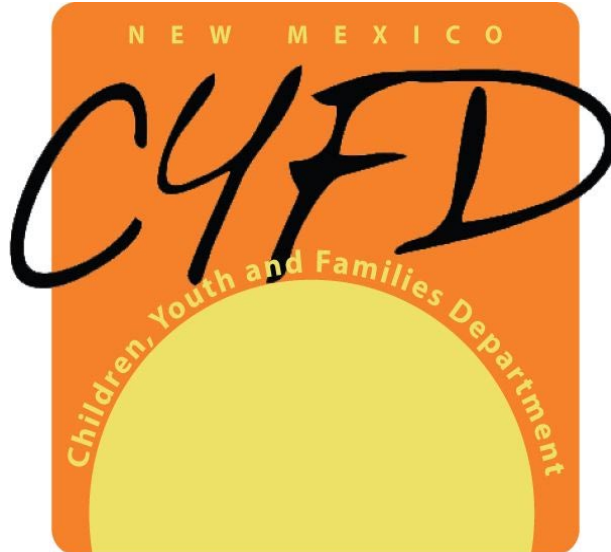


HOME VISITING SERVICE MANUAL



Please note: This document is revised on a yearly basis by the Home Visiting staff. Input is gathered throughout the year at Home Visiting quarterly meetings.

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INTRODUCTION/OVERVIEW

This *Home Visiting Service Definition Manual* is produced and disseminated by The State of New Mexico's Children, Youth and Families Department (CYFD). The purpose of this manual is to describe underlying philosophical principles, and to define practice parameters, standards, and reporting activities for all Home Visiting programs funded through CYFD.

CYFD is committed to supporting Home Visiting programs that provided services leading to positive, measurable outcomes for infants, toddlers and their families. The specific overarching goals established for all CYFD state-funded Home Visiting programs are:

1. Babies are born healthy.
 - a. Home Visiting services will improve the physical well-being of pregnant women and their to-be born babies.
2. Children are physically and mentally healthy.
 - a. Home Visiting services will support optimal the physical health and developmental capacities of infants, toddlers and their caregivers/families, including the social, emotional, and mental health of all;
3. Children are safe.
 - a. Home Visiting services will support optimize physical health and safety of infants and toddlers and their families;
4. Children are nurtured by their parents and caregivers.
 - a. Home Visiting services will actively promote healthy caregiver-child interactions and relationships through an established curriculum.
5. The family is connected to formal and informal supports in their community.
 - a. Home Visiting service providers will identify concerns/risk factors early and refer/link with families with form and informal community services and supports.

Home Visiting programs funded by CYFD will provide a continuum of services to families based on family preferences, needs, strengths and risk factors. Services provided through home visiting programs will be:

- Flexible and designed to meet the needs of clients and communities at the local level;
- Inclusive of and responsive to the ethnic, cultural, racial, linguistic, and socioeconomic diversity of our state;
- Focused on results with clearly defined and measurable outcomes for programs and the clients served.

UNDERLYING PHILOSOPHY: COMPETENCY-BASED PRACTICE; RELATIONSHIP-FOCUSED AND FAMILY-CENTERED APPROACH

Many of the practice and supervision requirements defined in this manual are based on the competencies outlined by the *New Mexico Association for Infant Mental Health Endorsement System for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health*. In addition, a family-centered approach that is responsive to the needs of individual families also underlies many of practice standards for programs. As noted above, all home visiting services are also to be delivered with cultural competence and appropriate responsiveness to the unique needs of the diverse communities served in New Mexico.

The core underlying philosophy behind the development of CYFD Home Visiting services is the belief that the quality of the caregiver-child relationship is primary in supporting all aspects of child development and health. It is well documented that nurturing caregiver-infant/toddler interactions are critical to the development of secure attachment relationships, optimal development in all domains of functioning, and later school readiness for children. To optimize the positive influence home visiting programs can have on the parent-child relationship; adult family members must also experience a strong, collaborative relationship with their home visitors. This represents the concept of “parallel process”. This means the quality of relationship between parents/caregivers and their home visitors can be seen as *directly linked* to the quality of the emerging interactions and developing relationship between the unborn child and/or infant/toddler and his or her caregiver(s).

Related to this, caregivers and families must be full partners and collaborators in the development of their home visiting plan and services. Home visiting programs should provide services from both a relationship-focused and family centered perspective. The latter refers to the need to view the family as a “whole” and with openness to supporting all caregivers/family members in the service of optimizing the emerging caregiver-child relationship and infant/toddler development. Giving up on families or labeling them as “unmotivated” or “resistant” is not acceptable within this framework. In instances where services are not accepted and/or families are not satisfied, providers reflect and try to understand the family’s perspective.

Additionally, CYFD believes wholeheartedly in the strengths and resiliency of families. Families are our partners in service delivery and we must advocate to enhance their safety and well-being. We respectfully serve and support children and families, in a responsive community based system of care that is client/family-centered and culturally competent. Of course, CYFD Home Visiting program services are always voluntary.

WHAT IS “HOME VISITING”?

A “Home Visiting” model of service delivery represents a *strategy* that can be used to provide a variety of informational, educational, developmental, referral/ linkage, screening/evaluation, and other direct intervention and support services for families. CYFD Home Visiting programs provide an array of services to promote parental competence and successful early childhood health and development by building optimal relationships with families and between parents and children in their home environments.* “Home Visiting” from this perspective can be seen as both a promotion and prevention level intervention strategy. Providing services in the family

home provides the opportunity for services to be delivered in the “real world” with families. This real-life focus offers the potential for better understanding of a family’s real experience, and thus for home visitors to better supporting wellness across multiple domains (physical health, developmental competence, social and emotional well-being, community involvement, etc.) for both infants/young children *and their caregivers/families*.

*A home environment may include schools or even jails, wherever the parent and child can be seen together, based on the specific needs of each particular family.

TARGET POPULATION

The priority target population for CYFD Home Visiting programs is first time parents and caregivers (including adoptive and teen parents) of children pre-natal to three years of age, without regard to income level, or any other criteria.

ELIGIBILITY CRITERIA:

The priority eligibility requirements for participation in Home Visiting Services are as follows:

- First time expectant mothers;
- First time parents of infants and toddlers birth to three;
- First time caregivers of infants and toddlers birth to three;
- Adoptive parents of infants and toddlers birth to three;
- Expectant teens and teen parents of children birth to three.

SERVICE COMPONENTS

State-funded Home Visiting programs are required to offer a variety of services and supports to families during the prenatal period and up until children in the home turn three years of age. CYFD Home Visiting programs are expected to include, at a minimum, the following service components. Service components are to be offered based on CYFD’s guidelines for screening and curricula use, in combination with each family’s needs, preferences, cultural context, and risk factors:

- Support and assistance in accessing prenatal care for pregnant women
- Support and assistance around accessing primary medical care for newborns, infants and toddlers served by the program
- Screening for possible risk factors within the child, caregiver, and family (using, at a minimum, CYFD selected tools and measures), including home safety, developmental concerns in children, pre/postnatal depression in mothers, domestic violence, and family social support
- Assessment of home, family and child safety
- Development of safety and “harm reduction” plans with families presenting with issues of concern or high risk
- Provision of information on community and educational resources
- Referral and linkages to other needed or recommended health, developmental, mental health, community and educational supports for the child, caregiver and family as appropriate

- Provide developmental guidance and parent-child interaction support based on an evidence-based curriculum;
- Identification of informal and formal social supports; referral of families to community resources;
- Provision of home visits one time per week for at least the first six months of the child's life, or as often as requested by the family, and then as determined collaboratively with the family and home visitor for the second and third year of the child's life.
- Follow up and engagement in collaboration with other service providers families are working with and/or have been referred to for additional services
- Provision appropriate referrals and follow up at the completion of Home Visiting services to appropriate community, educational, and other services and informal support networks

EVALUATION COMPONENTS

State-funded Home Visiting programs are required to participate in the CYFD defined evaluation process. This includes administering all screening tools at the intervals and frequency defined by CYFD, collecting and reporting required data using the data base and mechanisms outlined by CYFD.

Please refer to Home Visiting Program Service Requirements/Core Components and Appendix A for further information on evaluation requirements for Home Visiting programs.

GENERAL STAFF REQUIREMENTS

DEPARTMENT OF PUBLIC SAFETY AND CYFD

All staff, supervisors and consultants working in CYFD funded Home Visiting programs must receive criminal record clearances through CYFD/Early Childhood Services as required by regulation.

OVERVIEW STAFF REQUIREMENTS

CYFD Home Visiting programs must be staffed by individuals suited to perform the core Home Visiting service components outlined above. This array of service components requires staff members who have knowledge of pregnancy and the prenatal period, infant/toddler safety and health, early childhood development, early childhood mental health principles and practices, knowledge of community resources, and very strong relationship-building skills. It is, in reality, rare that any one individual will hold all these skills and knowledge herself. As such, the Home Visiting "team" is by definition multidisciplinary and composed of licensed/credentialed professionals who have knowledge in early childhood development and early childhood mental health in combination with non-degreed professionals or other disciplines. Each Home Visiting program is expected to be staffed by multidisciplinary personnel. Some examples of disciplines appropriate to work in Home Visiting programs include:

- Nurses
- Social Workers
- Psychologists
- Counselors
- Early Childhood Educators
- Promotoras/Community Health Workers
- Case Managers
- Developmental Specialists
- Other non-degreed professionals with appropriate background/experience

CLINICAL SUPPORT

Each Home Visiting programs *must* have access to at least one Master’s level clinically licensed mental health professional who is available for consultation when potential high risk situations, crises, and/or other “clinical” issues or concerns arise. This individual should possess the clinical training and experience to provide meaningful, mental health consultation to home visitors. Additionally, dependent on the staffing patterns of the program, this individual may also provide brief direct service support for families if/when clinical issues or needs prove beyond the scope or skill level for the primary home visitor. Such consultation may be warranted when safety concerns arise (in the home, for the family and/or or for the home visitor); when there are suspicions of child abuse or neglect; if/when screening tools (or home visitor observation) indicate the presence of pre/post-natal depression in mothers; there are indications of other mental health or substance abuse concerns in the home; and/or domestic violence is a concern. In addition, the licensed professional should be knowledgeable of issues related to pregnancy, postnatal adjustment, early childhood mental health, early childhood and family development, and resources in the community served.

SAFETY AND RISK REDUCTION

Overview: At their core, CYFD Home Visiting services have the goal of optimizing health and well-being by reducing the potential negative impact presented by family and child risk factors. In keeping with this overarching vision, CYFD Home Visiting programs are required to actively screen for risk factors in children, caregivers and families using tools and periodicity defined by CYFD. If risk is identified, Home Visiting programs bear the responsibility to assess immediate safety, refer to other community providers, and support linkages and collaboration with other needed services. As the “first line” screeners for risk, Home Visiting programs must have qualified personnel, as well as programmatic and supervisory policies in place, to support home visitors when possible risk situations and safety issues are identified either via screening tools or more informal observation by the home visitor. Clearly stated, Home Visiting programs need to be able to respond to families when an immediate crises or risk situation is identified. This response should include (with appropriate supervision and consultative support) the development of an initial plan with the family to define strategies for safety. In addition, the home visiting program should provide referrals and linkages for families to additional resources in their

communities as needed. Staffing patterns and program practices in all Home Visiting programs funded by CYFD need to support this level of care and intervention for families served.

Family Strategies to Promote Safety: The capacity to respond appropriately with a plan for family strategies to promote safety when an immediate safety or risk situation arises *is not intended to imply that Home Visiting programs provide clinical “treatment” for mental health issues or other services outside the scope of services defined by CYFD.* However, programs do need to have mechanisms and personnel in place to respond to immediate safety issues and identified risk factors as they are discovered by home visitors. Home visitors will inevitably often be the first to identify areas of concern in young families. This reality exemplifies the very essence of home visiting as a strategy for prevention. If home visitors are present and can identify risk *early* we have done our job. They then help families access additional services as needed and potential future negative impacts on children, parent-child relationships, and families can be minimized.

Community Relationships/Referral: The ability to respond to risk and safety issues also mandates that Home Visiting programs and staff cultivate and sustain relationships within their communities with medical care providers, mental health practitioners, domestic violence services and other community agencies. Building relationships within communities is essential to the development of a meaningful and comprehensive “system of care” to address the myriad of needs presented by the target population. As such, programs are also required to have a plan for cultivating and deepening community relationships in support of the families they serve and for the development of a community-based system of care that is responsive to the needs of the families they serve.

SUPERVISION OF STAFF

Supervisor Requirements: Home Visiting program supervisors are required to have a minimum of one year of supervisory experience and two years work experience with the target population. Supervisors should possess knowledge of pregnancy and prenatal issues, early childhood and family development (including social and emotional development), reflective practice, and family centered care. Home Visiting supervisors must be able to provide, or be prepared to hire qualified staff/consultants to provide, reflective supervision for all home visiting staff. Reflective supervision is critical to effective infant and early childhood practice and provides a regular forum for staff and supervisors to thoughtfully sort through the complexities presented by the work of home visitors. All direct service staff must receive at a minimum two hours per month of individual reflective supervision with a qualified supervisor. If an individual serves a dual role in the program as both a direct service provider and a supervisor for other staff (which is often quite common), such individuals need to be afforded supervision from another qualified supervisor to support their home visiting work with families.

Reflective Supervision guidelines: Reflective supervision is to be provided on an individual basis for all home visiting staff at a minimum of twice per month. Supervision may be provided individually and enhanced through group sessions. Supervision meetings should be predictable and consistently scheduled; supervision must be conducted by a qualified practitioner who is trained and knowledgeable in early childhood

development or early childhood mental health and utilizes reflective practice principles. Supervision sessions must be documented by a sign in sheet (signed by both the supervisee(s) and supervisor) and should include a brief summary of the session.

Field Supervision: Supervisors will accompany their home visitors on family visits at least twice in the first year of employment for new home visitors and once annually for all staff thereafter.

Administrative Supervision will also be provided for all home visiting staff. In addition to agency supervision practices, Home Visiting supervisors will include quality assurance for services provided, adherence to all CYFD policies, and review of screening tools and results in their supervision of staff. The current Home Visiting screening tools and responsibilities of supervisors include the following:

- Review *ASQ* and *ASQ: SE* for cut off scores and assure referrals are completed to appropriate services when indicated
- Review Edinburgh Postnatal Depression Scale and assure referrals when necessary
- Review WAST-Short and assure referrals when necessary
- Review Knowledge of Infants Development Inventory (KIDI) and discuss with Home Visitor
- Review Medical Assistance Division Anticipatory Guidance (MAD) and discuss with Home Visitor
- Review the Social Support Index and discuss with Home Visitor

Screening Tools: When reviewing screening tools, it is probable that administrative review of screening tools will at times lead to the need for a more reflective dialogue between staff and supervisor around how to approach issues of identified risk with a family and what referrals or additional services may be needed. As tools are reviewed, supervisors should keep an eye toward the need for consultation with the licensed mental health consultant on the team to assist with formulating a plan for dialogue with the family, referral strategies, or other more “clinical” issues that may arise as the result of actively screening for risk factors with families.

HOME VISITING PROGRAM SERVICE REQUIREMENTS/CORE COMPONENTS EXPANDED DETAIL

Home Visiting programs are expected to provide an array of service components designed to address five broad outcomes, with emphasis for the current year on 1, 4 and 5. These outcomes are again:

1. Babies are born healthy.
2. Children are physically and mentally healthy.
3. Children are safe.
4. Children are nurtured by their parents and caregivers.
5. The family is connected to formal and informal supports in their community.

In addition, CYFD has identified additional, but related, performance outcomes for state-funded Home Visiting programs. These specific performance outcomes will be evaluated via data obtained from screening tools and other program activities defined by the Home Visiting Evaluation team at the University of New Mexico Continuing Education Department and CYFD.

Core components for Home Visiting programs include the following:

1. No Cost to Families
 - All Home Visiting services are offered at no cost to qualified families.
2. Target population and priority
 - The target population is first-time pregnant women and all first-time parents of children under three.
 - Priority is given to all first-time pregnant women, first-time fathers and families parenting for the first time, including adoptive parents and teens;
3. Accessibility
 - Home Visiting services are accessible to all members of the communities served.
4. Voluntary Participation
 - All Home Visiting services is voluntary for all families.
5. Prenatal home visits include the following components:
 - Support and assistance around accessing prenatal care that is consistently utilized and attends to the physical, emotional, and spiritual health care as needed and/or as requested by the pregnant woman/family;
 - Provision of active assistance to families in identifying informal support networks;

- Provision of referrals to health, community and other resources AND follow up to support and link services as necessary;
 - Provision of information on prenatal health, newborn care, and infant/child development, including developmental guidance;
 - Determination as to whether families have been referred to Medicaid on Site; Initiation of Assistance/Presumptive Eligibility (PE/MOSAA) if appropriate.
6. Post-Partum visits include the following components:
- Assessment of mother's well-being including physical, emotional and social supports;
 - Assessment of any concrete needs the family is experiencing;
 - Other needs as identified by the family.
7. Home visits available for the first three years of the child's life include the following components:
- Inquiry related to infant health status
 - i. Has the baby received their second PKU testing?
 - ii. Is an appointment for the 2 month well-care check-up scheduled?
 - iii. What is the infant's current weight?
 - Developmental screening
 - Evaluation of eligibility for Women Infant and Children (WIC); support around enrollment in WIC for qualifying families;
 - Guidance to families through developmental curricula;
 - Accessing appropriate, consistent and comprehensive physical, emotional, and spiritual health care as needed and/or as requested by the family
 - Assistance to families in identifying informal support networks;
 - Provision of referrals to community resources as necessary;
 - Provision of developmental guidance to families and caregivers including adoptive parents;
 - Determination if families have been referred to PE/MOSAA.
8. Training:
- Staff are trained on required evaluation components
 - Home Visiting Staff, Managers and supervisors participate in the training provided by CYFD.
 - Managers and Supervisors will assure their staff has all needed, appropriate, and required training. Home visiting staff must be trained in the following topic areas:
 - i. Parent child interaction;
 - ii. Infant/child development;
 - iii. Community resources;
9. Collaboration:

- Development of a referral and follow-up system for families to community services.
- Collaboration with program evaluators by providing the necessary data, allowing access to information needed, including evaluation protocols.
- Collaboration with hospitals, Women Infants and Children (WIC), teen parent centers, OB-GYN practitioners, midwives, Primary Care Providers (PCPs), pediatricians and all other entities that may have contact with this population to discuss and develop referral and networking process.

10. Participation:

- Participation in quarterly meetings and conference calls with other funded home visiting programs
- Participation is defined as those in a managerial or supervisory position and should, as much as possible, be attended by the same individuals
- Participation in the continued development of a comprehensive Service Definition Manual to be used by New Mexico Home Visiting Service agencies.

11. Confidentiality:

- Confidentiality of client information, both written and verbal, within the policies of the Health Information Portability and Accountability Act (HIPAA).

12. Cultural Sensitivity:

- Cultural sensitivity in all aspects of program planning and service delivery by having bi-lingual and culturally competent staff as appropriate.

13. Supervision:

- **Reflective Supervision:** Provide reflective supervision session on an individual basis at a minimum of twice per month. Supervision may be provided individually and enhanced through group sessions. A practitioner who is trained and knowledgeable in early childhood development or early childhood mental health and utilizes reflective practice principles must conduct supervision. Supervision will be documented by a sign in sheet to include a short summary of the session.
- **Field Supervision:** Supervisors will accompany their home visitors on family visits at least twice in the first year of employment for new home visitors and once annually for all staff thereafter.
- **Administrative Supervision:**
 - i. Ensure that all evaluation materials are completed and entered into the database in a timely manner.
 - ii. Ensure that home visitors utilize the child development curriculum information with families on a regular basis and that this use is documented in contact/progress notes.
 - iii. Review status regarding acquisition of a Medical Home
 - iv. Other duties as identified throughout the Service Definition Manual and contract Scope of Work.

- v. In addition to other basic administrative requirements, supervisors will also regularly review all completed screening tools and measures with their home visitors, including:
 1. ASQs and ASQ: SEs for cut off scores and assure referrals are completed to appropriate services when indicated
 2. Edinburgh Postnatal Depression Scale instruments and assure referrals when necessary
 3. WAST-Short and assure referrals when necessary
 4. Knowledge of Infants Development Inventory – Adapted (KIDI) and discuss with home visitor
 5. Medical Assistance Division Anticipatory Guidance (MAD) and discuss with home visitor
 6. Review the Social Support Index and discuss with home visitor

14. Community Education: Community Education and development activities represent efforts made the local and state levels to assure awareness of home visiting services. Activities may include:

- Public awareness activities to promote community knowledge of the agency’s services and outreach to serve the target population.
- Advocacy, education, policy development and networking on behalf of the target population through formal systems.
- Consultation, education and training of other community service providers in the community to increase inter-agency collaboration and maximum service provisions to clients.
- Provision of presentations in order to educate, raise awareness, or provide materials such as child development, maternal infant social-emotional attachment, and brain development.
- Document dates, times, person performing the activities, number of attendees and a description of those activities in quarterly reports with a total in the final annual report.

15. Outcomes/Screening/Evaluation/Performance Measures and Activities: All Home Visiting programs must utilize the following screening and evaluation tools with all families at the defined frequency and periodicity outlined by CYFD:

- i. Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire Social/Emotional per required sequence (ASQ:SE)*
- ii. Edinburgh Postnatal Depression Scale
- iii. WAST-Short
- iv. Medical Assistance Division (MAD) Anticipatory Guidance
- v. Social Support Index (SSI)
- vi. Knowledge of Infants Development Inventory – Adapted (KIDI-Adapted)

- Home Visiting Program shall maintain data and provide documentation of the following to CYFD:
 - i. Number of home visits provided
 - ii. Number of families who receive their first home visit
 - iii. Number and type of referrals to community services
 - iv. Submission of quarterly data, as well as ad hoc reports when needed, to CYFD
 - v. Initiation and participation in collaborative activities with other community entities
 - vi. Participation with other agencies in training, referrals and integration of services
 - vii. Number of referrals to Child Protective Services

*When a child screens “positive” for potential developmental delay using the ASQ, and appropriate referral and linkages are successfully made to the NM Family Infant Toddler (FIT) program, Home Visiting staff in discussion with their supervisors should use their own discretion as to whether or not to continue to “screen” development based on recommended periodicity. Any potentially detrimental impact on the family of a child with an identified delay or a diagnosed disability should be considered thoughtfully in deciding to discontinue use of a recommended measure. A decision to discontinue the use of a screening tool and the rationale for doing so should be noted clearly in the client file and in the Home Visiting database.

15. Follow Up and Referral:

- Provision of Follow Up and Referrals during and at least once at the completion of Home Visiting Services.

DOCUMENTATION

File maintenance is required for client/agency interaction from initial referral and admittance to the program through discharge. Documentation in client files is required for all home visiting services.

The agency shall provide for suitable storage, access, and disposal of client records for three years after the contract has terminated.

DOCUMENTATION REQUIREMENTS

Client Services

1. Documentation at Intake/Admission (to be maintained in individual file):

- a. Determine if the client meets the eligibility criteria described above.
- b. Client Intake.
- c. Additional forms as follow:
 - i. Client Rights/Responsibilities/ Grievance Procedures
 - ii. Client Release of Information (Confidentiality Statement)
 - iii. Consent Form (Documentation of consent, or attempt to obtain consent, of the client and/or parent/legal guardian for admission, evaluation, aftercare or research).

- d. All forms must be signed and dated by the family and /or parent or legal guardian, and agency staff. A separate Release of Information Form must be used for each request.
- e. Client must also be informed of data collection methods utilized by the agency and to whom information will be reported including file reviewers. An evaluation Consent Form must be signed and dated by the family and/or parent/legal guardian.

NOTE: The funded agency must ensure HIPAA compliance.

2. Documentation of Performance Measures (Standardized Instruments).

- a. Completion of required performance measurement tools and/or data collection (i.e., Ages and Stages Questionnaire, Edinburgh Post-Natal Screen, WAST Short, KIDI, Social Support Index, MAD Anticipatory Guidance) as identified for the designated time required, please refer to periodicity grid.

3. Documentation of Appropriate Family and Infant/Toddler Goals.

Document when the goals were achieved.

4. Documentation of client progress through home visit records.

Documentation may consist of the following:

- a. Parenting skills
- b. Family Health
- c. Systems Issues
- d. Environmental Factors
- e. Social Supports
- f. Mental Health
- g. Strengths
- h. Concerns
- i. Curriculum

The progress notation shall also include date, time and duration of contact, type of service, and signature of individual completing the note. Visits should be numbered sequentially.

5. Documentation of Supervisory Chart Reviews.

(Please see Supervisory section above)

Supervisors must review active client files every 60 days to include:

- a. Review of services offered to the family
- b. Review of appropriateness and effectiveness of services provided
- c. Review of the intake, screening, progress notation and other pertinent information in file
- d. Review progress with regard to goals
- e. Reports of case staffing with supervisors and other involved professionals
- f. Developmental issues or concerns
- g. Developmental achievements that are age appropriate
- h. Parental/Caregiver concerns/developmental guidance given
- i. Review supplemental information attached to ASQ

*Note: Written summary notations must include the date and signature of the supervisor, licensure (if applicable) and be placed in the client file.

6. Documentation of Significant Events and Incident/Occurrence Reports.

All Home Visiting agencies must report to the CYFD Program Manager within 24 hours any serious incident or unusual occurrence that has threatened or could threaten the health, safety or welfare of the family or staff of the program. Documentation of any significant disciplinary action, health and safety issue, rules violation, or action involving liability may include but is not limited to:

- a. Fire, flood or other natural disaster that creates structural damages or poses health hazards;
- b. An outbreak of contagious disease dangerous to public health, e.g. Tuberculosis, food poisoning, Hepatitis A;
- c. Any human act(s) by staff members that present or pose possible physical and/or psychological impairment of a client;
- d. Any human act(s) by staff member(s) that results in serious illness, injury or physical and/or psychological impairment of a client;
- e. Any suicide or attempted suicide of a client;
- f. Death of client;
- g. Accidents involving or injuries to the client;
- h. Any suspected abuse, neglect or exploitation;

Suspected abuse or neglect must be reported to Protective Services Statewide Central Intake at 1-800-797-3260, and documented appropriately

7. Documentation of Service Discontinuation:

Face to face contact with a client (when possible) to complete a summary that addresses

- Reason for discontinuation of services
- Summary of services provided
- Family accomplishments while receiving home visiting
- Completion of a Family Satisfaction Survey.

8. Outcome Evaluation & Training

- Providers must complete all required evaluation measures as outlined above
- Providers must use evaluation information program and staff development
- Providers are required to attend and participate in all CYFD provided training

Quarterly Reporting

Quarterly Reports and an Annual Report summarizing the year's activities, number of families served, number of visits and community presentations. Quarterly Reports are due by the 15 of October, Jan, April and the Final and Summary Report June 30.

APPENDIX A

HOME VISITING FORMS

The completion of these screening tools is required as outlined in the periodicity grid below. They are:

1. Edinburgh Postnatal Depression Scale
2. Knowledge of Infant Development Inventory
3. Ages and Stages Questionnaire (ASQ) including supporting documents
4. Ages and Stages Questionnaire: Social Emotional
5. WAST-Short
6. Social Support Index
7. Medical Assistance Developmental Guidance

Frequency of CYFD New Mexico Home Visiting Screening Tools

	Newborn	1 wk.	1 mo.	2 mo.	3 mo.	4 mo.	6 mo.	8 mo.	9 mo.	10 mo.	12 mo.	14 mo.	15 mo.	16 mo.	18 mo.	20 mo.	22 mo.	24 mo.	27 mo.	30 mo.	33 mo.	36 mo.	
ASQ						X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X
ASQSE							X				X				X			X		X			X
Edinburgh*	X		X	X	X																		
KIDI**							X				X				X			X		X			X
SSI***							X				X				X			X		X			X
WAST#							X				X				X			X		X			X
NM MAD RAG	X	X	X	X		X	X		X		X		X		X			X					X

SCREENING TOOLS MAY BE USED MORE FREQUENTLY IF AND WHEN HOME VISITOR OBSERVATIONS MAY INDICATE THE NEED FOR FURTHER INFORMATION.

HOME VISITOR/SUPERVISOR DISCRETION CAN BE USED TO DETERMINE THE APPROPRIATENESS OF USING THE AGES & STAGES QUESTIONNAIRE FOR CHILDREN REFERRED TO AND ENROLLED IN NM FAMILY INFANT TODDLER SERVICES.

FORMS INCLUDED BELOW ARE EXAMPLES AGENCIES MAY DEVELOP OR USE

Forms included in the Service Definition Manual are:

1. Home Visit Record
2. Day in the Life
3. Baby goal/Family goal
4. Family Satisfaction Survey

Home Visit Record

Visit # _____

1. Status of Home

Toys Available Reading Materials Available Safety Problems

Describe Safety Problems. _____

2. Status of the Child Not at home Clean Sleeping Appears Healthy
Sick Alert Active Inactive Quiet Smiley Playful

3. Status of Participant Sleepy Appears Healthy Sick Quiet Alert
Clean Talkative Expecting
Other _____

4. Parent Child Interaction
Cues/Attunement:

Holding/Reflection and Embellishment:

Eye Contact/Tone

Empathy:

Environment

Rhythmicity Reciprocity/Flexibility

Smiles/Affect

Home Visit Record

Child name:

Family Name:

Date of visit :

Length of visit:

Location of visit:

WHAT DID YOU DO DURING YOUR VISIT?

AREA OF FOCUS/ACTIVITY:

Increase Parenting Skills

Improve Family Health

Improve Family Environmental Factors

Increase Social Support Systems

Improve Positive Mental Health

Curriculum Use: Name: _____ Section: _____ Name: _____ Section: _____ _____ _____

Strengths: _____

Concerns: _____

Next Visit: _____ Follow Up: _____

Family Name: _____ Child's Age: _____

My Family's Goal for (Child's Name): _____ Date: _____

Based on what we have discussed so far, one specific goal I want for my child is:	Benefits for my child/family? (Why do I want to reach this goal?)
Personal strengths, family and community resources that can help our family with this goal (strengths):	What could get in the way of achieving this goal? How could you handle this challenge?

What I/we will do to get there...steps to take over the next 6 months:

Steps:	Routines	Date (when will this happen)	How did this go?

What we learned/outcome of goal...

Developed:

Parent(s) Signature: _____ Date: _____ Parent(s)

Signature: _____ Date: _____

Home Visitor: _____ Date: _____ SUP: _____

The Family Goal _____ Date: _____

(Family's Name)

Based on what we have discussed so far, one specific goal I want for myself or my family is:	Benefits for my child/family? (Why do I want to reach this goal?)
Personal strengths, family and community resources that can help me with this goal:	What could get in the way of achieving this goal? How could you handle this challenge?

What I/we will do to get there...steps to take over the next 6 months:

Steps:	Date (when will this happen?)	How did this go?

What we learned/outcome of goal...

Developed:

Parent(s) Signature: _____ Date: _____ Parent(s) Signature:

_____ Date: _____

Home Visitor : _____ Date: _____ SUP: _____

A DAY in the LIFE of (Child's Name) _____ Family Name _____ Date: _____

Please date each entry/update

Children learn and grow everyday. They learn through play, through interacting with others, and through everyday routines like bedtime, mealtime, bath-time, play, etc. Please use the following prompt questions, in your own conversational style, to look at the family's daily routine.

- How does your family spend the day?
- Where and with whom does your child spend time?
- Please describe what dressing, bath time, mealtime, and other routines look like for your child (include who participates in these activities).
- What about weekends or special times together?
- Who lives in your home? Do you have family/friends who visit you regularly or who you visit?
- Any changes since the last plan?

Which people, toys, activities, routines and places interest your child (bath time, park, grocery store, daycare schedule, sleep)? Why?

Which people, toys, activities, routines and places are challenging for your child? Why?

Family priorities and concerns (support systems, stressors, lifestyle behaviors, discipline, etc.):

Things I've done that I'm already proud of (accomplishments):

Parent Satisfaction Survey

1. How would you rate the quality of services you have received from _____.
 - A. Excellent
 - B. Good
 - C. Fair
 - D. Poor

2. Have the services you've received helped you?
 - A. Yes, they've helped a great deal
 - B. Yes, they've helped a little
 - C. No, they haven't helped much
 - D. No, they've seemed to make things worse

3. Would you recommend our service to others if they needed support?
 - A. Yes, definitely
 - B. Yes, probably
 - C. No, probably not
 - D. No, definitely not

4. Has your home visitor spent enough time with you?
 - A. Yes, always
 - B. Yes, most of the time
 - C. No, not usually
 - D. No, never

5. About how long is each visit? _____

6. Have you been treated with respect and consideration?
 - A. Yes, definitely
 - B. Yes, pretty much
 - C. No, not really
 - D. No, definitely not

7. Overall, how satisfied are you with the help you have received from the home visitor?
 - A. Very satisfied
 - B. Satisfied
 - C. Not satisfied
 - D. Very dissatisfied

8. Have you been satisfied with the information received on child development and parenting skills?
 - A. Very satisfied
 - B. Satisfied
 - C. Not satisfied

D. Very dissatisfied

9. How often has your home visitor talked with you about your baby, parenting and his/her health and development?

- A. Every visit
- B. Some visits
- C. Seldom during visits
- D. Almost never

10. If applicable, have you been satisfied with the group activities (make-up party, infant massages, Christmas party and outings, etc.)?

- A. Very satisfied
- B. Satisfied
- C. Not satisfied
- D. Very dissatisfied

Do you have any suggestions to make the groups better?

Do you have any ideas for group gatherings?

11. Please mark (x) the following styles of your home visitor.

- Supportive
- Critical
- Truthful
- Warm
- Understanding
- Phony
- Rude
- Informed
- Rigid
- Calm
- Unavailable
- Helpful
- Organized
- Not Organized
- Not on time
- On time
- Respectful of family

- Smothering
- Doesn't listen
- Too business like
- Encourages me to do things for myself
- Available
- Easy to talk to
- Hard to talk to
- Trustworthy
- Other _____

12. Which areas of your life have improved since beginning the program? (Please check those areas that apply to you).

- More support
- My ability to solve problems
- My ability to cope with problems and stress (worry less)
- More friends
- My relationship with my boyfriend/husband/girl friends/family members
- Taking care of my children
- My living situation
- My ability to control my temper
- My knowledge about the warning signs of potential child abuse/neglect (i.e. anger, depression, low self esteem)
- My patience with my child's negative behavior
- My understanding of child development and parenting
- The health care of my child(ren)
- Other improvements _____

13. Please add suggestions regarding the program or your home visitor that could better assist you better

14. How long have you been in the program? _____ weeks _____ months _____ years

15. If you are leaving or have left the program, give your reasons. Please be honest, remember, we are not asking you to sign your name.

Date: _____ Home visitor name _____

**PLEASE MAIL THIS SURVEY IN THE STAMPED ENVELOPE PROVIDED
REMEMBER, WE ARE NOT ASKING YOU TO SIGN YOUR NAME**

Sample Letters included in the Service Definition Manual:

1. Contact Letter
2. Potential Discharge Letter
3. Closure/Parent Satisfaction Survey Letter

YOUR LETTER HEAD

YOUR NAME AND ADDRESS

Date: _____

Client's Name _____

Address

Dear

Our program has tried several times to reach you without success. Perhaps there was a misunderstanding about the dates and times we were to meet. We would love to hear from you and tell you more about what our home visiting program can actually offer you.

Many of the mothers in our program like to meet with their home visitor and discuss the many changes their babies are making. Home visitors help them enjoy their babies by providing interesting activities to help their babies learn and grow in a healthy way. Babies do not come with directions. Sometimes being a parent is exhausting and frustrating. It helps to talk to someone and share concerns and ideas. Home visitors are special friends to parents and babies.

If you would still like to take advantage of our home visitation service we would be glad to meet with you. Please feel free to phone me when you need to talk to someone.

Sincerely,

Home Visitor

YOUR LETTER HEAD

YOUR NAME AND ADDRESS

Date

Parent's Name:

Address: _____

Dear

I have been attempting to contact you by phone and/or leaving messages at your home, but have not heard from you. Our program policy is that after attempts for a 3-month period have been made and a parent doesn't respond, we will discharge you from our program.

Please call us at any time for any information you may need regarding your child or family's health care.

Sincerely,

Home Visitor

YOUR LETTER HEAD

**Your name
and address**

Date:

Parent's Name

Address:

Dear _____

You have been part of our program since _____. We have been pleased to offer you our Home Visiting Services throughout this time. It is time to end the home visits and I wish you well. Enclosed is a Parent Satisfaction Survey and self-addressed envelope. Please take the time to fill it out and mail it back to our office. This will help me to know how to best serve families.

Please call on us at any time for any information you may need regarding your child or family's health care.

Sincerely,

Home Visitor

APPENDIX B HOME VISITING GLOSSARY

DEFINITION OF TERMS

ASQ	Ages and Stages Questionnaire
ASQ: SE	Ages and Stages Questionnaire: Social/Emotional
Attachment	An emotional bond between a parent/primary caregiver and infant that develops over time and as a result of positive care-seeking behaviors (e.g., crying, smiling, vocalizing, grasping, reaching, calling, following) and responsive care giving (e.g., smiling, talking, holding, comforting, caressing).
Children’s Protective Services	a state-wide system to prevent or treat the abuse and neglect of children within the New Mexico Children, Youth and Families Department
Collaborate	Work willingly with other direct service providers, parents, community agencies, faculty, and other professionals to obtain, coordinate, and research services that effectively nurture infants and families.
Collateral Contacts	Sources that provide additional information to support or reinforce the assessment/evaluation and treatment of clients.
Community Collaboration	Participation with other community entities to address the health and well being of the community as a whole
Community Priorities	Issues identified through community collaboration that are paramount to provide positive affects to the health and well being of the community
Competency Guidelines:	Describe specific areas of expertise, responsibilities and behaviors that are required to earn the MAIMH Endorsement at Level 1 (Infant Family Associate), Level 2 (Infant Family Specialist), Level 3 (Infant Mental Health Specialist), and Level 4 (Infant Mental Health Mentor). Areas of expertise, very generally described here, include theoretical foundations; law, regulation and policy; service

systems; direct service skills; working with others; communicating; reflection; and thinking.

Consultation:	an opportunity for professionals to meet regularly with an experienced infant mental health professional to examine thoughts and feelings in relationship to work with infants, toddlers, and families.
Consumer	Someone who has a vested interest in the results of services for a specific, identified client (i.e. a judge, a public defender or an attorney).
Core Data Elements	Ages and Stages Questionnaire as well as output data such as ages, prenatal services, address etc.
Cultural Sensitivity	Unbiased knowledge of the family's culture and language which is an integral part of all efforts to deliver services. Beliefs and practices are identified which include, but are not limited to, family organization and relational roles (traditional and non traditional), spirituality, and understanding of ethnically related stressors such as acculturation, poverty, and discrimination.
Developmental Curricula	Evidence based curriculum, which has been developed for infants zero to three.
Developmental Guidance	Offering individualized guidance to parents about their children's development requirements, while focusing in the capacities of the child and the parent.
Early Intervention	Services that begin prior to pregnancy, during pregnancy or at anytime during the first three years of the child's life.
Family	At least one parent, caregiver, guardian, or custodian of the infant or toddler involved in the home visiting program on behalf of the identified infant/toddler.
Family Centered	This term refers to the need to look at the family as a whole. The aim is to support the family in service of the infant.
Family-Centered Practice	The infant and family professional's ability to focus on the infant or toddler within the context of the family and to respect the family's strengths and needs as primary.
First Visit	A First Visit is defined as the beginning of the relationship, which is established through the

implementation of the client intake form. **The First Visit is different from the Informational Contact.**

Formalized Session	A structured, scheduled meeting with a family.
Home visiting	An early intervention strategy used by states and communities to improve the health and well being of children and families.
Home visiting services	Services provided by a home visitor in a family's home or other community location which occur weekly during the first year of a child's life and as requested by the family during pregnancy and for the second and third years of the child's life.
Home visitor	A trained professional in early childhood development or non degreed professional who provides developmental guidance, educational and local community resource information, identifies social supports, and refers families to community resources to strengthen families and improve the well-being of children and families.
Human Services/Related Degree(s)	that include but are not limited to Social Work, Sociology, Counseling, Human Services, Criminology/ Criminal Justice, Public Administration, Educational Counseling, Education, Nursing and Health Education.
Identified/Billable Client	A family who meets the definition of the target populations identified by CYFD. The Identified Billable Family is a first time parent and the child's age is zero to three years.
Infant Family Associate	A professional who meets the requirements for NMAIMH Endorsement at Level 1.
Infant Family Specialist	A professional who meets the requirements for NMAIMH Endorsement at Level 2.
Infant Mental Health	An interdisciplinary field dedicated to promoting the social and emotional well-being of all infants, toddlers, and families within the context of secure and nurturing relationships. Infant mental health services support the growth of healthy attachment relationships in early infancy, reducing the risk of delays or disorders and enhancing enduring strengths.

Infant Mental Health Mentor A professional who meets the requirements for NMAIMH Endorsement at Level 4.

Infant mental health specialist: a professional who meets the requirements for NMAIMH Endorsement at Level 3.

Informational Visit Home visitor provide programmatic information **ONLY** to potential clients such as pregnant women, first time parents.

Informal Networks Informal networks refer to the parents' resources and access to family, friends and/or neighbors that may assist them emotionally, financially, with transportation, as in well as in other areas of potential need.

Database (MIS) Management Information System is an electronic tracking system for clients and service delivery.

Newborn Care Care that is provided to the mother and infant including medical, emotional, and psychological aimed at maintaining and enhancing the health and well-being of the infant.

The NM Association for Infant Mental Health Endorsement Process: A process that supports the development and recognition of infant and family professionals within an organized system of culturally sensitive, relationship-focused practice that promotes infant mental health.

Parallel Process Parallel Process is a way of modeling interactions, behaviors, attitudes, and possible responses exemplifying how these factors are incorporated into all aspects of home visiting. For example: Home visitor who are treated with dignity and respect will more likely apply these same values in their interactions with families.

Performance Measure A quantitative or qualitative indicator used to assess the outcome or result of a program/or service.

Pre Natal Care Pre Natal care refers to care that is provided to the mother during pregnancy. This includes medical, emotional, and psychological care, aimed at maintaining and enhancing the health of the unborn child, as well as the mother.

Reflective: Self aware, able to examine one's professional and personal thoughts and feelings in response to work within the infant and family field.

Reflective practice:	Able to examine one's thoughts and feelings related to professional and personal responses within the infant and family field.
Relationship-based practice:	Values early developing relationships between parents and young children as the foundation for optimal growth and change; directs all services to nurture early developing relationships within families; values the working relationship between parents and professionals as the instrument for therapeutic change; values all relationship experiences, past and present, as significant to one's capacity to nurture and support others.
Reflective Supervision	Reflective practice focuses on the development of relationships that support growth and development between supervisors and staff, staff and families, and parents and children. It is within these relationships that learning and change is able to take place. Is more a way of being than a way of doing (Zero to Three). Face-to-face, group or individual supervision of home visiting staff by a supervisor who meets relevant experience in reflective practice. The supervisor promotes the development of skills and responsibility in the delivery of home visiting services.
Related Field	An allied mental health field or counseling related field including social work, guidance and counseling, mental health, psychology, family studies, marriage and family therapy, family sciences, rehabilitation counseling, counselor education, or social anthropology.
Relevant Experience	Significant and demonstrable experience in providing services to the target population.
Service Collaboration	Participation with other community entities to benefit the health and well-being of children and families in the target population.
Service Priorities	Universal home visiting services for all first time parents and caregivers. These services cover the target population during pregnancy, with infants, and with toddler's ages zero to three.
Supervision	A learning experience in which a professional meets regularly with an experienced infant mental health professional to examine professional and personal thoughts and feelings in relationship to work in the infant and family field.

Target Population

First time parents, including adoptive parents or those who are parenting for the first time.

Universal Services

Services available to all individuals regardless of income or any other criteria; for the Home Visiting Program, services are provided universally to all first time parents or individuals who are parenting for the first time, including adoptive parents. Children are enrolled at any age through 3rd year of life.

PARA

Number of live births a woman has experienced.

APPENDIX C

**CYFD BACKGROUND CLEARANCE
PROCESS**

SUMMARY OF BACKGROUND CLEARANCE PROCESS

The Background Clearance Unit of Family Services is responsible for ensuring children are in safe, responsible and morally positive settings. Background clearances are conducted in order to identify those adults who have relevant misdemeanor convictions, felony and/or arrests that operate as a disqualification to provide services. In addition, the Unit conducts abuse and neglect screens, utilizing Protective Services data, in order to identify those persons who pose a continuing threat of abuse and/or neglect to minors or adults in their care.

PAYMENT REQUIREMENTS

The cost is \$34.00 for each set of fingerprint cards. The fee is used to pay the Federal Bureau of Investigation (\$24.00), the NM Department of Public Safety (\$7.00) and the Internet provider (\$3.00). The Children, Youth and Families Department does not charge a fee for its services at this time.

The fingerprint cards, along with the \$34.00 fee (money order or cashier's check only made payable to the NM Department of Public Safety) must be sent to:

Children, Youth and Families Department
Early Childhood Services Division
Background Checks Unit
P.O. Drawer 5160
Santa Fe, NM 87502-5160

FREQUENTLY ASKED QUESTIONS

Q: Where do I get fingerprint cards?

A: You can obtain blank fingerprint cards from the Child Care Licensing District Office in your area by calling (505) 841-4820.

Q: Where do I get fingerprinted?

A: Your local law enforcement agency can perform these services or can refer you to another source.

Q: How soon do I need to submit my fingerprints?

A: Two fingerprint cards must be submitted prior to commencement of employment, whether agency employed, contractual or volunteer.

Q: How soon can I begin work once the fingerprints have been submitted?

A: All personnel (agency employed, contractual or volunteer) who have any contact with clients must have a CYFD Background Clearance within 60 days of employment. Prior to obtaining the clearance, these employees must work in

direct supervision of a cleared staff person at all times. Personnel including but not limited to administrative, support and facilities staff, who do not have contact with clients must have a CYFD Background Clearance within 60 days of employment.

Q: Why do I need to submit two fingerprint cards?

A: The Children, Youth and Families Department submits criminal history inquiries to the Federal Bureau of Investigation (FBI) by scanning the fingerprint card into a computer software program.

The fingerprint card image is then forwarded to the FBI electronically. In the event the computer system is unable to read the first fingerprint card, we are able to use the second fingerprint card you submitted, in an effort to avoid delays.

Q: Is there a cost?

A: Yes. The cost is \$34.00 for each set of fingerprint cards. The fee is used to pay the Federal Bureau of Investigation (\$24.00), the NM Department of Public Safety (\$7.00) and the internet provider (\$3.00).

The Children, Youth and Families Department does not charge a fee for its services at this time.

Q: Where do I send my fingerprint cards and payment?

A: Mail your fingerprint cards along with the \$34.00 fee (money order or cashier's check only made payable to the NM Department of Public Safety) to:

Children, Youth and Families Department
Family Services
Background Checks Unit
P.O. Drawer 5160
Santa Fe, NM 87502-5160

Q: I was arrested but not convicted of the crime. Will that prevent me from receiving a Background Clearance?

A: No. The Children, Youth and Families Department will only deny Background Clearances when relevant convictions exist.

Q: I know of someone who was denied clearance, although they had never been arrested or convicted of a crime. How did that happen?

A: In addition to the criminal history, the Children, Youth and Families Department conducts a Protective Services screen for child/adult abuse and/or neglect. A denial of clearance is required if a fingerprint applicant is the perpetrator of certain substantiated abuse and/or neglect referrals.

Q: How long does it take to get a Clearance?

A: The Children, Youth and Families Department is committed to providing an answer within two

to four weeks of receiving the fingerprint cards. Obtaining a Clearance is not automatic. There are a number of important factors taken into consideration, such as criminal and Protective Services histories.

FINGERPRINT CARD INSTRUCTIONS

State and Federal regulations prohibit the verbal and written disclosure of information obtained through a background clearance and requires proper security for records containing criminal information.

Completed fingerprint cards and accompanying information are legal documents and should be treated as such.

All documents submitted to the Children, Youth and Families Department become the sole property of the Department. Two complete sets of fingerprint cards must be submitted to the Background Checks Unit in legible black print or typed in black ink. The following information is required on the fingerprint cards

(Note: All numbered items in this section correlate to the information required on each fingerprint card).

1. Last Name of Applicant
2. First Name of Applicant
3. Middle Name of Applicant **(complete name, not initial, “NMN” for no middle name and “_” for Initial only)**
4. Signature of Applicant in black ink **(The applicant must sign the fingerprint cards after all information on the fingerprint card is correct and complete)**
5. Mailing address of Applicant **(street, rural route number, P.O. Box, city, state and zip code)**
6. Aliases used by Applicant **(AKA –include maiden name or previous married names and any other names used)**
7. Citizenship of Applicant **(identify by country, i.e., United States or US, Mexico or MX)**
8. Date of fingerprinting
9. Signature of Official taking fingerprints
10. Originating Case Agency –**Leave Blank**
11. Employer complete name, address, city, state and zip code
12. FBI no. FBI – **Leave Blank**
13. Armed Forces Number of Applicant MNU **(if applicant has a current or previous armed forces number, enter the number. Otherwise leave blank)**
14. Social Security Number of Applicant
15. Miscellaneous Number of Applicant **(if applicant has another identification number, enter the number. Otherwise, leave blank)**
16. Sex of Applicant (Gender)
17. Race of Applicant
18. Height of Applicant

19. Weight of Applicant
20. Eye color of Applicant
21. Hair color of Applicant
22. Date of Birth of Applicant
23. Place of Birth of Applicant (enter state and/or country)
24. Reason Fingerprinted
25. Fingerprints