REPORT TO THE TWENTY-FOURTH LEGISLATURE

STATE OF HAWAII

2007

PURSUANT TO SENATE CONCURRENT RESOLUTION 227, SESSION LAWS OF HAWAII 2005, REQUIRING THE DEPARTMENT OF HEALTH TO CONVENE A TASK FORCE TO WORK WITH THE HAWAII HEALTHY START NETWORK PROVIDERS TO RESTRUCTURE THE PROGRAM FOR GREATER EFFECTIVENESS

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Senate Concurrent Resolution 227
Executive Summary for Healthy Start Task Force Report

The 2005 Legislature adopted Senate Concurrent Resolution (S.C.R.) 227 requesting the Department of Health (DOH) to convene a Task Force to work with the Hawaii Healthy Start (HHS) network of providers to restructure the program for greater effectiveness.

This report outlines Task Force recommendations and program improvements made in response to the seven focus areas stipulated in SCR227:

I. Strengthening the program focus and effectiveness:
   1. The Task Force re-affirmed the program focus as prevention of child abuse and neglect.
   2. The paraprofessional model would continue as the program model, with additional professional supports from the Child Development Specialists, Clinical Specialists.
   3. The program model requires continued and enhanced training to support home visitors to link family outcome goals to the family's identified risk factors.
   4. The Task Force affirmed Enhanced Healthy Start model is an effective vehicle for very high risk families.

II. Streamlining requirements related to IDEA and OSEP:
   1. The Child Development Specialist should be utilized to support the home visitors. The Task Force recommended reducing the worker to family ratios to better meet IDEA goal.
   2. Streamline the developmental screening schedule for children in the program.
   3. Reinforce the development of the IFSP to incorporate family risk factor goals as well as child development goals.
   4. Revise the program's Level System.
   5. Revise the program's data management system to facilitate OSEP reporting.
   6. Revise the program's quarterly reporting requirements.
   7. Revise the program's billing system.

III. Restructure intensity of services such as a two tier system:
   1. Revise the program's Level System.
   2. The Task Force affirmed that a two tier system currently exists with the Enhanced Healthy Start program and the regular Healthy Start program.

IV. Restructure contract goals in terms of outcomes required:
   1. The Task Force developed a Logic Model which details Long Term Outcomes, Short Term Indicators, Implementation Benchmarks, and Program Elements.

V. Consider piloting curriculum to structure home visits:
   1. The Task Force affirmed that the Healthy Start Program is partnering with Johns Hopkins University and the Centers for Disease Control to develop a home visiting protocol. The program has also begun a partnership with Hawaii Family Support Institute to develop training sessions for community partners who serve the same families as Healthy Start.

VI. Review and consider evidence based best practices:
   1. Dr. Anne Duggan, from the John's Hopkins University presented research on home visiting programs and the Task Force conducted reviews and interviews with 5 programs from Florida, Virginia, Kentucky, Washington DC, and Oregon.

VII. Consider reallocating more resource to training:
   1. Based on the Task Force's recommendations for better program effectiveness, it is recommended that 10-15% of the value of the overall budget be added for evaluation and 3% of the annual Healthy Start funding be dedicated toward training needs.

Senate Concurrent Resolution No. 227
Introduction and Background

Introduction

The 2005 Legislature adopted Senate Concurrent Resolution (S.C.R.) 227 requesting the Department of Health (DOH) to convene a Task Force to work with the Hawaii Healthy Start (HHS) network of providers to restructure the program for greater effectiveness. A listing of the designated organizations and their representatives is located in Attachment A. The task force has met monthly since July, 2005.

Seven (7) areas of focus were outlined in the resolution to guide the work of the planning Task Force as stated below, but are not limited to:

1. Strengthening the program focus on and effectiveness of interventions in prevention of child abuse and neglect based on strategies of nurturing, promoting capacity through parallel process, addressing family risk factors, and strengthening protective factors;

2. Reducing program complexity, streamlining requirements related to IDEA and OSEP to enable staff to achieve goal (1) above;

3. Considering restructuring intensity of services, such as a two-tier system based upon severity of risk;

4. Considering restructuring contract goals in terms of outcomes required by funders and establishing output monitoring within quality assurance at program and state-wide levels;

5. Considering piloting curriculum to structure home visits and ensure inclusion of basic activities to promote positive child development;

6. Reviewing and considering evidence-based best practices to enhance overall program effectiveness, particularly related to engagement and retention and outcome indicators, with a view to incremental piloting and statewide adoption; and

7. Considering reallocating more resources to training and technical assistance mentoring to enhance staff effectiveness and to program outcome data evaluation for regular reports to funders.

Task Force Planning Process

The Task Force identified a plan of action for this planning process, roughly as follows;

- Review of the history of program implementation to identify the key historical factors which have impacted on-going program evolution to establish a common understanding of program issues.

- Respond and prioritize responses to a set of questions regarding program implementation.
- Review the John Hopkins evaluation of Healthy Start (1995-1998).
- Establish priorities for addressing the issues raised by the resolution, allocating some for 2005 and 2006.
- Organize two sub-committees to expedite the process, a Redesign Committee and a Data/Evaluation Committee.
- Areas needing improvement will be identified to be addressed as immediate, the short term or long term issues.
- Addressed Issues #1 and #6 in 2005. These included: strengthening the program focus on and effectiveness of interventions in prevention of child abuse and neglect based on strategies of nurturing, promoting capacity through parallel process, addressing family risk factors, and strengthening protective factors; and reviewing and considering evidence-based best practices to enhance overall program effectiveness, particularly related to engagement and retention and outcome indicators, with a view to incremental piloting and state-wide adoption; and
- Addressed the rest of the issues outlined in SCR 227 in 2006.

2005 Task Force Achievements:

This section highlights issues previously reported on the history of Healthy Start as a refresher regarding the impact of events upon the program, summarizes task force work from the 2005 report, and the key findings and achievements.

History of Healthy Start: Healthy Start began as a demonstration child abuse prevention project in July 1985 in Leeward Oahu, using a para-professional model to support at-risk families with newborns with a strategic goal of preventing child abuse and neglect in a specific geographic area. The model featured home visits aimed at reducing risk factors and strengthening parental capacity in order to avert child abuse and neglect and also to reduce the long term costly consequences of abuse/neglect. Designed to meet needs of families at that time, and with initial success in averting abuse, the program expanded to focus on key geographic areas with higher proportions of families with identifying characteristics of risk, reaching 51% of the population by 1991. A multi-disciplinary Mother Infant Support Team was also established in 1986 to work with families of newborns at threatened harm levels of risk and active with the Department of Human Services, expanding to Hilo and Kona and operating for a decade before funding was cut. HHS also served as the model for the international Healthy Families America (HFA) home visiting program starting in 1992.

In1986, Congress enacted the Individual with Disabilities Education Act (IDEA) with the Office of Special Education Programs (OSEP) overseeing compliance with regulations Part C of IDEA established an Early Intervention (EI) service system for children ages birth to three years, and

their families. The Hawaii Early Intervention State Plan elicited to include environmentally at-risk families as well as families with children who are developmentally disabled, biologically at risk, or medically fragile.

Healthy Start adopted the IDEA Individual Family Support Plan (IFSP) component in 1994, which in retrospect modified service delivery. As the family plan drives the kind of services provided, services became more focused upon IDEA concerns for child development in addition to risk identified on the family stress checklist.

By the mid-nineties, assessments of families using the Family Stress Checklist (Kempe, 1976) reflected much greater numbers of families with substance abuse, domestic violence and mental health problems. This trend was also noted by child welfare workers, particularly in regard to the methamphetamine epidemic. This impacted significantly upon the effectiveness of Healthy Start, as the paraprofessional staff did not have the training and background to address these difficult situations in larger numbers.

During the late 90's, the need for Child Development Specialists was identified. The Child Development Specialists were added to the program to support the Family Support Worker's (home visitors) in the areas of child development screening and to deal with more complex issues.

Welfare reform greatly impacted program families and the ability of the program to see and engage families. It resulted in more stress for many families and left families with less time for home visits.

In the fall of 2001, Hawaii Healthy Start was approved as a Felix mandated early intervention service and additional State general funds enabled expansion to statewide service delivery. This resulted in very rapid expansion during the time that a new client data management and tracking system was being developed. Concurrently, additional requirements to come into compliance with IDEA law were placed on Hawaii Healthy Start as a Part C entity, which impacted program design and created burden and stress for staff.

The SCR 13/45 Resolution, established a task force to plan for underserved at risk newborns and young children from 2003-2005 to analyze service delivery vis-à-vis service coordination between the Department of Health (DOH) and the Department of Human Services (DHS). This resulted in Healthy Start accepting families of newborns at threatened harm levels of risk, and enhanced coordination between DOH and DHS in prevention of child abuse. It also resulted in a pilot program add-on to Healthy Start to serve infants and toddlers at threatened harm risk levels and also infants confirmed for abuse. Based on the earlier Mother Infant Support Team concepts, it was piloted in two sites and replicated statewide beginning in November, 2005 through Temporary Assistance to Needy Families (TANF) funding through DHS. Attachment B provides the findings and recommendations of the Senate Concurrent Resolution 13/45 Task Force.

In November 2005, the Enhanced Healthy Start (EHS) program which was a Department of Human Services secondary purchase on a Department of Health (DOH) Request for Proposals (RFP) for Healthy Start, was initiated statewide.

Referrals by Child Welfare Services and POS providers of Family Strengthening Services (FSS) and Voluntary Case Management (VCM) are mandatory for families with children up to one year of age and are optional for families with children 1 year to 30 months of age. Providers may move families with greater needs from the regular (Basic HS) to the enhanced program on a space available basis and may move families needing less intense service (e.g. closed CWS cases) to regular Healthy Start. The Enhanced Program is currently funded and administered by the Department of Human Services, but is attached to each regular Healthy Start program. The program is "enhanced" by the additional support of a nurse and certified substance abuse counselor.

The establishment of the current Advisory Task Force is timely, given the significant changes and challenges occurring over the past 20 years, and provides additional resources and support to assist the Hawaii Healthy Start program in its efforts to examine programmatic and fiscal details of the program and adopt strategies for quality improvement.

Task Force Activities in 2005

- Conducted the historical review outlined above.
- Responded to and prioritized responses to a set of strategic questions regarding Healthy Start.
- Reviewed the current evaluation of Healthy Start, particularly to identify areas of strength and areas in the program needing attention.
- Reviewed outcomes from Center for Disease Control and Prevention (CDCP) endorsed and Healthy Families America (HFA) outstanding programs.
- Established the Redesign and Data Committees.
- Addressed Resolution items (1) to clarify the purpose of Healthy Start and strengthen focus and effectiveness of interventions, and (6) to review evidence based best practices in home visiting). Work was also begun on item (2), to reduce program complexity.
- Determined that areas in need of improvement will be identified as short term and/or long term issues, specifically related to:
  - Reducing program complexity;
  - Streamlining requirements related to Individuals with Disabilities Education Act (IDEA) and Office of Special Education Programs (OSEP); and
  - Considering restructuring contract goals.

Critical Research Findings: A summary of pertinent research findings was presented by Anne Duggan of Johns Hopkins University School of Medicine, from her work with the Hawai`i Healthy Start program, as well as a meta-analysis evaluation summary and reports from three other Healthy Start like programs. This is provided below:

Highlights of John Hopkins research reports:

- Home visiting can be more effective than other strategies to prevent child abuse and neglect (CAN), with evidence of effectiveness for both paraprofessional and professional home visiting models. It is worth investing in home visiting and in efforts to improve the HHS program.

- Research is needed to test interventions to reduce variability, increase quality, and ascertain resulting changes in impact. Discrete interventions can improve the effectiveness of the basic HHS model.

- Discrete interventions which are added-on, even if theory and evidence-based, must be tested to establish efficacy and effectiveness. HHS should invest in research to test the impact of such interventions if it wants to be confident and have evidence that it is achieving intended outcomes.

- The malleable risks (e.g. domestic violence, substance abuse and maternal depression) for which families are targeted are, in fact, strongly associated with CAN and the quality of parenting. Risk reduction should be an explicit outcome measure.

- To effectively address the risks for which parents have been targeted, more training, protocols and supervision is needed, with testing of their fidelity to model.

- Experts agree that in order to provide effective services there needs to be a complete conceptualization of program design and implementation. There must be detailed measurement of service delivery, and programs need to be designed with evaluation in mind.

Implications for policy and practice include:

- Evaluating long as well as short term impacts, and a range of outcomes,

- Serving families until assessment shows risks have been substantially reduced, and

- Identifying families via prenatal screening.

In regard to Item # 6 (to review evidence based best practices in home visiting), there was an additional presentation which featured ten home visiting programs including some of those endorsed by the Centers for Disease Control and Prevention (CDCP) and others from the Healthy Families America (HFA) initiative with good evidence in prevention of child abuse. All of the programs showed success in averting abuse and neglect compared to either control groups, comparison groups or on pre-post testing. These programs have strategies to offer the field, several in regard to the effectiveness of pre-natal engagement and early reduction of risk factors, as well as overall effectiveness in improved child and family indices.

In addressing Issue #1 (to clarify the purpose of Healthy Start and strengthen focus and effectiveness of interventions), the Task Force members unanimously agreed that the overall goal of Healthy Start should be prevention of child abuse, through reduction of risk factors. The task force also answered a range of questions about the program, clarifying issues and setting priorities. Steps were also taken to streamline some program requirements as included below.

During 2006, there were also monthly meetings by the Maternal and Child Health Branch, (MCHB) Department of Health, with service providers to address areas for program improvement, with implementation of the following changes:

- Increased prenatal referrals in Healthy Start, as a strategy to enhance engagement, retention and effectiveness.
- Extended the window of eligibility from 3 months to 12 months to accommodate family needs.
- Revised the home visitation schedule to meet family needs, particularly related to welfare to work requirements.
- Reductions in the schedule for the child development screening retaining the critical months of assessment
- Definition of program success linked to family progress as opposed to length of stay
- Revised training curriculum and field testing adoption of the cognitive appraisal model for home visiting pilot project as part of Centers for Disease Control and Prevention research grant. This approach showed strong evidence of effectiveness in a randomized trial.
- Adding reports to the Child Health Early Intervention Resources System (CHEIRS) database to streamline reporting of progress on Office of Special Education Services (OSEP) required program data.

Work of the Task Force in 2006

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The Task Force focused on all of the issue areas defined by the Resolution. This work is described in detail in the following sections.

Response to the Resolution:

1. **Strengthening the program focus on and effectiveness of interventions in prevention of child abuse and neglect based on strategies of nurturing, promoting capacity through parallel process, addressing family risk factors, and strengthening protective factors:**

Previously, the Task Force summarized member responses related to the purpose of the program, and re-affirmed the basic purpose to be to avert child abuse and neglect, reduce risk factors and promote positive child development. Major goals are specifically restated as follows:

- Reduction in child abuse and neglect,
- Increasing family self sufficiency,
- Reduction of stressors and risk to children, and
- Improved child adjustment and achievement.

It was also previously determined the following will strengthen the program's service delivery and outcomes:

- increasing prenatal referrals to the Healthy Start Program,
- extending the window of eligibility from 0 months to 30 months,
- refocusing service delivery to focusing upon reduction of family risk factors and enhancing protective factors, in the context of how this influences the child, and
- enhancing and increasing training, protocols and supervision especially related to the refocus on risk issues.

Other specific changes to the program model which have been implemented, or are being considered include:

- Acknowledgement that the para-professional Family Support Worker's have limited amount of expertise which does not prepare them to fully address the issues of child development, domestic violence, substance abuse and other more complex conditions, hence the need for professionals on the team to work with these issues. The Clinical Specialist positions were piloted to meet this need.

- Assessing the Clinical Specialist model has resulted in streamlining previously prescriptive and stringent service requirements, to allow the clinician flexibility to meet the short term intervention needs of families and address family risk factors for issues beyond the capacity of the Family Support Worker, including domestic violence, substance abuse, and mental health issues as these relate to the Healthy Start child. A description of the Clinical Specialist model is in Attachment C.

  Based on the piloting of the Clinical Specialist in select programs, this position has been expanded to all programs statewide. This position has been found to be an important component of the program model and should be institutionalized. Programs across the country are considering this need. As the Clinical Specialist role is expanded, additional

training is being developed. The current staff ratio for the Clinical Specialists is 1 Clinical Specialist for 200 families. It is recommended that this ratio be lowered to 1 to 75 families to provide effective treatment readiness and clinical consultation.

- Strengthening the Child Development Specialist functions to better address child development and parent-child interaction. Child Development Specialist services include: assessment, intervention, consultation and training, and care coordination. Child Development Specialist staff can participate with one Early Intervention Services therapist in completing the Comprehensive Developmental Evaluation for both the environmentally at risk children who fall in the referable range on the developmental screening tool, Ages and Stages Questionnaire (ASQ), and for all the biologically at risk children, as these need an immediate Comprehensive Developmental Evaluation, not a developmental screen (ASQ). A description of the revised Child Development Specialist model is in Attachment D.

  The Child Development Specialist position started on a demonstration basis but is an essential component of the core model. The current ratio of Child Development Specialists is 1 to 200 families. It is recommended that this caseload be lowered to 1 to 100 families. Providing the Child Development Specialist with a lower caseload would enable this position to assist in compliance with increased requirements mandated by IDEA Part C, and free the Family Support Worker to address risk factors and family capacity building. The Child Development Specialists could take responsibility for the OSEP requirements for both children with identified delays as well as the transition work at 2.5 years of age. Additional training would be needed as the role for the Child Development Specialist is expanded.

  While some of the OSEP and other requirements cannot be eliminated, strengthening Child Development Specialist staffing patterns provides the opportunity to make the program more effective.

Enhanced training opportunities are being implemented to address:

- Family Support Worker capacity to identify and intervene with malleable risk factors of families (coping skills, stressors, anger management, and plans for discipline),

- Staff capacity in development of appropriate Individual Family Support Plans linking family outcome goals to issues identified on the Family Stress Checklist during the initial assessment. (For a better description of these interventions, see the diagram following this section).

It is anticipated the revisions to the model pertaining to services provided to families by the Child Development Specialists and Clinical Specialists will improve the overall service delivery in regard to the primary functions of Healthy Start to prevent abuse/neglect by clarifying functions and protocols for these roles, as recommended by the John Hopkins study. This should result in improved services to families with more complex needs.

The DOH Maternal and Child Health Branch and providers are reviewing the current "Level System" which prescribes the frequency of home visits dependent upon assessment and re-assessment of the family's risk factors and family stressors, as well as the families availability to participate in services. This is aimed at more realistic expectations and enhancing engagement and retention. This review has resulted in revised outcome measures (see Implementation Benchmarks on page 11).

Summary and Recommendations

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- The primary goal of Healthy Start to prevent child abuse and neglect was affirmed.

- The limitations of the Family Support Worker's capacity to work with families with severe risk factors and the needs of families for professional interventions were recognized. The Clinical Specialist is a necessary component and needs to be institutionalized into the program. It is recommended that this ratio of Clinical Specialist to families be lowered to 1 Clinical Specialist to 75 families.

- The Child Development Specialist position needs to be institutionalized as an essential component and is core to the model. It is recommended that this caseload ratio of the Child Development Specialist be lowered to 1 to 100 families. These recommendations address the need to deal with OSEP requirements and relieve barriers to the Family Support Worker's focus on family risk interventions.

- As the functions of the Child Development Specialist and the Clinical Specialist expand, additional training is needed.

- Enhanced Healthy Start has shown to be an effective vehicle for Family Support Workers for high risk families and families of infants and toddlers where abuse has already occurred. Key ingredients for this success are interventions utilizing a multi-disciplinary approach, staff ratios allowing more attention and intensive services to families with complex problems, and the program's mixture of consultation and direct services.

The chart below illustrates the growing professional component needs of the program. Increased professional interventions demonstrate the program's response to overall community challenges with increased acuity levels of families served.

Initial Healthy Start Model	Mid 1990's Model	2002 Model	Enhanced Healthy Start Model
5 Family Support Workers	10 Family Support Workers	10-15 Family Support Workers	10-15 Family Support Workers
1 Professional Supervisor	2 Professional Supervisors	2-3 Professional Supervisors	2-3 Professional Supervisors
	1 Child Development Specialist	1 Child Development Specialist	Registered Nurse
		1 Clinical Specialist	Certified Substance Abuse Counselor

- Enhanced Healthy start funding is expected for one more year. The Departments of Health and Human Services are discussing a possible merger of both the Enhanced Healthy Start and Hawaii Healthy Start. This is contingent on state funding.

- The following chart depicts the intervention model, showing the relationship between risk factors and interventions needed to effectively address these benchmarks. This affirms a major intention of program restructuring to refocus the program back upon the interventions relevant to averting child abuse and neglect. Again, training is being developed at a number of levels to prepare staff for greater effectiveness in identifying risks and needs, focusing on interventions to reduce risks and enhance parental capacity to provide nurturing and adequate care for their children.

- This training will support staff in better understanding the dynamics of abuse and the needs of families at risk, upon developing family plans which address risk factors, and in specific skills needed to carry out interventions. Training will also focus on team building between Family Support Worker's, supervisors and Clinical Specialists, so that each is better prepared to play the appropriate role in working with each family.

Healthy Start Service Interventions

Long Term Outcomes	Family Risk Factors	Program Strategies	Implementation Benchmarks
Reductions in the rate of child abuse and neglect.	Parent abused in childhood	▪ Persistent outreach ▪ Establish trusting relationship ▪ Nurture, re-parent ▪ Monitor infant safety	▪ Prevention of confirmed reports of CA/N. ▪ Reduction in confirmed reports of CA/N. ▪ Reduced incidences of re-abuse and neglect.
	Parent suspected of abuse in past		
Increases in family self-sufficiency.	Parent low self-esteem	Build self esteem Empower parent Facilitate development of a support system Support client learning to express needs, wants Role-modeling	▪ Improved problem solving and goal setting. ▪ Expanded support networks. ▪ Increased identification and referral to services. ▪ Improved management and coping skills. ▪ Improved caregiver mental health.
	Family has multiple crises or stresses	Role modeling of coping, problem solving skills Refer for professional counseling as appropriate	
Reduced stressors and risk to children.	Parent has violent temper outbursts	▪ Modeling behavior for impulse control ▪ Anger management classes	▪ Reduced environmental hazards. ▪ Increased positive parenting skills. ▪ Risk reduction (psycho-social factors). ▪ Reduction in risk behaviors. ▪ Reduction in unplanned repeat pregnancies.
	Parent has rigid, unrealistic expectations of child (lacks understanding of normal child development)	▪ Education re infant/child development ▪ Role modeling appropriate behaviors ▪ Therapeutic interventions as appropriate	
	Harsh punishment of child	▪ Teach appropriate discipline strategies ▪ Therapeutic interventions as appropriate	
	Child perceived as difficult, or was unwanted	▪ Explore feelings, encourage discussion; ▪ Review positive characteristics of baby; ▪ Facilitate positive experiences (infant massage); ▪ PCI therapeutic intervention as appropriate	
	Substance abuse, domestic violence, mental health issues (factors most correlated with confirmed physical abuse)	▪ Monitors infant safety ▪ Discuss issues with parents ▪ Clinical specialist work on stages of change ▪ Seek to engage client/family in therapy	
Improved child adjustment and achievement.	Children at risk for developmental delays problems	▪ Promote early pre-natal care for good birth outcomes. ▪ Facilitate developmental activities. ▪ Promote positive PCI. ▪ Programs will provide opportunities for father involvement. ▪ Assess developmental status. ▪ Refer children with suspect delays for testing and developmental services.	▪ Increased access and utilization of primary health care. ▪ Improved health maintenance behaviors. ▪ Increased access and utilization of prenatal care. ▪ Increased positive parent-child interaction. ▪ Increased positive father figure involvement. ▪ Improved identification of the child's health, developmental, and safety needs. ▪ Improved parental provision of appropriate development activities.
		▪ Ensure a medical home. ▪ Monitor immunizations. ▪ Promote oral health. ▪ Promote home safety.	

2. Reducing program complexity, streamlining requirements related to IDEA and OSEP to enable staff to achieve goals (1) above:

The Task Force initially proposed recommendations for change related to streamlining program requirements as either "Change Now", "Requires contract modification", or "Requires new request for Proposal". The following improvement activities were from the "Change Now" list identified in 2005 by the Task Force and from program changes initiated by the Maternal and Child Health Branch (MCHB) as a result of program monitoring.

- The Individuals with Disabilities Act (IDEA) Part C (relating to children 0-3) have challenged the para-professional nature of the program. The addition of the Child Development Specialist and reduction of ratios will assist the program to better meet IDEA goals.

- Requirements for ASQ and ASQ-SE screening have been streamlined, but have retained critical assessment months as identified by the American Academy of Pediatrics Standards

- Reinforcement of the Individual Family Support Plan (IFSP) was initiated following on-site visits where Individual Family Support Plans were reviewed for Office of Special Education (OSEP) monitoring. Monitoring revealed that plans were written and implemented with a heavy emphasis on child development goals rather than family risk factor reduction. Previous reports to the legislature have outlined reasons for this movement away from fidelity to the Healthy Start program model; the most obvious being the program's inclusion under IDEA which mandated numerous regulatory requirements with specific emphasis on child related goals and objectives.

  Refocusing programs back to the Healthy Start mission of reducing family stress risk factors in addition to meeting compliance requirements for OSEP has been the major impetus for re-tooling the program.

  Close collaboration with the Purchase of Service Provider for Training and Technical Assistance (The Institute for Family Enrichment) added an additional component to the core curriculum and resulted in strengthening the curriculum to assist Family Support Workers to use the initial assessment information, and to strategically and effectively address those risk factors during their home visits.

  Continued education on the IFSP and support to the Family Support Worker regarding risk factor discussion with the family will be an on going challenge, but are crucial to re-tooling Healthy Start to closer fidelity to its model.

- Revisions to the Level System began in July 2006. The Level System is a Healthy Families America (HFA) credentialing requirement for home visiting programs. The requirement stipulates that a home visiting program must have well defined criteria for increasing or decreasing intensity of services. Based on research and supporting literature, HFA

recommends that home visits occur on a weekly basis for at least the first 6 months following the birth of a baby.

The system is in the process of being revised to redefine program intensity to meet the family's needs for services based on assessment scores derived from the Kempe Family Stress Checklist (Attachment E) and the family's ability to accommodate a home visitor. The family is a part of the team. In keeping with HFA requirements, every family would be initially encouraged to participate in the Hawaii Healthy Start program on a weekly home visiting schedule. However, there are some families who do not want visits, do not engage in the program or disengage shortly after beginning home visiting services based on the stringent requirements. (It should be noted that another HFA requirement states that outreach services are required for 3 months because of the voluntary nature of the program. Families have the right to refuse services.)

The Hawaii Healthy Start Level Movement System determined that movement through this system would demonstrate a family's progress with Healthy Start program goals. The system also dictated that as a family moved through levels (1-4), they had to meet stringent external requirements and could only progress through the levels on a sequential basis.

The proposed revised Level System recognizes and requires the Family Support Worker to openly discuss the family's risk factors which should easily translate into an open discussion of goals and objectives on an Individual Family Support Plan. This discussion which will focus on those four malleable risk factors (Kempe Family Stress Checklist #4, 5, 6, 8) will occur every 6 months at every IFSP meeting.

Movement through the revised Level System will be described using frequency descriptors (weekly, bi-monthly, monthly, quarterly, outreach). Logically one would expect that the family's frequency of home visits would correlate with the intensity of risk factors occurring in the home. However, because the family's preference is factored into the formula, this may not always correlate. Nevertheless, this new system mandates that the Family Support Worker continuously focus on those malleable risk factors initially identified for each family. Therefore, families served by the Hawaii Healthy Start program are reassessed based on changes in specific risk factors identified as risks for child maltreatment.

- The Task Force developed a list of specific items to address and streamline program reporting:

  - The program's data management system was revised to facilitate automatic data collection. Prior to December, 2005 programs were manually collecting and aggregating monthly data for OSEP reporting.

  - Task Force members recommended more streamlined reporting requirements. Programs had previously been reporting data already available in the data management system. The Quarterly reports required by contract were edited and these streamlined reporting requirements began with the first quarter of the new contracts.

- Following months of collaboration with contracted providers, a revised billing system was developed and implementation was scheduled for January, 2006 – the start of a new contract period. However, this proved unfeasible and was rescinded, and the billing system reverted back to the current system. There was a tacit agreement among providers that DOH Maternal and Child Health Branch would continue to research and develop a new billing system.

  The first part of the current analysis compared the current unit cost system to a flat rate method of payment. Based on a comparison of standards and opportunities for program monitoring and the current Medicaid reimbursement definitions, it appears that the unit cost method provides the best system of payment at this time.

  DOH Maternal and Child Health Branch initiated a time study of Family Support Worker activities in May 2006. Results of this study will yield average number of hours spent on program activities. Preliminarily, the new billing system needs to clarify billing activities to a more streamlined unit to ensure better accountability, to align activities to Medicaid reimbursable requirements, and to maintain department and procurement policies. Programs submitted actual expenditure reports on a voluntary basis, which are being used to assist our current analysis in determining true administrative costs.

  Following this thorough analysis of all possible factors in determining program costs, MCHB will submit a proposal to revise the billing procedures. This will inevitably require another Request for Proposals as the current contract speaks specifically to the "old" billing unit cost rate with "old" billing definitions in operation. As the current contracts will run to 2009, when a new billing system can be operational, then the current contracts will be voided and new contracts written to reflect these fiscal changes.

Summary

In summary, the improvement activities to streamline program requirements and reporting include:

- Delegation of some OSEP requirements to Child Development Specialists to support the Family Support Worker and enable greater focus on interventions to prevent child abuse.

- Reduction of some contract screening requirements.

- Streamlining of documentation requirements.

- Adding OSEP reporting requirements to the data system for automatic retrieval.

- "Change later" items will be addressed in 2007. These changes will be based on the Logic Model developed this past year (page 18) which outlines the theoretical relationship between outcomes and program strategies.

3. Considering restructuring intensity of services, such as a two tier system based upon severity of risk:

Re-structuring of the Level System results in a more flexible approach to service intensity. Risk scores, family needs as well as family availability and preference will now all be considered in determining what level of service the family is placed on. This is intended to reduce unwelcome home visits and encourage engagement and retention.

The Task Force also affirmed that to some extent a two tiered system has already been created by the Enhanced Healthy Start component. Most Healthy Start families enter the program via a screening and assessment procedure which occurs prenatally or in the hospital following the birth of a baby. Families in the "Enhanced" Healthy Start program are referred for home visiting services through their Department of Human Services, Child Welfare Services (CWS) social worker.

"Enhanced Healthy Start" services funded through federal Temporary Assistance to Needy Families funds include para-professional home visiting services and professional services, as these families require more intense services for a higher severity of risk.

The Task Force examined the current two-tiered system. Families enter the program via a screening and assessment procedure which currently usually occurs in the hospital following the birth of a baby.

Within the regular Healthy Start program, para-professionals have Child Development Specialists and Clinical Specialists available for consultation. The Healthy Start Advisory Task Force noted the high acuity levels of families and noted that as acuity rose, professionals were required to provide more direct services as opposed to providing consultation to the home visitor. The Task Force will be recommending an increase in specialist positions for programs particularly for the Child Development Specialist (CDS) positions. The CDS would then be able to support more child development concerns, in direct response to increased OSEP requirements, thereby allowing home visitors more time to focus on family risk factors.

A second tier to the program encompasses the "Enhanced" Healthy Start program in which families are referred for home visiting services through their Department of Human Services, Child Welfare Services social worker. These families have either been investigated and abuse or neglect confirmed, or receive CWS services through the department's Voluntary Case Management program, or Family Strengthening program. The program is "enhanced" because of additional professional support; i.e., a registered nurse and Certified Substance Abuse Counselor.

Summary and Recommendations

- The Healthy Start Advisory Task Force recommends the continued addition of the Child Development Specialist and the Clinical Specialist to the core model.

- The HSATF further recommends that the ratio for the Child Development Specialist be lowered to 1 Child Development Specialist for every 100 families and the ratio of Clinical Specialist be lowered to 1 to 75 families to better address the OSEP requirements and the severity of issues among the Healthy Start families served.

- From an administrative perspective, the HSATF recommends that the Enhanced Healthy Start model be incorporated into the core program under the auspices of the Department of Health.

4. Considering restructuring contract goals in terms of outcomes required by funders and establishing output monitoring within quality assurance at program and state-wide levels:

The Task Force utilized a Logic Model (see next page) to address this issue. This enabled a review of activities, indicators, benchmarks and intended outcomes in a logical and sequential manner. Please see also the intervention chart on page 11, which further links these with the risk factors the program intends to address. The indicators and benchmarks took into consideration indicators of other HFA home visiting programs. Tools and assessment protocols were considered based on standards of practice. Restructuring of measurement instruments for specific contract goals is scheduled to be addressed in 2007.

Discussion of components to the logic model are discussed on the following pages.

Hawai`i Healthy Start Program Logic Model

Program Elements

Program Governance and Planning

Department of Health
HEICC
Healthy Start Network
Department of Human Services
Parent Council
Interagency Task Forces
AAP – Hawai`i Chapter
ACOG – Hawai`i Chapter

Target population

Overburdened caregivers of children age 0-3:
o Teens.
o Poverty.
o Low educational Level.
o Lack of supports.
o Multiple stressors.
o Pre-natally at-risk.
o Lack of child development knowledge.
o Unrealistic expectations of child development.
o Adverse Childhood Experience (ACE)

Program Features and Activities

Early Identification
o Screening and Assessments
o Identification of Needs
o Referral and Follow-Up
o Linkage to Services

Home Visiting
o Use of Professional and Para-Professionals
o Health Promotion and Care-Giving
o Parental Skill Building
o Family Needs
o Stress Reduction
o Enhanced Child Development

Local Interagency Collaboration
o Cultural and Community Effectiveness

Training and Evaluation
o Ongoing Staff and Provider Training
o Ongoing Internal and External Monitoring
o Client Satisfaction Surveys
o Ongoing Curriculum Design and Review
o QA based on Federal Accreditation Standards

Implementation Benchmarks

- 95% of families enrolled have a medical home.

90% of families enrolled comply with immunization schedules.

- 100% of families enrolled are given information on preventive oral health behaviors.
- 90% of Healthy Start mothers get early pre-natal care for subsequent pregnancies.
- 90% of eligible prenatally enrolled mothers utilize WIC services.
- 90% of enrolled families will evidence positive parent-child interaction.
- 90% of enrolled families have a positive environment for child development.
- 100% of Healthy Start programs provide opportunities for father involvement.
- 95% of enrolled children receive developmental screens/evaluations.

100% of enrolled families are administered a child safety checklist.
100% of enrolled families are given information on age appropriate disciplinary strategies.
90% of enrolled families receive a post test demonstrating a reduction in family risk factors.
99% of Healthy Start families will be CA/N free. (confirmed by CWS).
95% of Healthy Start families known to Child Welfare will not have incidences of re-abuse or neglect (confirmed).

100% of enrolled families identify goals related to risk factors on their IFSP.
90% of enrolled families increase their problem solving skills.
90% of enrolled families expand their support networks.
90% of enrolled families identify their needs and get referrals to services.
There is a 2% reduction in repeat pregnancies (less than two years apart) among Healthy Start families.
30% of enrolled families with an identifiable substance abuse or mental health problems will be referred and engaged in appropriate treatment programs.

Short-Term Indicators

Child Health and Development

- Increased access and utilization of primary health care.
- Improved health maintenance behaviors.
- Increased access and utilization of prenatal care.
- Increased positive parent-child interaction.
- Increased positive father figure involvement.
- Improved identification of the child's health, developmental, and safety needs.
- Improved parental provision of appropriate development activities.

Child Safety

- Reduced environmental hazards.
- Increased positive parenting skills.
- Risk reduction (psycho-social factors).
- Prevention of confirmed reports of CA/N.
- Reduction in confirmed reports of CA/N.
- Reduced incidences of re-abuse and neglect.

Healthy Family Functioning

- Improved problem solving and goal setting.
- Expanded support networks.
- Increased identification and referral to services.
- Improved management and coping skills.
- Reduction in unplanned repeat pregnancies.
- Improved caregiver mental health.
- Reduction in risk behaviors.

Long-Term Outcomes

Families enrolled in the Hawai`i Healthy Start Program will see -

- Reductions in the rate of child abuse and neglect.
- Increases in family self-sufficiency.
- Reduced stressors and risk to children.
- Improved child adjustment and achievement.

Long-Term Outcomes

This research demonstrates that a well implemented intensive home visiting program that utilizes a research based model for intervention and targets those families at risk for maltreating children – can reduce child protection costs, even after accounting for costs to operate the home visiting program. The recent publication *Neurons to Neighborhoods* by the National Council on Medicine has concluded that early childhood programs have proven effective in improving the growth, development and school-readiness of high-risk newborns and pre-school children. In addition, early intervention programs can head off long term dependency on other costly government programs, such as mental health services, special education services, juvenile justice, public assistance and crime.

The primary goal of Healthy Start to prevent child maltreatment is to stop abuse from ever occurring, thus sparing children and families from emotional and physical trauma, while decreasing the need for more costly intervention and treatment services. Studies on early intervention services show that it can have a significant effect on reducing child protection involvement. The result can be a net cost avoidance in the short term, challenging widely held perceptions that programs like Hawaii Healthy Start save money only in the long term arenas noted above.

It is intended that families enrolled in the Hawai`i Healthy Start Program will see :

- Reductions in the rate of child abuse and neglect.
- Increases in family self-sufficiency.
- Reduced stressors and risk to children.
- Improved child adjustment and achievement.

Target population

The target population is defined by the risk factors included in the Family Stress Checklist, developed by Dr. Henry Kempe et al, and further validated in a study titled ”Pre-natal Prediction of Child Abuse and Neglect; A Prospective Study” researches Solbritt Murphy, MD, MPH, Bonnie Orkow, MSW and Ray Nicola, MD, M.H.S.A. published in 1986.

Using characteristics gleaned from studies of families who have abused their children, this instrument was validated as having being a “remarkably accurate predictor with a sensitivity of 89%.” The risk factors are most commonly found among the populations listed below, which are used to provide examples of the kinds of families usually most in need of extra support services. Please note that not all teens, or families in poverty, etc. are at risk, rather risk factors usually occur in clusters to comprise a positive risk assessment.

In general, Healthy Start families are overburdened caregivers of children age 0-30 months within these general populations:

- Teen parents
- Families in poverty
- Parents with low educational levels
- Families who lack supports, are socially isolated
- Families experiencing multiple stressors
- Families may be identified pre-natally as at-risk
- Parents with lack of child development knowledge
- Parents have unrealistic expectations of child development
- Parents had Adverse Childhood Experience (ACE)

Program Features and Activities

Identifying and working with families early is an important prevention strategy, because child abuse and neglect often occur within the first year of life as indicated by the large numbers of cases confirmed before age one. Recent studies on early brain development have shown the devastating effects of abuse and neglect upon the emotional, cognitive and physical development of young children (Bruce Perry, "The Impact of Abuse and Neglect on the Developing Brain"; www.scholastic.com). Effective intervention also requires pro-active reaching out to families at risk, because these families usually have difficulty in trusting others, and are the least likely to seek services on their own.

The screening and assessment process, or early identification, includes the following steps:

- Identification of families of newborns or pregnant women for screening
- Conducting screening and assessments
- Identification of risk and family needs
- Referral of high risk families to Healthy Start teams; general referrals to other community services for low risk families.

Home Visiting

The U.S. Advisory Board on Child Abuse and Neglect (Federal Department of Human Services publication, 1991) identified home visiting as the most promising method of preventing child maltreatment. Studies (Jack P. Shonkoff and Deborah A. Phillips, Editors; Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families, From Neurons to Neighborhoods: The Science of Early Childhood Development, 2000) suggests that home visiting can be a promising approach but that it must contain certain elements for it to work as a preventive intervention. Programs showing the greatest promise addressed multiple problems, using comprehensive approaches to serving families. These programs hired well-trained visitors, addressed a multitude of family needs simultaneously, and followed families at least through the child's first birthday. Families at highest risk should be followed until the child is enrolled in preschool or public education. (Shonkoff et al, 2000)

Home visiting gives the worker an opportunity to understand the issues in the context of the family home environment. This enables the visitor to devise meaningful strategies to help parents deal with parenting, life coping and other issues (such as cigarette smoking, alcohol consumption, and illegal drug use). To be effective, visitors must not only teach caregivers about the risks and values of certain behaviors, but also help them devise individualized strategies for behavioral change. It is in these areas that standard prenatal care often fails and home visiting programs have the potential to make a difference. (Review of Research on Home Visiting for Pregnant Women and Parents of Young Children, David L. Olds and Harriet Kitzman, The Future of Children).

Use of Professional and Para-Professionals

- Early and intensive home visitation by para-professionals produces measurable benefits for participants in the areas of parental attitudes toward children, parent-child interaction patterns and type and quantity of child maltreatment. Mothers who received home visits significantly reduced their potential for physical child abuse and showed significant positive changes in maternal involvement and sensitivity to child cues. Treatment families exhibited more positive parent-child interaction patterns at both six and twelve month assessment points. Specific interventions are included in both the Family Interventions chart and the logic model. The following are some of the key interventions:

    - Build trust by meeting family needs, and teaching families better coping skills and how to meet family needs in order to both engage and retain families in the program and also begin to reduce stressors.

    - Promote maternal health pre-natally, to ensure positive birth outcomes and also teach fundamentals of caregiving.

    - Reduce risk factors identified by the Family Stress Checklist and early observations of the family. Pre-natal engagement offers the opportunity to reduce risks and promote maternal readiness for positive bonding and attachment with the infant.

    - Enhanced protective factors, such as positive parent child interaction, strengthening parenting skills as deterrents to abuse, neglect and to promote positive child development.

    - Promote activities to foster positive child development and school readiness.

Local Interagency Collaboration

Understanding that no one service can meet all of the needs of families, a program like Healthy Start is invaluable in connecting families to services and linking them to community programs and resources. Developing strong working relationships with a wide range of resources is a critical part of developing a successful program. Key resources include housing authorities, substance abuse programs, family friendly mental health services, domestic violence shelters and anger management programs. Developing strong pre-natal referrals also requires working

relationships with the Women, Infants, Children nutritional program, Obstetrician offices and prenatal clinics.

Cultural Competence is a critical component of service delivery for engagement, retention and success of service delivery. Staff need to understand the cultural context for parenting and raising children in order to work with families effectively. Training in these aspects of cultural competence is provided by the Institute for Family Enrichment, the training contractor for Hawaii Healthy Start.

Training and Evaluation

Effective training is fundamental to staff competence, particularly in a program where service delivery is provided mainly by staff without professional training. Foundation training is offered and focuses on the dynamics of child abuse and neglect, how to identify physical and psychological symptoms of child abuse and neglect, nurturing parents and fathering interventions. The curriculum has been strengthened by the current training contractor, The Institute for Family Enrichment.

There are "core" trainings for Family Support Workers, Family Assessment Workers, Supervisors, Child Development Specialists and a new curriculum for Clinical Specialists. There are sessions on a range of topics aimed at preparing staff to work effectively with families, roughly grouped as those to be received in the first 6 months of hire and others within 12 months of hire. (Appendix F)

Quality Assurance and Evaluation

Two on-site monitoring sessions of Hawaii Healthy Start (November, 2005 and February, 2006) have occurred. Monitoring findings have indicated that program paraprofessionals have demonstrated some difficulty in reconciling the program's mission of child abuse and neglect prevention and the increasing child development IDEA Part C mandates. DOH Maternal and Child Health Branch has worked with the Early Identification providers and training contractors to support and encourage providers to clearly link those risk factors which initially referred the family to Healthy Start to the family's service plan. Policy changes have been instituted this year requiring better documentation that family risk factors are clearly and openly addressed with families at the onset of services, and throughout the time the family is enrolled. This is an ongoing challenge to providers as broaching sensitive and potentially dangerous issues to a family by a paraprofessional is a task which requires specialized training and additional support. Extensive training is needed on an ongoing basis to assure that program staff has the support they need to follow the program model with its many implemented changes. DOH Maternal and Child Health Branch will continue to provide quality assurance activities and technical assistance to ensure program changes will comply with Task Force recommendations.

Short-Term Indicators

These are specific activities which are to be conducted and measured. All of these are intended to address the goals of Healthy Start, with targets to be measured as benchmarks. Specific indicators are listed below, along with explanations as appropriate to show the relationship between risk factors and issues to be addressed with interventions.

Child Health and Development indicators are aimed at enhancing child development, and promoting normal child development.

- Access to and utilization of prenatal care is critical to positive birth outcomes for infant and mother.
- Promote positive health maintenance behaviors.
- Access and utilization of primary health care for the infant, to help ensure normal growth and development.
- Promotion of positive parent-child interaction.
- Facilitation of father figure involvement is very important to normal child development.
- Identification of and provision for the child's emotional, cognitive and physical developmental needs.
- Parental provision of age appropriate developmental activities help ensure normal development.

Child Safety (the following should be self-evident)

- Staff work with parents to reduce environmental hazards.
- Staff promote increased positive parenting skills in assuring safety of their children, as well as in reducing abusive behavior.
- Staff seek to reduce psycho-social risk factors as a deterrent to abuse and to promote positive child outcomes.
- Prevention of confirmed reports of CA/N is a major objective of program.
- Reduction in confirmed reports of CA/N.
- Reduced incidences of re-abuse is an objective of Enhanced Healthy Start.

Healthy Family Functioning indicators reflect activities aimed at strengthening family problem solving and coping skills, developing social support networks as a source of emotional support and getting family needs met, as well as reducing psycho-social risks of substance abuse, domestic violence and mental health issues. All are aimed at reducing stressors and risk of child abuse.

- Problem solving and goal setting.
- Expanded support networks.
- Identification of needs and referral to services.
- Time management of and coping skills.
- Reduction in unplanned repeat pregnancies.

Healthy People 2010 calls for reductions in rapid repeat births (RRBs), defined as births occurring within 24 months after a previous birth for women of all ages, and prevention of repeat births during adolescence, regardless of the birth interval. There will be increased focus on this indicator. Rapid repeat births are associated with a greater likelihood of adverse consequences for both the mother and the index child. RRB was associated with adverse outcomes for both the mother and the index child. This is particularly relevant for this population of families that are already at risk for child maltreatment, for which we have found parenting stress to be associated with abusive parenting behavior by the mother. (PEDIATRICS Vol. 114 No. 3 September 2004, pp. e317-e326 (doi:10.1542/peds.2004-0618). Hawaii's Healthy Start Home Visiting Program: Determinants and Impact of Rapid Repeat Birth; Samer S. El-Kamary, MD, MPH[*], Susan M. Higman, PhD[*], Loretta Fuddy, LCSW, MPH[†], Elizabeth McFarlane, MPH[*], Calvin Sia, MD[‡] and Anne K. Duggan, ScD[*]

Interventions with caregiver mental health, substance abuse and domestic violence.

Mothers with higher levels of depression were up to three times more likely to severely physically assault their children than those with little or no depression. Mothers with no partner and those in violent relationships were up to six times more likely to severely assault their children compared to those in nonviolent relationships. Physical assault varied over time, with 2-year-olds incurring the highest risk of abuse Mothers who were depressed, who used illegal drugs, who did not have a partner or who were involved in violent relationships were at increased risk of mental abuse of their children. Infants born small for their gestational age were nearly six times as likely to be physically abused as normal weight babies.

In a study by Anne Duggan, et al, ("Randomized Trial of a Statewide Home Visiting Porgram: Impact in Preventing Child Abuse and Neglect," *Child Abuse & Neglect*, June 2004, Vol 28, Issue 6) found no significant difference between the groups in terms of mothers' desire for and use of community services available. It also found that home visitors often failed to recognize parental risks related to mental health and substance abuse at least per documentation, and usually did not successfully link families with community resources. This has led to specific

training for the para-professional to better identify the signs of mental illness and/or substance abuse.

Researchers did observe a reduction in poor mental health among mothers being visited by one agency; a modest reduction in maternal problem alcohol use and repeated incidents of physical violence from a partner in some of the families; and a modest impact in preventing neglect. (Duggan, Anne et al, "Randomized Trial of a Statewide Home Visiting Program: Impact in Preventing Child Abuse and Neglect," *Child Abuse & Neglect,* June 2004, Vol. 28, Issue 6).

Implementation Benchmarks

The program benchmarks will be used to determine the adequacy of outputs as indicators of progress towards meeting the program's long term outcomes, and also provide a measure of program objectives as a subset of program goals. These measurements are listed in the logic model and also in Attachment G. Measurement tools for each Implementation Benchmark are indicated in parentheses. The percentages used are aimed at both ensuring that families receive sufficient care or assessments to reach program goals and objectives, and constitute a reasonable workload for staff.

Program Governance and Planning

Actual governance of Healthy Start is the responsibility of the Department of Health (DOH), Maternal Child Health Branch with the Department of Human Services (DHS) currently overseeing Enhanced Healthy Start. DOH partners with the Healthy Start provider network on program issues. The following organizations comprise the planning structure for and/or coordinate closely with the Hawaii Healthy Start Program:

- Hawaii State Department of Health
- Hawaii Early Intervention Coordinating Council (HEICC)
- Healthy Start Network of Provider Agencies
- Department of Human Services
- Interagency Task Forces
- American Academy of Pediatrics (AAP) – Hawai`i Chapter
- American College of Obstetricians and Gynecologists (ACOG) – Hawai`i Chapter

In addition, consideration is being given to establish parent councils, similar to the Head Start model to allow consumer input and parental growth.

5. Considering piloting curriculum to structure home visits and ensure inclusion of basic activities to promote positive child development:

Decisions in regard to selecting a specific, statewide in home curriculum, which usually focuses on parent child interaction and child development, was deferred at this time. Curriculum can be used to structure the program for the home visitor by addressing the following components:

- Cultural, ethnic, age, developmental appropriateness and relevance
- Structured home visits
- Consistency with the logic model and tied into program focus

The Hawaii Healthy Start Program is a statewide, voluntary home visiting program that strengthens families and promotes positive parent child relationships. It consists of two components, Early Identification and Home Visiting. The Early Identification component provides screenings and assessments to identify prenatal women and families at-risk for sub-optimal health, developmental delay, and maltreatment. The Home Visiting component provides support services within the family's natural environment to reduce the likelihood of child maltreatment by reducing parental or environmental stressors. Home Visiting services are voluntary until the child reaches three years of age or five years if there is a younger sibling.

Hawaii Healthy Start utilizes a paraprofessional model. Home visitors are trained paraprofessionals working with a team consisting of a clinical supervisor, clinical specialist, and child developmental specialist. Home visiting services includes but are not limited to screenings for possible developmental delays and referrals for early intervention services, teaching the care giver about child development, positive parenting skills and problem solving techniques, linkages with community resources, and encouragement to seek professional help for substance abuse, maternal depression, and domestic violence.

Recently the Department of Health, Maternal and Child Health Branch, Hawaii Healthy Start program has partnered with the Federal Centers for Disease Control and Prevention (CDCP) and Johns Hopkins University to study the effectiveness of a protocol designed to modify the parents perception of the child's communication and needs and promote more positive parental responses to the child. This is called the Hawaii Family Thriving Protocol, which involves a cognitive retraining component to prevent child abuse and emotional neglect by reducing acts of harsh parenting and increasing the quality of parent child interactions. Piloting of this intervention offers a new component within the current model.

Use of this curriculum would also change the current model by adding a criterion measure for staff acquisition of necessary skills. A fidelity monitoring mechanism is being used to assure that the protocol is carried out appropriately at each home visit. This component is currently in a pilot phase and is scheduled for statewide implementation for a main study in 2007. The study will progress through 2009.

The Institute for Family Enrichment (TIFFE) has also partnered with DOH, Early Intervention Section to support orientation and training for all providers of early intervention services for children with developmental disabilities in compliance with IDEA Part C. Topics included in these trainings are located in Attachment H.

TIFFE has also partnered with the Hawai`i Family Support Institute to develop a training curriculum for the Healthy Start Clinical Specialist at each program site. Program improvement activities included streamlining the Clinical Specialist's services to allow for more flexibility and options to be more responsive to the specific communities which programs serve.

Prior to the model revision, the Clinical Specialist had stringent and prescriptive requirements for documentation and activities that did not seem to be effective. With the model revisions, the Clinical Specialist can now focus on supporting the Family Support Worker in on-going child assessment and development activities in the family home and can individualize services based on the Family Support Worker's and family's needs.

It is anticipated that this curriculum can be integrated with another proposed study by Johns Hopkins University on the role and effectiveness of the Clinical Specialists in Healthy Start. Implementation of this training curriculum is also expected to start in September 2006.

Revision to this model also allowed more flexibility and responsiveness to individual family and community needs. The original model required the Clinical Specialist to review all assessments that met a specific cut off score and write a clinical plan for the family – before a face to face meeting. With the new model changes, the Clinical Specialist is able to provide consultation and actual treatment to families after their initial engagement by the Family Support Worker. This allows for better actual services to families and easier entry into the family, thereby encouraging better follow through with possible clinical referrals for substance abuse, domestic violence and mental health treatment.

The initial assessment of a family usually occurs in the hospital following the child's birth. Mothers and fathers are assessed using the Kempe Family Stress Checklist. The checklist assesses 10 risk factors, and is scored: Normal (0), Mild (5), or Severe (10); on the following factors:

	Risk Factors
1	Parent Beaten or Deprived as Child
2	Parent with a History of Criminal/Mental Illness/Substance Abuse
3	Parent Suspected of Abuse in the Past
4	Low Self-Esteem, Social Isolation, Depression, No Lifelines
5	Multiple Crises or Stresses
6	Violent Temper Outburst
7	Rigid and Unrealistic Expectations of Child
8	Harsh Punishment of Child
9	Child Difficult and/or Provocative as Perceived by Parents
10	Child Unwanted or At Risk for Poor Bonding

Items # 4, 5, 6, and 8 are considered changeable or malleable, and are the environmental risk factors that home visiting programs will focus on to reduce child maltreatment.

DOH Maternal and Child Health Branch will continue partnering with TIFFE to provide on-site technical assistance for OSEP compliance as well as support for implementation of recent revisions to the Healthy Start model. TIFFE has revised its "core" training for Family Support Workers to ensure the malleable risk factors are addressed in a service plan for the family and to focus on fidelity to the model.

DOH Maternal and Child Health Branch has partnered with the Department of Human Services, Public Health Nurses and the Hawai`i Family Support Institute to develop collaborative training for social workers, nurses, family support workers for a pilot community (Kalihi). Planning has been instituted and actual training and collaboration is scheduled to start in the fall.

Summary

- Hawaii Healthy Start is currently in the piloting phase of a home visiting protocol study by the Centers for Disease Control and Prevention and The Johns Hopkins University.

- Cultural appropriateness of the program model was noted along with curriculum development consistent with the proposed Logic Model. The Task Force discussed the merits of determining one curriculum for all programs; however members were divided between the virtues of the consistency of one curriculum or giving individual programs the option of tailoring a specific curriculum to the community the program serves.

- The Department of Health will continue to work with it's training contractor to revise and strengthen core trainings for the family support worker, clinical specialist, child development specialist, and supervisors.

6. Reviewing and considering evidence based best practices to enhance overall program effectiveness, particularly related to engagement and retention and outcome indicators, with a view to incremental piloting and state-wide adoption:

Research on the effectiveness of the Hawaii Healthy Start Program was shared with members of the Task Force. These include materials listed on Attachment I.

As a result of these reviews, 5 mainland programs were contacted to discuss their service models, specifically in regard to engagement and retention. These programs have distinguished themselves as effective and successful models and include:

- Pinellas County Healthy Families in Florida
- Hampton Healthy Families in Hampton, VA
- the Kentucky HANDS Program
- Healthy Families DC in Washington, DC
- and a home visiting program in Tillamook, Oregon

These programs conducted a majority of assessments and intakes prenatally,(50-90%) through working relationships with pre-natal clinics, OB/Gyn offices, and WIC clinics.

These programs appear to have high engagement and retention rates, and credit their very family friendly assessment practices, offer tangible benefits to families at intake, practice careful protocols for encouraging family participation, careful transitioning of families from assessment to home visiting, and careful and sensitive marketing/public relations describing their programs.

These programs exhibited better outcomes than most Healthy Families America (HFA) programs in regard to child abuse/neglect and other child health indicators. Evaluations included comparison groups and pre and post testing.

The Task Force then pursued further investigation into four of these programs (not including the home visiting program in Tillamook, Oregon) by conducting conference calls that included selected Task Force members. Based on responses and discussion of these five program models, the following recommendations regarding engagement and retention were made. (A summary of these telephone conference calls is included in Attachment J).

<u>Recommendations Relating to Engagement</u>

1. Collaboration with other government agencies can provide effective engagement rates. These agencies include WIC, OB/Gyn. Offices, Teen parenting programs such as Grads, Welfare payment offices, the Judiciary's Juvenile and Adult Probation Services, and DOH Public Health Nurses Community Health Centers, Catholic Charities' Try Wait Program, Baby SAFE, Malama Program, the Native Hawaiian Health Systems, and resource centers for the homeless.

2. Provide educational outreach to doctors (perhaps utilizing their "grand rounds"). Access can be linked to subsidies being directed towards prenatal care.

3. Develop a directory of services in Healthy Start programs, DOH, and DOE so that information about services for new parents is available to both the families and the providers.

4. Working prenatally with families provides the opportunity to reduce risk factors and make an impact before the baby arrives. This in turn enables a stronger, early focus on bonding and attachment.

5. Where needed, develop memoranda of agreement between the various parties. In some cases, such as community health centers, utilize DOH contracts as a vehicle to support this effort.

6. Develop a marketing plan for Hawai`i Healthy Start. Develop outreach and information strategies to specific populations not easily reached by the current program including immigrant and Filipino families. Work with The Institute for Family Enrichment (TIFFE) and Early Identification (EID) to develop informational packets to distribute to teens, young families and others.

7. Expand the window of referral from 0-12 months to 0-30 months. Allow for families to exit and re-enter the program as needed. Changes to the client criteria will also allow for interventions with families identified as in need rather than limited to the birth period.

<u>Recommendations Relating to Retention</u>

1. Leave the door open to families up to 30 months to allow families that may have attempted self-determination to return for help if needed.

2. Increase prenatal screening and engagement. During screening, families should be informed of the issues they face. Educate the consumer on the natural path/tendency to drop out of the program. Share the warning signs and identify the pre-disengagement warning signs (anticipatory guidance).

3. The Task Force recognized the venue for "home visiting" is not always culturally appropriate for the families the program serves. The program model needs to be revised to allow for visiting and interventions to occur outside of a family's residence. The Task Force recognized a variety of ways to ensure that families enrolled in the program would want to stay in the program. Some of these different approaches include:

    - One on one consultation and services
    - Group settings. This works well with Micronesian and other families where participants meet out in the yard at a relative's home with FSW to get family support

- Meeting with mini groups at parks.
- Using the meetings to swap baby clothes
- Ohana Circles.
- Incentives at milestones such as shopping coupons.
- Evening sessions
- Involving fathers including models such as TIFFE's Nurturing Fathers' Program.

4. Conduct Family Satisfaction surveys to determine relevance and effectiveness. Conduct exit interviews when families leave the program.

7. **Considering reallocating more resources to training and TA mentoring to enhance staff effectiveness and to program outcome data evaluation for regular reports to funders:**

DOH Maternal and Child Health Branch has been proactive in modifying its data management system to capture information demonstrating program efficacy as it is presently managed. (e.g. capturing data on 'successful terminations/discharges' when child and family goals are met prior to staying in the program for the full three (3) years). Final recommendations from this Task Force related to these restructuring changes will dictate changes in the program's protocol for collection of data needed to demonstrate overall efficacy and cost effectiveness.

DOH Maternal and Child Health Branch has implemented systems within the Healthy Start Program to allow for timelier, more efficient, and more accurate reporting of financial information to management.

- The MAS 90 system is a financial accounting software that provides the program real-time information on program expenditures as well as allocation status. The Healthy Start Program is able to use the MAS 90 system to generate reports to project future program expenditures on a prescribed timeline, or through ad hoc reports that can be generated in a timely fashion.

- The Healthy Start Program has also increased its ability to utilize the CHEIRS Database Management System for the reporting of program and financial data. The improved utilization of this system is affording the program the necessary information to:

    - Conduct better monitoring activities at both the program and fiscal levels.

    - Identify quantitative benchmarks that effectively measure program outcomes.

DOH Maternal and Child Health Branch resources include funding for curriculum development through the Centers for Disease Control (curriculum development), Consuelo Foundation (Clinical Specialist training curriculum and study), and TANF for the Enhanced Healthy Start portion of the program.

Recommendations:

- The current budget for training is $250,000.00 per year for the next four years and has remained at this level for the last five years. Needs for additional training and expansion of training have been identified through this planning process. In light of changes in the program, new information and research findings, and increased complexity of needs within the client population, new training components should be added to the overall program. Based on current needs, it is estimated the current funding is inadequate to support increased training needs. In addition, the need to maintain local trained trainers which requires a training/mentoring process, and to provide technical assistance and quality assurance monitoring on a broader scale than the current budget allows.

- The Healthy State Advisory Task Force recommends setting aside 3% of annual Healthy Start funding towards training needs.

- To maintain consistency in training, establish common practices in the program, and incorporate systems wide accountability, the Department of Health needs to control the training programs instituted to prepare program staff and administrators.

- Recommendations highlighted the need for evaluation at several levels, including studies on new service components, as well as regular assessments of program performance. This activity is critical to ensure that the program attains and maintains program fidelity and is effective.

- The task force recommended that 10-15% of the value of the overall budget be added for evaluation to establish efficacy and effectiveness of the program model.

Healthy Start Advisory Task Force Members

NAME	ORGANIZATION
Ron Akana	DOH/ASO
Elaine Andrade	DOH - OHE
Gail Breakey	Hawaii Family Support Institute
Sue Brown	DOH – Early Intervention Section
Lorraine Davis	YWCA of Hawai`i Island
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Barbara Yamashita	DOH - CHD

SCR 13/45 Task Force Indicators

Population indicators for young children (0 – 5) and their families

#	Indicator	Data Source	Discussion
1	Percentage (and number) of reports, accepted for assessment of child abuse and neglect among children, 0-5, as measured by NCANS.	**CWS to provide data for FY 02, 03, 04**	Lee Dean, DHS, reported that there has been no response to his request for data and so he has now requested the data from Research and Stats (Ricky) Per Lee Dean, he has recently requested data for indicators 1 & 2. He will see if they can be expedited to be rec'd within two weeks. Data to be disaggregated by reports while child is in out-of-home placement and reports of suspected in home abuse. There will not be relevant baseline data (for indicators #1 & #2) in FY 05, but the committee believes the historical data will be useful anyway.
2	Percentage (and number) of confirmed abuse and neglect cases for children, 0-5.	**CWS to provide data for FY 02, 03 and 04**	Data to be disaggregated by type of abuse and by age (in 1 year increments). In future years CWS intends to include data on cases that are diverted to Diversion/Family Strengthening services.
3	Percentage and number of assessed cases, age 0 - 5, across the six levels of treatment/injury tracked by DHS.	**CWS to provide data for FY 02, 03, 04**	See note in #1 above Lee to request data for newly defined indicators 3 &4
4	Percentage and umber of confirmed cases, age 0 – 5, across the six levels of treatment/injury tracked by DHS.	**CWS to provide data for FY 02, 03, 04**	

Target population indicators specific to SCR 13

#	Indicator	Data Source	Discussion
5	Percentage (and number) of parents of newborns screened at birth of child.	**Healthy Start to provide data for FY 02, 03, 04**	New data was provided for indicator 5 & 6 as a result of some data work that has been done lately. A copy of the updated data report is attached by reference.
6	Percentage (and number) of parents, screened positive, who are assessed within three months of referral.	**Healthy Start to provide data for FY 02, 03, 04**	
6b	Percentage (and number) of parents, screened positive by HS who then appear as confirmed abuse or neglect cases with CWS within one year, two years and three years.	**Matching data between HS and CWS –** HS and CWS to consider how this data will be gathered.	Would like data broken down by type of confirmed abuse as well as by the six levels of treatment/severity CWS tracks.
6c	Percentage (and number) of families assessed positive by HS who then appear as confirmed abuse or neglect cases by CWS within one year, two years and three years.	**Matching data between HS and CWS –** HS and CWS to consider how this data will be gathered.	Would like data broken down by type of confirmed abuse as well as by the six levels of treatment/severity CWS tracks.
7	Percentage (and number) of confirmed reports of abuse or neglect among families who have an IFSP and at least one visit from Healthy Start worker with the last three months..	**Annual Healthy Start data matched with CWS data – FY 02, 03, 04** HS and CWS to consider how this data will be gathered.	Disaggregate data according to Family Stress Checklist scores, in increments of 10; disaggregate data by type of abuse and by six levels of severity/treatment.
8	Percentage (and number) of confirmed reports of abuse or neglect among families served (need to confirm what constitutes service) within the past one year, two years and three years by Healthy Start.	**Annual Healthy Start data matched with CWS data – FY 02, 03, 04** HS and CWS to consider how this data will be gathered.	Disaggregate data according to Family Stress Checklist scores, in increments of 10; disaggregate data by type of abuse.and by CWS' six levels of severity/treatment.

9	Percentage (and number) of confirmed reports of abuse or neglect among families (0-5 children) while being served by CWS, voluntary case management and Family Strengthening providers.	**Annual Family Strengthening data matched with CWS data – begin when CWS starts tracking. indicator will conform with the way in which CWS is collecting data. Lee to let us know when CWS begins tracking this indicator.**	Disaggregate data by type of abuse, CWS' six levels of severity/treatment; and age of child.
10	Percentage (and number) of Healthy Start families engaged in the program who show a decrease in family risk upon leaving the program.	**Healthy Start data base** **(don't include families that leave due to moving)**	Healthy Start has developed a set of measures to reflect decrease in family risk**.** Engagement means that a family has signed off on the IFSP.

System indicators specific to SCR 13

#	Indicators	Data Source	Discussion
11	Engagement rates among positive assessed families that enroll in Healthy Start.	**Healthy Start data system – baseline 04**	Engagement means a family has signed off on the ISFP. Disaggregate data by scores, grouped in increments of 10, on the Family Stress Checklist.
12	Retention rates among families in the Healthy Start program who remain active for at least one year.	**Healthy Start data system – baseline 04 (extend baseline if not too much work)**	Disaggregate data by scores, grouped in increments of 10, on the Family Stress Checklist. The rate will be defined as the number still active over the number engaged.
13	Percentage (and number) of families with young children (0-5) that are being served jointly by both DOH[1] and DHS[2].	**Healthy Start data system**	New indicator – assume no baseline.

[1] DOH refers to both Early Intervention Services and Healthy Start Services
[2] DHS refers to Child Welfare Services and all Family Strengthening and Voluntary Case Management Srvs contracted providers

14	Increase in the percentage (and number) of young children (0 – 5) confirmed by CWS who receive comprehensive health evaluation.[3]	**CWS**	Assume there will be no baseline. DHS & DOH to consider how this indicator will be tracked. Can we use case review data for both children in families and in out of home placements? Can we use date of last physical? Will the H-Kiss 0-3 data be useful? The committee should review the referral/acceptance practices currently in-place between CWS and EIS.
15	Percentage (and number) of Healthy Start families, assessed by Healthy Start with domestic violence, substance abuse, or mental health problems, who are engaged with appropriate services[4] at 6 month and 12 month intervals.	**Healthy Start data base**	New indicator – no baseline

[3] Comprehensive health evaluation is an evaluation in all domains by professionals with expertise in those domains. This would include at a minimum a thorough evaluation to include gathering of medical records and an evaluation that focuses on medical health, psychological/social evaluation (over age 3), and assessment of development attainment (under age 3).

[4] Appropriate services means that the services are appropriate for the specific problem. Appropriateness is determined by Healthy Start.

#	Indicators	Data Source	Discussion
16	Percentage (and number) of cases referred by DOH to CWS, in which DOH receives an assessment disposition within 60 days.	**Data will need to be matched between CWS and Healthy Start data bases**	
17	Number of cases referred to DOH by CWS.	**Healthy Start data base**	New indicator – no baseline.
18	Service satisfaction among families with children, 0 – 5, served by both DOH and DHS.	**Need to be determined**	Data collected by J. Hopkins researchers may be useful. Also enhanced HS might be useful. We will want to survey drop outs as well as those who are actively being served. Survey questions to be developed by a small working group. Consider the current family satisfaction survey used in the Healthy Start program.
19	Satisfaction of workers working with families jointly by DOH and DHS.	**Need to be determined**	This will need to be standardized. Survey questions to be developed by a small working group.
20 & 21	**% of families screened and with a full assessment within 30 days.** **% of families screened who refuse services.**		

MCHB CLINICAL SPECIALIST MODEL

The responsibility of the Clinical Specialist (CSp) is to provide services focused on family psychosocial issues including family violence, mental health, and substance abuse. The purpose is to support the optimal growth and development of children. The primary services are consultation, referral, training, assessment, and short term intervention. The CSp services supplement the Family Support Worker's (FSW) and the Clinical Supervisor's (CS) work with the family.

A. CSp Referrals

1. Procedure:

a. Identify concerns:
   1. FSW and CS identify concerns that may benefit from consultation and/or training from the CSp
   2. FSW and CS identify concerns that could be addressed through CSp assessment and intervention services.

b. Within 5 working days of identifying concerns, a referral form is sent to the CSp.

c. Within 5 working days of receiving the referral, the CSp attempts to contact the FSW and/or family for consultation, training, and/or services.

2. Identified concerns include but are not limited to:

a. Relationship difficulties, including family violence
b. Substance abuse
c. Mental health
d. Family crisis

B. CSp Service Options:

1. Consultation and Training

The CSp services include individual consultation and group training to families and staff on topics relating to the identified concerns (listed above) and on other topics as appropriate to staff and families' needs.

a. Examples for Staff:
   1. Interpret or explain clinical concerns on the EID Intake and/or other records.
   2. Education staff on how to identify typical warning signs of family violence, substance abuse, and mental health issues.
   3. Equip staff with ways to encourage families to accept CSp services when appropriate.
   4. Prepare staff to give an appropriate response to consumers in crisis.

b. Examples for Families

1. Educate families on how to self-assess and identify warning signs of family violence, substance abuse, and mental health issues.
2. Help families to create a safety plan.
3. Encourage families to access community resources, including short-term therapeutic services, when appropriate.

2. Assessment and Intervention

The CSp services include assessment and intervention to families who are treatment ready and who may benefit from short-term intervention or support for follow up of private providers' treatment recommendations.

a. Examples of Assessment

1. Assist in the development of IFSP objectives, which pertain to identified concerns and CSp services.
2. Complete a Psychosocial Assessment for a family.

b. Examples of Intervention

1. Develop with the family a Service or Care Plan, identifying goals pertinent to CSp services.
2. Provide short term interventions to address identified concerns. CSp services may be extended if community services are not available or appropriate.
1. Encourage families to access community services, including on-going therapy, when appropriate.
2. Follow-up with the family, when possible, to confirm and support families' use of community resources.

C. Documentation of CSp Services:

Documentation includes reasons for referral, concerns addressed in CSp services, goals and progress, CSp services provided (e.g. consultation, training, assessment, and intervention), and referrals offered to family as appropriate for each referral.

- **Examples of Documentation:**
  a. Psychosocial Assessments
  b. Service or Care Plans
  c. Pre and Post Tests
  d. Progress Notes
  e. Quarterly Reporting

MCHB CHILD DEVELOPMENT SPECIALIST MODEL

The responsibility of the Child Development Specialist (CDS) is to provide services focused on child development and parent child interactions. The purpose is to support the optimal growth and development of children. Services include assessment, intervention, consultation/training, and care coordination.

A. Required Referrals to CDS Within 5 Working Days of Identified Concern:

1. 1 SD in one developmental domain consecutively from one assessment period to the next (1SD in Gross Motor at 4 mos. and again at 6 mos.) on the ASQ
2. 1 SD in more than 1 developmental domain on the ASQ
3. 2 SD in any developmental domain on the ASQ
4. ASQ-SE with score above cut-off
5. 6 month Teach 44 and below
6. 18 month Teach 46 and below
7. Feed done at 1-5 months 49 and below
8. Feed done at 6-12 months 54 and below
9. HOME at 4-8 months 32 and below
10. FSW, CS, or parent concern on child development issues
11. Program specific referrals, e.g. scores on the Family Stress Checklist.

B. CDS service options shall include:

1. Assessment

- Use appropriate tools to assess child's development.
- Use appropriate tools to assess parent child interactions.
- Observe parent and child in their natural environment and group settings.

2. Intervention

- Demonstrate child development activities for families.
- Provide role modeling at home visits
- Provide advice and support to parents regarding child development, parent child interactions, and participation in Early Intervention services

3. Consultations/Trainings

- Recommend and demonstrate intervention activities and role modeling to other staff regarding child development and parent child interactions.
- Provide technical assistance to other staff regarding interventions related to child development and parent child interactions.

- Assist staff in the development of the IFSP, e.g. present level of development and outcomes.
- Conduct trainings for families and staff in child development issues and/or various developmental screening tools.
- Explain information from comprehensive developmental evaluation (CDE) to staff.

4. Care coordination

- Coordinate request for a CDE within two weeks of referral to CDS.
- Notify pediatrician of the CDE request within two weeks of referral to CDS.
- Provide outreach to parents for acceptance of CDE referral.
- Participate in CDE as appropriate
- Refer families to Early Intervention services as needed

C. Documentation of CDS service:

- Documentation should include reasons for referral, service plans, all services provided, e.g. assessment, intervention, consultation, and care coordination, and outcomes.

Kempe Family Stress Checklist

1. Childhood history of being abused
2. Substance abuse, mental illness or criminal history
3. Previous or current Child Protective Services involvement
4. Low self-esteem, poor coping ability
5. Multiple life stressors
6. Potential for violent temper outbursts
7. Unrealistic expectations for child's development
8. Harsh punishment of child
9. Perceives child as being difficult or provocative
10. Child unwanted or risk of poor bonding

Scoring:
0 = No problem
5 = Mild problem
10 = Severe problem

Positive assessment: A total score of 30 for either parent triggers a referral to home visiting

The Institute for Family Enrichment Training Topics

Family Violence
Substance Abuse Basics
Advanced Substance Abuse
Foundation Training: Dynamics of Child Abuse and Neglect
Foundation Training: Introduction to Nurturing Fathers
Foundation Training (Child Abuse and Neglect, Introduction to Early Intervention, and Nurturing Fathers)
Mental Health
Maternal Family Health
Nurturing Principles and Practices
Cultural Sensitivity
Culturally Relevant Programs for Families
Early Childhood Basics
Advanced Childhood Development
Working with Teens
Boundaries and Ethics
Family Support Worker Role Specific Training
Administering the ASQ
Clinical Supervision
Creating an Effective IFSP

Dates of Training	Training Topic	Number of Participants
10/11 – 10/12/05	Foundation Training: Healthy Start delivery system for the Prevention of Child Abuse & Neglect -Dynamics of Child Abuse & Neglect -Introduction to Early Intervention Services -Nurturing Fathers Program	9
10/25 – 10/26/05	Foundation Training	26
10/31 – 11/4/05	Core Training: Family Support Worker/Supervisor	14
11/7 – 11/8/05	Foundation Training	27
11/28 – 12/1/05	Core Training: Family Support Worker/Supervisor	16
12/5 – 12/9/05	Core Training: EID Worker/Supervisor	13
12/7 – 12/8/05	Foundation Training	34
1/24 – 1/25/06	Foundation Training	8
1/26 – 1/27/06	Early Childhood Basics: -Overview of Development -Baby Care Basics -Baby Health & Safety	12
1/31/06	Culturally Relevant Programs for Families: -6 Guidelines to Creating culturally relevant services	8
2/10/06	Maternal & Family Health: -Family Planning/Nutrition -Post Partum Depression	19
2/15/06	Nurturing Principles & Practices: -Discipline/Punishment/Behavior -Spanking/Choices/ASK	15
2/17/06	Family Violence: -Domestic Violence/Relationships/Kids -DV and Trauma	13
2/27 – 3/3/06	Core Training: Family Support Worker/Supervisor	17
3/21/06	Substance Abuse Basics: -Home Visitor Role -Interventions/Applications	13
3/24/06	Administering the ASQ: -Overview of ASQ & calculations -Score and overall section -ASQ-SE	13
3/28/06	Clinical Supervision: -Employee Selection -Supervisors “Home Visitor” Model	6
3/31/06	Mental Health: -Defining Mental Health -Paradigms of MH and Psychopathology -Functional Social-Emotional Development	15

4/4/06	Boundaries & Ethics: -Personal Safety -Defining Ethics -Setting Personal/Professional Boundaries	21
4/19/06	Advanced Substance Abuse: -Signs & Symptoms -Categories & Effects -Resources	14
5/1 – 5/5/06	Core Training: Family Support Worker/Supervisor	13
5/9 – 5/10/06	Foundation Training	16
5/11 –5/12/06	Early Childhood Basics	9
5/16/06	Working with Teens -Brain Development -Understanding Adolescents -Case Study and Resources	22
5/25 –5/26/06	Advanced Child Development: -Development (0-12 months) -Development (12 – 36 months)	5
5/30/06	Boundaries & Ethics	10
6/2/06	Maternal & Family Health	7
6/10 –6/11/06	Core Training: Family Assessment Worker	13
6/6/06	Culturally Relevant Programs for Families	13
6/16/06	Administering the ASQ	17
6/27 –7/3/06	Core Training: Family Support Worker/Supervisor	12

Hawai`i Healthy Start Logic Model Implementation Benchmarks.

The program benchmarks will be used to determine the adequacy of outputs as indicators of progress towards meeting the program's long term outcomes, and also provide a measure of program objectives as a subset of program goals. These measurements are listed in the logic model and also in Appendix F. Measurements tools for each Implementation Benchmark are indicated in parentheses. The percentages used are aimed at both ensuring that families receive sufficient care or assessments to reach program goals and objectives and constituting a reasonable workload for staff. Some of these have been changed from previous designations.

Child Health and Development

- 95% of families enrolled have a medical home for the infant. (CHEIRS)
- 90% of families enrolled comply with immunization schedules. (CHEIRS)
- 100% of families enrolled are given information on preventive oral health behaviors. (Checklist)
- 90% of Healthy Start mothers get early pre-natal care for subsequent pregnancies. (CHEIRS and EID)
- 90% of eligible pre-natally enrolled mothers utilize WIC services. (MCHB will extract data from database and cross check with data from WIC)
- 90% of enrolled families will evidence positive parent-child interaction. (NCAST)
- 90% of enrolled families have a positive environment for child development. (HOME and NCAST)
- 100% of Healthy Start programs provide opportunities for father involvement. (Narrative in Annual Report)
- 95% of enrolled children receive developmental screens/evaluations. (ASQ and ASQ-SE)

Child Safety

- 100% of enrolled families are administered a child safety checklist. (Home Visitor Records and the IFSP)
- 100% of enrolled families are given information on age appropriate disciplinary strategies. (Annual narrative report)

- 90% of enrolled families receive a post test demonstrating a reduction in family risk factors (Level System Assessment, Home Visitor Records and HOME)

- 99% of Healthy Start families will be CA/N free. (Quarterly Report, CWS Report, DOH/DHS communications)

- 95% of Healthy Start families known to Child Welfare will not have incidences of confirmed re-abuse or neglect (Quarterly Report and CWS Report)

Healthy Family Functioning

- 100% of enrolled families identify goals related to risk factors on their IFSP. (Annual narrative report)

- 90% of enrolled families increase their problem solving skills. (Level System)

- 90% of enrolled families expand their support networks. (Level System)

- 90% of enrolled families identify and get referrals to services. (ADCF and Annual Data Collection Form)

- There is a 2% reduction in repeat pregnancies (less than two years apart) among Healthy Start families. (Received family planning information via Annual Narrative report; DOH will extract data from database and DOH birth records)

- 30% of enrolled families with an identifiable substance abuse or mental health problems will be referred and engaged in appropriate treatment programs. (Clinical Specialist Quarterly Report, IFSP - Re-programming or CHEIRS is required to achieve this)

Early Intervention Services Training

Orientation:
Day 1:
History and Law of Early Intervention
Organizational chart
Eligibility
Mandated Services
Referral Process
Care Coordination
Family centered care philosophy
Home based services
Culture
Family Rights
Communication

Day 2:
Teaming
Evaluation and Assessment
IFSP Process
Family Concerns, Priorities, Resources
Outcomes/Objectives
Natural Environments
Transdisciplinary Approach

Day 3:
AFS Procedures
Referral procedures for EIS resources
Transition Process

Day 4:
Developing an IFSP with the family

Hawaii Early Learning Profile (HELP)
Determination of Part C eligibility
Origin and Design of HELP
Determination of Comprehensive Developmental Evaluation (CDE)
Glossary of Terms
Completing the HELP
Writing a CDE report
Resource materials
Training/Mentoring

The following reports were reviewed by the Task Force in its meetings:

- Samer S. El-Kamary, et al, Hawaii's Healthy Start Home Visiting Program: Determinants and Impact of Rapid Repeat Birth, Pediatrics, September 2004
- AnneDuggan, et al, Hawaii Healthy Start Program of Home Visiting for At-Risk Families: Evaluation of Family Identification, Family Engagement, and Service Deliver, Pediatrics, January 2000
- Catherine Nelson et al, Medical Homes for At-Risk Children: Parental Reports of Clinician-Parent Relationships, Anticipatory Guidance, and Behavior Changes, Pediatrics, January 2005
- Anne Duggan et al, Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors, Child Abuse and Neglect, 2004
- Amy Windham et al, Risk of mother-reported child abuse in the first 3 years of life, Child Abuse and Neglect, 2004
- Monica A. Sweet and Mark Appelbaum, Is Home Visiting an Effective Strategy? A Meta-Analytic Review of Home Visiting Programs for Families with Young Children, Child Development, September/October 2004
- Jack P. Shonkoff and Deborah A. Phillips, Editors; Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families, From Neurons to Neighborhoods: The Science of Early Childhood Development, 2000

Several documents have been shared with HSATF to identify practices in other Healthy Start/Healthy Families programs across the country. These documents include:

- Addressing the Issues: Using Research to Guide Practice, Hawaii Family Support Institute, October 2005
- Anne Duggan, Evaluating a Statewide Home Visiting Program to Prevent Child Abuse in At-Risk Families of Newborns: Father's Participation and Outcomes, *Child Maltreatment,* February 2004
- Anne Duggan et al, Evaluation of Hawaii's Healthy Start Program, *The Future of Children: Home Visiting: Recent Program Evaluations,* Spring/Summer 1999
- Summary on Outcomes of Home Visiting Programs, Hawaii Family Support Institute, 2005
- Summary of a Program Survey on Practices Related to Good Assessment, Engagement and Retention Outcomes, March 2006
- Effective Practice in Screening and Assessment within HFA: A survey of programs regarding these issues among programs evidencing good outcomes and conducting substantial pre-natal assessment, March 2006

- Home Visiting Programs which Showed Evidence Based Efficacy, Hawaii Family Support Institute, (presented at the HSATF)

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
How many births are there annually in your target area?	• 1,904 (2004)	• 9,000 usually closer to 10,000 but last year it was lower.	• 7,000 – 8,000 annually in Washington, DC. • All but one ward, serve 1 thru 8. • Do not have the capacity to serve all 8,000 births.	• Statewide 9,253 (projected families) • Target area 213 (projected families)
How was the target area(s) selected?	• In 1992, a conversation with the City about resources and who was not getting education, training, schools, children with specials needs, and how to make positive changes. It started with the decision makers taking a proactive stand at looking into change. The program followed Hawaii's healthy start program	• Expanded countywide began by looking at the census track (zip code) • 8 selected in 1992 • Using 4 risk factors on how to plan which area to target. • Looking at birth certificates and implemented in the South County (St. Petersburg) where the highest risk births were occurring. (4 risk factors): • (high risk) single teens • Low birth weight • Late or no prenatal care • 2006, 16 teams replicated the program throughout The county keeps the same process with regard with the high risk factors and where they are occurring. ▪ Added addition risk factors: previous CPS history/substance abuse. ▪ After area is targeted looking at the hospitals in that area ▪ The hospital is sub-contract ▪ Assessment piece coming in is a two-tier process: prenatal vs. postnatal. ▪ Dept. of Health	• Started back in 1994. • Grant opportunity through the Freddie Mac Foundation. • Because Washington, DC ranks 51st on all the key childhood indicators including C/A/N and child outcomes. • Grant opportunity to apply for funding to start a HFA program based on outcomes that were found in Hawaii. • Started with just 3 wards as a collaborative among 4 agencies in the city (the District is divided into 8 wards- do not have counties) ▪ Applied for [wards] 1,2,& 4, and based upon the outcomes and what people were seeing, expanded to every ward but ward 3. ▪ Ward 3 has better child outcomes than the rest of the city	• Divided into counties. • 120 counties in KT. • Did a massive roll out, rolled out 120 sites in three years. • There is a site in every county in KT. • First time parent births. • For a variety of reasons needed a powerful punch with the legislative body to be able to have a quick turn around. • Could get the best outcomes with the first time parents. • Start prenatally. • Start as soon as there is a positive pregnancy test (which gives the program ▪ 9 months to begin working on the particular environmental domains that affect children as soon as they enter the home). ▪ The entire state ▪ First time moms ▪ First time dads (it can be a first time dad and multi-gravitas mom)

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
How do socio-economic demographics of the target area compare with other areas of the state? (Child abuse, families below poverty level, etc.)	▪ Newport News is fairly close in this area. ▪ Williamsburg is at a higher socio-economic level – retired community, upscale housing. ▪ Virginia Beach is closest, ▪ Child abuse rates are similar – 8.8 families are below poverty level. ▪ Some above, some below ▪ Fairly large military presence, Langley Air Force Base, depends on income, dependant minors, have their own hospitals. Good relationship with military. ***Are the statistics all lumped together?*** ▪ The military keeps separate statistics of deliveries. ▪ However, if there is no room or depending on the types of insurance military families do delivery at private hospitals (these numbers are not separated out from Hampton's data).	▪ Highest risk area of county ▪ Cultural characteristics differ North vs. South ▪ 5 different health departments	▪ Washington, DC ranks 51st. ▪ Some wards have poorer outcomes than other wards. ▪ Wards 4,5,6, & 8 ▪ Starting to see families from ward 3. ▪ Serve the city because the city itself has poor outcomes.	▪ Highest risk area of county ▪ Cultural characteristics differ North vs. South ▪ 5 different health departments

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What are the rates for uninsured in the area? What percent of families are on Medicaid? What percent receive housing assistance? What percent are served by WIC and other MCH programs; what is the income eligibility for these?	▪ Uninsured/Medicaid ▪ Data was not available although Medicaid and FAMIS are represented. ▪ If the family does not have insurance, insurance can be obtained after the baby is born. ▪ (July '05) Pre-natal barriers: - An 18 year old is considered an adult and if residing with parents, the parents income is counted. - Housing/Section 8 has been closed for years. - Impossible to live on minimum wage salaries. ▪ Small number of uninsured if not covered pre-natally. ▪ Growing Hispanic population, because of residency status difficult to get Medicaid. ▪ WIC income eligibility fairly high but they do count the unborn child. Good WIC outreach. Including military, assessments are done pre-natally.	▪ Target group: rates of uninsured – 40% have 60% do not have ▪ Utilize ER as primary health provider. ▪ Because of the HMO process families never know which one they are on and if they were dropped.	▪ 50% of the families [served] are immigrants to the United States. ▪ Lack health insurance. ▪ Can get emergency Medicaid for the pregnancy and birth. ▪ Uninsured after the birth of baby but the child is insured. ▪ Program for adults called the "Alliance Health Insurance" that is new to the city which is helping to insure some of the adults. ▪ Majority (about 50%) come in uninsured ▪ The remainder which is African American with Medicaid. ▪ All of the families served have either the Alliance or Medicaid. ▪ Very few on housing assistance. ▪ Primarily because the resources are so slim in the city. ▪ Families get very little housing support or assistance. ***Does this mean a lot of them are homeless?*** ▪ A lot of families living together in households. ▪ Teen parents living with their parents. ▪ Total percentage of families in the program on housing assistance is small about 10 -15%. ▪ 85 -90% of the families in the program receive WIC.	▪ 75% Medicaid ▪ 25% non-Medicaid ▪ Tobacco dollars/non-Medicaid dollars that are budgeted at that particular rate all across KT. ▪ Each individual site has different ratios about how they draw down those dollars. ▪ Example: (in the four counties that Cheryl serves) 86-87% Medicaid – very high Medicaid area. ▪ No access to information today on percentage of families receiving housing assistance and WIC. –Did not have time to put together in time for conference.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS

Are there other contextual issues that might be different in your area than in other parts of the country, including Hawaii?	▪ Cannot think of anything
	▪ Urban population less than 150,000 probably 146,000 within city boundaries.
	▪ Newport News, pre-racially balanced:
	  ▪ 49% Caucasian
	  ▪ 48% African American
	  ▪ 2% Hispanic
	  ▪ 1% Asian
		▪ Large undocumented population in Northern County (from Mexico)
		▪ Children qualify for service, parents do not
		▪ Worked long on building trust, not linked with INS
		▪ Without SS number and proper documentation families try to fly under the radar and attract as little attention as possible.
		▪ Because of their status unable to link to services such as housing, etc.
		▪ Deterrent to accepting services.
		▪ Currently capped with regard to how many families can take.
		▪ Funding source several years ago allowed on team and that is the maximum for this population. (6 paraprofessional FSW average caseload 18 to 20 families).
		▪ Primarily in the Clearwater area in the Northern part.
		▪ Very tight community, hard to build trust, initially began visits through the health department.
		▪ Pinellas is the county and Clearwater is a city in that county.
		▪ St Petersburg is in the Southern county
		▪ Middle part of county is Pinellas Park.
			▪ ***Answered in # 3 & 4***	▪ Things that would hinder:
				  ▪ Literacy level
				  ▪ Difficulties with transportation
				  ▪ Difficulties with telephone
				▪ The other sites in KT are very rural,
				▪ There is an issue of literacy
				▪ In the way our children of ethnicity
				▪ Males, perform on Standardized Tests within the school system.
				▪ Have not performed well in the literacy arena.
				▪ Written up a Federal reading, “Reading First” grant
				▪ Several communities across the state
				▪ This is an area that we really needed to step up for our gateway region
				▪ We are a five county region to an ad district

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What are the rates of drug abuse, domestic violence, and mental health issues among families? How are rates measured?	▪ Only keep score on Family Stress Check List (not keeping these data/percentages). ▪ Everything lumped together, quite a few of all. ▪ Interested in Sexual Abuse stats. ▪ Data break out every year: Domestic Violence, Drug Abuse, and Mental Illness (ex: how many scored on #2, etc.) ▪ A lot of undiagnosed mental health issues. ▪ Problems more severe recently. ▪ (Agency) "Protect Our Kids" new resource for families of DV does pre-natal referrals.	▪ Cultural characteristics, instrument that lists the entire cultural characteristic. ▪ Took the list – went through each caseload. If it's a family with any characteristics - check all that apply. ▪ 25% Substance ▪ 20% ongoing problems with DV ▪ 23% mental health issues that either in therapy, on medication, or diagnosis that they are not seeking services. (Not 100% accurate but closest) ▪ Using the tool to can give an operational definition of what substance abuse means, etc. ▪ In a couple of months will create a glossary. ▪ Helps staff be more aware. ▪ Example: # of active mother in home, ▪ Grandparents, father, in home; # of children in foster care. Substance Abuse; where mother or father every in foster care. (Parents) ever removed by CPS, etc. ***Do you use the Family Stress Checklist?*** ▪ No, adopted the Healthy Families Florida assessment tool in 1999 ▪ The alternative to Family Stress checklist developed for Florida.	▪ Primarily alcohol abuse among the partners, about 40% of families ▪ Domestic Violence, 75% of population. ▪ Mental Health: started a depression screening tool and provide in-home mental health support. ▪ 45% with serious mental health issues that need follow-up and support (outside of just the FSW). ▪ CESD, depression screening tool to look for mental health concerns ▪ Screen for DV through the assessment and a DV screen. ▪ Drug & Alcohol abuse is assessed.	▪ High DV ▪ High substance ▪ Our outcomes around those areas have been excellent ▪ CA/N outcomes have been excellent. ▪ Influx of Methamphetamine ▪ There have more removals by CPS because of Methamphetamine use. ▪ Incidences are overwhelming ▪ Pornography ▪ Sexual Abuse skyrocketed around Methamphetamine use. ▪ Oxicodone is also a problem in Eastern KT, it is a very serious matter. ▪ Training all of the sites because of the oxicodone and methamphetamine. ▪ Everyone is encouraged to trainings because of workers going ▪ Into these homes, safety concerns. ▪ A lot of bi-polar ▪ Getting ready to institute for the state a depression inventory across the board. ▪ Some sites have been using a depression inventories. ▪ We want to make it more systematic so everyone is doing the same thing. ▪ We can do some measurement around that. ▪ Selecting the tool now to begin using in July 2006.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What is the severity of risk among families, and how is this defined and determined? (Assessment scores/cut-offs?)	▪ No cut off, have to score 25 or higher (90 was the highest ever enrolled). ▪ Families who are currently involved with CPS, families with children in foster care currently working toward reunification, Mother actively using, and baby positive toxic ▪ Screens, are seen as crisis. ▪ Referred to "Back to Basics" (a program of HFA) this is a short-term/temporary crisis management program. ▪ These families are served until the crises are over and the case is closed. ▪ Scores of 25-90 for 5 years. ▪ Currently case load full – cannot take all families. 5 open positions. ▪ No age cut off, 2weeks, & 5% 3months. ▪ Most assessments are done pre-natally. ▪ Case load limit by case load guidelines: 15-25 HFA standards ▪ Able to keep 10 families on wait list. ▪ If prenatal family on wait list will keep in touch and hopefully will have an opening by delivery. ▪ FSW = $23,000, Family Resource Specialist (equivalent to EID)=$25,000 annual salary.	▪ The cut off score for the pre-entry no cap ▪ 13 HFFAT , 13 compares to a 25. ▪ 13 (25) score entry. ▪ Currently involved in a research study that looks at the severity of risk ▪ Looking at the risk factors coming in at assessment ▪ Looking at 7 years of closed case files risk factor ▪ to see if there is a link to predicting successful outcomes.(funded by the Juvenile Welfare Board-Study being done by University of South Florida the Child Center) ▪ Money already allocated for study ▪ Looking for predictors and profiling of who we work best with ▪ Is there a population that we are not successful with ▪ How long do they stay, when do they drop out, etc.	▪ Use the Parent Survey for the HV program. ▪ Score of 25 or above. ▪ Used for the last 12 years; very effective. ▪ Derived from the Family Stress Checklist. ***If 25 is the cut-off, what is the average score for families?*** ***What proportion of your families are at a higher end risk, and what score you would consider being high end?*** ▪ This information is in the evaluation; will send information. ***Do you use a subsequent assessment as the family goes through the program?*** ▪ Yes, based upon screening different assessments may occur. ▪ Will refer out for some. ▪ Will refer out for drugs. ▪ Mental Health offered within agency can do diagnostic and assessment. ▪ If suspect drug abuse attributed to mental health concerns, will do mental health diagnostic & assessment internally. ***Are you able to get people successfully linked with substance abuse programs?*** ▪ Do not have a lot of resources in the city for Spanish speaking families, and/or for families that are parents, pregnant women & children. ▪ Connected with several programs for pregnant moms and their children but they are limited in space. ▪ Success once the family's enrolled. ▪ Getting enrolled can take some time. ▪ When the family is interested and wants to be enrolled, by the time they are actually enrolled it may be too late and have to work to reengage/re-enroll into program. ▪ May have to do other referrals. ▪ In the interim may include Protective Services based upon what is	▪ Parent Survey/ Family Stress Checklist ▪ Discussion about approaching on a statewide basis the use of the Parent Survey for the selection of adoptive and foster home parents . ▪ Parent Survey would be very beneficial there. ▪ Child and Family Rating Scale, more subjective, ▪ Getting this information as part of the HV and from the Parent Survey and Family Stress Checklist. ***PACT uses the Hudson Scales for depression, anxiety, mental health*** ▪ Wrap around training "Getting Past the Blues" used for post-partum depression, bi-polar, depression in general. ▪ Be able to tie to the curriculum and goal setting. ▪ Goes over very well ▪ They really feel a need for that. ▪ See a lot of un-medicated bi-polar. ▪ We do see (bi-polar) as being a very ever and present challenge in the case loads across the state. ▪ Especially during the pregnancy when the parent is trying to make the choice to medicate or not medicate ▪ Struggles within the family about whatever decision they make. ▪ Wanting to be able to provide support in a way that it will be utilized and the behavior will be changed. ▪ A big push there is not to be bearers of information but to be able motivate change and parenting behavior. ▪ Seem to be hitting the mark and raising the bar. ▪ Focused on health progress ▪ Focused on self sufficiency, all the primary goals ▪ Modeled from Hawaii Healthy Start ▪ Researched Hawaii HS and took those pieces and tried to match them on to what we had here. ▪ Cut off score 25 ▪ 11,000 visits a month every month

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What ethnic groups do you serve?	▪ 75% African American ▪ 24% Caucasian ▪ Less than 1% Hispanic & Asian	▪ 52% Caucasian ▪ 49% African American ▪ 7% English as a second language/Bi-lingual (more likely Hispanic)	▪ 46% Latino – El Salvador, Guatemala, Chile, Bolivia ▪ 49% African American ▪ The remainder are immigrants from, West & North Africa ▪ 5% non- Latino non-African American ▪ Latino population is rising and mostly from El Salvador	▪ Urban areas – African American & Asian ▪ Rural areas - Large Hispanic (and growing) ▪ 95% Caucasian ▪ Varies across the state ▪ Around the Universities you see a much better cultural mix.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What percentage of program families is uninsured for health care? Are on Medicaid? On Housing assistance?	▪ Do not have that info now ▪ Is tracked monthly ▪ Housing – No.	▪ Families were not taking advantage of services ▪ We receiving monies with Johnson, March of Dimes and other grants ▪ Sub contracted with other agencies in the community to provide: mental health services, housing, etc ▪ Found that if services were not housed with us staff did not refer to them, when referrals were made did not get the follow-up needed. ▪ Began to build a core of specialists outside of the HV, Supervisor, ▪ The specialized services included: ▪ (4) Nurses – 1 for every 4 teams, go out to mom's resistant to prenatal care, to reinforce the need for good prenatal care. After the baby is born it is a requirement that a nurse has to visit the home within the first 30 days. (So the FSW is not solely responsible for picking up on medical issues of mother & child)/Post-natally is with regard to the child. ▪ (4) Family Advocates/Mental Health counselors (licensed) to supervise in house counseling. – 1 for every four teams. Average case is a year, currently all four are capped. ▪ Some are just assessment at intake, going out and identifying issues, some can be resolved and some need more help. ▪ Masters Level, (1)Clinical Psychologist, (2) LCSW, (1) LMHC. ▪ (2) Housing specialist – (1:8 teams) initially thought families would take advantage of the home buyers program (and have assisted some families to purchase homes) . Most of the assistance is with tenant/landlord advocacy, helping with evictions, homelessness, temporary shelter, section 8. ▪ Housing assistance available ▪ Government housing, complexes, section 8	▪ *Answered in Part I no.4*	

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
		▪ (2) economic development specialist- (1 per 8 teams)help families with resumes, help them find jobs, job shadow, build relationships with the work force community, help them get GED, enrolled in school. ***What are the salary ranges?*** ▪ Masters level therapist – 32,000-35,000 ▪ FSW start at 19,500 / FSW II 22,000 ▪ Field Supervisor (if with a contract agency) 28,500 / (if Health Dept. employee) closer to 31,000 ▪ Nurse 30,000 ▪ Median price for a home: 150,000		

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
	▪ Yes, initially. ▪ No longer have prenatal clinic at Health Dept. ▪ Local health clinic (non-profit), have to pay but will not deny service if unable to pay. ▪ WIC – referral by WIC staff. ▪ Breakdown of assessment by trimester (will send in trimester breakdown).	▪ A little over 50% from Healthy Start system through the Health Dept. ▪ Healthy Start in Florida is a mandatory screen of all pregnant women in the OB arena at their private OB ▪ Mandated by state law ▪ Looking at low birth weight and the ability for the women to carry the pregnancy to term-prevention of premature labor. ▪ Risk assessment, Healthy Start Prenatal Risk screen ▪ Than get a family survey after that. Equivalent to Hawaii's screen (15) questions. ▪ OB's are required to do the screen and these screens are sent to the county health dept. in that county. ▪ Healthy Families are in the county health dept. so they get those screens. ▪ Than HF goes out and does the face to face assessments. ▪ Screens are done with potential consumers written authorization. ▪ When the families consent to the HS prenatal they also consent to the HF assessment. ▪ Electronic information sharing ▪ Kiosk in physicians office ▪ Have the woman go online and do the HS portion of the screen, the physician just pushes a button, transmits to HF ▪ Face to face happens in. ▪ home prenatally ▪ Families can stay in program for 5 years, but usually leave between 2 to 3 years (average 26 months). ▪ Strict definition of successful completion codes ▪ Losing valuable data because of moved out of area, etc.	▪ They are not DOH programs we have community pre-natal clinics. ▪ DOH does not oversee the clinics. ▪ DC Primary Care Association . ▪ They have Medicaid, fee for service. ▪ We are also a qualified health care center. ▪ Have a prenatal program & partnered with prenatal clinics through one of our largest hospitals in the city. ▪ Including the community clinics that are spread throughout the wards. ▪ 90% of intakes are prenatal. ▪ Try to get all intakes prenatal. ▪ Outreach workers to identify women not yet linked for care that is pregnant. ***What was the reason for that the need to encourage access to prenatal care or was it motivated for other reasons?*** ▪ Because of the poor outcomes. ▪ A variety of outcomes: - Insure women had access to prenatal care and break down the barriers. - Poor birth outcomes. - Ensure engagement in the program, screen for depression, & other indicators that could negatively impact the birth of the child once it was here. ▪ Support attachment once the baby is here	▪ Primarily located at the Health Dept. ▪ Partnering initial intake with WIC, working very well ▪ We do one of the Parent Surveys across the state at a variety of places ▪ Screenings occur in: ▪ Hospitals ▪ Maternity Centers ▪ Birthing Facilities ▪ Prenatal Clinics ▪ Referrals for Resource Centers in the schools ▪ Adolescent Health units in our schools • Nurse on site from the Health Dept. • Referrals from Protection and Permanency • Pediatricians and OB/GYNs
Are primary pre-natal				

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
Are your program and DOH programs serving as sources of intake under the same organization: Or do you have MOA's with these programs?	▪ Louise's position is an in-kind position from the Dept. of Health. ▪ Always been under Health Dept. ▪ Recently, have been able to bill Medicaid for Healthy Start services. ▪ DHS/DHR/Social Services/Healthy Start & others. ▪ Health Director is delegated by DHR (but is technically still under DOH). (DHR oversees Health Director oversees Healthy Start). ▪ DHR does not oversee WIC clinic. ▪ Able to work with Clinic without MOA because they are under the Health Dept.	▪ Contracts with four major hospitals in the county for post natal intakes ▪ Sub-contract a portion of dollars to do the intake at the hospital. ▪ Masters level Social Workers who are employed by the hospital but dedicated to the HF. ▪ Hospital employees who are funded positions. ▪ HF provide with the core HF training and the training of the assessment tool. ▪ Physically housed in the hospital on the OB ward and are hospital employees. (In three of the hospitals) ▪ Fourth hospital, 1.5 FTE health dept staff, physically housed in the hospital doing the screens of all the pregnant women who have positive screens. (Some of the 1.5 FTE are Bachelor's level- the lead is a Master's level and also a grant ▪ Coordinator). ▪ 53% prenatally once they go to the hospital they have a second chance to say yes. ▪ First home visit must be done prior to the child turning 90 days old. ▪ Most families come in prenatally, 87% prenatal or within the first two weeks of child's birth.	▪ Have MOA's, ▪ Partnered with community clinics across the city ▪ Program that works with teens identified through the Child Welfare System, pregnant/parenting teens partners to help provide support to those who are aging out of the Child & Family Services Administration (CFSA equivalent to CPS). ▪ Work with teens to support preventing second pregnancy, ▪ Relationships with group homes and clinics. ▪ All done through MOA's ▪ Total 12 MOA's	▪ Are under the same umbrella ▪ Ran into some glitches getting MOA's ▪ Are actually still maintaining a collaborative focus within the community. ▪ Work the OB/GYN meetings ▪ Rounds at the hospitals ▪ Go on the floor and introduce the service at the time of birth. ▪ One hospital it was a part of their outcome study for the year. ▪ Their quality outcome measurement. ▪ Visited with them when they came into pre-admit. ▪ Very collaborative throughout the state. ▪ Success with the grants because of the collaborative relationships. ▪ Everybody loves to come to the table here. ▪ 98% prenatal intakes. ▪ Use the prenatal ▪ Curriculum from Growing Great Kids. ***Does it help keep them engaged?*** ▪ It has helped a lot ▪ Supplement with other things ▪ Growing Great Families the other piece ▪ It's about goal settings, culture and traditions ▪ Strengths, the strengths index, resolving disagreements. ▪ Situations that families are more likely to encounter. ▪ Keep the family focused on the baby in the midst of all those things. ▪ Window of opportunity (prenatally) to create a more secure/safe environment for the child to enter into the home at the time ▪ Able to get 1 to 4 visits a month prenatally (most sites do 2 to 4) ▪ Right after the positive pregnancy test they are ▪ Immediately referred to WIC, Nutrition, and HANDS. ▪ Even if the mother is not sure about the visits at that time, still have a window of opportunity to engage for 9 months. ▪ Creative outreach around the assessment for the parent visitor piece.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
Does your program have any criteria/ requirements besides out of the program?	▪ Uses the screen and check list. ▪ No income criteria.	▪ Only requirement is they score on the assessment tool ▪ Say yes	▪ Parent Survey only. ▪ Any income, age, etc.	▪ Standard screen 1 thru 15. ▪ Added a #16 on second hand smoke (because it is such an issue in KT)
What is the acceptance rate at assessment; how determined?	▪ Determined by number of families who are offered services and how many accept. ▪ 99% acceptance. ▪ Universal screening, WIC, Medicaid, Pregnancy test at hospital, private doctors. ▪ 3 hospitals screen at hospital (universal), schools, nurses, and prenatal clinics. ▪ Families establish relationships with other agencies so it is not unusual to get 6 referrals for one family. ▪ Hospital negative screens : are more likely to be Prenatal?/Hospital? (Will find out – tracked monthly). These do not specifically identify teens who have not told their parents or mother's who have moved).	▪ 89-92% initial 3 hospitals ▪ (Adding the recent hospital) 86%, because in a new hospital the first couple years you get a higher rate of refusals. ▪ Usually in the hospital setting: 4% refusal rate after we've been in there a while. ▪ For those who accept the program the current acceptance rate across the board after the home visit is at 86%. ▪ When the FAW approaches the family for the interview 4% refuse and ▪ 96% accept and sign a consent form ▪ Tracked this for over 10 years and refusal and acceptance % have remained the same. (With the exception with the new hospitals and experience of FAW). ***How many refuse services after the interview?*** ▪ Acceptance rate for 2004/2005 was 86% ▪ Measure: got consent, score, consent to program, Home Visitor/Supervisor get a signature upon the first home visit. Sign all the initial paperwork.	▪ 99% very rarely does anyone decline the assessment. ▪ A lot of the assessments are done through the clinic. ▪ Have an established relationship with the primary care provider so families feel like HS is a part of the service being offered. ▪ People just see it as part of their service ***Is there any possibility that people will feel pressured to accept?*** ▪ Have not gotten that feedback from FAW ▪ Once families have been assessed and accept HV – sometimes people don't continue with the HV. ▪ They don't really engage, at this point have to work with the engagement process. ▪ People may not fully understand what the HV piece is and what it means.	▪ Statewide 98% ▪ [Cheryl's program] 99% ▪ Only had 2 refusals- (1) was a drug dealer & (1) was a sex offender. ▪ "I believe in what I do, and I believe in what I've got to offer, failure never enters my mind and I hope it never enters yours" because their going to want what you got, and they do.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What is the acceptance at home visiting; how determined?	▪ Don't know, there is a "refused" in the data base, but not sure if this is after receiving some services, or never engaged. ▪ Cannot tell, after services, never engaged, will check and get numbers. ***What will you do with the info?*** ▪ Families are informed that the information will be shared with FSW ▪ Try to be open with the family so the FSW has a place to start when meeting the family. ***What other education about program?*** ▪ Families are told that program provides information for parent and baby. ▪ There is a standard presentation or program given by workers. ▪ The resources by HFA are available to all families. ▪ HFA program more general population and is the umbrella organization and serves all societal levels. ▪ Tried to get away from being a social service agency. ▪ Child development (heavy) resources. ▪ Medicaid free car seat – FSW will pick up application on first meeting. ▪ Talk with all new families. ▪ Staff calls not a lot on Home visiting piece until they know they need it. ▪ Parent play groups, infant massage, parenting families (in partnerships with the City, HF Inc. fundraising) ▪ Prenatal classes- local restaurants provide dinner. ▪ Healthy Start gets different funding/funded through the City. ▪ Average stay in program: 70 graduated after 5 years (2005), 90 will be graduating in 2006. ▪ Annual caseload Home Visits 1277 (2005) ▪ 10% retention rate. ▪ *Will get:* - Retention rate at: 1 year, 2 years, & 3 years. - % of families that accept and actually engage in services. - Average stay for Healthy Start	▪ 4% at this point refuse services. ▪ 86% of the time we get a signature. ▪ Supervisors make initial visit with FSW so they can work as a team. ▪ Supervisor will than know what direction to steer the FSW, understand the family. ▪ Home visiting schedules have changed to accommodate family's needs ▪ Changed schedules so visits can be done in the evening and weekends. ▪ 27% visits occur after 5pm and on weekends. ▪ First visit has to be done within the first 30 days, the Supervisor is required to go on the first visit ▪ Shadowing is required once a quarter with every staff member. ▪ Finding that signing most of the families in the second trimester. ▪ Finding that even signing ▪ Pre-natally, it is too late. Looking at Inter-conceptual care, the period from one pregnancy to the next. It is hard to sell a home visiting program to a woman who is not pregnant and getting public funding for that. Finding that 18 months ▪ Prior to conception is when you can make the most difference. * Carol Brady, Healthy Start Coalition in Florida did a study. Getting the women healthy and getting ready for pregnancy. Focus in Pinellas county health dept. is to educate women on the intra conceptual period / between pregnancies.	▪ Ranged over the past 11 years between 77 – 90% ▪ Ward 7 & 8 more challenging areas, it's a large under served area for many years so building relationships & trust has been challenging. ▪ Improved that relationship by going into the schools. ▪ Running a pregnant teen lunch twice a month to help support the teens and letting them know who we are, what we are about, giving them a little education, and doing our screens. ***How do you define acceptance of home visiting?*** ▪ People who say yes and are enrolled. ▪ The minute they say yes and sign the consent, that's acceptance. ▪ (77 -90%) initially started off higher than 77%, than ▪ Went down, than moved up again. ▪ Also depends on the assessment worker. ***What % of those assessed is found to be eligible? How many are positive, and of the positive how many accept home visiting? How many decline?***	▪ 85% when they sign consent. ▪ Sign one for mom ▪ Come back and sign a second one for baby. ▪ HIPAA, forms, fairly simple, looking ▪ Section on if the program is closed or family refuses.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What are the paperwork and reporting requirements for programs are there other accountabilities	▪ Monthly Stats: number of referrals, screens, assessments positive or negative, accepted services, reasons for not accepting , home visits, reasons for closed cases, CPS reports ▪ Number accept ___ Why___ ▪ Moving/miscarriage not refusal ▪ Number of Home Visits ▪ Reason case closed ▪ Closed during month ▪ CPS reports ▪ Immunizations ▪ Spreadsheet, condensed 2 pages – in house ▪ Quarterly/Annual report ▪ Annual General Assembly report to Healthy Families Virginia ▪ Numbers and narrative ▪ Number of repeat teen births (0 teen repeat in Healthy Start) ▪ Center for Child & Family Services – 5 free visits ▪ Infant Toddler connection – Children w/special needs. ▪ Closer relationships ▪ Supervisor & workers ▪ Child and Family agency person sits on the HS board. ▪	▪ Absolutely overwhelming ▪ Required to document every home visit within 48 hours. ▪ Provide laptops, try to be flexible ▪ Individual Plan of Care (IPC) tool to manage case, the workers family support plan based on the ▪ Risk factors (workers hidden agenda). Has to be documented on every visit ▪ Family Support Plan (FSP) the family's goals and dreams (family and FSW work on together). ▪ What teaching, what happened, what curriculum did you use, parent's response, quality of parent interaction, ▪ Parent Child Inventory similar to ASQ ▪ If prenatal document on prenatal care ▪ Immunizations ▪ Very paperwork driven ▪ What was going on and the intervention ▪ Paperless, what happened, how long did it occur, what was the risk factors, what referrals did we make, any follow up, outcome of previous referral all done on computer. ▪ Quarterly / annual reports (management does) have to report on: ▪ Number of births ▪ Assessments ▪ How much of population able to reach ▪ Where the births occurred ▪ What assessment scores where ▪ How they came into the program ▪ Average acceptance rate ▪ Average number of assessments per worker	▪ Tracking Form to track the visits and contacts on the computer. ▪ Track all referrals and the outcomes of the referrals. ▪ Track everything with the home visits: - safety of the home, - parent/child interaction, - what was discussed, ▪ what was reported in terms of the goal plan ▪ goal plan/IFSP ▪ achieving goals ▪ Measures, ASQ ▪ Social support measure, informal & formal social support ▪ Depression to see if there is a change in mental health. ▪ Knowledge of child development. ▪ These are all done by the FSW. ▪ Management – there are a lot of funders to report to: ▪ Private foundations ▪ District contracts ▪ Evaluation, outside evaluator who reviews our work and we have a satisfaction survey that they review. ▪ Quarterly and Annual reports: ▪ Activities ▪ Progress on our outcomes ▪ 5 Goals and a couple of objectives to each goal ▪ Report on progress on achieving those goals, the objectives to those goals. ▪ Report on progress on achieving those goals, the objectives to those goals. ▪ Report on the challenges and successes.	▪ HV log one page CHEIRS o Strategies o Concerns o Strengths o Life Skills o Relationships o Curriculum ▪ Every visit, than attached to a supplemental billing form ▪ FSW is responsible for two forms when she makes her visit. ▪ Parent Visitor/Assessment Worker - Screen - Completing consent form front and back - Survey - Survey Score sheet - Welcome packet - Encourage on the day of assessment to set up an appointment with the FSW. - Should not leave the assessment without the first HV scheduled. - Family Status Form (demographic form). ▪ For continuity of care ▪ People get lost in the shuffle ▪ Try to make everything very succinct ▪ FAW has the FSW's schedule ▪ Some areas don't have cell phones/reception ▪ A lot of the surveys occur at the Health Dept. ▪ In some areas drive time would be 1 hour to get to a home. ▪ Time management, tie visits into WIC, doctor visits ▪ Space at Prenatal Clinic ▪ ASQ & ASQ-SE ▪ Parent Visitor has the Monthly Parent Visitor Summary log ▪ All the screens and all the surveys and where we stand with all of these and very clear on one page. o Caseload o Worksheets o Supervision ▪ Documentation

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
	▪ ***How receive funds?*** ▪ 200,000 General Assembly ▪ 200,000 City of Hampton ▪ 1.2 million MCH grant ▪ 1372 in contributions ▪ Title 4E: at risk of child being moved to Foster Care. ▪ Medicaid reimbursements. ▪ Annual 130,000 Community Service Act : funding (all states) families with children at risk of Foster Care, Child or sibling with IEP, children in Foster Care. ▪ Federal: (2005) 5,630 Medicaid ▪ State: 504,000 ▪ Local: 2,596,000	▪ Home visit completion rate (82%) ▪ (does not use NCAST) Parenting Stress Index, Parent Child Inventory : use after three home ▪ Visits, and following each ASQ schedule. ▪ ASQ/SE (does not do the HOME) ▪ No OCEP IDEA part C requirements for this program. ▪ Staff retention rates ▪ Home visiting rates	▪ Family stories. ▪ A lot of different things depending on the funders. ▪ How many families we saw. ▪ How many home visits.	▪ Encourage FSW Supervisor – specific forms around ▪ All of the information is keyed into a data software information system - Reports get back to us about: Summary - Acceptance rate - Demographics ▪ Keep hard copy also. ▪ Quarterly and Annual reports: ▪ On a spreadsheet ▪ Monthly report generated out of the state office that tells you: ▪ Projected number of families ▪ Projected number of assessments ▪ Visits – it will tell (each site) if the families are getting enough visits or are they getting too many. ▪ Percentage of financial breakdown (each site) – Medicaid /Tobacco/non-Medicaid dollars. ▪ Information generated by ▪ The state office by information that is keyed in. ▪ That data report has all sites on it so every site has access to that information. About 6 to 8 pages for the whole state. ▪ Ability to get on data base and get information by month, quarter, or cumulative. ▪ Each site can do it for itself the (supervisors and coordinators) ▪ Exactly how many visits a family has got. ▪ Percentage of the worker by month, etc. ▪ Not under OCEP, EIS requirements ▪ Under ASL ❖ At a particular time in the year the information in the data base can inform a certain site how they are doing on ▪ funds ❖ Are they doing alright, do they need to shift funds from another site. ▪ Let site know if they need ❖ To increase money.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

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How do programs receive funds? (billing, capitated funds, cost reimbursement)	▪ City & State reimbursement ▪ Healthy Families annual site visit ▪ Do not submit billing records ▪ State, local, CSA, volunteer, Medicaid timesheets vary. ▪ DSS reimbursement for children with IEPs ▪ Healthy Families VA funding (200,000). ▪ In-kind contributions from the community and volunteers.	▪ Most of the dollars are cost reimbursement contract. ▪ Local dollars about 25% of the funds come from the state of Florida flowing out of the DCF into the Ounce of Prevention fund which manages and runs Healthy Families Florida. ▪ Majority of the funds are locally through the Juvenile Welfare Board (an independent taxing authority taxing individuals and home owners of personal property and we get a certain mileage rate of that and goes to child services – county dollars). 75%	▪ Right now we do not get any reimbursements. ▪ Have looked into Medicaid reimbursements for Case Management, that's challenging for the city right now. ▪ Can bill through a mental health component if they have health insurance, Medicaid or one of the managed care Medicaid. ▪ We, Mary's (sp?) Center has a managed care program that is capitated but that does not support our home visiting We do get cost reimbursement from one of our managed care agencies for our support to insure compliance with prenatal appointments and well baby checks. ▪ Primary source of funding HERSA a federal grant – four year Healthy Start grant/ annual (non-competing) at the end of the fourth year you apply again. ▪ Private funding. ▪ District contract through the office of Child Dev. ▪ No billings on activities. ▪ Program. ▪ Do not have to do billings for any of the grants. ▪ Partnership with one of the managed care organizations in the city we do billing and we get paid per hour for service that we do for those families in that Managed care Medicaid program.	▪ Fee for Service

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
How are records kept? Is there an electronic database for system use?	▪ Hard copies, electronic ▪ Funders do not require stats. ▪ Use PIMS database. ▪ Statistics/Data base: - Name - SS number - Insurance - Children's names - Screens/referrals - When - Outcome - Whether referred or not	▪ Several data bases depending on the funders ▪ Case Management data base we have to enter through the Health dept. for everybody. ▪ Depending on the funders we have a data base for the state funds through Healthy Families Florida. ▪ Data base through the Juvenile Welfare Board. ▪ We have 13 – 15 clerical dedicated to data entry only (roughly one per team) ▪ Families are also plugged into a data base and when we get a referral we go into the data base to see what families are already receiving home visiting services. This helps cut down on duplication. ▪ ***How do you know who is being served?*** ▪ Healthy Families team in the areas that the families are in and they do a monthly report of who is in the program to the ▪ Hospital. ▪ A system where there are computers in the hospital and we have staff that go into the system and go into the health dept. and log on the data base. ▪ Access to view only. ▪ Enter date of birth, parents' name go into the data base to see if they have been served. ▪ Require all hospitals to keep an excel spreadsheet data base than forward to the program on a quarterly basis as a sub contract. ▪ The hospital is able to determine if the family is already receiving services prior to doing the screen in the hospital.	▪ System called "Kids II" ▪ Each FSW has their caseload in the system. ▪ When they log in they see their cases, what's due, what the alerts are. ▪ They can write their notes in their. ▪ They can also follow-up and track. ▪ Follow-up on referrals. ▪ Print out, have to have a paper chart/ prints out like a form. ***How many families do you serve?*** ▪ HFA guidelines ▪ 25 max	▪ All records in data base and hard copy charts.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
If the program has government contracts, what is the relationship with the funding agency? (Formal, informal).	▪ Government contract is with Healthy Families Virginia. ▪ Certain goals are required. ▪ Not sure of formal contract.	▪ The managing team (governing agency of the program) meets every 60 days with the funders. The program director and a representative from each of the agencies and the funding source, every third Friday. ▪ Contents of the meeting: ▪ Start off with a case presentation- brings the FSW and Supervisor into the management team and they present a case. It really helps to keep the funding sources and the management staff and the collaborative agencies staff, keeps their hand in direct services and keeps them grounded as to what the program can or cannot do. ▪ Talk about policies and procedures ▪ Budgetary issues ▪ Program Expansion ▪ New grants ▪ With the county and the state ▪ One Supervisor who rotates on a rotating basis.	▪ Good relationship with the office of Child Development which funds our site and serves ward 7 & 8. ▪ They have funded us for the past 3 years. ▪ Anticipate to be funded again this year. ▪ Rotating contract, we submit monthly reports with an invoice so they reimburse for the previous month. ▪ Deputy from that District that oversaw that contract sat on our board. ▪ With the DOH not quite as strong of a relationship but we continue to try to work together. ▪ DOH contracts to do the in home mental health support because they hear that it is effective. ▪ DOH pays some dollars to support that piece of the home visiting program. ▪ CFSA, we had a contract with them they still send ▪ Referrals for substance using women. ▪ It is not a formal government contract, it's just asking us to help them out. ▪ It is a law that all pregnant women get screened for substance. ▪ We have two in home mental health provider Masters level person. ▪ We were finding that a lot of our FSW were identifying mental health concerns and the families were seeing them as counselors. ▪ FSW's were being put in situations that were exhausting and draining. ▪ In addition to the Clinical Supervision and Case Reviews we wanted to provide other supports for them and the families. ▪ We were also seeing a resistance from the family to go to a mental health agency. ▪ We were trying to build	▪ Funding comes out of the state MCH Public Health office - MOA. ▪ That is determined than, and that information is sent out to sites. ▪ Regional meetings with the state office with all the coordinators and people in management ▪ Yearly contact with the TA (we're the voice from the field) ▪ Monthly TA meetings to troubleshoot, look at forms, to process, when the sites say something is not working than we take a look at how it can be fixed. ▪ Very good relationship with funders ▪ Very productive time spent with the legislature. ▪ A lot of representation ▪ Face to face ▪ Written support/testimony ▪ Learned a lot about us ▪ Everything they heard was good ▪ We just keep it coming ▪ Keep getting stronger and stronger ▪ Makes us harder to overlook now ▪ Commissioners and Secretaries had a meeting recently and HANDS was the only program they spoke of by name. ▪ Getting the word out there ▪ Try to be methodical and consistent with being ever present ▪ Went before the house and got a unanimous vote ▪ House Bill overall umbrella called "Kids Now" an early childhood office in the Governor's office. ▪ Ten programs that were part of a package which included: HS and childcare. ▪ Had legislative brunches across the state, early

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
If the program has government contracts, what is the relationship with the funding agency? (Formal, informal).			▪ Linkage for the family by providing home mental health services. ▪ About 3 months, the goal within this time is to identify if the family needs continue mental health therapy. ▪ To be able to get them to the point where you could link them to an outside agency. ▪ If not we try to work with them a little bit more depending on the severity of the problem. ▪ Also have a Psychiatrist on staff that we can do a diagnostic assessment, if the family agrees, if there are serious psychiatric concerns or they need medication. ▪ The Psychiatrist does not go into the home, but because they have already established a relationship with the FSW & Mental Health Provider the family is more ▪ Comfortable coming in for that. ▪ Average case load for Mental Health Provider 15. ▪ Program serves 375 to 400 families. ▪ 3 year SAMSA grant to look at the impact of mental health support. ▪ Positive impact ▪ Were seeing a decline in depressive symptoms before the babies were born. ▪ Sharper decline in depression prenatally and post partum. ▪ If you can impact before the baby is born you can really support attachment and a greater outcome for that family. ▪ SAMSA required a couple of tools, also used the CSD depression screen, support scale. ▪ Joan will send the evaluation.	▪ Childhood forums, encouraged input from the different regions. ▪ Assured governing officials families would come. ▪ Got families to come. ▪ Being the visit to life [crucial], a pretty strong father involvement piece and the male legislators liked that. ▪ *Cheryl will email their outcomes and how they faired.*

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
Is there a service provider network? If so, does the network have a formal different relationship with contracting government agency?	Network of Providers: HF Virginia, Family Resource Specialist, FSW, Supervisors meet quarterly. ▪ Agenda set by providers: - What people have - How to sell the program - Engage strategies - Changes with rating scales ▪ Network relationships : Project Link, Infant Toddler Connection, Healthy Families.	▪ Several providers in the area, get together on a quarterly basis for a network provider training. Provide relevant training for home visiting and make it available for the whole community. ▪ There has to be a real focus on what's best for the family and the community responding by coming together and looking at gaps in service. ▪ Core training provided by Healthy Families Florida the Training Institute they are funded to do all the core training ▪ One staff is also on staff on the state level to do core training. ▪ Most of the wrap around training is done locally in the community a lot done on line through the training institute: pre and post test on line.	▪ Collaborative ▪ Sub contract with other agencies ▪ 30 in the program ▪ 17 FSW	▪ Answered in # 4

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What is the nature of relationships within the system, i.e. with CPS, clinics, referral resources?	▪ Good relationship with CPS. ▪ Monthly meetings with FSW, Supervisor, & consultant.	▪ Have not always worked well with CPS however that system within itself went defunct a few years ago and that system is now privatized. ▪ Working better with system now. ▪ Still get inappropriate referrals trying to put program on case plans to get the children returned or to gain custody. ▪ Set up a day where we have to meet on a monthly basis. ▪ Exchanging numbers of all the workers. ▪ Within the last six months have been invited more to the case conferences. ▪ If a family is involved with CPS we will not close that case, we may not take that case at entry. Example: recently got a case where mom showed up on the abuse registry, having a CPS case 10 years ago. The Supervisor ▪ Advocated it's been ten years mom has lost several children already. The manager said dig a little deeper. What they found was the woman was not in the system for the last ten years because she was in prison for murdering her last child. They did not take the case. ▪ Better access to the abuse registry so when the referral comes in can find out immediately if the family is in the system. ▪ Can take the case as long as it is not in the 30 day window where a determination has not been made. ▪ If on the protective services side can take it but prefer not to because we are not an intervention program. ▪ Healthy Plus program: (4) teams dedicated to this. ▪ Most CPS involved. ▪ One hospital refuses to call CPS or do drug test. ▪ CPS is privatized in that the state sub contracts with the Sarasota YMCA to do all the services side of it. ▪ Sub contracted with the Sheriffs Dept. to do the investigation side.	▪ MOA's with the clinics ▪ Collaborative actually house the sites with the FSW & Project Supervisor. ▪ The assessment team comes out of us we provide supervision. ▪ The outreach worker, nurse, and mental health people all come out of the main site. ▪ Nurse goes out once prenatally, if there are medical concerns she will go out again to check and monitor those as a part of the medical piece. ▪ Nurse will do a post partum check and make sure they get their post partum visit. ▪ Nurse helps staff to understand any medical concerns with any of the families. ▪ CFSA refer directly to us substance, etc. no funding from them right now. ▪ Strengthening with this new director, building a ▪ New relationship. ▪ CFSA partners with a city collaborative more than with HFA. ▪ Staff cases together ▪ Have family team meetings bring everyone together if there is a risk of the child being removed. ▪ Everyone come together to identify best outcomes for the family. ▪ Depending on the worker we have had good relationships. ▪ Will work with CFSA and family while case is open and continue with family after CFSA closes their case. ▪ Very positive relationships with the Clinics, send them copies of the assessments. ▪ [Clinic] if concerned about someone clinic will refer to HFA. ▪ A lot of positive communication. ▪ With our referral ▪ The majority of the referral resources that we use especially child care are strong. ▪ DV and legal advocate resources are very strong as well.	▪ Answered in # 4

HEALTHY START TELECONFERENCE MATRIX

Attachment J

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Do you have MOA's: with what organizations? What are the roles of participating organizations; are there specific agreements?	▪ MOA with hospitals: - Newport News: Riverside Hospital - Hampton: Healthy Start - Local OBs	▪ 70 MOA's, some on paper only, but some we truly have a working relationship with, a lot of referrals back and forth.	▪ 12 MOA's	▪ Answered in #2
What training is provided: kind and amount? (core, wrap-around, other).	▪ March of Dimes, Great Kids material (State decided) ▪ Core Healthy Start: FRS & Supervisor: Louise ▪ Wrap Around: Square One through Dept. Social Services for several Healthy Start sites. ▪ Core FSW: Theresa, program manager HSA	▪ Training for senior staff and finding training that is relevant for them. ▪ When get together on quarterly basis focus in community, changes in law, new referral source, whatever the topic of the day is to keep everyone in Pinellas County current	▪ 1 FSW Core trainers that was trained through PCA. ▪ 1 FAW Core trainer that was trained through the "Great Kids Inc". ▪ Joan and Director were trained in technical assistance by "Great Kids" ▪ Joan does the technical assistance and quality assurance' ▪ Wrap around: partnerships with DOH ▪ DOH has a lot of quality staff training. On site Health Educator and Mental Health person provides training. ▪ "Ordinary Miracles" training on how to video tape families has a lot of good information on key concepts, understanding the strengths approach, how to work with folks ▪ Early childhood specialist does child development training for staff. ▪ "Parents as Teachers" curriculum ▪ "Partners for a Healthy Pregnancy" (out of FL)	▪ Four blocks of training: Core, Curriculum, Advanced, & Wrap Around - Core - Core FSW - Core PV ▪ Coordinator (Supervisor) if FSW supervisor: must also do FSW core, PV must do PV core, ▪ Manager both tracks: you don't ask anybody to do something you don't know how to do yourself ▪ FSW required to attend a Growing Great Kids training, curriculum, 3 times with families, seeing, saying, do. ▪ HV required to have goals. ▪ Advanced FSW & Advanced FSW Supervision ▪ Calendar with all these things in it ▪ Wrap around training requirements. Red Alert topics: - C/A/N - Substance Abuse - DV - Mental Health - Assessment/ Advanced Assessment – Supervisor ▪ Staff has HFA 25 Families ▪ 1 to 5 Supervision • 1½ to 2 hours supervision a week. • ½ of that for part time

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What competencies are looked for in hiring staff?	FSW- no degree, good listening skills, able to meet families where they are, High School diploma, child development experience (2years). FAW – Bachelors degree or higher, work experience in related field. Supervisor-BS in Nursing, 2 years field experience, previous supervisory experience. (32,000 annual salary). Staff retention: up & down, currently morale down, looking to hire more staff.	▪ Minimum qualifications for staff ▪ Supervisor minimum Bachelor's degree (most have Master's). 2 years previous supervisory experience in related field. ▪ Competencies: - focus on relationships - The person's ability to engage in a conversation. - Non-judgmental. - Boundaries - Prejudicial treatment - Willingness questionnaire, ex: getting on the floor with baby, transporting, providing birth control, etc.	▪ Minimum qualifications for staff ▪ FSW a lot from the community, childcare licensing, CDA, high school diploma or GED. Understand families, understand systems, understand child care, some knowledge of computer, ▪ FAW minimum Bachelor's level in social work/social service..	▪ Someone who feels comfortable with documentation. ▪ Comfortable with supervision. ▪ Wonderful family engagement skills ▪ People who like to learn. ▪ Like being in someone's home ▪ People who like to do activities with families. ▪ Understand the importance of father involvement. ▪ People who want to work on a team. ▪ It has to be a team approach. ▪ Have to be non-judgmental. ▪ PV- excellent writing skills
What competencies are looked for in hiring staff?				▪ Go get um attitude, because they will be your ambassadors out in the community. ▪ Be very professional, able to engage quickly ▪ Very knowledgeable about resources in your community. ▪ A nice house goes for $250,000-most people live in $60,000 to $80,000 homes ▪ FSW – 7.90 hr. non-degreed ▪ SW – 11.35 degreed ▪ Nurses

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What are the ethnicities and demographics of staff? What are qualification requirements for various positions/Do you try to match ethnicity of staff with families?	▪ 60% African American ▪ 40% Caucasian ▪ 1 Hispanic ▪ 1 Bi-lingual assessment worker ▪ Match by race, age, ▪ Client can request	▪ Staff ethnicities close to ethnicity of service population.	▪ Bi-lingual/ Bi-cultural staff who speak Spanish. ▪ African American staff ▪ 1 person from Haiti ▪ Caucasian staff ▪ 24 – 50 years ▪ Most from DC or surrounding areas Maryland or Virginia. ▪ Try to match workers with family if possible. ▪ Mostly language oriented.	▪ Varies ▪ Growing Hispanic ▪ Urban – African American, several males doing very nicely ▪ A couple sections that have a large Bosnian ▪ Japanese, Singapore, Korean, Kenya ▪ Higher across the board Caucasian ▪ Try to match ethnicity of family with worker. ▪ Each community has it own culture try to match. ▪ Nepotism, confidentiality concern

HEALTHY START TELECONFERENCE MATRIX

Attachment J

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What quality assurance procedures are used and who conducts the QA activities?	▪ Supervisor & FSW QA review assessments, review charts. ▪ Quarterly shadowing assessment & follow-up phone calls. ▪ Annual Site Visits by HF Virginia. ▪ Credentialing every four years.	▪ We meet the first Monday of every month and review the whole collaboration ▪ It is written into the sub contracting agencies that we sub contract with, they have to take part in the QI case file reading ▪ Meet monthly ▪ Rotate sites ▪ Pull a certain % of cases ▪ Review cases for about 5 hours. ▪ Seen variation of forms, how they are documenting, old forms, etc.	▪ QA./ Chart reviews. ▪ Management meeting look at: ▪ Productivity ▪ Random telephone calls ▪ Parent satisfaction survey ▪ Shadow visits ▪ Developed data based quality piece to see what's missing to keep folks up to date with what information needs to be in the data base. ▪ Shadow Supervision	▪ Encourage internal QA ▪ There is a section in the handbook roles, rules, policies, and procedures, forms ▪ .Statewide handbook ▪ Also available on the Web ▪ Revisions, get clarification ▪ Quarterly chart reviews ▪ Talk about weekly supervision ▪ Make sure forms are done correctly and in a timely manner. ▪ Yearly TA QA visit : out of this come strengths and a plan for growth for the site. ▪ Yearly Parent Satisfaction Survey all across the state. ▪ This year will do all at the same time using the same tool. ▪ Funders do annual visits ▪ Shadow each component of the process to see how the curriculum was used ▪ And mapped on to the parents' experience. ▪ Decline, monthly decline to find out why ▪ TA QA set inspection survey to see how we are doing in meeting the needs of the sites ▪ Training surveys ▪ Take the training piece and say if we grow the program than the training should follow nicely in its growth. ▪ Take the evaluations at training and pull out comments from the field and take those comments and turn them into trainings. ▪ Support system for sites. ▪ Must be strength based from the top down.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

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How is the program "marketed" in the community?	▪ Resources for families having new babies ▪ Never mention Child Abuse Prevention Program ▪ Mandated reporters ▪ Has found that C/A/N comes to forefront in publicity articles, but[program] tries not to put emphasis on this to avoid stigma.	▪ Families never couched as a Child Abuse Prevention program but as a Family support program, ▪ Two brochures, (1) participant, (1) funders **Will send brochures*	▪ Program and families do a lot of testimony at the City Council. ▪ Family Support, helping them to be the best parents they can be to their children. ▪ Focus on family strengthening, ▪ Healthy child growth and development ▪ School readiness. ▪ Is not generally marketed as C/A/N prevention program.	▪ Newspaper articles. ▪ Lined the tunnel where legislator go to meet ▪ Radio ▪ TV ▪ Billboards ▪ Laminated Card ▪ Video ▪ Meet with doctors on lunch hour ▪ Yearly Fall Retreat ▪ Roundtable discussion ▪ Governors office reminded program that C/A/N is a slippery slope ▪ Not allowed to talk about birth control in the homes. ▪ Market as Family Strengthening ▪ Reduction in C/A/N has been outstanding ▪ Strengthening families will ultimately ▪ Brenda Chandler has a wonderful power point presentation which shows the C/A/N outcomes.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What are the stated goals of the program?	▪ HFA goals and some other outcomes	▪ Sell it to funders as a Child Abuse Prevention program. ▪ The program focuses on the health and safety, immunizations, well baby checks, linking children to medical providers, subsequent births, family support plan and goals, developmental screens, home visit rates, success rates, initial home visits when they have to occur, the assessment part: prenatally or within the first two weeks. ▪ A lot of it has to do with credentialing requirements and being in line with what's required for credentialing. ▪ Florida always takes the most restrictive stance on anything that is required on the national level. At least our funders do.	▪ There are 5 goals: - Assess the programs target population - Promote optimal birth and child health outcomes - Promote optimal child development and school readiness - Foster positive parenting and successful parent/child interaction - Promote and support family self sufficiency. - Prevent C/A/N.	▪ Prevent C/A/N.
What are the program outcomes related to CAN; how is this measured?	▪ Reduction of Child abuse ▪ 1992 – 2000 26.8% reduction ▪ region decline 3.3% ▪ Benchmark Study 2002 ▪ Provider Resources ▪ Positive Parent/Child relationship-HOME/NCAST/ASQ ▪ Report to DSS – get back numbers but not names ▪ Almost all reports of confirmed reports referred by Healthy Start	▪ CPS goal: require 95% of families to be free of maltreatment during program participation. ▪ Require 95% of families who successfully complete not to have a finding of maltreatment within the first 18 months following completion. ▪ County rate is about 5.5% countywide. ▪ Program is a constant 2% meaning 98% of the families who come through this program are not involved with maltreatment. ▪ Cap on caseloads is we do not have more than 25 families for one worker. ▪ Typically run 18-20 families. ▪ The only cap is the one team that works with the illegal families, all bi-lingual. ▪ Have not had to cap other teams. ▪ Assessment is a service and the FAW can provide resources.		▪ Answered in # 12

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
Do you focus on father involvement? If so, how is this measured?	▪ Healthy Families specific father component. ▪ Pay special attention to relationship with father. ▪ Father coordinator (Healthy Families position) goes into the jail ▪ Large population of incarcerated fathers.	▪ Supervisor in 1996 ▪ Father Services component, monthly *Daddy and Me* play groups in North, Mid, and South counties. ▪ Six men, Family Development Specialist under supervision of Reggie Randolph. Across the entire county, they work with the HV. ▪ Issues are very different: ▪ Spending a lot of time with the criminal justice system ▪ Many cannot get jobs or housing because of criminal history/felonies ▪ Health issues ▪ Providing counseling ▪ A case load maximum of 25 ▪ Get referrals from HV, Supervisors. ▪ They do groups, play groups ▪ Their home visiting takes place in non traditional places. ▪ No research to back any of this up. ▪ Been doing good ▪ Grant until last year, some funding from the Healthy Start Project, Juvenile Welfare picked up the funding this year after grant ended. ▪ Father interaction scale, measuring the amount of time, quality of the interaction, increase the amount of time the dad spends in that home. ▪ If father is the primary care giver they get they full service. ▪ Separate support groups ▪ For mom's, dad's ▪ Undocumented Hispanic population ▪ No support groups for couple's	▪ Had 2 male workers to help with father involvement but they left. ▪ Have not been able to replace them. ▪ Staff are trained to work with father's (some better than others) ▪ Identify agencies in the area with really strong father programs ▪ Parenting ▪ Job training/readiness ▪ Support fathers in understanding their role beyond just income for the children. ▪ Challenging because fathers are not part of the visit ▪ There are instances where there is no mother in the home.	▪ It's been a struggle, hard to engage without a lot of activities. ▪ No reimbursement for group activities ▪ Father involvement piece with grants (in the past) ▪ Different locations have father involvement programs via grants. ▪ On going component of curriculum ▪ Flexible schedules to be available when dads' are available ▪ Dads' posters in waiting rooms on the walls ▪ Dads' magazines/posters ▪ Dads' involved in the visit ▪ Father involvement survey, Scott Walker, MSW recently became a Public Health ▪ Director, does SSW core training. Just completed study.

HEALTHY START TELECONFERENCE MATRIX

Attachment J

	Hampton, VA	Pinellas County, FL	Washington, DC	Kentucky - HANDS
What is the program retention rate at one year and how is this calculated? Is the denominator all families assessed as positive, engaged for x months, other?	▪ 3,900 participants in parenting and play groups by HF staff and contracted entities; also used for children with special needs. ▪ Will get back with more specific info.	▪ Calculated by looking at the entire number of families in the program and looking at how many dropped out. ▪ Take a look at the number of families served during the year and those families that dropped out. ▪ Factor out of that successful completion ▪ 37 Healthy Families programs in the state of Florida, whenever a transfer occurred from one program to another those families were still in services in another county but were being counted as a closure. ▪ Attrition rate : 800 close cases/200 successful or moved/divide by 600, subtract 100 of total. ▪ Lose 25% of the families every year ▪ Last look retention last four quarters 71% does not include transfers and successful completion. ▪ Staff turnover 21%	▪ Retention rate 2002-2003 88% ▪ 2004 – 75% ▪ Measure retention: once the family is accepted in the program it is counted into the measure of the retention rate there is no minimal period of contact necessary before they incorporate into the statistics. ▪ Evaluator uses a sample of: ▪ All the families ever enrolled into the program ▪ Enrolled during the current reporting period ▪ *Joan will send copy of evaluation	▪ Want to look at cost of staff retention. ▪ Brenda has this information on her presentation ▪ Committed to in supporting supervisors is “you set the tone everyday in your office” ▪ Lost 3 workers – 2 left for family issues. ▪ Lose only 25% case load ▪ Begin services introduce that family will be working with a team. ▪ No one person takes care all family needs- people get sick, have babies, and if you introduce that at the get go than it seems to work out better/ ▪ Each family has 2 workers plus the team ▪ Multi-disciplinary team: ▪ FSW – regular visits ▪ Every family gets 4 additional visits a year, one per quarter by another professional. ▪ Nurses and SW go to core training.