Department of Children and Families (DCF)
Division of Family and Community Partnerships (DFCP)
Office of Early Childhood Services (OECS)

Annex A Instructions: Healthy Families-TIP

IMPORTANT: The completed contract renewal materials are to be sent to the DCF contract administrator coordinating the contract renewal process. In addition, please provide a copy (and an electronic version of both the completed **Annex A** and **Annex B** documents for all DCF (i.e. DCP&P, DFCP, and CBCAP funded) Home Visitation (HV) grants (i.e. Healthy Families-TIP, Nurse-Family Partnership, Parents As Teachers, Home Instruction for Parents of Preschool Youngsters, etc.) to the designated DFCP Office of Early Childhood Services (OECS) Home Visitation Program Specialist assigned to review your contract.

Annex A – Section 2 Program Information

Section 2.1 Program Name and Service Delivery Information

Complete the designated forms as described in the general Annex A instructions.

Section 2.2 Program Description

The program description now provides a standard narrative for the specific HV models and underscores essential contract requirements for grantees. Please cut and paste this information into your agency's Annex A, as appropriate. Please be sure that you are aware of all DCF recommendations and requirements as a funded HV grantee. Read this template language carefully and add agency specific information (highlighted sections), as requested.

Section 2.2 #1 Provide a Brief Program/Component Description and its Purpose

The Healthy Families America (HFA) model is an evidenced-based home visitation (EBHV) program that provides in-home health and parenting education, and supportive services to at-risk families, especially those overburdened by stressors that may contribute to child neglect and abuse. HFA identifies eligible families through a systematic screening and assessment process conducted during pregnancy or within two weeks of the birth of the target child. In NJ, families with a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three. Services are strengths-based and rely on parent/family input and active involvement. Participation in HFA is voluntary.

Specially trained home visitors, who often share the families' culture and community, educate families on important issues: prenatal health, infant/child health and development, positive parenting practices, nurturing parent-child relationships, child safety, education and employment, and the prevention of child neglect and abuse. They also link parents/families to existing social service and health care resources.

DFCP and the NJ Department of Human Services (DHS), Division of Family Development (DFD) have collaborated to blend the TANF Initiative for Parents (TIP) with the Healthy Families (HF) model to ensure that all participating families benefit from a unified, research-based approach. The program, known as HF-TIP, provides HFA research-based parent education and support strategies to families that are receiving public assistance and supportive services, i.e., Temporary Assistance to Needy Families (TANF). A goal of this collaboration is to further

strengthen and support families who are receiving TANF and/or other assistance programs through home visits. *[NOTE: This paragraph does not apply to HF-only sites]*
All DCF-funded HF sites must complete the core training and adhere to the Healthy Families New Jersey (HFNJ) policies and procedures as set forth by the New Jersey state affiliate, Prevent Child Abuse New Jersey (PCANJ). Program staffing and supervision must be in keeping with the HFNJ program standards. HFA is based upon a set of 12 Critical Elements which provide a framework for program development and implementation, and assure quality services. All funded HFNJ sites must successfully complete the HFA accreditation process. The HFA model and these Critical Elements incorporate the principles outlined in the *NJ Standards for Prevention*. The HF model is strengths-based and emphasizes the importance of focusing on the *Protective Factors* in its work with families.

In additon, DCF has provided funding (through PCANJ) to complete training for use of the Parents As Teachers (PAT) *Foundational Curriculuam* as the *core* parenting curriculum for all HFNJ sites. In accordance with PAT national policies, programs will be considered a PAT approved user. [Note: Sites may supplement the PAT *Foundational Curriculum* with other parent education materials/handouts. If the program routinely uses supplemental curricula, please identify these materials _____.]

At present, __ of __ (total) staff have attended the PAT *Foundational* training.

All programs are expected to adhere to conceptual, practice and administrative standards as set forth in the *Standards for Prevention Programs: Building Success through Family Support* developed by the New Jersey Task Force on Child Abuse and Neglect. Grantee program and administrative staff are expected to have knowledge of *the Protective Factors Framework.*

Section 2.2 #2 Target Population
HFNJ is available to families from pregnancy to age three. Criteria for enrollment includes families during pregnancy or by three months of age.

Additionally, HF-TIP is available to parents with an infant up to twelve months old if they are currently receiving or eligible to receive TANF, Emergency Assistance (EA) or General Assistance (GA). *[The TANF extension to age one for HF enrollment does not apply to HF-only sites.]*

Potential clients are screened for a varity of risk factors, including but not limited to teen pregnancy, first-time or subsequent pregnancy, low income, inadequate or no prenatal care, unstable housing, social isolation, depression, substance use, domestic violence and other indicators that place a child at risk of abuse and neglect.

Section 2.2 #3 Service Delivery
EBHV programs are designed to promote protective factors that support the health and well being of pregnant women, parents/families and their infants and young children. Home visitors work closely with families to develop a trusting relationship, assess parent/family strengths and

promote a better understanding of the essential role of the parent (mothers, fathers and other responsible caregivers) in providing a nurturing, healthy and safe environment for their children. While the overall goal is to prevent child maltreatment, the program addresses key factors that are known (evidence-based) to contribute to child neglect and abuse--prenatal health, infant/child health, child growth and development, parenting skills/anticipatory guidance, parent-child bonding and interaction, early learning/school readiness, family/social support and adult relationships, education/employment, and linkages to needed treatment services, childcare and/or other community resources. As described elsewhere in this section, home visits are the key service delivery vehicle, and home visitors must adhere to the recommended schedule of visits to ensure that participating families benefit from the full impact of the program.

Documentation and Data Collection: All HF sites are required to record visit information and track specified data in the FAMSYS data system. To ensure accurate monthly, quarterly, and annual report data, EBHV sites must enter all documentation into the FAMSYS database by the 10th of the month for the previous month. This database is overseen by HFNJ state affiliate, PCANJ. [*NOTE: All HFNJ sites are required to pay a $600 annual fee for FamSys data management support.*]

SPECT Data System: DCF collaborates with the NJ Dept. of Health (DOH) and Family Health Initiatives (FHI) in regards to the Single Point of Entry Client Tracking data system (SPECT). The SPECT data system is utilized by prenatal providers, Central Intake, EBHV sites, and other core programs and partners. To ensure accurate monthly, quarterly, and annual report data, EBHV sites must enter all documentation into the SPECT database by the 10th of the month for the previous month.

DCF has established a standard quarterly report that is inclusive of a set of performance indicators for all EBHV programs supported by the department (refer to the attached word file, *EBHV Quarterly Progress Reporting Form*). These HV Objectives include three areas of focus--1) process, 2) impacts and 3) outcomes. Grantees are required to collect, review and analyze program performance data send it to PCANJ for preliminary review, quality checks, and then report to DCF on a quarterly basis.

Quarterly Service Reports: All programs are required to send quarterly report data to the designated DCF contract administrator and DFCP HV Program Specialist—using the following standard reporting periods: (The following is the program year for collecting the data required. It may not reflect the contract/fiscal year).

- July 1st to September 30th
- October 1st to December 31st
- January 1st to March 31st
- April 1st to June 30th
- Quarterly reports are due no later than 15 days after the report end date and should accompany the agency's submission of its quarterly *Report of Expenditures*.

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Continuous Quality Improvement (CQI): CQI is an essential aspect of service delivery. Funded agencies must demonstrate progress in meeting established program targets. The purpose of continuous quality improvement is to ensure that DCF funded programs are effective in reaching and supporting families, and helping families to achieve these core program objectives. Through this process, grantees identify areas for performance improvement to reach optimal levels of program functioning. **Refer to Section 2.2–subsection #8 for additional CQI requirements specific to the program model.**

CQI is initiated throughout the program year and as needed, based on the following guidelines:

a. Target Process / Level of Service (LOS) Measures (Table A)--Chronic underperformance (i.e. over 3-months) in any of the indicators in Table A- LOS, Enrollment, Discharges, Expected Visits and Retention. *Note: Retention is a challenge both nationally and statewide, but it is important to continue to strive to meet national and state standards. DCF, DHS/DFD and PCANJ will work collaboratively with sites to strengthen performance in this area over the next few years.*
b. Performance Objectives and Performance Measures (Table B)--Chronic underperformance (over 6months) in five or more areas Objectives- WIC enrollment, primary care providers, well visit, etc.

All grantees should strive to reach the above mentioned measures and benchmarks; however, we recognize that there may be variability across target populations and target communities. As part of the CQI process, programs respond to the underperformance as part of the quarterly report. Underperformance in any area is reviewed and addressed. If a program is placed on corrective action for underperformance, additional program data reports maybe requested more frequently. Revisions to mandated data reporting requirements for the federally legislated Maternal, Infant, and Early Childhood (MIEC) HV benchmarks will be issued in collaboration with all HV partners and will be required to track and be submitted by the program.

Note: These targets continue to undergo review and analysis. DCF HV program staff may make further refinements to specific targets, or add additional indicators, after this analysis is complete.

The CQI process will include input/consultation from all HV partners--PCANJ, grantee agency, DFCP HV Program Specialist, DCF contract administrator, DHS/DFD program manager (for TIP sites), and other stakeholders/local advisory board (including parent representatives), as appropriate. CQI processes will be reviewed on a regular basis.

Evaluation and Research Study: All DCF funded evidence-based HV grantees must participate in the statewide evaluation and research study being conducted by Johns Hopkins University and any other approved research projects in response to funding requirements. All DCF funded EBHV programs must notify the DFCP HV Program Manager and/or Program Specialist of their participation in any additional research/evaluation studies.

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Section 2.2 #4 Service Delivery Methods

HF services are provided to participating families primarily in the home setting. At times, visits may be conducted in an alternate mutually agreed upon setting, e.g. after school, work or community setting. Visits must be able to accommodate the participant's schedule and may be provided at alternate mutually agreed upon times, i.e. early morning, early evening or on a weekend day.

Referrals and Linkages:

HV program staff are encouraged to link families with additional resources that provide services in the target community, including other DFCP programs (e.g., Family Success Centers, School-Linked Services, DV support, Strengthening Families childcare providers, etc.), as appropriate. In addition, grantees shall routinely review and update exisiting entries in state, county and local resource networks and directories, e.g. DFCP's online directory or NJ's 2-1-1 Partnership Database, to ensure complete, accurate and up-to-date information for families and professionals trying to locate HV services.

Local Community Advisory Board:

HV grantees shall establish and/or maintain alignment with the local County Council for Young Children (CCYC) to form an active advisory board.

The advisory board must be an organized active body, which meets at least quarterly to advise/govern the activities of planning, implementation, and assessment of program services. This includes but is not limited to a review of program practices, policies, quarterly/annual performance measures, Continuous Quality Improvement (CQI) efforts, providing input and timely recommendations with respect to program strengths, areas of growth, and improvement. HV grantees are encouraged to integrate and/or develop this advisory role within the broader perinatal and/or early childhood community.

The HV grantee Program Supervisor/Manager (or other program representative) and the advisory board must work as an effective team in the planning and developing of program policies and procedures.

HV grantees must also identify at least one parent/caregiver from each FTE home visitor to invite to the advisory board and collaborate with the CCYC lead agency and/or members to encourage and facilitate parent/caregiver participation.

HV grantees must provide documentation of advisory board activities, have available meeting notes, and attendance records during site visits or as requested. HV grantees must also refer to the DCF Policy and Procedure: Advisory Boards

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Section 2.2 #5 Access to Services

Generally, HF services are provided in the participant's home. There are no physical limitations that preclude enrollment or participation.

Pregnant women and parents are screened by prenatal care providers, health care providers or other community agencies. HV sites are expected to be active partners with the local Central Intake (CI) and comply with the business agreements set forth, to ensure easy linkages for eligible pregnant women/parents and families. PCANJ and/or DFCP HV staff will help to facilitate these relationships with CI, as needed.

Once a family is referred to the program they receive an initial contact within three working days and are scheduled for an assessment visit from a Family Assessment Worker (FAW). The assessment process is essentially an interview/conversation with the parent. Content is guided by the questions outlined in the Parent Survey Checklist. Following the visit, the FAW completes and scores the Parent Survey. Families that score between 25 to 45 are offered participation in the program. Families with a lower or higher score may be accepted into the program on a case by case basis. Families with high score should be discussed with the HFNJ state affiliate (PCANJ). [Note: A family with an extremely high Parent Survey score may require a different level/type of service that offers treatment and/or intervention services not available from the HF program.]

Families that are assessed but not enrolled (i.e. score too low, too high or decline servcies) are provided with resource information about available/suitable community services and supports, and are assisted with any essential referrals. Based upon local Business Agreements/Rules, programs should provide a status report and re-route these families back to central intake for links to alternate services, as appropriate.

Families that meet program eligibility and agree to participate in the program are enrolled and visits are conducted by a Family Support Worker (FSW). The FSW will set up an appropriate visit schedule with the family based on the appropriate level of intensity. Criteria for each level is established by the HFA model and are assigned a case weight as follows:

Level P-1 (prenatal)	2 visits per month (minimum)	Case Weight = 2
Level I	1 visit per week (minimum)	Case Weight = 2
Level M-I (multiples)	1 visit per week (minimum)	Case Weight = 3
Level II	1 visit every other week	Case Weight = 1
Level III	1 visit per month	Case Weight = 0.5
Level IV	1 visit per quarter	Case Weight = 0.25
Level 1-SS	2 visit per week	Case Weight = 3
Level X (lost-to-care)	0 visit per week (active outreach)	Case Weight = 0.5
Level TR	transition to a new worker	Case Weight = 0.5

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Families that are enrolled but inactive, i.e. Level X - lost-to-care, will continue to receive positive, creative outreach for at least three months and not to exceed four months. The definition of "inactive status" is located in the HF-NJ policy and procedure manual.

The FSW and the parent/family collaborate to complete an initial Goal Plan within 45 days of enrollment. The Goal Plan includes measurable family goals (pregnancy, parenting, infant/child, family sustainability, TIP/employment) with ongoing progress documented. A new Goal Plan is developed at least every six months.

The FSW will assist participating families with referrals for health, social service, child care or other community supports as needed and mutually agreed upon.

Staffing/Caseload Requirements:

- HF Supervsior – The ratio of full time equivalent (FTE) Supervisor to direct service staff should not exceed 1:6 (one FTE Supervisor to six FTE staff).
- The ratio of FTE Supervisor to part-time direct service staff should not exceed 1:8 (one FTE Supervisor to eight part-time staff).
- Family Assessment Worker – minimum of 10 assessments monthly per 1.0 FTE
  Family Support Worker – caseload caseweight of 30 per 1.0 FTE (Note: at any point in time the FSW will have a caseload of a minimum of 15 families / max of 25 families).

Discharge Process: Ideally a participant remains enrolled in HF until the family is stable (at level IV), has made progress in achieving key goals on the Goal Plan, has reached specified HV health and well-being performance indicators, and the target child reaches age three. [Note: Families may remain enrolled beyond age three only on a case by case basis after consultation from the DFCP HV Program Specialist and HFNJ state affiliate, PCANJ.] For a variety of reasons, families may withdraw from the program earlier. Sites are required to track length of participation, reasons for discharge and progress in reaching specified goals and objectives.

Section 2.2 #6 Catchment Area/Neighborhood
Grantees provide services in the homes of participating families. The catchment area for this site is _____(specify county and major at-risk municipalities for your agency--remember all HF-TIP programs are county wide).

Section 2.2 #7 Emergency/Afterhours Contact
Client and staff safety is an important concern in home visitation programs. All program staff are required to undergo background checks. Field staff carry cell phones and are instructed to remain in regular contact with the office during the course of the day.

In the event of any staff or client emergency _____(briefly summarize key safety policies for your agency).

Emergency contacts for this agency are: _____ (complete this for your agency).

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Section 2.2 #8 Unduplicated Clients (Annual Report)
In compliance with the Healthy Families America Model, all sites must submit the most recent Annual Service Review/Quality Improvement Planning report to PCANJ within 90 days of the end of the contract period.

Furthermore, DFCP/OECS requires the Quarterly Report/Year-End Report to be submitted 15 days after the end of the report period. The Quarterly Reports should include explanations why a program may not be reaching a particular objective and what is the plan to make improvements.

It is recognized by DCF that collection, analysis and reporting of data for these objectives is an ongoing process. Adjustments to performance measures may still be needed and will include the federal MIECHV benchmarks. Adjustments will be made by DCF in consultation with PCANJ and HF partners, as indicated.

NOTE: As noted above in Section 2.2-subsection #3, programs are still required to submit quarterly reports on an ongoing basis during the year.

Section 2.3 Performance Outcomes
In lieu of the standard Annex A Section 2.3 form, HFNJ programs are to submit the 3-page HV Performance Outcome Form. Grantees must use the HF template for this form (posted on the DCF website) and insert projected numbers in the blanks (specifically in Objectives 1, 2a and 2b) where indicated for the upcoming year.

Section 2.4 Program Personnel Information Sheet
Please complete all of the information as requested in the general instructions. Be sure to include the **first and last name** of the employee and **educational credentials** of HV staff.

IMPORTANT: HV grantees must provide a breakdown of staff roles and specify the percentage (FTE and estimated hours per week) of time allocated for each worker in the specified HV roles, i.e. Program Manager, Supervisor, Family Assessment Worker, Family Support Worker and Data Entry/Program Support. Use the column titled Functional Job Duties to itemize core functions/role with an estimate of the average number of hours per week (e.g., administrative support – FamSys data entry and program support 10 hours per week).

Section 2.5 Level of Service
A monthly contracted level of service chart is to be completed for each program/component, if applicable. One program might require several LOS forms to be completed which can be downloaded from the website. This will be indicated to you by the Contract Administrator and/or in the renewal/award letter.

The information on this form is usually utilized as a reference/source document when completing reporting forms during the contract term, when required by DCF.

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Service Type: Per service dictionary, contact your contract administrator (i.e. individual counseling, residential placement, legal assistance, transportation)

Description of Unit Measurement: Indicate what is being used as the measurement for monthly Contracted Level of Service (CLOS), (i.e. beds, rides, sessions, hours)

Number of Contracted Slots/Units: Numbers should reflect unduplicated service counts. Unduplicated service counts refers to the practice of counting a customer receiving services only once within a service cycle.

Refer to Annex B2 and or Renewal/Award Letter for this number. (i.e. # of beds, # of rides, # of sessions, # of hours)

Annualized Units: Equivalent to the Annual Total under Column 3 on chart.

Column 1: Select Month from drop down menu. Month 1 should reflect 1st month of Contract.

Column 2: Indicate Actual Number of Expected Days of Service or Units Per Month.

Column 3: Indicate total Contracted LOS per month, this could be 'Days of Service' multiplied by Number of Contracted Slots/Units per month or equivalent to number listed in Column 2.

Annual Totals: This number will equal annualized number of units to be contracted per program type.