



Healthy Families Virginia GUIDANCE MANUAL

NARRATIVE

This *Healthy Families Virginia (HFV) Guidance Manual* is comprised of a set of recommendations and guidance to assist HFV sites in implementing the *2014-2016 Healthy Families America (HFA) Best Practice Standards* within the expectations of HFV's multi-site system.

The TA/QA Team had initially revised 2010 accreditation sample site policies as well as developed new ones to help sites be in alignment with the new HFA *Standards* (released April 2014), but subsequently determined that developing guidance for sites would be a far better tool for providing written technical assistance and support.

A review of *HFV's Multi-Site Policies and Procedures* led to discussions on the types of guidance given to sites this past year during annual QA site visits as well as recurring technical assistance issues related to the interpretation and implementation of the new *Standards*. This further led to a collective review of each HFA standard in light of HFV's five functional areas (administration, evaluation, policy, quality assurance and technical assistance, and training) and our expectations as a multi-site system.

What emerged was the document you now have before you, i.e., a list of key topical areas for focus, clarification, and guidance as you interpret and implement the *2014-2016 Healthy Families America (HFA) Best Practice Standards*. The *Manual* will be used by HFV TA/QA Specialists as a teaching tool when providing technical assistance during annual QA site visits. Yet it is also our hope that it will serve as a tool for sites to use and refer back to whenever they have a standards question, be it about HFV, their own practice, or the development of site-specific policies and procedures. Sites are also free to reference it when searching for language/verbiage to use when writing their own policies and procedures.

The *Manual* will be distributed to sites and initially reviewed at a Directors' Network Meeting. It will be added to HFV's *Quality Assurance Plan* to be reviewed and updated every two years. Updated copies will then be distributed and reviewed with HFV Directors and site staff.

Technical Assistance for: Policy and Procedure Development

May 2015

What is the need for policies?

Policies act as a guiding frame of reference for how an organization deals with everything from its daily operations or how to respond to requirements to comply with legislation, regulation and codes of conduct/practice. They are designed to influence and determine all major decisions and actions and all activities take place within their boundaries.

What is a policy?

Policies are clear, simple statements of how your agency/program/organization intends to conduct its services, actions or business. They provide a set of guiding principles to help with decision making. Well written policies are:

- Consistent with the values of the organization
- Ensure consistency in decision making
- Foster stability and continuity
- Provide a framework for planning
- Help clarify functions and responsibilities

What is a procedure?

Procedures describe how each policy will be put into action. They explain how to perform tasks and duties. Each procedure should include:

- Who will do what
- What steps need to be taken
- Which forms or documents to use

HFA Definition of a policy:

“Written statements of principles and positions that guide site operation and services which are typically approved by the governing body, the host agency and/or appropriate administrative body.”

HFA Definition of a procedure:

“The step-by-step methods by which broad policies are expected to be implemented and site operations are to be carried out. Procedures are clearly outlined in writing within the site’s Policy and Procedures manual.”

Remember: The policy is the “what” and the procedure is the “how.”

**Technical Assistance:
The Art of Reading HFA’s Best Practice Standards
When Preparing a Self-Study**

May 2015

Reading and understanding the Standards is an art form of sorts. Those new to the task often think if they read the Standard and respond to it, they have accomplished what was asked for. Yet, many of the Standards require integrating some or all of the following in one’s response:

- the **Standard** itself;
- the information contained in the **RATING INDICATORS box**;
- information found in the **chart** at the end of each Standard;
- information found in the Standards “**front matter**” (found on pages 2-16); and/or
- information found in the **Intents**.

One good way to grasp this is to take a look at specific examples.

Thus, **Standard 4-2.A** calls for the site to have “policy and procedures that clearly define the levels of service (e.g., weekly visits, bi-weekly visits, monthly visits, etc.) offered by the site and the criteria for moving to a different level of service.” That seems fairly straightforward until we go on to read the **Intent**, which provides a list of “typical levels and associated case weights” and also responsibilities for both the home visitor and the parent that could be incorporated into level change criteria.

These case weights and enumerated role responsibilities seem like useful suggestions until we read the **4-2.A RATING INDICATORS box**, which reflects that in order to pass this Standard (i.e., obtain a “2” rating) sites’ policies and procedures must “define levels of service and criteria for level change *that include the criteria listed above*,” i.e., the role responsibilities enumerated for FSWs and parents! Similarly it is expected that sites will assume the new practice of assigning Level X families a case weight of “0.5 to 2 points, i.e., equal to the family’s level prior to being placed on creative outreach *to ensure space is retained to move the family back to that level if they are re-engaged*” by incorporating this into their 4-2.A Policy, too.

But this isn’t the end of it. If we then proceed to the **Chart at the end of Standard 4**, we find that in addition to submitting a Level Change Policy (4-2.A), we also need to 1) “Submit a report showing home visit completion rates by family for the most recent quarter” (4-2.B) and 2) a “Plan to increase home visit completion [rates], including which

strategies have been implemented” (4-2.C) before we move on to drafting our next policy in response to 4-2.D.

Standard 4-2.D, which requires that sites have “policy and procedures regarding the process for reviewing progress made by families that include how the home visitor, the family, and the supervisor are involved in the level change decision,” certainly appears more straightforward than 4-2.A until we, once again, review the **Chart at the end of Standard 4** and find that in addition to submitting a Policy, we are expected to “submit ... blank level change forms.” And so on and so on it goes. The examples are numerous but let’s look at just one more, one which requires a review of the Standard’s “front matter.”

Standard 3-4.B requires sites to “comprehensively analyze at least once every 2 years (e.g., both formally through data collection and informally through discussions with staff and others involved in site services), which individuals dropped out of the site, at what point in services and why.” It then directs the reader to “**Please see common terms associated with analyses beginning on page 13.**” There we learn HFA’s definition of Retention Rate, their methodology for calculating it, and expectations for conducting and writing a retention analysis, including the programmatic, demographic, and social factors that ought to be addressed. Whew!

In conclusion, reading the Standards involves circling around and around, taking the broadest possible view of what’s being asked for, and sifting and sifting. Although there’s no need for providing *more* information than what’s asked for, it is crucial to be thorough in determining **just exactly what is being asked for** before constructing a response. If you can master this sensibility, you’re well on your way to assembling a comprehensive self-study.



Healthy Families Virginia Guidance

Critical Element 1: Initiate services prenatally or at birth.

HFV Guidance:

- ❖ **CE 1-1.A** Ensure your target population is narrow and that you have community data to justify the target population you've chosen. This community data should be a part of your target population description (i.e., all potential families) and should be ≤ 2 years old. Also, consider the accessibility of families when defining your target population as well as your site's staff capacity.
- ❖ **CE 1-1.B** Developing and maintaining relationships in the community is key to maintaining your target population access point(s). Touch base with your partners at least annually to discuss your partnership and, ideally, at least every 6 months.
- ❖ **CE 1-1.C** Identify the number of births in your target population then divide the number of screens you have completed by this number of births to determine the percentage of potential families you are screening. Monitor the number of families every six months. Make this monitoring part of your site's *Quality Assurance Plan*.
- ❖ **CE 1-2.** Be aware of the timeliness of each step of your process – i.e., from referral, to screen, to assessment, to the offer of home visiting services – as timeliness of service provision is crucial to enrollment. The shorter the period of time between referral and assessment to the offer of home visiting services, the more likely the family will enroll and engage in your program.
- ❖ **CE 1-2.C** Remember that no more than 20% of your assessments can occur later than two weeks after the birth of the baby.
- ❖ **CE 1-2.D** Create a system for keeping contact information current for families who screened positive so that an assessment can be offered.
- ❖ **CE 1-2.E** Annually monitor the families who verbally decline an assessment or home visiting services in order to better connect with,

- engage, and enroll families. Make this a part of your site's *Quality Assurance Plan*.
- ❖ **CE 1-4.B** Use the HFA tool, *Standard 1 Spreadsheet (1-1.C, 1-2.C-E, 1-3.B, and 1-4.A-C Screening/Assessment Data plus Acceptance Analysis Grid)*, when conducting your biennial *Acceptance Analysis*. This *Analysis* must include the collection of all relevant data, staff input, a summary of trends, and a plan of improvement based upon those trends.

 - ❖ See HFV's ***Best Practice Recommendations*** on 1) *Assessment* and 2) *Prenatal Enrollment* for additional guidance.

Multi-Site Functional Areas: Policy and Quality Assurance/Technical Assistance.



Healthy Families Virginia Guidance

Critical Element 2: Use standardized screening and assessment tools to systematically identify and assess families most in need of services. These tools should assess the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences.

HFV Guidance:

- ❖ **CE 2-2.** Be sure to use the *Parent Survey* or *KEMPE Family Stress Checklist* as your assessment tool. Document only what the parent says, i.e., the facts. Do not include interpretive or judgmental statements. Write detailed narratives and use actual quotes whenever possible. Be sure to ask about the FOB, even if he is not present, and to document what MOB says about his background/current circumstances.

Dual role staff (Home Visitor/Assessment Worker) should be particularly careful to consistently cover all areas on the *Parent Survey*.

- ❖ See HFV's **Best Practice Recommendations** on 1) *Assessment* and 2) *Prenatal Enrollment* for additional guidance.

Multi-Site Functional Areas: Policy, Quality Assurance/Technical Assistance, and Training.



Healthy Families Virginia Guidance

Critical Element 3: Offer services voluntarily and use positive, persistent outreach efforts to build family trust.

HFV Guidance:

- ❖ **CE 3-1.** Be sure that staff members document their conversation with the parents about voluntary choice on their *Home Visit Logs*, even if your site requires family signature on a form indicating participation is voluntary.
- ❖ **CE 3-2.** Develop specific pre-engagement outreach/creative outreach strategies to engage fathers/partners.
- ❖ **CE 3-3.** Monitor the number of families per Home Visitor and program wide on Creative Outreach. A high number could indicate engagement issues.
- ❖ **CE 3-3.A** Pre-engagement outreach services (i.e., prior to the first home visit) need only last just 30-45 days. However, be sure that you provide creative outreach services for at least 3 months (i.e., to those families who already had their first home visit). Try to obtain signed consents to contact secondary/ emergency contacts in case you lose touch with families.

Every creative outreach effort should be a message of caring. Never send threatening letters.

Review your *Policies and Procedures (P&Ps)* to determine how long, potentially, a service slot could be held for a family on Creative Outreach and then confirm that you do, indeed, want to hold service slots this long for families. For example, your *P&Ps* may reflect that a slot can be held for up to 3 months for a family “out of the service area.” If, after those 3 months, there has been no contact from the family, they can then be placed on Creative Outreach for at least another 3 months. Thus, according to these *P&Ps*, a service slot could be held for a family for 6 months or longer.

Be sure to calculate home visit rates for families on Creative Outreach according to guidance provided by HFV Executive Director via e-mail on February 8, 2015 (see attached).

- ❖ **CE 3-4.B** When conducting your biennial *Retention Analysis* use the HFA Excel spreadsheet tools, *3-4.A Retention Measurement Worksheet* and *3-4.B-C Analysis Grid*. The period of time being examined should be 2 years at minimum and, ideally, 3 years. Keep the same process every time you conduct your *Analysis* to ensure you're comparing apples to apples and not apples to oranges. Create a plan for improvement that relates to the trends discovered in your *Retention Analysis*.
- ❖ See HFV's ***Best Practice Recommendations*** on 1) *Creative Outreach* and 2) *Family Retention* for additional guidance.

Multi-Site Functional Areas: Policy, Quality Assurance/Technical Assistance, and Training.



Healthy Families Virginia Guidance

Critical Element 4: Offer services intensely and over the long term, with well-defined criteria for increasing or decreasing intensity of service.

HFV Guidance:

- ❖ **CE 4-1.A** Be sure families receive weekly home visits for at least 6 months excluding time on Creative Outreach.
- ❖ **CE 4-1.B** Use HFA's Excel spreadsheet tool, *4-1.B Tracking Form*.
- ❖ **CE 4-2.** Make sure you use your level change form's criteria to move families up, i.e., be sure to document all of the criteria met. If you have a level change form reflecting these criteria, make sure it is completed – including signature. If your site does not have a level change form, please use the bulleted list from CE 4-2.A and, again, document the criteria met. Remember, all parties (families, Home Visitor, and Program Supervisor) have to be in agreement in order to make a level change (CE 4-2.D). Also, all conversations regarding the level change need to be documented.

Your site's level system should be reviewed at least annually, as it can be adjusted to meet your service population needs. Keep your level system simple and remember that it is used to support families' needs and not higher home visit completion rates.

- ❖ **CE 4-2.B** Use HFA's Excel spreadsheet tool, *4-2.B Tracking Form*, to calculate home visit rates. Review Home Visit Rates monthly by Home Visitor and program wide. This should be part of your site's *Quality Assurance Plan*. If rates decrease, the Program Supervisor and Home Visitor should collaborate on strategies for improvement.
- ❖ **CE 4-4.** Begin transition planning 6 months prior to closure/the transition. Incorporate the steps to completion in a *Family Goal Plan*.
- ❖ See HFV's **Best Practice Recommendations** on 1) *Level Changes* and 2) *Transition Plan* for additional guidance.

Multi-Site Functional Areas: Policy and Quality Assurance/Technical Assistance.



Healthy Families Virginia Guidance

Critical Element 5: Services are culturally sensitive such that staff understands, acknowledges, and respects cultural differences among families; staff and materials used should reflect the cultural, language, geographic, racial and ethnic diversity of the population served.

HFV Guidance:

- ❖ **CE 5-1.** Begin the *Cultural Sensitivity Review (CSR)* process with a discussion with staff on the cultural make up of your service population. Develop a list of as many cultural dynamics as you can.
- ❖ **CE 5-4.** Use the HFA *Cultural Sensitivity Workbook* as guidance when conducting the CSR process. The CSR should include family and staff input. This can be a combination of informal and formal input. For instance, sites can include notes from discussions during past Team Meetings or supervision. Ensure the CSR reviews and reports on home visiting, assessment, and supervision services.

The CSR must be reviewed with your Advisory Group and this discussion documented in meeting minutes. Ensure strategies for growth are identified and discussed during this review. The CSR must include at least one strategy for growth or improvement.

- ❖ **GA-3.B** Include the CSR in your *Quality Assurance Plan*.
- ❖ See HFV's **Best Practice Recommendations** on *Cultural Competency* for additional guidance.

Multi-Site Functional Areas: Policy, Quality Assurance/Technical Assistance, and Training.



Healthy Families Virginia Guidance

Critical Element 6: Services focus on supporting the parent(s) as well as the child by cultivating the growth of nurturing, responsive parent-child relationships and promoting healthy childhood growth and development.

HFV Guidance:

- ❖ **CE 6-1.** Be sure to document the discussion on assessment review. Develop a systematic process that includes a written plan to address issues identified in the assessment. Risk factors need to be processed and documented throughout the course of home visiting services. Risk factors should be linked to goal planning.
- ❖ **CEs 6-1.B & 6-2.A** The Program Supervisor and Home Visitor should review the *Family Goal Plan* and discuss the relevance of the goals to the family, including planning how identified goals will build on each family's protective factors. Goals should help families to grow and focus on their strengths. Supervision notes should include documentation on the process of developing goals and the feedback from the Supervisor regarding the Home Visitor's use of goals in planning for families. This review and documentation should be more than whether or not the goal was completed.
- ❖ **CEs 6-2.B & 6-2.C** The goal planning process is a collaboration between the Program Supervisor, Home Visitor, and family. Be sure your practice and documentation demonstrates this. Tools to use for developing a *Family Goal Plan* include, among others, *KIPS*, the assessment, Value Cards (from Core training), "What I'd Like for My Child," and topics that families bring up in conversations about what they would like to achieve.
- ❖ **CE 6-2.D** Goal planning practice should include those items listed in 6-2.D RATING INDICATORS #3. Start with small, short-term goals to develop families' confidence, especially those who have come from backgrounds of trauma. Ensure staff has an understanding of the importance and value of goals with families who have past traumatic experiences. Home Visitors should ask about goal progress regularly and ensure this is documented. Each site must define for itself what

“regularly” means, using the “Glossary of Common Terms” found at the beginning of the *HFA Best Practice Standards*.

Use the “community team approach” with children who have developmental delays. Get copies of the child’s Early Intervention goal plan.

- ❖ **CE 6-3.B.** It’s important that Home Visitors document the work they do to promote positive parent/child interaction as well as the other positive parenting they observed. Documenting detailed notes using CHEEERS and other tools used with the family should support planning for the next home visit.

CHEEERS documentation is required for each home visit where the child is present and prenatally beginning the 2nd trimester. CHEEERS must include observed behaviors, i.e., facts not interpretations, and focus on the 3 F’s (Facts, Feelings, and Flavor) of the home visit for each of the CHEEERS letters. The Supervisor and Home Visitor should reflect on parent-child interaction (PCI) documentation and collaboratively use it to plan for the next home visit.

- ❖ **CE 6-4.** Home Visitors should document which of the 6 reflective strategies they used during the home visit (Problem Talk, Normalizing, Explore and Wonder, Feel, Felt and Found, Accentuate the Positive [ATP] and/or Strategic Accentuate the Positive [SATP]).
- ❖ **CE 6-5.B.** A primary, evidence based curriculum needs to be identified for every family served. The primary curriculum should be used regularly (on most visits).
- ❖ Due to changes in Integrated Strategies for Home Visiting Core training (formerly known as FSW Core training), Advanced Family Support Worker Training is recommended for staff that has 2 or more years of experience.
- ❖ See HFV’s **Best Practice Recommendations** on 1) *Family Goal Plans*, 2) *Home Visitation*, and 3) *Choosing a Parenting Curriculum* for additional guidance.

Multi-Site Functional Areas: Policy, Quality Assurance/Technical Assistance, and Training.



Healthy Families Virginia Guidance

Critical Element 7: At a minimum, all families are linked to a medical provider to assure optimal health and development. Depending on the family's needs, they may also be linked to additional services related to: finances, food, housing assistance, school readiness, child care, job training, family support, substance abuse treatment, mental health treatment, and domestic violence resources.

HFV Guidance:

- ❖ **CE 7-1.** Support families in connecting to a medical provider. Encourage their use of the emergency room for emergency needs only and not for routine care or as a medical home. Give guidance on the difference between emergencies and routine care or non-emergency care.
- ❖ **CE 7-2.** For families who choose not to immunize, sites need to ensure this family decision is documented clearly.

Sites need to let families know that some children participating in groups or activities may not be immunized. Sites need to do this while protecting the privacy of families' information.

- ❖ **CEs 7-3.B & 7-3.D** Each site's resource referral tracking system needs to clearly document the outcome of and follow up on referrals.
- ❖ **CE 7-4.** The Program Supervisor and Home Visitor should process strategies to address challenging issues by building on the family's protective factors. These strategies need to be documented and implemented in home visiting services. Click this link for more information <http://www.cssp.org/reform/strengthening-families/2013/Core-Meanings-of-the-SF-Protective-Factors.pdf>.

Be sure to consider possible cultural aspects related to the challenging issues families face (IPV, SA, MH, etc.). Have a proactive approach to supporting families through challenges by having educational and current research-based resources to share. These resources can be made available for staff to use with families as needed to address challenging issues and for supervisory support.

- ❖ **CE 7-5.** Remind staff that the depression scale is a screening tool and that staff are not clinicians. Families with indications of possible depression will need to be referred for professional clinical help. Boundaries should be established with clear delineation of the Home Visitor's role. The Home Visitor's role is to help the family become treatment ready (see CE 7-4 Intent).

- ❖ See HFV's ***Best Practice Recommendations*** on *Depression Screening* for additional guidance.

Multi-Site Functional Areas: Evaluation, Policy, Quality Assurance/Technical Assistance, and Training.



Healthy Families Virginia Guidance

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.

HFV Guidance:

- ❖ **CE 8.** Sites are encouraged to continuously maintain full caseloads (*not exceeding HFA guidelines*) in order to serve the maximum number of families/operate at full service capacity.

Multi-Site Functional Areas: Policy and Quality Assurance/Technical Assistance.



Healthy Families Virginia Guidance

Critical Element 9: Service providers should be selected because of their personal characteristics, their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

HFV Guidance:

- ❖ **CEs 9-1.A-C.** Sites screening and selection process should include the staff criteria listed in this standard. These criteria can be documented on each position's job description and the standardized interview questions used during the hiring process.

Sites should consider using the reflective capacity questions that are provided in the *HFV Best Practice Standards* as part of the interview/hiring process for all positions. The link for these questions can be found on page 10 of *HFA's Best Practice Standards*.

It is necessary to create and implement a staff development plan for anyone not meeting the experiential criteria for the role they have been hired to perform. The site should include in that plan experiential training over and above the wraparound trainings provided by HFA.

- ❖ **CE 9-2.** Each site must have written procedures for notifying Healthy Families Virginia (HFV) within 14 days in the event it has an EEOC complaint filed against it. The site must also have written procedures for notifying HFV of the resolution of the EEOC complaint within 14 days of receipt of the resolution.
- ❖ **CE 9-4.** Staff satisfaction and retention are to be analyzed at least every two years. It is important to review the Intent of this standard and follow the guidance given. It is expected that an improvement plan will be completed to address any issues found in the analysis. These improvement strategies should be added to the site's comprehensive *Quality Assurance Plan*.

When developing the staff satisfaction survey, it is important to include open-ended questions such as how, what, when, and where.

- ❖ See HFV's ***Best Practice Recommendation*** on *Background Checks* for additional guidance.

Multi-Site Functional Areas: Administration, Policy, Quality Assurance/Technical Assistance, and Training.



Healthy Families Virginia Guidance

Critical Element 10: Service providers receive intensive training specific to their role to understand the essential components of family assessment, home visiting and supervision.

HFV Guidance:

- ❖ **CE 10-1.** Healthy Family Virginia's (HFV) Power Point training describing the role and function of the state multi-site system should be used as a part of each staff member's Orientation training.
- ❖ **CE 10-2.** Stop-Gap training does not replace HFA Core training. When sites develop their Stop-Gap training, they must be sure that each item in the CE 10-2.A Intent is incorporated into it.

HFV will provide a list of Stop-Gap training topics to include in each site's training plan for direct service staff and for Program Supervisors and Program Managers. These lists are included in the Training multi-site standard.

Documentation of all Stop-Gap trainings must be on each individual training log, as well as on each site's training plan.

- ❖ **CE 10-3.** HFA Core training does not fulfill the requirements for Orientation training.
- ❖ See HFV's **Best Practice Recommendation** on *Training and Orientation* for additional guidance.

Multi-Site Functional Areas: Policy, Quality Assurance/Technical Assistance, and Training.



Healthy Families Virginia Guidance

Critical Element 11: 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, reporting child abuse, determining the safety of the home, managing crisis situations, responding to mental health, substance abuse, and/or domestic violence issues, drug-exposed infants and services in their communities.

HFV Guidance:

- ❖ **CE 11-1.** Sites should develop a standardized process for documenting and tracking orientation, group/team trainings, and on-going trainings. Backup documentation should include a training agenda, certificate of completion, and/or Power Point handouts. Sign-in sheets may also be used to provide verification that the staff member was in attendance.

All staff training logs must include the date of training on all tools used as well as the date that each was first administered. This includes tools such as the *Parent Survey*, *ASQ*, *KIPS*, the *HOME*, the *RAT*, any depression screening tool, the curriculum, etc.

Program Supervisors should closely monitor the training of new staff for at least 6 months.

Sites should develop and follow a standardized way of organizing their training binders.

- ❖ **CEs 11-2., 11-3, & 11-4.** Formal education, previous training and experience may be counted toward wraparound trainings if it occurred within 3 years of hire and directly applies to the topics identified in the standards. Documentation of these trainings must be present in the staff member's training log/file.

Sites should make every effort to complete required wrap-around trainings within the specified time frames. Additionally, recurring trainings, such as the annual requirement for Cultural Diversity and CAN training, should also be done within the specified time frames. However, any training not completed within the required time frame still needs to be completed and as soon as possible.

- ❖ **CE 11-5.C** Sites must ensure that staff members receive Family Goal Planning training. This training must include a discussion on the "3 M's" of

goal setting (mission, mini, and measure). Sites are highly encouraged to use the HFA webinar on Family Goal Plans and/or have staff attend one of the HFV Goal Setting trainings. Program management can refer to the HFV training calendar at www.pcav.org and the Home Visiting Consortium training website at www.homevisitingva.org for registration details.

- ❖ See HFV's ***Best Practice Recommendation*** on *Training and Orientation* for additional guidance.

Multi-Site Functional Areas: Policy, Quality Assurance/Technical Assistance, and Training.



Healthy Families Virginia Guidance

Critical Element 12: Service Providers receive ongoing, effective supervision so they are able to develop realistic and effective plans to empower families.

HFV Guidance:

- ❖ **CE 12.** It is critical for site management to review the Intent section of the standard to ensure they fully understand the 3 required supervisory components which include: 1) *Administrative*, which includes review of goal plans, referrals, assessments, etc.; 2) *Reflective*, which includes items such as helping staff members explore their thoughts and feelings about the work; and 3) *Clinical*, which includes items such as helping staff members develop strategies for working with families.

Supervision Logs must include the work that is completed in each of the required components. Supervision documentation must reflect the work that is done in supervision with the individual staff member and should not be simply a reiteration of family *Home Visit Logs*. However, *Supervision Logs* do need to include family updates, e.g., FGP progress, referrals made and their outcomes, assessment issues discussed, potential upcoming level changes, tools provided to the staff member, etc.

Supervision can be tracked on multiple documentation forms, e.g., one page for administrative tracking and another for clinical and reflective documentation.

Supervision documentation should reflect the applicable reflective strategies used with the staff member during the supervisory session (Problem Talk; Normalizing; Explore and Wonder; Feel, Felt, and Found; Accentuate the Positive [ATP]; and/or Strategic Accentuate the Positive [SATP]).

Supervision of the FRS role must also include all 3 required components and be documented in that manner. Sites may want to consider having separate documentation forms for both the Home Visitors and the Assessment Workers to help them ensure they are meeting the unique needs of each role.

- ❖ **CE 12-1.B** It is important that the supervisor understand the Intent of this **sentinel standard** and become familiar with its “Tips,” especially the need for the Program Supervisor to arrange a “back-up” Supervisor for the times she/he is away from the site for more than two weeks. This plan should be in sites’ supervisory procedures.

Supervisors must also pay attention to HFA’s new supervision duration requirements for part-time staff members. Please review CE 12-1.B.

Shadowing staff members on home visits and assessment interviews should occur at least 2 times per year for staff members who have been in their role over 1 year and quarterly for staff who are in the first year of their role. Shadowing expectations should be incorporated into the site’s *Quality Assurance Plan*.

Sites are encouraged to use HFA’s Excel spreadsheet tool, *12-1.B Supervision Frequency and Duration*, to document the dates and length of supervision sessions.

- ❖ **CE 12-1.C:** If your site uses a contractor to provide monthly reflective consultation groups in lieu of individual supervision for staff who have been employed for at least 12 months, the Program Supervisor must attend the group.
- ❖ **CE 12-2.A:** Supervisors should support the “transfer of learning” process when staff receives new trainings, i.e., help the staff member incorporate their learning into their daily work with families. Program Supervisors should encourage their staff to complete the HFA Tier 1 certification process after completion of their Core training.
- ❖ **CEs 12-3. & 12-4.** Sites should develop a system to record the supervision of the Program Supervisor and the Program Manager. This supervision must be documented.
- ❖ See HFV’s ***Best Practice Recommendation*** on *Supervision* for additional guidance.

Multi-Site Functional Areas: Policy, Quality Assurance/Technical Assistance, and Training.



Healthy Families Virginia Guidance

Governance and Administration: The site is governed and administered in accordance with principles of effective management and of ethical practice.

HFV Guidance:

- ❖ **GA-1.A** If the individual Healthy Families (HF) site does not have an Advisory Council, then oftentimes the site's host agency Advisory Board is used. If this is the case, there needs to be adequate time set aside to discuss the HF site's planning, implementation and evaluation activities during the meetings. These conversations need to be documented in the *Meeting Minutes* and used as evidence for accreditation.

Sites should be aware of the difference between an Advisory Council and a Governing Board. Governing Boards often have fiduciary accountability and have the final say on policies and practices. Advisory Councils often review daily programs and practices and do not have any official governing capacity.

- ❖ **GA-1.B** Each HFV site's Advisory Council needs to be culturally diverse and representative of the population served by the site.
- ❖ **GA-2.B & GA-2-C** If the site is using surveys to garner familie's input, then please limit the number of questions asked to not overwhelm participants. Some topics to focus on are: cultural competency of the site, family satisfaction, and questions regarding families' understanding of the site's grievance protocol. Also, please make sure families know their input is to remain confidential.

This survey should be included in the site's *Quality Assurance Plan*.

- ❖ **GA-3.B** The site's *Quality Assurance Plan* should document areas of improvement, who is responsible for each item, and timeframes for when they should be completed. The *Quality Assurance Plan* is an HFA requirement and should be used as a Program Manager's guide or to-do list.

- ❖ **GA-5.B** Staff should be obtaining parents' signatures on the *Family Rights and Confidentiality* statement during the first home visit. This form should also be verbally reviewed with the family and this discussion needs to be documented on the *Home Visiting Log*.

Sites who conduct chart reviews should also make sure a form reflecting these reviews is part of the chart and that chart reviews are documented on it. Sites should have a signature page in each family's chart for anyone other than program staff who review or look at the chart. The signature page needs to have a confidentiality statement stating that the information will be kept confidential.

- ❖ **GA-5.C** *Releases of Information/Consents* need to be completed for every external source with which the family's information will be shared. These releases are to be renewed on an annual basis with the parent's signature. It is recommended that sites maintain them in one place in the chart organized by profession or agency with the most current one on top.
- ❖ **GA-5.D** When the site chooses to participate in outside research, HFV staff need to be notified of the type of research done and the timeframe for its completion.
- ❖ See HFV ***Best Practice Recommendation*** for *Consents* and *Generic Quality Assurance Plan* sample for additional guidance.

Multi-Site Functional Areas: Administration and Quality Assurance/Technical Assistance.