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**Special thanks to ...**

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Healthy Families America
Site Development Guide

Table of Contents

Section I – Introduction
Welcome ................................................................. 1
Healthy Families America Overview ............................... 2
Healthy Families America’s Critical Elements ................. 5
Using This Guide ...................................................... 7
Key to Icons .......................................................... 10
Additional Resources - Section I ................................. 11

Section II – Getting Started by Gathering People Together
Getting Started by Gathering People Together ...................... 13
Stage One: Forming a Planning Group ............................. 16
Stage Two: Building Trust and Ownership ...................... 20
Stage Three: Thinking Strategically and Planning ............. 24
Stage Four: Designing Your Program ............................. 41
Stage Five: Providing Program Services ......................... 46
Stage Six: Promoting and Maintaining Your HFA Program ...... 47
Additional Resources - Section II ................................. 48

Section III – Designing Your Program
Beginning to Design Your Program ................................ 51
Establishing Program Goals and Objectives ..................... 55
Worksheet #1: Developing Program Objectives .................. 57
Establishing Program Outcomes .................................... 58
Worksheet #2: Developing Program Outcomes .................. 59
Defining the Target Population ..................................... 60
Determining Services to be Offered ................................ 61
Working with Partners .............................................. 63
Staffing .................................................................... 68
Worksheet #3: Determining the Number of Families to be Served 78
Worksheet #4: Family Assessment Worker Projection ........... 81
Worksheet #5: Family Support Worker Projection ................ 83
The Training Plan ...................................................... 85
Quality Assurance and Credentialing ............................... 88
Data Management ..................................................... 94
Planning for Evaluation ............................................. 96
Challenges and Lessons Learned in Program Planning ......... 103
Additional Resources - Section III ................................. 106

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## Appendix D – Budgeting and Funding Documents

- Sample HFA Program Budget ................................................................. 239
- Sample Grant Proposals ................................................................. 243
- Seeking the Gift ........................................................................... 264

## Appendix E – Service Provision Documents

- Sample Record Screen .................................................................... 265
- Sample Family Stress Checklist ...................................................... 267
- Sample Consent and Authorization Form ......................................... 268
- Sample Program Flyer .................................................................... 269
- Sample Confidentiality Policies ..................................................... 270
- Sample Individual Family Support Plan .......................................... 272
- Sample Training Request Form ...................................................... 274
- Recommended Wraparound Training Topics .................................. 278

## Bibliography

- Endnotes .................................................................................... 283
- Source Material ........................................................................ 284
- Additional Resources ............................................................... 288
Section One

Introduction
Welcome to the Healthy Families America Site Development Guide. Since you are reading this guide, it is likely that you’re seriously considering undertaking the challenging yet rewarding project of developing a Healthy Families America® (HFA) program in your community. (If, instead, you are looking for general information about the HFA program, you will find some of our other publications to be more suitable for your purpose. Please see the Additional Resources section for a list of materials available from Prevent Child Abuse America.) This guide proceeds from the assumption that you already have a good understanding of the HFA program model and are now looking for detailed information about bringing the initiative into your community to provide services for children and families.

In Section I of the HFA Site Development Guide we will provide a brief overview of the Healthy Families America program model and the research-based Critical Elements that form the structure of the program. It is important that you become familiar and comfortable with the program so that you can speak about it clearly and persuasively as you begin to gather people together to work with you on developing an HFA program in your community.

Beyond reading informational material on HFA, there are many resources for you to strengthen your understanding of the program. Speaking with Program Managers of existing HFA sites and actual site visits will be beneficial. Additionally, every state has a State Leader and Primary Contact to provide support for HFA sites in their state, including technical assistance. Prevent Child Abuse America/HFA staff can also provide information and support. Don’t hesitate to reach out! A significant benefit of being involved with the Healthy Families America program is the wide network of supportive colleagues available to provide assistance.

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Healthy Families America

Healthy Families America (HFA) is a national program model designed to help parents of newborns get their children off to a healthy start. Participation in HFA services is strictly voluntary. HFA offers home visiting and other services to families in over 420 communities (as of July 2000), with a ninety percent acceptance rate.

In 1992, Prevent Child Abuse America (PCA America), formerly known as the National Committee to Prevent Child Abuse, launched Healthy Families America in partnership with Ronald McDonald House Charities. The HFA model is based on two decades of research, the experiences of Hawaii’s successful Healthy Start program and best practices from numerous communities and prevention models. The program promotes positive parenting and child health and development, thereby preventing child abuse, neglect and other poor childhood outcomes. By providing services to overburdened families, HFA fits into the continuum of services provided to families in many communities. Ongoing major support from the Freddie Mac Foundation and Ronald McDonald House Charities has enabled Prevent Child Abuse America to ensure the quality and growth of this national, voluntary home visiting program.

The Need for Healthy Families America

Each year an estimated three million cases of suspected child abuse and neglect are reported to Child Protective Service (CPS) agencies, yet more than half of child abuse fatalities are typically unknown to CPS. Almost three children die from child abuse and neglect each day. At the same time, according to a report released by the Carnegie Corporation of New York, “the earliest years of a child’s life are society’s most neglected age group, yet new evidence confirms that these years lay the foundation for all that follows.”

Programs that begin working with
parents right after birth stand the greatest chance of reducing the risk of child abuse and promoting positive childhood outcomes for several reasons:

1) New parents are eager and excited to learn about caring for their babies; 
2) Positive parenting practices are supported before patterns are established;
3) Most physical abuse and neglect occurs among children under the age of two;
4) Forty-four percent of fatalities due to child maltreatment occur before the first birthday;
5) Children need to be immunized from childhood disease during the first two years of life; and
6) The most critical brain development occurs during the first few years of life.

**HFA is Unique Among Home Visiting Programs**

Traditionally, home visiting programs have assisted new parents by providing information and reassurance about caring for their babies. Recognizing that other family issues must be addressed as well, HFA offers additional referral services to improve the functioning of the entire family. In addition to supporting parents in overcoming challenges with housing, finances, social isolation, substance abuse, domestic violence and mental health, staff focus on promoting the parent-child relationship and healthy child development. Home visitors develop a trusting relationship with parents and help them to be more emotionally available to their child.

HFA is unique for several other reasons, as well:

- The Critical Elements, which are grounded in research, form the foundation on which the program is structured. This enables programs to be built on best practices while still allowing a great deal of flexibility to be responsive to the needs of the community.
Healthy Families America Overview

Healthy Families America (HFA) is one of only a few home visiting programs that are part of national organizations providing a range of other prevention services. Therefore, programs receive the benefit of access to child abuse and neglect research and support around marketing and communications activities.

Prevent Child Abuse America supports HFA programs in a number of ways: training and technical assistance; a data reporting system developed specifically for credentialing; a list serv and regular newsletter; a national conference every 18 months; development and certification of state trainers; state system development; and a network of programs across the country that are available to answer questions and support the growth of your program.

**HFA and Prevent Child Abuse America**

Prevent Child Abuse America (PCA America) is the nation’s leading child abuse prevention organization. Founded in 1972, PCA America is committed to preventing the abuse and neglect of our nation’s children. PCA America, in collaboration with its Chapter Network, is improving the quality of life for children and families.

PCA America/Healthy Families America has nationally recognized strengths in public awareness, research, training, quality assurance and a system to provide technical assistance to the HFA State Leaders network. This combination of strengths enables HFA to put research into practice and assures the consistent provision of quality services as programs grow and expand.
HEALTHY FAMILIES AMERICA’S CRITICAL ELEMENTS

All HFA programs adhere to a series of twelve Critical Elements, representing the field’s most current knowledge about implementing successful home visitation programs. These elements are the backbone of the program, providing the framework for program development and implementation. Staff are trained on the Critical Elements and programs are credentialed based on adherence to them. The Critical Elements define the Healthy Families America program. In addition to helping assure quality, these basic elements allow for flexibility in service implementation to permit integration into a wide range of communities and provide opportunities for innovation. Please review the Critical Elements, seek to understand them and begin to think about how you will incorporate them into your own program.

The following are brief descriptions of each Critical Element. Please also read the complete text of the Critical Elements and supporting research-based rationale, which may be found in Appendix A.

Service Initiation

1. Initiate services prenatally or at birth.
2. Use a standardized assessment tool to systematically identify families who are most in need of services.
3. Offer services voluntarily and use positive outreach efforts to build family trust and engage parents in program services.

Service Content

4. Offer services to participating families over the long term (i.e., three to five years), using well-defined criteria for increasing or decreasing frequency of services.
5. Services should be culturally competent; materials used should reflect the diversity of the population served.
6. Services are comprehensive, focusing on supporting the parent as well as the parent-child relationship and child development.

7. All families should be linked to a medical provider; they may also be linked to additional services.

8. Staff members should have limited caseloads.

**Staff Characteristics**

9. Service providers are selected based on personal characteristics and their ability to establish a trusting relationship.

10. Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families.

11. Service providers should receive thorough training specific to their role to understand the essential components of family assessment and home visitation.

12. Service providers should receive ongoing, effective supervision.

The Critical Elements will provide the foundation for every aspect of your HFA program, and all members of your planning group should become familiar with them. Refer to the Critical Elements often throughout your program development process.

If you are unclear about any of the Critical Elements, please contact the Prevent Child Abuse America national office.
USING THIS GUIDE

One of the unique features of the HFA program is its flexibility. Your HFA program can be adapted and tailored to the specific characteristics and circumstances within your community while remaining true to the research-based principles, represented by the Critical Elements, that shape the program. Along the same lines, we have organized the *HFA Site Development Guide* in such a way to direct your progress through the planning, design, implementation and maintenance phases of your new program using a logical, proven process.

This guide is designed to provide a basic framework for developing your HFA program. Because each program is as different as the populations it is designed to serve, you shouldn’t expect your program to look exactly like any other. We anticipate that you will use the information presented in this guide as a starting point, making adjustments as needed to the suggested timetables, action steps and sequence of activities in order to reflect the way things work in your community.

In addition to information about the program development process, the *HFA Site Development Guide* has been designed to provide you with examples and case studies from actual program sites, sample program and planning forms as well as additional resources to assist your effort. You may use this guide in a number of ways: skim through it for a process overview; share it with your planning group and discuss the material provided; and use it as a resource for each step along the way.
For the purposes of this guide, we’ve organized the process of developing an HFA program site into six stages.

Stage One: Forming a Planning Group
Stage Two: Building Trust and Ownership
Stage Three: Thinking and Planning Strategically
Stage Four: Designing Your Program
Stage Five: Providing Program Services
Stage Six: Promoting and Maintaining Your Program

The first three stages focus on the very early days of the program development process – where you are right now. This is the time when you will bring people together who feel as passionately as you do about the need to provide supportive services for the children and families in your community. You will learn how to work effectively together and begin the planning process. These are very important stages, not to be rushed or taken lightly. After all, the people you bring together, the information you gather and the planful decisions you make now will dictate the shape of the program you are constructing. The Site Development Guide discusses these stages in-depth in Section II: Getting Started and Gathering People Together.

Once your group has been convened and the groundwork has been laid, it will be time for Stage Four: Designing Your Program. This is still a planning phase – similar to architects drawing up blueprints for their buildings – in which your planning group will make key decisions about the population to be served, services to be offered, community partnerships to be made and measurements to be calculated in order to determine the success of the program in meeting the needs of families in your community. This stage is discussed in Section III: Designing Your Program and Section IV: Budgeting and Funding.
There are many issues around the actual provision of assessment and home visiting services, including staffing, training, supervision and administration. Although service delivery is at the heart of the HFA program, it would be a mistake to rush into this phase without the careful planning that has occurred in the previous stages. In-depth information may be found in Section V: Providing Program Services.

Stage Six has to do with the long-term sustainability of your program once the doors are open and you have begun delivering services to families in your community. There are many activities that may be undertaken to solidify your program’s place within the continuum of services available to families in your community, such as advocacy, marketing and public awareness. Any preventive maintenance you do by building relationships with key policymakers and with the community at-large will benefit you down the road if, for example, you were to encounter legislative setbacks or the loss of funding streams. This information may be found in Section VI: Promoting and Maintaining Your Program.

We hope that you will find the Healthy Families America Site Development Guide to be helpful as you begin to construct a supportive program for the benefit of children and families in your community.
This guide is annotated with symbols to highlight certain information that may be of particular value to you.

The **tools** represent the resources that you’ll use over and over again during the process of building and maintaining your HFA program. They are frequently, but not always, documents.

The **hardhat** symbolizes key personnel involved in the project or specific talents or traits that collaborators might bring to your program planning and implementation effort.

The **wheelbarrow** represents information or data gathered in an activity or step that will be carried forward throughout the program development process. Be sure to spend enough time and attention on steps bearing this symbol – they will have long-reaching impact on your program.

The **tape measure** indicates information about evaluation or measuring the outcomes of the program.

The **blueprint** indicates a topical area that will be rated during the HFA credentialing process. Refer to the HFA Credentialing Manual and Self-Assessment Tool for information about the criteria for becoming credentialed.

The **bullhorn** symbol invites you to reach out and call on others within the HFA Network and your own community for information, resources and support. You are not alone in your effort, and there is a wealth of information to be shared.

This **sign** stands for people working together, partnering across agencies or organizations to the benefit of the families and children in the community.

**Painting** the picture with examples or case studies from actual HFA program sites can sometimes clarify a point more effectively than a description can.

The **flashing lights** signal caution. Proceed carefully and watch your step!

The **t-square** will direct you to other sections of the *Guide* for related information.
ADDITIONAL RESOURCES - SECTION I

Prevent Child Abuse America
200 S. Michigan Avenue, 17th Floor
Chicago, IL 60604
Phone: 312/663-3520
Fax: 312/939-8962
www.preventchildabuse.org

Healthy Families America: A Snapshot View. Prevent Child Abuse America

Answers to Frequently Asked Questions About HFA. Prevent Child Abuse America

HFA Credentialing Manual and Self-Assessment Tool. Prevent Child Abuse America

See the bibliography for additional resources and complete citations.
Section Two

Getting Started by Gathering People Together
GETTING STARTED BY GATHERING PEOPLE TOGETHER

Comprehensive planning is a critical ingredient for developing and implementing an HFA program. This guide outlines a recommended process for planning and also highlights successful strategies used by existing HFA sites. It is important to recognize, however, that the planning process will vary from community to community, depending upon the focus of leadership, the way in which human services function within the community and much more.

First Things First

Before getting started with planning and developing your HFA program, take some time to find out if there are other HFA programs in your community or state. It is also important to identify your state leaders and primary contacts. They will be valuable resources throughout your planning stages and through the life of your program.

We recommend that you begin by contacting your HFA Primary Contact and your local Prevent Child Abuse America Chapter. They should be able to recommend next steps and provide you with any pertinent local information that will assist you as you begin your process. Other good sources of information are the existing HFA sites in your state, which may be able to provide

Prevent Child Abuse America can provide the following:

- A State Leaders Directory that includes contact information for all key State Leaders, your Primary Contact and the Prevent Child Abuse America State Chapter contact;
- A Prevent Child Abuse America Chapter Directory; and
- A list of HFA program sites with contact information for all currently affiliated sites.
information about training, technical assistance and funding that will support your efforts.

It is important that you have a solid grasp of the Healthy Families America model, outcomes for evaluation and Critical Elements so that you can effectively describe the program to others. This could include consultations with State Leaders, PCA America Chapter representatives, Program Managers or national office staff to support your understanding of the HFA program.

It is recommended that you begin documenting your process from the very beginning. In addition to the benefits of documentation, such as accurate recording of events and assignment of responsibilities, it will be helpful and interesting to refer back to where you started, the thoughts, ideas and vision that helped you reach your goal of starting a new HFA program site.

**Getting Started**

First you need to spend some time figuring out whether your community is ready for HFA. Have you determined why HFA is needed in your community? Are other community members ready to support an effort to establish a program? Are all of the right people involved? Are you and others who are at the table willing to take the time to get to know one another, build trust among the group and collaborate, plan and implement a program?

Collaboration is hard work. Preparing to work together to develop and implement an HFA program can be difficult and challenging. Like any collaboration, it will take energy, careful attention and commitment. But it will also lead to new partnerships, new or expanded services for parents and their babies in
your community and great benefits for the children and families who will be served by the program.

You will know best how your community works and who the key players are for such an undertaking, but the average time frame for an effective HFA planning process may take anywhere from 8-12 months. Keep in mind that the focus of the collaboration is on supporting new parents and their babies and ensuring that the necessary support systems are in place to do this in your community.

We will describe a six-stage process to assist your efforts to develop an HFA program.

   Stage One: Forming a Planning Group
   Stage Two: Building Trust and Ownership
   Stage Three: Thinking Strategically and Planning
   Stage Four: Designing Your Program
   Stage Five: Providing Program Services
   Stage Six: Promoting and Maintaining Your HFA Program

Here in Section II, we will provide in-depth information on the very early stages described in Stages One through Three and touch briefly on Stages Four through Six. Those stages will be covered in-depth in Sections III through VI of the Site Development Guide. We will also provide suggestions for addi-
tional resources to assist you with your program development process.

**STAGE ONE: FORMING A PLANNING GROUP**

This stage is about formalizing your community’s interest in Healthy Families America and creating a planning group or task force to lead the way.

The nature of your planning group may vary depending upon the community. There may be several folks or lots of folks already involved in your discussions about bringing HFA to your community. The reasons for forming the group may be driven by state level policymakers, local community agencies that recognize a gap in services for new parents, or a galvanizing event such as the death of an infant or a newly released report highlighting a lack of resources or high rates of child abuse and neglect, etc. Regardless of the motivations, the planning group is the foundation for developing an HFA program.

**The Role of the Planning Group**

The main functions of the planning group are to:

- Lead the planning process for an HFA program;
- Serve as the collective representative for HFA in the community;
- Develop a shared understanding of:
  - The needs of new parents in the community; and
  - The existing resources available to address those needs;
- Foster collaboration among its members; and
* Develop a shared commitment to working toward implementation of an HFA program.

**Members of the Planning Group**

The planning group should include a broad range of individuals who have a potential stake and role in expanding the family support system in your community. It is important to recognize our tendency to include only those whom we have worked with previously or those whom we know well or with whom we get along. You are encouraged to look beyond the obvious partners and consider those individuals and organizations who can help build the broad foundation necessary for this effort. It is also important to engage individuals and organizations who offer a wide range of skills and expertise and a cross-section of ethnic, racial and cultural perspectives. Don’t forget father involvement initiatives and men’s movements!

Consider the following questions as you form your planning group:

* Which community stakeholders or leaders have an interest in serving families and children through home visiting?

* Who might be willing to join the planning group and how will the attitudes and cultures of some of the organizations they represent impact the partnership?

* How can you get the departments of public health, maternal and child health, children and family services and others to become involved and share their resources and capacities?

“Bringing people together is a challenge that requires patience and courage. Patience, because several meetings may be necessary to assemble the ‘right’ people; courage, because we need to select some people while leaving others out.”

Michael Winer & Karen Ray

© 2000 Prevent Child Abuse America
Are members regularly assessed to ensure that the “right” people are at the table as the planning group’s needs grow and change?

Some questions to consider for membership selection include:

- Why is it important for this person to be involved with the HFA planning group?
- What skills or strengths does this person bring to the table?
- What role(s) could this person play within HFA?
- What strategies could be used to engage this person in the HFA planning group?

Some strategies for asking people to join your planning group might include:

- Being able to talk about the possible community benefits that this effort will create, such as better awareness of available resources and improved communications between programs;
- Being clear about the task, their roles and the time commitment; and
- Telling people why they are being included and what they or their organization might gain from involvement.
### Possible HFA Planning Group Members

- Business leaders
- Child protective services representatives
- Community library system
- Cooperative Extension Services
- Domestic violence victim advocates
- Evaluation experts
- Funders/foundation representatives
- HFA State Leader (particularly if this individual lives in the community)
- Head Start/Early Head Start
- Local/county government
- Local hospitals
- Local departments of public health and maternal and child health
- Media representatives
- Members of faith communities
- Mental health providers
- Other community-based organizations, such as United Way or the League of Women Voters
- Parents/new parents
- Prevent Child Abuse America Chapter representatives
- Public assistance representatives
- Representatives of cultural/ethnic groups, such as La Raza or National Black Child Development Institute
- Representatives of early intervention programs
- Representatives of other home visiting programs
- Substance abuse counseling/treatment providers
The cross-section of planning members should not be so broad and the number of members so large that the collaborative process becomes unmanageable.

**STAGE TWO: BUILDING TRUST AND OWNERSHIP**

This stage is about developing the shared vision, trust and ownership that differentiate a collaboration from an individual effort.

Developing and implementing an HFA program is about bringing together a cross-section of the community to provide the necessary supports for parents with young children in your community. Taking the step to create a planning group signals that your community is ready to look at your service delivery system from a new angle and to consider the opportunities for improving and expanding this system.

You must, however, take the time to nurture and develop your collaboration. This is about establishing common ground rather than defending one’s own turf. It is about understanding one another’s differences and ultimately building common trust and ownership of this collaborative effort.

**Focusing on the Process**

There are many critical components for building a collaboration and ultimately designing and implementing an HFA program. Many collaborations have found it helpful to spend a lot of time up front on developing and understanding the process the collaboration will undertake.

Consider the following strategies:

- **Develop a common base of knowledge.** In effective collaborations, partners take the time to learn about each other’s systems as well as their own and explore their differences. Understanding what each partner has to offer allows the collaboration to build a foundation of information for this effort.
✦ Build on strengths. It isn’t uncommon for planning groups to look for outside assistance without considering resources they may already have available.

✦ Learn which population each program serves (e.g., those who serve families prenatally, those who work with children and families, those who work with developmentally delayed children, etc.).

✦ Learn what services each program offers.

✦ Ask members to identify what brings them to the group.

🌟 Pay attention to process. It’s important to plan and talk about how you are going to work together. It’s also important to take the time to get to know one another.

✦ Include everyone in the process.

✦ Focus attention on members who aren’t yet sure of their level of commitment to the effort.

✦ Remember to periodically reflect on how much the group has accomplished.

✦ Build in rewards and victories along the way.

✦ Use more than one approach to gather input from the group – remember that everyone has different learning and communication styles. Ask the group what style of communication and information-sharing will best meet their needs.

✦ Think about rotating your meeting locations – this represents shared leadership.

✦ As new members join the group, take the time to bring
them up to speed on issues, activities and background.

✦ Everyone should be treated with common courtesy, despite any ideological or programmatic differences.

✦ **Disclose self-interests.** A willingness to share self-interests and the goals of individual organizations can help to establish trust and mutual respect among planning group members. The following areas may be considered for this type of discussion:

✦ Cultural differences

✦ Organizational and individual gain

✦ Common definitions for how to perceive certain actions (e.g., attendance at meetings)

✦ Power – what does each individual bring to the group?

✦ **Hold effective meetings.** Effective meetings are important for establishing rituals, the structure and expectations of the collaboration.

✦ Involve everyone in the meetings.

✦ Establish routines (e.g., develop agendas, set beginning and ending times, etc.).

✦ Identify a facilitator.

✦ Establish decision-making processes and a governing structure for the group.

✦ Define common terminology.

✦ Define committees to work on identified tasks. (Allow the members to choose the groups they want to be involved in and their strengths will shine through. Further, you will see the level of commitment of various members by

Intervene for Effective Meetings*

Any group continually improves by modifying its ideas and behaviors through the interaction of its members. While conveners do not control others, they do respond to situations in a way that can strongly influence others. Key here is the ability to intervene at the needed moment with a variety of responses. Conveners’ interventions can be:

**Conceptual:** an overview that pulls together the ideas and trends with which the group has been dealing. (“We’ve addressed a number of ideas tonight, and all of them seem to be concerned with ways to reach agreement.”)

**Experiential:** an expression of current behavior or a report of personal experience. (“I’m feeling pretty tense over what just happened.”)

**Structural:** a suggestion of planned activities to focus attention on the issues at hand; this may include taking a break. (“We seem bogged down. Let’s break into small groups and brainstorm solutions to our problem.”)

The convener may directly intervene with the group as a whole, a relationship within the group, or the actions of one member of the group.

Because these interventions increase group effectiveness, they also affect the trust level. Sometimes an intervention works; sometimes it doesn’t. If an intervention fails, try another. Remember, the one guarantee of failure is to let the group simply plod on without doing anything!

*Reprinted from The Critical Incident In Growth Groups with permission by Dr. Arthur M. Cohen and Dr. R. Douglas Smith.
what they bring back to the group.)

- Periodically assess the effectiveness of the meetings. Be willing to adjust as necessary.

**STAGE THREE: THINKING STRATEGICALLY AND PLANNING**

This stage is about laying the groundwork for deciding the direction your collaboration will pursue. It will help to answer several questions: What is the purpose and vision of your effort? Is HFA needed in your community? What will be the framework for your HFA program (e.g., target population, defined outcomes, etc.)? Decisions made during this stage will determine the ultimate “shape” of your program: what services are provided and for whom and how the program will operate.

Now that you have done some of the hard work to establish relationships and create a planning group focused on ensuring that new parents in your community have the support and resources they need, it is time to consider your options for meeting these needs. It’s time to begin planning. While it may be tempting to jump immediately into designing your HFA program, we caution you to first consider several questions:

- What does the collaboration want?
- What do families want?

“If you’re bringing HFA to a community that has a history of agencies being competitive, it may be helpful to bring in a neutral party who is familiar with the community to facilitate the early planning stages.”

- Lori Fuller, Outcome Research Specialist
  Children’s Home Association of Illinois

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How will you find out what families want and need?

What resources already exist in the community to meet these needs?

What will be done with this information once it has been collected?

We recommend a two-part planning process:

- Developing a vision; and
- Conducting a Community Needs and Resources Assessment.

A vision statement will help to focus the planning group and succinctly capture where you are going. A Community Needs and Resources Assessment will guide your efforts in determining the needs of parents and their babies and gaps in existing community services. It will also help identify existing resources and strengths in your community. In this section, we will provide information to help you with both processes.

### Developing a Vision

You have begun a process where you are bringing together individuals and organizations who may have very different opinions and viewpoints about what it means to provide the necessary support services for new parents in your community. This might also mean that each of you have very different ideas of what strategies should be used in order to address these needs.

A shared vision will enhance trust among your collaboration and establish a common understanding of what your collaboration is about. The vision statement demonstrates what the collaborative intends to accomplish and how they intend to achieve this vision. Developing a shared vision can be a challenging process that may take many meetings and document drafts. The result will be worthwhile, however, as it is the cornerstone of your HFA program.

It is helpful to have the members of the group who are experienced facilitators lead the way so your efforts will result in a clear, concise and easy-to-understand vision.
Stage Three: Thinking Strategically and Planning

**What is a vision?**

A vision is:

✶ A process;

✶ A shared expression of core values and philosophy;

✶ Clear, succinct and inspirational;

✶ Built upon the mission of Healthy Families America; and

✶ A guiding force (but only if it is widely disseminated, discussed and revisited).

**Why is a vision important?**

A vision:

✶ Generates ownership;

✶ Transforms strategies into a way of life;

✶ Gives the community a direction rather than a destination; and

✶ Helps people overcome barriers by showing them the difference between what is and what could be.

**What should be included in a vision statement?**

Consider including the following elements:

✶ A description of what the planning group will accomplish, where and for whom you will achieve your vision;

✶ An account of the scope of the work (e.g., how big, how much, how many);

✶ A statement of unique purpose; and

✶ Clarity – make your vision statement easy to understand.

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*Adapted from Working Together Toward Success. State of Illinois, Project Success Steering Committee and the North Central Regional Educational Laboratory (NCREL). Used with permission.

Conducting a Community Needs and Resources Assessment

Assessing the challenges and strengths of a community is an important step in laying the foundation on which to build an HFA program in your community. To provide effective services, you must first find out what services the members of your community want, what they need and how a program like HFA can be integrated into your community’s service delivery system.

A Community Needs and Resources Assessment will help the HFA planning group to:

- Understand the current condition of all families in the community and specifically new parents and their babies;
- Evaluate the current system’s capacity or incapacity to support healthy child growth and development;
- Build community support for and ownership of HFA;
- Determine how families and providers view the family support system; and
- Learn whether reform initiatives that focus on child and family issues are already underway in the community and, if so, how these efforts can be linked.

“Community assessment is the systematic process of identifying the challenges and strengths of people in a specific geographic area.”
- Samuels, Ahsan and Garcia

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Planning your Community Needs and Resources Assessment Process

Creating a plan for your assessment process will provide a common framework for your planning group to work from. It will help create common definitions and a shared understanding of the direction and purpose for conducting the assessment.

Consider the following questions prior to moving ahead with your process:

- What do we mean by needs?
- What do we mean by needs assessment?
- What is the purpose of our needs assessment?
- Is there a Community Needs and Resources Assessment that has already been completed to use as a foundation or resource?
- Whose needs are we going to assess? Children and families? The family support systems? Existing home visiting programs?
- What questions do we want to answer?
- What information do we already have?
- What information do we need to collect?
- How are we going to collect this information? Who is responsible for collecting the data?
- Are all of the necessary individuals or agencies involved?
- How are we going to use the data?

A Community Needs and Resources Assessment is not a quick undertaking. It may take up to six-nine months. Be patient, flexible and remember that this assessment will serve as the point of reference for how you move forward in enhancing and expanding the support systems for parents and their babies in your community.

*Adapted from Working Together Toward Success. State of Illinois, Project Success Steering Committee and the North Central Regional Educational Laboratory (NCREL). Used with permission.
What are the main components of a Community Needs and Resources Assessment?

The components are described in the following pages:

- Defining community/neighborhood boundaries;
- Developing a community/neighborhood profile;
- Collecting information and data;
- Identifying available community resources; and
- Analyzing the information collected.

**Defining Community/Neighborhood Boundaries**

Now that you are ready to begin your Community Needs and Resources Assessment process it is important to begin by defining the community or neighborhood that you are assessing. States, counties and cities often define community areas or boundaries differently. These definitions or assignments don’t always account for the historical, cultural or economic barriers that may also exist.

It is recommended that your planning group consider a variety of factors specific to your community in defining your community boundaries. An assessment should account for the particular characteristics and adaptive strengths of the specific community and/or neighborhoods under consideration. For example, community agencies, parents and other residents generally have a good idea of their own community’s boundaries which do not always correspond to school attendance areas, census tracts, political wards or boroughs.

“Failing to recognize the boundaries formed by informal support networks may result in inappropriate or underutilized service delivery systems.”

- Samuels, Ahsan and
To best understand how your own community defines its boundaries, draw a map of the community and share it with residents, service providers, etc. Then redraw this map based on their input. You can use symbols to identify various community agencies, schools, churches, childcare centers and other resources that will give you an easy-to-see diagram of the resources – or lack thereof – in the area.

**Developing a Community Profile**

Your community/neighborhood profile will provide a baseline understanding of the current community conditions, strengths and areas of concern in your community. The most comprehensive assessment will look at indicators related to the status of children at key transition points – prenatally or at the time of birth through adulthood. Ultimately, this information can be used to set goals for improving the service delivery system for parents and their babies.

The community profile can serve as:

- An internal planning document to help set priorities and establish accountability for improving selected outcomes;

- The basis to publish an annual report, calling attention to HFA and issues related to supporting new parents and their babies in the community; and

- Documentation for use in funding proposals.
### Sources of Community Information

- Census data
- Child Protective Services
- Children’s Defense Fund
- Department of Education
- Department of Public Health
- Department of Maternal and Child Health
- Department of Social Services
- Local Community Action agencies
- Other Local Programs (e.g., Head Start, Early Head Start)
- Prevent Child Abuse America 50-State Survey
- State *Kids Count* sourcebook
- United Way
Collecting Information from Community Members

It is important to get feedback and input from parents and other community residents when conducting your Community Needs and Resources Assessment. This will enhance the quality and comprehensiveness of the community profile you are developing and will provide critical direction for enhancing your existing family support system.

There are a variety of effective methods for gathering information from parents, community residents and others including focus groups, surveys, site visits and community forums. Using a combination of strategies will enable you to collect information from a range of sources. These strategies require time and valuable resources – it is up to the planning group to decide the most cost effective and efficient approach. Each strategy is outlined in the following pages.

Regardless of the strategies you choose, consider the following questions before you begin gathering information.*

✶ Who will conduct the focus groups, surveys or community forums?

✶ Why is this information being collected?

✶ How will the information be used?

✶ How will the information benefit the families that participate in the process?

✶ Who will document the process?

Some suggested areas for planning groups to focus on include:

✶ Positive characteristics that define the community;

✶ Strengths of the community;

✶ The most pressing challenges or concerns confronting parents;

*Adapted from Working Together Toward Success. State of Illinois, Project Success Steering Committee and the North Central Regional Educational Laboratory (NCREL). Used with permission.
The services, activities or resources needed to address these issues;

The service barriers that prevent parents from obtaining the services they need or want; and

The community services that new parents want and/or need the most and the ways in which they would like to receive those services.

Focus Groups

Focus groups are a great way to learn more about how participants see and identify their own needs. Your planning group will need to decide which audience(s) to address. A typical focus group includes a small number of participants (8-10).

Several factors are critical to the success of any focus group:

Have a facilitator moderate the group and another individual record the discussion.

Plan focus group(s) during convenient times for participants and host them at accessible and neutral locations (e.g., schools, libraries, community centers, etc.).

Make the meeting attractive. Provide incentives like food, transportation and gift certificates.

Create a climate that is open and comfortable.

Make sure that the groups adequately represent the population to be served (i.e., culture, ethnicity, age, etc.).

Ask open-ended questions – avoid “Yes” and “No” questions.

Select participants with common traits for each focus group (e.g., teen mothers, service providers, etc.).

Focus groups are relatively easy to arrange and are an efficient method for gathering information. They are also an excellent way to introduce HFA to the community.
Surveys

Surveys allow respondents to remain anonymous and to provide information that they may not otherwise be comfortable discussing in public or with a large group. Surveys should also be confidential and allow respondents to take more time to think about the questions and their answers.

If at all possible, try to pilot-test the survey before mass distribution to identify problem areas. Consider the following questions before disseminating the survey. Also consider reviewing your survey further if you cannot answer most of the questions listed below.*

• What is the purpose of the survey?
• What do you want to learn?
• Have you spent enough time designing the survey?
• Does the survey include at least one question that allows participants to make comments?
• Is the answer to any question likely to be influenced by preceding questions?
• Are there any questions that might be misunderstood?
• Are all of the questions necessary? How will each be used?
• Are the questions written in a language and at a reading level that respondents will understand?
• Who will compile and analyze the results?

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Site Visits

Site visits are a good way for the planning group to learn first-hand about existing services and agencies in the community. It will be important to meet with key individuals at each agency who can talk about the services they provide, the population they reach, gaps in services they have identified for new parents and their babies as well as the strengths of the agency. This information will help the planning group avoid duplication of services and will provide an understanding of the existing family support system and where HFA might fit into this system. If any agencies that you visit are not engaged with the planning process, you will want to include them.

Community Meetings

A community meeting is a good way to introduce HFA and/or home visiting to the community. It can also serve as a way to unite the community around the idea of family support services for new parents and their babies while gathering opinions about how to improve services for new families. A community meeting should be publicized as widely as possible. Ways to announce the meeting might include:

- Local newspapers may have free or low-cost advertising space, or may be willing to donate the space;
- Local radio stations;
- Libraries;
- Flyers;
- Ask local agencies to pass out flyers and make announcements;
- Schools;
- Hospitals;
- Public health clinics;
- Faith community newsletters or bulletins;
- Community centers; and
- Grocery stores.
A successful meeting will be well organized and provide opportunities for participants to share their ideas and opinions. There should be a clear, pre-set agenda. Meeting facilitators must be willing to be flexible if the discussion moves off the agenda, but remain focused on the needs for families and children.

The best facilitators are familiar with the community and its resources, knowledgeable of the agenda and are able to keep focused on the topic. Outside consultants or new community members may not make the best facilitators in this situation since they may not understand the dynamics of the group or the culture.

Identifying Available Community Resources

By determining existing resources in your community you are better able to identify the strengths of your family support system. You are also better able to determine whether your existing network is utilizing available resources to most effectively meet the needs of families and children in your community. Finally, knowing what resources are available enables you to match existing resources with identified needs and to develop strategies to meet unfilled needs.

Your assessment process should include both formal and informal resources. It is critical that you document the resources that are important in your community, no matter how unconventional they may be. The informal support system is the key to understanding the strengths of the community and identifying the foundation on which you can build your HFA program.
### Stage Three: Thinking Strategically and Planning

#### Formal Resources Might Include:

- Child protection services
- Domestic violence victim advocates
- Early Head Start
- Family preservation programs
- Head Start
- Health care clinics
- Hospitals
- Libraries
- Mental health and alcohol treatment programs
- Non-profit organizations
- Parks
- Parenting groups
- Parents as Teachers programs
- Police
- Public assistance offices
- Public health nursing
- Public housing authorities
- Schools, colleges and universities
- United Way

#### Informal Resources Might Include:

- Block clubs
- Citizens’ groups
- Civic clubs
- Family child care providers
- Religious institutions
- Volunteer groups

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You can collect information about existing resources at the same time you are conducting your surveys, community meetings, focus groups or other mechanisms for collecting feedback about your community. This will save you time and will be most cost effective.

**Analyzing the Information Collected**

Now that you’ve gathered all of this information about your community, what are you going to do with it? How are you going to analyze it? How are you going to share it with the planning group? The community?

The following questions can help guide your process:

* How much of a link is there between existing resources and strengths of the community and priorities and needs identified by parents and others?

*For example, your focus groups may have suggested that educational materials for all new parents are a priority, while the other information you collected indicates that this type of information is not available in your community.*

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*Adapted from Working Together Toward Success. State of Illinois, Project Success Steering Committee and the North Central Regional Educational Laboratory (NCREL). Used with permission.*
Do families in your community think that there are enough resources in your community? Do they feel that these are quality resources?

*For example,* families may have indicated that there is enough child care in your community, but they may have expressed concerns about the quality of the care available.

Are the support services in your community accessible?

*For example,* your data may suggest that there are enough prenatal care resources in your community, but the new parents who need these services may not be able to access the services. Is transportation a problem? Are the office hours difficult for working families? Are there language barriers?

What do families and the community want to see happen?

The information you have collected should give you a sense of the community’s priorities for new parents and their babies. Look for common themes and recommendations that may have been suggested more than once or by different sectors of the community.

How does the vision developed by your planning group compare with the information you’ve gathered through your community assessment?

You may want to revisit your vision and consider making changes depending on your community assessment. This is also a good opportunity to pause as a planning group and ensure that the information you have collected indicates support for a program like HFA.

Some agency representatives on your planning group may be providing services in the community and be resistant to hearing that there is a need. This is one reason it is so important to build the trust and relationship from the start so members are open to learning, sharing and attaining their vision.
Your community assessment will most likely reveal several priorities for new parents and their babies. Your planning group won’t necessarily tackle all of these priorities at once. You should spend some time reviewing these priorities and discussing them among the planning group. You may find that several will be addressed by developing and implementing an HFA program. You may find that others will be addressed by other groups or organizations in your community.

If you find that your community assessment suggests limited interest or support for an HFA program, it does not mean that you should not continue your planning. What it does tell you is that your planning group has more work to do in learning about your community and including more key players in the process.
STAGE FOUR: DESIGNING YOUR PROGRAM

This stage is about deciding to act – deciding to design an HFA program in your community.

At this stage in the planning process, your collaboration will have continued to grow and develop and you will have completed an assessment of your community. You’ve learned and confirmed that an HFA program will meet some of the needs of parents in the community and you are ready to begin designing it.

In this stage you will better define your target population, identify outcomes and goals for the program, decide what the program will look like and who will staff and administer the site. This is also the time when you will begin to plan for the credentialing process, for providing technical assistance and training, for what your evaluation process will entail and how you will fund and support this program.

Program Planning

To prepare for developing and implementing your program, it is a good idea to document your ideas. This will ensure that everyone involved is on the same page and will also serve as a guide as you move forward. Don’t worry about creating an elaborate masterpiece. In fact, it is recommended that you keep this step of the process as simple as possible. And don’t forget, a lot of your planning is already done. It’s now a matter of putting it down in a concise, consolidated format.

Getting Organized

Start by getting organized. Make sure your community needs assessment and related research results and recommendations are in order. Then decide who is going to develop the plan. Is your entire planning group going to be involved? Are you going to use a sub-committee? Or are you going to divide certain tasks among the committee? Regardless of how you proceed, the most important factor is that you have a clear plan in mind.
Assembling an Advisory Board

This is a good time to think about forming or assembling an advisory group for your HFA program. Depending on your community, you may decide to continue working as a full planning group or collaborative and assign or create a smaller group that is more directly responsible for implementation, oversight and support for your local HFA program.

This type of advisory board usually includes community leaders, professionals and family representatives who meet regularly to help further the goals and objectives of the program. Some communities use the Board of Directors that oversees the primary agency housing or running the program. Other planning groups form special advisory boards.

Your advisory board might include some of the following:

- Community/civic leaders (i.e., mayor, city councilperson, health commissioner, etc.)
- Representatives of collaborating government agencies (i.e., public health, children and family services, etc.)
- Representatives of collaborating local organizations (i.e., the local hospital, private non-profits, etc.)
- Fundraisers/fund development individuals
- Members of the faith community
- Local business leaders
- Community college or local university affiliates
- Consumer representatives (i.e., parents, etc.)
- HFA Program Manager
- Head Start representatives
- Representatives of other home visiting programs
- Public health nursing program representatives
Parents as Teachers programs
Mental health and alcohol treatment programs
Family preservation programs
Child protection services
Public assistance providers
Domestic violence victim advocates

Keep your program planning process as simple as possible and be sure that everyone knows who’s assigned to what! Assign a notetaker to record action steps, or establish a rotation system for sharing notetaking duties.

Writing the Plan

You’ve already spent a lot of time identifying the critical issues impacting new parents and their infants in your community. You’ve identified gaps in services and you’ve also probably discovered some resources that you didn’t know existed in your community. You’ve confirmed that there is indeed a need for a program like HFA in your community and you’re ready to sit down at the computer and begin to write.

The following is a recommended outline for your written plan. As with this entire guidebook, feel free to make adjustments and adaptations to meet your planning group’s needs. There is no prescribed way to capture your plan.
You may use this sample outline as you continue on to Sections III-IV, which will help you define in more detail how your program will operate.

- Executive summary
- Vision statement
- History/summary of community profile
- Situation analysis – Why is more support needed for new families?
- Goals
- Strategies
- Service level
- Staffing
- Funding plans
- Outcomes
- Implementation plan

**Maintain Momentum - Celebrate Success**

This step is often forgotten or ignored by many collaborations and partnerships. Take some time to celebrate your successes and reflect on your accomplishments. You have created and established an HFA planning group in your community, you have completed your Community Needs and Resources Assessment and you are about to begin shaping and designing an HFA program in your community. Congratulations!
A Word About Funding

Funding is a topic that raises a lot of questions. Don’t get too caught up in how you are going to fund your HFA program in the beginning. However, you do need to think about it and plan for it. In the meantime, here are a few things to consider as you get started:

**Do your homework.** Funding is critical to the success of your HFA program. There are a variety of ways to fund your program and there are many examples and success stories out there. Don’t reinvent the wheel. Talk with your HFA State Leaders and your Prevent Child Abuse America Chapter to learn more about potential funding sources in your state. Also, contact Prevent Child Abuse America for potential opportunities and funding resources. Finally, talk with other HFA programs or home visiting/family support programs in your state and/or community.

**Develop a plan.** Creating a plan for how you are going to fund your HFA program is just as important as developing your plan for what your program will look like. Consider creating a sub-committee focused exclusively on funding issues. Think about other individuals or organizations who may be important to include on this sub-committee. Your local United Way or development staff from some of your partner organizations may be helpful. This committee can then take the lead for mapping out the direction that you need to go in order to secure funding. This most likely will require grant writing. It may also entail local fundraising events and capital campaigns.
STAGE FIVE: PROVIDING PROGRAM SERVICES

This stage is about realizing your vision and implementing the HFA program that you have designed for your community.

Congratulations! It takes a lot of hard work and collaboration to reach the point where you open your doors and begin providing services to community members. You are hiring staff, preparing to serve families and putting into place the variety of policies and procedures necessary to run the program. You are preparing to provide training and technical assistance for your program staff. Now is the time to ensure that you have designed your HFA program to reflect the Critical Elements, begin checking and monitoring for quality, and ensure that the program adheres to expectations laid out in the credentialing guidelines.
STAGE SIX: PROMOTING AND MAINTAINING YOUR HFA PROGRAM

This stage is about keeping the good work going after you’ve achieved the goal of developing and implementing your HFA program. You are entering the phase of long-term sustainability and viability.

Now you can devote some attention to building public awareness for your program through public relations and marketing. Becoming involved with advocacy efforts in your community and state will help you reach your legislators and policymakers with a message about the good work your program is doing and the benefits received by families in your community.

Now is the time:

★ To think about future funding needs and building relationships in the community and with policymakers; and

★ To ensure that families and the community know about your program’s services.
ADDITIONAL RESOURCES –
SECTION II

Amherst Wilder Foundation
Community Services Group
919 Lafond Avenue
St. Paul, MN 55104
Phone: 651/642-4022
(For information on Wilder Foundation publications, call 800/274-6024.)

Prevent Child Abuse America
200 S. Michigan Avenue, 17th Floor
Chicago, IL 60604
Phone: 312/663-3520
Fax: 312/939-8962
www.preventchildabuse.org

Prevent Child Abuse America’s Chapter Directory (Updated monthly)
Healthy Families America State Leaders Directory
Healthy Families America Program Site List (Updated monthly)


Working Together Toward Success. State of Illinois, Project Success Steering Committee and the North Central Regional Educational Laboratory (NCREL)


Strategic Planning Workbook for Nonprofit Organizations. Berry, Bryan.

See the bibliography for additional resources and complete citations.
In Section II, you’ve cleared the ground and paved the way for the development of an HFA program in your community.

☑ You’ve developed awareness and secured support from appropriate stakeholders at the state and/or local levels for family support programs like HFA.

☑ You’ve brought people together to collaborate on developing and implementing HFA.

☑ You’ve completed a Community Needs and Resources Assessment and shared the results with all key players.

☑ You’ve ensured that members of the planning group are familiar with the 12 Critical Elements.

☑ You’ve developed a plan.
BEGINNING TO DESIGN YOUR PROGRAM

This section of the HFA Site Development Guide provides more in-depth information about designing your program, which was briefly described in Stage Four in the previous section.

Careful program planning helps to clarify and integrate the information needed to develop a program that will best meet the needs of those people it is designed to serve. To create a successful program, you must set clear goals and objectives that are implemented through reasonable and appropriate methods by qualified staff. A comprehensive planning process can be expected to take 8–12 months. Program planning can appear to be an overwhelming task, but don’t be intimidated. Remember that there are no right or wrong ways to plan for a program.

Keep this Guide in your toolkit. A good first step is for the planning group to thoroughly review this Guide to gain a better understanding of what HFA is all about.

Organizational Readiness

As you begin planning, it is important to understand how an HFA program will fit into your existing community of services. Addressing these questions early on will help you avoid problems later.

★ Where will the HFA program be housed?

★ How can other programs within the parent or host organization support the work of the HFA program (i.e., parent support groups, job training, child care services, etc.)?

★ Where will the new or re-designed program fit into the host organization’s structure? Is there support and buy-in from the organization’s executive level? Will there be senior-level support for the program as regards ongoing development, administration, data tracking, advocacy, fundraising and marketing?
If this will be the parent or host organization’s first home visiting program, will changes be required in organizational policies related to staff work hours, safety, contact with supervisors and insurance, if your program will be transporting participants?

“Healthy Families DC (HFDC) began as a collaborative of four agencies, with all of the Executive Directors (EDs) making a commitment to support the collaborative and act as the governing body. When one agency found themselves unable to continue this commitment, they decided to leave and we became a collaborative of three agencies. The EDs’ support has been imperative. Having the EDs actively involved allows for a greater understanding of HFDC’s role in their overall organizational missions and ensures that they will continue to be committed to the program. The EDs’ relationships with public officials, city administrators and foundations helped HFDC obtain the public and private backing it has today. Without that, we would not have survived.”

- Joan Yengo, Program Manager
Healthy Families DC

**Developing a Logic Model or Program Plan**

You may find it helpful to develop a logic model as a beginning step in program planning. A logic model is a tool that helps planners decide what their program is supposed to do, who they are going to work with and why the program is being developed. It is also helpful for evaluation planning.

Logic models vary widely in how they look, from flowcharts to outlines. There are no rules about logic models – they just need to be easily understood by the members of the planning group who will be using the model. You may find it easier to start at the bottom of the model, beginning with the desired outcomes and working your way up. Ask the question, “What change do we want to bring about and how are we going to do it?”
Planning and implementing an HFA program requires a variety of interconnecting factors, which will not follow any set chronological order. However, most programs do include the following components in their logic model or program plan:

- **Statement of Goal:** Broad statements that define the program’s expected accomplishments.

- **Objectives:** Statements that map out the tasks required to reach a goal, including timeframe, direction, magnitude and measurement of change.

- **Target Population:** The specific families your program will serve.

- **Methods and Activities:** The specific services your program will offer and the staff who will provide the services.

- **Resources:** The resources in your community that may be used to help your program meet its goals.

- **Constraints:** The constraints that are expected to work against the program.

- **Quality Assurance:** The strategies developed to ensure program quality.

- **Evaluation Plan:** The procedures for determining whether the program performed as planned.

- **Implementation of Plan.** The policies and procedures for operating the program.

Each component is discussed further in the following pages.

As you identify these components during your program development, they should be written down. A written plan will have many uses, such as serving as a resource when training new staff, supporting requests for funding and providing evidence about why decisions were made regarding certain aspects of the program.
Involving Your Target Population

You have already involved your target population during early planning stages and during the Community Needs and Resources Assessment. Keep that involvement going! You may find it helpful to talk to a variety of community residents and service providers to get their input and ideas about potential service delivery barriers and considerate and respectful ways to overcome these perceived barriers. Examples of this include:

- Territorial boundaries due to social realities, such as gang activity, farm families vs. town families or other commonly acknowledged physical barriers such as train tracks, rivers, viaducts or public housing;
- Negative community perceptions of potential collaboration sites, such as specific hospitals, clinics or service programs;
- Migrant labor patterns;
- Language issues;
- Cultural norms; and
- Lack of buy-in from direct service staff of collaborating partners.
ESTABLISHING PROGRAM GOALS AND OBJECTIVES

A significant benchmark in the planning process will be the development of your program goals and objectives. You must be clear about what you want to accomplish before you can determine how to accomplish it. Creating a logic model should help with the development of goals and objectives.

The HFA Critical Elements were created to facilitate program development and ensure quality. Refer to them regularly during the planning process, as they provide a valuable framework.

Goals are statements that broadly describe what you plan to accomplish. Goals and objectives help shape the way a program will look. The goal sets a direction for the program.

From a national perspective, the overarching goals of the HFA program are:

☆ To promote positive parenting;
☆ To encourage child health and development; and
☆ To prevent child abuse and neglect.

Objectives are descriptive statements specifying the activities necessary to reach a goal. Program objectives define the type of services to be provided and must be measurable.

Here are some examples of program objectives:

80% of all new moms in the target population will be served.

All infants served by the Healthy Families program will be linked to a medical provider for preventive health care within six months of enrollment into the program.
Strategies are the methods and activities you will pursue to meet your objectives and goals. Family assessment and home visiting are the primary strategies for achieving HFA program goals. Some programs may choose to add goals and objectives, which may require other implementation strategies to achieve the desired outcomes. Adoption of goals such as parental self-sufficiency or increased educational/vocational skills, for example, might require the addition of educational or job training and placement services to an HFA program site or linkages with community resources that provide these services.

Give thoughtful consideration to the impact of adding new goals to your program and ensure that the chosen implementation strategies are likely to achieve those outcomes. In some HFA sites, additional program strategies, such as parent groups or father involvement projects, are used to enhance the assessment and home visiting activities. Programs that target specific subsets of overburdened families may find that supplemental strategies are critical to achieving desired outcomes.

Effective planning will result in a set of clearly stated goals and measurable objectives. Each objective should have a specific timeframe for achievement and staff assignments should be clearly delineated.

In addition to a narrative format, consider developing an outline that focuses specifically on goals, objectives and action steps. Include the person responsible for each action step and when it is to be completed. An outline of this type can be written as an annual program plan which may be used as a measuring stick for implementation achievement.
WORKSHEET #1: DEVELOPING PROGRAM OBJECTIVES

To help develop program objectives, you may want to use the DART method to describe what will be done, by whom, with what resources and for how many people. DART stands for Deliverables, by Agency staff, with agency Resources, for a number of Target population (DART).

Step One: Deliverables

Describe the major services and activities the staff of the program will have to deliver to ensure the achievement of the goals and objectives.

Step Two: Agency Staff

Identify who or what position will provide these services and activities. How much of their time will be involved? What qualifications will they need? What training and support will they need? What will be the cost of the staff position?

Step Three: Resources

What resources or equipment are needed to effectively deliver these services?

Step Four: Target Population

How many clients or participants will receive services or participate in activities?

Once your goals and objectives have been developed, the outcomes will naturally follow.

**Program outcomes are the changes the program expects within the target population.** Program outcomes are the reason why the program is being implemented and they focus on what the program causes to happen. They are the intended results of the program, not the process of achieving them. There are usually short-term and long-term outcomes.

**Short-term outcomes:** These are the direct results of the program on its participants. They show why the program activities will lead to the long-term outcomes.

*Example:* In an HFA program, short-term outcomes might be increased compliance, such as securing a medical home and obtaining prenatal care or improved parenting skills.

**Long-term outcomes:** These reflect the consequences of your program in the broader community. They tend to be the ultimate goals of the program. As long-term outcomes take a long time to occur, there will probably be several long-term outcomes for any given program.

*Example:* Long-term outcomes may include improved health status, decreased rates of child abuse and neglect and a decreased dependence on public financial supports.

Here is a formula to help write outcomes.

By __________________________ (Date or Amount of Time)  
______________________________ (Percent or Number)  
of ____________________________ (Participants)  
will ____________________________ (Specific Achievement)

*Example: By the end of the year, 90% of HFA participants’ children will be up-to-date on their immunizations.*
WORKSHEET #2: DEVELOPING PROGRAM OUTCOMES

Use the SMART method to help write your outcomes. SMART stands for Specific, Measurable Achievement of the participant that is Related to goal achievement and is Time-limited (SMART).

Step One: Specific
Describe the specific change in knowledge, attitude, behavior or level of problem that you are seeking.

Step Two: Measurable
Describe the measure. Is it number of participants or how much change will occur? How will it be measured?

Step Three: Achievement of the participant
Identify the participants who will make the change.

Step Four: Related logically to goal attainment
It may not be evident immediately, but there is a rationale that connects this outcome with the eventual attainment of the goal.

Step Five: Time-limited
There are specific time parameters for the achievement of this outcome. By what date will this happen?


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DEFINING THE TARGET POPULATION

One of the first questions to answer in your planning is, “What population will be served?” Refer to your Community Needs and Resources Assessment and consider the following questions:

* Are there particular groups of parents (i.e., teen parents, first-time parents) who have higher needs than others?

* Are there some families that have limited or no access to health care or other supportive services?

* Will your program be collaborating with a local health department, hospital or clinic that may have an impact on the population to be served?

* Does your organization have the capacity to meet the demands or number of your target population potential?

* Have potential funders indicated that they want to serve a particular population?

Your target populations can be defined in terms of socio-demographic characteristics such as age, income, race, ethnicity, level of education and/or social support. They can also be determined by geographic boundaries.

It will be important to consider all of these factors when defining your target population. Because HFA is designed to be flexible, the target population will vary from program to program. However your target population is defined, try to be as specific as possible.

Your planning group should also decide how you will work with families who meet the criteria for inclusion in the program but are not members of your target population. Will they be referred to another program or service? If so, where?
DETERMINING SERVICES TO BE OFFERED

This section relates to the Methods and Activities category on the Logic Model. Program services offered are the strategies being employed to achieve your goals and objectives.

The Critical Elements provide a framework for all programs planning to become HFA credentialed sites. Credentialed HFA programs must provide services that:

- Are voluntary, long-term and culturally competent;
- Focus on supporting the parent, fostering the parent-child relationship and enhancing child development; and
- At a minimum, link families to a medical provider.

Your program objectives will help to determine which services to offer. While the HFA program is designed to provide systematic screening and assessment along with home visiting for those at highest risk, the services offered need not end there. Many HFA programs provide other services such as parent support groups, father involvement programs and job training. Factors such as a program’s capacity to provide these additional services and the target population’s specific needs should help direct the decisions regarding these additional services.

Consider the results of your Community Needs and Resources Assessment as well as your program’s goals and objectives when making decisions about program services.

Planning for Screening and Assessment Services

Consider the following questions:

- Will your program screen families? If so, who will conduct initial screenings – HFA program staff or others?
- If other organizations conduct the screenings, how will HFA assure the quality of this aspect of the program?
- Will assessments be conducted prenatally, at the time of...
Determining Services to be Offered

- birth or both?
- How will families be engaged and retained in the program?
- Which assessment tool will be used?

The HFA planning process can provide an excellent opportunity to educate local stakeholders and state-level decision-makers about the importance of assessment and the early identification of families in need of support. Early needs assessment, when linked with coordinated referrals, can stand alone as a service to families.

**Planning for Home Visiting Services**

Consider the following questions:
- What will take place during the home visits?
- When and how does a participant complete the program?
- Which curricula will you use?
- How will quality be assured and by whom?
- How will referrals for other services be handled?
- How will the program be promoted to families and the community?
- What complementary services will your program offer?

State Leaders, Prevent Child Abuse America Chapter representatives and Program Managers from other HFA sites can be valuable resources as you plan your program’s service delivery.

**WORKING WITH PARTNERS**
Establishing linkages with other social support agencies is a critical step for ensuring that the needs of the families your program serves are being met. In addition to providing a range of services, collaborative partners can also be helpful in promoting the HFA program, recruiting staff and serving in an advisory capacity. No one program is capable of being all things to all people and HFA is no exception. However, HFA can serve as a gateway to other services. Therefore, decisions need to be made regarding which services will be provided directly through HFA and which services are best provided through other organizations. Many times, services will be provided concurrently.

**Identifying Partners for Assessment Services**

A central partnership is the one between your program and the hospital, clinic or referral program such as Women, Infants & Children (WIC) where you will identify, screen and assess new parents. Include supportive medical professionals on your team when you meet with administrators of these potential partners who serve families and children in your target area. Carefully assess the capacity of the desired hospital, clinic or agency to determine whether they have the enthusiasm and staff commitment for supporting new parents. Some questions to consider when evaluating a potential partner for collaboration include:

- Does the hospital have on-site prenatal care or are those services offered only at community clinics?
- How many patients give birth as “walk-ins” to the emergency room, without any prenatal care?
- Is there a minimum stay after birth before hospital discharge, i.e., 24 or 48 hours?
- Does the hospital have neonatal intensive care services or a pediatric unit with whom you can coordinate follow-up care?
- Does the hospital have a social work department? Are social workers involved with families prenatally? Do the social services provided focus primarily on crisis care?
Do administrators and staff have enthusiasm for the HFA approach and this program in particular?

How will you work with hospital or clinic administrators to ensure confidentiality and access patient information?

Will hospital or clinic staff be available to screen potential participants for further assessment?

HFA has organized collaborations with the American Hospital Association, the American Nurses Association, the National Association of Children's Hospitals and Related Institutions (NACHRI) and the American Academy of Pediatrics. You may want to contact local chapters of these organizations and include them in your hospital/clinic selection process. Your own board members may have access to hospital board members or administrators who may be helpful in the planning process.

Planning the Services to be Delivered by the Collaborating Assessment Partners

Keep in mind when planning for the delivery of screening and assessment services that patient confidentiality is of the utmost importance, and policies and procedures to ensure families’ rights must be put into place and rigorously enforced.

The partnership with the selected hospital, clinic or agency may involve differing degrees of involvement by their staff. A key question involves the screening of new parents. Will the hospital/clinic staff screen clients and refer to you those parents who are eligible for assessment? Or will the HFA Family Assessment Worker (FAW) be permitted access to patient information to do the screening? The benefits to both approaches follow.

Benefits of having the assessment partners’ staff conduct screening:

* Saves time for the HFA program; and
Engenders a sense of real involvement in the program for the hospital or other assessment partners’ staff.

Benefits of having HFA staff conduct screenings:

- The ongoing presence of an HFA Family Assessment Worker in the hospital or clinic can strengthen the collaboration and promote increased involvement in the program.

- FAWs may make the screening and referral of potential participants a higher priority than hospital/clinic staff would.

- Because the assessment partners’ staff are not supervised by the HFA program, there may be a greater chance that screening would not be systematically completed or done in a standardized manner, as it would be if conducted by an FAW.

- Because hospital/clinic staff are so busy with other priorities, the screening and referral process might not be completed before the mother and baby are discharged and the window of opportunity to connect with that family might be lost. The most overburdened families are often the most difficult to locate once they leave the hospital.

Memoranda of Understanding with Assessment Partners

Once a hospital or prenatal clinic or other assessment partners are selected and the method of screening has been considered, it will be important to establish procedural details and develop a Memorandum of Understanding (MOU) with each assessment partner. A Memorandum of Understanding is a document that clearly outlines the scope, nature and extent of services being provided by each organization. The MOU with the hospital, clinic or other partnering organization should address the following issues:

- How will HFA staff determine which families of newborns (deliveries within past 24 hours) or expectant parents are from the target area?

- Will HFA staff be able to talk briefly to all parents from the target area? Following pre-established confidentiality procedures, will they have access to patient information? Will they be able to communicate with hospital staff by noting in the patient
charts that they have seen the family and indicating any referrals that were made?

* If program staff cannot see patient information, which clinic/hospital staff will screen potential participants and ask for patient consent to refer them for HFA assessment?

* What logistical arrangements will be made for program staff to interview families while at the hospital or clinic? Will they check in with someone routinely and who will be the contact person?

* Does the hospital or clinic use some form of psycho-social or health assessment that can be used as a baseline for identifying stress indicators rather than your program’s assessment tool? Can they be combined?

**Partnering with Other Community Resources**

Today’s families typically have a wide variety of needs. Some may need assistance with housing, clothing or food. Some may
need substance abuse or mental health counseling. Others may be looking for support through literacy or fathering programs. While some of these needs may be addressed in your program, most likely there will be other organizations in your community that provide some of these other services. It will be important to form linkages with these organizations, so that FAWs and FSWs can confidently refer families to these services. When direct service providers are able to help families access appropriate services concurrent with Healthy Families home visitation services, families will be supported by a continuum of care.

Your community needs and resources assessment should be helpful in identifying other resources in the community. Once you know who these other organizations are, efforts should be taken to reach out to them to develop Memoranda of Understanding. Identifying and forming relationships with other organizations should be an ongoing process. You are encouraged to meet regularly with your partners to assess what is working and what needs changing to improve the relationship. Update MOUs annually, as attrition of programs, staff and other programmatic changes can impact the nature of relationships. You are encouraged to develop a process for evaluating the effectiveness of partnerships and share those findings with all personnel involved in the partnership. This can enhance the quality of the partnership.

**STAFFING**

Now that you know which services your program will provide,
how do you find the right people to provide these services? The best laid plans mean nothing without qualified staff to carry out the day-to-day functions of the program. The staff will be a key contributing factor to the success of your program, particularly your direct service staff. They are the ones who will connect with potential participants and whom participants will eventually come to know and trust. **Direct service staff are the face of HFA in a community.**

The two key direct service positions are the **Family Assessment Worker (FAW)** and the **Family Support Worker (FSW)**. The FAW conducts the assessments and sometimes the screenings. The FSW is the home visitor who works with families on an ongoing basis.

Other core staff include a **Program Manager/Supervisor** who oversees the overall running of the program, funding, quality assurance, evaluation and supervision of other staff. This person often provides supervision to the FAWs. Another position is **FSW Supervisor**, who will provide support, balance caseloads, establish training, etc. Sometimes, especially in the early stages of a Healthy Families program, the Program Manager and Supervisor positions are combined. We strongly recommend keeping these two positions separate. If the Program Manager is doing too much, the direct service staff may not receive the support and supervision they need, and overall program quality may suffer.

Both FSWs and FAWs need ongoing supervision. Supervisors provide support, help staff work with families, balance caseloads, arrange trainings, etc. Typically, when programs are first implemented, the Program Manager/Supervisor will provide supervision to both the FSWs and FAW(s). It is recommended that supervision is provided to staff on a 1:5 ratio – that is, one Supervisor to every five staffpersons. (The HFA credentialing guidelines allow a ratio of 1:6, but the optimal supervision load is 1:5.) Keep in mind that as your programs expand and add more direct service staff, the program will require a separate position for an FSW Supervisor. If the program also increases the number of FAWs, these direct service staff will also need an FAW Supervisor. Supervision is a critical component of HFA and should be addressed seriously to ensure that staff receive
the support needed to provide effective services to families.

Different program sites use a variety of options to provide program management and supervision to staff. You will need to determine the most appropriate staffing pattern for the initial program start-up and develop a plan for adjusting the staffing pattern as the number of FSWs and FAWs increases.

Consider the following questions when it comes to staffing your program:

- How many staff will the program need?
- How will staff be recruited?
- How will you keep staff turnover low?
- Where/how will staff receive training?
- How will staff be supervised and by whom?

**Staffing Characteristics**

As you begin planning your staffing needs, remember to incorporate the Critical Elements of the HFA program. They provide best practice standards to enhance the effectiveness of the program.

- The Critical Elements state that direct service staff should not be hired based on their formal education alone. Service providers should be selected because of their personal characteristics (i.e., a non-judgmental attitude, compassion, the ability to establish a trusting relationship, etc.), their willingness to work in or experience working with culturally diverse communities and their skills to do the job.

- It is beneficial to recruit staff who have experience working with families with multiple needs. In addition, staff must have the ability to separate their professional and private lives in order to reduce boundary issues and potential burnout.

- All direct service staff should have the ability to comfortably interact with families from a broad range of racial, ethnic and cultural groups. If at all possible, the staff should reflect the racial and cultural make-up of the community and fami-
ilies to be served. In any event, programs will need to provide ongoing training around the norms, value systems and parenting beliefs of the families that will be served.

- In those communities where English is the second language, every effort should be made to include a staff member(s) proficient in the first language of the community.

- Since Healthy Families America is a program for parents, not just mothers, staff need to feel comfortable and have the skills to work with both male and female participants and members of their support systems. It will be important for staff to be comfortable working with many different family structures.

- Healthy Families America is built on the concept that all children and their parents should be nurtured. Given this, all staff must not only believe that infants and children should be well nurtured and loved, but they must also be willing to advocate for positive, nurturing, nonviolent discipline of children.

Many HFA programs have found it helpful to recruit and hire staff that come from or live in the communities that will be

“It is important to recognize changes in family structure so that staff are hired with a comfort level for working with same-sex parents, or in families where the grandparent of the baby may be in a same-sex relationship and the mother of the baby is living in the grandparent’s home. We have the latter situation quite often in DC. We want to ensure that FSWs are able to work in any family setting, recognizing the family-centered approach to the program.”

- Joan Yengo, Program Manager
  Healthy Families DC
served, as they typically possess a knowledge of the communities and available resources. Recognize, however, that some staff may have had experiences similar to the population being served. That is why training, weekly supervision and careful hiring practices are so important to successful delivery of services.

Although many of the traits sought in staff members are subjective, try to make hiring decisions as objectively as possible. To that end, seek input not only from program staff, but also from agencies that are currently serving the target population, including partner organizations. Once the job descriptions are finalized and the hiring process begins in earnest, encourage these agencies to get involved in the process by posting job opportunities and utilizing their networks to identify qualified candidates.

Because welfare reform has required many parents to seek out educational or employment opportunities, fewer parents are available for home visits during a typical nine-to-five workday. Therefore, HFA staff need to be able to work flexible hours to meet the needs of their families. Let all applicants know about this up front to avoid any confusion or resentment later on and consider adopting flex-time policies to accommodate the needs of your staff.

**Staff Retention**

We recommend that you think about ways to retain staff members, as turnover in this field can be high. Staff need to know that they are valued. Programs should seek out opportunities for staff development, such as cross-training to expand their skill sets. (Program Managers who choose to do this are encouraged to let staff serve in their primary roles for a minimum of three months before receiving training in another role.) Other contributors to job satisfaction are time off and recognition for achievements.

Some HFA programs have developed a staff leveling system for
career advancement or staff development. Staff may start as an FSW I, then in a year or so meet the requirements to reach the status of FSW II, with more responsibility and an increase in salary. Later on, they may be ready to move to FSW III with much more responsibility. This method helps in identifying FSWs’ career goals and supporting them to reach those goals. For example, if an FSW is skilled at conducting in-service trainings, support her/him in possibly becoming an HFA trainer. Some staff may wish to develop a second language in order to better assist their families. The point is, when planning your program be sure to identify the strategies and funding that will encourage staff longevity.

**Determining Your Staffing Needs**

Refer back to your Community Needs and Resources Assessment as you begin to develop a staffing plan for your Healthy Families America program. Every community is unique and staffing requirements will vary. However, much has been learned from existing HFA sites. Their experiences have provided information that can assist you in determining your site’s needs.

This section of the *Site Development Guide* provides projection worksheets to help you determine your staffing needs. Use them to calculate the number of families you will serve in your first three years of program implementation, the number of staff needed, etc. In order to provide you with calculation examples, we have selected numbers and percentages that are easy to calculate and represent real life experiences of HFA sites that have been in operation for two or more years. Before moving into the worksheets, consider the following:
Number of Births Among the Target Population

Determining the annual number of births in your target geographic area will require some research. You may gather data from numerous sources (i.e., Kids Count, county and city departments of health, census bureau, etc.) to arrive at an educated estimate. If you are serving the entire population within a clearly defined geographic area, your data may be easier to retrieve than if you are serving a sub-population within a less well-defined geographic area. Depending on your data source(s), you may be able to access data by zip code, city, county, census tract, etc. Make sure you can define your geographic area and target population in these terms before you call your data source.

Once you determine the number of births in your target population annually, you will be able to calculate the number of families that need services and the number of staff required to serve those families.

Screening

In some instances, hospital or clinic staff will do the screening for you and refer to you those new parents who should be assessed. In other cases, assessment workers will review and screen hospital/clinic records themselves following pre-established confidentiality procedures to ensure parents’ privacy. You will need to decide if the program will screen clients and if so, determine who will provide this service – HFA staff or hospital/clinic staff.

Assessment

Community demographics and characteristics will determine the percentage of families most in need of services being identified. Consider how your target population compares to the average for your state/U.S. on indicators such as child abuse rates, substance abuse rates, poverty, etc.

The Critical Elements require programs to use a standardized assessment tool to systematically identify families who are most in need of services. Your program must ensure that there is sufficient support to provide this service.
Some communities have an unusually high percentage of overburdened families and may choose to forego the individual risk assessment process and offer services to all of those families who meet the criteria for inclusion in the program.

If your HFA site is conducting individual family assessments, determine the number of assessments that need to be completed by your staff in a year. This will help you project the number of assessment staff you will need to hire.

If your program uses a risk assessment tool other than the Family Stress Checklist in determining the need for services of overburdened families, you may need to account for variations in staff time in your projections.

Determine the number of births per day among your target population by dividing the annual number of births by 365 days. This will give you the average daily number of screens that need to be completed, assuming you are serving your entire target population.

In most communities, there are more births in the target area than the program has the capacity to serve. We recommend that programs continue conducting assessments in order to document unmet needs in the community and provide families with referrals to other resources.

Some communities conduct assessments only until caseloads are full and then assign the FAW to other duties. However, it is important to remember that assessment is a service, and a vital part of the service delivery strategy for Healthy Families programs. By continuing to conduct assessments even after caseloads are full, you will still be able to refer families to other community support resources. Also, families in need of support other than that offered by Healthy Families may be identified through the assessment process and referred for other services.

If the annual number of births in your community is low, you may wish to hire an FAW to do screenings and assessments as well as other projects such as community education, outreach, facilitation of parent support groups, etc.
In some HFA programs, some families are assessed and referred to support services other than HFA. In order to calculate the expected annual number of assessments and referrals to other support services, you should consider whether your staff resources are adequate enough to assess all the births among the target population in a given year.

**Acceptance of Services**

- In most cases, HFA services are widely accepted by the families to whom they are offered.

- When a family is unsure about receiving support from HFA, an FAW or FSW will often seek to clarify services and offer families the chance to see the potential benefits of participation in HFA.

- If a family expresses clear disinterest in home visitation, assessment and support, HFA staff will respect this decision.

**Attrition**

- Some attrition, or dropping out, should be expected in all programs. Various factors may account for attrition, such as participants moving out of the target area, time constraints, participants becoming employed, etc.

- You may be able to develop an educated guess about attrition rates by looking at community variables, such as mobility, employment opportunities, etc. Also, it may be helpful to talk with other programs in your community or in similar communities to find out about their attrition rates.

**Home Visiting Caseload Size**

- The HFA Critical Elements recommend that FSWs have limited caseloads to assure that they have an adequate amount of time to spend with each family. Among current HFA sites, caseload sizes range from 8 to 25 cases on various levels of service provision per FSW. For most communities, it is recommended that one FSW should serve no more than 15 families on the most intensive service level.
In some instances, the caseload number may need to be significantly lower to accommodate families with greater needs (e.g., eight families per FSW) or to accommodate communities with long travel distances between home visits. The decision about caseload size should be based on the site’s ability to provide services while adhering to the Critical Elements.

You may feel considerable pressure to increase caseload size in order to “serve more families.” (Often this pressure comes from funding sources.) We encourage you to review the research and supporting literature related to caseload size and program effectiveness and to develop productive ways to communicate these findings with your funding sources, legislators and other agencies.

In some communities, an FSW is able to serve a larger number of families due to a concentrated target area. In these cases, some support services, such as providing transportation to a doctor’s appointment, can be provided to several families at one time.

Managing a Weighted Caseload System

Typically, HFA programs use a level of service protocol to manage home visits for participants. It often consists of creative outreach, weekly visits, biweekly and monthly visits. This leveling system is based on the degree of support that is necessary for each family. While the goal is for families to progress through the levels, they may be moved from a less intensive level of service provision to a more intensive level of home visitation depending on individual needs. The leveling change may occur when a family’s situation affects their ability to meet the baby’s needs. The decision to change a family’s service provision level should be made logically, in consultation with the Program Manager/Supervisor and should be based on pre-established program criteria. Criteria for increasing or decreasing home visitation service levels include family circumstances such as a second birth, a crisis situation, employment, etc.
Since participants at different levels of service have varying requirements for the number of home visits per month, HFA sites usually develop a weighting system to ensure that workers have appropriate caseloads. For example, families receiving weekly home visits carry more weight than those on a less frequent home visiting schedule.

Supervision

Typically, HFA sites in their first year have only one supervisory staff person – a Program Manager. As the staff grows, it will be necessary to hire an additional Supervisor to work with the Program Manager on supervision of FSWs and FAWs.

Programs may set a maximum ratio of one supervisor to six full-time FSWs/FAWs. However, the preferred ratio is 1:5.

The HFA Critical Elements recommend ongoing, effective supervision of service providers. Many HFA Program Managers and Supervisors spend a minimum of 1½ to 2 hours per week per employee on formal supervision. However, additional informal supervision is often necessary to adequately support the worker and respond to crisis situations.

Supervisors will also spend time shadowing the FSWs and FAWs periodically to ensure they are culturally competent and implementing the services effectively. Shadowing assists the staff in identifying what they are doing well and what areas need strengthening. Supervisors also shadow when the FSW has identified the need to have the supervisor accompany them on a visit or when an FAW’s rate of refusals for program services is high.

“Sometimes staff at smaller sites get overwhelmed when they hear about large sites and compare the numbers of families they are serving. Staff should always be reminded that making a difference in one life is still making a difference.”

- Laura Grutz, Program Manager
Healthy Families Pottawatomie County (OK)
WORKSHEET #3: DETERMINING THE NUMBER OF FAMILIES TO BE SERVED

Step 1: Target Births
Obtain the annual number of births in your targeted geographic area for the target population you will serve.

Example: There are 200 births annually among the target population within the target area.

Step 2: Screening
(If your HFA site will not be screening families [i.e., because all families are assessed, you are receiving systematic referrals, etc.], you may skip this step and go directly to Step #3.)
Multiply the number of births in your target area by the percentage of families you expect to be screened in a year. This will provide you with the number of families in your target area that you expect to be screened in a year.

Example: 200 births x .90 (90%) actually screened = 180 families screened in the target area in one year

Step 3: Assessment
(If your HFA site will not be assessing families prior to offering services [i.e., because the program services are offered to all families] you may skip this step and go directly to Step #4. Please keep in mind, however, that some form of systematic assessment should still be conducted to determine the individual needs of the family.)
Multiply the number of families screened in a year by the percentage of families you expect to screen positive. This will identify the number of families in your target area you would expect to assess.

Example: 180 families screened x .90 (90%) high risk = 162 families screened positive x .90 (90%) who will agree to be assessed = 146 families appropriate for the assessment
Step 4: Identification of High Risk

Multiply the number of families assessed by the percentage of families that you expect will assess positive. This will give you the number of families that will be offered home visiting services.

Example: 146 families x .90 (90%) high risk = 131 families

Step 5: Acceptance of Services

Multiply the number of families you identified as high risk by the percentage of families that you expect will accept services in a year. This will give you the number of families you will serve during year one.

Example: 131 families identified as high risk x .80 (80%) accepting services = 105 families that are appropriate for services in year one (Note: many programs will not be able to serve this many families in the first year, but this calculation may provide a picture of the need within the community and help to build the case for program expansion.)

Step 6: Attrition

Note: HFA has no hard information to offer about attrition rates; the calculation is only an approximation. Estimate the percentage of families that will drop out of the program in year one (attrition rate). Subtract that percentage from 100% to determine the percentage of families that will continue on to year two. Multiply the number of families served in year one by the percentage of families that will continue on with HFA in year two. This will give you the number of families you will be serving at the end of year one.

Example: 1.00 (100%) - .20 (20%) dropping out of program = .80 (80%) continuing with program in year two

105 families served in year one x .80 (80%) families continuing HFA in year two = 84 families receiving services at end of year one
Step 7: Year Two Families Served

Add the number of families receiving home visiting services at the end of year one to the number of new families you expect to add to the caseload in year one. (Note: it is recommend that programs use the year one figure of new families and project it into year two unless you have reason to believe your year two births will be different.) Then multiply this number by the percentage of families that will continue with HFA into the next year.

Example: 84 families receiving home visiting services at end of year one + 105 families served in year one = 189 families

189 families x .80 (80%) families continuing HFA into next year = 151 families receiving HFA services in year two

Step 8: Year Three Families Served

Add the number of families receiving home visiting services at the end of year two to the number of new families you expect to add to the caseload in year one. Then multiply this number by the percentage of families that will continue with HFA into the next year.

Example: 151 families receiving home visiting services in year two + 105 families served in year one = 256 families

256 families x .80 (80%) families continuing HFA into year three = 205 families receiving HFA services in year three

All numbers in these worksheets are used to demonstrate how you might formulate your projections for families served and staff requirements. Your actual numbers will vary.
In order to determine the number of Family Assessment Workers you will need to hire, you will need to know the average number of births per day in your target area and how your HFA program is planning to do the screening and/or assessment. Remember that screening can either be conducted by hospital/clinic staff or HFA program staff.

**Step 1: Consider these Factors**

- Staffing is based on a 40 hour work week.
- Typically, 1½ to 2 hours per week are spent on formal supervision.
- Five hours per week are expected for lunch.
- Each assessment requires about two hours of time: one hour for the interview and one hour to document and score the assessment.
- Each record screen will take approximately fifteen minutes.
- If screenings and assessments are conducted at a number of locations (hospitals, prenatal clinics, etc.), FAWs will need to add travel time into their schedules.

**Step 2: Calculate Assessments and Screenings Per Day**

Considering all of these factors, it was calculated that each assessment worker can conduct a combination of assessments and screenings per day, leaving time for lunch, paperwork and supervision.

**Example:**

40 work hours in a week minus 2 hours supervision = 38 hours

38 hours - 3 hours/week for paperwork and staff meetings = 35 hours

35 hours - 5 hours/week for travel time = 30 hours

30 hours - 5 hours/week for lunch = 25 hours

25 hours ÷ 5 work days = 5 hours per day to spend on assessments and screenings

Therefore, it was determined that each assessment worker has five hours per day to spend on conducting, documenting and scoring assessments and screenings. For this example, it has been calculated that an FAW can conduct two assessments (four hours) and four screenings (one hour) per day.
Step 3: Calculate Assessments and Screenings Per Year

To calculate the number of screenings and assessments you can expect an FAW to do per year, multiply the number of assessments that can be done per day by five work days. Then multiply that number by 44 weeks (52 weeks in a year minus 40 working days for vacation, federal holidays, sick leave, trainings, conferences = 44 work weeks). Do the same for screenings.

Example: 2 assessments per day x 5 work days = 10 assessments per week
10 assessments/week x 44 weeks = 440 assessments per year
4 screenings per day x 5 work days = 20 screenings per week
20 screenings per week x 44 weeks = 880 screenings per year

Step 4: Calculate Number of FAWs Needed

Now that you have determined how many assessments and screenings can be done by an assessment worker, consult your community needs assessment in order to assess the average number of births per day among the target population. Then you can calculate how many assessment workers will be needed in your program.

Example: On average there are .5 births per day among the target population (based on 200 births per year). If we conclude that one assessment worker can do two assessments per day, this calculation shows that a part-time Family Assessment Worker can be be hired to meet this workload.

The figures presented here are used to simplify calculations. Please note that the number of assessments and screenings conducted will vary based on availability of families and additional travel time. Many programs calculate the rate of completed assessments assuming the FAW assesses and screens four days per week. The fifth day is used for paperwork, staff meetings, supervision, in-service trainings, group workshops, networking with community agencies, etc.
WORKSHEET #5: FAMILY SUPPORT WORKER PROJECTION

By calculating the number of families you will serve at the end of each year, you can project the number of Family Support Workers you will need to hire over the course of each year. Please keep in mind that you do not need to hire all FSWs at one time, since your client intake will be staggered throughout the year. To project your HFA program’s need for FSWs, you may use the following formula:

**Step 1: Type of Caseload Management System**

Decide what type of caseload management system you will use — either a straight number of families per worker or a weighted caseload management system. If you use the latter, you need to make projections of how you expect the families you serve to move through the system by the end of year one and determine the weighted value of the families. Be sure to make this calculation for years two and three as well.

**Step 2: Number of FSWs for Year One**

Divide the number of families receiving services at the end of year one by the caseload amount you have designated for each FSW. Typically, a full-time FSW caseload for first year home visiting services is no more than 15. However, some communities have decided on caseload sizes within a range of 8-15 families per worker, depending upon the needs of the families they serve and the resources available in the community. This calculation will give you the number of FSWs you need during the course of year one to serve the number of families identified.

**Example:** 55 families receiving services at the end of year one ÷ 15 cases = 3.5 FSWs needed for year one
Step 3: Number of FSWs for Year Two

Divide the number of families receiving services at the end of year two by the case-load amount you have designated for each FSW. This calculation will give you the number of FSWs you need on staff during the course of year two to serve the number of families identified.

Example: 98 families receiving services at the end of year two ÷ 15 cases = 6.5 FSWs needed for year two

Step 4: Number of FSWs for Year Three

Divide the number of families receiving services at the end of year three by the case-load amount you have designated for each FSW. This calculation will give you the number of FSWs you need on staff during the course of year three to serve the number of families identified.

Example: 133 families receiving services at the end of year three ÷ 15 cases = 9 FSWs needed for year three

The numbers used in this example are based on FSWs carrying a straight caseload of 15 families, not a weighted caseload.
THE TRAINING PLAN

The Critical Elements provide a framework for training, requiring HFA service providers to receive intensive training specific to their roles, including both primary and wraparound training. Primary training establishes a foundation for the HFA program and instructs staff in their roles as FAWs, FSWs, Supervisors and Program Managers. Wraparound training complements primary training and covers an orientation to the agency and community, the details of parent education and information on topics relevant to the needs of families in specific communities, such as domestic violence or literacy.

Because the HFA Critical Elements are rooted in concepts of empowerment, it is important that all training be strength-based and family-centered. A strength-based approach recognizes that all families have strengths and that programs should build on strengths rather than focus on correcting weaknesses. Strength-based programs focus on helping families build their own abilities to manage life’s challenges, rather than becoming dependent on an outside helper.

Orientation

When direct service staff are first hired, they should receive training from program staff that covers the topics listed below. Staff must receive this training prior to working with families.

- The agency’s structure, policies and operating procedures;
- Information about the community and state in which they will be serving families;
- The culture of the target population;
- Confidentiality policies;
- Child abuse and neglect, mandated reporter requirements and child protective services;
- Community resources and social service partners, including site visits; and
- An overview of their role in the organization.
Primary Training

Primary or core training is mandatory for HFA programs and covers the areas listed below. This training should occur within six months of hire, and it is strongly recommended that direct service staff receive this training prior to working with families.

* The history, structure and basic principles of the HFA program;
* The Critical Elements; and
* Role-specific job training, i.e., home visiting and systematic family assessment.

Primary training is delivered by certified state or national HFA trainers. Contact the PCA America office to receive information about the training source in your state.

Wraparound Training

The phrase “wraparound training” refers to both the initial orientation and ongoing or advanced training that programs plan for their staff. The wraparound training plan will include information about the challenges faced by the community’s families and the local resources available to support those families.

Reach out to community experts and invite them to provide training on resources, core elements of home visitation, child development, cultural diversity and other issues staff may confront in their work with families, such as domestic violence, substance use, etc.
Staff will benefit from site visits to other agencies that provide support services for families in the community. Not only will they develop greater understanding of the issues involved, but they will also become more knowledgeable about the agencies to which they refer families.

Staff should devote one-third of their time to wraparound training within the first six months of employment (approximately 80 hours). Ongoing training of staff is a continuous skill-building process that should be provided throughout the careers of HFA staff. Opportunities for ongoing or advanced training should be built into your program’s annual operating plan.
QUALITY ASSURANCE AND CREDENTIALING

Quality assurance is an integral component of any family support program. Funders, legislators and communities want to know that the programs they support maintain high quality standards. Healthy Families America is dedicated to ensuring that any program that affiliates with the national model adheres to high standards of quality. This is accomplished through the credentialing process, which provides a foundation for sustaining and expanding HFA programs.

Development of the HFA Credentialing System

The credentialing system was born from discussions among HFA State Leaders, Program Managers and trainers who were interested in developing a process to ensure that a high level of quality would be sustained beyond the initial phase of program setup. They wanted a system that would ensure that the integrity of the HFA model remained intact.

Prevent Child Abuse America worked closely with The Council on Accreditation of Services for Families and Children, Inc. (the Council) to create such a system. The Council is a national accrediting body founded in 1977 to establish an independent, objective process of agency review in the field of mental health and human services. The Council establishes, through a process of consensus-building in the field, requirements for accreditation that include all aspects of an agency’s administration, organization and program. With guidance from the Council, the HFA credentialing process was developed. It utilizes the Critical Elements, a set of standards reflecting over 20 years of research into effective home visitation programs. Adherence to these Critical Elements is essential, as research has shown that they contribute to improved program outcomes.
Application for Affiliation

The first step towards becoming an HFA credentialed program or multi-site system entails applying for affiliation status. The Application for Affiliation provides a mechanism for the national office to review a program’s plans for implementation of the Critical Elements to meet the needs of the community it will serve. Programs that apply for affiliation commit to completing the credentialing process within three years.

The HFA Credentialing Process

HFA credentials both individual sites and multi-site systems. Multi-site systems have multiple sites providing direct services in more than one geographic location and follow a set of common program policies determined by a central administration. The central administration ensures the quality of each site and the entire system through quality assurance, training, technical assistance and evaluation services. While policies are the same, local procedures and funding streams may differ. The multi-site addendum standards are based on best practice and quality assurance literature rather than home visitation research.

HFA follows the typical credentialing process used most often by credentialing organizations which involves three major steps:

- Site self-assessment;
- External peer review; and
- Credentialing decision.

“This program found the credentialing process helpful because it forced our staff to take a comprehensive look at how they conduct the business of serving families. Because of credentialing, our documentation procedures improved.”
Site Self-Assessment

Completing the site self-assessment involves gathering input from all key personnel involved with the program. This process provides the program with an opportunity to critically review its organizational structure and service delivery and compare its results against professionally accepted, research-based national standards.

This activity also enables a program to gauge its staff’s understanding of program goals and objectives and their related roles and responsibilities. As program staff begin preparing their self-assessment, they often become keenly aware of the importance of keeping written documentation of all aspects of the program. Many programs find that having a written workplan, a policies and procedures manual and a variety of tools to capture program activities prove most helpful in assuring quality.

You will want to identify or create forms to capture not only program activities but also the services being delivered in conjunction with other collaborating organizations.

For example, if your program has a cooperative agreement with a hospital whereby the hospital staff conducts the record screens, it will be useful to devise a way to track the quality of these “out-of-house” services. Many of the tools used for quality assurance may also be used for evaluation purposes.

“The credentialing process has been helpful not only to the program but also to staff and participating families. It helped us organize and ‘clean up’ our program. Most policies and procedures were already in place but the credentialing process made everyone more aware of their existence and the importance of them.”

– Marcia Andresen, Program Manager
Healthy Families Polk (FL)
Policies and Procedures

Becoming credentialed requires rigorous quality assurance measures, including documentation of most aspects of your program. It is imperative to develop written policies and procedures for every aspect of the HFA program, from where you will identify potential participants to how participants will be “graduated” from the program. (Refer back to your program’s logic model to ensure that all aspects of your program are covered.)

Developing a comprehensive documentation process will help with quality assurance and with evaluation. You may want to develop a program form or flow chart that describes all the activities and related forms to be used throughout the program, from the initial screening through Individual Family Support Plans to exit interviews. Under each activity indicate who provides the service, when it is provided and why the service is needed. This process will ensure that there are clear, consistent guidelines regarding program activities.

It is recommended that you develop your policies and procedures before beginning to deliver program services. It will be much harder to develop them after the program has been up and running for awhile.

You may want to consider inviting those staff who will be implementing the policies and procedures to participate in their creation. It is important to remember that the development and adherence to policies and procedures should be an ongoing process. Program staff should review their policies and procedures on a regular basis to ensure their continued relevance.
**Peer Review**

Once the self-assessment tool has been completed and submitted, a team of at least two external, trained peer reviewers conduct a site visit. The purpose of this visit is to provide a comprehensive and objective review to validate a program’s self-assessment and adherence to the Critical Elements. The peer reviewers use a rating scale to assess the evidence provided by the site and to quantify a site’s adherence to the twelve Critical Elements. They then send a report of their findings to the national office.

**Credentialing Decision**

The peer reviewers’ findings are reviewed by the HFA Credentialing Panel – an advisory board of PCA America’s Board of Directors. This group is comprised of ten representatives from the following groups: two HFA Program Managers, two HFA trainers, two HFA evaluators, two HFA State Leaders and two PCA America board members. The Panel makes the final determination about credentialing and may elect to:

- Grant a four-year credential;
- Defer decision to credential for three, six or nine months to give programs another opportunity to provide evidence of adherence to the Critical Elements; or
- Deny the credential (in rare instances).

The main goal of credentialing is to assure nationwide standards of quality while promoting flexibility at the local level with regard to the Critical Elements. Programs affiliated with HFA benefit from the credibility associated with a nationally recognized, research-based program.

It is important to note that the credentialing process is not intended to be punitive. To the contrary, it was designed to provide a framework for program implementation based on best practice standards. With this in mind, it is the goal of PCA America to credential all sites; some programs may move through the process more quickly than others. It is an intensive but worthwhile endeavor. Any program that opens itself up to such an intensive review deserves to be commended.
Technical Assistance for the Credentialing Process

Credentialing is an intensive, comprehensive and critical component of ensuring that participating families receive quality services. While at first it may seem to be a daunting task, you are not expected to go it alone. There are a wide number of resources in addition to the national office, such as trainers, State Leaders and peer reviewers within your own state to help your site proceed through this process. You can expect the following support from PCA America credentialing staff:

- Technical assistance at affiliation and/or during preparation for credentialing, including a complete overview of the HFA credentialing process, from preparation of the self-study through the credentialing decision;
- Materials such as the self-assessment tool and credentialing manual which you’ll receive prior to or at the time of affiliation with the HFA network;
- Linkages to technical assistance resources, such as trainers and state leaders within your state, or if unavailable, PCA America staff will provide you with additional resources to meet your needs;
- Technical assistance in developing a schedule and process for becoming credentialed; and
- Preparation before the site visit.

PCA America staff are always available to answer questions and provide direction about both the HFA Critical Elements and the credentialing process. They can be reached via phone, fax and e-mail.

You will find expert advice close to home by contacting Program Managers at other HFA sites in your state who have already gone through the credentialing process, as well as State Leaders.
By now, the critical importance of documenting each aspect of your program is apparent. Program data is used by multiple people for a variety of purposes – by FSWs to track the progress of their families, by Supervisors to provide support and guidance to their staff and by Program Managers to assess the impact the program is having on participants and to substantiate the efforts of the program to funders.

It is recommended that you establish a data management system for your program that facilitates documentation.

Reach out to community partners for assistance in establishing your data management system.

- You will need to create or identify forms to capture the services provided.

- Staff will need to be assigned to collect the data and enter it into whatever management system your program uses. This record-keeping needs to become a routine process.

- While a data management system can be as simple as putting pen to paper, most programs prefer using an electronic (computer) system to capture program activities and manipulate information.

- In areas where multiple HFA programs exist, it is beneficial for programs to capture information consistently to facilitate comparisons among programs.

PCA America has developed the Program Information Management System (PIMS), which is available to help programs track their activities and outcomes. PIMS is a computerized data collection, management and reporting tool that enables HFA programs to manage and report on the community programs and participant services they provide.
PIMS has a program management component that tracks key information such as:

- Site overview (i.e., size, structure, resources, etc.);
- Staff characteristics and training history;
- Target community characteristics;
- Sources of funding; and
- Collaborating agencies.

The program also has a participant-level tracking component that captures information on a program’s services such as:

- Screening and assessment of potential participants;
- Participant family profiles;
- Participant services overview (i.e., nature, home visits, level, referrals, etc.); and
- Preliminary data about program outcomes.

PIMS generates standard reports with up-to-date information that can be used to meet a variety of needs. In addition, PIMS captures virtually all the quantitative information required to complete the credentialing process.

The type of data management system a program uses is less important than the fact that it has a system in the first place. In this era of accountability, data management may be viewed as a means to an end.

Whatever type of record-keeping system is utilized, it is of the utmost importance that policies and procedures are put into place and strictly enforced regarding program participants’ privacy and confidentiality. It is recommended that participants be informed that:

- Their personal information will be entered into a record-keeping system (in most cases, a computerized system); and
- Some parts of the computerized records may be shared with evaluators for purposes of quality assurance and improvement of the program. Confidentiality will be protected by removing participants’ names and identifying information from records before information is shared.
PLANNING FOR EVALUATION

Without an evaluation process it would be impossible to determine whether a program is having any impact on its participants. Because HFA programs are operating in diverse communities with different economic, socio-cultural and political climates all across the country, it is imperative to incorporate evaluation into HFA services. It is important to build an evaluation component into the program plan and invite evaluation experts to be part of the planning process from the outset.

Before embarking on an evaluation, there are many issues to be discussed (some of which have already been addressed), such as:

- What are the program’s goals and objectives?
- Who is the target population?
- How can internal and external support for evaluation be developed?
- How can a realistic evaluation plan based on organizational needs and resources be developed?
- How will the evaluation be funded?
- Where can evaluation experts who can assist with this process be found?

Form an ad hoc committee to focus on evaluation. (This may be a sub-committee of the original planning group.) They can link with State Leaders and other HFA sites for information about ongoing evaluation efforts and for
advice on beginning your own evaluation process.

Then consider these more specific issues relating to evaluation:

✶ What is the purpose of the evaluation?

✶ Who wants the evaluation to be conducted — internal parties, external parties or both?

✶ What are their expectations of the evaluation?

✶ What do you want to evaluate – how the program operates or the program’s impact on families?

✶ What do you want to be able to do as a result of the evaluation?

✶ What issues or key questions about the program are to be addressed by the evaluation?

✶ Who needs to be involved in the evaluation?

✶ How will evaluation results be used?

✶ Who will implement any recommended changes identified through the evaluation?

✶ Are specific requirements mandated by the funding agency?

✶ Are you required to use particular tests to measure outcomes or to report on special forms?

Once the basic foundation for your evaluation has been established, some thought can be given to actual evaluation strategies. As a general rule, the preparation and design phase for an evaluation takes two to three months. The actual implementa-

According to Dr. Carter McNamara and evaluation experts such as Michael Quinn Patton, program staff can conduct an effective program evaluation without being an expert in the area. With most evaluations the “20-80” rule applies: 20% of effort generates 80% of the needed results. Try to do the best evaluation you can with your available resources.
tion and analysis phases vary greatly depending upon the complexity of the evaluation.

**Developing an Evaluation Approach**

The following guidelines represent an ideal structure for evaluation. While each program will need to develop an evaluation approach that complements the program’s specific service goals, staffing skills and participant characteristics, all evaluation planners should strive to incorporate as many of the following principles as possible.

**Comparison Groups**

- Your planning group’s evaluation subcommittee will decide whether the community is comfortable having a control or comparison group, or if they want to compare outcomes to the same demographics of others not screened or assessed, or simply compare the outcomes of the program with the overall state/national outcomes. If you choose to use a control group, all measurement tools must be completed with the participants not receiving services. You will need to develop a way to maintain contact with the comparison group.

- If the evaluation will provide for a formal control or comparison group, subjects may be either randomly assigned or matched in terms of age, race, income, risk factors and other relevant variables. While random assignment is more rigorous because it controls for all risk factors you can identify and those you don’t know about, it is often more realistic for programs to utilize control or comparison groups.

**Determining What the Evaluation Should Measure**

- Deciding which outcomes to measure will depend on a number of things, such as available resources, expertise and evaluation goals. At a minimum, all programs should track services provided and basic outcomes.

  - Services offered and/or provided to families:

    - Types of services offered/provided (e.g., home visits, other contacts, referrals); and
Quantity of services used by families (e.g., duration/intensity of service delivery).

Basic family outcomes:

- Parent and household demographics;
- Six-month follow-up on parent and household demographics;
- Medical provider;
- Dates of well-child visits and immunizations;
- Child development screening and referral; and
- Child maltreatment reports.

In addition, an evaluation may include a range of outcome measures for the caregiver and the child.

Caregiver:

- Quality of caregiver-child interaction;
- Stress/coping strategies;
- Knowledge of parenting/child development;
- Home environment; and
- Use of information and formal social supports.

Child:

- Attachment;
- Well-child doctor visits and immunizations;
- Cognitive development;
- Social development; and
Methods of Data Collection

- If possible, use multiple methods of data collection to obtain information on all critical outcome measures.
  - Formal assessment instruments (e.g., standardized measures of outcomes);
  - Structured staff assessments;
  - Chart reviews; and
  - Qualitative data.

Follow-up Assessments

- Following an initial assessment of client functioning, conduct subsequent assessments on the participants and comparison group (if applicable). You will work with your evaluator to identify the timeline for conducting follow-up assessments. Often the timing is as follows:
  - An initial assessment at the time of intake; and
  - Reassessment at six-month intervals after the baby’s birth until graduation from the program.

Post-Program Contact

- If possible, obtain post-program interviews or observations on at least a sample of program recipients. Ideally, this would include the following:
  - Interviews in-person or by telephone; and
  - Participant status tracked through case files.
- Make an effort to have at least one post-program contact
with all families who drop out of services.

**Program Development Process**

* Include documentation of the process undertaken to establish home visiting services. Include a detailed accounting of how programs:
  - Established their goals;
  - Selected their staff; and
  - Determined program content and focus.

**Conducting the Evaluation**

Regardless of the complexity of your evaluation, every program will need to:

* Determine the type of evaluation you want to conduct (which will be based on the outcomes to be measured and the expertise and resources available);

* Identify and/or create appropriate instruments to measure your program activities (the instruments selected should be relevant and sensitive to the cultural and racial groups represented within your target population, and be suited to the skills and abilities of your staff);

* Determine which staff will perform which responsibilities pertaining to the evaluation;

* Implement the evaluation plan;

* Analyze the data;

* Write up the evaluation results; and
Disseminate the findings.

Ideally, evaluation findings are used to improve program services. Share results from your evaluation with everyone who is involved with the program – direct service staff, managers, funders, legislators, key policymakers and even community representatives. Evaluations provide an opportunity to expand the base of knowledge about what works regarding home visiting.

Although conducting an evaluation can be a complex undertaking, there are many resources available to assist with this process. Seek guidance from experts within your organization or community. The HFA Research Network is comprised of evaluation experts. Many universities have staff who conduct evaluations. You may also want to contact the American Psychological Association or American Evaluation Association for additional resources. For more information on conducting evaluations or for a list of instruments utilized by HFA programs, contact the Research Center at Prevent Child Abuse.

“In order to sustain Healthy Families Florida over time, we are going to have to show the governor, legislature and policymakers that the program really makes a difference in the lives of the families we serve. To show them that it works, we must have data. Accurate, complete and timely data is critical. Although Family Support Workers have to constantly work to balance the time-consuming demands of documenting data and spending time with the families they serve, they know in the end it will be well worth it. The numbers will prove what they see everyday – Healthy Families works!”

- Carol McNally, Executive Director

Healthy Families Florida, Ounce of Prevention Fund
Planning for a Healthy Families America program site in your community is a difficult but critical step toward providing valuable services to families. The program planning process is one that should be guided by patience, thoughtful analysis, flexibility and creativity. To assist you with this crucial process, this section offers some of the lessons learned about successful approaches to program planning.

* Be certain that all the key players understand the Critical Elements. Since the Critical Elements are the foundation of the HFA program, continue to review them and the literature that supports them throughout the planning process. This will ensure that all of the partners in your effort are using the same frame of reference.

* If possible, attend an HFA training as an observer to familiarize yourself with the program goals and objectives. Observing a training will allow you to learn first-hand the philosophy behind HFA and the ways in which program staff implement that philosophy into practice. It will also provide you with an opportunity to meet with HFA colleagues who have had similar program experiences. Participating in an HFA training will help the program planning process by clarifying what you already know about Healthy Families.

* Identify the key players and decision makers in the community and include them in the planning process. Be creative about the types of representation you include. In addition to the usual partners (i.e., health department, child protective services, child advocacy organizations, etc.), consider engaging new players who have an interest in children and families and have organized networks for advocacy purposes (e.g., business representatives, religious community representatives, etc.). Legislators are also critical partners in the planning process. Remember to involve these decision makers.
makers throughout the process.

**Build onto existing services in the community.** Healthy Families America serves as a gateway to a host of services for children and families. Since not all families will need home visiting services, HFA connects families with an array of other valuable programs in the community. In order to avoid duplication, encourage collaboration and garner additional resources for families, HFA programs should seek ways to build onto existing service systems in their community. By doing so, HFA will become more comprehensive and integral to the community.

**Involve all perspectives in the planning and consider each encounter an opportunity.** All stakeholders in the process should participate in HFA program planning in some way. Families, hospital nurses, policymakers and many others will provide unique insights and perspectives to the planning process. By considering each encounter an opportunity, new and creative partnerships and ideas will be generated to benefit the families in your community and your program.

**Do your homework.** Visit other HFA sites to see how they are working with nurses, hospitals, health departments, etc. After doing so, you will be able to bring all of the information you have gathered back to the planning team for their decisions about how to implement working relationships in your community.

**Put all of the planning, protocol and agreements in writing.** By establishing a written work plan, the planning team can regularly review their progress, new issues for planning and timelines. In addition, written agreements, or Memoranda of Understanding, can be a critical step toward formalizing working relationships and partnerships for your HFA program.

**Create committees for all phases of the planning process: initiation, implementation and institutionalization.** By organizing the planning process into phases and creating committees to work on each phase, HFA programs have been able to achieve established goals, objectives and
actions for the long term.

* Incorporate a strength-based approach into your planning. You may want to ensure that your planning process and interactions with partners mirror those used with families. By doing so, you will maintain a commitment to strength-based actions throughout all aspects of your program.

* Build consensus toward a unified vision, purpose and knowledge of program goals. Building consensus among the planning team and within the community will be critical to the effectiveness of the program. Planners should recognize that this may require some time, but it is necessary to achieve the vision of providing services for all new parents.

* Establish relationships with funders, legislators, government agency staff, etc. Cultivating and maintaining relationships is a critical piece toward building an infrastructure for HFA. If you do not have the time or expertise to cultivate and maintain such relationships, you should be sure to partner with those who will do so on your program’s behalf (e.g., an HFA State Leader).

* Be patient. Thorough planning takes time and there is no one way to do it. When people are excited and motivated about a new idea or service, it can be challenging to harness that excitement and focus it toward a time consuming planning process. And yet, that is precisely what is necessary to successfully launch and integrate HFA services in your community. The excitement generated by HFA can be put to good use in your planning, understanding that thorough planning does take time.
ADDITIONAL RESOURCES -
SECTION III

Quality Assurance & Credentialing Resources

HFA Credentialing Manual and Self-Assessment Tool. Prevent Child Abuse America
Council on Accreditation of Services for Families and Children, Inc. - www.coanet.org
Free Management Library – www.mapnp.org

Evaluation Resources

The National Center on Child Abuse Prevention Research
John Holton, Ph.D., Director
Prevent Child Abuse America
200 S. Michigan Avenue, 17th Floor
Chicago, IL 60604
312/663-3520


Handbook of Practical Program Evaluation. Wholey, J., Hatry, H. & Newcomer, K.

Quality Improvement and Program Evaluation: Managing Into the Next Century

American Psychological Association – www.apa.org

See the bibliography for additional resources and complete citations.
In Section III, you have drawn the blueprints for your HFA site through planning and program design.

- You've developed a logic model or other planning tool to help you organize your program plan.
- You've established program goals, objectives and outcomes, keeping them measurable and realistic.
- You've determined the services your program will provide and built relationships with community service providers to which you'll refer families for additional services.
- You've developed MOUs detailing where and how the program will conduct screenings and assessments.
- You've calculated your staffing needs for the first three years of the program.
- You've developed a training plan for program staff, including orientation, HFA primary training and ongoing training from community and subject matter experts.
- You've begun preparing for credentialing by planning your program's quality assurance efforts.
- You've set up a data management system and established a committee to focus on the plan for evaluating your program's effectiveness.
- You've referred to the Critical Elements throughout your program design process to assure compliance with the best practice guidelines that are the foundation of the HFA program.
Section Four

Budgeting and Funding
Preparing a budget is a necessary aspect of program management. Budgets provide a framework to enable Program Managers to make decisions about how much money is available to support program services. They also help programs keep track of expenses and resources, such as grants and in-kind donations. It may be helpful to try and obtain a budget from programs similar to your own in size and other characteristics (i.e., rural vs. urban, geographical region, number of families served, etc.) to get a sense of their expenditures.

To simplify the budgeting process, it may be helpful to use a computer spreadsheet program (such as Excel), which can easily calculate the various line items in a budget and can be set up to provide a variety of reports.

**Personnel**

The first step in developing your budget is to review the services your program will provide, as this will allow you to determine minimum staff requirements. Personnel costs are typically the largest single part of a program budget and can run anywhere between 60 and 80 percent of expenses. In addition to salaries, you’ll need to determine how much money will be allocated towards employee benefits.

**Salary Expenses**

Salaries for Family Support Workers, Family Assessment Workers and management staff will vary from community to community. Some factors to consider when budgeting for salaries are:

- The cost of living in your community;
- The degree or professional status of the employee;
The employee’s prior work experience;

- The salary range for comparable work within other departments in your agency;

- Salaries and benefit packages offered for similar positions in other local organizations; and

- The prevalent salary range for that type of work in your community.

Particularly during the first year of operations, a program will incur higher expenses from staff recruitment, such as advertising for positions.

Because staff turnover in this field tends to be high, program planners should think creatively about the approach to employee retention. Staff development is also important and programs should allocate resources that enable employees to attend conferences and refresher courses or to reward employees for outstanding performance. Also look for inexpensive ways to boost morale, such as birthday treats or the occasional fun outing.

**Training Expenses**

Other costs associated with personnel are training costs. As training is one of the most critical aspects of the program, it is an area that should not be skimped on. Your organization will need to determine if it will host a training or send staff to another location for training. If you will be sending staff to an HFA training hosted by another organization (as opposed to hosting it yourself) you can expect to pay between $300–$500 for each new staffperson to be trained or cross-trained, exclusive of hotel accommodations, per diem, travel or materials.
If your program hosts an HFA primary training, you will be responsible for covering the following costs:

**Training fee:** $3,300 for each trainer

**Hotel:** Cost of accommodations for trainers for 5-6 nights. Each trainer must have his/her own room.

**Travel:** Cost of transportation to site for trainers (air, train, car, taxi, shuttle)

**Materials:** Cost of training manuals is $45 per participant plus shipping/handling fees

Training expenses may vary depending on whether the program is located in a state that has in-state training capacity. Contact PCA America’s training staff for assistance in determining your training costs.

Programs typically provide wraparound training through local sources, so it is expected that these costs will be lower. Many programs are quite resourceful in how they provide wraparound training and often share opportunities and trainers with other programs in their communities.

"We have found that many potential sites think that they can operate a quality program for significantly less than is recommended in the sample budgets by cutting corners (usually in the training areas). We have found that sending out the Site Development Guide really helps potential sites understand the concept of what it takes to set up a high quality program. Once these sites understand the components for quality, they develop an appropriate budget and staffing pattern.

Also, when planning a program, immediately obtain a copy of the Credentialing Self-Assessment Tool. While setting up a program, you might as well set it up to meet the standards of best practice!"

- Kate Whitaker, Training and QA Coordinator
  Healthy Families Arizona, LeCroy & Milligan Associates
Rent and Utilities

Your program will need a physical space or home base. At a minimum, this will enable HFA program staff to meet to discuss progress, store case files, prepare materials and reports and allow participating families to get in touch with their home visitors. Many programs have in-kind arrangements with other organizations that share their office space with HFA staff. All the fixed costs associated with a physical space such as rent, insurance and utilities should be included in your budget.

Equipment/Supplies

Programs will operate much more efficiently in today’s environment if they are equipped with computers, Internet access, printers, copiers, fax machines and telephones. Fortunately, the demand for technology and the proliferation of Internet service providers has greatly reduced the price of computer equipment and Internet services. You will also need software. At a minimum, you should have a word processing software for reports and program materials, spreadsheet software for budgeting and database software for data management.

Your program will also need supplies such as curricula for staff and materials for families. These might be educational brochures and books. It is a nice touch to be able to provide children’s toys, games and books. Many programs also make accommodations for families by having “lending libraries” stocked with car seats, cribs, high chairs, clothing, etc. Others purchase equipment such as Polaroid or video cameras to use with families.

In addition, some programs provide staff with cellular phones or beepers for safety purposes. Staff safety is critical and should be considered an investment, not an expense.
Transportation Expenses

Programs may also incur transportation expenses, including mileage and insurance reimbursement for your staff who must travel to provide services. This could also include cab fare for parents to attend medical appointments or participate in program activities such as parent support groups. If your staff will be transporting parents anywhere, be sure to find out about adding insurance coverage.

Family Needs

You may also choose to provide incentives for families such as food/restaurant certificates, clothing or children’s items. Some programs also provide awards, plaques or host “graduation” ceremonies for families who complete the program. Other programs set aside emergency funds to be used in times of crisis.

Be alert for opportunities to request in-kind donations to alleviate expenses.

Credentialing Fee

HFA programs also need to prepare financially for the credentialing process. You are encouraged to set aside one percent of the program budget to pay for the credentialing fee. In addition to the fee for credentialing, programs will need to cover the expenses for the peer review team that conducts their site visit. These expenses are estimated to be approximately $1,600 per team of two reviewers. (These costs are not incurred until two–three years after affiliation.)
Evaluation Expenses

Another service that should be factored into the budget is evaluation. While most programs do not conduct anything more sophisticated than a process evaluation for the first year or two of operation, it is recommended that some money be allocated towards evaluation. Programs typically spend from a minimum of $10,000 to conduct a pre/post evaluation to over $3 million for a randomized study. A good guideline is to allot five–ten percent of your overall budget for program evaluation, but no less than $10,000.

Promotion Expenses

You will want to develop promotional materials for your program. This will help you educate the community about the program and provide information to families about the availability of supportive services. They are great tools to share with potential funders and policymakers as they bring some validity to your program. Promotional expenses can range from developing flyers to utilizing the services of an ad agency to launch a full-scale campaign. Promotional dollars should be allocated according to the goals of your program and available resources.

Miscellaneous Expenses

Finally, allocate some money for incidentals such as postage, telephone and other miscellaneous items.

Based on the number of years covered by your budget, you will need to account for staff raises, ongoing training and equipment replacement. You will also need to plan for program expansion and the associated costs.
Resources or Assets

Once all the expenses are accounted for, you will need to offset them with the program’s resources. These include monies raised through grants, matched dollars, fundraisers, gifts and in-kind donations. You will want to include everything to provide the “true cost” of running your program.

Be sure to have other members of the planning group review the budget to ensure it includes everything associated with the program. If possible, involve some staff members in the process. Budgeting is a learned skill and should get a little easier every year.

Additional Resources

If you are looking for more assistance with budgeting, consider utilizing some of the following resources:

* Your organization’s board members;
* Other HFA programs in your state or region;
* Members of the HFA State Leaders network;
* Prevent Child Abuse America Chapters;
* A local United Way office;
* Local universities may have faculty with expertise in non-profit management and/or classes or seminars;
* A CPA or accounting firm in the community who may assist with the budget on a pro bono basis;
* Your local Rotary Club; and
* Your local library may also have resources to assist with the budgeting process.
OVERVIEW OF FUNDING SOURCES

Identifying and securing funding to develop and implement a Healthy Families America program can be one of the most challenging and rewarding components of your planning process. It will require time, commitment and resources dedicated specifically to this task. HFA sites across the country have found a variety of ways to support their programs, through both monetary and in-kind support. This section will provide you with an overview of some potential funding sources, steps for pursuing funding and a reference section that will offer a variety of tools and resources to access support, technical assistance and funding opportunities.

Federal Funding

There are a number of federal programs that might generate resources for HFA, either through direct application to the federal government or as a source of funding that is distributed through state governments. You will need to do some research in order to assess these opportunities and review funding criteria. These organizations all have web sites, Requests for Proposals (RFPs) and detailed information about the types of programs they support. Some potential sources include:

- The Department of Health and Human Services (DHHS);
- The Department of Agriculture (DOA);
- The Department of Education (DOE);
- The Department of Housing and Urban Development (HUD);
  and
- The Department of Justice (DOJ).
State Funding

There are a variety of state funding sources ranging from general revenue funds to state public health and human services funds to sources that are a combination of state and federal support. Highlighted below are three options, detailed reports for which are available from Prevent Child Abuse America.

**Medicaid/Child Health Insurance Program (CHIP):** Medicaid is the nation’s largest program providing health care to low-income families and children and is operated as a partnership between the federal government and states. CHIP is a federal program administered by the states to provide health insurance to children in families who earn too much to qualify for Medicaid, but cannot afford private health insurance. Providing funding for prevention of health problems in families and children through HFA makes sound fiscal sense for the Medicaid and CHIP programs.

**State Tobacco Settlement Funds:** In November 1998, a series of state lawsuits against tobacco manufacturers were settled. This resulted in a total fiscal payment to the states of more than $246 billion over a period of 25 years. The tobacco settlement funds may provide a source of long-term, secure funding for programs like HFA.

**Temporary Assistance for Needy Families (TANF):** Formerly Aid to Families with Dependent Children (AFDC), TANF is a state-administered federal program that is intended to provide assistance to needy families so that children can be cared for in their own homes or homes of relatives. Another goal of TANF is to end the dependency of needy families on government programs by promoting job preparation and work. By using TANF funds to support HFA programs, states will promote healthy child development and help families to become self-sufficient while preventing child abuse.
Additional state resources include:
- Department of Public Health;
- Department of Human Services;
- Department of Children and Family Services;
- Department of Education;
- Department of Maternal and Child Health; and
- Juvenile Justice and Delinquency.

Private Funding Sources

It is important to seek out private funding resources in addition to public dollars. As you think about private sources, challenge yourself to think creatively and remember that this will take time and research.

Highlighted below are some potential sources:
- Private or family foundations;
- Corporate giving programs or foundations;
- Individual donors;
- Small businesses;
- Civic groups;
- Volunteer organizations; and
- Hospitals.

Face to face solicitations are the preferred method for acquiring investments in your program. When you approach private organizations for resources, think of ways to position your request as a win-win situation. Determine what benefits they will receive from supporting your program. Will they be promoted in a newsletter? Can they distribute information such as coupons to your clients, for example?
Community-Based Organizations

Community-based organizations may not always be able to offer cash support. Many Healthy Families America programs have developed partnerships with other community-based organizations for in-kind support and to build awareness for the program. Listed below are potential in-kind supports to consider:

- Office space;
- Shared office equipment (e.g., fax, phone, copier, etc.);
- Volunteers;
- Space and/or food for meetings;
- Joint trainings and/or shared staff;
- Referrals; and
- Public awareness by passing out program information, “spreading the word” about the Healthy Families America program.
IDENTIFYING EXISTING AND POTENTIAL FUNDING SOURCES

Scanning the Landscape

With the political climate constantly shifting, it can be challenging to keep up with changing federal, state and local funding streams. New funding streams develop as others dry up. Buzzwords like “devolution,” “block grants” and “doing more with less” are probably familiar. While change can be frustrating and difficult to navigate, it can often present new opportunities. Sources such as Temporary Assistance for Needy Families (TANF), Tobacco Settlement funds and Title IV-E (Family Preservation) are just a few examples of challenges that have become opportunities for some communities and states.

As was discussed in Section II, it is strongly recommended that your planning group create a sub-committee specifically dedicated to developing a funding plan and researching and evaluating potential funding opportunities. You may also have several agencies involved with your planning group that have development staff who are willing to dedicate some time and effort to this program. Regardless of your approach, it is critical to assign this task to someone or some planning entity.

Getting Started

You may want to pursue short-term funding specifically for the initial stages of the planning process, including building internal capacity to launch and support the advocacy, planning, fundraising and administrative demands of an HFA program. Organizational development, increasing your private fundraising capacity and community involvement in neighborhood
needs and resources assessments are all potentially “fundable” activities.

Some communities have secured start-up grants to implement their Healthy Families program. This can be very helpful in getting your program off the ground, demonstrating its effectiveness and assisting with accessing additional funding resources. Some states or communities may also refer to this funding as **pilot funds** or **pilot projects**. Essentially, this means your funder wants to test things out to see how it works. They may then opt to continue the program, expand the program or in some cases, move on to another pilot or test project.

Because securing long-term, sustainable funding can sometimes be more difficult than securing short-term, initial funding, this type of support can be very beneficial. There are never any guarantees with funding sources. Your program should always be planning for and seeking a variety of financial and in-kind supports. Programs are encouraged to develop a diverse mix of funding streams. This will ensure that your program will remain viable even if you were to lose a particular funding source.

Communities and states across the country are learning how to access more sustainable funding sources. You are encouraged to build upon their successes and learn from their efforts.

Contact your HFA State Leader(s) and your Prevent Child Abuse America Chapter as you begin researching potential funding sources. They may know of existing resources in your state that other Healthy Families or home visiting pro-
grams are accessing.

**Developing the Plan**

Now that you have a sub-committee, funding planning group or other entity in place, you will want to ask the following questions:

* Do you have planning group members, board or agency staff who have previous fundraising experience?

* What amount of funding are you seeking? What is your timeframe for securing funding? Do you have long-term funding needs?

* Do you have resources that can be allocated to fundraising efforts (e.g., board, staff, financial, etc.)? Some money should be set aside to offset the costs of fundraising and the cultivation and stewardship of potential and existing donors.

**Developing a Grant Proposal**

Your next step is to strategize how you are going to obtain funding. Answering the questions below will help you get started in developing the first outline of a grant proposal.

**Mission and Goals**

* Can you describe your planning group’s purpose or the purpose for your Healthy Families program in 25 words or less?

**Defining the Need and Your Approach**

* Who are you going to serve? Who will benefit from the program? Which communities will benefit? Why have you chosen a particular community or population to work with?

* Is there another program or effort underway in your community that potential funders might confuse you with?

* If so, how is your effort or program different? How will you ensure that there is no confusion?

* To borrow language from the corporate world, what is your
business? Who are your customers? What does the customer consider valuable? Why is there a need? What are your expected results? What is your action plan?

**Strategy for Program Implementation**

* Do you have a program or workplan in place for implementing your Healthy Families America program?

**Costs**

* Do you have a budgeting and accounting system in place? Who will serve as the fiduciary agent for your HFA program? Who would be the key agency(s) seeking funding?

**Existing Funding Sources**

* Do you have any existing funding resources? Are they restricted or unrestricted?

* What types of in-kind support do you have or are you seeking (e.g., office space at the local Department of Public Health, shared staff at your local hospital, etc.)?

**Potential Funding Sources**

Listed below are some suggested steps for identifying potential funding resources:

* Learn how other home visiting or family support programs are funded in your community or state.

* Research companies, foundations and other private funders in your community or state.

* Brainstorm about other potential funding sources (e.g., the faith community, small businesses, etc.).

* Determine your potential connections or links to these funders (e.g., does a board member work for a large company, does one of your planning group members run a family support program, etc.).
**SUGGESTED STEPS FOR SECURING STATE AND LOCAL FUNDING**

- **Learn how a program or potential funder works.** Become familiar with your local Department of Children and Family Services or learn more about a local foundation you are considering approaching for funding.

- **Identify the appropriate agency, official or contact person.** Find out who the appropriate agency or individual is for your program to be working with. Once you have identified key staff, build relationships. Add your new partners to your mailing list, send them press releases and positive news about your program. Keep them updated on your progress. Invite them to a planning meeting to learn more about what you are doing. Maintain these mutually beneficial relationships by keeping them involved.

- **Build a coalition that supports home visiting.** You may find that you already have all of the right people at your planning group table. Consider forming a coalition focused specifically on securing funding for HFA and/or other home visiting programs in your community. Support from other home visiting and family support programs will help build your case for funding HFA. Your local Kiwanis, Rotary or Lions clubs will probably be interested in learning about and supporting your program.

- **Be persistent!** You may not get funding from your targeted source the first time around. It may take some time and a lot of hard work. Bureaucracies move slowly and foundations often have very specific funding cycles. It is critical to build relationships with your local funders, local legislators, foundation staff and others. You have already built these relationships by inviting them to join your planning group and keeping them updated as to your progress. Remain patient and remember that the payoffs for children and families in your community can be great.
**Make the case for investment and prevention.** HFA is a cost-effective program. When compared to the costs of placing a child in foster care or an alternative out-of-home setting, HFA produces great savings. For every dollar spent on prevention, at least two dollars are saved that might otherwise have been spent on child welfare services, special education services, medical care, foster care, counseling and housing juvenile offenders.12

**Make the case for HFA funding.** Be persuasive when discussing the program with potential funders. When you approach them, make sure that you have hard data and facts about your program: how many people you will serve, what services you will provide and your projected outcomes. Use outcome data and success stories from existing HFA programs to make your case. Also ask local departments of health for the costs of hospital stays for premature infants or for emergency room visits. Contact the department of education for the cost of special education. Contact the local child welfare agency for the cost of foster care and special needs foster care. Those local dollars per person compared to the cost per family in prevention are important comparisons.

**Highlight outcomes.** Funders are looking for programs that have positive, demonstrable outcomes. Use national and local evaluations of the HFA program to stress the program’s successful results. If there are already HFA programs in your state, you should highlight outcomes and success stories from these programs.
ADDITIONAL RESOURCES - SECTION IV

Budgeting Resources

The Alliance for Nonprofit Management — www.allianceonline.org
Free Management Library — www.mapnp.org/library
Idealist — www.idealist.org/firsttime.html
Nonprofit Mining Co. — www.nonprofit.miningco.com
The NonProfit Resource Center — www.not-for-profit.org
Service Corp of Retired Executives — www.score.org/
The Finance Project — www.financeproject.org
The Management Center — www.fmcenter.org
Support Center for Nonprofit Management — www.compasspoint.org
Innovation Network, Inc. — www.innonet.org/peak.html
Center for Non-Profit Boards — www.nenb.org

Funding Resources

The Healthy Families America and Child Abuse Prevention Funding Series:
Healthy Families America, Medicaid and the Child Health Insurance Program
State Tobacco Settlement Funds and Child Abuse Prevention Programs
Temporary Assistance for Needy Families and Healthy Families America
available from: Prevent Child Abuse America, 312/663-3520
101 Ways to Raise Resources. Vineyard, S. and McCurley, S.
Foundation Center — www.fdncenter.org
Grantwriting — www.grantscape.com
Charity Counts — www.charitycounts.com
Federal Funding Resources
(State resources listed in Bibliography)

Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research)
201 East Jefferson Street, Suite 501
Rockville, MD 20852
301-594-1364 (Voice)
Internet Resources
info@ahrq.gov
www.ahrq.gov

Association of Maternal and Child Health Programs
1220 19th Street, NW
Suite 801
Washington, DC 20036
202-775-0436 (Voice)
202-775-0061 (FAX)
Internet Resources
info@amchp.org
www.amchp.org/

Health Resources and Services Administration, U.S. Department of Health and Human Services
Office of Communications
5600 Fishers Lane
Parklawn Building, Room 14-45
Rockville, MD 20857
301-443-3376 (Voice)
301-443-1989 (FAX)
Internet Resources
www.hrsa.gov/

National Institutes of Health, U.S. Department of Health and Human Services
Office of Communication
9000 Rockville Pike
Building 31, Room 2B03
Bethesda, MD 20892
301-496-4143 (Voice)
301-402-1485 (FAX)
Internet Resources
nihinfo@od31tm1.od.nih.gov
www.nih.gov/

National Health Information Center, U.S. Department of Health and Human Services
Referral Specialist
P.O. Box 1133
Washington, DC 20013-1133
800-336-4797 (Voice)
301-565-4167 (Voice)
301-984-4256 (FAX)
Internet Resources
nhic-nt.health.org
nhic.info@health.org

Policy Information Center, U.S. Department of Health and Human Services
Technical Information Specialists
Room 438-F, HHH Building
200 Independence Avenue, SW
Washington, DC 20201
202-690-6445 (Voice)
202-401-6228 (FAX)
Internet Resources
aspe.os.dhhs.gov/PIC/gate2pic.htm
pic@osaspe.dhhs.gov

U.S. Department of Agriculture
14th & Independence Ave. SW
Washington, DC 20250
202-720-2791 (Voice)
202-720-2681 (FAX)
Internet Resources
www.usda.gov/
See the bibliography for additional resources and complete citations.
In Section IV, you've considered budgets and funding, the mortar of your HFA program which forms the support and holds the pieces together.

☑ You've prepared a budget, including all expenses associated with the program as well as the resources and assets, including grants, donations and in-kind support.

☑ You've assessed funding opportunities through federal, state and local government agencies, as well as private foundations and community-based organizations.

☑ You've developed a funding plan for securing short- and long-term support for your program.

☑ You've begun to draft a grant proposal.
Section Five

Implementing Program Services
PREPARING TO PROVIDE PROGRAM SERVICES

Now that you have secured funding for your program, established collaborative partnerships within the community, submitted your application for affiliation, hired staff and arranged for their training, it’s almost time to begin providing program services.

Your program will benefit from including a pre-implementation phase prior to beginning service delivery to families. This phase will allow programs the opportunity to develop policies and procedures, administrative structure and data collection strategies; hire staff and conduct initial training; develop MOUs with partnering agencies; equip the physical facilities with computers, supplies, etc.; and start promoting Healthy Families America in your community.

The pre-implementation phase can last between three and six months. It allows the time to fully develop program components prior to serving the first families. Some funders and administrators may expect programs to start serving families the moment that funding becomes available. Unfortunately, this pressure could result in haphazard service provision without providing adequate staff training and developing the necessary policies and procedures, merely to satisfy funders.

Some programs may have already developed policies, procedures and other program components prior to receiving funding and may need only a brief pre-implementation phase or none at all. Carefully consider whether a pre-implementation phase is necessary for your program and under what conditions it would be acceptable to your collaborating partners, funders and agency administrators.

Once you have addressed all aspects of the pre-implementation phase, it will be time to begin providing program services to families. The two main service components are assessment and home visitation.
PROVIDING ASSESSMENT SERVICES

In this section, we will take an in-depth look at the screening and assessment processes; supervision of Family Assessment Workers (FAWs); and administration of the assessment process.

Goals of the Assessment Process

Goals of the family assessment process include:

- Systematically assessing all families within the target population prenatally or within two weeks of the birth of a child;
- Identifying family strengths and support systems;
- Identifying needs for supportive services and parenting education among families within the target population; and
- Successfully referring overburdened families to HFA home visiting services and other resources appropriate to family needs.

FAWs accomplish these goals by talking to expectant or new parents either prenatally or at the time of their baby’s birth in order to assess their strengths and need for education and support services and linking them to appropriate services.

Screening

In some programs, all new parents are offered assessment services to determine whether they could benefit from participation in an HFA program or other support services. However, it is much more common to screen the pool of expectant and new parents. To do this, staff use a pre-assessment screening tool, or record screen, to collect information about the expectant or new parents. If the record screen indicates the presence of two or more risk factors the parent will be referred for a more complete needs assessment.
Most programs obtain access to their target population through hospitals and clinics in order to address the requirement of Critical Element #1, which calls for provision of services within two weeks of the time of the child’s birth. However, some programs may find that they have greater access to their target population through schools, WIC or Medicaid offices. Wherever you determine you will have the greatest access to your target population within the recommended timeframe surrounding the baby’s birth, you may complete the screen based upon the partnering site’s records of the participant or by asking the questions from the screen of the potential participant.

Screening may be conducted either by the hospital, clinic or other partnering site’s staff or by a Healthy Families America FAW. This decision will be made jointly by your program planning group and the agencies with which you partner. The details should be outlined in the Memoranda of Understanding with your partners.

Because HFA program involvement is voluntary, the screening and assessment process must be carefully designed and implemented so that each family’s privacy and right to choose is honored. It will be important to train HFA staff as well as hospital, clinic or partnering sites’ staff in the concept of voluntary services and provide specific language to be used when talking to parents about program involvement.

Training and ongoing monitoring is key when asking partnering sites to complete the screen for you. Hospitals, clinics and other partnering sites need to clearly understand the importance of completing screens on all potential participants, not just those parents that they feel would benefit from the program.

**Conducting the Assessment**

Once families have been screened positive or have otherwise agreed to an assessment, a meeting with the FAW is scheduled either prenatally or within two weeks of the birth of the baby. Most HFA programs use the Kempe Family Stress Checklist (FSC) as their assessment tool, although you may choose another tool that meets the needs of your program.
The FSC follows a semi-structured interview format to assess family issues in the following areas:

- Parents’ childhood history;
- Potential for violence;
- Stressors or concerns;
- Perception of the infant;
- Current/past substance abuse history;
- Discipline issues;
- Parents’ expectations of the infant;
- Bonding and attachment issues;
- Support systems and problem-solving skills; and
- Current/previous Child Protective Services involvement.

To establish rapport and lay the groundwork for building trust, the FAW engages the family in a friendly, nonjudgmental and respectful manner. While gathering information, the FAW creates a comfortable environment by beginning with less personal questions and maintaining a relaxed, conversational style.

The FAW must be careful not to promise assistance that cannot be carried out by the Family Support Worker or is not in keeping with the agency’s policies.

When concluding the assessment, the FAW thanks the family, assures confidentiality and gets contact information for the family, so that s/he can follow up with referrals or resources for the family. In almost every program, the FAW will leave behind some general parenting education materials about newborns along with the name, phone number and address of the FAW and her/his agency. FAWs are trained not to make any on-the-spot referrals or promises of HFA home visiting services until after they have completed and scored the assessment documentation.
After the assessment interview, the FAW will document and score the FSC, or other assessment tool. Documenting an accurate and objective account of the information gathered is critical to determining a valid, reliable score and providing needed information for the Family Support Worker. The FAW documents a family’s strengths as well as their needs. Supervisors should receive the completed and scored assessments within 48 hours of the assessment being completed. Based on the score, the supervisor and FAW will decide together whether to offer the family HFA home visiting services or other community services. At this point, either the FAW or the FSW, depending on program-specific protocols, will contact the family with further information and referrals.

**Administration of the Assessment Process**

The number of assessment staff and the scope of their duties will depend on the size of your program and the projected number of assessments to be conducted each day, week and month. Depending on the projected number of assessments, you may only need a part-time assessment worker. You might opt to hire a full-time person who does assessments and other program activities, such as serving lower-need families with referrals or running support groups. Some programs also have the FAW trained to administer developmental tools, such as the Denver Developmental Screening Tool.

In most programs, there will be periods of time when the caseloads for home visiting are full. Be sure to plan for these periods with your hospital or clinic partner. In the event that your caseloads are full, we recommend that you continue screening and assessing in order to identify the need for services and to maintain a program presence in the hospital. Consider how FAWs will use their time once the program is at capacity. If you choose to continue screening and assessment even when home visiting caseloads are full, FAWs can make referrals, provide information and limited follow-up for families who can’t be further enrolled in your program. When planning for staff recruitment, consider how non-assessment activities will fit into the overall job description of these staff members.
It is likely that any combination of assignments for assessment workers has been tried at one of the HFA sites. If you have particular questions, contact your HFA Primary Contact, HFA state trainer, another site within your state or Prevent Child Abuse America.

Policies, protocols, forms and staffing patterns will need to be established and documented for conducting the screening and assessment process.

**Supervision of Family Assessment Workers**

The program will be well-served by having the FAW Supervisor attend the assessment track of HFA primary training, in order to fully understand the FAWs’ activities and provide adequate support. It is strongly recommended that the Supervisor have some actual field experience conducting assessments. Without the benefit of training and/or field experience, it will be difficult for the Supervisor to determine the competency or reliability of the FAWs’ documentation and scoring efforts.

The FAW Supervisor must be available to provide daily supervision in the form of support and guidance whenever assessments are being conducted. As a quality assurance measure, all assessments completed by the FAWs should be reviewed by the Supervisor within 48 hours. To provide maximum support and availability, a ratio of one Supervisor to five direct service staff is recommended, although 1:6 is the maximum acceptable ratio.

In addition to daily support, FAW Supervisors should provide weekly scheduled supervision which would include periodic reviews of forms and documentation. The most important reason for supervision of FAWs is to provide the FAWs with the opportunity to share their concerns and stressors regarding the families they assess. It also ensures that documentation and scoring remain consistently reliable. Supervisors may also be able to recommend other services that FAWs can direct families to through referrals. In the early stages after training, FAWs must be carefully supervised to support their growing skill in implementing the assessment tool and to track how often families decline assessments.
Goals of the Home Visiting Process

Goals of the home visiting process include:

- Enhancing family functioning by establishing a trusting, nurturing relationship;
- Improving the family’s support system and teaching effective problem-solving skills;
- Supporting healthy child growth and development; and
- Promoting positive parent-child relationships.

Preparing for the First Home Visit

After an FAW has met a family, assessed their strengths and needs and rated the FSC (or other assessment tool), the Supervisor may refer the family for HFA home visiting services, based on the assessment tool’s score. At this point, either the FAW or the Family Support Worker (FSW), depending on program-specific protocols, will contact the family to offer program enrollment and home visiting services and to set up the initial home visit. It is recommended that the FAW, Supervisor and FSW meet together to discuss information gathered during the assessment interview and to discuss a possible course of action for working with the family.

It is important to develop protocols for the first visit, including:

- The way in which FSWs should introduce themselves and the program; and
- Specific activities to accomplish on the early visits, such as:
  - Completion of the Consent to Participate Form;
  - Explanation of the family’s confidentiality rights; and
  - Assisting the family in developing goals.
Many programs have developed a flyer or fact sheet answering the basic questions many families have. The content of program flyers and the initial home visits will depend, in part, on whether your point of first contact occurs prenatally or shortly after the child’s birth.

All participants in HFA programs must be fully and respectfully informed of the program’s confidentiality policy. It is recommended that you develop a Release of Information Form specific to your program, as well as a form that clearly explains the family’s confidentiality rights. These forms should be written in clear language, translated for any families whose first language is not English and explained to parents. (Depending on program- or hospital/clinic-specific policies, families may have previously signed consent forms during or prior to the assessment process. Even so, it is required that the home visitor obtain a signed Release of Information Form and Consent to Participate Form upon program enrollment and initiation of services.)

It is also important to carefully explain the fact that HFA staff are mandated reporters of child abuse and neglect and describe the circumstances under which home visitors would be required to file a report with Child Protective Services. Staff may find this difficult to discuss, yet it is of critical importance that families have a solid understanding of this program requirement.

**Initial Home Visits**

Once a family has enrolled in the program, the FSW will make a series of initial home visits that will set the tone for the entire relationship between the family and the program. The critical issue at this stage is communication. The FSW will introduce her/himself, provide an overview of the HFA program and answer family members’ questions. In addition to concrete questions, the FSW may encounter unstated concerns that family members may have about an outsider becoming involved in their lives. The FSW will need to be sensitive to issues above and below the surface.
In order to lay the groundwork for working together, the FSW will integrate the following elements into early home visits:

- Introducing the program brochure and list of services, asking the parent(s) in which services they’d be interested;
- Discussing goal setting;
- Showing the parent(s) the curriculum and developmental tool to be used;
- Informing them that each visit includes a discussion on infant care, development or an activity with the baby; and
- Providing information on safety tips for newborns.

**Prenatal Visits**

The birth of a baby is a highly significant event in the life of any family, and it is a prime time for the FSW to become a part of that expectant parent’s formal support system. FSWs can also use this time to meet and learn about others who may be an important part of the mother-to-be’s support systems. Many programs have found that prenatal engagement is particularly helpful in laying the groundwork for the parent education process, since unfamiliar or challenging ideas about child-rearing are best offered in the context of a relationship.

Initial home visits with a prenatal participant may be somewhat different for the FSW than visits after the baby’s birth. The parent is likely to be more self-focused and may have significant fears or concerns about the upcoming birth process. In some programs, the prenatal engagement process concentrates on concrete planning for the new baby as well as health concerns of the mother. For those women who have complicated or high-risk pregnancies, the added support from an HFA program can be a great help. HFA staff can encourage or help with the final stages of prenatal health care and assist the participant in learning birth and baby care techniques.

Each program will set its own policies for determining at which point during pregnancy to engage the family. Many HFA programs engage families during the third trimester of pregnancy. However, if a family is facing significant challenges services may begin earlier.
Developing an Individual Family Support Plan (IFSP)

During the early home visits, FSWs are developing relationships with parents, the baby and other significant household members. There are numerous tools and activities that can support this relationship-building as well as introduce parents to the idea of developing an IFSP, such as an information-gathering worksheet or Family Resource Scale. These tools may help parents and staff identify concrete and emotional goals that may be focused on in the future. Remember that any materials used with families should be customized to reflect your program’s unique approach and community context.

When participants set goals and work toward achieving them they learn problem-solving and coping skills and become more purposeful in their behavior. When problems are broken down into manageable parts, real progress can be made which supports the parents’ sense of mastery and self-efficacy, leading to improved self-esteem. When the FSW and the parents work together on the development of an Individual Family Support Plan, they are well on their way to accomplishing these goals.

The IFSP is a tool for documenting the work of the family as well as the home visitor. The FSW uses the IFSP process as a way to build an empowering partnership with families. Program staff will see that the process of developing a mutually-agreed-upon plan with a family is often more important than the plan itself.

“It is important to connect families to training programs, substance abuse treatment centers, domestic violence shelters and mental health services, as appropriate, while they are receiving HFA services. Approximately 70% of our families have domestic violence issues; 50% have substance abuse issues and an equal percentage have mental issues – these are significant issues for families and children.”

- Debra Caldera, RN, MPH, Unit Manager Family and Community Services, State of Alaska Maternal, Child & Family Health
A completed IFSP will contain several goals that family members have identified for themselves. The standard IFSP format contains these goals, the resources available, activities assigned, and a timeline for achievement. The plan itself is based on the resources and strengths of the family, the community and the HFA program.

It is recommended that IFSP planning take place within the first 30-45 days of program involvement. Parents are asked to select goals to focus on for the next six months. The IFSP should be reviewed with the family and rewritten every six months. The FSW and supervisor will review the IFSP every two months to assess the family’s progress toward meeting their goals.

**Supporting the Parent-Child Relationship**

A unique element of HFA programs is the emphasis given to parent-child interaction. We know that parents who have strong, positive attachments with their infants are at lower risk for child abuse and neglect and a host of other problems. We also know that infants require appropriate stimulation and love in order to fully develop their capacities. Recent research findings on early brain development further support the Critical Element calling for FSWs to focus on the parent-child relationship in the course of home visiting.

The HFA program provides a number of concrete ways to assist FSWs in maintaining this focus on parents’ bonding and attachment with the baby, despite the complexity of the parents’ needs. The FSW’s emphasis on the parent-child relationship and advocating for the child’s perspective can serve as a model for parent education.

“Believe strongly that the relationship between the parent and the infant/child is the key to success for positive outcomes in children and families, in preventing child maltreatment and in supporting positive health and development outcomes for children.”

- Linda Kimura, Program Manager
  Early Years Training & Technical Assistance Center (CA)
Promoting Healthy Child Development

It is important for all families with young children to be con-
ected to a primary health care provider. Immunizations and
well-baby care are at the forefront of prevention and represent
the point of entry for a lifelong relationship with a physician.
FSWs can take a lead role in helping families identify an appro-
priate doctor and follow through on well-child appointments.

A medical provider offers HFA participants:

- Regular well-child exams and immunizations;
- Developmental screening and identification of children at
  risk for developmental delays; and
- Medical case management.

The FSW can assist the medical provider by:

- Encouraging families to see the same physicians regularly;
- Discouraging use of emergency room services for minor ill-
nesses; and
- Monitoring well-child care and developmental screening, and
  alerting physicians to family concerns or possible develop-
  mental delays.

FSWs will want to initiate a developmental screening schedule
for each child in connection to their well-baby care. Devel-
opmental screening can be implemented in either a health

care setting or by HFA staff certified to deliver a tool such as the
Denver Developmental Screening Tool or the Ages and Stages
Questionnaire. Delays identified by the tool may be further

investigated through referrals to specialized early intervention

programs.

In addition to being an early identification tool for interven-
tion, developmental screening results can be included in
program evaluations as evidence of the positive impact of
the program on child health.
Administration of Home Visiting Services

There is a lot of paperwork involved in the provision of home visiting services, including procedures for developing, reviewing and updating IFSPs and any other case management procedures, such as number of home visits, the leveling system, ongoing child development tracking, etc. If possible, program management staff should be closely involved with the development of policies, procedures and documentation. A process that includes staff input generally results in more effective policies and procedures that are more likely to be adhered to.

An annual review of program procedures and forms used is a good practice for new programs. In the beginning, programs might be inclined to design a form and then redesign it two months later, causing confusion. It is a good idea to use a form for a year, keeping a file of potential improvements, for annual review and revision.

Supervision for Family Support Workers

Supervision is critical to the success of the program. You will want to establish procedures defining the frequency, duration and format of home visiting supervision. The role of supervision is particularly critical for staff with less experience and/or no home visiting experience. Staff need structured, consistent supervision and access to their Supervisor for crisis situations, as well as for general reassurance and support. The Critical Elements recommend a minimum of 1½ to 2 hours of weekly supervision for each staffperson, including a review of home visit reports. The maximum allowable ratio of Supervisors to FSWs is 1:6, although the preferred ratio is 1:5.
Selecting Program Curricula and Support Materials

You are encouraged to gather and/or develop educational and resource materials for parents. You may want to create a lending library of videos, books and developmental toys for parents to borrow, in addition to materials that can be given to each family. Instead of providing toys, you may also identify a curriculum that encourages families to make toys with materials in the home and then identifies how these handmade toys can promote the growth and development of the child.

Remember that parent education and child development materials are typically written from a specific point of view, with a particular audience in mind. FSWs and their Supervisors will need to critically review materials, looking closely at cultural and community belief systems. Materials should be applicable to families with limited resources or reading skills. You may want to consider using several curricula that accommodate various adult learning styles, other languages and various cultures etc., and encourage interaction and discussion.

Go directly to the families you work with. Ask participants for feedback on your program’s support materials.

The following core concepts are important for inclusion in program curricula. You may find one curriculum that covers all of these areas or you may wish to combine several curricula.

 Mothers’ Health and Personal Needs

The birth of a baby causes many physical and emotional changes. Feelings of exhilaration, excitement and joy as well as frustration and the “baby blues” all are normal. A home visitor may be able to assist in helping the mother to understand her feelings and health needs. A mother’s concerns about the following should be covered:

- Healthy pregnancy;
- Basic childbirth information;
∙ Enhancing self-esteem;
∙ Fatigue and loss of sleep;
∙ Physical and emotional changes; and
∙ Changes in relationship with spouse or significant other.

**Attachment and Bonding**

Assuring a positive parent-child relationship depends on facilitating a strong initial bonding between the parent and infant. The parent’s ability to initiate this contact and understand and respond to the infant’s cues form the basis of interaction between the parent and infant. The home visitor’s primary goal in the first weeks and months of the infant’s life is to support the bonding of the parents (or primary caregiver) with the child. This includes supporting the parents in developing this bond through recognizing and responding appropriately to the infant’s cues. Specific areas to be covered include:

∙ Trust building;
∙ Talking to your baby;
∙ Holding and touching your baby;
∙ Father-baby bonding as well as mother-baby bonding; and
∙ Eye contact.
Growth and Development

The first few months and years of a child’s life are critical stages in their growth and development. It is important to provide support for new parents by informing them about their child’s development and what to expect. Not only does this contribute to parent-infant bonding, but it also allows the parent to track and facilitate their child’s healthy growth and development. Topics to include are:

- Supporting your baby’s cognitive and emotional development;
- How to play with your baby;
- Major milestones in physical development;
- Ensuring realistic expectations of the baby’s development;
- Characteristics of the toddler years; and
- Fostering early literacy.
TRAINING CONTENT AND PROCEDURES

Training for HFA program staff is an ongoing process. Orientation training provides program staff with information about the agency and community in which they work. HFA primary training provides instruction in role-specific skills and information necessary for effectively working with overburdened families. Ongoing or advanced wraparound training can provide in-depth information on issues and skills that impact the continued delivery of services to parents and their children.

Orientation Training

Orientation training is the initial information provided to new staff upon being hired. This training is designed and delivered by the program staff. It consists of information about agency policies and procedures, service provision in their community and state and community resources or services available to them and the families that they will serve.

HFA Primary Training

HFA primary training is mandatory. It may be delivered by certified national or state HFA trainers. PCA America staff or your State Leader can provide information about scheduling an HFA primary training.

The purpose of HFA primary training is to assist program staff in providing services specific to their job responsibilities. Training content is designed around the Critical Elements and is based on best practices of family-centered and strength-based theory and service provision. Prior to training, you will have planned for specific methods for service delivery that are based on the unique qualities of the communities and families you serve. By focusing on the Critical Elements in training, program staff will be able to relate theory to practice.

Primary training is conducted over five consecutive days. One
day of training is reserved for Program Managers and Supervisors to discuss specific program implementation issues and receive training pertinent to their role(s) in the program. One day is spent with the full group covering the basics of the HFA program, including the Critical Elements. The next three days are divided into two role-specific training tracks – FSWs and FAWs. (Supervisors who will be overseeing staff in both roles will need to receive training in both tracks.)

FSWs are trained in key concepts related to home visitation services which include:

- Supporting healthy childhood growth and development;
- Promoting positive parent-child relationships;
- Enhancing family functioning by teaching parents to utilize solution-focused problem-solving skills; and
- Improving family support systems.

FAWs are trained to administer the Family Stress Checklist (FSC), the assessment tool used in many HFA programs to systematically identify those families most in need of services.

Separate trainers are provided to handle each role-specific training track: the FSWs and the FAWs. The maximum number of participants in an FSW training group is 15; for an FAW training group, the maximum number is 12. To ensure the quality of training, larger groups will require additional trainers.

Staff who have completed primary training in one role and wish to be cross-trained in the other role may attend the final three days of the training week.

We recommend that staff spend at least three months in their primary roles before undergoing cross-training.

New staff members who have joined a program after the site has completed its primary training may receive training by attending another program site’s primary training, based on space availability.
**Scheduling Primary Training**

It is important that a program be committed to the HFA approach and have a plan in place to implement the Critical Elements before scheduling HFA primary training. This will be demonstrated by the program filing an Application for Affiliation with PCA America.

To request primary training from certified HFA trainers, submit a Training Request Form (TRF) to PCA America at least two months prior to the desired training date. The date of the actual training, however, will depend upon the availability of trainers and the site’s adherence to the Critical Elements. Once the TRF and Application for Affiliation are on file at PCA America, a technical assistance phone call will be scheduled with the Program Manager to reaffirm the presence of the Critical Elements in the program and provide an opportunity for any additional pre-training technical assistance that may be required.

**Wraparound Training**

Wraparound training consists of ongoing or advanced training that includes information about the challenges faced by the community’s families and the local resources available to support those families.

Some training topics are critical to be taught before staff begin working with families, such as dynamics of child abuse and neglect and community resources. Other training topics should be offered within the first six months of hire, including infant care, staff boundary issues, crisis intervention and language development. In order to address the multiple needs that families may be facing, it will be important for staff to receive training on substance abuse, mental health and domestic violence issues. There are some topics that should be repeated in trainings throughout the career of the provider, including parent-child interaction, family cultural issues and child development and learning.
TECHNICAL ASSISTANCE

Technical assistance is a broadly used term that has several meanings and interpretations. Here we define it as support provided to planning groups to assist in the development, implementation and maintenance of an HFA site or system. This section will focus on technical assistance available at the HFA program site level.

You are encouraged to seek technical assistance throughout the program planning process to ensure that the Critical Elements are reflected in your planning efforts. Program planning and technical assistance are available from a variety of sources including:

- HFA State Leaders;
- HFA state trainers;
- Existing HFA sites;
- HFA peer reviewers within your state;
- Local community experts;
- PCA America national office; and
- Local or state HFA partners.

Technical assistance can be provided in a variety of ways, including:

- Telephone conversations;
- E-mails;
- One-on-one meetings; and
- Group meetings.
Pre- and Post-Training Technical Assistance

HFA primary training is usually scheduled once funding is secured, staff are hired for a pilot site and the HFA Application for Affiliation is submitted. Technical assistance is available before training is scheduled to ensure that the program is on-track with a solid plan for implementing the Critical Elements within the structure of their program. Upon completion of primary training, technical assistance is available from the trainer who conducted the training as well as PCA America program staff, on an as-needed basis.

A number of states have the capacity not only to assist developing sites in tailoring the Critical Elements to meet their individual needs, but also to provide primary training and technical assistance. This may help new sites’ budgeting efforts by lowering training costs and travel expenses.
**ADDITIONAL RESOURCES - SECTION V**

**Assessment Resources**

Kempe National Center for Prevention and Treatment of Child Abuse and Neglect  
1205 Oneida Street  
Denver, CO  80220  

Description/History and Use of the Kempe Stress Assessment. Korfmacher, J.

**Home Visiting Resources**

Home Visiting: Reaching Babies and Families “Where They Live.” Zero to Three: National Center for Infants, Toddlers and Families  
The Future of Children 9(1) 1999. The David and Lucile Packard Foundation  
Home Visiting: Procedures for Helping Families. Wasik, B.H., Bryant, D.M., & Lyons, C.M.

**Technical Assistance Resources**

Prevent Child Abuse America, 312/663-3520, offers several communications vehicles that provide technical assistance:  

- **Healthy Families America Spotlight** – periodic newsletter that includes questions from the field and profiles of program sites  
- **State Systems Scoop** – bi-monthly electronic newsletter designed to provide information to facilitate state systems development  
- **HFA Listserv** – electronic bulletin board for HFA practitioners to share information and resources

See the bibliography for additional resources and complete citations.
In Section V, you've nearly completed construction and are about to open your doors and lay out the welcome mat to families and children in your community.

☑ You've developed policies, protocols, forms and staffing patterns for the delivery of screening and assessment services.

☑ You've planned for the initial home visits by developing procedures and forms for introducing the program to parents and sharing information about confidentiality and releases.

☑ You've selected and/or developed program curricula and support materials for home visitors to use with parents.

☑ You've hired staff and begun wraparound training by delivering orientation training to program and agency staff.

☑ You've prepared for HFA primary training by ensuring that the Critical Elements are in place through accessing technical assistance from either your state system or the national office.
Section Six

Promoting and Maintaining Your Program
Two activities that often get lost during program planning and implementation are public relations and marketing. While it may seem more important to focus on the details of getting a program up and running, it may be difficult to find people to actually participate and benefit from the services you are offering if no one knows about the program. The way your program is presented to people can have a significant impact on their decision about whether or not to participate.

In addition to promoting your program to prospective participants, public relations and marketing strategies aimed towards the community at large will enhance your program’s credibility, promote its name recognition and may capture the attention of potential funding sources. These ongoing efforts can go a long way toward eliciting community support and acceptance and sometimes even ownership of a program such as HFA.

**The Four P’s of Marketing**

It may be helpful to think about the four Ps of marketing – product, promotion, place and price – to help develop a promotional strategy or campaign.

**Product**

Consider the needs and interests of your community to help determine the most appropriate way to position your program. The product is the actual array of program services being offered to the target population.

* To prospective participants, your HFA program may promote itself in a variety of ways:
  - Parent support program;
  - Parent education program;
  - Family support program; or
Family self-sufficiency program.

To the community at large or potential funders, your HFA program may use the same tactics or you may present the program in a slightly different light. You may promote HFA as a:

- Child abuse prevention program;
- Gateway program that helps link families up with an array of supportive services;
- Community resource; or
- Health promotion program, etc.

Be prepared to back up these descriptions with evaluative outcomes from your own program and/or statewide or national data.

Promotion

You will need to determine how to promote the program.

To engage prospective participants, you may want to use word-of-mouth strategies such as encouraging the hospital and WIC staff that you work with to promote your program. You may want to advertise in the local newspaper or put flyers on bulletin boards in high traffic areas. Once the program is up and running, you might ask participating families to tell their friends and family about the program.

For the larger community, you may want to try to gain publicity for your program through local media (this will be discussed in greater detail in the next part of this section). You might decide to create a newsletter that is disseminated in your community and to potential funders. You can also invite members from the community to come visit your program to learn first-hand what it’s all about.

Place
The place informs potential participants where they will actually receive the product.

* For HFA participants, this will mean primarily receiving services in their home. It is important to remember that while this may be a benefit for some people, it can be a barrier for others. When you promote the program either with written materials or in person, you may want to consider strategies to emphasize the benefits and downplay perceived barriers.

**Price**

This refers to the cost of participating in or offering the program.

* While potential participants need to be informed that the program is free, there may be a perceived cost in terms of time and convenience.

* For the community, this may be perceived as dollars being taken away from other programs or the stigma of having a program such as HFA being offered. It is HFA’s position that the benefits of lower child abuse and neglect rates and increased immunization rates outweigh the perceived costs.

Again, it is important to anticipate every reaction that may occur and prepare accordingly. You will want to refer back to your needs assessment to determine what messages are most likely to be successful with your different audiences.

**Testing Your Messages**
It may be helpful to test your messages with members of your target audience. This process provides valuable feedback that can help make or break your program. For example, even though a funder may be supporting your program because it’s a child abuse prevention program, that angle may not go over well with parents. If you position your HFA program as a family-strengthening or parent support program, you may be much more likely to attract potential participants.

Make sure your messages are clear and easy to understand. If you show your brochure to anyone on the street, they should be able to understand what your program is about. If you are using photographs or artwork, try to select images that are meaningful to your target audience. Finally, whenever possible, use testimonials from people who have actually participated in the program. They lend the most credibility.

**Strategies for Promoting Your HFA Program**

Participants in a Minnesota Dept. of Public Health evaluation felt that word-of-mouth was one of the best ways to generate interest in a program, particularly when the referral comes from respected sources such as doctors, WIC clinics or friends. They said it was very important to promote the program in a way that makes it sound like a worthwhile program being offered to everyone who wants it. People don’t want to participate in a program where they feel they are being stigmatized.

Participants also said they were more inclined to join a program when they knew exactly what it was designed to do and when they believed it would be worth their time and effort.*

*Adapted with permission from the Minnesota Department of Health, Promoting Minnesota Healthy Beginnings: Findings from Focus Groups with Expecting Moms and New Parents.
HFA programs utilize a variety of public relations and marketing strategies and vehicles. Many programs produce printed materials such as newsletters, brochures and flyers. Some have produced videos and posters to visually describe what HFA is all about. Others have created products such as pins, t-shirts or tote bags to sell that have a dual purpose of generating revenues and promoting the program.

You may also hold special events to bring attention to the issue of child abuse and neglect, the importance of family support or parenting. Many programs schedule activities during April to coincide with Child Abuse Prevention Month. Others host events in May and/or June to celebrate Mother’s or Father’s Day. The possibilities for highlighting HFA are limitless.

Beyond creating materials about your program, you may want to also consider reaching out to the media. Establishing contact and developing relationships with newspaper, television and radio station staff can serve a program well. It will help your program gain the valuable reputation of being a helpful, accurate, reliable and fair resource.

To help cultivate this media relationship, your HFA program should consider:

- Contacting representatives at each media outlet to describe what the program is all about, who the program serves and how they can get in touch with you;
- Appointing one staffperson who will be responsible for media contacts;
- Keeping up-to-date lists of media contacts;
- Building a reputation as a respected resource with regard to your program and its place in the community; and
- Preparing and distributing informational materials about your program for your media contacts.

Most newspaper, television and radio stations have several key contacts. They may include: managing editor, city edi-
tor, feature editor, editorial writer, business columnist, reporters, photographers, station manager, program director, assignment editor, news director, editorial director, public services director or talk show producer. Be sure to include them all when disseminating information about your program.

When pitching a story idea, it is always preferable to strategize your angle. Is your information newsworthy? How will it impact people? Does it have a human interest storyline? Why would people be interested in the story? Can interesting pictures accompany the story? The more you can tailor your story to fit the needs of the media outlet you are trying to reach, the more successful you will be.

Remember to go to your media contact with the story in hand instead of describing your program and allowing them to identify the story. You don’t want to let the media impose their own interpretation of your program.

It will be important to present consistent messages about your program and its mission or vision. Anyone who speaks to the media on behalf of your HFA program should relay the same message. Anticipate the tough questions you might receive about the program and be prepared with responses that are honest but are relevant to the point you want to make.

Developing relationships with the media is an ongoing process. While it may seem frustrating and pointless at times, it is worth the effort. The impact of having one article in a newspaper or a blurb on the evening news can be long-lasting.

Public relations and marketing strategies are limited only by
one’s creativity. They can be challenging and fun and there are many ways to get program staff and families involved in the process.

Remember, before you include participants or pictures of participants in any story, you must obtain their informed, written consent. Even if the participant has consented at the start of the program, obtain a new, specific consent for any media event/story.

Don’t forget to check with your Primary Contact, other sites or State Leaders to find out about any public relations and/or marketing activities or campaigns that may be underway in your state.
ADVOCACY

In order to reinforce the time and hard work that you’ve put into developing and implementing your HFA program, it’s important to think about ensuring the future of your program. This means making sure that your community understands the program and learns more about the good work that you are doing and the benefits that families are receiving. It means that local, state and other policymakers and key decision-makers know about your HFA program and the impact that you are having on the community and on families and children. It also means building relationships with potential funders who will be critical to the future sustainability of your efforts. Advocacy is integral to building the foundation for your HFA program.

Advocacy means many things to many people. There are different levels of advocacy – national, state, local, etc. Individuals and groups can advocate for policies, programs and legislation and also on behalf of other individuals or groups. They can also advocate for themselves or for their families. It is important for your program to determine what level of advocacy involvement makes sense given staff, resources, your organizational goals and the role of your organization in your community. Here are some ways to think about the role that you might play.

Program Level Advocacy

Program level advocacy defines the work that you might do to educate local and state level policymakers about HFA, to build community and state support for your program and to ensure future funding for your efforts. This might involve some of the following activities:

* Sending your newsletter or other program information to local officials, state legislators and others;

* Inviting decision-makers to visit your program or to go on a home visit;

* Honoring key decision-makers at a fundraising dinner or other visible event;
Scheduling meetings with your state and national legislators to tell them more about HFA and to thank them for their support;

Attending a local town meeting or coffee with your legislators and sharing information about HFA or asking a question about their support for strategies like home visiting and prevention;

Inviting key decision-makers to talk with families about HFA and the benefits they receive from the program; or

Working with other local home visiting and/or family support programs to influence local and state policies.

“Decision-makers often enjoy visiting smaller sites and going on home visits. Small sites are often associated with smaller towns and more of a one-on-one relationship with decision-makers.”

– Laura Grutz, Program Manager
Healthy Families Pottawatomie County (OK)

State Level Advocacy

There may already be a statewide coalition or other advocacy effort underway in your state related to home visiting and/or HFA. It is important to learn about these efforts and to find ways to become involved. Your Primary Contact and Prevent Child Abuse America Chapter can help provide this information. Often these statewide coalitions or work groups will play a lead role in statewide advocacy efforts. They may focus on securing funding for home visiting statewide or they may work to galvanize statewide support for particular legislation. Some activities that your program might get involved with include:

Joining the advocacy committee or work group;

Committing to providing support via letter writing and phone calls from your community and site;
Sharing information about the outcomes and success stories from your program; and

Scheduling meetings with your local legislators to talk about HFA and home visiting – legislators always like to hear from their local constituents!

You don’t have to lead a major advocacy campaign on behalf of HFA. What’s important is that you use advocacy to build support and awareness of your program and the benefits for your community. This should be part of your strategic planning efforts.

**Tips for Advocacy**

- **Get to know your legislators and other key policymakers.** Build relationships with your state and national legislators. Learn about their voting records, their priorities, their perspectives and which issues are important to them.

- **Establish relationships before you need them.** Build relationships with legislators, key decision-makers and funders before you need them. Develop their interest and support so that they know you and your program when an opportunity arises.

- **Get to know legislative and other staff.** Get to know the staff who work with your legislators and other policymakers. They are often great resources for information and support and may also have significant influence when it comes time to make a decision.

- **Identify other local advocates and partners.** There is too much work to be done alone. Other family support and home visiting programs/partners can help build strength and a broader network of support for issues related to home visiting and family support.

* **Be open to negotiation.** Always be open to negotiation. Especially when it comes to legislation or policy decisions, you might not always get exactly what you want.

* **Remember names and always thank those who help you.** Don’t forget to always thank those who have helped you – no matter how big or small your success.

* **Be honest, straightforward and realistic.** Don’t make any promises that you can’t keep. Never lie or mislead a policy- or decision-maker about the importance of an issue or other matters.

* **Always be sure to follow up.** Always send a thank you note after a meeting. Also, periodically send information about your program’s progress and new evaluation data to keep your policymakers informed.

Don’t forget that the progress families make during their involvement with HFA is an impressive story in and of itself. Who better to sell the benefits of HFA than the participants themselves! Always try to involve families in your advocacy efforts.

### Getting to Know Your Government

It is helpful to know the difference between the different levels of government so that you are better able to know which level might be responsible for your particular issue. Here is a brief summary of the different levels.

* **City Government.** City government may include a mayor and/or city council representatives, depending upon the size and structure of your city or community. Council members may serve at-large and represent the entire city or they may have specific districts to represent. These elected officials often have jurisdiction over any program or department that is operated by the city with city funds. Most meetings are open to the public and individuals are usually free to give comments and/or testify.
• **County Government.** County government can also include a county mayor and/or county commissioners. County commissioners may serve at-large and represent an entire county or they may represent specific districts. They may have jurisdiction over any program or department that is operated by the county with county funds. Most meetings are open to the public.

• **State Government.** The legislative body of state government has two houses – the house of representatives and the state senate. In most states, each state representative and senator is elected to represent a specific district in the state and has jurisdiction over any program or department that is operated by the state with state funds. Most legislative sessions and committee meetings are open to the public.

• **Federal Government.** The legislative body of the federal government is also comprised of two houses – the United States House of Representatives and the United States Senate. When referring to both houses, they are called Congress. Each congressperson/state representative represents a specific district in his/her state. Each state has two United States Senators who represent the entire state. Congress has jurisdiction over any program or department that is operated by the federal government with federal funds. Many committee meetings and sessions of Congress are open to the public.
Tips for Grassroots Organizing

“In a rural state such as ours, figuring out an efficient, cost-effective way of communicating with organizers throughout the state is crucial, but very frustrating. In the long term, our goal is to get people on-line or to assure them access to e-mail through a university, library or school. In the short-term, however, we have tried to overcome the communication barriers in these ways:

Delegate. In Maine, we have divided much of our organizing by county. Each county has key people in each of the priority areas (child care, parenting support and education) who are responsible for getting information to anyone in that county who might be supporters of the common goals.

Keep it simple. There’s lots of great philosophical stuff written about why we should support early childhood legislation and many ideas about how to do it. We are trying to give people one-page, bulleted information on each bill and/or issue. We try to avoid giving out so much information that people are overwhelmed and think they can’t help.

Choose one action. If we think people are discouraged because the task of organizing a whole state, county or city is too overwhelming, we ask them to take on one thing. We don’t want to lose people because they are overwhelmed.”

– Lucky Hollander, VP Advocacy and Prevention Services
Prevent Child Abuse Maine
USING EVALUATION DATA

In Section III of the *Site Development Guide* you developed an evaluation approach through the efforts of your evaluation subcommittee or evaluation partners and laid the groundwork for conducting the evaluation. In this section we will take a look at using your evaluation data and findings.

**Organize Your Data Analysis**

When you get data back from your evaluation, regardless of how it was collected (i.e., questionnaires, interviews, focus groups), the data should always be put into the framework of your evaluation goals. This will help you organize your data and focus your analysis.

For example, if you want to improve your program by identifying its strengths and weaknesses, you can organize data into program strengths, weaknesses and suggestions to improve the program.

If you want to fully understand how your program works sequentially, you can organize data in the chronological order in which clients go through your program.

If you are conducting an outcomes-based evaluation, you can categorize data according to the indicators for each outcome.

You can use your evaluation data to assess which services were provided, who received the services and whether the services produced the anticipated outcomes.

* Evaluating service delivery enables program administrators to assess the actual intensity of services, content of the home visit and quality of additional services provided, such as referrals to other supportive agencies. These findings can lead to recommendations on program quality.
Determinations about who was eligible for services and who actually received services helps programs learn about acceptance rates. Answering these questions can also provide insights as to perceived benefits and barriers to participating in the program.

Outcome evaluations are much more complex. This type of evaluation requires programs to demonstrate that any changes that occurred were caused by the program and not by other factors. While this type of evaluation entails a higher degree of planning and cost, the results typically receive more respect and attention. Statistically significant outcome evaluations can influence both policymakers and practitioners and may suggest that a program has the potential to be replicated in other communities.

**Using Evaluation Findings**

Once evaluation data has been analyzed, the findings can be used in a number of ways, both internally and externally.

From an internal perspective they can:

- Provide direction for staff;
- Identify training needs;
- Improve programs;
- Support annual and long-range planning;
- Guide budgets and justify resource allocations;
- Suggest outcome targets;
- Focus board members’ attention on programmatic issues; and
- Suggest the potential for replication in other locations.
From an **external** perspective, results can be used to:

* Recruit talented staff and volunteers;
* Promote the program to potential participants and referral sources;
* Identify partners for collaboration;
* Enhance the program’s public image;
* Support your advocacy agenda; and
* Retain and increase funding.

**Sharing Evaluation Data with the Field**

Finally, programs that conduct evaluations also have a greater obligation, which is to contribute to the body of knowledge around home visiting. It is critical that home visiting programs share their stories, their triumphs and shortfalls with their colleagues in this field. The only way we can learn and improve upon the work that we do is to share best practice standards. Evaluation data can lead to the creation of new policies, better programs and the allocation of new resources. We can do this by presenting at conferences, participating in discussions and ensuring that the work we do is represented in the family support literature. It is through these ongoing efforts that we will continue to enhance the effectiveness of our programs.
ADDITIONAL RESOURCES -
SECTION VI

Public Relations & Marketing Resources
Connect For Kids – www.connectforkids.org
USA Kids – www.usakids.org
Best Practices Toolkit: Publicizing Your Efforts –
www.benton.org/Practice/Toolkit/publicize.html
Hot to Do It Yourself – www.causecommunications.com/
KRON Channel 4 Media Access Guide for Non-Profit Organizations –
www.kron.com/nc4/4listens/media_guide

Advocacy Resources
http://thomas.loc.gov
http://www.congress.org
Capitol Advantage – http://capitoladvantage.com
Independent Sector – http://independentsector.org
National Clearinghouse on Child Abuse and Neglect Information –
www.calib.com/nccanch/
60 Seconds Media Guide: Quick Tips for Staff and Volunteers in Building
Good Media Relations – www.independentsector.org/media/sixty_second_guide.html

Evaluation Resources
Free Management Library – http://www.mapnp.org/library
The United Way – http://www.unitedway.org/outcomes/
Department of Health and Human Services –
http://www.acf.dhhs.gov/programs
Innovation Network, Inc. – www.innonet.org/peak.html
Children’s Trust Fund – www.ctfalliance.org
Eric Test Locator – www.ericae.net

See the bibliography for additional resources and complete citations.
In Section VI, you’ve done preventive maintenance for your HFA program by building relationships with legislators, policymakers, the media and your community.

☑ You’ve developed and tested public relations messages in order to promote the program to prospective participants and enhance the program’s standing with the community in general.

☑ You’ve begun to reach out to your local and state level policymakers to educate them about HFA and the families in your community who are receiving services.

☑ You’ve formed linkages with other advocacy efforts already underway in your state related to home visiting or HFA.

☑ You’ve planned your data analysis process in order to focus evaluation findings to be used both internally and externally for program quality improvements.
Appendix A

The Critical Elements
HFA CRITICAL ELEMENTS

Research has demonstrated that home visitation programs can be successful in addressing a host of poor childhood outcomes such as failure to thrive, lack of school readiness, and child abuse. Recognizing the potential of home visitation for new parents, Prevent Child Abuse America launched Healthy Families America (HFA) in 1992, in partnership with Ronald McDonald House Charities. Based on two decades of research, the experiences of Hawaii’s successful Healthy Start program and best practices from numerous communities and prevention models, Healthy Families America offers support to all parents of newborns, and offers voluntary home visitation services to those parents facing the greatest challenges. To realize this vision, Healthy Families America emphasizes the importance of collaboration – integrating and building onto existing service delivery systems.

The Healthy Families America approach to home visitation is defined by a set of critical program elements as suggested by repeated evaluations of early intervention programs with new parents. The HFA credentialing program uses the critical elements as a way to measure and improve quality. These basic elements represent research-based, field-tested qualities of effective home visitation, yet allow for flexibility in service implementation to permit integration into a wide range of communities, as well as opportunity for innovation. The following are the critical elements central to all HFA programs, representing the current knowledge base for best practice in home visitation.

Initiation of Services

- Initiate services prenatally or at birth.

- Use a standardized (i.e., consistent for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse, and parental history of abuse in childhood).

- Offer services voluntarily and use positive outreach efforts to build family trust.
Service Content

- Offer services intensively (i.e., at least once a week) with well defined criteria for increasing or decreasing intensity of service and over the long term (i.e., three to five years).

- Services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; staff and materials should reflect the cultural, linguistic, geographic, racial, and ethnic diversity of the population served.

- Services should focus on supporting the parent(s) as well as supporting parent-child interaction and child development.

- At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.) Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

- Services should be provided by staff with limited caseloads to assure that they have an adequate amount of time to spend with each family, meeting their unique and varying needs and planning for future activities. In many communities a home visitor will do best serving no more than 15 families on the most intense service level; in some communities the number may need to be significantly lower, for example, fewer than 10 families.

Selection and Training of Service Providers

- Service providers should be selected because of their personal characteristics (i.e., non-judgmental, compassionate, able to establish a trusting relationship, etc.), their willingness or experience working with culturally diverse communities, and their skills to do the job.

- Service providers should have a framework based on education or experience for handling the variety of situations they may encounter when working with at-risk families. All service providers should receive basic training in areas such as cultural competency, substance abuse, child abuse reporting, domestic violence, drug-exposed infants, and services available in their community.
Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation (i.e., identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, managing crisis situations, etc.)

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

The literature review on the following pages outlines the rationale and supporting research for each of the Healthy Families America program’s Critical Elements.
Critical Element #1

Initiate services prenatally or at birth.

**Rationale**

There are a variety of reasons to initiate home visiting services prenatally or at birth. An early delivery system:

- Links parents and infants to early preventive medical care, improves service utilization, and results in improvement of overall healthy status;
- Reaches families when parents are eager to learn how to care for their child and are receptive to information;
- Helps promote parent-child bonding and attachment, a process that begins even before birth;
- Assists families in developing appropriate expectations for their child’s development and helps foster that development;
- Provides support for families with children under the age of two at an exciting and potentially stressful time, when most physical abuse and neglect occurs;
- Identifies overburdened families early on and provides guidance and support to curb drastic outcomes related to child abuse; and
- Facilitates the formation of a long-term, trusting relationship between home visitors and families.

**Supporting Literature**

**Services initiated prenatally or at birth reach parents when they are most open to information and assistance.** Early interactions between parents and home visitors serve as the basis for all future interactions. “Pregnancy is a time of anticipation and preparation, and for first-time mothers it brings anxiety that makes them especially eager for the information and reassurance that the program worker can provide.” (Fair Start for Children, 1992, p.227) Once parenting patterns and a resource network have been established, it is much more difficult to intervene. Thus, offering home visiting services prenatally or at birth facilitates the formation of a long-term, trusting relationship between visitors and families.
Early initiation of services results in healthier mothers and higher birth weight babies. Olds (1992) evaluated a nurse home visiting program serving a sample of 400 mothers-to-be in Elmira, New York. Women receiving services during pregnancy reduced the number of cigarettes smoked and improved their diets. Specifically, women receiving services who smoked prior to pregnancy had 75 percent fewer preterm births than a control group. Finally, adolescent mothers receiving services delivered infants who were 395 grams heavier at birth than the control group.

Early initiation of services results in healthier babies. Between 1987 and 1990, the Hawaii Healthy Start program provided home visiting services starting at birth for 2,256 families. (State of Hawaii, Department of Health, 1994) Comparisons of families receiving home visiting services and Hawaii’s general population showed that 90 percent of children receiving services were fully immunized at two years of age compared to 60 percent of the general population. Furthermore, 95 percent of eligible children receiving services were enrolled in EPSDT services, while only 43 percent of eligible children in the general population were enrolled in EPSDT services.

Early initiation of services seeks to prevent child abuse and related fatalities. According to Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1994 Annual Fifty State Survey (Wiese & Daro, 1995), an estimated 3.1 million children were reported to Child Protective Services agencies in 1994 as alleged victims of child maltreatment. Furthermore, an estimated 1,271 child abuse and neglect-related fatalities occurred. Of these fatalities, 88 percent occurred among children under the age of five. Forty-six percent of the fatalities occurred among children under the age of one. Early prevention and intervention efforts hold promise for reducing these statistics.

Early initiation of home visiting services provides the opportunity to influence the quality of the early childhood environment and its stimulus effect on infant brain development. According to a 1994 report of the Carnegie Corporation, brain development that takes place before the age of one is rapid and extensive. This brain development is highly susceptible to environmental influences. Environmental factors affect the number of brain cells, the number of connections in the brain, and the ways that brain connections are wired. These influences have long lasting impacts, and evidence suggests that early childhood stress has a negative impact on brain function. Early childhood home visiting services have the opportunity to influence brain development by promoting safe, stimulating early childhood environments.
The quality of parent-child interactions plays a significant role in determining positive child outcome. “Infants thrive on one-to-one interactions with parents. Sensitive, nurturing parenting is thought to provide infants with a sense of basic trust that allows them to feel confident in explaining the world and forming positive relationships with other children and adults.” (Carnegie, 1994, p.5) By initiating services at birth or earlier, home visitors are in a position to help shape the quality of these early interactions. Through role play and modeling, home visitors can help parents learn how to touch, hold, soothe, and communicate with their babies in ways that promote healthy development.

Early initiation of services facilitates the development of an attachment relationship between parents and children. Bowlby (1969, 1973, & 1980) suggests that attachment relationships between parents and children are generally formed by nine months. A good quality parent-child relationship that is developed early in life leads to a secure attachment relationship, which provides the cornerstone for all later development. By supporting parents through stressful situations and helping them to bond with their babies, home visitor services beginning prenatally or at birth have the greatest opportunity to assist in fostering positive parent-child relationships.

Reaching parents when they are most willing to accept information and assistance is an important element of a home visitor program. Pregnant women who receive services are healthier, and their babies have higher birth weights accompanied by fewer immediate health problems. Later, these infants have healthier childhoods as a result of receiving proper medical care and immunizations. Thus, family stress related to health problems is reduced. Additionally, home visitors increase parents’ knowledge about the importance of forming early relationships with their children. Good parent-child relationships lessen the likelihood of serious child abuse, neglect, and related fatalities and promote healthy families.
Critical Element #2

Use a standardized (i.e., consistent for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse and parental history of abuse in childhood).

Rationale

Several factors contribute to the rationale for using assessment tools in determining a family’s need for services.

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- If it is not fiscally possible to provide services universally, standardized assessment tools identify families most in need of services in an objective manner.
- Standardized assessment tools insure home visiting services are provided to those families the program is designed to serve (e.g., limited services for all families and more intensive services for high-risk families). Assessment tools promote better program management and more efficient use of scarce resources.
- Consistent use of standardized assessment tools provides home visitors with an understanding of the unique strengths, risk factors, and needs of a family and affords an opportunity to provide individualized service. This understanding provides a uniform starting point for working with families and building on their strengths.
- Follow-up assessments, completed at regular intervals, provide opportunities to recognize progress, revise family support plans as needed, and prepare families to meet the needs of their members and achieve their goals when their home visiting services come to an end.

Standardized assessment tools should not be used to predict which families would commit abusive acts. However, they can effectively identify families experiencing the stressors or risk factors associated with an elevated risk for maltreatment.
Supporting Literature

Standardized assessment tools assess a range of factors to identify families at a higher than average risk for child maltreatment or other poor childhood outcomes. In the past, home visiting programs have used demographic characteristics, such as number of previous live births, young age of mother (<19 years), single-parenthood status, and low socio-economic status, to predict which infants are predisposed to health and developmental problems. (Olds, Henderson, Chamberlin, & Tatelbaum, 1986) However, no single factor is sufficient to predict who faces the high levels of stress that may lead a parent to abuse or neglect a child. It is also not possible for a single factor to predict which children are at-risk for developmental delays or poor health outcomes. Thus, more comprehensive assessment tools have been developed to reflect the complexities of child maltreatment.

Standardized assessment tools can establish risk categories for child abuse, which also predict other poor childhood outcomes. Gray, Cutler, Dean, and Kempe (1979) classified 150 mothers into risk categories for child abuse. Mothers were placed into “Low-Risk,” “High-Risk Non-Intervene,” and “High-Risk Intervene” groups. Placement was based on a prenatal interview and a 72-item questionnaire, which covered parents’ upbringing, feelings about this pregnancy, expectations for the newborn child, attitudes about discipline, availability of a support system, and present living situation. Other assessments included observations of the mother during labor and delivery and a postpartum interview.

Results showed that mothers assigned to high-risk groups differed significantly from mothers in the low-risk group in the number of child abuse cases reported to the Central Child Abuse Registry at the 17-month milestone. The high-risk infants also had five failure to thrive cases, significantly more accidents requiring medical attention, and more failed items on the Denver Developmental Screening Test. High-risk families experienced more out-of-home placements and family moves, while high-risk mothers experienced significantly more postpartum depression.

The Family Stress Checklist is an example of a broadly used assessment tool that identifies pregnant women who are at-risk for child abuse. Murphy, Orkow, and Nicola (1985) used the Family Stress Checklist to assign 587 mothers to risk categories during pregnancy. Results obtained when the children were between two and two-and-one-half years old showed that mothers classified as at-risk for abuse had a 52 percent child abuse and neglect incidence, while mothers classified as not at-risk had a 2 per-
cent child abuse and neglect incidence. It is important to note that when making these assignments, single or teen mothers did not fall disproportionately into the high scoring group, which again suggests that demographic factors alone are not always a reliable method for identifying risk for child maltreatment.

**The Child Abuse Potential Inventory (CAPI) also measures an individual's likelihood to abuse children.** The CAPI designed by Milner (1986) is a standardized, self-administered assessment tool that measures an individual’s likelihood of physically abusing a child. Daro, Jones, and McCurdy (1993) discuss the high validity and reliability of this instrument. Studies have shown a strong positive relationship between high CAPI scores and subsequent confirmed cases of physical child abuse. (Milner, Gold, Ayoub, & Jacewitz, 1984) Furthermore, the CAPI can distinguish between different levels of risk for child abuse (Milner and Ayoub, 1980; Ayoub et. al., 1983) and has been standardized for race, income, and level of risk for abuse groups. Other measures may more specifically predict poor childhood outcomes such as developmental delays or increased need for medical care.

A broad range of other assessment tools has been used widely among family support programs. Summaries of these instruments and the constructs used are available in *The Parenting Program Evaluation Manual*.

Certain risk factors are associated with a higher likelihood of abuse. Assessment tools measure the likelihood of abuse by screening for a combination of these risk factors, including family background, current living condition, and attitudes towards pregnancy and child rearing. The use of standardized assessment tools is essential to determine those families who may benefit most from home visitor services, thereby making the best use of scarce resources.

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Critical Element #3

Offer services voluntarily and use positive, persistent outreach efforts to build family trust.

Rationale

Home visiting services should be provided to those parents who voluntarily accept them. Voluntary acceptance of services allows parents to make decisions in their own best interests. Families who participate willingly are more receptive than those who feel coerced into participating. Services should be offered voluntarily because:

- Services are designed to be socially supportive, not socially controlling;
- Voluntary participation and goal-setting empowers families and helps them to build on their strengths;
- Forcing families to accept services may limit the amount of information they are willing to share or accept, and their willingness to make changes that improve family functioning; and
- Voluntary acceptance of services increases service effectiveness.

Some families do not recognize the benefits of home visiting services or may be distrustful of people offering assistance. Therefore, persistent outreach efforts should be extended to those families who are hesitant to accept services, but have not clearly indicated an unwillingness to accept services. Persistent outreach is beneficial because:

- Families may decide after a period of time that services will be helpful;
- Families may recognize that situations at home are more stressful than anticipated; and
- Families may develop a sense of trust with a home visitor who offers and follows through with services, increasing their likelihood of eventually accepting services.
**Supporting Literature**

**Voluntary services increase trust and receptivity among families.** In the article, “Home Visiting: Analysis and Recommendations”, Gomby et. al. (1993) note,

All home visitation services must be voluntary. The entire context and tone of the program should be one of respect for families – their desires and their strengths. Most American families do not expect governmental involvement in child rearing and some families may actively oppose it. They may feel that such involvement invades privacy and weakens the family (Emphasis added.) If home visiting is offered on a universal and entirely voluntary basis, families in America may well begin to value home visiting services and see them as a logical and helpful support, just as most European families apparently do. (pp.15-16)

**Voluntary services are supportive rather than controlling.** According to Daro (1988), an important reason for voluntary programs is that mandatory programs shift emphasis from one of social support to one of social control. Additionally, Daro answers critics of voluntary programs who charge that the people most likely to voluntarily use prevention services are those who would be less likely to abuse or neglect their children. The most violent and seriously dysfunctional families may avoid early intervention. According to Daro, self-selection, “may not be detrimental to the efficient use of prevention resources,” (p.16) because extremely dysfunctional families may not be good candidates for home visiting services. Abusive behaviors in these families may not be due to a lack of knowledge about child development or parenting, but rather due to deep and complex personal dysfunction. Such parents may require court-ordered services in order to change or may be simply unwilling to accept their parenting responsibilities under any service condition. Self-selection weeds out families who may be least receptive to services and avoids allocating scarce resources to those unable to capitalize on them.

**Outreach efforts for those families who do not clearly reject services are necessary.** Daro, Jones, and McCurdy (1993) evaluated 14 programs providing services to high-risk families. They learned that outreach efforts must be made for those families who do not clearly reject services. Although most programs relied on referrals for their participants, two of the programs successfully attracted a large number of high-risk families to their programs by using aggressive door-to-door canvassing, proving that outreach efforts can be successful in enrolling families facing substantial risk for maltreatment, not merely those who demonstrate strong service utilization skills.
**Outreach programs allow parents time to recognize that home visiting services may be beneficial to them.** Olds and Kitzman (1993) argue in favor of outreach because, “many highly stressed and defensive parents are, at first, wary of accepting visitors into their homes. These parents require persistent and sensitive efforts to establish a relationship so they can be in a better position to know whether the offered service is one that can be of benefit to them” (pp.87-88). The authors add, “These parents, in our opinion, often are at greatest risk and, therefore, are in greatest need of the service. Efforts should be continued to connect with them until they have explicitly indicated that they do not want the service,” (pp.87-88) Olds and Kitzman imply that outreach efforts allow families to build trust and rapport with home visitors while deciding if services will help their family.

When home visitor services are offered on a voluntary basis, families are more likely to be receptive and recognize the supportive role of the visitor. Understanding that the home visitor is offering assistance and information rather than seeking to control, the family builds trust in the visitor-family relationship. Although some families are not initially interested in services, they may later realize the benefit of services. Ongoing outreach efforts permit these families to take advantage of services when they are ready to accept them.
Critical Element #4

Offer services intensively (i.e., at least once a week) with well-defined criteria for increasing or decreasing intensity of service and over the long term (i.e., three to five years).

Rationale

Service intensity and length of involvement are crucial components for successful interventions.

✶ Intensive services allow home visitors to establish a solid rapport and trust with families, increasing the families' receptiveness to new information.

✶ Intensive services allow home visitors to meet family needs as they arise. Such services may be particularly important at birth when family needs are greatest. Service intensity may be decreased later as parents become more comfortable in their roles.

✶ Intensive services have been demonstrated to result in the greatest impact on the range and degree of gains made by families.

✶ Long-term services are necessary because new issues arise for families as children develop and family circumstances change (e.g., marital status, employment). Long-term services allow home visitors to help families face these new challenges and to incorporate new knowledge and life skills.

Social science literature and common sense support the idea of offering intensive home visiting services. Intuitively, regular and consistent visits allow home visitors to establish rapport and trust with families. This base increases family receptiveness to new information. Furthermore, intensive services allow home visitors to become truly supportive of families.

Supporting Literature

Successful programs provide comprehensive and intensive services. Schorr (1987) provides examples of intervention programs with quantified results. Among these, the most successful programs provide comprehensive and intensive services. The problems facing families at risk for abuse or neglect are so complex that, “fragments of services – a few classes in parent education, a one-visit evaluation at a mental health center, or a hurried encounter with an unfamiliar and overburdened physician – are often so inadequate that they can be a waste of precious resources.” (p.368)
Early intensive family support can significantly improve long-range family functioning. Seitz et al. (1985) discuss a ten-year follow-up comparing families who received a family support intervention with a control group. Family support was provided from the mother’s pregnancy until 30 months after birth. Results indicated “early, intensive family support intervention has significant potential for improving long-range family functioning in at least certain kinds of impoverished families.” (p. 386)

To realize the most significant weekly gains, weekly home visits are recommended. A comparison of families involved in weekly, bi-weekly and monthly home visits in Jamaica by Powell and Grantham-McGregor (1989) reveals that weekly visits produced the most positive outcomes while monthly visits had no discernable impact. As visiting increased, both the range of outcomes and degree of gains broadened. Though Olds and his colleagues (1986) did not specifically assign families to different amounts of home visitation services and compare their outcomes, they do report that gains from the Elmira program were directly related to the number of visits received by the family.

Frequency or intensity of home visits is a strong predictor of whether participants will benefit from intervention. A comparison of 14 child abuse prevention programs offering a range of services noted that weekly contact with the program produced the greatest reductions in parental potential to engage in physical abuse. (Daro, Jones, and McCurdy, 1993)

Services must be provided at least once or twice a week for a period of at least two years to effectively prevent child abuse. Daro, Jones, and McCurdy (1993) evaluated 14 child abuse and neglect prevention programs in Philadelphia. “Effectively preventing child abuse requires an intensive level of service contact. These data [from the 14 programs] suggest services be provided, on average, at least once or twice a week,” (p.40) from birth to around age two. The most rapid development occurs in the first two years in a child’s life. This period is critical to a child’s physical, social, and emotional development and is also the time when parenting patterns are established. As parents become more confident and children’s needs become less complex, the frequency of visits should naturally decrease.

Families receiving more intervention demonstrate greater benefits. According to Gomby et al. (1993), experimental data do not suggest a preferred duration and intensity for home visiting. However, quasi-experimental data and correlational studies show, “that weekly visits are better than monthly, or that generally, families that receive more of an intervention

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2 Gomby et al. cite the work of Olds and Kitzman (1993).
demonstrate greater benefits” (Gomby et al., 1993, p. 12)³ Although the precise intensity and duration are not stated, more rather than less is considered most helpful.

**Intensive services have the most consistent relationship with positive outcomes.** In reviewing findings from family-centered, home-based service programs, Frankel (1988) learned that intensive services may be more effective, regardless of the type of services. The results of an evaluation of 14 child abuse and neglect prevention programs in Philadelphia (Daro, Jones, and McCurdy, 1993) concur. In terms of cognitive development, greater participation in the Infant Health and Development Program (IHDP) resulted in more benefits for children. (Ramey et al., 1992)

**It is logical to extend services until children reach school age.** There is no experimental evidence regarding the optimal duration of home visiting services. However, Brazelton (1992), a nationally recognized pediatrician, puts forth an argument that supports the logic of extending services until children reach school age. Brazelton discusses “touchpoints.”

Touchpoints, which are universal, are those predictable times that occur just before a surge of rapid growth in any line of development – motor, cognitive, or emotional – when, for a short time, the child’s behavior falls apart. Parents can no longer rely on past accomplishments. The child often regresses in several areas and becomes difficult to understand. Parents lose their own balance and become alarmed. (pp. xvii-xviii)

Examples of touchpoints include the newborn individual, newborn parents, three weeks, six to eight weeks, four months, seven months, etc. During these times children develop rapidly. Touchpoints offer an opportunity for parents to understand their child and the behavioral mechanisms that lead to troublesome behavior. “A caring professional can use such times to reach into the family system, offer support, and prevent future problems.” (p. xviii) Brazelton’s touchpoints only cover developments to age three, however there are touchpoints later as children develop play relationships and enter school. When children enter school, evolving support networks allow for the gradual decrease of home visitor services.

³ Correlational and quasi-experimental studies are found in Powell and Grantham-
Successful home visitor programs provide comprehensive and intensive services. Early intensive family support can significantly improve long-range family functioning. There is also evidence that when visitors offer more frequent intensive services there is a greater impact on functioning and services are more effective. To capture these effects, services should be provided at least weekly for a period of several years. There is inherent logic to extending services beyond this period in order to help families deal with stresses they may encounter later as their children continue to develop.
Critical Element #5

Services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; and materials used should reflect the cultural, linguistic, geographic, racial, and ethnic diversity of the population served.

Rationale

For home visitor services to be effective it is imperative that cultural context is incorporated into program design and delivery. There are two underlying assumptions to this statement: 1) that the diversity of families is of great significance to intervention programs; and 2) services may be provided by persons whose culture differs from that of the participating family. Thus, in developing home visitor programs, it is important to consider that:

妃 Family needs, health beliefs, coping mechanisms, and child rearing practices vary by population, and interventions should reflect this variation;

妃 Failure to value diversity in its many forms (e.g., cultural, linguistic, racial, geographic, and ethnic) may restrict a home visitor’s ability to establish quality relationships with families; and

妃 A home visitor’s failure to establish strong relationships with families based on mutual respect and understanding will limit the opportunity for providers and families to work together.

Supporting Literature

While there is no strict empirical support for culturally competent services, efforts to provide services to children and families that are sensitive and responsive to their needs and adaptive strengths have their roots in the late 1800’s. When Jane Addams founded the first settlement house in America, it was intentionally located in an area accessible by the majority of families in the neighborhood and staffed by providers who lived in the community being served. The success of the settlement house was due, at least in part, to the fact that service providers appreciated the families’ “indigenous language and cultures, specifically their behavioral norms, rituals, and routines, that is, their agreed-upon shared ways of behaving within constituted family and community groups.” (Slaughter-Defoe, 1994, p.175)
Cultural sensitivity begins during program design. When implementing programs, it is always important to consider that the cultural characteristics of the target population may suggest an alternate or complementary strategy to home visitation. For some groups, the support gained from peers in a group-based setting will be more effective as an agent of change than support delivered in the home. For instance, among Native American Pueblos and traditional Hispanic families, seeking outside support to address family problems is not an accepted practice. (Harris-Usner, 1995) By contrast, in rural settings where families do not live in close proximity to one another, home visiting is a more pragmatic strategy than trying to convene a group. These reasons underscore the need for community members and potential participants to be involved in the program design phase.

Successful home visiting programs must provide culturally competent services so that new skills and ideas fit into the context of each family. The National Commission to Prevent Infant Mortality describes the key components of successful home visiting programs. Successful programs are sensitive to the culturally different values and decision-making systems of families. To strengthen families’ coping abilities and independence, visitors must respect differences among families. In discussing her work with rural families, for example, Windsor (1995) explains, “Understanding the advantages and disadvantages of choosing to live outside the mainstream, they are comfortable with their choice. They are proud of their ability to survive and flourish with the seasons.” Yet, not all families who live in rural areas espouse the traditional rural culture; families who flee the hassles of the city will maintain some of the urban values and norms once they live in the country. (Forest, 1995) Clearly, visitors must begin by understanding and accepting family differences.

Families vary in many ways, so it is important that home visitors understand differences among them. Cultural groups may define “family” differently, which affects the audience for home visiting services. For example, in African-American families when both parents are in the home, it is customary for mothers and fathers to share the responsibilities of child care. In addition, extended family has traditionally played an instrumental role in the care and socialization of children. (McAdoo, 1988) It follows that home visitor programs serving African-Americans should extend their focus beyond the mother and the nuclear family by including all of the relatives and or mentors who play an influential role in the child’s life in planning for services and service delivery.
Home visitors should observe cultural differences and use them as a springboard for inquiry and understanding, asking families about particular behaviors. Home visitors must then facilitate the family’s consideration of alternate perspectives. (Bernstein, Percausky, & Wechsler, 1994) Family background and ethnicity influence value systems, how people seek and receive assistance, and communication practices (e.g., native language, slang, body language), among other things. If home visitors ask questions that are non-judgmental in tone, then families have an opportunity to reflect. Answers to questions provide home visitors with greater understanding and allow visitors to share alternate perspectives with families. As Slaughter-Defoe (1993, p.178) points out, “Bridging the communication gap could be the most important prerequisite to building trust between visitors and family members.” Even such basic child development activities as counting games will be more effective if they are culturally relevant. City children will be more interested in counting the number of floors in the apartment building while children being raised in the country might learn by counting bales of hay. In the end, home visitors act not as teachers per se, but as facilitators of informed choices and decision-making.

Culturally competent home visitors help families search for positive strategies while keeping the family context in mind. According to Bernstein, Percansky, and Wechsler (1994), home visitors should not argue about values, but rather work with families to search for the best strategy for their children and consider what the family feels is important. Furthermore, the essence of acceptance of cultural diversity is understanding that families have the right to choose to live their lives differently from ours. “We believe, however, that whatever the choice in an area of concern, it should result from parents sharing their perspective and programs sharing information – rather than the result of ignorance, habit, or personal history – without considering alternatives.” (Bernstein, Percansky, & Wechsler, 1994, p.16) This type of exchange should be routine in any home visitor program so that there is ongoing and open dialogue regarding mutually established goals.

Geography also has a profound effect on service design and delivery. Whether providing home visiting services in rural or urban settings, pragmatic issues of safety, transportation, and resource availability must be considered. To that end, programs need to address safety concerns of the home visitor. If the home visitor feels threatened either due to real or imagined issues, he or she will not be able to connect with the family. Home visitors in rural areas may drive hundreds of miles in any given day and on occasion may need to forego plans for a home visit due to hazardous road conditions. Transportation also presents a problem in urban areas as it may often be unsafe for home visitors to take public transportation or drive their
own car. These reasons lend further support for utilizing service providers from within the community. For both urban and rural communities, availability and accessibility of additional resources present challenges. While there may be a large number of potential referral sources in urban areas, the high density of these communities often means that the resources are insufficient to meet the needs. By contrast, the narrow range of service options in rural areas often necessitates that an individual with training in one particular area develops many areas of expertise. (Jones, Paine, et al., 1995)

**Program administrators, supervisors and service providers should closely examine their own beliefs and values to foster a healthy group culture and guard against the development of stereotypes.** (Kaplan & Girard, 1994) As stated by Slaughter-Defoe (1993, p.179), “How staff members feel about each other, those they serve, and the program itself can have a very strong influence on program outcome.” For instance, when home visitors feel that they have control over their work allowing them the flexibility to meet families’ needs, they have a better chance of fostering that same sense of empowerment in the families they serve. Stereotypes influence the provider’s relationship with families, so home visitors must examine their own beliefs.

There is a consensus among social scientists that home visiting programs and visitors should provide culturally competent services. Providing culturally competent services requires that knowledge of diversity be applied to policy and practice. Agencies and their staff must observe and understand differences among families so that new skills and ideas fit in with existing family behaviors and contexts. Home visitors must facilitate the family’s consideration of how new perspectives fit into their lives. This practice allows families and home visitors to work together to craft positive family development strategies.
Rationale

It is essential that home visitors maintain three foci: the parent(s), the child, and the parent-child relationship.

* Services that support parents’ needs reduce stress, improve the home environment, and create healthy conditions for children. In addition, these services strengthen the relationship between parents and home visitors and increase parents’ receptivity to the other forms of service.

* Services supporting parent-child interaction ensure that parents have reasonable expectations of their child, enhance the child’s growth and development, and thereby reduce the risk of maltreatment.

The types of services that support parents’ needs include reducing social isolation, and helping families access resources to meet food, housing, electricity, educational, employment, and health care needs. Home visitor services that support parent-child interactions include improving parents’ knowledge of child development and modeling of appropriate parent-child interaction. Home visitors should provide these services in a way that leads to the independent growth and development of both parents and children while providing opportunities for mutual enjoyment. Home visitor services should also cover a broad array of areas and be provided to the family as a whole. Providing services to the whole family is important because services to parents alone do not “trickle down” to children. (Brooks-Gunn, 1990, as cited by Bernstein, Percansky, & Wechsler, 1994) However, if services help change the caregiving environment, then there are benefits for the parents and the children. (Seitz & Apfel, 1994)

Supporting Literature

Supporting parents and parent-child interaction results in a significantly reduced risk for child maltreatment and a positive parent-child relationship. Daro, Jones, and McCurdy (1993) evaluated 14 child abuse and neglect prevention programs in Philadelphia. The evaluation showed that prevention programs seeking to enhance parenting skills among high-risk populations need to offer intensive services that do more than merely transfer specific parenting or child development knowledge. Enhanced parenting skills will be achieved only if a program addresses its clients’ personal as well as parenting needs. (p.7)
Programs provided medical and day care services to meet personal needs. Direct services to children included therapeutic child care or parent-child play groups. These services influenced child functioning and provided opportunities for supervised parent-child interactions. Parents who received an array of services significantly reduced their risk for maltreating their children (as measured by the Child Abuse Potential Inventory). Parents also reduced specific at-risk behaviors, such as corporal punishment, inadequate supervision of children, and ignoring their children’s emotional needs. Furthermore, an array of services promoted child functioning, parent-child interactions, and parents' knowledge of child development.

**Home visitors must address the financial, social and psychological needs of the family when working to develop good parent-child relationships.** Olds and Kitzman (1990) reviewed results from a number of home visiting programs. The authors argue that the prenatal, postnatal, and prevention of maltreatment home visiting programs with the greatest chance of success use ecological models. These models view parent-child interactions in terms of systems of interactions that include material, social, behavioral, and psychological factors.

To be optimally effective, programs must address simultaneously the psychological needs of the parents (especially their sense of mastery and competence); the parental behaviors that influence maternal, fetal, and infant development; and the situational stresses and social supports that can either interfere with or promote their adaptation to pregnancy, birth, and early care of the child. (p.114)

For example, home visitors in successful prenatal home visiting programs evaluated maternal personal resources, social support, and stresses. Then the home visitors educated mothers about health-related behaviors such as smoking and alcohol consumption. Home visitors also facilitated social support by involving family members and friends in the home visiting program, and the visitors helped families find needed health and human services.

**Successful home visiting programs support the parent-child relationship within the framework of the family.** Schorr (1989) discusses successful early intervention programs. “Successful programs deal with the child as part of a family, and the family as part of a neighborhood and community.”
Increasing parents’ knowledge about child development, including intellectual stimuli, increases the likelihood of the child’s educational success. According to Campbell and Ramey (1994), children’s cognitive development is enhanced by strengthening the developmental appropriateness and intellectual stimulus value of their early environment. As a result, children will be more prepared to enter school, and this early school success contributes to later school success. Campbell and Ramey evaluated the Carolina Abecedarian Project. The project provided children of 109 low income families with either preschool (infant to age eight, or infant to age five), school-age (age five to eight), or no educational intervention.

Preschool services, provided in a day care center, included primary medical care, supportive social services for families, and a school curriculum to enhance cognitive, language, perceptual-motor, and social development. Preschool children later received language development and pre-literacy skills. Campbell and Ramey (1994) found that, “positive effects of preschool treatment on intellectual development and academic achievement were maintained through age 12. School-age treatment alone was less effective.” (p.684) Brooks-Gunn, Klevanov, Liaw, and Spilker (1994) also found that early intervention services provided benefits for cognitive development at ages two and three. The results of these studies underscore the importance of early childhood environment and of home visitors providing parents with information on child development.

Family stress resulting from financial, psychological, or social needs interferes with good parent-child relationships. Supporting parent-child interactions in the context of the family and helping parents meet their needs significantly reduces the risk for child maltreatment. Furthermore, providing parents with information that increases their knowledge of child development enhances the likelihood of the child’s educational success.
Critical Element #7

At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.) Depending on the family’s needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

Rationale

Home visitors must perform the dual role of supporting families’ personal and parenting needs. Personal needs may include food, electricity, educational, employment, housing, and health care, while parenting needs include information on child development and parenting skills. The home visitor’s priority in supporting personal needs is to link families to health care information and services and to help families learn to use the health care system preventively.

✦ Home visitors who work with families prenatally are the linchpins to facilitating family access to prenatal care. Following birth, they help ensure timely postpartum care, immunizations and well-child care, which prevent future health complications.

✦ After positive involvement with the health care system, families may feel more comfortable and confident about using other social service systems.

✦ It is easier to meet families’ non-health personal needs once they are physically healthy. (Note: there may be situations in which other needs must be addressed concurrently, e.g., lack of basic material needs may interfere with a family’s ability to access and utilize health services.)

✦ When children are healthy, they are more likely to achieve school success and grow up to be more productive members of the workforce and become better parents.

Supporting Literature

Home visitor services that begin prior to birth help assure that pregnant women receive comprehensive prenatal care and support. The benefits of prenatal care are well documented; women receiving complete and comprehensive prenatal care are much more likely to deliver full-term, normal-weight, healthy babies than women who do not. By educating pregnant women about the benefits of prenatal care and helping them gain access to such services, home visitors are the keys to improving birth outcomes.
**Home visitors facilitate access to health care services.** The 1989-1990 measles epidemic (National Vaccine Advisory Committee [NVAC], 1991) illustrates why home visitors must help ensure access to health care. Measles is preventable through early immunization. A measles epidemic occurred despite the fact that immunizations are often available for free or at reduced costs. Many barriers limit successful immunization even if vaccinations are low-cost or free. Barriers include: missed opportunities to administer vaccine, shortfalls in the health care delivery system, inadequate access to care, and incomplete public awareness of and lack of public requests for immunization (NVAC, 1991). Several factors cause inadequate access to health care.

- Inadequate access to health care and immunizations occurs when families have no ongoing relationship with a health care provider (NVAC, 1991).
- Families isolated from the health care system may fail to understand the importance of beginning immunization in infancy. (NVAC, 1991)
- Families may not be able to overcome the difficulties of making appointments, enrolling their child in a well-child program, or obtaining a physical in order for their child to receive immunizations.

Home visitors alleviate access and information problems by acting as supportive mentors who help families understand the importance of immunizations. Home visitors also help families overcome deterrents, such as lack of transportation or the need to enroll a child in a well-child program.

**Linkages to health care services through home visitation can alleviate the potential problems associated with early hospital discharge following child birth.** Infants and particularly newborns are developmentally vulnerable and entirely dependent on their care givers. In addition to providing advice and support, home visitors serve as the important link between the family and other community supports, primarily health care. From promoting immunizations and well-child care to encouraging the use of car safety seats and other safety measures, these services help prevent avoidable childhood diseases and injuries. (Carnegie, 1994)

**Education about the importance of health care encourages parents to access well-child health services for their children.** Short and Lefkowitz (1992) found that expanding Medicaid eligibility encouraged preventive health care visits among low-income, preschool children. However, factors other than insurance and income influenced health care visits. To encourage parents to obtain age-appropriate well-child visits for their children, parental lack of education about child welfare must be combated. (Short &
Lefkowitz, 1992) Educating parents about the importance of preventive health care greatly increases their use of well-baby services.

**Early initiation of health care services helps prevent long-term health-related problems, including those that result in educational difficulties.** Another reason for home visitors to build bridges from families to health care providers is that health status affects other life areas. (Shearer, 1994)

* Health status affects education because health problems, such as hunger, poor vision or hearing, high levels of lead in the blood, or dental problems, interfere with learning.

* Mental health or physical disabilities may impede successful development.

* The health of children affects their parents' employability and the resulting income.

**Early education about the importance of health care decreases the frequency of childhood illnesses and emergencies.** Olds, Henderson, Chamberlin, and Taelbaum (1986) found that during the first and second years of life, babies of nurse-visited, unmarried teenage mothers experienced fewer emergency room visits. Emergency visits decreased because infants had fewer upper respiratory infections, accidents, and poisonings. Increased knowledge of health risks appears to reduce negative health outcomes. Home visitors should play a role in educating families about health needs and in creating medical homes, where children can receive consistent, ongoing health care.

Home visitors have the dual responsibility to educate families about the importance of early health care for children and to help families access appropriate medical services. Parents need to know that early initiation of health care services, including immunizations and well-child visits, lower the risk of illness and emergencies. Early initiation of health services also helps prevent long-term health-related problems, such as educational difficulties. Home visitors help families access medical services by identifying and removing the barriers that discourage parents from using these services. When families are physically healthy, they are more likely to be responsive to interactions with home visitors and the information that visitors have to share. Furthermore, a successful experience with the health care system will encourage families to access other useful service systems.
Critical Element #8

Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities (i.e., for most communities no more than 15 families per home visitor on the most intense service level. For some communities the number may need to be significantly lower e.g., less than 10)

Rationale

The number of families that each home visitor serves comprises a caseload. Home visitors’ caseloads should be limited in size for several reasons.

* Limited caseloads allow home visitors to spend more time with each family. This additional time encourages the development of strong relationships between home visitors and the families receiving services. These relationships are essential to the quality of home visiting services.

* Limited caseloads facilitate intensive and responsive services individualized to family needs. Home visitors have ample time to make frequent visits and to work jointly with families developing and implementing realistic service plans responding to family changes and crises as they occur.

* Limited caseloads afford service providers time to receive ongoing training and supervision that augment their ability to serve families and their professional development.

* Limited caseloads reduce the likelihood of staff burnout and turnover resulting from home visitors “spreading themselves too thin.”

Supporting Literature

More families remain intact when home visitors have limited caseloads. Though not directly comparable to home visiting programs geared towards child abuse prevention, the literature on family preservation points to the need for low caseloads. A family preservation program in Ramsey County, Minnesota, had caseloads for home-based services that were half as large as caseloads among traditional services. (Lyle & Nelson, 1983, cited in Frankel, 1988) Home-based service providers met with families for an average of 29 hours per month. Subsequently, 67 percent of families remained intact. Simultaneously, traditional service providers met with families for an average of 12 hours per month, which resulted in only 45 percent of families remaining intact.
Leeds (1984) evaluated a home-based family preservation program and found a positive relationship between small caseloads and children remaining in their homes (cited in Frankel, 1988). In addition, children in the small caseload group received an average of five hours of service per week.

**Limited caseloads allow visitors to increase time spent with families during critical child development changes.** For example, touchpoints as defined by Brazelton (1992) occur during the second year when children are speaking, feeding themselves, and getting ready for toilet training. Since these touchpoints are often challenging and frustrating for parents, a home visitor's support and guidance may help change a period of tension into a time of excitement and anticipation. By limiting caseloads, home visitors will have ample time to help turn possible family crises into family opportunities.

**Limited caseloads reduce burnout among home visitors.** Burnout is the “progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of the conditions of their work.” (Edelwich & Brodsky, 1980, cited in Wasik, Bryant, & Lyons, 1990, p.14) Burnout can result from heavy caseloads, among other things. (Wasik, Bryant, & Lyons, 1990) The costs of burnout include staff turnover, expense of training new staff, lowering of staff morale, and loss of continuity and contact with families. From a family's perspective, the importance of minimizing staff turnover cannot be overstated. For many individuals who have difficulty establishing trust and building relationships, the notion of having to “start over” with a new home visitor may be so disconcerting that the family may drop out of the program altogether.

**Limited caseloads provide the necessary time for home visitors to consult with and receive guidance from supervisors.** “Appropriate individualization of home visiting work is probably less likely to occur when caseloads are unreasonably high and the level of supportive supervision of home visitors is minimal.” (Powell, 1990, p.72) High caseloads result in home visitors receiving supervision through review of written records. In contrast, when home visitors work with eight to ten families, they tend to have weekly consultation with a supervisor to review each home visit (Jester & Guinagh, 1983; Lambie, Bond, & Weikart, 1974, cited in Powell, 1990)
Critical Element #9

Service providers should be selected because of their personal characteristics (i.e., nonjudgmental, compassionate, able to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

Critical Element #10

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

Rationale

Home visitors should be selected based on their personal characteristics and their educational or experiential background.

* Service providers must have receptive, sensitive, nonjudgmental personalities to establish the rapport required to provide effective services.

* Home visitors should have educational and/or experiential background in child health and development, child maltreatment, and parenting.

* Service providers must be able to work with diverse family types and meet their varying needs.

Of these selection criteria, personal qualities may be the most important. Program managers must look closely at what potential professional or paraprofessional home visitors bring to the position through life, work, and educational experiences. And yet, to meet the varying needs of families, service providers need to augment their existing experience and education with training. Training should be in areas related to the range of services being offered.
**Supporting Literature**

**Home visiting programs must consider a variety of skills and personal qualities when hiring service providers.** Wasik (1993) names five factors for consideration when hiring home visitors: professional experience or education; race, ethnicity, and culture; experience, age, and maturity; gender; and interpersonal and helping skills. Hiring decisions should map these considerations onto the program’s philosophy, client base, and resources.

**Personal characteristics of the home visitor may be the most important criteria for successful interaction with families.** It is important to look closely at what potential professional or paraprofessional home visitors bring to the position through life, work, and educational experiences. Relevant work or volunteer positions may serve as an indicator that the prospective home visitor can participate cooperatively as part of a team. Experience may also predict that a home visitor will be responsive to training and supervision. (Wasik, 1993) Some home visiting programs place an emphasis on hiring individuals who are parents (e.g., HIPPY), because parent home visitors have knowledge about children that cannot be gained from work or training experiences. Furthermore, the experience of being a parent usually makes the visitor seem more credible to the families they visit. (Wasik, 1993)

Personal characteristics may be the most important criteria for selecting home visitors, whether they are professionals or paraprofessionals. (Wasik, 1993) Home visitors must have strong interpersonal skills, maturity, flexibility, and good judgment. In addition, if home visitors share some similarities (e.g., ethnicity, gender, marital status) with the families they visit, then more trusting relationships develop between families and home visitors. If a home visitor is from the target population’s community and has a similar background, then families will be more likely to embrace and trust the visitor. Other key considerations should be the home visitor’s respect for the values and beliefs of many different cultures and the ability to respond appropriately and sensitively to others. (Wasik, 1993)
Home visitors who have strong personal, social, and medical skills are most able to develop a good relationship with clients. The National Commission to Prevent Infant Mortality also suggests characteristics for home visitors. In the article “Home Visiting: Opening Doors for America’s Pregnant Women and Children” the Commission notes that,

Experts agree that several personal characteristics of home visitors make them successful across programs. These characteristics include strong skills in observing, organizing, listening, supporting, probing, interpreting, prompting, and gently confronting. Home visitors need to be particularly sensitive to various cultures and to the variety of conditions they face in the homes. It is imperative that they be non-judgmental.

Generally, a program should select visitors who have strong “people skills” and the right mix of medical and social skills appropriate for the needs of the families they serve. Of equal importance are issues of training, supervision, and support. (p.13)

To work successfully with families, home visitors must be supportive and nonjudgmental in their approach, and have the appropriate educational qualifications. Other authors make recommendations for hiring based on the success of formally evaluated home visiting programs. For example, Schorr (1987) discusses intervention programs evaluated qualitatively. Among successful programs, “staff have the time, training, and skills necessary to build relationships of trust and respect with children and families.” (p.368) It follows that these qualities should be considered in hiring home visitors. Daro, Jones, and McCurdy (1993) evaluated 14 child abuse and neglect prevention programs in Philadelphia. Results indicated that “competent and empathic direct service staff are the linchpin for successful prevention efforts. In selecting staff, project directors need to evaluate applicants not only in terms of their educational and technical qualifications, but also in terms of their ability to relate to clients in a nonjudgmental and supportive manner.” (p.7) Both studies show that successful home visitors are characterized by particular personal qualities. Thus, home visiting programs should consider these qualities when making hiring decisions.
Effective home visitors possess a strong social-relational orientation that fosters the development of good relationships with families. Fair Start for Children (1992) discusses the outcomes of seven demonstration projects that include home visiting services. Halpern, in the chapter “Issues of Program Design and Implementation,” noted that a common characteristic in effective home visitors is a strong social-relational orientation. This orientation fostered the development of visitor-family relations. A later chapter, by Halpern, Larner, and Harkavy, delineates the critical personal characteristics of family workers, including maturity, social ease, open-mindedness, self-awareness, and warmth.

Standardized training programs assure that all home visitors have the knowledge necessary to work effectively with families. Wasik (1993) makes recommendations about the necessary content of a home visitor training program. Wasik recommends six major areas of training: history of home visiting, philosophy of home visiting, knowledge and skills of the helping process, knowledge of families and children, knowledge and skills specific to programs, and knowledge and skills specific to communities. Providing home visitors with a standard training program brings all staff, whatever their background, to the same point.

Home visitors must have a combination of personal qualities and educational training to work effectively with families. Personal qualities are perhaps the most important criteria for successful interaction with families. These qualities include strong social skills, sensitivity to the values and beliefs of different cultures, and a supportive, nonjudgmental approach. Beyond personal qualities, home visitors must be well trained in family systems, child development, health and safety, and specific issues such as drug abuse and chronically ill children. Training insures that all home visitors receive the standard level of training that is needed to work effectively with families. Both training and personal qualities foster the development of good relationships between home visitors and families.
Critical Element #11

Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation (i.e., identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunization, utilizing creative outreach efforts, establishing and maintaining trust with families, building on family strengths, developing an individual family support plan, observing parent-child interactions, determining safety of the home, teaching parent-child interaction, managing crisis situations, etc.)

Rationale

In addition to having dispositions and interpersonal skills that prepare them for their role, home visitors must also receive formal training to develop the knowledge and skills necessary to achieve program goals. Both pre-service and in-service training are essential.

- Formal training prepares home visitors to assess family needs, assist with parent-child interactions, provide accurate information, engage in appropriate case management activities, and meet certain standards of service delivery.

- Training establishes a link between theory and practice.

- Training provides the opportunity for home visitors to develop and implement practical approaches to real situations in a safe environment.

- Training allows staff to share information, experiences, and to learn from each other.

- Training helps home visitors feel supported in their work, and promotes their professional development.

- Training home visitors insures consistent service delivery and allows for improved program evaluation.
**Supporting Literature**

**Intensive training enhances the home visitor’s ability to sensitively transmit information to families and to change entrenched parenting behaviors.** Weiss (1993) reviews the history of home visiting and discusses qualities of effective home visiting programs. According to Weiss, effective programs must provide an educational curriculum and training in communication strategies for home visitors. This educational core should be grounded in knowledge of child health and development and an understanding of the environmental and psychosocial circumstances that influence parenting behavior. The goal of this training is to help home visitors transmit information on child development and parenting to families while being responsive to family needs. Furthermore, this knowledge is essential because home visitors need an array of tools to change entrenched parenting behaviors.

**Intensive home visitor training results in visitors using their time more efficiently.** Wasik, Bryant, and Lyons (1990) discuss four sets of characteristics and skills essential for helping relationships between home visitors and families. Helper characteristics are an element of the home visitor’s personality. Basic helping skills are among the necessary characteristics, and they include observing, listening, questioning, probing, and prompting. Home visitors must employ specific helping techniques, such as modeling, role playing, and use of examples. In addition, home visitors should be skilled in behavioral change procedures. Another skill is that of problem-solving. These skills must be mastered so that home visitors use their time constructively and productively. (Wasik, Bryant, & Lyons, 1990) Training programs must provide visitors with supervised opportunities to practice these skills in addition to written materials and clinical skills.

**Effective home visitor training is experiential and incorporates elements of the home visitor’s work.** Bernstein, Percansky, and Wechsler (1994) discuss the development of a training program for the Chicago Ounce of Prevention Fund home visitors. The training program developed due to staff frustration and feelings of ineffectiveness in addressing family needs. This program uses didactic training to instruct staff on the use of the Denver Developmental Screening Test. The program also provides concrete information on child development, its influence on parenting, and risk factors in prenatal and early childhood development. However, creative methods used to develop parent-child observation skills are the real strength of the training. These creative methods involve watching and rating parent-child interactions on videotapes and demonstrating certain behaviors. This creative approach to training evolved from a desire to model and parallel home visitors’ successful work with families. Thus, successful training must be experiential and based on the home visitor’s work.
Additional training and supervision curricula should be developed in conjunction with colleges and universities. Gomby, Larson, Lewit, and Behrman (1993) stress the importance of training.

Training and supervision are so crucial to the field [home visiting] that we believe any large expansion of home visiting programs should be accompanied by increased training opportunities at colleges and universities for both home visitors and supervisors. Further, within a community and nationally, there should be an attempt to catalog and maintain a resource center for training materials for home visitors and home visiting curricula. (p.18)

Home visitors must possess many skills and significant knowledge to work with families. Each family is unique and presents specific challenges. Many families have established parenting practices that are difficult to change. Home visitors need insights acquired from intensive training to meet these challenges, to facilitate change, and to develop an atmosphere of trust. Through training, the home visitor acquires in-depth, multidisciplinary knowledge and develops practical solutions to the problems arising in everyday work. In addition, training is a necessary support to the worker and reduces frustration and feelings of ineffectiveness.
Critical Element #12

Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations.

Rationale

Supervision serves multiple purposes for home visitors who work away from their peers and face tremendous challenges on the job.

- Supervision promotes both staff and program accountability (Wasik, 1993).
- Supervision encourages the home visitor’s personal and professional development (Wasik, 1993).
- Supervision may reduce staff burnout and turnover, through providing home visitors with much needed support.
- Supervision enhances the quality of service families receive.

Supporting Literature

There is no strict empirical support for the inclusion of supervision in home visiting programs. However, many authors who have assessed successful home visiting programs strongly recommend supervision.

Supervisors provide guidance, education, and emotional support to home visitors. “Supervision is defined as a relationship with another person that fosters professional growth (Wasik, Bryant, & Lyons, 1990, cited in Wasik, 1993).” Supervisors may take on multiple roles, including: administrator, teacher, and therapist (Wasik, 1993). In the administrative role, supervisors evaluate the performance of home visitors and even go on visits with providers. Administrative supervisors also provide feedback, which encourages the visitor’s professional development. In the teaching role, supervisors add to the home visitor’s knowledge and enhance the visitor’s abilities. Teaching supervisors help place cases in context or model how to best approach a family. Another teaching role involves discussing difficult families and how best to work with them (Wasik, 1993). Because home visiting is a high stress job, a supervisor in the therapist role offers the visitor emotional support and collegiality. Finally, providing visitors with supervi-
sion also allows for congruency between the visitor’s expectations of the family and the program’s expectations of the visitor, which ensures program quality (Wasik, 1993).

**Supervision ensures that training programs are properly implemented.** “Staff supervision and training provide education, support and nurturance and serve as a vehicle through which to build an esprit de corps, imperative for staff who need to know that they can count on each other (Kaplan & Girard, 1994, p. 103).” Supervision contributes to effective home visiting programs by ensuring that training programs are properly carried out and that core program curricula are transmitted to home visitors (Bernstein, Percansky, & Wechsler, 1994; Weiss, 1993).

**Effective family support programs provide supervision to home visitors, which serves multiple purposes.** Larner, Halpern, and Harkavay (1992) assessed the effectiveness of seven demonstration projects for children and families. In these programs,

> At its best, supervision provided an opportunity to review and assess the relationship that was developing with individual families from a deeper and more complete perspective than the group setting of in-service training meetings allowed. It also served as an important vehicle for containing the strong feelings that some families evoked in the workers. ... The most significant element of the supervision, however, was the support it provided for the family workers in their often-stressful work with families (Larner, Halpern, & Harkavay, 1992, p. 194).

**Supervision may reduce burnout among home visitors.** According to Edelwich and Brodsky (1980, cited in Wasik, Bryant, & Lyons, 1990), burnout is the “progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of the conditions of their work (p. 14).” Supervisors provide emotional support and objectivity that may reduce burnout among providers (Wasik, 1993). Families benefit from a decrease in staff burnout because they gain stability from having a long-term relationship with a service provider.

Home visitors often work in stressful environments apart from their peers. Supervision directly affects home visitors through its impact on their emotional comfort. Supervision helps the home visitor maintain perspective, evaluate his or her level of performance, and learn new methods of working with families. Proper supervision may reduce home visitor burnout. Furthermore, supervision indirectly benefits families receiving services by enhancing the quality of home visiting services.
Appendix B

Planning Documents
**WORKSHEET #6: IDENTIFYING KEY STAKEHOLDERS**

**Who are key stakeholders?**

Anyone who has an important stake in or can potentially influence the situation.

**Why identify key stakeholders?**

We can rarely be successful in an initiative by ourselves. We need to know who has a stake in the issues at hand. We need to ensure that we include the right people in the right ways to take advantage of opportunities or resolve issues. To lay groundwork for the effective relationships needed. To begin thinking from others' perspectives.

1. Describe the work you believe must be done to move from your current situation to your desired situation.

2. Brainstorm all the people you can think of that have a stake in your situation (i.e., those who may be doing the work, those impacted by the work, those who may create barriers later, etc.).

3. Look for relationships between stakeholders (i.e., similar interests, needs).

4. Identify the key stakeholders in your situation by creating a stakeholder map.
   - Center circle: You cannot go forward without this group.
   - Next circle: You want to inform/invoke them; you need them in the process.
   - Outer circle: You invite them, but they are not essential; you will go forward without them.

5. What do you know about these individuals/groups (i.e., background, history, their possible needs, your needs from them)?

*used with permission from the National Resource Center on Homelessness and Mental Illness*
SAMPLE HFA VISION STATEMENTS, MISSIONS AND GOALS

Central Virginia

Vision: A healthy community built on strong families and individuals

Mission: To strengthen families and promote healthy relationships.

Goals:

* Increase and ensure positive health outcomes for children from birth to age five in the areas of health, welfare and societal adjustment.

* Enhance parent-child development and preventive care during early childhood.

* Advance optimal child development and preventive care during early childhood.

* Reduce the number of repeat pregnancies for teen parents enrolled in the program.

Hampton

Mission: To ensure that every child born in Hampton is born healthy and enters school healthy and ready to learn.

Goals:

* Advance optimal child development and preventive care during early childhood.

* Enhance family functioning by building trusting relationships, teaching problem-solving skills and improving the support systems of families.

* Reduce negative health outcomes such as poor immunization rates, child abuse and neglect and repeat teenage births.
Alexandria

Goals:

* Ensure adequate prenatal care as prescribed by the parent’s medical provider or by the College of Obstetricians and Gynecologists.
* Ensure preventive well-care and advance optimal child development.
* Prevent child abuse and neglect.

*used with permission from Healthy Families Virginia*
INDICATORS OF COMMUNITY CONDITIONS FOR COMMUNITY PROFILE

Overview of Community

* Number of individuals
* Number of families
* Number of households
* Number of children, by age groups
* Number of single parent homes
* Ethnic make-up of community
* Median per-capita income
  * Income distribution
* Percentage of children living below the poverty line
* Percentage of substandard housing
  * Housing mobility rates
* Youth employment figures

Education

* Percentage of kindergarten and first-grade students assessed as ready or not ready for school
  * Size of Head Start-eligible population
  * High school graduation rate
* Number and percentage of students identified for special education services
  * Educational attainment for persons 18 and over
* Number and percentage of children three and older enrolled in school
* Number of children enrolled in various types of schools (i.e., public, private, etc.)
  * Literacy or basic skills level
Primary grade retention rates

**Health**

- Birth rate
- Rate of low birth weight in babies
- Rate of attainment of prenatal care
- Immunization rates for young children
- Median age of women giving birth
- Infant mortality rate
- Median number of school days missed due to illness
- Number of children with developmental delays at entry into school
- Number of residents eligible for Medicaid
- Number of residents enrolled in Medicaid

**Child and Family Welfare**

- Percentage of parents who participate in parent-teacher conferences
- Percentages of children who live with one parent, two parents
- Percentage of families in which both parents are in the labor force
- Percentage of teen parents
- Rate of reported and substantiated cases of child abuse and neglect
- Rate of reported and substantiated deaths due to child abuse and neglect
- Rate of out-of-home placements of children
- Rates of juvenile crime
- Juvenile incarceration rates
- Number of people on day care waiting lists
SAMPLE FOCUS GROUP QUESTIONS

Service Provider Focus Group

Purpose: To discuss the needs of new parents and the barriers within agencies that make it difficult to meet those needs.

❖ Why do new parents need the support services your agency provides?
❖ Describe the barriers that families may encounter when they attempt to obtain services from your agency (i.e., language difficulties, fees, etc.).
❖ What barriers does your agency experience that keep it from effectively providing support services to new parents (i.e., strict rules on documentation, lack of referrals, lack of outreach, lack of support, etc.).
❖ What has been your experience in working with other agencies to provide comprehensive services to families? Have you experienced any barriers to working collaboratively? Identify any bureaucratic problems.
❖ If you could change one specific policy or procedure in your agency to improve services for families, what would it be?
❖ What activities, policies and procedures are working well at your agency?

Key Informants Focus Group

❖ Would home visits be an effective way of working with overburdened families in this community? What would the barriers be?
❖ What kind of male mentoring or fatherhood programs would be effective?
❖ How can support groups complementing HFA services be most effective in this community?
❖ How can we engage teens in the HFA effort?
❖ Could the HFA approach be implemented prenatally in this community/neighborhood?
❖ What other groups are an important force in the community and how can we best work with them?
Consumer Focus Group

Purpose: To discuss the needs of new parents and the problems they experience in getting the help they need.

✶ What services do you and your children need most or what services did you need when you were a new parent?

✶ What problems or barriers do you experience when you attempt to obtain services?

✶ Describe your most positive encounter with a family support service delivery agency after the birth of your child.

✶ Describe your most negative encounter.

✶ If you could change one aspect of the present service delivery system, what would it be?

✶ Who helps you raise your children?

✶ Did you feel prepared to be a parent?

✶ What kinds of services are or should have been available to help you as a parent?

✶ How would you feel about home visiting services to support your role as a new parent?

✶ What would you change about the way you were raised?

✶ What are some good things about living in your community?

✶ What are your hopes and expectations for your children?
SAMPLE SURVEY QUESTIONS

When using a survey, information may be obtained that respondents may not feel comfortable discussing in front of a large group. The survey should provide a range of responses (i.e., not comfortable – very comfortable, not likely – very likely, not important – very important, etc.)

✶ How do you feel about living in this community?

✶ How safe do you think this community is for raising children?

✶ How important is it to talk to other parents about their experiences as parents to help you raise your children?

✶ How do you feel about having a worker help orient you to the challenges of pregnancy and parenthood?

✶ How can we reach the community members who need services?

✶ Do you think a father involvement program would be effective in this community?

✶ Would home visitation be an effective way to support and educate new parents in this community?
Appendix C

Program Design Documents
SAMPLE HFA LOGIC MODEL

I. Introduction
   A. Problem to be solved: New parents do not receive the support they need to ensure their child’s healthy growth and development.
   B. Target population: All new parents in a particular geographic region
   C. Intended outcomes: New parents enroll in HFA to receive supportive services to enhance their parenting skills.

II. Goals: To increase the number of new parents who enroll in HFA to become better parents

III. Objectives: Within X amount of time after the program has been implemented, as assessed by XYZ measures, HFA participants will be able to bond with their babies, take care of their babies’ essential needs and utilize non-physical forms of discipline.

IV. Resources and Constraints
   A. Resources
      1. Program staff
      2. Planning group
      3. Collaborating hospital and clinics
   B. Constraints
      1. Limited funding
      2. Some organizations unwilling to collaborate
      3. Critics who may not want HFA in their community

V. Methods and Activities
   A. Methods
      1. Home visiting
      2. Referrals to local family support agencies
   B. Activities
      1. Bonding activities
      2. Health status check-ins
VI. Quality Assurance
   A. Training for staff
   B. Regular supervision
   C. Development of policies and procedures

VII. Evaluation
   A. Process: Regular review of files and forms
   B. Outcome: Pre/post test measures
   C. Client Satisfaction

VIII. Implementation of Plan
   A. Outreach to hospitals and clinics
   B. Development of written materials
   C. Strategies for serving families
## SAMPLE GOALS, OBJECTIVES AND OUTCOMES

<table>
<thead>
<tr>
<th>Goal #</th>
<th>Goal Statement</th>
<th>Process Objectives</th>
<th>Participant Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 3, &amp; 5</td>
<td>Reduce the incidence of child abuse and neglect</td>
<td>All infants served by HF project will be linked to a medical provider for preventive health care within six months of enrollment into the project.</td>
<td>Ninety-five percent of infants enrolled in the project will be linked to a medical provider within six months of enrollment into the project.</td>
</tr>
<tr>
<td>1, 3, &amp; 5</td>
<td>Enhance parents' abilities to create stable, nurturing home environments</td>
<td>All participating parent(s) served by the HF project will be linked to a medical provider for preventive health care within six months of enrollment into the project.</td>
<td>Ninety-five percent of participating parent(s) will be linked to a medical provider within six months of enrollment into the project.</td>
</tr>
<tr>
<td>1, 3, &amp; 5</td>
<td>Promote child health and development</td>
<td>All families served by HF projects will be linked to a medical provider for preventive health care, including immunizations, and will be encouraged to remain compliant with schedules as indicated by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.</td>
<td>Ninety (90) percent of infants enrolled in the project will be fully immunized by age two (2).</td>
</tr>
<tr>
<td>1, 3, &amp; 5</td>
<td>Help develop positive parent-child interaction</td>
<td>All participants will be educated on the importance of Well Baby Checks or Child Health Check-Up, formerly known as EPSDT.</td>
<td>Ninety (90) percent of infants enrolled in the project for six months or longer will be in conformity with Well Baby Checks or Child Health Check-Up, formerly known as EPSDT.</td>
</tr>
<tr>
<td>1, 3, &amp; 5</td>
<td>Help ensure that families' social and medical needs are met</td>
<td>Ensure families are satisfied with project services</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Ensure families are satisfied with project services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal #</td>
<td>Process Objectives</td>
<td>Participant Outcomes</td>
<td></td>
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<tr>
<td>-------</td>
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<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>1 &amp; 5</td>
<td>Family Support Workers (FSW) will implement at least two (2) teaching sessions directed at enhancing appropriate decision-making skills including the benefits of spacing between the birth of each child.</td>
<td>Eighty-five (85) percent of mothers enrolled in the project will not have a subsequent pregnancy within two years of the target child’s birth.</td>
<td></td>
</tr>
<tr>
<td>1, 2 &amp; 5</td>
<td>FSWs will assess all participants at enrollment to determine if there is a need for linking participants to employment services or some type of self-sufficiency improvement program. Project will link and/or refer participants to appropriate services based on needs identified.</td>
<td>At least seventy (70) percent of project participants who have reached Level IV, who were identified at enrollment as in need of employment services or some type of self-sufficiency improvement program will have involved themselves in some type of self-sufficiency program. This could include securing employment as indicated by WAGES reform, enrolling in a GED/educational, vocational or job training program.</td>
<td></td>
</tr>
<tr>
<td>1, 2 &amp; 4</td>
<td>The project will assess all parents to determine if there is any concern about parent-child bonding. All participants will receive parent education through home visits by an FSW to encourage appropriate parent-child interaction.</td>
<td>Within 18 months of initiating home visiting services, eighty (80) percent of participants demonstrated a need in this area will show improvement in parent-child interaction skills.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>The HF project will administer satisfaction surveys every June and December. Survey results must be submitted to the Ounce/HFF two times annually in a summary report.</td>
<td>Ninety-five (95) percent of families receiving home visiting services will report an overall satisfaction with the services they received.</td>
<td></td>
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</tbody>
</table>
The following are **Process Outcome Measures:**

<table>
<thead>
<tr>
<th>Goal #</th>
<th>Process Objectives</th>
<th>Process Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 &amp; 5</td>
<td>The HF project will determine eligibility of participants through the HFF assessment process which will be completed prenatally or within two weeks of the birth of the baby. Assessments are conducted by a service provider who has received Family Assessment Worker core training.</td>
<td>At least eighty (80) percent of all assessments must occur either prenatally or within the first two weeks after the birth of the baby.</td>
</tr>
<tr>
<td>1, 2, 3, 4, &amp; 5</td>
<td>FSWs will work with all families to develop realistic and effective Family Support Plans (FSP) to empower families to meet their FSP goals and objectives.</td>
<td>Ninety (90) percent of families participating in the project will develop an FSP with their FSW within the first ninety days of continuous service.</td>
</tr>
<tr>
<td>1, 3 &amp; 5</td>
<td>FSWs must update FSPs every 90 days.</td>
<td>Ninety (90) percent of families participating in the project will have their FSPs updated every 90 days.</td>
</tr>
<tr>
<td>1, 3 &amp; 5</td>
<td>All target children enrolled in HF will be assessed for appropriate age-development using Denver, Ages and Stages or other developmental assessment instruments approved by Ounce/HFF.</td>
<td>At least ninety (90) percent of the participating infants will have received age appropriate developmental assessments using an Ounce/HFF approved, developmental assessment.</td>
</tr>
</tbody>
</table>

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SAMPLE OUTCOMES OF HFA PROGRAMS

Parent- or Family-Related Outcomes

- Increased use of formal and informal social supports
- Increased knowledge of child development
- Increased knowledge and skills related to childrearing and behavior management
- Reduction in tendency to use corporal punishment
- Increased length of subsequent pregnancy interval
- Increased level of education or employment of parent
- Reduced rates of expected abuse or neglect reports

Child-Related Outcomes

- Reductions in infant mortality rates
- Increased physical development gains
- Increased cognitive development gains
- Improved social functioning
- Full immunization and preventive health care

Community-Related Outcomes

- Increased collaboration between service providers
- Increased parent participation in community systems
- Decreased rates of abuse or neglect reports for the community area
- Increased economic stability for the community
- Decreased number of special-needs children in the local school or preschool
SAMPLE MEMORANDA OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING

Between

HEALTHY FAMILIES

and

(Name of agency/program)

 will continue to provide the following service as a member of the Healthy Families team:

• Regular participation in staffing and case review meetings.

• Home visits to all families requesting services, yet unable to be served by Healthy Families.

• The provision of ____________ services to families found to be eligible.

• Involvement in the development of Individual Family Service Plans.

• Advisory Board membership.

• Joint public information/education activities.

• Training regarding the use of the IFSP.

It is also understood that Healthy Families will continue to include in the hospital screening process the indicators for ____________ eligibility and refer to appropriate individuals for further evaluation and assessment.

__________________________  __________________________
HFA Program Manager       Collaborating Partner

__________________________  __________________________
Date                       Date
MEMORANDUM OF UNDERSTANDING BETWEEN

HEALTHY FAMILIES _____________________________ and

__________________________________________________

(Name of agency/program)

_______________________________ agrees to provide the following for the clients and/or organizations of Healthy Families ____________:

1. Training for home based Family Service and Family Assessment staff.

2. Administrative and financial services for the Healthy Families ____________ project.

3. Prenatal services, using a multi disciplinary team, for women identified as needing such service.

4. Full pediatric care for children enrolled in the project, who did not have a medical home. This will include EPSDT services, well child service according to the American Academy of Pediatrics periodic schedule, and episodic care.

5. Family planning services will be available to all women enrolled in the project.

6. Substance use prevention classes will be available to all family members enrolled in the project.

7. All services will be available in English, Spanish, and American Sign Language.

8. Coordination of all participating agency services to meet client/family needs through the Project Director.


10. Full participation on the Healthy Families ____________ Board of Executives.

11. Assure coordination of Healthy Families ____________ with County Councils.

12. Be the administrative link between Healthy Families ______ and funding agencies.

13. Assure cooperation with and participate in all evaluation services associated with this project and appropriate funding sources.

_________________________________________  _______________________
Signature                                      Date
SAMPLE HFA JOB DESCRIPTIONS

Program Manager

The Program Manager is responsible for the day-to-day management of the program, and is involved in program planning, budgeting, staffing, training/service, program evaluation and office management. The Program Manager may also be responsible for or involved in fund raising, facilitating ongoing collaboration with community/state partners and public relations. In some instances, the Program Manager may also provide direct supervision to the direct service staff, the Family Support Workers and Family Assessment Workers, depending on the size and resources of the site. If a site has a Supervisor for the direct service staff, the Program Manager may provide supervision to that individual.

Selection Criteria:

- Confident/provides leadership
- Administrative experience in human services program
- Experience with family services that embraces the concepts of family-centered and strength-based service provision
- Knowledge of maternal-infant health and concepts of child abuse and neglect
- Supervisory and counseling skills
- Experience in providing services to culturally diverse communities/families and the ability to be culturally sensitive and appropriate
- Experience in home visitation with a strong background in primary prevention services to the 0-3 age population
- Master’s degree in human services preferred (social work, psychology, sociology, family counseling, early childhood, nursing)

If the Program Manager will also be providing supervision to the direct service staff, she/he should have experience and proficiency in the expertise of the Family Support and Family Assessment Workers.
**Supervisor**

The Supervisor’s primary role is to provide ongoing, intensive, professional supervision to the direct service staff. This may include either or both of the components of service, family support or family assessment. The supervision should be directed not only toward assuring quality of service provision, but also toward protecting the integrity and respect of the families served. As a result, the Supervisor should have weekly supervision time for each staff member, with at least two hours allotted for each session. Guided by the Critical Elements, this time should be directed at assisting the staff to support the families in developing realistic and effective support plans that will develop their capacity to become empowered to meet their (the families) objectives/goals; to understand why a family may not be making the expected progress and determine effective methods of intervention; and to allow the staff to express their concerns/frustrations in working with overburdened communities and families to avoid burnout.

The Supervisor also assists in the selection of staff, participates in the orientation and in-service training, conducts record reviews, assists in or maintains the data collection system, implements a quality assurance plan, directs and provides case management and monitors the performance of the Family Support and Family Assessment Workers. To support their competency, the Supervisor must be knowledgeable of and have maintained expertise in providing home-based services as well as been trained in and have experience in completing the assessment procedures utilized to determine families to be served by the program.

The Supervisor may also act as a liaison with other agencies and monitor contracts as well as the ongoing program development. The Supervisor usually functions as the team leader, conducting team meetings and planning groups and provides daily support and crisis management. The Supervisor may also act as the Program Manager, depending on the size and resources of the site.

**Selection Criteria:**

- Sense of acceptance and fairness
- Empowering, nurturing
- Administrative experience in human services programs
- Knowledge of maternal-infant health and concepts of child abuse and neglect
Should have a solid understanding and experience in managing/motivating staff as well as providing support in stressful working environments

Extensive clinical experience in working with multi-problem families

Experience in working with culturally diverse communities/families and the ability to be culturally sensitive and appropriate

Master’s degree in family counseling, social work, psychology/sociology, nursing preferred

**Family Assessment Worker**

The Family Assessment Worker (FAW) is responsible for reviewing hospital or clinic records in accordance with confidentiality policies and interviewing/conducting the identified assessment tool with parents (prenatally and/or immediately after the birth of their child) to determine eligibility for home visitation services. Depending on the service system, the parents served by the program, may be either new parents or first time parents. If the family doesn’t enter the program, the FAW will make referrals to the appropriate community-based agencies, depending on the family’s needs.

**Selection Criteria:**

- Maturity and experience in working with families
- Experience in working with community agencies, including implementing referral processes
- Strong interpersonal skills/ability to relate to people with respect for their individuality
- Non-judgmental
- Task oriented; behavior supports beginning and completing a project/task within a specific time frame
- Experience in working with culturally diverse communities and families with the ability to be culturally sensitive and appropriate
- Demonstrates good writing and organizational skills

*If serving a bi-lingual community, the FAW should be proficient in the first language of the community.*
Family Support Worker

The Family Support Worker is responsible for initiating and maintaining regular (at least weekly) and long-term (up to five years) contact/support with families. This activity will occur primarily within the family’s home; each visit should last for at least one hour. The interventions should be family-centered and strength-based and directed at establishing a trusting relationship; assisting in strengthening the parent-child relationship; assisting parents in improving their skills to optimize the home environment; improving the family support system; and increasing the family’s ability to problem solve and assume the role of advocate for themselves and their children. The activities may also include identifying and referring for contact/appointments at other supportive agencies, including health care appointments. The Family Support Worker will also be responsible for assisting the family in establishing goals and a plan for accomplishment of those goals, as well as the assessment of the normal growth and development of the target child.

Selection Criteria:

- Maturity and experience in successfully working with children (0-3 years of age) and their families
- Knowledge of normal child growth/development and parent-child relationships
- Ability to relate to families from a strength-based model even in an apparently chaotic family environment; ability to approach families from a family-centered service model
- Demonstrates motivation and the ability to learn and practice basic supportive skills
- Available to families after-hours on an emergency basis
- Non-judgmental
- Creative and knowledgeable about community resources
- Enjoys and functions appropriately with long-term, ongoing projects; doesn’t need immediate feedback or results for personal validation
- Ability to establish and maintain personal/programmatic boundaries, while providing supportive services
Strong interpersonal skills and the ability to relate to individuals who may not share basic commonality, including value system and behavior norms

Believes in and is comfortable with advocating for nurturing, nonviolent discipline of children

Experience in working with culturally diverse communities and families with the ability to be culturally sensitive and appropriate

Demonstrates good writing and organizational skills

**Child Development Specialist**

The Child Development Specialist (CDS) tracks immunizations, conducts/monitors developmental screening and assessments of parenting and suggests parent-child interaction. The CDS is responsible for intervening with appropriate developmental activities necessary to address developmental and parenting deficits. The CDS may also facilitate parenting support groups to encourage the development of additional support systems as well as increase the knowledge base of families within the program/community. They work closely with FSWs in assisting the family to create the IFSP and identifying appropriate goals specific to the target child. The CDS may also assume the role of advocate for the family and child regarding referral and acceptance into early intervention and treatment programs.

**Selection Criteria**

- Extensive experience in providing services to children ages 0-5 (beginning at birth), preferably developmentally appropriate, and their parents
- Experience in providing services within a home-based model to overburdened communities and families
- Experience in working with culturally diverse communities and families and the ability to be culturally sensitive and appropriate
- A belief in a strength-based and family-centered service provision model
- Bachelor’s degree in child development, human development or early education
- Working knowledge of attachment theory, parent-infant relationships, and effective/nurturing parenting techniques
SAMPLE CASELOAD MANAGEMENT
PROCEDURES

Weighted Caseload System

<table>
<thead>
<tr>
<th>Level</th>
<th>Value</th>
<th>Home Visits Due/Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1-Prenatal</td>
<td>2.00</td>
<td>2-4</td>
</tr>
<tr>
<td>Level 1-SS</td>
<td>3.00</td>
<td>4</td>
</tr>
<tr>
<td>Level 1</td>
<td>2.00</td>
<td>4</td>
</tr>
<tr>
<td>Level 2</td>
<td>1.00</td>
<td>2</td>
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<tr>
<td>Level 3</td>
<td>.50</td>
<td>1</td>
</tr>
<tr>
<td>Level 4</td>
<td>.25</td>
<td>0-1</td>
</tr>
<tr>
<td>Level X</td>
<td>.50</td>
<td>1-4</td>
</tr>
</tbody>
</table>

Full Caseload for (1) full time FSW = 30.

Special Service Cases: Level 1-SS

Work intensity is estimated @ 1 ½ times normal Level 1 cases. Participants should not be assigned special services (SS) status upon admission, but need to demonstrate that they require this intensity of service. Participants may be assigned to special service status for as little as one month. Special service status should be reviewed monthly by the Supervisor. Only Level 1 cases should be assigned to special service status. Supervisors should consider returning a participant to Level 1 when more intensive services are required by a family on Level 2, 3, or 4. While many families are multi-problematic and crisis ridden, they are not assigned special service status unless they are consistently requiring more than one home visit weekly in addition to an inordinate amount of support and advocacy.

Home Visits Required

Participants are assigned to levels according to the intensity of service needed. All participants enter on Level 1 or Level 1-Prenatal and receive weekly (or four per month) home visits. Some prenatal families will not need weekly visits and may receive a minimum of two visits per month. Level 2 participants receive two visits per month. Level 3 receive one home visit per month. Level 4 participants are visited quarterly. Home visits generally will be attempted weekly with Level X participants. This, however, may not be appropriate for some families. The Supervisor is to make a clinical judgement regarding the type and frequency of participant contact for Level X participants.
For Level 1 participants, one group meeting per month can be counted as a required weekly contact if the FSW attends with the family. This is to encourage participant and Family Support Worker involvement in parenting, socialization and play groups and to compensate the FSWs for the considerable time and energy groups require.

If a group is being used as that week’s contact, the FSW is required to follow the home visit documentation format in the participant record. Participants on Levels 2-4 may participate in group meetings, but these should not be used in lieu of their required home visits. Participants who enter the program after the first week of the month are not required to have four visits that month, just one per week.

The total number of home visits done by each FSW is compared with the total number due each month, as a means of evaluating productivity and compliance with state contracts. For example, if 55 home visits were due, this is compared with the number of combined successful and attempted home visits and 14 attempted home visits, would be acceptable. It is important to give Family Support Workers feedback monthly on these calculations as they are available.

Experience from a number of HFA sites suggests that there is typically a 10-15% attempted home visit ration, especially during the initial months. If it is found that this rate increases or appears to be associated with a particular type of family problem or community, the Program Manager should aggressively work with the FSW to determine if a change in service delivery methods might alleviate the problem. In some cases, the Program Manager/Supervisor may need to meet with the family to determine how the program might better meet their needs.

While the above data should be calculated monthly according to this formula, the Supervisor needs to take other factors into consideration, such as employee illness, special training, holidays and many participants in crisis, when determining if the Family Support Worker met job expectations during the month. Supervisors are to look for patterns over several months to determine acceptable productivity levels, compliance with state contract requirements and problems a Family Support Worker may be experiencing in engaging participants. When utilizing this caseload management system, it is important for Supervisors to stay focused on the overall productivity of the FSW’s rather than minor problems.

developed by the Hawaii Family Stress Center
WORKSHEET #7: WEIGHTED CASELOAD MANAGEMENT

Program Name ___________________________________________________________

Manager ________________________________________________________________

Month __________________________________________________________________

Family Support Worker __________________________________________________

<table>
<thead>
<tr>
<th># of Participants Per Level</th>
<th>HV's Due</th>
<th>HV's Done</th>
<th>Weighted Caseload per level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-Prenatal ____ x 2-4 HV's = ______</td>
<td>HV's____</td>
<td>1-P ____ x 2 = ____</td>
<td></td>
</tr>
<tr>
<td>1- SS ____ ____ x 4 HV's = ______</td>
<td>AHV's____</td>
<td>1-SS ____ ____ x 3 = ____</td>
<td></td>
</tr>
<tr>
<td>1 ____ ____ x 4 HV's = ______</td>
<td>1 ____ ____ ____ x 2 = ____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 ____ ____ x 2 HV's = ______</td>
<td>2 ____ ____ ____ x 1 = ____</td>
<td></td>
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</tr>
<tr>
<td>3 ____ ____ x 1 HV's = ______</td>
<td>3 ____ ____ ____ x .5 = ____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 ____ ____ x 0-1 HV's = ______</td>
<td>4 ____ ____ ____ x .25 = ____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X ____ ____ x 1-4 HV's = ______</td>
<td>X ____ ____ ____ x .5 = ____</td>
<td></td>
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</tr>
</tbody>
</table>

Total ______ Total Weight _______

HV's - home visits
AHV's - attempted home visits
SAMPLE DATA COLLECTION FORMS

HEALTHY FAMILIES PIMS INTAKE FORM

This form collects information on all persons whose assessment is positive and who accept services, including identifier and contact information for the participant, emergency contact information, demographics, medical information for the mother of the target child, and information about the participant’s household.

This form should be completed at intake and the information should be entered into PIMS within one month after intake.

Site ID: __________________________  FSW ID: __________________________
Participant ID: __________________________
Assessment ID: __________________________

Participant's General Information

Last Name: __________________________  First Name: __________________________
Street Address: __________________________
City: __________________________  State: _______  Zip Code: _______
Home Phone: __________________________  Work Phone: __________________________

Is mother married to father of target child: Yes  No  Unknown
Is mother living with father of target child: Yes  No  Unknown
If not living with or married to father of target child, does mom have a current partner: Yes  No  Unknown

General HFA Information

Date accepted HFA services: _______/_______/_______
Level of service: __________________________
Date Service Level Assigned: _______/_______/_______
Signed participant agreement form? Yes  _  No
If YES Date signed: _______/_______/_______

Emergency Contact

Last Name: __________________________  First Name: __________________________
Street Address: __________________________
City: __________________________  State: _______  Zip Code: _______
Home Phone: __________________________  Work Phone: __________________________

Relationship:  ___ Spouse, not father of target child
(checkbox)  ___ Current partner, not father of target child
 ___ Father of target child
 ___ Mother
 ___ Father
 ___ Grandfather
 ___ Aunt
 ___ Uncle
 ___ Sibling
 ___ Other relative
 ___ Other non-relative
 ___ Unknown

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HEALTHY FAMILIES PIMS INTAKE FORM (CONTINUED – P. 2)

Mother of the Target Child Medical Information

Clinic: _________________________________
Name: _________________________________
Physician's Last Name: __________________ First Name: __________________
Physician's Phone: _______________________

First time parent: Yes  No  Unknown
High Risk Pregnancy: Yes  No  Unknown
Trimester of first prenatal care: None  First  Second  Third

Insurance Type: 
(choose one)  
- Medicaid – regular
- Medicaid – emergency
- Private carrier
- No insurance, have applied
- No insurance, have not applied
- Other (specify): __________________________
- Unknown

Gravida: _______ Spontaneous abortion/miscarryings: _______
Parity: _______ Induced termination pregnancies: _______

Household Characteristics

Income level: 
(choose one)  
- Under $5,000
- $5,000 - $9,999
- $10,000 - $14,999
- $15,000 - $19,999
- $20,000 - $24,999
- $25,000 - $29,999
- $30,000 - $39,999
- $40,000 - $49,999
- $50,000 and over
- Unknown

Income source: 
(choose one)  
- Employment
- Public aid
- Employment and Public Aid
- Other (specify): __________________________
- Unknown

Public Aid (check all that apply):  
- AFDC/TANF  
- WIC  
- SSI  
- Food Stamps  
- School meals

- Medicaid
- Housing assistance
- Energy assistance
- Unemployment
- Unknown
- Other (specify): __________________________
HEALTHY FAMILIES PIMS INTAKE FORM (CONTINUED – P. 3)

People contributing to household income (check all that apply):

___ Mother of child  ___ Mother’s current partner
___ Father of child  ___ Unknown
___ Grandmother of child  ___ Other (specify): ____________________
___ Grandfather of child

Type of housing:  ___ Owns house/apartment/trailer
(choose one)  ___ Rents house/apartment/trailer
___ Lives with family (no rent)
___ Lives with family (pays rent)
___ Guest in someone else’s home (no rent)
___ Lives with friends (pay rent)
___ Lives with foster family
___ Lives in a shelter/group home
___ Lives in a treatment center
___ No housing
___ Other (specify): ____________________
___ Unknown

# of other adults living in home: ____________________

Relationship of other adults to PARTICIPANT (check all that apply):

___ Spouse  ___ Grandfather
___ Current partner  ___ Siblings
___ Mother  ___ Other relatives
___ Father  ___ Other non-relatives
___ Grandmother  ___ Unknown

# of other children living in home: ____________________
### Sample Data Collection Forms

#### HEALTHY FAMILIES PIMS INTAKE FORM (CONTINUED – P. 4)

**Information about other children living in home:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Birth date</th>
<th>Gender</th>
<th>Relationship (check one)</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td>Adopted child</td>
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<td>Niece/nephew</td>
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<td>Other (specify):</td>
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<td></td>
<td>Unknown</td>
</tr>
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</table>

**# of children living outside the home:** ________________

**Residence of other children:** ____________________________________________________________

______________________________________________________________
Appendix D

Budgeting and Funding
### Funding Period: October 1, 1999 to September 30, 2000

Healthy Families Application

#### Budget Summary

<table>
<thead>
<tr>
<th>GRANTEE NAME:</th>
<th>FEDERAL I.D.:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Point Code/Description</td>
<td>Total Budget</td>
</tr>
<tr>
<td>.1 Personnel Salaries &amp; Fringe</td>
<td><strong>$469,375</strong></td>
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<tr>
<td>.2 Rent &amp; Utilities</td>
<td><strong>18,150</strong></td>
</tr>
<tr>
<td>.3 Telephone &amp; Postage</td>
<td><strong>17,816</strong></td>
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<tr>
<td>.4 Contracted Services</td>
<td><strong>24,134</strong></td>
</tr>
<tr>
<td>.5 Materials &amp; Supplies</td>
<td><strong>17,804</strong></td>
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<tr>
<td>.6 Equipment (cost over $500.00)</td>
<td><strong>10,743</strong></td>
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<tr>
<td>.7 Travel</td>
<td><strong>26,179</strong></td>
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<tr>
<td>.8 Other Costs</td>
<td><strong>57,673</strong></td>
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<tr>
<td><strong>TOTAL BUDGETED</strong></td>
<td><strong>641,074</strong></td>
</tr>
</tbody>
</table>
BUDGET NARRATIVE

1. Personnel:
   Salaries:
   Executive Director/Program Manager
   full-time (40 hours per week x 52 weeks) $30,181
   Family Support Worker Supervisor
   full-time (40 hours per week x 52 weeks) $25,704
   Family Support Worker Supervisor
   Full-time (40 hours per week x 52 weeks) $23,587
   Family Support Workers
   1 part-time (30 hours per week) $16,473
   1 one-half time/half-time QA $21,883
   1 full-time (30 + 10 Group Coordinator hours per week) $19,802
   1 full-time (40 hours per week) $19,385
   1 full-time (40 hours per week) $19,136
   1 full-time (40 hours per week) $20,197
   2 full-time (40 hours per week) $39,000
   2 full-time (40 hours per week) Proposed $39,000
   Program Family Assessment Worker/Supervisor
   full-time (40 hours per week x 52 weeks) $22,736
   Program Family Assessment Worker
   Full-time (40 hours per week x 52 weeks $20,000
   Family Assessment Workers PRN Riverview In-kind $ 4,228
   Riverview Family Assessment Worker Supervisor
   Riverview In-kind $ 497
   Reception/Administrative Assistant
   Full-time hourly (40 hours per week at $8.89, per hour $18,500
   Raise of 3.5% for last quarter for all staff $ 2938

Fringe Benefits
   Fringe benefits include Workmen’s Compensation, SUTA, FUTA, Life Insurance,
   Health Insurance, Retirement TDA, annual anniversary date Savings Bonds for
   retention incentive, short term disability, and Sam’s Club Membership.
   18.87% + $3350 @ for all full-time staff $101,464
   Increase for last quarter raises 554

2. Rent and Utilities
   5 % of building utility cost at Conner ($250 average per mo.) $ 3000
   Rent for office facility ( 6 months) $ 9450
   100. x 12 mo. Conner School In-kind $ 4800
   Conference room usage United Way In-kind $ 600
   Conference room usage for Executive Committee (12 mo. x $25) Step Ahead In-kind $ 30

3. Telephone and Postage
### Sample HFA Budget

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic mo. fee</strong></td>
<td>$450 per mo. x 12</td>
<td>$5400</td>
</tr>
<tr>
<td><strong>Long Distance</strong></td>
<td>$40 per mo. x 12</td>
<td>$480</td>
</tr>
<tr>
<td><strong>Itinerant Phone Use</strong></td>
<td><strong>United Way In-kind</strong></td>
<td>$180</td>
</tr>
<tr>
<td><strong>Monthly Pager Cost</strong></td>
<td>(16 x $107. annually)</td>
<td>$1712</td>
</tr>
<tr>
<td><strong>Cellular Phone</strong></td>
<td>16 x ($45 per mo. x 12 mo.)</td>
<td>$8640</td>
</tr>
<tr>
<td><strong>B-Mail Cost</strong></td>
<td>$17 per month</td>
<td>$204</td>
</tr>
<tr>
<td><strong>Regular Postage</strong></td>
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<td>$400</td>
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### 4. Contracted Services

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$75. x 30 hours ACSW Consultation and Training</td>
<td>$2250</td>
</tr>
<tr>
<td>$75. x 12 hours (Group Facilitators)</td>
<td>$900</td>
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<tr>
<td>Desktop Services $10 per hr. x 50 hrs.</td>
<td>$500</td>
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<tr>
<td>Custodial Services 2 hour avg. per wk. x $8.(128 hrs.)</td>
<td>$1024</td>
</tr>
<tr>
<td>Building Maintenance 40 hrs. x $10. Per hr.</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Computer Consultant &amp; DATAutoe Fee</strong></td>
<td>$3000</td>
</tr>
<tr>
<td><strong>Volunteer Time ($30. x 36 hours x 12) Board of Directors</strong></td>
<td>$12,960</td>
</tr>
<tr>
<td>($60 x 4 hours annually x 15) Advisory Team</td>
<td><strong>In-kind</strong></td>
</tr>
</tbody>
</table>

### 5. Materials and Supplies

#### Program-related Expenses

**Supplies**

- Business cards                                    | $200  |
- Binders for each family to house developmental information (100 at $5.@) | $500  |
- First Aid kits 9 at $16.                          | $144  |
- Denver II - 2 Complete Kits                       | $200  |
- Curriculum Videotapes 12 at $30.                  | $360  |
- Curriculum/Resources                               | $600  |
- Local Program Brochures                           | $600  |
- Logo Bags for Participants (200 at $6)            | $1200 |
- Small Celebration Gifts for Moms and Children     | $1000 |

**Group Expense**

- Material and supplies for group meetings 24 mtgs. x $40. | $960  |
- Curriculum for support group meetings              | $180  |
- Group facilitators 12 x $60. per meeting            | **In-kind** | $720  |
- Toddler play equipment                             | $500  |
- Food, gifts, door prizes for group activities      | **In-kind from Marsh, Kemley, etc.** | $500  |

**General Staff/Office Materials and Supplies**

- $.04 x 25,000 copies                               | $1,000 |
- Copier/FAX/Printer Supplies                       | $1200 |
- Desktop supplies for 16 employees at $140 @        | $2240 |
- Computer Accessories / Supplies                   | $480  |
- Stationery and envelopes                          | $200  |
- Riverview copies and desktop supplies             | Riverview **In-kind** | $100  |
- Copy paper                                        | $600  |
Sample HFA Budget

2 four drawer file cabinets with Locks $300
3 phones at $250 @ + installation $1000
Surge Protectors for computers $360
4 desk chairs $130 @ $520
Batteries for pagers $200
Supply Bags for Workers (14 @ $10) $140
Board of Directors Supplies (14 members x $40) $560
Advisory Team Supplies (25 members x $10) $250
2 Printers $800

6. Equipment

4 Computers/ Setup $10,000
Lease of Copier/FAX ($38.57 x 12 mo) $463
Copier Use Step Ahead, U-Way In-kind $100
Copier Service Agreement $180

7. Travel

Program Manager/FSW/FAW Supervisor $672
200 miles per mo. x $0.28 per mile x 12 mo.
FSW Supervisors 2 x (300 miles per mo. X .28 x 12 mo.) $2016
FSWs 10 x (600 miles per mo. x $0.28 per mile x 12 mo.) $20,160
Program FAW x 2 (200 miles per mo. x .28 per mile x 12 mo.) $600
FAWs 2 x (avg. 5 miles per visit x 54 x $0.31) Riverview In-kind $86

FAW Staff Meeting Travel 3 x (5 miles x 24 mtgs. x $0.31) Riverview In-kind $113
HF Board Travel (12x $30) In-kind $360
Advisory Team Travel (15 x 20 mi. x .28) $84

8. Other Cost

Training $4800
HFA National Conference (15 staff x $300. per person)
Conference (16 staff x $150.) $2400
Mileage/per diem to State training $2112
Basic training: (5 staff x 16 x 60 mi. x $0.28 per mi.) +
Core training: (200 miles x $0.28 per mile x 3) + per diem $403
Advanced training: 8 staff groups $629
(Riverview Staff Mileage: 60 mi. x $0.25 x 4 per yr. Riverview In-kind $67

Other $2000
Fee for HFA Site Credentialing
Program, Site, Liability Insurance $3500
Audit $300
7% of Monetary for Fiscal Services Fee $42,583
SAMPLE HFA GRANTS

HEALTHY FAMILIES
A PROPOSAL FOR FIVE PILOT SITES

INTRODUCTION

Healthy Families America (HFA) is a nationwide research-based initiative, with proven success, creating and sustaining a community-based system of support for new parents. The Healthy Families Initiative endorses a comprehensive approach to home visiting including: information and access to health services; parenting education; intensive services tailored to the family’s needs; close partnership with local public and private organizations; and the maintenance of high quality consistent services.

The positive outcomes documented by Healthy Families programs are directly related to some of the goals of First Steps as well as the Nexus initiative. At the recent Key Leaders Forum to launch the Nexus initiative, Mr. Shay Bilchik of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) promoted home visitation programs for new parents as his first recommendation for delinquency prevention. In addition, this program, with proven experience, would provide a critical component of the First Steps initiative, offering home visitation to all families with most intensive services to those at highest risk for maltreatment, poor health outcomes and lack of school readiness.

In addition to reducing child maltreatment (programs show at least a 95% non-abuse rate in participating families), decreasing the occurrence of repeat pregnancies (in Virginia, second time births to teen mothers were reduced by 20-25% in the HFA population) and producing higher school completion rates (nationally, 60% of mothers made progress toward high school completion in the first year of HFA and 8% finished GED before the baby’s 1st birthday), Healthy Families programs in other states have met the following First Steps goals.

First Steps Goal 1: Increase comprehensive prenatal and postnatal care to reduce premature births
HFA programs show:
- Decrease in birth complications and low birth weight babies to mothers seen prenatally (in Virginia, HFA families had a 31% higher rate of full-term births)
- Increases in the use of well baby care and other preventive and routine health care services (in one program in Virginia, 92% of all program participants attended all recommended prenatal visits, while another 1% missed only a single appointment)

First Steps Goal 2: Provide services enabling all children to receive the protection, nutrition and health care needed to thrive at birth and in the early years so that they arrive at school ready to learn
HFA programs show:
- More than 98% of children fully immunized (in several states the rate is as high as 97-98%)
- Increases in link to primary health care provider (in Virginia 98% of children had a primary care provider within 3 months of enrollment)
- Increases in quality of home environment based on parental stress, child safety, improved child/parent interaction (about all programs noted improvement in the quality of the home environment)
- Earlier screening of children with special needs leads to earlier intervention, increasing chances that children will be developmentally ready for first grade (in Florida, 98% of children involved with HFA were on target developmentally entering first grade)
• 100% children in HFA programs receive developmental screenings at early stages, allowing intervention as early as possible
• An increase in school readiness among program participants compared to non-program participants (e.g. in Virginia, 90% of children enrolled exhibited age-appropriate skills in all developmental areas and the remaining 10% were enrolled in fine motor, gross motor or speech therapy classes; in Florida 90% of children enrolled in HFA were age-appropriate with regard to developmental milestones)

First Steps Goal #2: Provide parents with access to the support they might seek and want to strengthen their families and to promote the optimal development of preschool children

HFA programs show:
• An increase in participant use and satisfaction in using various community resources and family support services (in Florida 39% of participants have moved into improved housing)
• Notable improvement in parent-child relationships and development of more positive child-centered home environment (Florida shows 13.5% increase in father involvement)
• Most frequent referrals are health-related - prenatal/postnatal, primary and dental care, family-planning (in New York 34% were referred to health care services)
• Reduced dependency on welfare (Florida shows 23.6% decrease in welfare dependency)

Healthy Families America, which is operating in 39 states, offers a statewide program, implemented at the local level to complement the First Steps and Nexus. It provides a well-researched home visitation program with demonstrated capacity to achieve results sought by both First Steps and the Nexus initiatives. Healthy Families will support the governor’s efforts to improve the health of children, reduce family violence and enable children to enter school ready to learn.

BACKGROUND

Research has demonstrated that home visitation programs can be successful in addressing a host of poor childhood outcomes such as failure to thrive, lack of school readiness and child maltreatment. In 1991, the US Advisory Board on Child Abuse and Neglect recommended the judicious use of voluntary home visitation to prevent child abuse and neglect. Recent brain research indicates that the quality of the home environment is critical in healthy brain development. As pointed out in the Carnegie Corporation’s Starting Points document (1987), “the unfolding of the developing brain ..., depends on a fostering environment, one that is reasonably stable while at the same time stimulating, responsive, protective and loving.”

Home visitation was recognized in this document as an ideal strategy for providing parents with the education and support needed to create this environment and Healthy Families America was identified as a premier program.

Recognizing the potential of home visitation for new parents, Prevent Child Abuse America (formerly the National Committee to Prevent Child Abuse) launched Healthy Families America in 1992 in partnership with Ronald McDonald Children’s Charities and based on the Hawaii Healthy Start initiative. This fast-growing program, which promotes positive parenting and child health and development, is defined by a set of critical
elements that have been identified by research as producing the best outcomes in children and families.

These elements include:

- initiation of services prenatally or at birth
- intensive services (at least weekly) for those families facing the greatest challenges
- long-term services (3-5 years) to achieve lasting behavioral change
- services are culturally competent
- services are comprehensive
- all families are linked to a medical provider and families are linked to additional services depending on need
- limited caseloads for staff (maximum of 15)
- service providers are selected for personal characteristics
- all service providers receive intensive training and program staff receive ongoing effective supervision.

To assure that we continue to expand our knowledge base, all HFA programs include an evaluation component that includes measurable outcomes (e.g. immunization rates, age appropriate development and reports of maltreatment).

The Healthy Families vision is to offer all new parents support when their babies are born and to offer those families facing the greatest challenges intensive home visitation services. There are currently 331 Healthy Families sites in 38 states and The District of Columbia. During the past year, HFA programs have assessed more than 28,000 families, with almost 18,000 of these families receiving intensive services, an impressive scope of effort for an initiative which is only a few years old. Prevent Child Abuse (formerly the National Center on Child Abuse and Neglect), the Home Visitation Project of Prevent Child Abuse America, has been committed to the implementation of the Healthy Families model in Georgia since 1993.

HEALTHY FAMILIES

Healthy Families (HF) is the Georgia version of this critical voluntary home visitation program and it complements Governor Zell Miller's First Steps initiative and Nexus goals. It is a program which will be grounded in legislation, organized by the Governor's Cabinet and other state agencies in partnership with private community-based organizations and higher education at the state level and by local First Steps Councils at the community level. HF is a primary collaboration among Prevent Child Abuse Georgia (PCA-GA), The Department of Health and Environmental Control (DHEC) and the Institute for Family and Neighborhood Life (IFNL) in partnership with The Department of Health and Human Services and The Department of Social Services.
Initially, five counties have been identified for pilot HF\textsuperscript{2} programs. The selection of these sites was based on their readiness for First Steps implementation grants as well as their readiness to implement HF\textsuperscript{2} programs in their community.

Based on individual community needs, the HF\textsuperscript{2} program structure will be different in different communities. All programs will adhere to the HFA critical elements for results. Expectant parents and parents of newborns will be visited and assessed with voluntary follow-up services offered (interventions offered will vary based on the assessment). Home visitation will be offered to all families, with those at highest risk receiving the more intensive services. HF\textsuperscript{2} will build on existing resources in the community such as Baby Basics, Parents as Teachers, Early Headstart or Family Read. The length of service for Healthy Families participants will be up to three years or until the family chooses to end participation.

Three year state funding for the five pilot sites is requested (see attached projections). During the pilot phase, legislation will be introduced and state funds sought to provide funding to replace pilot funds and to expand the program. These state funds will be used to match both Medicaid and TANF dollars to support pilot programs. The goal is to implement the program statewide. Also during the pilot phase, PCA will seek funding from private foundations to support HF\textsuperscript{2} sites.

Additional three year funding is requested for the development of a statewide network to guide and direct program development in the state as well as to provide training and technical assistance to HF\textsuperscript{2} programs.
## Healthy Families America
### PREVENT CHILD ABUSE
### HEALTHY FAMILIES
### PROPOSED BUDGET

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Y1</th>
<th>Y2</th>
<th>Y3</th>
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### Other Expenses

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<td>Equipment (computers, phones, software)</td>
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<tr>
<td>worker @ .30/mile</td>
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### Healthy Families Budget for County

1872 live births, 649 to 1st time parent
441 will need some level of service; 119 quality for HFA services

<table>
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<tr>
<th>Families Served</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
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#### Personnel
(Salaries including benefits @ 27%)

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<th>Position</th>
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<th>YEAR 3</th>
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<td>45000</td>
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<td>68000</td>
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<td>Identification Specialist</td>
<td>31000</td>
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<tr>
<td>Quality Assessment Specialist</td>
<td>30000</td>
<td>31500</td>
<td>33000</td>
</tr>
<tr>
<td>Family Support Workers (7 yr 1, 12 yr 2, 16 yr 3)</td>
<td>160020</td>
<td>279120</td>
<td>378932</td>
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<tr>
<td>Secretarial Support</td>
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<td>Contract Personnel</td>
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#### Other Expenses

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<tr>
<td>Office Space</td>
<td>20000</td>
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<tr>
<td>Mileage ($2000 per FSW/FAW)</td>
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<td>Center Activities</td>
<td>500</td>
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<td>Staff Training/Conferences</td>
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<tr>
<td>HFA Credentialing</td>
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**TOTAL**

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<tr>
<td>FAMILIES (per year with duplications)</td>
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**PER FAMILY SERVED PER YEAR**

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<th>5043.2</th>
<th>3021.6</th>
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<tbody>
<tr>
<td>(Georgia average is about $3500/year, and they have smaller sites)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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**TOTAL FAMILIES SERVED** without duplication

|                     | 325 |

**AVERAGE COST PER FAMILY OVER 3 YEARS**

|                     | 6597.76 |
### Healthy Families Budget for County

(2103 live births, 737 to first-time parents)

501 families need some level service; 135 need high level

<table>
<thead>
<tr>
<th>Families Served</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>100</td>
<td>180</td>
<td>245</td>
</tr>
<tr>
<td>Level 2</td>
<td>0</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Level 3</td>
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<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>200</td>
<td>275</td>
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**Personnel**

(Salaries including benefits @ 27%)

<table>
<thead>
<tr>
<th>Position</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
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<tbody>
<tr>
<td>Director</td>
<td>42000</td>
<td>43500</td>
<td>45000</td>
</tr>
<tr>
<td>Clinical Supervisors (2)</td>
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<td>Identification Specialist</td>
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<tr>
<td>Quality Assessment Specialist</td>
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<td>31500</td>
<td>33000</td>
</tr>
<tr>
<td>Family Support Workers 7(yr1) 12(yr2) 15 (yr3)</td>
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<td>279120</td>
<td>378932</td>
</tr>
<tr>
<td>Secretarial Support</td>
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<td>42000</td>
<td>44000</td>
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<tr>
<td>Contract Personnel</td>
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**Other Expenses**

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<tr>
<td>Equipment</td>
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<tr>
<td>Office Space</td>
<td>20000</td>
<td>22000</td>
<td>24000</td>
</tr>
<tr>
<td>Mileage ($2000 per FSW/FAW worker @ .30/mile)</td>
<td>14000</td>
<td>24000</td>
<td>32000</td>
</tr>
</tbody>
</table>

**TOTAL**

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<thead>
<tr>
<th></th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
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<tbody>
<tr>
<td>Families served</td>
<td>504320</td>
<td>604320</td>
<td>721632</td>
</tr>
<tr>
<td>(per year with duplications)</td>
<td>100</td>
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<tr>
<td>PER FAMILY SERVED PER YEAR</td>
<td>5043.2</td>
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<tr>
<td>TOTAL FAMILIES SERVED without duplication</td>
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<td>(Georgia average is $3500 per family)</td>
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**AVERAGE COST PER FAMILY OVER 3 YEARS**

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<td>5597.76</td>
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© 2000 Prevent Child Abuse America
### Healthy Families Budget for County

1607 Live Births, 494 to 1st time parents

335 will need some level of service; 90 qualify for HFA

<table>
<thead>
<tr>
<th>Families Served</th>
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<tbody>
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<tr>
<td><strong>Total per year, with duplications</strong></td>
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<td><strong>135</strong></td>
<td><strong>185</strong></td>
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#### Personnel

(Salaries including benefits @ 27%)

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<th>YEAR 2</th>
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<tr>
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<td>Contract Personnel</td>
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#### Other Expenses

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<tr>
<td>HFA Credentialing</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
</tr>
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</table>

**TOTAL** | 445400 | 443549 | 531531 | 1420480 |

**FAMILIES (per year with duplications)** | 65 | 135 | 185 | 385 |

**PER FAMILY SERVED** | 6662.3 | 3285.6 | 2873.1 | 3689.558 |

**TOTAL FAMILIES SERVED without duplication** | 228 |

**AVERAGE COST PER FAMILY OVER 3 YEARS** | 6458.13 |
# Healthy Families Budget for County

<table>
<thead>
<tr>
<th>Families Served</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
</tr>
</thead>
<tbody>
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<td>Level 1</td>
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<tr>
<td>Level 3</td>
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<tr>
<td><strong>Total per year, with duplications</strong></td>
<td><strong>65</strong></td>
<td><strong>135</strong></td>
<td><strong>185</strong></td>
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</table>

## Personnel
(Salaries including benefits @ 27%)

<table>
<thead>
<tr>
<th>Position</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>42000</td>
<td>43500</td>
<td>45000</td>
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<tr>
<td>Clinical Supervisor</td>
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<td>32500</td>
<td>34000</td>
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<td>Identification Specialist</td>
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<td>32500</td>
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<tr>
<td>Quality Assessment Specialist</td>
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<td>236931</td>
</tr>
<tr>
<td>5(yr1), 7(yr2), 10(yr3)</td>
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<td></td>
</tr>
<tr>
<td>Secretarial Support</td>
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<tr>
<td>Contract Personnel</td>
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## Other Expenses

<table>
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<th>YEAR 3</th>
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</thead>
<tbody>
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<tr>
<td>Program Supplies</td>
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<td>3000</td>
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<tr>
<td>Postage</td>
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<td>400</td>
<td>400</td>
</tr>
<tr>
<td>Phone</td>
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<td>3500</td>
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<tr>
<td>Copy/Print</td>
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<tr>
<td>Equipment</td>
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<tr>
<td>Office Space</td>
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<td>Mileage ($2000 per FSW/FAW worker @ .30/mile)</td>
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<tr>
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<tr>
<td>Evaluation</td>
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<td>HFA Credentialing</td>
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<td><strong>FAMILIES</strong> (per year with duplications)</td>
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**Per Family Served**

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<td>6852.31</td>
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<tr>
<td>3689.555</td>
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TOTAL FAMILIES SERVED without duplication = 228

**Average Cost per Family Over 3 Years**

<table>
<thead>
<tr>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>6458.13</td>
<td></td>
<td></td>
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</tbody>
</table>
## Healthy Families Budget for County

317 Live Births; 215 will need some level of service

**58 Families per year qualify for HFA**

<table>
<thead>
<tr>
<th>Families Served</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
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<td>90</td>
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<tr>
<td>Level 2</td>
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<tr>
<td><strong>Total</strong></td>
<td>40</td>
<td>100</td>
<td>170</td>
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**Personnel**

(Salaries including benefits @ 27%)

<table>
<thead>
<tr>
<th>Position</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
</tr>
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<tbody>
<tr>
<td>Director/Clinical Supervisor</td>
<td>42000</td>
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<tr>
<td>Quality Assessment Specialist</td>
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</tr>
<tr>
<td>Family Support Workers(3,6,10)</td>
<td>70485</td>
<td>143085</td>
<td>241355</td>
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<tr>
<td>Secretarial Support</td>
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<tr>
<td>Contract Personnel</td>
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<td>7000</td>
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**Other Expenses**

<table>
<thead>
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<th>Expense</th>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Supplies</td>
<td>1000</td>
<td>1000</td>
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<tr>
<td>Program Supplies</td>
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<tr>
<td>Postage</td>
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<td>Phone</td>
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<tr>
<td>Copy/Print</td>
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<td>Equipment</td>
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<td>Mileage ($2000 per FSW/FAW worker @ .30/mile)</td>
<td>8000</td>
<td>14000</td>
<td>22000</td>
</tr>
<tr>
<td>Staff Training/Conferences</td>
<td>10000</td>
<td>3000</td>
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</tr>
<tr>
<td>Evaluation</td>
<td>20000</td>
<td>22000</td>
<td>22000</td>
</tr>
<tr>
<td>HFA Credentialing</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
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</table>

**TOTAL**

<table>
<thead>
<tr>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>329685</td>
<td>344335</td>
<td>457856</td>
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<tr>
<td><strong>FAMILIES</strong></td>
<td><strong>PER FAMILY SERVED</strong></td>
<td><strong>TOTAL FAMILIES SERVED UNDUPLOCATED</strong></td>
</tr>
<tr>
<td>40</td>
<td>100</td>
<td>170</td>
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</table>

**PER FAMILY SERVED**

<table>
<thead>
<tr>
<th>YEAR 1</th>
<th>YEAR 2</th>
<th>YEAR 3</th>
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</thead>
<tbody>
<tr>
<td>8242.1</td>
<td>3443.4</td>
<td>2693.3</td>
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**TOTAL FAMILIES SERVED UNDUPLOCATED**

195

**AVERAGE COST PER FAMILY OVER 3 YEARS**

3586.7
Sample Grant for Prevent Child Abuse America/Campaign for Healthy Families

The following document is a template for grant proposals used by the Resource Development department at Prevent Child Abuse America when applying for funds for the Campaign for Healthy Families. The template is updated regularly to reflect recent accomplishments and updated figures and statistics. It can also be tailored toward the interests of the specific grant-making institution being solicited.

While there are some aspects of this template that might not be applicable to an actual HFA program site, there is a wealth of descriptive language about the HFA program model, its history, goals, outcomes and services that may be helpful to you in the development of your own grant proposals. Feel free to borrow language as you see fit. And good luck in your fundraising endeavors!
A Proposal Submitted to ________
For Support of the Campaign for Healthy Families

I. Executive Summary

Since its inception in 1972, Prevent Child Abuse America has been a national leader in the field of child abuse prevention. Notable accomplishments include: significantly raising public awareness about child abuse and its prevention; developing a nationwide network of state chapters dedicated to prevention; successfully advocating for states to fund local child abuse prevention efforts worth more than $30 million annually; developing innovative educational materials on child abuse prevention for professionals, volunteers, parents, and children; providing training and consultation to numerous government and private organizations; and establishing the National Center on Child Abuse Prevention Research, the leading source for data on child abuse reports and fatalities and for successful prevention strategies.

Prevent Child Abuse America’s most comprehensive initiative to date, Healthy Families America (HFA), builds on these efforts by providing voluntary, home visitation services for new parents. Launched in January 1992 with lead support from Ronald McDonald House Charities and the Freddie Mac Foundation, HFA is based on more than two decades of research and the experience of a successful statewide program in Hawaii. HFA’s primary goal is to assure that new parents, particularly those facing the greatest challenges, get off to a good start. Already helping families in more than ______ communities across the country, Healthy Families America:

- Offers services to parents prenatally or from the time of birth to identify the presence of stressors that may inhibit positive and healthy parenting practices.
- Offers parenting education and support commensurate with a family’s level of need.
- Makes weekly home visits available to interested families. These visits can continue for as long as five years.
- Collaborates with other family support organizations to provide a comprehensive array of services to families and avoid duplication of effort.

The growth of Healthy Families America has far exceeded our original expectations. One of the reasons for this growth is that HFA allows services to be tailored to meet the needs and characteristics of the parent(s) and child in their natural setting. However, the most compelling reason behind HFA’s expansion is the public recognition of its potential to reduce the incidence of child abuse and build stronger, healthier families.

Ongoing HFA research shows positive results, especially in the area of parent-child interaction and parental capacity. In addition, various studies indicate that those engaged in HFA services showed a significant decrease in their overall potential for parental stress and child maltreatment. Other findings, including results from 17 HFA-site evaluations, indicate health benefits for children whose parents participate in the HFA program. HFA sites across the country are reporting improved parent-child relationships and noteworthy increases in well-baby health visits and immunization rates.

To ensure that Healthy Families America does not meet the fate of so many other efforts—forced to water-down its effectiveness or narrow its reach when initial funding runs out—Prevent Child Abuse America launched the Campaign for Healthy Families. Chairing the Campaign is Leland C. Brendel, Chairman and Chief Executive Officer of Freddie Mac. The campaign seeks a minimum of $15 million by the end of 2001 to expand HFA in every state and to maintain and improve the quality of its services to better serve more families in more communities across the country. The Campaign is well underway and we are poised to meet our financial goal.
Ten-year goals for the HFA initiative include:

- ensuring that all states have a multi-disciplinary task force that can include public, private agency and chapter representatives working to obtain the necessary funding for Healthy Families America at the state level;
- establishing at least one HFA site in every state;
- ensuring that all states with more than one HFA site have the capacity to provide training and technical support;
- increasing eightfold the number of high-risk new parents receiving intensive home visitation nationwide; and
- continuing to significantly reduce the rates of child abuse and neglect in the population served.

II. Statement of the Problem

Lack of affordable housing, substance abuse, economic stress, inadequate health and child care, and limited or chaotic social supports make life overwhelming for many parents. Unable to cope, they too often take it out on those least able to defend themselves: their children.

While the nation’s crime rate fell 22 percent from 1993 to 1997, reports of child abuse and neglect grew by 8 percent and confirmed cases increased by 4 percent. In 1998 alone, more than three million children were reported abused or neglected. Even more tragic, at least three children died each day as a result of abuse.

Child abuse isn’t a problem confined to the families that experience it. Abusive parents often bring their troubles to the workplace. Abused children are more likely to commit crimes and have substance abuse problems. They tend to be poor learners and, over time, unproductive workers. They frequently drop out of school, become teenage parents, and abuse their own children.

Child abuse costs taxpayers billions of dollars each year to support governmental, legal and social services targeted at abusive parents and their children. Despite this level of funding, the current fragmented, crisis-oriented approach has failed. Results from our surveys, as well as those conducted by the Government Accounting Office (GAO), show that states continue to spend only a fraction of their child welfare resources on preventing child abuse before it happens.

III. The Rationale of Healthy Families America

While there are many approaches to working with new parents, a program of home visits, offered on a voluntary basis to parents and their babies, is one of the most promising.

Home visiting affords an opportunity to work with individuals in the family context, enabling the home visitor to learn first hand the conditions of life for the parent and child and to respond to them. Additionally, home visits provide a way to reach families that typically do not participate in center-based programs and families who are geographically isolated.

Home visiting programs also provide important support to new parents who are at risk for child abuse. The most recent brain development research findings make a clear case for voluntary home visitation in the earliest years of a child’s life. These findings indicate a window of opportunity during the first three years of life when a child’s brain is most able to respond and grow from positive interactions with his or her parents. A stimulating environment can maximize a child’s learning potential, physical health and brain development. HFA provides parents with the skills and knowledge to help their babies grow and thrive. HFA focuses on issues such as parent-child interaction and bonding, nutrition, health care and the well being of the family. It significantly increases children’s immunization rates and well-baby health visits.
IV. Growing Healthy Families America

Grounded in the belief that all families can benefit from support, we envision a day when all new parents will have the opportunity to receive the education and support they want and need at the time their baby is born. Under the leadership of the professionals at Prevent Child Abuse America and with the dedicated efforts of those working on the state and local level, HFA has become a successful national movement.

The effort is well underway in more than ____ communities around the country, but there is a long way to go to make support available to all new parents who wish to use it. To continue the momentum established thus far, we need more states to make home visitation part of their overall family support, school reform or welfare reform plans; expertise to be developed at the state and community level; and more funding to be directed towards HFA efforts. This proposal describes progress made to date and the steps we intend to take over the following years to move closer to our mission.

V. Components of the Healthy Families America Initiative

A. Implementing Programs

By making the most of existing community resources and developing collaborations between public and private partners, HFA avoids duplication efforts. Funds secured through the Campaign for Healthy Families will be used to implement programs through: (1) building upon HFA’s partnerships; (2) mobilizing public and private agencies to develop statewide plans for voluntary home visitation; and (3) establishing national and state-based capacity for ongoing training and technical support.

Partnerships:

HFA serves as a gateway into a community’s approach to supporting families. For it to succeed, every site must be intricately linked with the array of other services within the community and state. The most effective services are those that are coordinated and comprehensive. To that end, we have made the establishing of new partnerships and the fostering of existing partnerships a priority.

Prevent Child Abuse America has partnered with more than 25 national organizations, corporations and public agencies to promote the education and support of all new parents. Some of our partners include: the American Academy of Pediatrics (AAP), American Hospital Association, Cooperative Extension Systems of the U.S. Department of Agriculture (CES), First Steps, The National Association of Children’s Hospitals and Related Institutions (NACHRI), and the National Head Start Association.

With some partners, such as First Steps and Cooperative Extension, we are working to expand the scope of these programs to incorporate HFA components. With others, such as NACHRI and AAP, we are involving the medical community in the HFA initiative. These partnerships also have been successfully established at the state and local levels.

To assure that our partnerships reflect the diversity of the populations served by HFA, we are reaching out to organizations such as the National Black Child Development Institute, the National Council of the La Raza and the Native Indian Child Welfare Association. If HFA services are to be tailored to individual communities, then these organizations must have a role in assuring that the overall standards
of HFA also reflect an understanding of diversity. In addition, we will continue to support programs, such as early Head Start, First Steps and others to help maximize support networks within a community.

**Developing State Systems:**

To achieve our goal of providing high quality home visiting services and educational support to all families who want and need this service, it is necessary to further strengthen and develop our network of state systems. The state systems involve a network of individuals who are building capacity at the state level in the areas that will ensure program success: training and technical support, quality assurance, public awareness and advocacy. These systems have the capacity to support and maintain such an initiative over the long run. This type of infrastructure will help to facilitate effective communication and ensures that services are implemented as planned and designed.

Over the past year we have identified this network of individuals throughout the country who have expertise in such areas as: training, quality assurance, advocacy, public awareness and evaluation. This network remains our primary link to the states as well as to our HFA sites. Our Prevent Child Abuse Americas chapter network is an essential component of this effort.

The chapters account for approximately 50 percent of our primary state contacts. Many of the chapters have the capacity to provide critical support around advocacy, public awareness and securing long-term funding. Others are taking the lead in training, quality assurance and evaluation. We are continuing to strengthen the link between the chapter and HFA networks. Cultivating state leadership remains a priority as we recognize that to effectively build capacity, we must build a cadre of leaders to assume these various roles within each state.

Many states have created state level task forces or work groups to build a statewide presence and support for HFA and home visiting in their states. These task forces often take the lead in such efforts as developing strategic plans, securing long-term funding, advocating on behalf of HFA and building collaborative relationships with other home visiting and early childhood programs. There are approximately sixteen states that have established, statewide work groups. These same states have more advanced support systems in place for their HFA programs. Strengthening those existing systems, while cultivating new ones is critical for building state capacity.

In 2000, some of our priorities in this area include helping states build strategic plans for developing state systems for HFA, designing and hosting the annual State Leaders meeting that focuses on building capacity and sustaining the HFA initiative, providing technical assistance to more states, developing and revising materials and guides such as the Community Planning and Site Development guide to better assist states with their local HFA efforts, and producing a State Systems Development manual to more effectively guide the development of state systems.

**Developing Training and Technical Support Capacity Nationwide:**

Implementing an HFA program requires attention to a multitude of issues, including the context in which the program will be placed, the proposed target population it will serve, and the broader health, social service, economic and political environments in which it will operate. Training is one of the most important components of HFA and the program implementation process. It is both rigorous and comprehensive and includes many different training opportunities for staff members at varying levels of experience.
As the number of HFA programs continues to expand throughout the country, the demand for consistent and continuous training increases. Developing in-state training teams – comprised of at least one certified Family Assessment trainer and at least one Family Support trainer – has proven to be the most effective and cost-efficient mechanism for addressing this need. There are currently twelve states with in-state training teams and 8 states with at least one certified trainer.

Our training curriculum reflects and integrates the critical elements and our quality assurance standards. We also must be able to provide the special tools and unique information that our network demands. We believe we are at a crucial crossroads, where our curriculum must be updated and enhanced to incorporate up-to-date information in the following areas: working with families prenatally; literacy; brain development; and working with fathers.

In the year ahead, we are committed to meeting the demand for training, ensuring that this training is provided by certified trainers and linking the training curriculum with quality assurance mechanisms to further build the capacity among states and local programs.

In the year ahead, we are committed to identifying more states that have an on-going demand for training and to assist these states with building in-state training teams. In addition, we plan to develop and test a two-day supervisory training with curriculum to ensure that it reflects supervisor and staff needs. We expect that at least 75 percent of states with in-state training teams will include this in their regular training programs to enhance and improve the skills of supervisors thus improving overall service delivery to families. And finally, we will revise existing training materials to reflect new research and information on such topics as working with families prenatally, literacy, brain development and working with fathers.

Providing Training to Ensure National, State, and Local Development:

During the first years of HFA, training focused on the implementation of the critical elements (see attachment A) and emphasized quality. HFA trainers work with communities in determining how they can adapt specific components of the HFA approach without compromising service integrity. While each HFA site is tailored to meet the needs and build on the strengths of the community it serves, all embrace the critical program elements as defined by research and the positive experiences of other effective home visitation programs, including Hawaii’s Healthy Start.

On the national level, we will continue to convene HFA Conferences. These conferences allow program staff from across the country share their knowledge and expertise with one another. The last HFA Conference, the largest to date, took place in March 1999 and attracted more than 1,200 attendees – up from 350 in 1994. Our next HFA conference is scheduled for September 2000 in Atlanta.

In addition, we will continue to offer teleseminars - a cost effective and efficient way of offering follow-up support to HFA programs. Other components include: one-on-one follow-up between trainer and site; meetings of program managers and supervisors; and advanced trainings. All of these strategies are designed to ensure quality services at all sites.

To enhance state and regional coordination, we encourage quarterly or regional meetings of HFA sites. Indiana sites participate in quarterly technical assistance meetings and are sharing their experiences about collaborating with Illinois and Ohio. The states of New York, New Jersey, the District of Columbia, Virginia, and Maryland are exploring ways to pool their resources regionally. Over the next several years, we will continue to encourage states to develop the internal capacity to provide ongoing training and technical assistance.
Underscoring all of our training and technical assistance efforts is the recognition that it is a dynamic process. By working with partners such as the Cooperative Extension (CES), we have been able to clarify ways HFA and CES training complement one another and can be enhanced. Ultimately, we hope to offer joint trainings with a variety of our partners, including First Steps, Head Start, and CES.

B. Public Awareness, Education & Promotion

Public support and public awareness are central to the expansion of HFA. Local sites, state leaders, and state chapters must have the resources to launch their own public awareness efforts in order to develop and promote HFA in their communities. To this end, we are committed to educating the public about child abuse, prevention, and positive parenting as well as creating the necessary resources for sites, state leaders, and state chapters.

Prevent Child Abuse America employs a variety of methods to educate the general public. Through a partnership with the Ad Council, we have ongoing multi-media public awareness campaigns that reach every household in the country. Over the last several years, we have also collaborated with the National Basketball Association to develop a series of public service announcements featuring NBA players. This past year, we developed and ran two separate campaigns. The first campaign, which aired in the beginning of 1999, focused on educating the public about the severe consequences that can result from years of emotional neglect. This campaign, like those in the past, featured our 1-800-CHILDREN number where viewers could call to get more information on child abuse prevention and local efforts in their communities. During the first week of the nationwide airing of this television spot, calls to 1-800-CHILDREN increased four-fold, with the majority of the callers requesting our brochure on emotional neglect that we developed specifically for the campaign.

Our most recent ad campaign, titled “What Children are Made Of”, delivered an uplifting message about children, the joys of childhood, and our responsibility as adults to protect them. This spot made its debut in the summer of 1999 and was recently redistributed to again air nationwide beginning in January 2000.

Calls to 1-800-CHILDREN have been steadily increasing since the beginning of the year. In addition, our Web site is receiving an average of 50,000-90,000 hits per week and recently experienced a surge in activity with 240,000 hits in a one-week period alone!

Additionally, we educate the public about child abuse prevention and HFA through more than 70 publications, cause-related marketing ventures, television and radio talk shows, newspaper and periodical stories, and television magazine segments and specials.

These activities are only part of how we build support for HFA. Other methods include the development and distribution of materials from the national office to program sites, state leaders, and chapters on key issues including working with the media and the community to promote HFA efforts, how to benefit from and enhance the efforts of the 1-800-CHILDREN number, and how to start HFA sites in their communities.

During the next several years we intend to dramatically enhance the public’s understanding of how child abuse can be prevented. We will work to increase the general public’s awareness and understanding of HFA efforts as well as increase states’ involvement in the HFA initiative. We will also work closely with the media to promote child abuse prevention and HFA nationwide.
In 2000, we plan to develop educational materials, as well as media and promotional materials, press kits, HFA brochures, child abuse prevention month packets and promotional videos. HFA sites will be provided with user-friendly guides, templates and manuals to assist them with local media relations and public awareness efforts. In addition, we will continue to develop training guides and videos for use at HFA sites across the country. As research is disseminated and new public awareness plans evolve, we will continually provide sites, state leaders, and chapters with updated materials and technical support.

C. Assuring Program Quality

To ensure that all parts of the country can offer the in-depth training and quality controls necessary for effective Healthy Families sites, campaign funds will be used to develop standards and monitor systems for every HFA site.

Comprehensive planning and training offers programs a sound basis to begin. From the onset, HFA identified 12 critical elements that represent the standards of program excellence. To ensure that all HFA sites adhere to the critical elements, we partnered with the Council on Accreditation of Services for Families and Children (COA) to implement a rigorous quality assurance system — HFA Credentialing.

The purpose of HFA Credentialing is three fold: 1) to promote quality at every HFA site. 2) to protect each local effort by ensuring that anyone using the name adheres to the set of principles. 3) to allow HFA sites and state leadership to engage in independent and on-going quality management. Only those sites which adhere to all criteria, as determined through this credentialing program, will be entitled to use the trademarked name, Healthy Families America.

An essential component of the credentialing process is the use of Peer Reviewers who conduct on-site verification of programs' written self-assessments. Peer Reviewers are selected for their professional qualifications and experience in home visitation. We currently have a national team of 45 trained Peer Reviewers.

To move closer to our goal of quality support services available to all new parents, we offer our credentialing system to programs that embrace the HFA approach and want to be recognized as quality. To that end, the Council on Accreditation recently established its own home visitation standards using HFA's critical elements as the basis. HFA and the Council on Accreditation are establishing mutual recognition of their home visitation standards to further expand the HFA umbrella. Already, the American Academy of Pediatrics has given our credentialing system their seal of approval.

The pilot test of HFA Credentialing was completed in January 1997. Following the pilot phase, participants reviewed the process and refined the system before it was formally implemented. Since October of 1997, credentialing of single-site HFA programs has been ongoing.

The tools and process for credentialing multi-site systems were finalized this past December, field testing in two states began in January, with site visits occurring between August and November. Full implementation of the multi-site credentialing process is expected to occur in January 2000. To date, 46 programs have successfully completed the credentialing process and approximately 60 sites are expected to go through the process in 2000.
D. Research & Evaluation

To provide new insights on the most effective approaches to support new parents, as well as on how to tailor HFA to fit different communities, campaign funds are being used to implement a national research network and to develop a national data bank. In addition, a variety of site-specific and multi-site evaluations are underway to examine the relative influence different participant, service and community factors have on program outcomes.

Our National Center on Child Abuse Prevention Research plays a major role in expanding the field's understanding of the impacts of home visitation services and how best to implement them in various communities. To date, the Center has managed over $4 million worth of research, the majority of which has been supported by private foundations. Most relevant to HFA, the Center recently conducted a comprehensive assessment of Hawaii's Healthy Start program. This three-year study of 400 families included a 24-month follow-up. In addition, comprehensive evaluations have been completed on numerous prevention programs including agencies in the Greater Philadelphia community and agencies in various neighborhoods within Chicago and in the U.S. military. These findings have been used to identify program characteristics most likely to produce positive outcomes as well as the types of families most likely to benefit from early support.

In 1994, with funding from the Carnegie Corporation of New York, the Center established a Research Network with over 50 evaluators representing research projects in 25 states. The goals of the Research Network are to improve the quality, comparability and relevance of evaluations of HFA-type programs and to ensure they lead to a distinct improvement in our knowledge about how to most effectively deliver such services, particularly as HFA efforts expand. Network activities enhance the HFA program by providing empirically-based guidance to changes in training strategies, development of a quality assurance system and enhancement of the overall relationship between research and practice at HFA sites.

In 1998, our National Center on Child Abuse Prevention Research implemented a nationwide survey of HFA programs to track the development and quality of the initiative overall. This annual effort provides the most comprehensive data available on the characteristics of HFA programs and the services they provide to families.

Furthermore, the Research Center is moving forward with the development of a Program Information Management System (PIMS) to assist in the monitoring of HFA sites across the country. This computerized data system enables us to track the progress of HFA nationwide as well as to facilitate comparison among sites across the country. PIMS also enables sites to generate standard program reports to support data-based advocacy and fund raising efforts.

To facilitate the introduction of the PIMS into the field, the system has been divided into two phases. PIMS-1 is designed to collect program information related to program size, target community, funding, partnerships, staff characteristics, and participant assessment. PIMS-2 focuses on collecting data related to participant description and program participation level, including, participant characteristics, pregnancy and delivery history, participation and progress, services received, and the date and reasons for not remaining in the program. Once fully implemented, PIMS will enable us to efficiently gather information about the scope of HFA activities and generate a national HFA profile.

Developed in collaboration with Andersen Consulting, PIMS is now completed; The two components of the system, the Program Management Component and the Participant Level Tracking Component have been fully integrated and a demonstration of the full system occurred at the HFA pre-Conference in February. Since its launch in February 1999, seven PIMS trainings have been conducted across the
country, including state systems in Virginia, Oklahoma, Connecticut, Maryland, Pennsylvania, Michigan, as well as individual sites in Illinois, Ohio and Wisconsin.

The Center will continue to conduct controlled evaluation experiments involving HFA sites. Over the last several years the Center has been evaluating the partnership between a number of HFA (including Healthy Families Chicago, a site started to pilot test HFA in an inner city) sites and the U.S. Cooperative Extension Service. The evaluation of the Healthy Families Chicago program provides an exceptional opportunity to study the processes that impact effectiveness, endurance, and growth of HFA programs in a challenging urban community.

Finally, the Center is currently in the process of analyzing data from a pilot study, launched in September 1997, on factors influencing engagement and retention of families in HFA programs in Chicago. The purpose of the study is to examine methods that will improve enrollment, engagement, and retention in HFA programs across the country. The study examines families who resist HFA programs with two goals in mind: to identify variables whose presence indicates a high potential for a family to resist or drop out of services; and, to use this knowledge to refine recruitment and service delivery to better serve these families. Results of the Engagement and Retention study will be published in 2000.

E. Advocacy: Building for the Future

To meet our goal to secure diversified and sustainable funding for the HFA initiative, we will continue to explore and advocate for public sources of funding, including, Medicaid, welfare reform monies, and child health. We will also focus our efforts on expanding the capacity of HFA sites/state leaders to mobilize their efforts to identify and secure long term funding streams at the state, regional and national level. While foundation and corporate grants often provide seed money for new programs and research, long term funding is needed if HFA is to become permanent and self-sustaining.

State legislative initiatives are a promising way to guarantee stability for HFA services. So far twenty states have passed legislation to increase the availability and quality of home visiting services for families with newborns. Massachusetts, Arizona, and Illinois are just a few examples of states that have pursued these opportunities.

Over the past year, we continued to explore several long-term funding opportunities. Our efforts identified several new recently established funding streams including the Temporary Assistance for Needy Families (TANF) Block Grant and the State Children’s Health Insurance Program (CHIP). TANF is part of the 1996 welfare reform legislation which allows states increased flexibility in creating programs to assist needy families. To date, Indiana, Texas, Ohio, and Michigan have been able to access TANF funds for HFA services in their state. Indiana received $3.8 million in 1997-98 from TANF Maintenance of Effort (MOE) funds, which increased to almost $20 million for fiscal year 1999. The state is providing intensive technical assistance and training to HFA site managers and staff. HFA reaches all of Indiana’s 92 counties, and served an estimated 3,000 families in 1998. States that are currently working to access TANF funds include Florida, Oklahoma, Virginia, and New York.

Prevent Child Abuse America will continue to help our chapters and HFA sites access TANF funds. In May 1999, we released the first publication in the HFA Funding Series that provides detailed information on the TANF program. It includes an analysis of the potential impact of TANF provisions on the families that HFA serves, including time limits, work requirements, and family caps. In addition, it outlines an advocacy strategy for accessing the funds and highlights two state’s experiences in obtaining TANF funding.
Our second HFA Funding Series publication, *State Tobacco Settlement Dollars and Child Abuse Prevention Programs*, was released in September. The report was disseminated at the state leaders meeting and sent to our chapter network and primary state contacts. This document explains the tobacco settlement and how it can be used for child abuse prevention programs, including HFA. Already, Florida and Maine have received appropriations, and others are expecting to be able to access these funds. These funding series will strengthen our efforts to prevent child abuse and neglect by expanding and diversifying our funding sources.

We will also continue to assist states in drafting and advocating for HFA-related legislation. Typically this legislation provides funding to launch an HFA initiative, support a task force to study the feasibility of a statewide effort, and/or establish training capacity. Action alerts, legislative updates, sample letters to members of Congress, and one-to-one technical assistance are some of the ways we have worked with HFA state leaders.

This year, we continued to expand our efforts to develop partnerships between HFA and managed health care systems, Medicaid and other health insurance programs. As hospitals increasingly release new mothers and their infants within 24 to 48 hours of delivery, we will demonstrate the long-term benefits and the relative low cost of home visitor services in providing important after-care services. In such partnerships, for example, a managed health care organization could cover the initial family assessment for all new parents and if necessary, three or four home visits. Already a number of states including Michigan, Oregon, Virginia, Wisconsin, Indiana, Texas, Maine and the District of Columbia have received reimbursements from third party payers or managed care organizations for their home visitor services. As we continue to document their experiences, we will develop guidelines that sites can use to receive managed care and other third party payer support.

Over the next year, we also will continue to explore additional areas of funding. This requires us to continue to explore and advocate for public sources of funding, including Medicaid, TANF, tobacco settlement funds and child health. We will also continue to focus our efforts on expanding the capacity of HFA sites and state leaders to mobilize their efforts to identify and secure long-term funding streams at the state, regional and national levels.

**VI. Conclusion**

The Healthy Families America initiative has evolved at an extraordinary pace. Representatives from public and private agencies, as well as committed civic volunteers, have sent a message that they are ready to invest in prevention. Broad-based coalitions have come together and have committed resources to make services more responsive to the needs of families and children. As a result of these efforts, more than ___ HFA sites have opened their doors. Moreover, planning that ensures these services are included as part of a state's long term strategy for supporting families is underway in nearly all fifty states.

As the movement continues to thrive, there will be many challenges and opportunities. First, to keep the HFA vision at the core of our efforts while striving for the expansion of home visitor services nationwide. Second, to maintain a focus on quality to assure that all new parents receive and benefit from the services they want and need. And third, to promote the vision of voluntary home visitation so that one day it will be available to all families who wish to participate. With support and leadership from _____, we believe that these challenges can be met during the forthcoming years.
**SEEKING THE GIFT**

**Solicitation Strategies to Consider**

* Introduce the organization to the prospect
  - Frequent, sharp newsletter
  - Special-status letter from the CEO
* Invitation to organization’s facilities for:
  - Meetings
  - Open house
  - Special events
  - CEO meal
  - Academic, health care, planned-gift seminars
* Trustee- or volunteer-hosted luncheons, dinners, etc.
* Consultation sessions to market test the case
* Invitation to a special council or committee for public relations or special purpose involvement
* Cold call “to get acquainted”
* Sequences of impelling (but not soliciting) communications
* Create desire for personal achievement through personal gift objectives

**Techniques for Solicitation**

* Person to person (one-on-one with printed or non-printed presentation)
* Verbal presentation, letter follow-up
* Special printed presentation with personal follow-up
* Special printed presentation with letter follow-up

**Forms for Solicitation**

* Place for solicitation
  - Neutral environment preferred
  - Organization environment
  - Prospect’s environment
* Suggest underwriting
  - People
  - Physical facilities
  - Programs and services
  - Endowment for security and stability
* Methods of giving
  - One-time cash gift
  - Multi-year (3 to 5) cash gift
  - Cash plus assets
    - Securities
    - Life insurance
    - Real property
    - Personal property
Appendix E

Service Provision Documents
SAMPLE RECORD SCREEN

<table>
<thead>
<tr>
<th>DC</th>
<th>OB Chart Note</th>
<th>OB Chart Note</th>
<th>OB Chart Note</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NSY Chart Note</td>
<td>NSY Chart Note</td>
<td>NSY Chart Note</td>
</tr>
<tr>
<td></td>
<td>NA; Phone Interview</td>
<td>NA; Phone Interview</td>
<td>NA; Phone Interview</td>
</tr>
</tbody>
</table>

FAW Worker _____________________  Service Area ______________ TA ______ Date __________
Hospital ________________________________ OB___________________ PED ___________________
Address________________________________________________________________________________
Mother's Name ________________________ (AKA) __________________ Birthdate/Age _________
Address____________________________________________ Phone _____________________________
Date of First Prenatal Visit ___________________

EDC_____Delivered_____G_____ P_____
ITOP_____ SA_____ C/S_____VAG_____

Infant                M     F      NICU   NIN     NORM U        Y    N
Gram Weight        Sex              Nursery Care            Multi-Births            GA     APGAR

Circle Appropriate Health Insurance
a) Medicaid
b) List other major sources of health insurance in your state
c) Other
d) No Insurance
e) Unknown

RECORD SCREEN

1) Marital Status: Single, Separated, Divorced, Widowed
2) Partner unemployed
3) Inadequate income per patient or no information regarding source of income
4) Unstable housing
5) No phone
6) Education under 12 years
7) Inadequate emergency contacts.
   If given, relationship/name _____________
   phone _____________
8) History of substance abuse
9) Late prenatal, no PNC, poor compliance
10) History of abortions
11) History of psychiatric care
12) Abortion unsuccessfully sought or attempted
13) Relinquishment for adoption sought or attempted
14) Marital or family problems
15) History of current depression

1) Screen Result
   Positive _____
   Negative _____

2) Screened Positive, Not Assessed
   □ Refused
   □ Missed at hospital
   □ Adoption
   □ Deceased baby
   □ CPS status
   □ Other

3) Assessment Result
   □ Assessed Negative
   □ Assessed Positive

4) Referrals for Community-Based Services
   □ Public health nurse
   □ Private social services
   □ Primary medical doctor
   □ Other community-based organizations and agencies
   (Put the names of CBO in your program area here)

5) Not Taken Into Home Visitor Service
   □ Refused
   □ No home visitor service available
   □ CPS Status (See below)
   □ Other (specify)

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Record Screen Definitions and Clarifications

1. Self-explanatory.

2. Pertains to spouse or partner who will be involved with mother and baby in such a capacity. If no known partner, then FALSE.

3. Inadequate income means Medicaid, employed without insurance or stated concerns about finances by family.

4. No home, uncertain of having home or questionable address, such as homeless shelter.

5. Self-explanatory.


7. No immediate family (i.e., parents, siblings, partner) listed for the emergency contact or no phone given for the emergency contact.

8. Excessive use of drugs or alcohol.

9. Prenatal care started after the 12th week of pregnancy, poor compliance (i.e., missed appointments or not following medical advice) or no prenatal care.

10. Two or more ITOPS ever or one ITOP within the 12 months of current pregnancy.

11. History of psychiatric care or active psychiatric care (does not include counseling for "life crisis").

12. Abortion considered this pregnancy.

13. Adoption considered this pregnancy.

14. Marital or family problems refers to any indication of discord among family members as relevant to the patient.

15. Self-reported or staff reported.

Scoring:

- T = True
- F = False
- U = Unable to ascertain truth value (i.e., unable to obtain information from chart)

Positive Screen: 1) True score on either #1, #9, or #12.
2) Two or more True scores.
3) Seven or more Unknowns.
<table>
<thead>
<tr>
<th>Mother</th>
<th>Father</th>
<th></th>
<th>Score</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5-10</td>
<td>0-5-10</td>
<td>1. Childhood History</td>
<td>0-5-10</td>
<td>0-5-10</td>
</tr>
<tr>
<td>0-5-10</td>
<td>0-5-10</td>
<td>2. Substance Abuse, Mental Illness, or Criminal History</td>
<td>0-5-10</td>
<td>0-5-10</td>
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<tr>
<td>0-5-10</td>
<td>0-5-10</td>
<td>3. Previous or Current CPS Involvement</td>
<td>0-5-10</td>
<td>0-5-10</td>
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<tr>
<td>0-5-10</td>
<td>0-5-10</td>
<td>4. Self-Esteem, Available Life-Lines (Possible Depression), Coping Skills</td>
<td>0-5-10</td>
<td>0-5-10</td>
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<tr>
<td>0-5-10</td>
<td>0-5-10</td>
<td>5. Stressors/Concerns</td>
<td>0-5-10</td>
<td>0-5-10</td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

Mother Father
SAMPLE CONSENT AND AUTHORIZATION FORM

I, ___________, am interested in having a ______________ (name of program) Family Support Worker contact me. I understand that this person will provide me with assistance as needed to the best of their ability.

Permission is hereby given to ______________ (name of program) to release information concerning myself and my family to the below-named agencies and individuals. This consent will also authorize the named agencies and individuals to release information to _________________ (name of program).

1. OB ____________________________ Needs of family/referrals made
2. PED ___________________________ Needs of family/referrals made
3. PHN ___________________________ Needs of family/referrals made
4. TIME-OUT NURSERY ___________ Needs of family/referrals made
5. OTHER ________________________ Needs of family/referrals made
6. DHS ____________________________ Program Evaluation

Signed: ________________________________ Date:__________
Witness: ________________________________ Date:__________

This consent is to remain in effect for the duration of services. This consent is subject to revocation upon my written request, as of the date of receipt by _________________ (name of program).

I, ___________, understand that _________________ (name of program) services are not available at this time.

I, ___________, am not interested in _________________ (name of program) services at this time.
Healthy Families Anytown, USA

Healthy Families Anytown is a new program in our community to assist families of newborns. It is the first program of its kind in our area. Since it is so new, Healthy Families Anytown is only available in one area of town and to a limited number of families.

What can Healthy Families Anytown do for me?
The purpose of Healthy Families Anytown is to help you relieve some of the stress of having a new baby and coping with other situations at the same time. Your Family Support Worker will become a friend that you can count on! She will help you decide what you want out of life and then help you get it!

What can Healthy Families Anytown do for my baby?
Your Family Support Worker can help give you and your baby the most valuable gift of all - a loving, nurturing, happy family. She will teach you ways to care for your baby that will help him/her become the very best he/she can be.

What about my husband (boyfriend) and other children?
Healthy Families wants to help strengthen your family life. We want to involve the baby’s father whenever possible and also help you with your other children.

When does this take place?
Usually, your Family Support Worker will visit with you in your home. She may also take you to doctor’s visits or other appointments.

How much does it cost?
All Healthy Families Anytown services are free, thanks to support from state/local governments and private funders.

What if the program is full?
If Healthy Families Anytown is full when you deliver your baby, the Family Support Worker will visit with you, tell you about services in our community that would be helpful and give you information about other programs.
SAMPLE CONFIDENTIALITY POLICIES

How do we keep your information confidential?

❖ Records are kept in a locked file.

❖ Records cannot be removed from office areas unless they are signed out for a specific purpose.

❖ Information is shared only on a need-to-know basis with appropriate staff, consultants and other professionals.

Who can see your records?

❖ Appropriate staff members of _________________ (name of program).

❖ Consultants on a need-to-know basis.

❖ You can see your own records, but not those of others.

How do we use your confidential information?

❖ To assess the needs of you and your child(ren) in areas of health, social services and education or training.

❖ To make reports to our funders (your name is not used).

❖ To work cooperatively on your behalf with other agencies. (You will sign consent forms to allow this exchange of information with health professionals, consultants, etc.)

Are there times when we would share information about you without your permission?

❖ If we have reason to believe any child is being abused or neglected, we are required by law to report it to the Department of Human Services.

❖ You will be informed before any such report is made, except in a life-threatening emergency.

❖ Such reports are made so families will receive the assistance they need to help keep their children healthy and safe.
Family’s Rights and Confidentiality Policy

____________________ (name of program) shall ensure that the following policies and procedures are provided so that a family’s rights are protected in accordance with Federal and State requirements:

* The right to services that respect your personal liberty.
* The right to an individualized, written service plan (to be developed upon program entry), periodic review and re-assessment of needs and appropriate revisions of the plan.
* The right to ongoing participation in the planning of services to be provided and in the development and periodic revision of the services plan.
* The right to refuse service.
* The right to confidentiality of records.
* The right to access, upon request, of one’s own records.
* The right to referral, as appropriate, to other providers’ services at anytime, including upon discharge from the program.

Parent/Guardian Signature _____________________________  Date __________
Home Visitor Signature _____________________________    Date __________

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## INDIVIDUAL FAMILY SUPPORT PLAN

<table>
<thead>
<tr>
<th>Family:</th>
<th>Admission Date:</th>
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<tbody>
<tr>
<td>Address:</td>
<td>Today's Date:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Frequency of visits during this six (6) month period:</td>
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<tr>
<td>FSW:</td>
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### Family Strengths

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### Health Information

<table>
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<tr>
<th>Medical Home (Baby’s M.D.):</th>
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Are immunizations up to date? YES NO
(if no, explain)

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<tr>
<th>How do you know?</th>
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<tr>
<td>care givers</td>
</tr>
<tr>
<td>PIN/PMD</td>
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<tr>
<td>saw immunization card</td>
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<tr>
<td>other</td>
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### Other Community Services We Use

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### Other Family Accomplishments During IFSP Period

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# Sample IFSP

<table>
<thead>
<tr>
<th>What we want</th>
<th>Who will do it</th>
<th>By when</th>
<th>What happened</th>
<th>Date</th>
<th>FSW:</th>
<th>Date</th>
<th>FSW:</th>
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Plan Signed By: Parent(s) __________ Date: __________
Review Signed By: Parent(s) __________ Date: __________
Manager / Supervisor __________ Date: __________
Manager / Supervisor __________ Date: __________

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SAMPLE TRAINING REQUEST
FORM

Guidelines

* The Training and/or Materials Request Form (TRF) must be completed and mailed to Prevent Child Abuse America (PCA America) at least one month prior to the desired training date.

* The date of the actual training will depend upon the availability of HFA trainers.

* The form must be completed as specifically and descriptively as possible.

* Each site, whether new or existing, must complete a separate TRF.

* Training will be scheduled after the TRF is received by PCA America.

* A copy of the TRF will be forwarded to the HFA trainers who will conduct your training, thereby familiarizing them with your program.

Please note, although it is important that all Critical Elements are in place, HFA is not a replication model. As such, it is appropriate that specific strategies may be unique to the community and families served, without compromising the HFA Critical Elements.

Please return the completed Training Request Form to:

Attn: Diana Jemison, Training Coordinator or
Phyllis Medrano, Training Assistant Coordinator
Prevent Child Abuse America
200 S. Michigan Ave., 17th Floor
Chicago, IL  60604
If you need assistance completing the Training Request Form or have any question, please call Phyllis Medrano at 312/663-3520 ext. 115.

Healthy Families America Site ________________________________

Administrative Organization _______________________________________

Contact Person ____________________________________________________

Address ____________________________________________________________________________

City __________________________ State ________ Zip _______________

Phone __________________________ Fax __________________________

E-mail __________________________ Today’s date ________________

**What are you requesting?**

- Trainer for FSWs ☐
- Trainer for FAWs ☐
- Materials ☐

**Date training is requested:** (Please provide a 1st and 2nd choice for the week you would like to schedule training, i.e., 1st choice: January 10th - 14th or 2nd choice: January 17th - 21st.)

1st choice __________________________ 2nd choice __________________________

If you are not requesting a trainer, who is providing your training?

FSW Trainer: __________________________

FAW Trainer: __________________________

Is this a **New Program** ______ or an **Existing Program** ________?

How long has the program been in existence? ______________

Have you completed and submitted the HFA Application for Affiliation?
Yes □  No □  Unsure □

**Program Descriptors:**

1. **Program’s geographic service area** (CHECK ONE)
   - □ Multiple counties
   - □ Multiple cities
   - □ Neighborhood
   - □ Single county
   - □ Other (specify) ____________________________

2. **Type of communities served** (CHECK ONE)
   - □ Urban
   - □ Suburban
   - □ Rural
   - □ Mixed, urban/suburban
   - □ Mixed, urban/rural
   - □ Mixed, urban/suburban/rural
   - □ Other (specify) ____________________________

3. The program’s target community includes more than 25% of the following ethnic groups:  
   - Yes □  No □  Unsure □
   - American Indian/Alaskan Native
   - Asian/Pacific Islander
   - Hispanic/Latino
   - White, non-Hispanic origin
   - Other
   - Specify ethnicity ___________________ and ______ %

4. **Program’s target population** (CHECK ONE)
   - □ All births
   - □ First-time parents
   - □ Teen parents
   - □ Other (specify) ____________________________
5. How many births occur in your target area annually? __________

6. Please list the anticipated number of staff that will attend this training and/or any materials you will need for this training:

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Manuals</th>
<th>Handouts</th>
<th>Certificates</th>
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</thead>
<tbody>
<tr>
<td>FSWs</td>
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<td>FAWs</td>
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<tr>
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<tr>
<td>Manager/Director</td>
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</table>

7. Will you need HFA training videos for your training?  
☐ Yes ☐ No

8. Please indicate which track the Supervisor(s) and Manager(s) will be attending.

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<thead>
<tr>
<th></th>
<th>FSW</th>
<th>FAW</th>
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</thead>
<tbody>
<tr>
<td>FSW Supervisors</td>
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</table>
# RECOMMENDED WRAPAROUND TRAINING

The wraparound training topics and hours are presented as general guidelines and recommendations. HFA program sites may choose to provide these or additional topics in any sequence that meets their organizational needs, and may decide to devote more or less time to the training topics, in order to provide their staff with sufficient knowledge in the subject areas.

<table>
<thead>
<tr>
<th>Wraparound training topics to be covered prior to direct work with children &amp; families</th>
<th>Hours</th>
</tr>
</thead>
</table>
| **Orientation**  
Learning Objectives: Familiarize staff with site-specific operating policies and procedures. Include information on the services provided, work hours, supervision requirements, emergency procedures, confidentiality issues, etc. | 3 |
| **Dynamics of Child Abuse and Neglect**  
Learning Objectives: Understand possible causes, types, and impact of child abuse and neglect on family and community, and learn appropriate interventions to use. Learn what indicators may be present if abuse or neglect have occurred. | 6 |
| **Child Protective Services (CPS) Reporting**  
Learning Objectives: Present information on state child abuse and neglect reporting laws, mandated reporter status, and agency reporting procedures. Participants are informed of the possible courses a case can take upon referral to CPS. The reporter’s emotional reaction and the need for supervisory support are to be explored. | 2 |
| **Introduction to Community Resources**  
Learning Objectives: Become familiar with community resources available to address the challenges faced by program participants. Information must be directed to facilitating referrals and appropriate utilization of community services. | 3 |
| **Site Visits to Community Resources**  
Learning Objectives: Conduct on-site visits to the referral sites to become familiar with available community resources. | 5 |
| **Shadowing**  
Learning Objectives: Observe other home visitors working with families to gain an understanding of the realities and practicalities of working with families in their homes. | 5 |
<table>
<thead>
<tr>
<th>Wraparound training topics recommended for completion within six months of hire</th>
<th>Hours</th>
</tr>
</thead>
</table>
| **Communication Skills**  
Learning Objectives: Enable clear transfer of ideas and thoughts using verbal, written and listening skills. | 3 |
| **Crisis Intervention**  
Learning Objectives: Explore appropriate interventions to use when handling crises with the families, team members or in one’s personal life. | 3 |
| **Developmental Screening**  
Learning Objectives: Provide an overview of developmental screening and its benefits. Develop basic proficiency in administering the site’s screening tool and understand the tracking system that will be used to monitor the completion of screens and the resulting referrals for assessment and diagnosis. | 3 |
| **Domestic Violence**  
Learning Objectives: Explore the dynamics of domestic violence, the general characteristics of the victim and the batterer and the impact of domestic violence on infants and children. Define appropriate methods for intervention by home visitors, including maintaining personal safety, assisting the victim in writing a safety plan with emphasis on utilizing problem-solving strategies and community services and referrals. | 3 |
| **Family Planning**  
Learning Objectives: Learn about methods currently available that allow a woman to control her fertility rate. Appropriate nonjudgmental methods for sharing information with parents should be discussed. | 2 |
| **Financial Management**  
Learning Objectives: Learn to help families develop an appreciation for household budgeting, and know when and how to access financial assistance. | 3 |
### Recommended Wraparound Training Topics

<table>
<thead>
<tr>
<th>Wraparound training topics recommended for completion within six months of hire</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant Development I (0-6 months)</strong></td>
<td>7</td>
</tr>
<tr>
<td>Learning Objectives: Understand the dynamics of normal human growth and development beginning prenatally, including an overview of the neurologic development of infants, nurturing techniques, the important role of the parent-child relationship, indicators of mental health problems and techniques for providing an environment conducive to healthy growth and development. Emphasize development of observation skills, proper use of supervision and utilization of community resources when the infants’ well-being and mental health is a concern. (Nutrition and feeding can be presented as a separate component.)</td>
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<tr>
<td><strong>Infant Development II (6-18 months)</strong></td>
<td>7</td>
</tr>
<tr>
<td>Learning Objectives: A continuation of Infant Development I focusing on ages six to eighteen months. Emphasize information that should be transferred to the parents while addressing positive parent-child interaction, including nurturing techniques. Also address developmental issues such as separation anxiety, “spoiling”, toddler exploration and biting.</td>
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</tr>
<tr>
<td><strong>Perinatal Loss</strong></td>
<td>3</td>
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<tr>
<td>Learning Objectives: Understand the ways perinatal loss impacts families and become knowledgeable of strategies that can be implemented by supervisors and FSWs in helping families integrate such losses into their lives.</td>
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<tr>
<td><strong>Pregnancy and Prenatal Care</strong></td>
<td>6</td>
</tr>
<tr>
<td>Learning Objectives: Become familiar with the prenatal period, including information to share with the family for the successful completion of the pregnancy, such as establishing a medical home and keeping prenatal appointments to provide positive birth outcomes. Include information specific to nutrition, exercise, emotional changes and the importance of medical care. (Additional training hours may be necessary for programs serving families prenatally.)</td>
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</tbody>
</table>
### Recommended Wraparound Training Topics

<table>
<thead>
<tr>
<th>Training Topic</th>
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<tbody>
<tr>
<td><strong>Wraparound training topics recommended for completion within six months of hire</strong></td>
<td></td>
</tr>
<tr>
<td>Problem-Solving Skills</td>
<td>3</td>
</tr>
<tr>
<td>Learning Objectives: Learn appropriate methods for addressing challenges encountered in providing direct service to families.</td>
<td></td>
</tr>
<tr>
<td>Safety in the Home and Community Environment</td>
<td>3</td>
</tr>
<tr>
<td>Learning Objectives: Provide basic safety information for homes with infants, toddlers and preschoolers. Learn how to present information to parents in a respectful, nonjudgmental manner.</td>
<td></td>
</tr>
<tr>
<td>Stress Management and Personal Health Issues</td>
<td>5</td>
</tr>
<tr>
<td>Learning Objectives: Examine methods to maintain energy and staff commitment. Explore health issues related to provision of home-based services and precautions to take for maintenance of personal health.</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>3</td>
</tr>
<tr>
<td>Learning Objectives: Learn the symptoms, dynamics, origins, family challenges and appropriate interventions associated with substance abuse. Address its impact on consistent, nurturing parenting.</td>
<td></td>
</tr>
<tr>
<td>Team Building: Getting Acquainted</td>
<td>7</td>
</tr>
<tr>
<td>Learning Objectives: Gain familiarity and understanding about each person’s uniqueness. Learn to incorporate teamwork and trust into the work environment.</td>
<td></td>
</tr>
<tr>
<td>Toddler Development I (18-24 months)</td>
<td>4</td>
</tr>
<tr>
<td>Learning Objectives: Explore the life of the toddler, including discipline, fears, limit-setting, motor skills, feeding, sleeping, language development, play, toilet training, attachment and separation.</td>
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</table>
### Recommended Wraparound Training Topics

<table>
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<th>Training Topic</th>
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<tbody>
<tr>
<td><strong>Values Clarification</strong></td>
<td>3</td>
</tr>
<tr>
<td>Learning Objectives: Examine that which makes us who we are, our values. How are they formed? What if other people’s values are different from our own?</td>
<td></td>
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<tr>
<td><strong>Well Baby Care</strong></td>
<td>4</td>
</tr>
<tr>
<td>Learning Objectives: Explore the components of normal well baby care. Include information to be shared during parent education, such as recommended schedules for immunizations and physician visits. Provide instruction on basic infant care such as bathing, taking a temperature and diaper changing.</td>
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<tr>
<td><strong>Worker Safety</strong></td>
<td>2</td>
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<tr>
<td>Learning Objectives: Address personal safety issues that may arise when providing home visiting services; discuss site-specific safety policies and procedures. Provide an opportunity to address specific concerns within the community.</td>
<td></td>
</tr>
<tr>
<td><strong>Working Effectively with Parents</strong></td>
<td>4</td>
</tr>
<tr>
<td>Learning Objectives: Participants will gain an understanding of various learning, teaching, counseling and communication styles that are most effective in working with parents to support family growth.</td>
<td></td>
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<tr>
<td><strong>Working with HIV/AIDS-Impacted Families</strong></td>
<td>3</td>
</tr>
<tr>
<td>Learning Objectives: Become knowledgeable and sensitive to the physical, psychological and emotional manifestations of providing services to a family that has an HIV/AIDS-infected family member.</td>
<td></td>
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</tbody>
</table>
Bibliography


3 Ibid.


5 Ibid.


10 Ibid.


Jester and Guinagh, 1983


National Resource Center on Homelessness and Mental Illness

National Vaccine Advisory Committee [NVAC] (1991)


Project Success State Steering Committee & North Central Regional Educational Laboratory. (1996). Working Together Toward Success: A Guidebook for Planning and Implementing Project Success in Your Community. Oak Brook, IL: North Central Regional Educational Laboratory.


ADDITIONAL RESOURCES

Prevent Child Abuse America
200 S. Michigan Avenue, 17th Floor
Chicago, IL  60604
Phone: 312/663-3520
Fax: 312/939-8962
www.preventchildabuse.org

Prevent Child Abuse America’s staff in the following areas are available to provide assistance and answer your questions:

Administration/Finance
Advocacy
Chapters Network
Healthy Families America/Programs
  Credentialing
  State Systems
  Training and Technical Assistance
Marketing and Communications
Research and Evaluation
Resource Development

Publications


