completion, Supervisor Review, and Documentation

Action	Responsibility	When
1. Staff complete Foundations and FROG Core training (see Role Specific Training).	Any staff administering or supervising the FROG	Prior to administration and/or supervision of the FROG

2. Schedule FROG with SSA from PHC serving family's region. Generally, the FROG is completed before enrollment. In cases where families are transferred from another HFA, a previous FROG can be used, or the ONE Senior PHNs can decide whether it is beneficial to administer another FROG to update information and allow the family the opportunity to tell their story again.	ONE SSA	Contact is initiated in one business day from referral receipt
3. SSAs review the FROG Conversation Starters to prepare for the FROG visit: a. SSAs will adjust the FROG as needed to fit families to account for child's age by providing age-appropriate development examples and asking about the child's history of missed milestones). b. SSAs can also enroll in FROG Shorts on the HFSDC LMS to review specific domains.	PHC SSAs	Before scheduled FROG meeting with the family
4. Conduct FROG with the family in no more than two visits. a. The FROG is completed with at least one, ideally two, parents/caregivers of the target child. b. The FROG visit is typically one hour. Depending on the number of caregivers or other family members included in the conversation, the visit may extend to two hours. c. Explain and complete required consent forms, rights and confidentiality, and mandated reporting/relationship with CFWB.	PHC SSAs	At the family's convenience
5. Enter the FROG narrative into Persimmony ECM and fully describe the concerns/needs and strengths expressed by the caregiver(s)/parent(s) during the FROG Scale conversation. Staff can use the HFA Documentation Guidelines for reference. a. In documentation, it is highly encouraged that the parent is referred to by their first name. Staff may also use "mom" and "dad." Acronyms "Mother of Baby (MOB), MOM, DAD, Father of Baby (FOB)" are no longer used. b. If other persons are present, they will be referred to using family-friendly language, e.g., grandma instead of the acronym Maternal Grand Mother (MGM). c. Part of a parent's story might be relevant to multiple domains in the FROG Scale. Staff do not need to document the same information in multiple places. Staff may instead reference the domain using "see domain xx" to reduce documentation. When referencing another domain, staff will document how the information is related to the impact on each domain to tell the full story and support accurate scoring.	PHC SSA's	Within three business days of conducting the FROG

6. SSAs will use the HFA FROG Scale Scoring Guide to ensure accurate scoring and propose tentative scores (0-4 or Unknown Risk (UR)) in all domains the parent shared information for. The reason is documented when staff do not explore a particular area of the FROG. a. FROG scores are only entered for caregivers/parents present for the visit. If a caregiver/parent is not present, UR is entered. a. UR is also used when there is not yet enough information and staff are planning to learn more as they partner with the family.		
7. SSAs will use the HFA FROG Scale Scoring Guide to ensure accurate scoring and propose tentative scores (0-4 or Unknown Risk (UR)) in all domains the parent shared information for. The reason is documented when staff do not explore a particular area of the FROG. a. FROG scores are only entered for caregivers/parents present for the visit. If a caregiver/parent is not present, UR is entered. b. UR is also used when there is not yet enough information and staff are planning to learn more as they partner with the family.	PHC SSAs	Within three business days of conducting the FROG
8. Senior PHN will review the FROG in advance of the FROG supervision session.	Senior PHN	Within three working days of receiving FROG narrative draft
9. Before FROG supervision: Senior PHNs provide written feedback on FROG narrative and scores in the FROG Feedback Documentation Template located in SharePoint to prepare for the supervision session. • Feedback will include family strengths and inclusion of any change talk/readiness by family and rationale for proposed changes in scores. • A good indicator of a complete FROG is if the reader has the sense that they know the family's story and, if not, why there may be gaps in that story. Any domain/area not yet documented is identified for later conversation and inclusion in the Family Service Plan (FSP). SSAs do not need to update the FROG for domains discussed with the family at a later time.	Senior PHN	Within three working days of receiving FROG narrative draft

10. FROG Supervision session: Review FROG, discuss family and scores for each domain. Senior PHN will provide SSA with verbal feedback and have reflective conversations as appropriate. Any domains not discussed with the family should be explored in preparation for developing the FSP. a. Senior PHNs will also document rationale for final scoring to support staff learning and reflection in using the FROG.	SSA and Senior PHN	Within one week of FROG administration
11. SSA and Senior PHN sign final revision of FROG in Persimmony ECM.	SSA and Senior PHN	Within one business day of the FROG supervision session

TIP: UR acts as a bookmark for areas we want to come back to and learn more about as we partner with families.

TIP: If you are stuck between two scores, it's possible that you need a little bit more information. This is a great example of an appropriate use of UR which shows you are still learning more about the family.

TIP: Sharing rationale and process for scoring in Supervisor feedback models and supports staff learning and development in using the FROG!

TIP: Any updates or new information learned after the FROG will be documented in the FSP or Home Visit Record. The FROG is not updated after the FROG visit.

FROG: Intake Completion, FROG Hand-off, and Initiation of Home Visiting Services

Policy

Intake process concludes after FROG has been completed and signed. Home visiting services and Family Service Plan are initiated at this time. All activities, outcomes, and dates are entered into Persimmony ECM.

Procedure

Action	Responsibility	When
1. The SSA will schedule initial PHN home visit with assigned PHN and enter date of FROG completion and PHN home visit in Persimmony.	PHC SSA	At close of FROG visit.
2. FROG will be reviewed, signed, and documented in Persimmony ECM. FROG supervision forms will	PHC SSA and Senior PHN	Within 1 week of FROG administration.
3. FROG team will discuss impressions related to FROG domains, family strengths and challenges with PHN assigned to provide home visiting services with family.	FROG team and home visiting PHN/PHN Supervisor	Prior to scheduled first home visit.
4. The PHN will make at least three attempts to contact the family by phone to confirm home visit. In addition to the three phone calls, at least one of the following alternative means of contact should be attempted, as permitted by HIPAA and agency-specific policies: • A letter or postcard sent to the family • A text sent to the family's cell phone (if Alternate Communication form has been signed) • Another means of contact if the supervisor and PHN agree it is safe and appropriate (i.e., e-mail, an unscheduled in-person visit)	PHN	First attempt within one business day after home visit is scheduled.

Transfer Families from Other San Diego HFA MSS Sites or HFA Programs

Policy

Transfer families may be accepted from other San Diego HFA MSS sites and other HFA programs in accordance with site specific eligibility criteria.

For a transfer referral to be enrolled into the PHN HFA, the following criteria must be met:

- The target child must be no older than five years.
- The transfer family must be a resident of San Diego.

All transfer families will initially be placed on Level 1 to establish rapport. It is recommended that the family stay on Level 1 for at least one month, even if the family was previously at a higher level.

Procedure

When HFA PHN accepts Transfer Families from other HFA Programs (HFA Sites from San Diego HFA MSS and Outside of San Diego HFA MSS):

Action	Responsibility	When
1. Request submission of referral through the Persimmony Referral Portal.	ONE Senior PHN	When requested
2. Request copies of the family's chart, or at least the FROG, Family Goal Process form (FGP), Family Transition Plan, and copies or scores from the most recent assessments and screens, as available and consistent with family's wishes.	ONE Senior PHN	Within one business day of receiving the referral
3. If FROG is not available, process transfer according to regular intake process.	ONE Senior PHN	Within one business day of receiving referral
4. If FROG is available, call the family to offer service. • If the family accepts, inform family that a PHN will contact them to schedule home visit. • If family declines, follow agency protocol on record retention/destruction and notify referring agency if ROI permits.	ONE SSA	First attempt within one business day of receipt of transfer.
5. If FROG is available and family accepts services, communicate with PHN supervisor to make "best match" PHN assignment.	ONE Senior PHN	Within one business day of receipt of FROG
6. Assign the transfer family to the "best match" PHN .	PHN Supervisor	Within one business day of receiving the referral
7. Ensure the family remains on Level 1 for a minimum of one month, even if the family was previously on another level. This supports relationship building and retention.	PHN	After the first visit

For Transferring Families to another San Diego HFA MSS Site:

(In the steps below, "Sender" = Agency **sending** the transfer, "Receiver" = Agency **receiving** the transfer)

Action	Responsibility	When
1. Discuss the possibility of transfer with the family. Document the discussion in the Home Visit Record (HVR) and obtain a signed ROI.	Sender's PHN	As soon as family informs PHN of relocation plans
2. Contact the receiver's PM to request the transfer.	Sender's PHN Supervisor	If possible, 30 days before the desired transfer date
3. Discuss the transfer with supervisor(s) to determine capacity and decide whether or not to accept transfer. Inform sender of the decision to accept or decline the transfer.	Receiver's PM	Within two business days of the initial request for transfer
4. Discuss transition process with the family and document those conversations in the HVR.	Sender's PHN	Once acceptance into the new region is verbally confirmed
5. Make a copy of the family's chart and Family Progress Reviews (FPR) in supervision records to send to new FSS and Supervisor.	Sender's Supervisor or other staff	Within five business days of receiving verbal acceptance of transfer
6. Document client transfer and complete a Case Closure Summary for the family in Persimmony ECM.	Sender's PHN	Within five business days of receiving verbal approval for the transfer
7. Assign the transfer family a "best match" FSS.	Receiver's PM	Within two business days of receiving the Family Transfer Form
8. Contact the family's previous PHN or supervisor to discuss the family's FROG, most recent FSP, family goals, and the family's needs.	Receiver's New FSS	First attempt within one business day of receiving transfer assignment
9. Attempt to schedule the family's transitional visit at a time when both previous PHN and new FSS may be present with the family, if possible.	Receivers New PH FSS	First attempt within five business days of receiving transfer assignment

TIP: If needed, the site may schedule and complete a new FROG with the family.

Transferring Active San Diego HFA PHN Families to Another PHC

Policy

A San Diego HFA PHN site may transfer families who are relocating within the geographic boundaries of another PHC. Transfer of these families will depend on acceptance by the other PHC.

Procedure

Action	Responsibility	When
1. Discuss plans for relocation, including approximate date and location.	PHN	Preferable as soon as they are aware of relocation plans
2. Notify the Supervisor of relocation plans.	PHN	As soon as PHN is aware of relocation plans
3. Determine if there is capacity in PHC located in family's place of relocation.	PHN Supervisor	At least 30 days before the desired transfer date, if possible
4. Contact the new PHC to assess for eligibility and capacity, including ONE Senior PHN in communication.	PHN Supervisor	At least 30 days before the desired transfer date, if possible
5. Ask the family if they are interested in transferring to another PHC.	PHN	At the next visit, following confirmation of transfer eligibility at the new site
6. Initiate transfer protocol in Persimmony and conduct joint PHN transitional visit if possible.	Supervisor or PHN	As soon as the family accepts transfer or following timetable of the new site's protocol

Families Who Relocate Within San Diego County but Wish to Remain with Current Service Provider

Policy

When a family moves to a new location, they may stay with their original PHN if the PHN and supervisor determine the new home is within a reasonable distance. San Diego HFA PHN PHC will determine on a case-by-case basis which receiving PHC would be the best fit for families that move outside of a reasonable distance based on:

- How long the family has been in service
- The family's new location
- The demographics and cultural background of the family

Procedure

1. If a family is moving outside of the typical service area of an HFA site or agency but wishes to remain with the current PHN, the PHN will notify their supervisor.
2. The supervisor will gather information on driving distance to the new location and then share that information with the PM.
3. The PM and supervisor will jointly determine the feasibility of continuing to serve the family at the new location.

4. If continued services are deemed feasible, the PHN Supervisor will contact the PHN Supervisor of the PHC that typically serves the area the family is moving to and obtain permission to serve this family in the new location.

Re-enrollment

Policy

The San Diego HFA MSS allows families who have been served previously to re-enroll provided they meet all of the following:

- The family has previously demonstrated commitment to the program. This can be determined in various ways, such as verifying that the family met at least 75% of their visits over the course of their previous enrollment.
- The target child(ren) is under 5 years of age.

Families may also re-enroll into a different San Diego HFA MSS site provided the above requirements are met and they reside within the region covered by that site. The ONE Senior PHN can determine if a family is re-enrolled. In addition to not meeting the above requirements, other reasons for ineligibility can include:

- Safety concerns for staff in the home
- A change in the family's circumstances that now makes them a better fit for a different program
- No staff person available to meet the needs of the family
- Family has already completed HFA program.

Procedure

When the family contacts the agency to request re-enrollment, the ONE Senior PHN is responsible for seeing the following procedures are completed:

1. Verify target child/children is under 5 years of age.
2. Review the case for any pertinent issues such as safety concerns for staff, indicators of the possibility the case will be closed again before program completion, and availability of staff able to meet the family's needs.
3. The ONE Senior PHN determines if the family can be re-admitted.
4. If approved, the PHN supervisor will assign the family to a PHN who will contact the family and re-initiate services.
5. If the family is ineligible for services, the ONE Senior PHN or SSA will call the family. Appropriate referrals for other programs and services will be made.
6. All re-enrolling families will be placed on Level 1 initially and until progress criteria are met to move to Level 2 or their previous level, whichever the family, PHN, and supervisor agree is needed. At a minimum, families remain on Level 1 for one month.
7. If a new PHN sees the family, the previous PHN will accompany the new PHN on the first re-enrollment visit whenever possible.
8. Review all consent forms with the family and have them sign again even if they had signed during their initial enrollment.

New Enrollment for Past Families Who Exited the Program

Policy

The San Diego HFA MSS allows families who have been served previously to start as a new enrollee in certain circumstances. An example is if a parent experiences a pregnancy loss after enrollment and then becomes pregnant again at a later time. Site PMs will decide on a case-by-case basis whether or not to enroll a family. Families that have graduated may not enroll in the program again to ensure space is reserved for families who have not had the opportunity to participate in services (on rare occasions exceptions may be made with prior approval from AAP-CA3).

Procedure

When the family contacts the agency to request a new enrollment, the PM/PHN Supervisor is responsible for seeing the following procedures are completed:

1. Verify that the family case aligns with the policy above.
2. Review the case for any pertinent issues such as safety concerns for staff, indicators of the possibility the case will be closed again before program completion, and availability of staff able to meet the family's needs.
3. The PM determines if the family can enroll in the program.
4. If approved, the PM or supervisor will assign the family to a PHN who will contact the family and initiate services.
5. If the family is ineligible for services, the supervisor or other staff will call the family. Appropriate referrals for other programs and services will be made.
6. If a new PHN sees the family, the previous PHN will accompany the new PHN on the first visit whenever possible.
7. The PHN will begin the paperwork and data entry process as if this was a new family.
8. Enter a new record for the family into Persimmony. Do not enter services and assessments in the family's previous record.
9. Complete a FROG prior to enrolling the family in services.
10. Staff will consult Persimmony Modules for additional data entry instructions.

4. Offering Services

Voluntary Services (HFA 3-1.A)

Policy

Services are offered to eligible families on a voluntary basis. Although there may be external agencies that attempt to require HFA as part of mandated treatment (e.g., CFWB or court mandated services), PHNs will inform families that regardless of the intent of the referral entity, enrollment is voluntary, and families may refuse to accept services. Once the family has accepted services, they may discontinue services at any time.

Procedure

1. At the time of offering services, ONE SSA will inform parents that services are voluntary.
2. The ONE SSA will explain to the family that they may discontinue services at any time. If a family initially accepts services during the intake visit, the PHN/SSA will remind the parents that the services are voluntary and can be ended by the family at any time.

3. The PHN will also provide the family with written information regarding the voluntary

nature of the program using the Home Visiting Program Consent.

Serving Unhoused Families

Policy

Agencies may enroll unhoused families if the supervisor and PHN agree that the family has at least a moderate chance of successfully enrolling and following through with services. The agency must locate a consistent and safe location to have the visits.

Serving Family Members of Site Staff

As agencies have differing policies on serving family members, agencies should follow their internal policies.

Procedure

PMs will inform supervisors and PHNs regarding their agency-specific policy on serving family members.

5. Ineligible Families

Resource Sharing for Ineligible Families

Policy

Sites will provide information on community services to families who are ineligible for the program.

Procedure

If a family does not qualify for services, refer to other community programs and/or provide any additional resources the family may need. Document referral, contact attempts, resources shared, and outcome in Persimmony.

Referring Ineligible Families to Another Home Visiting Program

Policy

Sites assess family eligibility for the San Diego HFA MSS and other HVPs. The determination of ineligibility will occur during the intake process.

Procedure

1. The ONE Senior PHN will determine the HVP for which the family may qualify by using their internal processes or completing the FSC tool .
2. The ONE Senior PHN/SSA will discuss the best fit program with the family and if the family is interested in being referred to the program, the PHN will obtain a verbal consent and make the referral or instruct the family on how to self-refer.
3. The ONE Senior PHN/SSA will document the referral in the family's record in Persimmony.

TIP: Identify a representative to join the FSC "monthly" meetings to learn, develop stronger program relationships and improve referrals for families.

6. In-service Policies and Procedures

Defining the Target Child

Policy

The target child is defined as the child or children that prompted a referral into the program. They are the primary focus of screenings and assessments conducted throughout the program. In many cases, families are referred prenatally; therefore, the target child is the expected child at the time of referral. If the family is expecting twins or other multiples, all multiples are considered target children and so each multiple will receive their own set of assessments (ASQ-3 and ASQ-SE:2, CCI, etc.). Older siblings and siblings resulting from subsequent births are defined as non-target children.

Serving a Non-Target Child

Policy

Some services and support can be provided for other children in the family in addition to the target child(ren). Non-target children will benefit from the work PHNs are doing with the entire family. Non-target children, age 0 to 5, may receive the following additional services:

- PHNs will re-administer the Patient Health Questionnaire-9 (PHQ-9) to mothers for every subsequent birth, following the same administration schedule as the target child
- PHNs will administer the ASQ-3 and ASQ:SE-2 to non-target child(ren) if the parent requests it or if the PHN and supervisor agree there is a reason
- PHNs will make referrals for non-target children as needed or as requested by families

Procedure

1. During initial visits, the PHN will explain to the family that the child they are expecting, or have just delivered, will be the focus of the program. The PHN will avoid using the phrase “target child” with the family and will explain that the entire family will benefit from the services.
2. Over the course of services, the PHN may support the family with issues and challenges pertaining to their non-target children.
3. If the family and PHN elect to conduct an ASQ-3 or ASQ:SE-2 for a non-target child, they will create a data record in Persimmony for that child and enter that assessment and resulting referrals into the system. This record is entered as “non- target” in the client code field. Please reference the Data Dictionary for further instructions on data entry.
4. Non-target children will not be included when assessing HFA best practice standards. Thus, they will not be included in HFA worksheet or Tableau dashboards.

Pre-Enrollment Outreach (HFA 3-2.A)

Policy

Pre-enrollment outreach is outreach that happens after a family has verbally accepted services but before their PHN visit. For HFA PHN, pre-enrollment outreach includes the initial outreach conducted by the ONE SSA to schedule the FROG up until a completed first PHN visit. Sometimes families say they want visits but then experience challenges with officially enrolling.

Prior to the FROG, PHC SSAs and Senior PHNs will utilize positive methods to engage new families, build family trust, and promote family involvement. In order to build trust with families, ONE team will use family centered approaches that include, but are not limited to:

- Warm telephone calls focused on the family's well being
- Offering flexible and convenient times for visits (within the limits established by the home visiting agency)
- Creative and upbeat notes which encourage parents to want to participate
- Texting brief messages to let a parent know you are thinking about them
- Anchoring conversations based on family's interests
- Inviting the family to community events
- Drop-by visits and leaving a card when families are not home
- Encouraging self-care practices

After FROG is complete, the PHN and PHC SSAs will work together to engage new families, build family trust, and promote family involvement. In order to build trust with families, the PHC team will use family centered approaches that include, but are not limited to:

- Warm telephone calls focused on the family's well being
- Offering flexible and convenient times for visits (within the limits established by the home visiting agency)
- Creative and upbeat notes which encourage parents to want to participate
- Texting brief messages to let a parent know you are thinking about them
- Anchoring conversations based on family's interests
- Inviting the family to community events
- Drop-by visits and leaving a card when families are not home
- Encouraging self-care practices

It is recommended that pre-enrollment outreach end within 30-45 days of the first attempted contact with the family subsequent to their verbal acceptance. Even if families verbally accept services, they have the right to change their mind and not enroll.

Procedure

1. Prior to conducting both the FROG and first PHN visits, SSAs and PHNs will discuss with their supervisor the most appropriate and effective means of engaging the family and building trust.
2. Techniques will vary from one family to the next and will be based on factors such as cultural considerations and the family's preferences.
3. SSAs and PHNs will observe what engagement techniques are most effective and share their experiences during supervision.
4. When an SSA or PHN faces challenges with family engagement or trust, they will discuss ideas with their supervisor and explore new means of engaging the family.

Conducting the First Visit (HFA 1-3.A)

Policy

The first PHN visit will occur either prenatally or within three months of the child's birth for at least 80% of families.The first visit may occur after this timeframe if health reasons (e.g., extended Neonatal Intensive Care Unit (NICU) or hospital stay) make it impossible to conduct the first visit within three months after the child's birth. Such reasons are to be documented in the family chart.

Sites track and monitor the age of the target child at the time of the first visit following the procedure below:

Procedure

1. PHNs will enter the child's birthday and first visit date into Persimmony.
2. At least 80% of first visits will occur prenatally or within the first three months after birth.
3. In instances where a visit does not occur prenatally or within the first three months of birth, PHNs will discuss such cases with their supervisor and document reasons for delaying the first visit.

TIP: HFA acknowledges that there will always be families that would benefit from services after the outlined window. Sites can enroll up to 20% of families after three months and still adhere to the standard.

Recommended Content for the First Visit

Policy

> ***"The most important outcome of a first visit is to be invited back!"***
> - *Healthy Families America*

The goal of the first visit is to establish trust and make the family feel that participation in the program will be beneficial and worth their commitment. Some consents and other paperwork will be necessary, but these should be kept at a minimum to the extent possible. Minimize the amount of information or education shared and focus on learning about the family and building trust. Each family will be different, and the PHN will customize their approach to fit the family's pace. The suggested content that follows can provide a general framework for most newly enrolled families on their first visit.

Procedure

1. Express empathy, curiosity and support for the family. Offer at least one Accentuate The Positive (ATP) based on what you observe to build trust and demonstrate your interest in the family.

2. Use Problem Talk (PT) questions and reflections to understand each family's need and connect that need to what the program has to offer. Assist the family in obtaining resources such as medical care, housing, food, and supplies for the baby.
3. Observe and ask PT questions about the safety, health and care of the baby and parent. Only address any immediate safety and health concerns for now.
4. Begin to establish the boundaries of the family-PHN relationship. Ensure that required consent forms, rights and confidentiality, and mandated reporting/relationship with CFWB are complete.
5. Schedule the next home visit with the family, prioritizing their availability to the extent possible.
6. Summarize what you learned from the family and any next steps prior to leaving the visit.
7. Use the HVR to document observations of concerns to address and discuss with the family once trust and a sense of safety is established.
8. Update the FSP with any new information regarding protective factors or risk as well as new concerns related to health and safety.

TIP: Be mindful of bias or assumptions regarding CFWB and families who receive CFWB. Practice the language you plan to use with your supervisor.

Use of Family Service Plan to Review and Address Family Risk Factors Identified During the FROG (HFA 6-1.A)

Policy

Protective and risk factors identified during the FROG and those that emerge or are identified later in services are considered during the course of services. Any domains not yet documented in the FROG narrative (e.g., scores of UR) are identified for exploration in the FSP. The supervisor will work with the PHN using the FSP to track and monitor risk and protective factors over the course of services. These factors will be used to plan out specific activities and determine appropriate prioritization and pacing for approaches/interventions to mitigate risks and continue building upon the family's protective factors.

HFA has specific model components or requirements that all families receive (e.g., CHEERs, FGPs, developmental screening). The FSP outlines individualized service delivery beyond required model components. The initial draft is developed within two weeks of a family's first visit and updated at least once monthly for families on Level 1P, 1, 1b, or SS, every other month for families on Level 2, and quarterly for families on Level 3. The FSP will be accessible to both the supervisor and the PHN.

Procedure

Action	Who	Documentation
Initial FSP Development		
1. The supervisor and PHN meet to discuss the initial FSP. Using the FROG narrative, the supervisor and PHN walk through each of the 14 domains. They prioritize plans in domains where families demonstrate readiness and/or a need to address concerns based on safety or stabilization. In domains that were not addressed during the FROG (i.e., UR), they develop plans to learn more about the risk and protective factors. In the case of transfer families, the transferred FSP is reviewed and updated based on family status and local resources. 2. In developing the FSP, the PHN and Supervisor will keep in mind the scope of the PHN role and identify appropriate referrals to support families in addressing challenging issues when they are ready. PHNs are not counselors or therapists. Their most important role as it relates to substance use, intimate partner violence, and mental health challenges is to support families to become "treatment ready" (e.g., completing Mothers & Babies to develop readiness for therapy). 3. The supervisor guides the development of the FSP by ensuring it addresses the development of protective factors using program specific tools and approaches: • Specific HFA reflective or Baby TALK strategies to address specific issues (e.g., Narrating behavior to promote empathy for the baby's experience) • Specific curriculum tools (i.e., Baby TALK components, and the Mothers and Babies program. • Referrals made to other programs and services pertaining to the issues being addressed.	PHN and Supervisor	FSP
Ongoing FSP Development & Progress Monitoring		
1. PHNs partner with families to implement the activities outlined in the initial FSP to mitigate family risk factors and promote protective factors.	PHN	HVR
2. The supervisor ensures the PHN is implementing the FSP as intended through discussion and reviewing HVRs.	Supervisor	HVR, FSP
3. The PHN and supervisor review the FSP to reflect on family progress based on the timeline outlined in the policy above to: • Refine or replace plans based on progress and current priorities. • Updates risk and protective factors with the current date • Add new concerns and outlined plans in the FSP. New concerns include elevated screening tools (e.g., ASQ, PHQ-9, IPV screen), CCI scores below 4 or other impacts on family stability or functioning outside of the 14 FROG domains.	PHN and Supervisor	FSP, HVR

4. The FSP "Plan Implementation" column is updated to reflect the supervisor's role in supporting plan implementation by the staff. Documentation includes the three-part supervision recipe (action/intervention word + topic + intended outcomes).	Supervisor	Recommended - FSP; alternative - FPR
* Supervisors can add more detail regarding family-specific conversations in the FPR, which may include reflective conversations regarding the relationship between the PHN and family.		

TIP: PHNs may review family values and hopes for the child to guide the conversation and explore possible short- or long-term goals.

Family Goal Process (FGP) (HFA 6-2.A - *Essential*)

Policy

To develop self-efficacy and scaffold the development of problem-solving skills, each PHN will work with their families to create family goals. The FGP will consist of:

a. The goal and specific steps the family will take to reach the goal
b. Family wants, needs or dreams rather than site needs.
c. Goal-setting throughout the course of services, with new goals set as previous ones are accomplished or retired
d. A focus not on how many goals families accomplish but instead on the skills parents build in the process of developing and working on goals

During supervision:

e. PHNs will go over the FGP with their supervisor
f. Discussion and documentation of each family goal will also include the family's strengths and how these strengths will support goal development and achievement.

Procedure

Action	Who	Documentation
1. The process to develop the initial family goal will be initiated no later than 60 days from the date that services began and has three phases as outlined in the Preparing for the Family Goal Process document. This document prepares and supports PHNs in assessing family readiness and facilitating conversations during the FGP. The three phases are: a. Brainstorming Phase b. Development Phase c. Maintenance Phase 2. Brainstorming Phase: PHN will conduct *Family Values* and *What I Want for my Child* activities early in services to build trust and explore motivation for change. 3. Brainstorming Phase: PHN will introduce the idea of setting goals to families at least a month prior to identifying the goal. 4. Development Phase: Staff do not need to complete the FGP form within 60 days. However, staff need to show documentation that the family goal setting process starts within 60 days from when services began. This process	PHN	HVR

includes the use of PT to facilitate parental thinking around their goals and motivation. a. PHN can also use the FGP Conversations Bookmark to assess importance and readiness and guide family goal conversations. b. PHNs will use ATP and Strategic Accentuate the Positive (SATP) to highlight the family's strengths and support the achievement of goals.		
5. Maintenance Phase: Families will have at least one active goal, which includes the use of the 3MMMs – mini, mission, and measurable – with a target date for accomplishing that goal.	PHN	FGP Form
7. Maintenance Phase: The PHN will discuss with their supervisor: a. How they will support each family with their goal(s) b. Progress toward goal(s) for each family 8. Maintenance Phase: The PHN and supervisor will discuss how goal achievement will be celebrated. When families are challenged in identifying and engaging in celebration, the PHN and supervisor will document strategies to support families with celebrating goal accomplishment (e.g., use of Explore and Wonder (E&W)).	PHN and Supervisor	HVR & Family Progress Review (FPR)
9. Brainstorming Phase: Once a goal has been completed, the PHN and family will create a new goal to work on. This may include revisiting the Family Values and Hopes for My Child activities. PHNs and their families will continue to develop goals until the family begins initiating a Transition Plan to exit the program. 10. It is important to note that families may not go through phases in a linear way and may jump from phase to phase based on their level of readiness. Families may decide to change or no longer pursue a goal. In these circumstances, the PHN will utilize PT, SATP and active listening with the family to explore a new goal(s) or adjust timelines and interim steps for an existing goal(s). Some examples include: a. Situations where the family must focus on more pressing issues b. The family reframes or shifts priorities c. The family shares the current goal is no longer a good fit or realistic with current circumstances.	PHN	HVR

TIP: PHNs may review Family Values and Hopes for the Child to guide the conversation and explore possible short- or long-term goals.

Use of the CHEERS to Assess, Address and Promote Parent-Child Interaction (HFA 6-3.A)

Policy

PHNs will observe and document CHEERS (cues, holding, expression, empathy, rhythm/reciprocity, and smiles/joy) in each session with the family to assess the quality of interactions between the parent and child. Based on these observations, the PHN will address concerns and promote positive parent-child relationships and interactions. CHEERS will be

used during both prenatal and postnatal visits.

At minimum, PHNs will document at least three CHEERS domains on the HVR. The PHN will attempt to assess the remaining domains on the subsequent visit to ensure that all six domains are regularly addressed throughout the family's time in the program.

g. Prenatal Visits: During prenatal visits, PHNs will attempt to complete at least one domain for visits beginning at 24 weeks gestation (second trimester) and two domains for visits beginning at 31 weeks+ (third trimester). When gestational age is unknown, supervisors and PHNs may use estimated age to determine how to start recording CHEERS until medical professionals establish gestational age.
h. Postnatal Visits: With postnatal visits, at least three domains of CHEERS will be observed and documented at every visit, except for when the Cheers Check-In (CCI) is administered. Accurate documentation includes the 3-step process and frequency of the observation.
i. Parent Reporting: Parent reporting can replace direct observation in rare circumstances when the child is not present, awake, or during a virtual visit with a limited frame in the screen. In these cases, PHNs should use reflective strategies, such as PT, to elicit the parent's perception of how the child responded and what the parent did (See CHEERS Virtual Visits Tips for more guidance). Direct observation is encouraged as often as possible.

Procedure

1. PHNs will use CHEERS to observe parent-child interactions (PCI) at each visit (except for when the CCI is administered).
2. After a visit, the PHN will document a minimum of three CHEERS observations in the CHEERS section of the HVR.
3. PHN documentation will include observations of interactions and frequency.
    - Staff will use the 3-part process to document interactions: *What did the child do? How did the parent respond? How did the child respond?*".
    - In addition, PHNs document the frequency of the observed interaction during the visit using "once," "some," or "most of the time".
4. PHNs partner with parents to support PCI by using reflective strategies based on observations of strengths and areas of concern from CHEERS. The strategy used is documented in the HVR.
    - ATP will be used based on the positive PCI observed during the visits to promote the development of parental awareness of their strengths in interacting with their child to support the attachment relationship.
    - PHNs will use Explore & Wonder (E&W), SATP, PT, and Normalizing (NORM) to address concerning CHEERS observations. When a parent cannot respond to their child in a consistently safe, predictable, comfortable, or pleasurable manner, supporting PCI by using a reflective strategy helps to build the reflective capacity required to provide sensitive and responsive parenting.

See the example below for documentation in the HVR.

Cues ☒ Once ☐ Some ☐ Most	Mom held baby. Baby looked up at mom and cried. Mom fed baby. Baby stopped crying. PHN used E&W to learn more about baby's cues.

Cues ☐ Once ☐ Some ☒ Most	Mom held baby. Baby looked up at mom and cried. Mom fed baby, made eye contact and said “Aw, you were hungry huh buddy?” Baby stopped crying and looked up at mom. PHN used ATP to highlight how mom’s consistent responsiveness teaches baby how to trust.

5. The PHN, working with their supervisor, will use CHEERS documentation to assist in planning future visits.
6. PHNs can use curriculum materials and resources as one approach to promoting nurturing parenting skills and secure attachment. The selection of curriculum activities and information for each visit will be primarily based on needs identified through CHEERS observations.

TIP: Staff who have completed Baby TALK training may use curriculum strategies instead such as Narrating Behavior (NB), Meaning Making (MM), Supporting Parental Mastery (SPM), Pivot.
TIP: Did you know many Baby TALK strategies meet the same goal as a reflective strategy but may provide more flexibility?
E&W = NB + MM
ATP/SATP = SPM

Use of the CHEERS Check-In (HFA 6-3.D)

Policy

The San Diego HFA MSS uses the CCI as its validated PCI tool, and sites administer the CCI three times before the child's 1st birthday and twice annually by each subsequent birthday for each family according to the schedule in step 1 below. In cases with multiples (twins and triplets), a CCI will be administered for each target child. Staff will not document CHEERS on visits where the CCI is completed.

Supervisors support PHNs in conducting the CCI with fidelity and updating the FSP with a plan for scores of 4 or less.

Procedure

1. PHNs will administer the CCI according to the following timepoints

Time of Enrollment	Timepoints
Prenatal/Postnatal	3, 7, 11, 15, 21, 27, 33 months after birth
3 or more months after birth*	3 mos. after enrollment, 7, 11, 15, 21, 27, 33, 39, 45 months after birth

2. PHN and Supervisors will complete the HFA LMS required training for the CCI prior to administering with families or providing supervision of staff.
3. PHN will reference the HFA CCI Training Manual and FAQ to ensure fidelity in implementing with families (e.g. how to introduce, score, and build interventions) and address tool-specific questions.
4. Supervisors will support PHNs in the administration of the CCI, including planning for ways to introduce the tool to the family and debriefing on the experience of administering the tool.

5. Supervisors will use reflective strategies to explore the results of the CCI, including how the results align with CHEERS observations, patterns of PCI overtime, and the current social emotional competence and parental resilience risk factors on the FSP.
6. Supervisors will document these conversations on the CCI form.
7. Any item rated a 4 or less on the CCI will be documented on the FSP to be addressed. Items rated as 5 are to be strengthened and items rated 6 or 7 are to be promoted.

Primary Evidence-Based Curriculum (HFA 6-4.A)*

Policy

Sites use a primary evidence-based curriculum (i.e., Baby Teaching Activities for Learning and Knowledge (Baby TALK) for promoting nurturing parent-child relationships, healthy child development, preventative health and safety, safer sleep practices, and improving parenting skills. PHNs will use this curriculum and supplemental materials with intentionality and a strengths-based approach that builds on parental capacity and in response to parent child interests and observations made by the PHN. At a minimum, at least one of these topics will be discussed monthly for Level 2P through Level 1b families and every other month for Level 2-3 families. Each topic is outlined based on the child's age and area of focus.

Sites also uses other curricula and/or approaches as appropriate for some families. See section on Secondary Curriculum that follows. Examples include:

- Mothers and Babies for promoting parental well-being,
- Motivational Interviewing for behavior change, or
- Specific information from validated sources when appropriate (e.g., HealthyChildren.org).

Procedure

1. All PHNs will receive training in the Baby TALK or PHN approved curriculum before conducting their first regular (post-FROG) visit. For Baby TALK , at a minimum this training includes the HFSDC LMS Baby TALK Stop Gap or Baby TALK Core.
2. PHNs and supervisors will select curriculum materials to use at visits. Selection of these items is guided by the FSP and parent interests and requests (e.g., issues the family is having with baby's sleep, fussiness) as well as by the need to address developmental touch points for the parent and child and ensure health and safety.
3. PHNs will integrate the HFA Reflective Strategies (or alternatively Baby TALK strategies) into the delivery of curriculum.
4. In addition to the primary curriculum, PHNs may draw on other evidence-based resources to support families if qualified.
5. PHNs will choose the content and approach to sharing the information based on what is developmentally and culturally appropriate for the child and their family. Parenting skills will be promoted within the context of the child's development and normal family routines.
6. Use of curriculum will include promotion of positive PCI, health and safety, and safer sleep. For example, use of Baby TALK will include:
    a. Methods to promote positive PCI:
        i. Visit planning with the age-based protocols
        ii. Developmental Perspectives
        iii. Activities and Come Sign with Me
        iv. Baby TALK strategies including parental mastery, pivot, narrating behavior, and meaning making.

v. Discussions or handouts related to attachment and nurturing parenting highlighted in Baby TALK's *Parenting Topics, Let's Talk Kids Column* and *Trauma-Informed*

b. Baby TALK's Health and Safety curriculum guides staff to use conversations to explore preventative strategies and areas of concern observed. Topics include mental health, nutrition, oral health, physical health and safety practices as outlined in the Baby TALK curriculum. Safety practices topics include issues such as smoking cessation, SIDS, shaken-baby syndrome, baby-proofing, safe sleeping practices, and other safety issues.

7. The PHN will promote safer sleep with all pregnant parents and families with an infant from birth to twelve months of age. Safer sleep content can be found in Baby TALK *Health and Safety* and *Parenting Topics.* In addition, staff may refer to other evidence-based resources as outlined in step 4. This will be documented in the HVR. Any concerns related to safe sleep should be added to the new concerns section of the FSP with outlined plans to address.
8. PHNs will document conversations about child development, parenting skills, and health and safety practices in the FSP section of the HVR. Use of the Baby TALK or PHN approved curriculum is documented in the curriculum section of the HVR and includes what curriculum components were used at each visit.
9. Supervisors will regularly discuss and help PHNs assess and improve their efforts to support parents in promoting optimal child development, parenting skills, and health and safety practices.

TIP: See the training section for more details on curriculum training.

Secondary Curriculum: Mothers and Babies

Policy

The San Diego HFA MSS recognizes the importance of perinatal mental health for all families. Because perinatal depression is a risk for many families, the evidence-based Mothers and Babies (M&B) Course has been adopted for First Steps sites as a secondary curriculum. M&B is a nine-session stress management program designed to be implemented weekly in sequential order, with each session expected to last 20-25 minutes. M&B can support parents in strengthening their protective factors of social-emotional competence, parental resilience, and social supports.

Parents may demonstrate concerns in the FROG's social-emotional competence, parental resilience, and social connections domains. M&B can help strengthen these domains because it supports the development of PHN and parent awareness of:

- The quality of a parent's current social relationships and parental readiness to engage in developing new social relationships, and
- The impact of a parent's mood on their thoughts and interactions with their child

As such, all families may benefit from the curriculum. Families at risk for depression or anxiety concerns are particularly suited for M&B as it supports strengthening protective factors of parental resilience and social support. For some families, M&B will not be sufficient to address their mental health needs but will promote becoming "treatment ready". These families should

be supported with referrals to behavioral health services in addition to receiving the curriculum. An PHN will be trained in M&B before administering the curriculum.

Procedure

1. The PHN and Supervisor will discuss how a family might benefit from M&B during the development of the FSP. This discussion will include recognizing the concerns within the domains of social-emotional competence, social connections and parental resilience, and the parent's readiness to address these concerns. During the course of services, an elevated Patient Health Questionnaire-9 (PHQ-9) score may also prompt the discussion of a parent's readiness for M&B and whether there might be a need for a clinical referral in addition to M&B.
2. M&B materials focus on children under age one, but the PHN may also implement M&B with families of children older than one year of age. Staff will shift the wording of "baby" to "child" and make shifts to examples related to the child that address age-appropriate concepts. See *Resourceful Parenting Guides* on the First Steps Team Member Corner for more guidance.
3. PHNs should introduce M&B to the parent or family as a stress management program, normalizing the idea that everyone experiences stress, and there are specific and effective strategies to support the management of this stress. Participation in the course will positively impact the parent's relationship with their child and allow them to be a more responsive and connected parent. See *Introducing M&B to Parents* on the First Steps Team Member Corner for more guidance.
4. PHNs facilitate the M&B sessions *in order* as parents will develop skills and understanding during early sessions that they will then build on in later sessions.
5. As M&B is implemented, the PHN and supervisor will periodically assess the family's progress as a result of receiving the curriculum. The supervisor will update progress in the FSP.
6. Supervisors will monitor implementation and ensure all nine one-on-one sessions, or if administered in a group setting, all six group sessions, are completed sequentially to maintain fidelity to the model. Supervisors will reference *M&B Adaptation Guidance* and *Supervision Guide* for questions.
7. The PHN will implement the course at a pace that is appropriate for the family. Instances may arise when the PHN may need to postpone an M&B session (e.g., family crisis, family leaves town). Wherever possible, the PHN should wait no more than two weeks between sessions. If this is not possible, the PHN will review the last M&B session that was implemented with the family before moving on to the next.
    a. The PHN will reinforce M&B concepts and content as needed throughout the family's time in the program.
    b. When families miss a session, go more than two weeks between sessions, or if the family has been assigned to a new PHN, the PHN will review the previous session at the next visit before proceeding to the next session.
    c. Adaptations may be made on a case-by-case basis. Contact AAP-CA3 to discuss implementation.
8. The PHN will provide the family with a certificate of completion once they complete the final M&B session.
9. The PHN will enter every M&B session in Persimmony.

Motivational Interviewing

Policy

The San Diego HFA MSS uses Motivational Interviewing (MI - *a collaborative, goal-oriented style of communication with particular attention to the language of change)* to guide and empower families to make healthy changes based on their own values, priorities and readiness. The spirit and skills of MI are useful in a wide range of conversations, but MI is designed to help people examine their situation and options when they are facing decisions regarding a change. Common decisions or behavior changes that may be addressed using MI include but are not limited to:

- Initial engagement or engagement in services
- Immunizations, well-child visits, safe sleep, or breastfeeding
- Engaging in referrals such as those to mental health providers, IPV prevention, substance use support or early intervention

MI ensures these conversations are respectful, compassionate, and supportive instead of directive, which research demonstrates increases behavior change.

1. Staff will be trained in motivational interviewing prior to use with families or prior to supervision of its use.
2. PHNs will discuss the use of MI as an intervention to be used in the FSP.
3. Supervisors will support PHNs to identify the family's readiness for change and the desired behavior change.
4. PHNs and supervisors may role play scenarios to ensure MI adherent approaches.

Administration of Standardized Developmental Screens (HFA 6-5.A)

Policy

The San Diego HFA MSS conducts developmental screening at regularly scheduled intervals for the purposes of:

- Promoting parental mastery in screening and advocating for their child's educational needs
- Facilitating discussions about developmental behaviors and appropriate activities to promote the relationship and healthy development
- Early detection of developmental and/or social-emotional concerns
- Referral for assessment and services as warranted.

Sites use the most current version of the developmental screening and monitoring system, the ASQ-3 and ASQ:SE-2, with all target children, unless developmentally inappropriate. The ASQ-3 and ASQ:SE-2 were designed for parents to administer the screenings themselves with support from their PHN if needed (e.g., language). Developmental screens aim to identify risks for developmental concerns and provide timely and appropriate follow-up. As screening tools, the ASQ-3 and ASQ:SE-2 are not evaluation or assessment tools and do not conclude a diagnosis.

Staff track all children suspected of a developmental delay with appropriate referrals and follow-up as needed. For follow-up, see the procedures outlined below. If the child is engaged in early intervention services, staff are not required to complete the ASQ-3 during that time.

Procedure

1. All staff complete the ASQ-3 and ASQ:SE-2 HFSDC LMS trainings prior to administering or supervising screenings.
2. At a minimum, the ASQ-3 and ASQ:SE-2 will be administered according to the following timepoints.

Screening	Timepoints	Administration
ASQ-3	2, 4, 10, 18, 20, 24, 28, 32, 36, and 42* months after birth	At least twice per year of the child's life or more as needed if clinically appropriate
ASQ:SE-2	6, 18, and 30 months after birth	At least once per year of the child's life or more as needed if clinically appropriate

*For children over 3 months old at enrollment

3. For families that enroll when the target child is more than 3 months old, complete the first ASQ-3 and ASQ:SE-2 timepoints 2 and 4 months "after enrollment", respectively.
4. To be counted toward HFA screening requirements and be considered valid, all screenings must be age-appropriate. Refer to the ASQ calculator to identify the correct version of the screening tool.
5. If a screening timepoint is missed, the PHN will complete the screen as soon as possible using the tool calculator to determine if a different version of the tool is needed.
6. The tools will be administered to all children enrolled in the program unless developmentally inappropriate or if the child is enrolled in early intervention services (EIS).
7. When a child is participating in EIS, staff should follow-up on progress and request a copy of screenings (with signed parental consent). If the parent refuses the screening, PHNs will document that in the HVR. Participation in EIS should be documented as the reason the screenings were not completed in Persimmony.
8. The ASQ-3 and ASQ:SE-2 are designed to be completed by parents, recognizing them as the experts on their child(ren). Whenever possible, the PHN will work with families to build their capacity to conduct the screening with their child(ren). The PHN may support with scoring and by ensuring selection of the age-appropriate tool version. If families complete the tool, the PHN should request a copy to add to their file.
9. Developmental screens will be entered into Persimmony, and copies will be kept in client charts.
10. Any concerns identified during the screening will be used to develop a plan in the new concerns section of the FSP.
11. Supervisors will support PHNs by ensuring training is completed, monitoring selection of the appropriate tool version, ensuring timepoints are met, discussing scoring and referral and adding any concerns to the FSP.
12. Supervisors monitor staff's progress and practice in completing screening.

TIP: Ensure that all screening tools are entered into Persimmony even if it is only to note that the family declined the screening. This lets us know that all families are still being offered screenings even if they decline.

Tracking Children with Suspected Developmental Delays (HFA 6-5.D)

Policy

Sites track target children suspected of having a developmental delay and make appropriate referrals and follow-up to address those delays. The following table contains the developmental screening results protocol.

ASQ-3 Score	Category	PHN Action(s)
Scores are above the cut-off (WHITE zone)	Monitor	1. Provide parents with age-appropriate activities (e.g., ASQ-3 Intervention Activities, evidence-based curriculum). 2. Facilitate a parent-child activity when appropriate. 3. Re-screen at the next regularly scheduled interval.
Score in one domain is close to the cutoff or falls within the monitoring zone (GRAY zone).	Monitor	1. Any concerns identified during the screening will be used to develop a plan in the new concerns section of the FSP, which may include activities outlined below. 2. Provide parents with age-appropriate activities specific to the area of concern (e.g., ASQ-3 Intervention Activities, curriculum activities). Facilitate a related parent-child activity using Reflective or Baby TALK strategies to engage the parent when appropriate. 3. Re-screen in two months unless child is receiving early intervention services. Discuss with Supervisor. 4. Based on the child's age and concern, consider a referral to a pediatrician, Healthy Development Services (HDS), or California Early Start (CA-ES) if the concern is unresolved. Discuss with supervisor. • If an HDS or CA-ES referral is made, seek the family's written permission to receive a copy of the developmental assessment from HDS to support the identified developmental concerns. • If a pediatric referral is made ensure the family is clear on next steps (e.g., insurance authorization for private pay services) • If a referral is declined, this will be documented in the Action Plan.
Scores in two or more domains are within the monitoring zone (GRAY zone) OR	Referral and Follow-up	1. Any concerns identified during the screening will be used to develop a plan in the new concerns section of the FSP, which may include activities outlined below. 2. Provide parents with age-appropriate activities specific to the area(s) of concern (e.g., ASQ-3 Intervention Activities, curriculum). 3. Consider using Baby TALK (or PHN approved curriculum) activities that meet Illinois Early Learning Guidelines (IELG) standards for domains identified with concerns. Facilitate a related parent-child activity when appropriate.

Scores in one or more domains are below the cutoff area (BLACK zone).		4. Offer referral to pediatrician, HDS, CA-ES or school district (children 3+). Discuss with Supervisor. • If a referral is made, seek the family's written permission to receive a copy of the developmental assessment from HDS, CA-ES or the school district to support the identified developmental concerns. • If a pediatric referral is made ensure the family is clear on next steps (e.g., insurance authorization for private pay services) • If a referral is declined, this will be documented in the Action Plan. Discuss with supervisor to plan support for treatment readiness. Consider appropriateness of MI to increase treatment readiness. 5. Re-screen in two months unless child is receiving HDS or CA-ES developmental services.

Procedure

1. Using the table above as a guide, PHNs and supervisors work together to determine when a child should be referred for developmental concerns based upon the ASQ-3, the ASQ:SE-2, parent concern, and/or observations made during visits.
2. PHNs will offer the family a referral to HDS, CA-ES or the local school district to assess for developmental delay. PHNs will refer to the family's pediatrician to provide a referral for pediatric developmental services funded through private insurance. The PHN should also obtain written permission to follow up with the agency where the child was referred and the pediatrician about the referral.
3. PHNs follow-up on all referrals to help children obtain appropriate early intervention or behavioral health services (e.g., referral to CA-ES, HDS or school district).
4. PHNs document referrals made and follow up on the Action Plan or PHN approved form.
5. The PHN will also document if the family declines a referral in the Action Plan or PHN approved form. Discuss declined referrals with supervisors to develop a plan to support treatment readiness.
6. PHNs will track target children suspected of a developmental delay by making referrals, following up on referrals and tracking progress. PHNs will also follow up with parents about referrals made and document those conversations on the HVR.
7. PHN will enter the completed screening (i.e., ASQ3 or ASQ:SE-2 assessment) and the Action Plan (i.e., referral assessment or PHN approved form) in Persimmony.
8. PHN will follow up on the outcome of each referral and enter the outcome into the Action Plan (i.e., referral assessment or PHN approved form) in Persimmony.
9. A referral assessment must still be entered for families that decline a referral for ASQ-3 or ASQ:SE-2 follow up.
10. To the extent possible, PHNs attempt to integrate HFA services with any early intervention or behavioral services the target child receives. Integrated services are outlined as interventions in the FSP and may include collaborating with treatment providers, attending therapy services, integrating the goals from the intervention service and incorporating developmental enrichment strategies into visit activities.

TIP: Referrals for services include both verbal and/or written offers. If a family declines a referral, the PHN has still made the offer of a referral and should document this.

Tracking Children with Suspected Social-Emotional Concerns

Policy

Sites track target children who may be experiencing social-emotional concerns and offers appropriate referrals and follow-up to address those concerns. The following table contains the ASQ:SE-2 developmental screening results protocol.

ASQ:SE-2 Score	Category	PHN Action(s)
White	Monitor	1. Provide ASQ:SE-2 Parent Activities to practice skills. 2. Talk with parents about opportunities to practice skills.
Grey	Monitor	1. Complete activities from the white category (above)
Black	Referral and Follow-up	1. Complete activities from the white category (above) 2. Any concerns identified during the screening will be used to develop a plan in the new concerns section of the FSP, which may include activities outlined below. 3. Consider use of Baby TALK (or PHN approved curriculum) activities that meet Illinois Early Learning Guidelines (IELG) standards for social-emotional development. 4. Offer referral to HDS or other community resources as appropriate. 5. Document in the Action Plan or PHN approved form when referrals are declined. 6. Discuss declined referrals with supervisors to develop a plan to support treatment readiness. 7. Rescreen in 4-6 months if a concern arises and inform parents about HDS parent workshops.

Regardless of the score on the ASQ:SE-2, if a parent has concerns, the PHN will address their concerns, provide activities and refer as appropriate.

Procedure

*See procedures **outlined** for ASQ-3 above.*

Administration of a Standardized Depression Screen (HFA 7-4.A)

Policy

Sites use the Patient Health Questionnaire–9 (PHQ-9) to screen parents for depression around the birth of the target child and after all subsequent births that occur while the family is enrolled in the program.

All PHNs must complete the HFSDC LMS PHQ-9 training before administering the tool (HFA 7-5.D). Supervisors must complete PHQ-9 training prior to providing supervision related to the tool.

Procedure

1. Administer the PHQ-9 according to the following timepoints. It can also be administered as needed if the PHN or parent has concerns about a parent's mood, if the family experiences loss, such as a miscarriage or stillbirth, or if the family experiences a major transition.

Time of Enrollment	Timepoints
Prenatal/Postnatal	Prenatal (if applicable) and 2 months, 5 months, and 12 months after birth
3 months or more after birth	2 months after enrollment, and 5 months and 12 months after birth
Subsequent births	2 months after birth of non-target child

2. The PHQ-9 is administered by the PHN to the parent or other caregiver.
3. The total PHQ-9 score for the nine items ranges from 0 to 27. Depression severity is determined using the table below and proposed supportive actions are outlined based on the score.
4. PHNs will immediately notify their supervisors if a parent expresses suicidal ideation to determine the appropriate course of action
5. PHNs will discuss with their supervisors and the family an appropriate course of action based on the PHQ-9 score. Guidance for each depression severity category is outlined below:

PHQ-9 Score	Depression Severity	Proposed Supportive Actions
0	None	No immediate actions are required. Repeat the PHQ-9 according to timepoint schedule.
1– 4	Minimal	
5 – 9	Mild	1. Offer education and explore strategies (e.g., M&B) for enhanced well-being and coping, 2. Repeat PHQ-9 at a follow-up visit and 3. Discuss with supervisor and refer as appropriate.
10 – 14	Moderate	1. Offer education and explore strategies (e.g., M&B) for enhanced well-being and coping, 2. Refer to medical and/or mental health provider and 3. Discuss with supervisor to assess risk to safety.
15 – 19	Moderately Severe	1. Offer education and explore strategies (e.g., M&B) for enhanced well-being and coping, 2. Refer to medical and/or mental health provider and 3. Discuss with supervisor as soon as possible to assess risk to safety.
20 – 27	Severe	1. Expedite or make an immediate referral to a medical and/or a mental health provider (e.g., Access and Crisis Line) and 2. Discuss with supervisor immediately or as soon as possible to assess risk to safety

6. PHNs will discuss with their supervisors when the M&B curriculum is an appropriate educational tool to use with parents who score in the 0-14 range. M&B alone may not be sufficient to meet the parent's needs in many cases.
7. PHNs may also make referrals when parents score low on the PHQ-9 but have ongoing stressors or heightened risk factors.
8. Supervisors monitor PHN skill and consistency in administering PHQ-9s in a timely manner using the PHQ-9 Tableau Dashboard.
9. PHNs will enter the completed screening (i.e., PHQ-9 assessment) and associated referral assessment in Persimmony and go back to the Action Plan to update the referral outcome.
10. A referral assessment must still be entered in the Action Plan for families that declined a referral, following an elevated score (10+).

TIP: The PHQ9 can be used with any of the target child's primary caregivers if there is a concern beyond the primary caregiver. Staff are encouraged to offer screenings to fathers and/or grandparents caring for the child.

TIP: The outlined time points are a minimum. Anytime there is a parental or PHN concern about a parent's well-being a screen should be completed. Parents with a history of mental health issues or a significant trauma background may benefit from additional screenings. The increased screening frequency may be included in the FSP as part of an individualized intervention.

TIP: Veteran staff may retake the HFSDC LMS training as a refresher or opportunity to enhance PHQ-9 administration skills.

Working with Pregnant and Parenting Adolescents

Policy

SSA/PHNs will attempt to obtain parental consent for adolescent parents under eighteen years of age that reside in their own parents' home. Consent will be sought by SSAs during the FROG visit. Whether or not parental consent is required for participation in services will depend on each site's agency-specific policies.

Procedure

1. SSAs will request parent consent in accordance with CoSD policies from the mother, father or legal guardian of the adolescent parent to be enrolled in services during the FROG visit.
2. Consent forms will be kept in the family's chart.

7. Supporting Families through the Level System

Level System (HFA 4-2.A-C: 4-2.C - *Essential*)

Policy

The San Diego HFA MSS has a well-defined level system for managing a family's intensity of visits to ensure that their frequency of visits is based on their needs and progress in the program. The level system outlined below is adopted from the HFA Level Completion Forms with HFA's approval to develop the San Diego HFA MSS Level Change System. In general, families are offered:

- More frequent visits during initial enrollment when families are still getting to know and trust their PHN (Levels 1P, 2P or 1), or when families have more needs and challenges (Level Special Services-SS)
- Reduced visits as they progress through services (Levels 2-3)

Family Levels & Frequency of Visits

FAMILY LEVEL	CASE WEIGHT	FREQUENCY OF VISITS
• 1P (Prenatal)	2	Weekly*
• 1	2	
• *Special Services (SS - may need more than a weekly visit)	3	
• 1b (Level 1 families who request less frequent visits)	2	Bi-Weekly
• 2P (Prenatal)	2	
• 2	1	
• 3	.5	Monthly
• Creative Outreach (CO)	0.5-3**	Refer to guidance in P&P
• Temporary Out of Area (TO)	0.5-3**	
• Temporary Reassignment (TR)	0.5	

** *Points are equal to the family's previous level. Point value can be no lower than 0.5 nor higher than 3 points.*

- Tailored outreach to support reengagement of services (Creative Outreach-CO)
- Efforts to ensure families experience high-quality services with limited pause in care (Temporary Out-of-Area -TO or Temporary Re-assignment-TR.)
- Additional case points when families require more time/frequency of visits (designated by the letter “a” next to the level, i.e., “Level 1a”)

Procedure

1. At enrollment, the PHN and supervisor will review the service levels to determine the family’s initial service level.

Prenatal Service

Policy

Sites provide prenatal families with either weekly (1P) or every other week (2P) visits. If a family enrolls in services at 28 weeks gestational age or later, offering weekly visits (1P) is required to promote improved birth outcomes and established relationships with the PHN prior to the birth of the child.

Procedure

1. Development of the FSP will serve as a guide to determine service level (2P vs. 1P).
2. PHNs will offer 1P families weekly visits. 2P families may also be offered weekly visits initially as an opportunity to establish rapport, but the family may choose to meet every other week.
3. FSP considerations for service intensity include parent’s childhood history, early pregnancy experience, stressors, social connections, access or receipt of prenatal health care, etc.
4. Families scoring higher on the FROG are offered weekly visits for a longer period of time than families with lower scores. For example, if a family scores a 4 on at least one FROG domain, Level 1P should be considered.
5. Families on Level 2P may occasionally or temporarily receive weekly visits if needed without being moved to Level 1P. If it appears that weekly visits are needed through the remainder of the prenatal period, then they should be switched to Level 1P.

TIP: Use *HFA Prenatal Attachment Questions*, available on the First Steps Team Member Corner, to consider progress in bonding when determining frequency of visits.

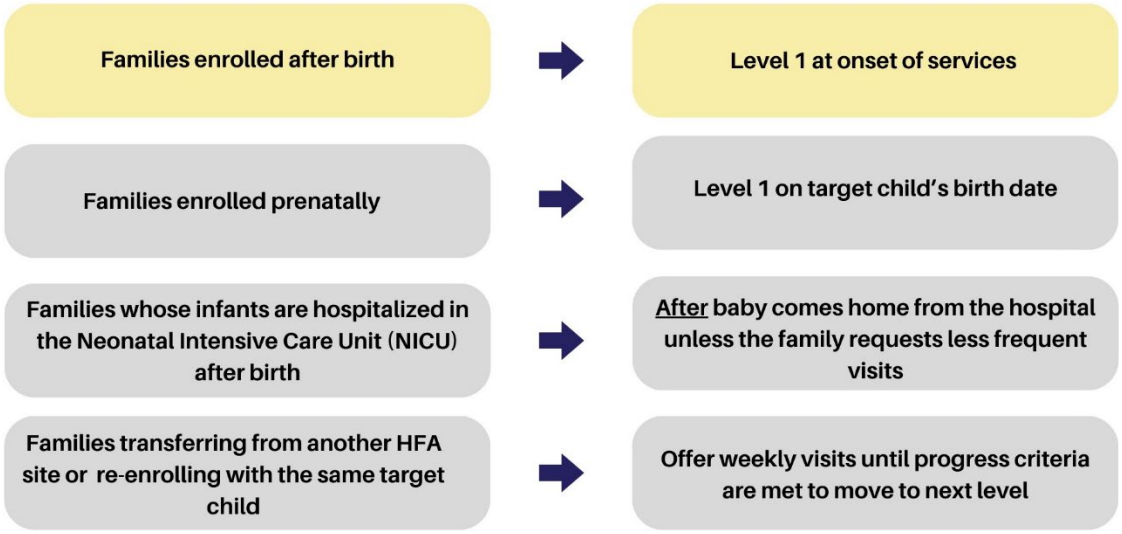
Level 1 Service (HFA 4-1.A)

Policy

The San Diego HFA MSS offers all families Level 1 weekly service after the baby's birth. These first months after the baby's birth are a critical time in which parents need support with parent-child interactions, newborn care and safety and adjustment to parenthood. There may be situations in which a family may request reduced visits due to time and scheduling conflicts (e.g., returning to work or school). In these cases, the site will respect the family's wishes and may adjust visit frequency according to the parent's schedule.

Procedure

1. Families are placed on Level 1 when any of the following occurs:



2. When progressing from Level 1P or 2P to Level 1, the PHN will fill out the Level P Completion Form for families enrolled prenatally.
   a. If a family is placed on Level TO, CO or TR shortly after birth, the PHN will still complete a Level P Completion Form indicating that the family has delivered and will return to Level 1 after their time spent on TO, CO or TR, if applicable.
3. If a Level 1 family requests reduced visits, the PHN will document the request in the HVR and update their supervisor. In these cases, the family will be placed on Level 1b and will receive no less than biweekly (every other week) visits. The family will maintain a case weight of 2 points to ensure they can return to weekly visits if desired.
   a. **Offering reduced visits may begin no earlier than three months after birth or enrollment.**
   b. As appropriate, PHNs will continue to offer weekly visits until the family meets the progress criteria to move to Level 2, ensuring that families are aware the opportunity to resume weekly visits is available to them.
4. Families will remain on level 1 until they progress to level 2 based on the level completion form criteria.

TIP: A site is still adhering to the policy even if families request reduced visits as long as families are offered weekly service after the baby is born and meet all requirements in the Level 1 Completion Form before moving to Level 2.

TIP: Attachment relationships are solidified within the first 4-6 months of life. This is a critical window to come alongside a family with a relationship that is safe, comfortable, predictable and pleasurable.

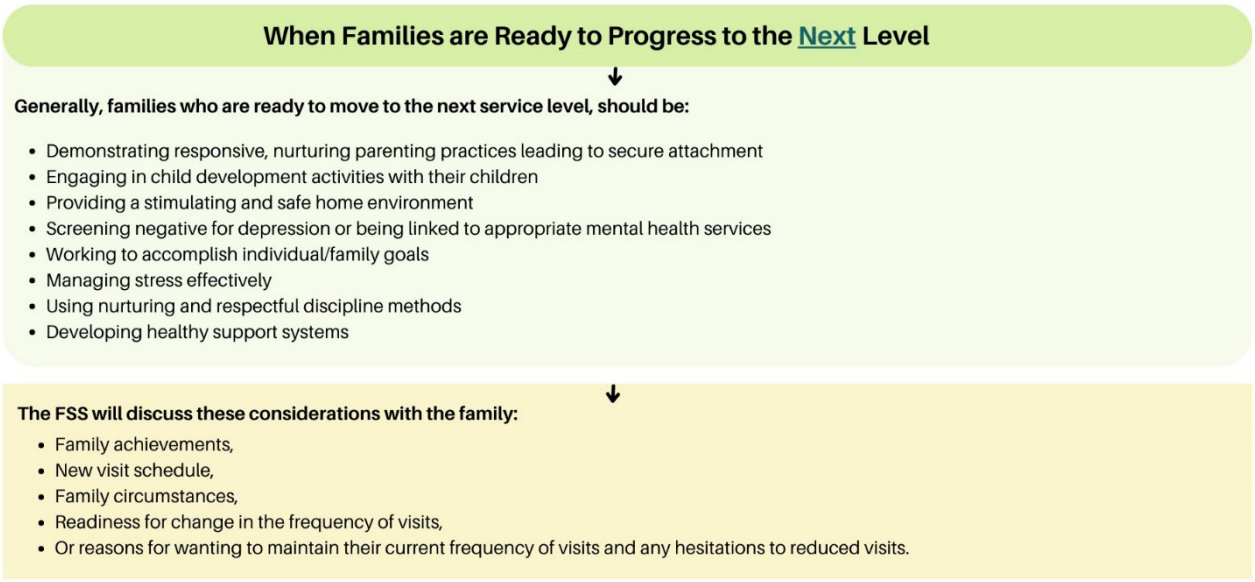
Progressing through the Level System (HFA 4-2.A-C: 4-2.C - *Essential*)

Policy

Families receive less frequent visits as they gain more skills and self-sufficiency. The Level Completion Forms outline the primary indicators that families are ready to change levels. Before any level changes, family progress and changes to the frequency of visits are reviewed and agreed upon by the family, PHN and supervisor.

Procedure

1. Staff will follow guidelines in the Level Completion Forms when considering transitioning families to a new level.
2. The PHN will review and discuss the factors listed on the corresponding Level Completion Form with the family and their supervisor before moving the family to another level. PHNs will also consider the following when discussing and determining the family's progress to the next level with the family and supervisor:



3. When the PHN and family agree that the family is ready to be promoted to a lower intensity level, the PHN will discuss with their supervisor. Discussions around a level change will be documented by the supervisor and PHN:
    a. The supervisor will use the Level Completion Form to document discussions and to review the family's readiness for level promotion based on the established criteria for the level change. Families must attain all the required achievements listed on the Level Completion Form to progress to the next service level (excluding optional criteria).
    b. The PHN should add details on the discussion with the family to the HVR.
4. Once the supervisor agrees that a family can be promoted to a new service level, they will sign off on the Level Completion Form, and the family can begin their new level of service. The completed and signed Level Completion Form will be kept in the family's file.
    a. The level change will also be documented on the home visit completion and caseload worksheet (HVCC) and the FPR.
    b. PHNs may also continue to update the HVR as needed.
5. The PHN will complete the corresponding Level Completion "Accomplishments" Certificate, share it with the family and maintain a copy in the family file.
    a. PHN will discuss with the family how they want to celebrate and be celebrated for their progress. Discussions and celebrations will then be documented in the HVR.
6. Subsequent visits with the new service level will be entered in Persimmony.

TIP: Level Change Certificates are available on the First Steps Team Member Corner for download.

Returning Families to a Previous Level

Policy

Although most families are expected to progress from Level 1 to Level 3 over the course of services, there may be some circumstances where a family may need to be moved back a level, from Level 3 to Level 2, or from Level 2 to Level 1.

The primary indicators to move a family back a level is when:

- There is a long-term need to increase visit frequency where Level SS would be inadequate.
- The family is no longer demonstrating some of the criteria on the corresponding Level Completion form. For example, a family on Level 2 experiences a catastrophic loss in the family resulting in the parent no longer demonstrating healthy coping behavior and losing interest in child development activities.

Procedure

1. When a PHN believes a family may need to be returned to a previous level, the PHN will discuss with their supervisor why there is a need for more frequent visits.
2. The PHN and supervisor will review the family's last Level Completion form and explore if the family is no longer demonstrating the required criteria listed on the form.
3. The supervisor and PHN will consider if the family can be helped by moving them to Level SS for a period of time. Families can either be directly moved back to a previous level or moved to Level SS and then later transitioned back to a previous level if it is unclear how long it will take for a crisis to resolve.
4. Once a family is moved back a level, they must again meet the criteria on the appropriate Level Completion form before moving to the next level. All criteria should again be reviewed and discussed in supervision. This will result in two Level 1 or Level 2 completion forms being in the family's file.
5. The PHN documents that the family was returned to a previous level in the Narrative/Comments section on the new/second Level Completion form.

Creative Outreach (CO; HFA 3-3.A)

Policy

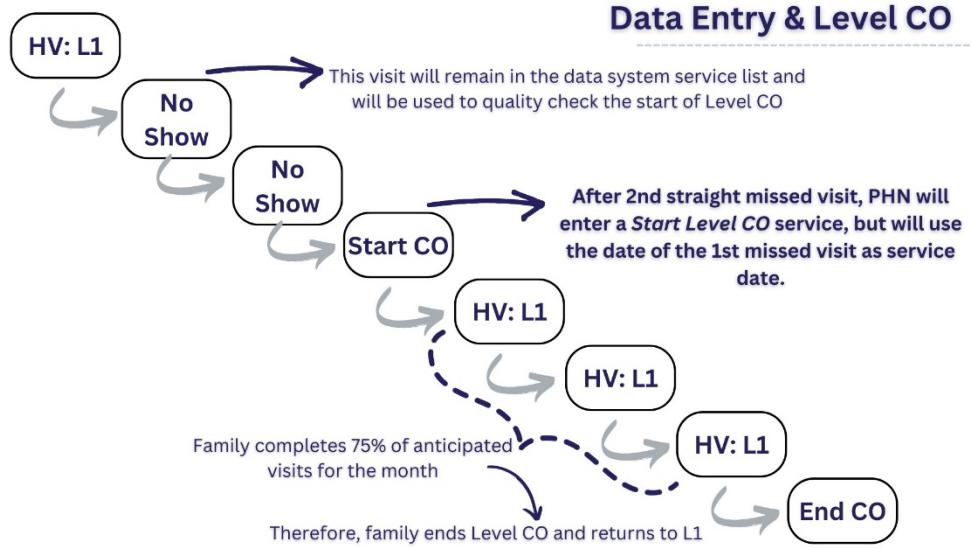
Sites reach out to families who have enrolled in services but then disengage and lose contact or do not consistently participate in their schedule of visits. When a family becomes disengaged, they are placed on CO for at least three months to ensure reasonable steps are taken to re-engage the family before ending services. This communication aims to demonstrate the program's interest in continuing to partner with the specific caregiver and family.

Families who appear to be engaged in services, but routinely miss or have difficulty scheduling every other visit are not placed on CO. In these cases, PHNs should discuss with their supervisors and reconsider if the family is truly a good fit for the program.

Procedure

1. Sites will transition a family into CO when the family misses at least two consecutive visits. "No Shows" can include:
    a. When a rescheduled visit also results in a "no show".

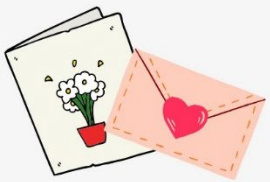
b. When a family “no shows” and communication is lost, such that the PHN cannot reschedule another visit within the due time period (e.g., within the following week for a Level 1 family)
c. Staff can reference the Data Entry & Level CO graphic below for information on data entry.



2. PHNs will follow and complete the Level CO form by:
   a. Documenting the date of the first “no-show” visit as the date CO began (Note: the same date will be listed on the HVCC Worksheet).
   b. Describing individualized CO activities used to engage the family.
3. Supervisors review the Level CO form to prepare for supervision discussions regarding re-engagement.
4. During CO, the case weight from the family’s previous level will be maintained. The PHN will reach out to the family at least weekly for Levels 1, 1b, or 1P and once every other week for all other levels with personalized activities that demonstrate the PHN holding the family in mind such as:

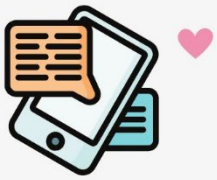
Phone or web-based contacts (e.g., Zoom, Facetime) to give families time to re-build trust with the FSS

Visits to connect with families when they are available or unscheduled drop-by visits to attempt to reconnect



Send individualized hand-written notes or greeting cards for family birthdays, welcoming the baby, or “thinking of you”

Mailing a Baby TALK Developmental Newsletter based on the child’s age with a note



Texting a nurturing note or image

Inviting parents and their families to parent groups where there will be social and fun activities

5. Agencies, supervisors and PHNs will determine the frequency and appropriateness of these activities based on the unique populations they are working with and their agency-specific regulations.
6. Visits may occur while a family is on CO and may look different than a "typical" visit. For example, discussion can focus on re-engagement or exploring reasons why engagement might be challenging. These visits will not be counted in the HVCC Worksheet.
7. CO will be carried out for a minimum of 3 mosnths (whether 3 consecutive months or 3 cumulative months during a 6-month period).
    a. Note: Families who are assigned a permanent PHN from TR or returned to the service area from TO but are unable to be engaged on an active service level will be moved to CO. In these situations, the cumulative time on TR or TO plus CO will be for a minimum of 3 months.
8. Once a family shows signs of re-engagement, including receiving at least 75% of expected visits for at least 30 days, the PHN will discuss with their supervisor the recommendation to remove the family from Level CO and return them to their previous level. Once the supervisor agrees, the family can officially return to their previous level at their next scheduled visit.
9. The next scheduled visit (the date the family returns to their previous level) will also mark the end of CO date for data entry and the HVCC worksheet.

CO may end before 3 months only if/when the family has:

- Re-engaged in services consistently and demonstrates re-engagement by receiving 75% of expected visits over a month or 30 days
- Moved from the service area or transferred to another program
- Stated that they refuse services
- Loses custody of the target child with no plans for reunification
- Loses the baby (miscarriage, etc.)
- Experiences the death of the primary caregiver
- There are significant staff safety issues.
- Supervisors may seek approval from their PM if they determine a family's situation warrants a CO period longer than three months; this should be documented in supervision notes. Any liability concerns arising from maintaining an open case in the absence of any services, have been considered and mitigated.

Policy

Temporary Out of Area (TO) Level

Level TO is used for families that demonstrate engagement and commitment to the program, but are temporarily unable to make their visits. A family is placed on TO for a maximum of 3 months when they notify the PHN that they will not be able to participate in visits for a period of time that exceeds 2 weeks if on Level 1 or 1P or 4 weeks for all other levels. Acceptable reasons include:

- Temporary deployment
- Hospitalizations, severe illnesses, or other medical circumstances where visits are inappropriate or dangerous (e.g., risk of acquiring a contagious illness)
- Extended visits to countries of origin

Procedure

1. When a family notifies their PHN that they will be away for a period of time, they will discuss when the next possible visit can be scheduled, and methods of checking in with the family, such as phone calls, texts, or e-mails, as permitted by agency policies.

2. The PHN will ask when they can contact the family to confirm their return and readiness for the next visit.
3. Families are placed on TO the day after the last visit before their planned absence.
4. To ensure space for the family upon their return, the case points while on TO remain equal to the weight they were on before being placed on TO.
5. The PHN follows and completes the Level TO form.
6. Families are taken off TO at the first visit after returning from their absence, or at the end of the 3 months.

Level TO cannot exceed 3 months, unless the following conditions are met:

- The site has sufficient open slots for new families, such that keeping the family on TO for more than 3 months does not prevent a new family from enrolling in the program
- The PHN, PM and supervisor discuss and document the justification for keeping the family enrolled as well as the plan of action for re-engaging the family after the long absence
- Any liability concerns arising from maintaining an open case in the absence of any services, have been considered and mitigated.

7. In the event that a family misses their first visit following their absence, the family is placed on CO, and the process for re-engaging the family begins following the Level CO policy.

Managing Caseloads during Staff Absences - Level TR (Temporary Re-Assignment)

Policy

There may be circumstances where a disruption in staffing leads to difficulties in maintaining visit frequency for families. When a PHN leaves or takes an extended absence, site staff will take steps to continue providing services to families by placing them on Level TR. TR is a temporary level, limited to three months.

TR occurs:

- When a family's PHN leaves employment and a new PHN has not yet been hired.
- When an PHN is out on extended leave.
- Any other type of staff leave that results in interrupted services for 2 or more weeks if on Levels 1, 1b or 1P, or 4 weeks for Levels 2 or 3.

TR is only for families not receiving the same frequency of service as before. If a family is reassigned to another PHN or supervisor but receives the same frequency and intensity of visits, the family is not considered to be on TR and will remain at their previous level.

Procedure

1. In the event of a staff leave, the supervisor will attempt to reassign families to a new PHN if the family is a good fit for the new PHN and there is room on the caseload. If that is not possible, the supervisor may temporarily place the family on TR until a replacement PHN can be assigned or the existing PHN returns.
2. While on TR, case weight will be reduced to .5 points for whomever the case is assigned and will return to the previous weight when a staff member on leave returns or the family is permanently re-assigned.
3. The supervisor will be responsible for maintaining contact with the family throughout their time on TR. In cases where the family speaks another language, the supervisor may seek the assistance of a translator or a PHN who speaks the same language.

Communication with the family will occur as follows:

Level	Communication
Level 1, 1b, & 1P	Attempt to contact the family at least once a week to inquire about the parent's and baby's well-being and send out every other week curriculum/information mailings as deemed appropriate by the supervisor.
Level 2 & 2P	Attempt to contact the family at least every other week and provide monthly curriculum/information mailings as appropriate.
Level 3	Attempt to contact the family at least monthly and send out monthly mailings

4. Families are taken off TR when families are permanently assigned to a PHN and are able to reengage in their typical visit frequency, or when the 3 months of TR has ended.

TR is a temporary placement and is limited to 3 months:
- The supervisor with PM approval will determine on a case-by-case basis if a family may remain on TR longer than 3 months or whether they should be referred to other services.
- Any liability concerns arising from maintaining an open case in the absence of any services, have been considered and mitigated.

5. Documentation of TR activities will be made on the Levesl TR Form
    a. PHNs will follow and complete the Level TR Form
    b. Supervisors will document communication attempts
6. All TR start and end dates should be documented on the HVCC Worksheet as a level change or note.
7. When families on TR are assigned a permanent PHN but are unable to be re-engaged in services, they are moved to CO. The cumulative time on TR plus CO will be for a minimum of 90 days.

Special Services (SS) Level - During Difficult Times

Policy

The PHN and supervisor will decide together whether a family needs to be assigned to Level SS which is a temporary assignment for families who are experiencing a crisis or difficulty that has a foreseeable resolution or end.

SS occurs when a family temporarily requires more frequent visits or additional overall time due to:
- Family needs for additional services
- Attendance with therapists or other treatment providers as per the guidance of the Level SS form.

Level SS is not intended to meet permanent needs of families who experience crisis for longer periods of time, require more intensive services than the HFA program can provide or have less severe but longer-lasting circumstances that warrant a family being assigned additional case weight (e.g., translation needs, multiple births, extended travel time). See section on Assigning Additional Points to Families for more detail.

Procedure

1. The PHN and supervisor discuss the challenges the family is facing.
    - If the family's needs cannot be met by temporary assignment to SS, the team will identify other services where the family may be referred.
2. The supervisor will document that the PHN's time spent with the family is at, or greater than, 1.5 times a "typical" level's time (e.g., a L1 family is needing 2 visits/week instead of 1; a L2 family is needing weekly visits instead of every other week).
3. The PHN and supervisor will identify strengths to support the development of a plan and resolution to the crisis, so that more intensive services will only be needed temporarily.
4. One point will be added to the family's case weight while on Level SS. For example, a L1 family would go from 2 to 3 points when moving to SS.
5. The PHN will document assignment to SS on the Level SS Form.
6. The PHN and supervisor will review the need for continued special services within 3 months of placement on SS to determine whether the family should move back a level or whether HFA services should be supplemented with other services.

8. Supporting Staff with Caseload Management

Caseload Size (HFA 8-1.A)

Policy

The San Diego HFA MSS Level System provides guidance to help staff maintain limited caseloads to ensure Family Support Specialists (PHNs) have an adequate amount of time to spend with each family to meet their needs.

Procedure

1. Caseload size is continuously monitored by supervisors. Supervisors will review each PHN's current caseload before assigning new families.
2. Supervisors will consider staff tenure when assigning caseloads. Supervisors are encouraged to increase PHN caseloads for newly hired staff gradually.
3. It is highly recommended that PHNs serving families referred by CFWB maintain smaller caseloads due to the higher needs of families served.

TIP: Spread CFWB referred families across site staff rather than concentrating all on one or a few workers to reduce staff burnout.

Managing Caseloads (HFA 8-2.A)

Policy

Thoughtful consideration goes into assigning cases to each PHN. Supervisors take into account multiple factors (listed in the procedures) that may impact the PHN's ability to dedicate sufficient time to each family.

Procedure

1. The supervisor will use the following criteria when assigning cases:
    a. Experience, length of time in role, and skill level of the PHN assigned
    b. Nature and urgency of the challenges observed or shared by families
    c. Work and time required to serve each family
    d. Potential conflict/boundary challenges due to an existing personal relationship
    e. Current staff capacity
    f. Travel and other non-direct service time required to fulfill responsibilities
    g. Extent of other resources available in the community to meet family needs
    h. Other assigned duties
    i. Referral source (e.g., CFWB)

Assigning Additional Points to Families

Policy

PHNs for various reasons may need to spend significantly more time than usual in working with some families to prepare, travel and/or conduct the visit. Supervisors and PHNs can jointly decide whether to assign such families additional case points to reflect the additional time spent with these families. These circumstances are long-term, not temporary crises that would warrant a Level SS designation.

Procedure

1. Supervisors and PHNs can jointly decide to assign a family one additional case weight point for any of the following circumstances:
    - Families with multiple children born (e.g., twins, triplets)
    - Families with other children 0-5 years of age that are typically present during visits and have special needs or need additional referral coordination
    - Families that live 45 minutes or more from the PHN's office
    - Families that have significant language or literacy barriers that require the PHN to translate assessment(s) and handout(s)
    - Families who are approaching graduation and require additional visits or time spent to ensure all appropriate assessments and referrals are in place before services end
2. For families who require additional time, the letter "a" for "additional" is added to the service level and 1 point is added to the case weight. For example, a family enrolled in service prenatally with twins would be on Level 1P during pregnancy. When the twins are born, they would move to Level 1a and be assigned 3 points.
3. Document the service level in the family chart, Level Completion Forms, and supervision records. The Persimmony database does not need to reflect the sublevel ("a") designation.

TIP: Consider staff characteristics and capacity when assigning families referred by CFWB.

Level System Table with Additional Points

Family Levels & Frequency of Visits

FAMILY LEVEL	CASE WEIGHT	FREQUENCY OF VISITS	ADDITIONAL POINTS*
• 1P (Prenatal)	2	Weekly*	1Pa - 3
• 1	2		1a -3
• *Special Services (SS - may need more than a weekly visit)	3		3
• 1b (Level 1 families who request less frequent visits)	2	Bi-Weekly	1ba - 3
• 2P (Prenatal)	2		2Pa - 3
• 2	1		2a - 2
• 3	.5	Monthly	3a - 1.5
• Creative Outreach (CO)	0.5-3**	Refer to guidance in P&P	0.5-3**
• Temporary Out of Area (TO)	0.5-3**		0.5-3**
• Temporary Reassignment (TR)	0.5		0.5

* *Additional points are calculated when families need additional time. See policy on Assigning Additional Points to Families for more information.*

** *Points are equal to the family's previous level. Point value can be no lower than 0.5 nor higher than 3 points.*

9. Supporting Families Through Transition or Case Closure

Length of Services (HFA 4-3.A)

Policy

Families will be offered services by for a minimum of three years after the birth of the baby or three years after enrollment (whichever is later), except for families who transfer from another HFA site.

Procedure

1. At the time of enrollment, PHNs will explain to families that services will be for a period of three years after the birth of the child or after enrollment.
2. PHNs will explain that toward the end of the three-year service period, efforts will be made to link families to further resources and services they may need when services end.
3. If a family chooses to leave the program before three years of service, staff will determine if the family has met HFA's Successful Completion of Program criteria using the HFA Level form. If criteria are met, staff will acknowledge the family has completed the program. Staff will attempt to create a Transition Plan as outlined below and document that the family was "offered" services for three years.

Service Closure and Transitioning Families (HFA 4-4.A)

Policy

Families may exit services when any of the following planned or unplanned events occur:

Planned Closures	Unplanned Closures
• The target child has reached the age of three years or at least 3 years of services have been provided after birth or enrollment (whichever is later)	• The family requests discontinuation of services
• The family "graduates" from the program	• The family relocates out of the program's service area (the family will be transferred to another HFA site if possible)
	• The family has been on CO or a combination of CO and TR or TO for 90 days or more and has not re-engaged
	• The target child is no longer in the home
	• The PHN's safety is at risk
	• The primary caregiver is deceased (and the new caregiver does not want to remain in the program)
	• The target child is deceased (the PHN may continue to see the family for 3 months at either Level 1, SS or the family's previous service intensity and refer the family to grief counseling)

Procedure for Planned Service Closure (Graduation)

1. Transition and closure planning will ideally begin approximately 6 months before, but at a minimum of 3 months before the target child's third birthday or the completion of three years of services after birth or enrollment (whichever is later).
2. If a family declines the transition plan, PHNs will document the date of the initial discussion regarding the closure and the date the family declined the transition plan in the HVR.
3. The Transition Plan will include the reason for planned closure, the date the discussion was initiated with the family, and if the family declined a transition plan.
4. The PHN, supervisor and family will also discuss additional resources or services that the family needs or wants to continue progress after services close.
5. The PHN will keep a copy of the Transition Plan in the family's chart.
6. For families who are graduating, the PHN will meet with them to discuss their progress and readiness for graduation. Family goals still in process are incorporated into the Transition Plan.
7. The PHN will notify collaborating services (i.e., other programs or services the family is or will be involved with) of the date the family will be graduating from services when a Release of Information (ROI) has been signed. The PHN will also work with the family to outline steps for obtaining those services.
8. The PHN will fill out the Completion of Program form, marking all the criteria the family accomplished. If all the criteria are met, the PHN will also share the Completion of Program certificate with the family during the final visit or one of the last visits. Families that do not meet all the criteria on the Completion of Program form will still be celebrated for their accomplishments and invited to participate in graduation ceremonies.

9. The PHN will complete the Exit Assessment form.
10. The family will officially be exited from the program no sooner than the child's third birthday.
11. After a family exits, PHNs, supervisors or other staff can continue occasional phone or email communication with the family for the following purposes:
    a. Arranging their participation at a family graduation event
    b. Inviting them to participate in some form of parent alumni volunteer activity, such as serving on an advisory group or speaking to a parent group

Procedure for Other Types of Service Closure (Non-Planned)

1. The PHN will meet with their supervisor to discuss the reasons for exiting the family from services.
2. Whenever possible, the PHN will take the appropriate follow-up steps to ensure the family has other resources available after ending services. The PHN will attempt to refer the family to another HFA program if available.
3. If the service closure occurs with at least 3 months of notice, the PHN will complete a Transition Plan. It is recommended that a Transition Plan be attempted regardless of how much advance notice is given. If the family declines a Transition Plan, the PHN will document this in the HVR.
4. The PHN will complete the Exit Assessment form and close the family's file in Persimmony.

10.Family Resources

Information Referrals and Linkages to Health Care and Community Resources (HFA 7-3.A)

Policy

Participating families may need referrals and resources for other services, including health services. PHNs will provide information, referrals and linkages to available health care and community resources for all participating family members, when appropriate.

Procedure

1. PHNs will discuss health service needs with the families.
2. PHNs will gather information about appropriate referrals and resources for their families and check-in with their supervisors if necessary.
3. When providing referrals or resources to the family, the PHN will verify if the family needs assistance with access. If so, the PHN will follow up by making the referral or being present and providing support while the family accesses the service for themselves.
4. Prior to making a referral on behalf of the family, the PHN will obtain a signed ROI from the family.
5. After making a referral, the PHN will enter the referral into the Action Plan (i.e., referral assessment or PHN approved form).
6. The PHN will follow up on the outcome of each referral and enter the outcome into the Action Plan (i.e., referral assessment or PHN approved form) in Persimmony.
7. The PHN will monitor progress in receiving services provided through the referral by discussing the family's experience with that resource or agency at subsequent visits.

Linking Children to Medical/Health Care Providers (HFA 7-1.A)

Policy
For families of children without a primary medical/health care provider, PHNs will work with the family to link them to a medical/health care provider and support families in using health care appropriately, including receipt of well-child care for their child(ren).

Procedure
1. PHNs should have a discussion with their families to find out if they are already connected with a medical/health care provider. If they are not, the PHN will talk to the family about connecting them with a provider to meet their needs.
2. Concerns related to linkages to a medical/health care provider should be noted on the family's FSP with planned interventions/activities to address and track progress.
3. The PHN should then work with their team and supervisor to identify medical/health care providers in the area where their family is located. PHNs should consider the family's ability to get to appointments (e.g., transportation).
4. The PHN will communicate with the family to help parents ensure their child receives the appropriate well-child visits, including addressing barriers in access, and document these discussions in the HVR in Persimmony.

Immunization (HFA 7-2.A)

Policy
The San Diego HFA MSS follows the American Academy of Pediatrics (AAP) Immunization Schedule. PHNs will routinely share information with families about childhood immunizations and follow up with their families when immunizations are due and if a family has missed an appointment.

Procedure
1. PHNs will follow the AAP Immunization Schedule to inform families about childhood immunizations.
2. PHNs will enter immunizations in the IZ section of Persimmony and document any information regarding why a child did not receive a scheduled vaccination and all attempts to ensure that child receives the vaccination in the Action Plan.
3. PHNs will document how information shared with families promotes and educates families on the importance of immunizations in the HVR.
4. PHNs will document progress on immunizations in the HFA Child Health Data Collection Form in Persimmony.
5. Supervisors monitor staff progress with the Immunization Tableau Dashboard and offer support for facilitating discussions with families and accurate documentation.

11. Equal Opportunity Employment (HFA 9-1.A, 9-2)

Policy
San Diego HFA MSS sites comply with the Equal Opportunity Act and communicate their equal opportunity practices in recruitment, employment, transfer and promotion of employees. Each site informs staff of the equal opportunity practices and uses recruitment materials that specify the non-discriminatory nature of the site's employment practices.

The system for hiring new staff takes into account the candidates' personal characteristics, lived expertise and knowledge of the community they serve, ability to work with culturally diverse

individuals and knowledge and skills to do the job. By hiring staff from the community and increasing language capacity, we aim to help families of the community feel seen, valued and included.

Procedure

The sites hiring system includes the following practices:

1. Job descriptions include at least the minimum criteria in HFA 9-1.B-D for the positions of PM, Supervisor, and direct service staff.
2. Standardized interview questions appropriate to each role, including questions to screen for reflective capacity .
3. At least two reference checks and a criminal background check prior to hire.
4. PMs are responsible for ensuring updates that reflect the most recent HFA BPS.

TIP: Sites are encouraged to consider staff characteristics at the time of hire if they will be serving families referred by CFWB. A minimum of a bachelor's degree in human services or a related field is strongly recommended for these staff.

TIP: It is extremely beneficial to hire staff with at least one year of experience working with infants and young toddlers.

TIP: All new staff need to be fully aware of local community resources, their eligibility requirements and the referral process. This is a major benchmark for evidenced-based programming.

TIP: To reduce turnover, ensure staff are clear on the role during the hiring process. Some examples:

- Much of the work is done sitting on the floors of homes with parents and their child(ren)
- Staff may also spend a lot of time in transit from one location to another
- There is a significant amount of paperwork that needs to be completed in a timely way
- Staff work alone when they visit families
- Staff are not hired to "fix" families, instead, they are expected to support and encourage parents

TIP: Consider inviting potential candidates to shadow a home visit or watch a video-taped visit to be clear on the job expectations.

12.Training (HFA 10-11)

Staff Role Specific Training Plan

Policy

All staff members, including interns and volunteers who provide direct service, must complete intensive role-specific training to understand the key components of the HFA model. Role-specific training is completed within the first 12 months of hire, with exceptions for PMs outlined below.

Note: For any staff re-hired or hired from an HFA site outside of the San Diego HFA MSS, the expectation is for all hires to receive orientation again, regardless of time since previous employment. Staff re-hired after a three-year or longer absence are required to complete all new hire training if the staff member has not worked with an HFA program for three or more years,

including HFA Core training.

To meet training requirements, all pertinent staff will complete the HFA Community Learning Management System (LMS) and AAP-CA3 HFSDC LMS modules. Supervisors are responsible for monitoring staff participation, supporting the completion of practical application activities in the outlined timeframes, and documenting training completion dates in the Training Tracker.

Trainees attending an HFA or AAP-CA3 hosted training should commit to being fully available for live sessions and activities for their training.

- **Attendance is mandatory for all sessions**, including virtual, in-person, or hybrid sessions. **Staff must attend every session in full to receive a certificate.** This includes trainings with a morning and afternoon session, which constitute one full training day.
- **Any absence from a session will require the staff member to retake the full training later.**
- Cancelations must be sent by email to AAP-CA3. Be mindful that training fees are only reimbursed if training is canceled no later than two weeks in advance.
- In case of emergency, contact AAP-CA3 immediately to discuss opportunities to continue training. AAP-CA3 will work with the staff member and their supervisor on a case-by-case basis to determine if flexibility is available.

TIP: See the HFSDC LMS Course Catalog for more information on the courses offered.
TIP: See the First Steps New Hire Training Guide for tools and additional information to support the new hire onboarding process.
TIP: If new staff are hired without a direct supervisor in place, organizations will work with current staff to ensure HFA training is completed, as outlined below. This includes the additional resources necessary and plans to reduce the burden to one staff.
TIP: When a new PM is hired, organizational leadership, or the PM's direct supervisor, oversees the PM's training plan. This may include partnering with current supervisors while ensuring they have sufficient time to address their typical responsibilities.

Procedure

Each site is responsible for keeping track of their role-specific staff training using the Training Tracker. PMs have a unique training plan. To see the list of trainings specific to PMs, click here. The following training is **required** for staff unless otherwise noted:

DIRECT SERVICE STAFF & SUPERVISORS		
Timeframe:	**Training:**	**Where to Access:**
Within 4 weeks of hire (Prior to serving families or providing supervision)	Orientation (HFA 10-2.B-G)	Site Specific
	HFA Quick Start* (10-2.A)	HFA LMS
	Orientation: Coming Together as a Family Support System to Prevent Child Abuse and Neglect (HFA 10-2.H)	HFSDC LMS
	AAP-CA3 Foundations Stop Gap Series (HFA 10-3.A)	HFSDC LMS
	Supervisors only: HFA Core Supervisors Stop-Gap (HFA 10-3.A)	HFA LMS
Within 3	AAP-CA3 Stop-Gap BABY TALK Curriculum (First Steps sites)	HFSDC LMS

months of hire	AAP-CA3 Stop-Gap Mothers and Babies (First Steps sites)	HFSDC LMS
	AAP-CA3 PATH Reproductive Health and Intention Framework (for First Steps sites)	HFSDC LMS
Within 6 months of hire	HFA Core Foundations Training (HFA 10-4.B - Essential)	HFA LMS
	HFA FROG Scale Training** (HFA 10-4.A - Essential)	HFA LMS
	Baby TALK Core Curriculum (or PHN approved curriculum; HFA 6-5.C)	HFSDC LMS
	Mothers and Babies Core Curriculum (HFA 6-5.C; First Steps sites)	HFSDC LMS
	Supervisor only: HFA Core FROG Supervisory Training (HFA 10-4.C - Essential)	First Steps Zoom
	Supervisor only: HFA Supervisors Relationships & Reflection Supervisory Training (HFA 10-4.C - Essential)	HFA LMS
Prior to first use	ASQ-3 (HFA 10-6.B) and ASQ:SE-2 (HFA 10-6.C) Developmental Screens	HFSDC LMS
	CCI (HFA 10-6.A)	HFA LMS
	PHQ-9 Depression Screen (HFA 10-6.D)	HFSDC LMS
	Healthy Families Parenting Inventory (Modified HFPI; First Steps sites)	HFSDC LMS
	University of Idaho Survey of Parenting Practice (Modified UISPP; First Steps sites)	HFSDC LMS
	Parent Satisfaction Survey (PSS)	HFSDC LMS
	NBQ	HFSDC LMS
	Persimmony (required for all system users)	CMEDS Help Section (or Persimmony training resource)
* Only required for staff hired after 1/1/2022 **Both Foundations Core (or Foundations Stop-Gap) and FROG Core training need to be completed prior to staff beginning to administer or Supervise the FROG.		

PROGRAM MANAGERS		
Timeframe:	**Training:**	**Where to Access:**
Within 3 months of hire	Orientation (HFA 10-2.B-G)	Region Specific
	HFA Quick Start (10-2.A)	HFA LMS
	Orientation: Coming Together as a Family Support System to Prevent Child Abuse and Neglect (HFA 10-2.H),	HFSDC LMS
	AAP-CA3 Stop-Gap Foundations Series (HFA 10-3.A)**	HFSDC LMS
	HFA Core Supervisors Stop-Gap training (HFA 10-3.A)	HFA LMS
Within 6 months of hire	HFA Core Training Foundations (HFA 10-4.B - Essential)	HFA LMS
	HFA Supervisors Core: Relationships & Reflection Supervisory Training (HFA 10-4.C - Essential)	HFA LMS

Within 12 months of hire	Baby TALK Core Curriculum (or PHN approved curriculum; HFA 6-5.C) **-** Modified agenda	HFSDC LMS
	Mothers and Babies Core Curriculum (HFA 6-5.C; First Steps sites)	HFSDC LMS
Within 18 months of hire	HFA Implementation Training (HFA 10-5)	HFA LMS

PROGRAM MANAGERS		
Timeframe:	**Training:**	**Where to Access:**
Within 18 months of hire or before directly supervising staff	HFA Core FROG Scale Training (HFA 10-4.A - Essential)*	HFA LMS
	HFA Core FROG Supervisory Training (HFA 10-4.C - Essential)	First Steps Zoom
	ASQ-3 (HFA 10-6.B) and ASQ:SE-2; (HFA 10-6.C) Developmental Screens	HFSDC LMS
	CHEERS Check-In (CCI; HFA 10-6.A)	HFA LMS
	PHQ-9 Depression screen (HFA 10-6.D)	HFSDC LMS
Recommended; Required if supervising staff	HFPI Modified (First Steps sites)	HFSDC LMS
	UISPP Modified (First Steps sites)	
	PSS	
	New Baby Questionnaire (NBQ)	
	CMEDS or Persimmony data system training	CMEDS Help Section or PHN training resource
**Program Managers are not required to complete Foundations Stop Gap if they enroll in core training prior to 6 months.		

TIP: Site Specific Orientation is an onboarding training provided by site supervisors that addresses HFA BPS 10-2.B-10-2.D requirements.
TIP: HFA Community offers brief training to address optional HFA BPS 10-2.B-10-2.D in addition to Site Specific Orientation.
TIP: Recommended for Program Managers to receive FROG Core training earlier than 18 months in case supervision is needed.

Stop-Gap Training (HFA 10-3.A)

Policy

All direct service staff and supervisors must complete the HFSDC LMS self-paced stop-gap series to begin working with families or supervising staff who work with families. Staff will be enrolled in the series once they have been in their role for two weeks and prior to working with families or providing supervision. Staff will have a minimum of one week per course in the series to complete these trainings with extensions available on a case-by-case basis.

Stop-gap training is defined as customized role-specific training conducted to meet an individual's urgent need for skills necessary to perform work prior to receiving HFA Foundations Core training. PHNs, supervisors and PMs are still required to attend the full HFA Core training as soon as they are able to enroll and no later than 6 months after hire.

Supervisors receive supervisor stop-gap training, including all required components, within four weeks of hire to the HFA Supervisor role unless they are able to complete HFA Core Training in that time frame.

Each stop-gap training is supplemented by a series of practical application activities that must be completed before staff can receive credit for the training. Practical application activities include shadowing an experienced staff person during assessment and visits, inter-rater reliability of CHEERS observations, reviewing family charts and completing training on forms,

form use and expectations for documentation. The HFSDC LMS training will prompt staff to complete these activities, but Supervisors are required to ensure staff have both opportunity and support. AAP-CA3 will review activities and provide feedback to both staff and supervisors as needed. For activities that require review to proceed in the modules, AAP-CA3 will provide feedback within **24-48 hours** of completion.

The Stop-Gap Training Series Includes:

- Multi-Site Orientation
- HFA Advantage
- Foundations for Family Support Stop-Gap
- Baby TALK Curriculum Stop-Gap
- Mothers & Babies Stop-Gap

The Practical Application Includes:

- Shadowing of other staff in a similar role
- Hands-on practice, including role-plays (with observation, reflection, and feedback)

The LMS Training Includes:

- Theoretical background (HFA Advantage)
- Strengths-based approach (HFA Advantage)
- Science behind Family Support Services (rationale)
- Overview of role-specific activities
- Introductory training on specific forms as related to Core training
  - Referral Form, NBQ, Family Service Plan (FSP), Home Visit Record (HVR), Family Goal Process (FGP) Form
  - Supervision & Professional Support (SPS), Family Progress Review (FPR)
- Use of the strength-based tools and reflective or Baby TALK strategies
- Prompts and instructions to complete practical application with supervisor support

Staff Wrap-Around Training Plan

Policy

All direct service staff and supervisors must participate in wrap-around training to ensure they have the skills necessary to fulfill their job functions and achieve improved family outcomes.

PMs are only required to complete wraparound training related to diversity, equity, inclusion and belonging. To see the list of trainings specific to Program Managers, click here.

Procedure

Each site is responsible for keeping track of their wrap-around staff training using the Training Tracker. The following training is **required** for staff:

DIRECT SERVICE STAFF & SUPERVISORS		
Timeframe:	**Training:**	**Where to Access:**
Within 3 months of hire (11-1.A-C)	Infant Care (HFA 11-1.A),	HFA LMS
	Child Health and Safety (HFA 11-1.B)	HFA LMS Interim: Wraparound Training for First Steps Staff
	Family Health (HFA 11-1.C)	
	Cultural Self-Awareness (HFA 11-1.D & CalWORKs Bias Self-Assessment)	

Within 6 months of hire (HFA 11-2.A-F)	Infant and Child Development (HFA 11-2.A)	HFA LMS Interim: Wraparound Training For First Steps Staff
	Supporting the Parent-Child Relationship (HFA 11-2.B)	
	Professional Practice (HFA 11-2.C),	
	Mental Health (HFA 11-2.D)	
	Prenatal (HFA 11-2.E),	HFA LMS
	Family Goal Process (HFA 11-2.F)	HFA LMS
	Cultural Humility in Home Visiting (HFA 11-2.G; CalWORKs Inter-Cultural Competence)	Interim: Wraparound Training For First Steps Staff
Within 12 months of hire (HFA 11-3.A-F)	Child Abuse and Neglect (HFA 11-3.A)	HFA LMS Interim: Wraparound Training For First Steps Staff
	Intimate Partner Violence (HFA 11-3.B)	
	Substance Use (HFA 11-3.C)	
	Engaging Families (HFA 11-3.D)	
	Inequity and Family Context (HFA 11-3.E; CalWORKs Disproportionality)	HFA LMS
Within 18 months of hire	Motivational Interviewing	UCLA Tour of Motivational Interviewing or approved External Provider

PROGRAM MANAGERS		
Timeframe:	**Training:**	**Where to Access:**
Within 3 months of hire	Cultural Self-Awareness (HFA 11-1.D & CalWORKs Bias Self-Assessment), including: • Seeking clarity on personal identity, values, and beliefs	HFA LMS
Within 6 months of hire	Cultural Humility in Home Visiting (HFA 11-2.G; CalWORKs Inter-Cultural Competence)	HFA LMS Interim: Wraparound Training For First Steps Staff
Within 12 months of hire	Inequity and Family Context (HFA 11- 3. E; CalWORKs Disproportionality)	

Annual Training Plan

Policy

All direct service staff, supervisors and PMs hired longer than 12 months must receive annual training that considers the individual's knowledge and skill base and supports ongoing professional development. All pertinent staff must complete three annual trainings: 1) child abuse and neglect, 2) diversity, equity, inclusion and belonging and 3) relevant professional development. All staff do not have to attend the same training.

Annual trainings are not available in the HFA LMS. AAP-CA3 may host trainings that meet these requirements, or sites can identify alternative sources to meet these requirements.

Procedure

Each site is responsible for keeping track of its annual training using the Training Tracker worksheet. The following training is **required** for all staff including PMs:

ALL STAFF ANNUAL TRAINING		
Timeframe	**Training**	**Where to Access**
No later than the second year of hire and every year after that	**Annual Professional Development (HFA 11-4.A):** • Based on the staff and supervisor's identified individual training needs that would be most beneficial to enhance job performance. Takes into account the individual's knowledge and skill base and professional development. • This may include topics related to shifts at the site, for example, serving a community or demographic.	PHC Specific
	Annual Child Abuse and Neglect (HFA 11-4.B): • Intended to stay updated on current child welfare policies, practices, and trends in their community.	
	Annual Diversity, Equity, and Inclusion (DEI) (HFA 11-4.C): • Designed to increase awareness and understanding of concepts associated with diversity, equity, inclusion, and belonging and how families, communities, home visiting services, and staff are impacted.	

13. Supervision

Ensuring Adequate Staffing for Effective Supervision (HFA 12-1.D)

Policy

Sites are responsible for having a PM and a sufficient number of supervisors at the appropriate FTE to ensure adequate support for all staff. Each site will have at least one supervisor for every 6 PHNs or a supervisor with at least 0.17 FTE for each PHN that individual supervises. If a site has staff whose caseloads are comprised mainly of families scoring with especially elevated risk on the FROG Scale, HFA recommends maintaining a 1:5 supervisor to direct service staff ratio.

The PM role is distinct from that of a supervisor. While the same person can assume both roles, the FTE status of each role is protected to ensure sustainable program leadership and adequate support to staff being supervised. If one person has dual roles, the site will specify what FTE that individual will have for each role. HFA recommends a minimum PM FTE of 0.17 for very small sites (2.0 FTE direct service staff or less), which increases as site size increases. Sites will have a minimum of 0.17 FTE for every 2 PHNs at that site. Sites with 12 or more PHNs will have a 1.0 FTE PM.

TIP: When there are job vacancies and other staff are asked to step in and assume those responsibilities, ensure they receive adequate support.

Supervision Frequency and Duration (HFA 12-1.A)

Policy

Supervisors are responsible for providing all direct service staff (including volunteers and interns performing the same role) with weekly professional support and supervision. Supervisors will supervise no more than six full-time direct service staff.

Procedure

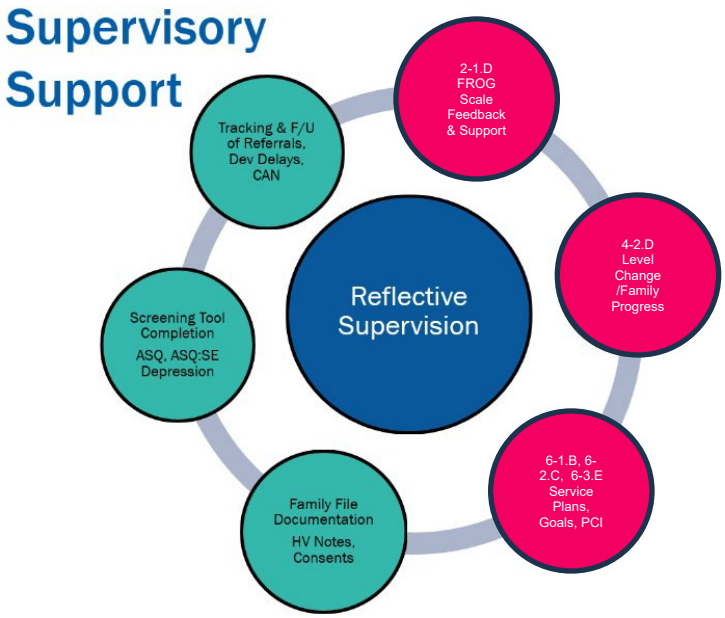
1. All direct service staff who are at 0.75-1.0 FTE must receive a minimum of 1.5 hours per week of regularly scheduled individual supervision, and part-time staff at less than 0.75 FTE should receive a prorated amount of supervision as follows:
    - 0.25-0.75 FTE: 1 hour/week of supervision
    - Less than 0.25 FTE: Supervision is provided according to the occurrence of services. For example:
        - Supervisor/Senior PHN and PHN/SSA discuss all FROGs that occur in a given week; however, this may not take the full hour of discussion.
        - Supervisory discussions may vary in length according to the level of service the families are on.
2. Supervision sessions can be divided into no more than two sessions per week. For example, holding two one-hour sessions instead of one 2-hour session.
3. Full-time staff serving in more than one role (e.g., 30% supervisor time and 70% PHN time) will receive a minimum of 1.5 hours of supervision per week to meet the supervision requirements of both roles and functions. Documentation will clearly indicate both roles are being addressed in supervision.
4. Full-time staff who administer the FROG should receive supervision related to the FROG assessment, with supervision documentation clearly indicating how they are supported.
5. Reflective supervision groups can count as one session per month if conducted by a supervisor or other qualified individual who has been trained in providing reflective supervision.
    - This only applies for PHNs that have been in their role for at least 12 months and who have demonstrated proficiency in their role (as determined by the program and based on supervisor judgment).
6. Direct service staff new to their role or without full caseloads are still expected to receive the required weekly supervision.

TIP: If providing supervision remotely by phone or video call, HFA recommends the site have at least one supervision session per month as an in-person meeting, if possible.

Reflective Supervision (HFA 12-2A)

Policy

Reflective supervision is at the core of supervisor support in HFA and is integrated with administrative and clinical aspects of the role. Supervisory sessions use reflective conversation to address tasks outlined by the model:



Administrative tasks:

- Tracking and follow-up of referrals
- Screening tool completion
- Family file documentation

Other tasks:

- FROG Scale feedback and support
- Level change/family progress
- Service Plans, CHEERS and family goal process

Supervision sessions must include reflective supervision pertaining to the PHN/SSA and relationships with individuals across the integrated parallel process.

Supervisors partner with staff in both a mentoring and monitoring role. As a monitor, supervisors ensure the completion of activities that meet the HFA BPS and other site requirements and provide strengths-based feedback to nurture the staff's professional development. As the mentor, supervisors support the integration of training into the work, add to the knowledge of direct service staff, discuss how to work with families and generally enhance their abilities.

Procedure

1. Supervisors are encouraged to have reflective conversations for each family:

Family Level	Minimum Discussion Frequency
Levels: 1P/2P, 1/1b, SS	Monthly
Level 2	Every Other Month
Level 3	Quarterly

2. Reflective supervision is also used to discuss efforts to promote family voices, challenges and successes. Supervision sessions provide an opportunity to strengthen staff skills in this area.

TIP: Supervisors are not expected to facilitate full reflective practice during weekly supervision. Reflective supervision allows for the development of reflective capacity, while also ensuring sufficient time for all families and program requirements.

TIP: HFA outlines key reflective facilitation skills as:

- Creating Safety, Comfort, Predictability & Joy/Pleasure

- Holding space for feelings
- Getting curious instead of giving advice
- Using Reflective Strategies in supervision
  - ATP – SATP – FNT – E&W – PT – Norm - MSR
- Noticing and reflecting on power dynamics across the parallel process

Documentation of Supervision

Policy

Supervisors will track and keep brief documentation demonstrating the supervision provided to the PHN during the session. The FSP, FPR and Supervision and Professional Support (SPS) forms are used for documenting supervisor conversations. The Supervision Frequency and Duration (12-1.B) Worksheet is used for tracking receipt and duration of weekly supervision for all direct service staff. The HVCC worksheet supports monitoring family engagement by service level and tracks case weights for each PHN to ensure they do not exceed 30 points. The procedure below outlines which discussions/information to document on each form.

All supervision forms will be maintained in specifically designated OneDrive folders for each PHN, SSA, and family served.

Supervision documentation in the FPR, SPS and "Plan Implemented" column of the FSP can follow the three-part framework: Action/Intervention Word + Theme/Topic Discussed + Intended Outcome to support keeping notes brief and capturing reflective supervision.

Procedure

Action	Form	Responsible	Frequency	Approach
1. Document risk and protective factors from the FROG and over the course of services to develop an individualized FSP and monitor progress over the course of services (includes clinical supervision).	FSP	PHN & Supervisor "Plan Implemented" - Supervisor Only	**Develop:** Within 2 weeks of intake visit **Update:** • Monthly for Level 1/1P/1b/SS • Every other month for Level 2, • Quarterly for Level 3.	Supervision Recipe: Three-Part Framework
2. Document reflective discussions focused on monitoring staff to address a specific family's engagement in activities that meet the HFA BPS. Include support for CHEERS observations, the family goal process, screening implementation, level changes and other requirements not outlined in the FSP.	FPR	Supervisor	• Monthly for Level 1/1P/1b/SS • Every other month for Level 2, • Quarterly for Level 3.	Supervision Recipe: Three-Part Framework
3. Document discussions focused on how the supervisor enhances the PHN skills in family support services and overall professional development.	SPS	Supervisor	Monthly	Supervision Recipe: Three-Part Framework

Action	Form	Responsible	Frequency	Approach
4. Document shadow observations and debrief regarding the staff member's ability to conduct a FROG or provide a visit session. The shadow is counted as weekly supervision.	Home Visit Shadow Form, FROG Shadow Form	Supervisor/ Senior PHN	Minimum of annually for each form (2 total shadows per PHN per year)	Debrief Section - Supervision Recipe: Three-Part Framework
5. Document the frequency and duration of supervision in the Supervision Frequency and Duration (12-1.B) Worksheet according to the instructions on the worksheet.	Supervision Frequency and Duration (12-1.B) Worksheet	Supervisor or other staff	Document - Monthly Monitor - Quarterly	Excel Worksheet
6. Document the number of completed visits per family based on the assigned service level (4-2.B) in the Home Visit Completion Worksheet according to the instructions on the worksheet.	Home Visit Completion (4-2.B) Worksheet	Supervisor & PHN	Document - Monthly Monitor - Quarterly	Excel Worksheet
7. Document and monitor the case weight (8-1.B) for each PHN according to the instructions on the Caseload Worksheet.	Caseload Calculator (8-1.B)	Supervisor or other staff	Document – Monthly and every time a staff member receives a new family or a family change levels Monitor - Quarterly	Excel Worksheet

Reflective Group Supervision (12-1.C)

Policy

Sites may elect to offer staff reflective consultation groups. These are not required, but staff often benefit from regular group reflective sessions with their colleagues. A reflective consultation group facilitator must have the following qualifications:

- Infant Mental Health Endorsement at Level III or Level IV or for California Infant Family and Early Childhood Mental Health Endorsees - Reflective Practice Facilitators I, Reflective Practice Facilitators II & Reflective Practice Mentors; a Master's or doctorate in counseling or another degree specific to one's professional focus in infant mental health; university certificate program and/or coursework in areas such as infant/very young child development, family-centered practice, cultural sensitivity family, family relationships and dynamics, assessment, and intervention.
- Two years of post-graduate work experience providing culturally sensitive, relationship-focused infant mental health services with infants and toddlers and their families
- Has been a recipient of reflective supervision
- Training or experience facilitating groups and managing group dynamics

Procedure

1. Sites can determine the frequency of reflective supervision groups.
2. Reflective consultation group sessions will last at least two hours.
3. After 12 months of weekly supervision and proficiency in the staff role, one reflective group per month can be used to meet individual weekly supervision. The staff must still receive 1.5-2 hours of individual supervision for the other weeks of the month.
4. Staff that have not yet received 12 months of weekly individual supervision may attend the reflective consultation group. However, attendance cannot be counted towards

weekly supervision.

5. Sites may subcontract with qualified individuals to provide reflective consultation groups. When subcontracted, supervisors attend the reflective group to support staff with recommended action steps pertaining to the family discussed during the group.
6. For sites with multiple supervisors, at least one supervisor should be present in each group. If a particular FFS's supervisor is not present for the session, there should be a short debrief note from one supervisor to another specific to the staff person and family presented/discussed during the group. Alternatively, the qualified individual leading the reflective group session can provide this level of detail in their documentation. This is to ensure continuity related to the next steps from the conversation and ongoing support for that staff person.
7. The reflective facilitator completes documentation for each session provided that includes the individuals in attendance and content areas discussed.

Supervision for Supervisors (HFA 12-3.A)

Policy

Supervisors will receive a minimum of once monthly regularly scheduled supervision with their own direct supervisors (in most cases, PMs). Supervisors will also receive skill development and professional support from their respective agencies and AAP-CA3. The goal of supervision for supervisors is to hold them accountable for their work and support professional growth and skill development opportunities.

Supervisors will also receive reflective supervision at a minimum of every other month, individually or as part of a group for supervisors. Reflective supervision aims to facilitate each supervisor's ability to integrate a reflective lens into their work with direct staff and, ultimately, the work with families. The individual providing supervision to the supervisor must have received all HFA required training as outlined in the Training section or the Reflective Group Supervision section.

Procedure

1. Agencies will hold supervisors accountable for the quality of their work through:
    - Review of supervisor documentation
    - Annual performance reviews (to be done by their respective agencies)
    - Regularly scheduled meetings to discuss progress, address challenges, explore and promote skill development
    - Addressing personnel issues
    - Feedback/reflection to supervisors regarding team development and agency issues
    - Review of site documentation, including monthly or quarterly reports and site statistics (screening and initial engagement, home visit rates, content of visits, quality assurance mechanisms, etc.)
    - Review of progress towards meeting site goals and objectives,
    - Strategies to promote professional development/growth, and
    - Quality oversight that includes shadowing of the supervisor (see below)

2. AAP-CA3 will provide oversight through:
    - Reflective conversations and feedback to supervisors regarding team development and agency issues
    - Facilitation of monthly group meetings with supervisors (Supervisors Workgroup)
    - Facilitation of peer collaboration between supervisors
    - Site-specific technical assistance (TA) based on annual QA site visits, including supervision documentation
    - Strategies to promote professional development and growth, including providing or referring to trainings for skill development

Supervision for Program Managers (HFA 12-4.A)

Policy

PMs will receive a minimum of monthly regularly scheduled supervision with their own direct supervisor. PMs will also receive skill development and professional support from their respective agencies and AAP-CA3. The goal of supervision for PMs is to support their professional growth and skill development opportunities and hold them accountable for their work. When PMs also serve as supervisors, the site will determine the respective FTEs performed for each role to ensure adequate support for the individual with the dual role.

When possible, sites are encouraged to provide monthly reflective supervision to PMs.

Procedure

1. Agencies will hold PMs accountable for the quality of their work through:
    - Review of supervisor documentation
    - Annual performance reviews (to be done by their respective agencies)
    - Regularly scheduled meetings to discuss progress, address challenges, explore and promote skill development
    - Optional monthly reflective supervision to reflect on the work and the complex challenges they may experience in their role.
2. AAP-CA3 will provide oversight through:
    - Reflective conversations and feedback to PMs regarding team development and agency issues
    - Facilitation of monthly meetings with PMs (Leadership Workgroup)
    - Facilitation of peer collaboration between PMs sites in the San Diego HFA MSS
    - Tableau dashboards that monitor the site's quality assurance benchmarks (initial engagement, home visit completion, screenings, referrals, etc.)
    - Annual site visit reviews and reports to assess the site's adherence to the HFA BPS
    - Site-specific TA based on annual QA site visits, including supervision documentation
    - Review of progress towards meeting site goals and objectives
    - Strategies to promote professional development and growth, including providing or referring to trainings for skill development

TIP: Participating in reflective supervision as a PM ensures the development of a culture of reflection as an HFA site.

14. Quality Assurance Activities and Forms

The San Diego HFA MSS is dedicated to continuous quality improvement so that families receive the best service possible. To achieve this goal, sites strive to create inclusive and supportive environments for staff and families through QA activities. Through these activities, staff receive the necessary professional support and growth opportunities to continue delivering high-quality services to families.

Family Charts & Forms

Policy

Sites use standardized forms to meet the data and documentation requirements of HFA. Required forms are listed in the Appendix of this document. Sites may also have additional agency- and funder-specific forms to include in their families' charts.

Required forms, with the exception of Level Change forms, may be edited to include additional information the site must collect. In these instances, an updated version will be submitted to AAP-CA3 for approval.

Family charts should be organized in a consistent way for all families. The structure outlined in the Family Review form may be used as a guide (former "Client File Checklist").

Procedure

1. AAP-CA3 will share all required forms (i.e., family, supervision, PM and QA forms) with sites by July for each fiscal year.
2. Sites are responsible for updating forms with their site-specific details (e.g., logo) and distributing them to all relevant staff.
3. Sites will ensure staff are using the most recent version of required forms.
4. Family files will be maintained in a consistent manner inclusive of all required family forms.

Shadowing of FROG and Visits (12-2.A)

Policy

In alignment with the Site-specific QA Plan, supervisors will support the continued skill development of each SSA/PHN by shadowing two FROGs and two home visits each year. Shadows provide staff with an opportunity for professional development and ensure all families are receiving the same high-quality service. Shadowing will consist of a supervisor being physically present with the SSA/PHN during the FROG or visit. Following all shadows, supervisors and SSA/PHNs will schedule time to debrief. The shadow and debrief can take the place of supervision for the week.

In cases where supervisors do not speak a family's primary language, supervisors and SSA/PHNs are still required to complete shadows to support staff learning and development. The method of shadowing in another language may differ from a typical shadow and can include, but is not limited to, the following:

- Inviting a translator to the visit

- Attending the visit, observing non-verbal or body language and then discussing details in supervision

Please contact AAP-CA3 to discuss challenges and possible solutions with shadowing.

Procedure

1. Supervisor/Senior PHN will shadow FROGs or visits based on staff's time in the program:

Staff	Shadows Required	When
New Staff	2 FROGs (SSA**) or** 2 Visits (PHN)	Within 6 months of hire
Veteran Staff	2 FROG (SSA) **or** 2 Visits (PHN)	Annually

2. Supervisors/Senior PHNs and PHN/SSAs will schedule the FROG or visit shadow and let the family know their supervisor is attending and the purpose of shadowing before the visit.
3. Supervisors/Senior PHNs will use the FROG Shadow Form and the Home Visit Shadow Form to document observations and support reflective debrief conversations related to the FROG or visit shadowed.
4. Supervisors/Senior PHNs and PHN/SSAs will then schedule time to debrief after the shadow to discuss areas of strength and opportunities for growth.

Policy

Supervisors will also participate in regular Parent Experience QA Surveys to elicit feedback on parents' experiences during the initial engagement period and over the course of services. The QA survey s are important for informing continuous quality improvement (CQI) efforts in program implementation.

Parent Experience QA Survey

In cases where supervisors do not speak a family's primary language, the site is still required to complete Parent Experience QA Surveys as it supports the site's efforts in CQI and staff professional development. In these cases, if appropriate, sites may ask a staff member who speaks the family's language to conduct the QA surveys. Please contact AAP-CA3 to discuss challenges and possible solutions with Parent Experience QA Surveys.

Procedure

1. Supervisors will conduct a minimum of two QA surveys annually per PHN or more if concerns warrant additional surveys for initial engagement and visits.
2. Supervisors will use the Parent Experience Survey – Initial Engagement & Home Visiting Forms to gather parent feedback and support reflective debrief conversations related to the parent's experience.
3. Supervisors and PHNs will then schedule a time to debrief after the survey to discuss areas of strength and opportunities for growth.

Shadowing of Supervision Sessions

Policy

In alignment with the Site-specific QA Plan, PMs will support the continued skill development of each supervisor through supervision shadowing.

Shadowing can consist of a PM being physically present with the supervisor during a supervision session.

Procedure

1. PMs will shadow one supervision session a minimum of once annually, per supervisor.
2. PMs and supervisors will work together to identify supervision sessions to shadow.
    a. To ensure that every staff member has the opportunity for professional development, PMs and supervisors will monitor the selection of PHN supervision shadows so that the same PHN is not selected consecutively each year.
3. PMs will use the "FROG Supervision Shadow Form" and "Home Visit Supervision Shadow Form" to document observations and support reflective debrief conversations related to the respective shadow experience.
4. PMs and supervisors will then schedule time to debrief after the shadow to discuss areas of strength and opportunities for growth.
    a. If additional shadows would be helpful for staff professional development, PMs may shadow more supervision sessions.

15. *A Work in Progress:* Advancing Accessibility and Service Quality Through Diversity, Equity, Inclusion, and Belonging (HFA Standard 5)

The San Diego HFA MSS recognizes that promoting and embracing Diversity, Equity, Inclusion and Belonging (DEIB) is an ongoing and complex process that needs active participation of staff and families. The policies and procedures below are designed to provide a foundation for DEIB efforts that will be refined through network discussions.

In alignment with HFA, the San Diego HFA MSS will use the lens of the Diversity Informed Tenets for Work with Infants, Children and their Families to guide efforts to strengthen awareness of inequities and implicit biases and how they impact staff, families and communities served.

Strengthening Staff Relational Skills and Self-Reflection to Foster Respectful and Responsive Team Environments and Family Services (HFA 5-1.A)

Policy

The San Diego HFA MSS aims to foster a sense of community within teams, ensuring that all staff members feel secure, valuable and included by prioritizing self-awareness and recognizing and acknowledging individual perspectives and biases.

The intent is to strengthen relational skills by encouraging diversity, equity and inclusion through honest conversations and reflective work. By being vulnerable, brave and open, we can identify areas of personal development and create space for growth that positively impacts oneself and reflects upon the team and families.

Procedure

1. The San Diego HFA MSS will develop a timeline to discuss topics to promote DEIB in the workplace.
2. Supervisors will support staff during reflective supervision to discuss strategies for enhancing self-awareness, self-regulation, self-reflection, skilled listening and empathy.
    a. Supervisors will support staff in their personal development by fostering an environment for honest, respectful and brave conversations.
    b. Site leadership can use The Haywood Burns Institute Equity Assessment Resources prepared for HFA as a foundation for exploration and discussion.
3. Sites will create team commitments and ground rules together to demonstrate staffs' commitment to respectful interactions.

Partnering with Families and Honoring Their Voices to Improve Services (HFA 5-2.A)

Policy

The San Diego HFA MSS acknowledges that parents are the experts when it comes to their family and children. Incorporating family feedback is a powerful way for sites to understand their strengths and identify areas for improvement. By valuing and prioritizing family voices, sites can provide inclusive and equitable services tailored to honor families' identity, culture and experience. Ultimately, this approach fosters trust and strengthens the relationship between families and staff.

The San Diego HFA MSS recognizes that there are cultural differences, and historical or current events related to DEIB that impact family and staff experiences, interactions and relationships. Sites cultivate open and non-judgmental relationships with the families by focusing on family strengths and priorities and avoiding assumptions. If necessary, staff provide a safe space for repair in relationships when needed.

Procedure

1. The San Diego HFA MSS will develop a timeline to:
    a. Identify methods for elevating family voices (i.e., Family Satisfaction Surveys) including discussing barriers to gathering feedback and potential solutions.
    b. Discuss strategies to continue promoting family voices and applying what is learned to the work and services.
    c. Discuss best practices to documenting efforts to promote and listen to family voices.

Using Quality Assurance Data to Promote Access & Quality of Services

Policy

The San Diego HFA MSS is dedicated to CQI to ensure families receive the highest quality services possible. Sites use Tableau dashboards and HFA worksheets as well as informal data collected through team meetings, advisory boards and family feedback (5-1.A, 5-2.A, 5-3.A, and 5-4.A) to discuss and analyze trends (e.g., access to services, retention) and identify opportunities for improvement.

Procedure

1. Staff enter family data in Persimmony.

2. Supervisors/QASs complete and update HFA worksheets a minimum of quarterly:
    a. HVCC (Supervisors)
    b. Supervision Tracker (Supervisors)
    c. Training Trackers (QASs)

1. PMs and Evaluators follow the HFA & Tableau QA Data Calendar to monitor the quality of data for analysis.
2. AAP-CA3 develops Tableau Dashboards and Worksheets:
    a. Acceptance & Retention
    b. Developmental Screens (ASQ3 & ASQ:SE-2)
    c. PHQ9 & CCI
    d. Medical Home, Immunizations and Well-Child Visits
    e. Referrals and Site Capacity
3. PMs and Evaluators complete the Data QA process in partnership with AAP-CA3.
4. PMs use the completed dashboards and worksheets to identify trends and patterns that inform best practices, areas for improvement and inequities.
5. PMs facilitate dialogues with supervisors and staff to elicit informal data on the observed trends.
6. PMs work with supervisors and ONE team to develop and implement plans and strategies for improvement based on the data and identify and reduce gaps in access to services.

TIP: Tableau Dashboards support identifying obstacles to initial engagement and challenges with retention to inform new strategies.

Continuous Quality Improvement Efforts for Respectful and Responsive Services (HFA 5-4.A)

Policy

HFA Standards 5-1, 5-2 and 5-3 guide each site in collecting important information and perspectives from staff, families and the community. These standards inform the creation of an equity plan that supports efforts in providing respectful and responsive services.

The equity plan identifies strengths and areas for improvement based on analysis of feedback received at the site. Feedback and findings will be used to create strategies to help the site improve DEIB in service delivery.

Procedure

1. Sites will collect feedback from staff and families (e.g., Staff Satisfaction Survey, Family Satisfaction Survey (FSS), Community Advisory Boards, Family Advisory Boards, etc.) and will:
    a. Analyze trends and discuss strengths and challenges within their site.
    b. Discuss solution opportunities and plan to grow in areas identified as a challenge.
    c. Document discussions and efforts in the interim until the Equity Plan template is provided by AAP-CA3.
2. The San Diego HFA MSS will tailor the HFA Equity Plan template and discuss timelines to begin updating the Equity Plan and best practices to document CQI efforts.

16. Governance and Administration

Community Advocacy and Site Partnerships

Equitable Opportunities (HFA 5-3.A)

Policy

Sites work within their communities to address the needs of both major and underrepresented ethnic, racial and cultural groups. This includes ensuring that services are accessible and truly reflective of the communities served.

The San Diego HFA MSS recognizes that racial and ethnic minorities and other marginalized groups face additional challenges in accessing vital resources and services due to systemic inequities. Sites work to remove those barriers and ensure families have access to the services and resources they need. To support this goal, all sites have a Community Advisory Board (see GA-1.A), create marketing and outreach materials that celebrate diversity and review data on family acceptance and retention data annually to address gaps in service. These steps help sites improve community engagement and participation, foster a sense of trust and ultimately enhance equity and accessibility of services.

Procedure

1. AAP-CA3 will work with site leadership (i.e., workgroups) to:
    a. Update marketing and outreach materials, making them more inclusive of the communities served and identifying necessary languages for translation.
    b. Discuss best practices to document efforts in collaborating with the community.
    c. Discuss strategies to include family experiences and community feedback to improve program equity in efforts and elevate family voices (5-2.A).

TIP: Consider how marketing materials impact initial engagement with families and bring feedback to meetings with AAP-CA3.

Community Advisory Board (GA-1.A)

Policy

Each site within the MSS will have a community advisory board (CAB) to serve in an advisory or governing capacity and provide guidance on planning, implementation and continuous quality improvement of site services and activities. The CAB will meet a minimum of quarterly.

Procedure

1. Site PMs or other site representatives will recruit and maintain an active CAB with a wide range of skills, strengths, community knowledge, professions and cultural diversity to serve the interests of the local community and advocate on behalf of the needs of site participants.
2. Sites will have a process for identifying gaps in membership and recruit additional CAB members as needed to effectively advocate for participant and site needs within the community.

3. The CAB will meet a minimum of quarterly to discuss site information provided by the PM and support planning, implementation and continuous quality improvement of site activities and services.
4. The site will maintain minutes to document conversations with the CAB.

Countywide Workgroup Participation

Policy

All PMs and Supervisors are expected to attend the San Diego HFA MSS countywide working groups. This includes the twice monthly Leadership (PMs) meeting and the Supervisors monthly workgroup. These workgroups promote systemwide alignment in practice and provide a shared space for peers and Central Administration to discuss issues related to administration, policy, quality assurance, technical assistance and training. It is recognized that individuals may be unable to attend some meetings due to conflicts with other commitments or unforeseen circumstances. Sites or staff will be responsible for reviewing missed information or materials.

Procedure

1. AAP-CA3 will coordinate scheduling and host workgroups either virtually or in person.
2. PMs and Supervisors will maintain calendar holds for their respective meetings.
3. PMs and/or Supervisors will contact AAP-CA3 to suggestion agenda items or topics to address.
4. AAP-CA3 will send meeting reminders including agenda topics the week of the meeting.
5. AAP-CA3 will disseminate meeting minutes and other materials following the meeting.

HFA Data Reporting

HFA Data Collection

Policy

Sites will ensure all data requests from HFA are completed within outlined timeframes including ongoing staffing updates and data for annual reporting.

HFA requires sites to provide the following information:

- Site contact information: Site name, address, etc.
- Staff profiles: Basic characteristics for all current program staff
- Site Profile Report: Site characteristics and family, financial and program policy data

Procedure

1. Sites will maintain up-to-date “site information” in the HFA Community for communications with the HFA National Office and for sharing site information with families and other HFA sites.
2. Sites will maintain up-to-date staff profiles for each active staff member within the HFA community. HFA requires a minimum of 90% completion for each staff profile. Staff who have left the program should be removed from the HFA Community.
3. Each site will complete an annual Site Profile Report in the HFAST system within the timeframe provided by HFA.

Family Rights, Confidentiality, and Mandated Reporting

Reviewing and Recommending Approval or Denial of Research Proposals involving Families

Policy

The San Diego HFA MSS does not conduct research. All system data is property of the F5SD or CoSD, and any research proposals must first be approved by F5SD or CoSD. Connect with COR or County project lead for additional details.

Procedure

1. If an entity submits a research proposal request to any The San Diego HFA MSS site, that entity will be informed of the above policy and re-directed to F5SD or CoSD.
2. First Steps sites: F5SD will review the research request following its Guidelines for Authorizing Research Using Commission Resources (First 5 San Diego Policy Number: F5C-019).
    a. In the event that F5SD approves a research proposal, F5SD will notify AAP-CA3 and the two entities will jointly develop an implementation plan that includes steps to ensure participant privacy and voluntary choice.
3. AAP-CA3 will notify the HFA National Office of any intent to implement a research proposal no later than two weeks after being notified by F5SD or CoSD.

Family Rights & Confidentiality (HFA GA-3.A)

Policy

Before or during the intake visit, the family is informed about their rights, including confidentiality, both verbally and in writing. Parents are also informed of their rights and sign a consent form every time information is to be shared with a new external agency. Parents are assured that consent is voluntary and are never pressured to participate. Participant confidentiality and privacy will be protected throughout any research conducted. Voluntary consent without pressure to participate in research will be assured.

Procedure

1. During the intake visit, the SSA/Senior PHN will go over the Home Visiting Program Participant Consent, Notice of Privacy Practices, and the Acknowledgement of Notice of Privacy Practices.
2. Families will, at a minimum, be informed of the following rights both verbally and in writing:
    - The right to be treated fairly with courtesy and respect
    - The right to decline service (voluntary nature)
    - The right to be referred, as appropriate, to other service providers
    - The right to participate in the planning of services to be provided
    - The right to file a grievance/complaint and how to do so should the need arise and the process and timeframes associated with response and resolution
3. Families will also be informed of their right to private and confidential interactions with staff. All information shared between families and staff will be protected and treated in a confidential manner. The only exception occurs when the law mandates report of illegal or potentially life-threatening behavior. SSA/Senior PHNs will inform families of their confidentiality before or during the intake visit. Families will be informed of the following both verbally and in writing:
    - The manner in which information is shared, with whom and the process for

consent forms to be signed when exchanging information
    - The circumstances when information is shared with consent (e.g., for purposes of referral, if participating in research or evaluation study where identifying information is shared or when data required by funders or model developer includes identifying information)
    - The circumstances when information would be shared without consent (i.e., reporting suspected child abuse and neglect)
4. The participant will sign and date the forms to indicate informed consent. The SSA/Senior PHN will then sign and date the forms as a witness, and the participant will be given copies of the forms. The SSA/Senior PHN will keep copies and upload into Persimmony.
5. Before information can be shared with an external agency, an ROI must be completed and signed by the participant. This must occur for each new agency information is shared with (no blanket release forms). ROIs will be renewed annually if the participant is still receiving the referral service for more than a year. ROIs will be specific for each referral and each external agency and will at a minimum include the following:
    a. The signature of the person whose information will be released or parent or legal guardian of a person who is unable to provide authorization
    b. The specific information to be released
    c. The purpose for which the information is to be used
    d. The date the release takes effect
    e. The date the release expires (not to exceed 12 months)
    f. The name of the person/agency to whom the information is to be released
    g. A statement that the person/family may withdraw the authorization at any time
6. In the event that F5SD or CoSD approves a research project involving families (see GA-4.A), participants will be informed that their identity and privacy will be protected.

TIP: Include a space on the ROI form to detail exactly what will be released. Blanket statements or categories may be difficult for a family to understand.

Mechanism for Families to File a Complaint

Policy

Sites allows families to file complaints at any time during or after their participation in the program.

Procedure

1. During the intake visit, SSA/Senior PHNs inform families that any questions or complaints they may have can be directed to their supervisor or whomever is determined by the site/agency policy. The phone number for that individual will be provided to the family along with a copy of the site's grievance policy.
2. If a family informs their PHN of a complaint, the PHN will notify his/her supervisor as soon as possible but no later than 1 business day from when the complaint was filed.
3. The supervisor will follow their agency's policy to resolve the complaint.
4. A resolution or proposed response to the complaint will be reached no later than 30 days after it was originally filed.
5. The supervisor will document the complaint and how it was resolved, and submit to PM for review.
6. The PM compiles the complaints that are received and retains a copy without participant identifiers. This file is shared with Central Administration (AAP-CA3) during QA visits upon request.

7. When, as a result of a complaint, system-wide program improvements are needed, a recommendation will be brought to Central Administration. Central Administration will review the recommendation for improvement. The final recommendation will be brought to a San Diego HFA MSS Leadership Meeting for review and any necessary changes or adjustments to practices will be made.

Reporting Cases of Child Abuse and Neglect to Appropriate Authorities (HFA GA-4.A - *Safety Standard*)

Policy

Consistent with State of California law, all staff, including PMs, SSAs, supervisors and PHNs, are mandated reporters and are therefore required to report suspected child abuse or neglect. Child abuse and neglect, as defined in the Child Abuse Neglect Reporting Act (CANRA), includes physical abuse, sexual abuse (including both sexual assault and sexual exploitation), willful cruelty or unjustified punishment, unlawful corporal punishment or injury, and neglect (including both acts and omissions such as ignoring medical, emotional or physical care needs or failure to provide access to appropriate health care and support). More specific information regarding criteria to report child abuse and neglect can be found in the document, *The California Child Abuse and Neglect Reporting Law, Issues and Answers for Mandated Reporters*, available at all sites and on the First Steps Team Member Corner.

Procedure

1. If PHNs or SSAs have a reasonable suspicion of the abuse and/or neglect of a child, they are to follow the guidelines set in the current CANRA, as well as the written policy for their individual agency.
2. When child abuse and/or neglect is suspected, SSAs/PHNs are required to immediately contact their supervisor. If the supervisor is unavailable to discuss the situation, the SSA/PHN will contact the PM. Staff will also report all suspected cases of child abuse and neglect to Child Welfare Services (CWS; now housed under the CFWB Department).
3. Staff are responsible for reporting all suspected cases of abuse and neglect to the proper authorities, even if it is believed another individual or organization has made a report.
4. If a PHN or SSA witnesses child abuse in progress, such that the safety of the child is in jeopardy, they should call 911 and notify the supervisor immediately thereafter. The PHN/SSA and supervisor then call CWS and follow up with filing a written report.
5. Supervisors will maintain a log of incidents of suspected abuse/neglect reported by staff to ensure appropriate follow-up to include at a minimum:
    a. Persimmony Client ID
    b. Date abuse/neglect was noted/suspected by staff
    c. Brief description of follow-up or dates of supervision notes where follow-up was discussed to ensure safety concerns were addressed

When the Target Child is Removed from the Home

Policy

In situations where the target child is removed from the home, if it is safe to do so, the PHN will remain involved with the family when reunification is the plan and will strive to hold visits as often as possible.

In situations where the site is unsure whether reunification will be planned, they may exit the family from services and re-enroll them at a later date if reunification occurs. Sites are

encouraged to continue serving families when reunification is the goal.

Procedure

1. When a target child is removed from the home, the Supervisor and PHN will partner to discuss any staff safety concerns and will connect with CWS as appropriate.
2. If the Supervisor and PHN determine that reunification is planned and it is safe to continue working with the family, they will work to schedule as many visits as possible with both the parent and child.
3. PHNs may join a CWS-supervised visit but it will be made clear that the PHN will not be responsible for supervising the visit.
4. If the family does not yet know if reunification will be planned:
    a. The site PM and Supervisor should discuss their capacity to continue serving the family while they await a decision. The site should also keep the scope of services and the PHN role in mind when determining whether the program will be able to meet the family's needs.
    b. Ask the family about their interest in continuing services and what supports they are looking for. Make referrals where appropriate.
    c. If the site determines they do not have capacity to continue serving the family, they may then exit the family from services.
    d. If reunification occurs after a family has exited the program, the site may re-enroll them in services following the guidance outlined in the Re-enrollment policy.

TIP: Connect with AAP-CA3 to discuss opportunities to support families facing uncertainty following the removal of a child from the home. HFA encourages sites to keep in mind the intent behind home visits to promote nurturing PCI, support healthy child development, and enhance family functioning. These goals may be met when the child is not present, and sites should take time to consider their capacity to serve these families before exiting them from services.

Participant Death (HFA GA-5.A)

Policy

In the event of a death of a program participant (parent or child, including a fetal demise/miscarriage), the PHN will immediately notify their supervisor and PM. The protocol for responding to the parent, siblings, family and PHN will be initiated, and the site PM will notify AAP-CA3. As appropriate, sites will provide services up to three months after a loss to support the healing process and to link the parent and family to needed services, resources and support.

Procedure

1. Upon learning of a death, the PHN will immediately notify their PM and supervisor.
2. The PM will notify the Project Director at AAP-CA3 by email.
3. The PM and supervisor will meet with the affected PHN(s) to discuss what occurred and together develop a plan to provide appropriate and needed resources and services to the parent and family.
    - Talking points will be developed for PHN(s) to use while working with the family
    - Resources will be identified for the family and sibling(s), such as service resources for the deceased, burial/cremation resources, counseling for adults, play therapy for siblings and school-based support to siblings (principal, teachers, counselors, etc.)
4. Resources and support will be provided to the directly impacted PHN(s): reflective supervision, emotional support and counseling resources such as Employment

Assistance Programs (EAP) and/or local Hospice programs.

5. Resources and support will also be provided to all PHNs on the team.
    - Counseling services will be offered to all PHNs
    - Reflective supervision will be offered as another opportunity for PHNs to discuss feelings, concerns and impacts of the incident
    - Group discussion will occur with supervisors and all PHNs at a minimum of one staff meeting. Additional group meetings will be arranged as needed.
6. If appropriate, the PHN, supervisor and/or PM will visit the parent/family in the hospital.
    - Condolences will be provided to the parent/family, as well as discussion and support as appropriate to provide an opportunity for the caregiver/family to express thoughts, feelings, concerns, questions and plans.
    - If applicable, parent/family will be informed of available room options and other support services while in the hospital (move to a quieter/different recovery room, time with the baby, baptism/blessing of the baby, clergy, other spiritual support, social services support, etc.)
    - If not already offered by hospital staff, inform parent/family that they can obtain a lock of hair, photographs of the baby, and wash/dress the baby themselves (some exceptions may apply, e.g., coroner or medical examiner's case)
    - Supervisor and/or PM will debrief with PHN after the hospital visit and reflect on the feelings and needs of the PHN and parent/family.
    - Based on the findings from the visit, the PHN (with support of their supervisor and PM) will identify and allocate resources specifically tailored to the needs of the parent/family
7. Visits will continue as needed for a maximum of three months but more likely for 3-5 visits to be sure the family is linked to needed resources and support.
8. The supervisor may attend 1-2 visits or more with the PHN after the incident to support the PHN, if desired, and to help assess how the family is doing and their ongoing needs. The family will be exited from services, unless there is another "target" child in the program (e.g., a twin or prior "target" child under the age of 5 years old). Documentation will be charted (family file) and input into Persimmony as appropriate. Final resources and referrals will be provided to the parent/family.
9. Convene a closing debrief with PM, supervisor and PHN for reflective discussion and to identify any further resources and support for the PHN.
10. If the death is suspected to be connected to IPV, child abuse or neglect, staff will cooperate fully with the investigation, following program and agency procedures consistent with mandatory child abuse and neglect reporting laws.

Appendix

Forms to Include in the Family Chart

Referral Form (to services)
Consents/Notices – Consent to Services, Family Rights, Grievance Policy
Site's Notice of Privacy Practices
Intake Form(s)
Referral Authorization to Release Information
Action Plan (located in family record in Persimmony)
Family Transfer Referral Form (if applicable)
FROG
Home Visit Records
Family Goal Process Form
Level Completion Forms
Copy of Level Completion ("Accomplishments") Certificate
Child Follow Up Assessment(s)
Parent Follow Up Assessment(s)
PHQ-9 Adults or PHQ-9 Adolescents
CHEERS Check-In
ASQ-3 and ASQ:SE-2
Parent Satisfaction Survey (PSS)
Graduation Form
Transition Plan (if applicable)
Case Closure Summary

Forms to Include in Supervision Files (for each PHN and/or family)

PHN Chart Review Form
Original FROG with supervisor feedback
Family Service Plan
Supervision and Professional Support (SPS)
Family Progress Review (FPR)
Home Visit Shadowing Form
FROG Shadow Form
Parent Experience Survey Form (Home Visit and Initial Engagement)

Forms to Include in Program Manager Files

Supervision Shadow Form – FROG (for each supervisor)
Supervision Shadow Form – Home Visit (for each supervisor)
Supervision of Supervisor Notes
Quality Assurance Plan (w/ updates)
Quality Improvement Plan (in progress)

Additional CoSD HFA Resources

HFA PHN SharePoint Site