Florida MIECHV Initiative

Implementation Policies for Local Implementing Agencies

The Florida MIECHV Initiative provides funding for the implementation of three evidence-based models: Healthy Families America (HFA), Nurse-Family Partnership (NFP) and Parents As Teachers (PAT). Federal MIECHV funding is intended to support services for high-risk families at an intensity and duration that can influence outcomes across the six MIECHV Benchmark areas. These policies are intended to support local implementing agencies (LIAs) with procedures that will help them meet the performance measures. LIAs should also visit https://www.flmiechv.com/ to reference the following documents:

- Florida MIECHV Data Collection Manual
- Florida Home Visiting Information System (FLOHVIS) User Manual
- Florida Home Visiting Information System (FLOHVIS) Reports Manual
- Florida MIECHV Initiative Continuous Quality Improvement Plan
- Florida MIECHV Subrecipient Fiscal Policy Manual
- Florida MIECHV Initiative Provider Quality Assurance Review Procedure Manual
- Florida MIECHV Supplemental Policies for Parents As Teachers Sites

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Policy 1: Participant Eligibility, Recruitment, and Enrollment in MIECHV Services

1.1 Eligibility

MIECHV participant recruitment should focus on serving eligible families per the HRSA Priority Populations:

- Pregnant women under age 21
- Low income families
- History of child abuse/neglect or involvement in the child welfare system
- Current or previous substance abuse
- Tobacco use in the home
- Low student achievement for participant or child
- Participant has a child with a developmental delay or disability
- Participant is an active/former member of the US military or participant/child is a dependent of an active/former member of the US military

MIECHV services are offered in designated high-risk counties and zip codes. Families enrolled should meet the model's definition of high-risk and a large proportion of the participants should also represent many of the priority populations listed above. Services funded by MIECHV are reserved for families with multiple risk factors.

Enrollment in MIECHV programs must be voluntary on the part of the participating family. A family cannot be court-ordered or in any way required to participate. If a family is involved in child welfare services and receiving in-home services, it must be clear to all parties that participation in MIECHV is voluntary and does not replace any services normally provided as part of the family's case plan with child welfare. There can be no perception that enrollment will support re-unification or another desired outcome. These issues must be addressed prior to offering enrollment to the family. Because MIECHV programs achieve the desired outcomes only when services are delivered with fidelity to the evidence-based model, only long-term primary caregivers should be enrolled. A child in the custody of foster parents or other temporary guardians should not be enrolled. See Section 2.2 for additional information about serving families when children are removed after enrollment.

1.2 Recruitment

Recruitment must be on-going in order to maintain service to the contracted number of families. Each program should have a policy on recruitment and must participate in the Local Coordinated Intake and Referral (CI&R) process implemented by the local Healthy Start Coalition, which includes the universal prenatal and infant risk screening infrastructure. The CI&R process will be used as a source for identifying potentially eligible program participants. Agencies may also conduct outreach and directly enroll families as a supplement to CI&R. The program will also participate as a referral agency within this infrastructure to foster a coordinated screening and intake strategy for families in need of services.

1.3 Enrollment

Formal enrollment includes completion of the consent form(s). These should be signed during the first completed home visit as defined by the model.

1.4 Re-Enrollment in MIECHV Services after Program Exit

Families who completed the program may <u>not</u> be re-enrolled. At the discretion of the program supervisor, families may be eligible to re-enroll if they have not completed the program. While each model has specific guidance, the following offers an overview:

- PAT: Families who exit the program before completing two years of service may be considered for re-enrollment within 180 days of program exit. This is only possible if enough time remains for the family to receive at least two years of active service before the youngest target child ages out.
- HFA: A family may be re-enrolled with the same target child if the closure date was within 90 days prior to re-enrollment <u>or</u> the target child is less than three months of age.
- NFP: Families who exit the program may be re-enrolled up until the child's second birthday.

In making a decision about re-enrollment, the supervisor and previously-assigned home visitor should review the circumstances of the case and consider the following:

- potential impact the program could have before the target child ages out;
- suitability of other community programs to meet the family's needs;
- reason(s) the family left the program previously and to what extent those reasons may still be a concern; and
- the amount of time the family has been out of service, since the program will be accountable for missing data and screenings that were required during the time the family was not receiving services.

<u>Florida MIECHV data collection and management when a family re-enrolls with same target child:</u>

- Contact the FLOHVIS Specialist to request that the dismissed Participant Record be re-enrolled in the program. Update the necessary demographic fields.
- Complete a Household Profile and a Child Wellness Update.
- Continue MIECHV data collection schedule based on the *first* date of enrollment.
- If family was not enrolled when data collection was due, skip it (exception: Relationship Assessment Tool for HFA and PAT). Please note that data not collected due to dis-enrollment/re-enrollment will be reported as missing data, even though the family was not technically enrolled during this time.

In *rare* circumstances, families whose previous target child is no longer eligible and who did not complete the program *may* be eligible to re-enroll with a new target child. This is allowed only if the mother became pregnant or had a child *after* the family left services. The supervisor should contact the MIECHV Data Quality and Reporting Manager for specific guidance to ensure Florida MIECHV policies are followed.

Policy 2: Engagement, Caregiver Changes, and Family Retention

2.1 Engagement

From the first contact with the parent(s), staff are making efforts to engage the family in a long-term commitment to home visiting services. While the mother may be the one referred to the program, every effort should be made to engage fathers, spouses and other primary caregivers.

Staff may request a training called "Strategies for Effectively Engaging Families" through the MIECHV Training Coordinator.

2.2 Caregiver Changes

When a caregiver changes, the home visitor and supervisor must assess if the family can continue receiving services. If the caregiver changes to an individual who is or will be a parent to the target child and that individual wants to continue services, the family may continue to be served. A change in the participant would only occur if the original participant is not returning. Contact the MIECHV data manager if that is the case.

If the target child is removed from the participant's care and placed with a temporary guardian, services may continue with the participant only if there is a plan for reunification and if the participant wants to receive home visits with the target child during visitation. Due to the voluntary nature of the program, home visits cannot be mandated. If visits cannot continue, then the family need to be closed. Services cannot be provided to foster parents, unless there are no plans for reunification and they plan to adopt the child. Contact the MIECHV data manager if that is the case.

2.3 Family Retention

If a family is missing home visits, the home visitor must actively employ and document strategies to re-engage the family in the program. Programs should consider using continuous quality improvement (CQI) methods to identify, test and implement strategies for successfully engaging and retaining families in services. There are multiple reports in FLOHVIS that can assist with using data to inform CQI. It is recommended reviewing the report, "No Home Visit in 30, 60 or 90 Days" at least monthly to identify participants disengaging from services.

Each program must have policies and procedures clearly stating the following:

- Steps that should be taken when a family misses a visit and/or shows signs of disengagement from the program.
- Different methods of creative outreach to re-engage the family in services, including how often the home visitor should contact the family.
- Criteria for closing a family due to disengagement.

Policy 3: Intimate Partner Violence

3.1 Memorandum of Understanding with the Local Domestic Violence Center(s)

Sites must have a memorandum of understanding (MOU) with the certified domestic violence center(s) (DV) in their service area. The Florida Coalition Against Domestic Violence maintains a list of the certified DV centers here: https://www.fcadv.org/local-center-services. At a minimum, the MOU should include the following:

- Roles and responsibilities of both agencies
- A description of the types of services provided
- Confidentiality and information sharing
- Procedures for cross-training staff from both agencies
- Procedures for the referral processes for both agencies
- A designated position dedicated to being a point person for each agency
- A description of strategies and activities necessary to achieve the contents of the MOU
- Term in effect and review/renewal process

3.2 Training on Intimate Partner Violence

Home visitors must receive an orientation to the procedures for intimate partner violence (IPV) screening and working with participants experiencing IPV, as well as services provided by the local DV center, prior to screening for IPV or serving families known to be experiencing IPV.

Within 12 months of hire, home visitors and supervisors must receive the Supporting Families Affected by Intimate Partner Violence training that was developed in partnership with the Florida Coalition Against Domestic Violence. Staff can check for training events in the Learning Management System.

3.3 Screening for Intimate Partner Violence

Sites must screen all participants within six months of enrollment. It is not recommended that the tool be used on the initial visits, unless there are concerns. Screenings must be conducted using the tool designated by the model developer (Relationship Assessment Tool for HFA and PAT; IPV Clinical Assessment for NFP). Program staff should not screen participants when other individuals are present, with the exception of nonverbal children.

Information regarding available services should be offered to all participants, regardless of the screening outcome, unless it is unsafe to do so. Every participant with a positive screen must be offered a referral for IPV services within seven days of the screening date. If program staff have any questions or concerns about the safety of the participant and/or the children in the home, the case should be staffed with the supervisor, even if the screening is negative. All IPV screening results and referrals should be entered into FLOHVIS.

3.4 Local Protocols and Referrals for IPV

Sites must have a protocol with specific procedures in place for working with participants who are experiencing domestic violence. This must include procedures for documentation with the understanding that, under some circumstances, the file could be accessed by the abuser or

subpoenaed which could put a participant at additional risk if the file contains information regarding intimate partner violence.

Participants who screen positive or self-disclose to staff must be offered a referral to a certified domestic violence center within seven days. Continuation and quality of services should not depend on the acceptance of the referral. Referrals should be entered into the data system following the protocol designation by their site's policies and procedures.

When participants decline services, home visiting staff can contact staff at the DV center for technical assistance without disclosing personally identifying information that may support staff as they support the participants.

3.5 Workplace Violence and Staff Safety

If a staff person discloses current IPV, they should be offered a referral to a certified domestic violence center. They should be provided the same information regarding services available that is offered to participants, assuming it is safe to do so. The staff person's willingness to accept services should not have any impact on their employment with the agency and confidentiality must be respected at all times.

Reflective supervision should include a discussion of the potential impact of the current IPV on working with families experiencing IPV to determine the home visitor's capacity for working with those families.

Site policies will need to include procedures that consider workplace safety for the survivor and co-workers, as well as the safety of home visitors working in homes where IPV is present.

Policy 4: Child Development

4.1 Memorandum of Understanding with the Local Early Steps Program and Other Providers of Developmental Services for Young Children

Sites must have an MOU with the Early Steps program(s) in their service area, as well as any other providers to whom referrals will be made for developmental promotion/delays. At a minimum, the MOU should include the following:

- Roles and responsibilities of both agencies
- A description of the types of services provided
- Confidentiality and information sharing
- Procedures for cross-training staff from both agencies
- Procedures for the referral processes for both agencies
- A designated position dedicated to being a point person for each agency
- A description of strategies and activities necessary to achieve the contents of the MOU
- Term in effect and review/renewal process

4.2 Developmental Screening

All target children should be screened using the ASQ-3 at the 10, 18 and 30-month intervals and the scores for each domain must be entered in FLOHVIS. If a child already has a delay and is receiving services to address the area of concern, do not complete that subscale on the screen. You must mark the box "Score not recorded for this subscale…" for the applicable areas. The other subscales should still be administered unless the child's provider provides documentation they have screened in those areas or indicate it is inappropriate to do so.

While the ASQ:SE is not required to meet the HRSA Performance Measures, social-emotional development is a critical part of infant/early childhood development. LIAs should follow the model developer's guidelines for administering the tool and include the ASQ:SE in procedures for addressing developmental promotion and referrals.

4.3 Training on Developmental Screening

Staff must be trained on using the ASQ-3 prior to administering it. This training can be provided by MIECHV or through a local trainer, such as the Healthy Start Coalition. Training must also include observing other staff conduct an ASQ-3 and receiving coaching from a peer or supervisor after being observed until competency is demonstrated. Role playing can be used for practicing how to introduce the screen and discussing the results.

4.4 Local Protocols, Developmental Promotion, and Developmental Screening Referrals

Sites must have a protocol with specific procedures in place for working with children who have developmental concerns.

If a child scores in the monitoring zone (gray area) or below the cut-off (black area) on one or more domains on the ASQ-3, the home visitor must deliver in-home developmental promotion activities during home visits to encourage improvement in the specific domain(s). Documentation in FLOHVIS should include the name of the activity/activities, the date(s) delivered, and the area(s) of concern being addressed.

After delivering developmental activities, a rescreen should be conducted at the next interval (e.g., a 12-month ASQ-3 should be administered for a child with a score in the monitoring zone of the 10-month ASQ-3). Rescreens following a low score should be entered in FLOHVIS.

For scores that fall below the cut-off, a referral to Early Steps must be offered within seven days of the date the ASQ was administered and the referral must be recorded in FLOHVIS, even if the participant declines. Other referrals may also be made and recorded. These referrals do not replace the need for in-home developmental activities.

The outcomes of referrals made for developmental concerns must be recorded in FLOHVIS. For children with a score below the cut-off, they must receive an Early Steps evaluation within 45 days of referral, service from another provider within 30 days of the referral, or in-home developmental support activities.

4.5 Developmental Surveillance

During every home visit, home visitors should ask parents if they have any concerns about their child's development, behavior or learning. In addition to recording their response in FLOHVIS, home visitors should develop and implement a plan to address any concerns. This could be through providing information, referrals, developmental guidance, activities, etc.

4.6 Early Language and Literacy

Four times during the target child's first year (0-1 month, 2-3 months, 6-7 months and 10-11 months) and twice per year for children of all ages, the home visitor should ask participants to think about a typical week and answer how often they read, told stories or sang to their child. While the answer may vary in atypical weeks, a parent will ideally read, tell stories or sing to their child every day during a typical week. These activities foster early language and literacy skills. If the parent is not doing this, the home visitor should provide developmental guidance and encouragement to the participant and help them take steps to increase these activities.

4.7 Parent-Child Interaction

A primary role of home visitors is to promote parent-child interaction (PCI) through modeling and activities. While home visitors are always informally observing PCI, it is important to periodically observe and document PCI using a standardized tool. PCI tools should be administered as follows:

- CHEERS Check-In/CCI (HFA): 4-7 months old, 16-19 months, 28-31 months old, 40-43 months old, 52-55 months old.
- DANCE (NFP): 1-3 months old, 8-10 months old, 15-17 months old, 21-23 months old.
- HOME (PAT): 6-8 months old, 18-20 months old, 30-32 months old, 42-44 months old.

LIAs are responsible for ensuring staff receive training on the tool and use it correctly. The date the tool was completed should be recorded in FLOHVIS. Activities should be delivered to improve PCI based on results from prior intervals with the goal of improving PCI over time.

Policy 5: Depression

5.1 Memorandum of Understanding with Mental Health Providers

Sites must have an MOU with mental health providers that may serve MIECHV participants and their families. The following resources may be helpful to developing a resource list and potential partners for MOUs:

- http://www.fccmh.org/
- https://www.faimh.org/local-chapters
- http://www.postpartum.net/locations/florida/

At a minimum, the MOU should include the following:

- Roles and responsibilities of both agencies
- A description of the types of services provided
- Confidentiality and information sharing
- Procedures for cross-training staff from both agencies

- Procedures for the referral processes for both agencies
- A designated position dedicated to being a point person for each agency
- A description of strategies and activities necessary to achieve the contents of the MOU
- Term in effect and review/renewal process

5.2 Training on Depression Screening

Staff must be trained on using the Edinburg Postnatal Depression Scale (EPDS) prior to administering it. This training can be provided through a MIECHV LMS Archived Webinar Training or through a local trainer. Training must also include observing other staff conduct an EPDS and receiving coaching from a peer or supervisor after being observed until competency is demonstrated. Role playing can be used for practicing how to introduce the screen and discussing the results.

5.3 Depression Screening

The EPDS must be administered to all participants within three months of enrollment for postnatal enrollments or within three months of delivery for prenatal enrollments. It is not recommended that the tool be used on the initial visit, unless there are concerns. While the enrolled participants are typically the mother, the EPDS is also validated with fathers and for identifying depression in parents with older children. Therefore, this tool can be used at any time during services when parental depression is a concern.

5.4 Local Protocols and Referrals for Depression

Sites must have a protocol with specific procedures in place for working with participants experiencing depression, particularly those at risk of harming themselves.

A referral must be offered for participants when an EPDS score is 10 or greater or the answer to #10 is anything other than “never.” A referral should be offered within seven days. However, local procedures should be followed for addressing any situation in which the participant could be at risk for suicide, including but not limited to answering anything other than “never” on #10. Local procedures must include an immediate response under these circumstances.

While a referral to a mental health clinician or in-home program such as Moving Beyond Depression (MBD) should always be offered to participants with depression or other mental health concerns, an internal referral for Mothers and Babies (where available) is also recommended. Home visitors referring to MBD must follow the requirements for that program including training, ongoing support and joint visits with the clinician.

Mothers and Babies may prevent depression from worsening by helping participants gain insight and develop healthy coping skills. While it does not replace treatment for depression, it may assist with helping participants to recognize they need treatment for depression. Mothers and Babies is recommended for all participants and, for those with depression, works best when offered in conjunction with treatment. Home visitors must be trained prior to delivering this curriculum.

When referring participants for mental health treatment, it is important to follow-up on services, including but not limited to obtaining release to communicate with the clinician. Several referrals may be needed before finding a good fit for the participant. The home visitors should also encourage the participant to continue treatment until no longer needed. All referrals and the outcome of referrals, as well as Mothers and Babies modules delivered, should be entered in FLOHVIS. All EPDS administration dates and scores must be entered to track increases or decreases in symptoms.

Policy 6: Participant Tobacco Use and Referrals

6.1 Determining Tobacco Use and Services

At enrollment and twice per year thereafter, the home visitor should ask the participant if they use any type of tobacco in the home. If the answer is "yes," the home visitor must also determine if the participant is currently receiving adequate tobacco cessation services. If the participant is not currently receiving adequate cessation services, a referral to tobacco cessation services must be offered within seven days. These answers and the referral must be recorded in FLOHVIS.

6.2 Referrals for Tobacco Cessation

Referrals for tobacco cessation can include an internal referral to one's self or another staff member for SCRIPT (Smoking Cessation & Reduction in Pregnancy Treatment), Tobacco Free Florida (http://tobaccofreeflorida.com/), or other tobacco cessation services. The referral should be recorded in FLOHVIS and the home visitor should follow-up on the outcome of the referral. Additional referrals, support and encouragement may be needed, since it usually takes multiple attempts before a person finally quits using tobacco.

Policy 7: Safe Sleep

7.1 Identifying Risk and Protective Factors

It is important to educate all parents and caregivers about safe sleep, as there are certain risk factors and protective factors that increase or decrease the chances of sleep-related infant deaths. At least four times during the target child's first year (0-1 month, 2-3 months, 6-7 months and 10-11 months), the home visitor should ask participants three questions and record the answers in FLOHVIS. The questions are:

- Do you always place your baby to sleep on his or her back?
- Do you always place your baby to sleep alone without bed sharing?
- Do you always place your baby to sleep without soft bedding?

A trusting relationship is important as many parents know they are expected to answer "yes" to these three questions. However, answering truthfully allows home visitors to explore why parents may not be following the recommendations for a safe infant sleeping environment, and potentially change their behavior by addressing their concerns/needs.

7.2 Promoting Safe Sleep and Training on Safe Sleep

Since MIECHV programs serve families during the period of greatest risk for a sleep-related infant deaths, promoting safe sleep practices is a vital part of the education provided by home visitors. Discussion of needs (e.g., safe bedding), and the parents' beliefs and desires are an important part of this education. Education about safe sleep should begin prenatally, if possible, as it easier to follow the American Academy of Pediatrics recommendations prior to initiating practices that are not in line with this guidance. Safe Baby Training is offered for staff through MIECHV. Additional resources can be found here:

- American Academy of Pediatrics - https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-child-care/Pages/Safe-Sleep.aspx
- Sleep Right, Sleep Tight - https://www.ounce.org/safe_sleep.html
- National Institute for Children's Health Quality - https://www.nichq.org/
- Cribs for Kids - https://cribsforkids.org/

Policy 8: MIECHV Data Requirements

8.1 MIECHV Data Collection

Federal MIECHV funding mandates the reporting of programmatic and Participant-level data in aggregate on a monthly, quarterly, and annual basis. Florida MIECHV programs are therefore required to collect specific data elements to meet these federal reporting requirements. The MIECHV Data Collection Manual and tools referenced therein should be used by all MIECHV staff to access the most up-to-date data collection forms and accompanying guidance. This manual, the required Assessment and Screening Tools, and the MIECHV Data Planners for each program model are posted in the FLMIECHV GroupSite share folders.

All MIECHV staff should complete the MIECHV Data Collection Training as part of the new hire orientation process. This training is an online, self-paced video training that can be accessed at any time. Register in the MIECHV LMS.

8.2 Access to and Use of FLOHVIS

The Florida Home Visiting Information System (FLOHVIS) captures all data required for federal reporting, and additional data as needed to facilitate tracking and reporting on CQI efforts. The FLOHVIS User Manual and FLOHVIS Reports Manual are posted in the FL MIECHV GroupSite share folders and on the Home Page of FLOHVIS. MIECHV programs are required to follow the policies and protocols detailed in these manuals.

The only data entered in FLOHVIS are those on home visiting program Participants who:

1) are served by staff funded by the Florida MIECHV Initiative and
2) have signed consent forms that specify FAHSC and the University of South Florida as named entities with permission to access these confidential data.

All FLOHVIS Users must complete the MIECHV Data Collection Training and the FLOHVIS Basic Training before gaining access to their live site. Full users must also complete the next scheduled FLOHVIS Data Entry Training and should be closely supervised by a fully trained

FLOHVIS User until that training is complete. Users should also complete the FLOHVIS Reports Training once all other training is complete.

There are a limited number of user accounts available for each MIECHV team. Supervisors and administrators may request a new user account for their staff via email, with the following information about the new FLOHVIS User:

- First and last name
- Email address
- Confirmation that the new user has completed both the MIECHV Data Collection Training and the FLOHVIS Basic Training.
- Role on the team (home visitor, data entry, supervisor, etc.)
- Whether the user should have permission to delete data.
- Report User (only running reports) or Full User (entering data and running reports).

In the event that a FLOHVIS User leaves employment with the MIECHV team, the FLOHVIS Administrator should be notified as soon as the termination date is known, and in no case later than the user's last day of employment. If access to a user account needs to be terminated immediately and the FLOHVIS Administrators are unavailable, please contact Social Solutions directly (866.732.3560 ext. 2) and request that the account password be changed to block access to the data system.

MIECHV programs are required by contract to comply with the data privacy and security provisions established in state and federal law. All staff handling Protected Health Information (PHI) must complete HIPAA training upon hire and then complete periodic refresher training as needed to remain in compliance with changing HIPAA regulations. These trainings should be documented in the MIECHV LMS.

FLOHVIS users must create passwords that are at least eight (8) characters long and include at least one letter and one number. Users should select passwords that are not easily guessed (e.g. *password1* is not a good password). Passwords should be protected and never shared with others. Users should log off any time they are not using FLOHVIS. This includes when stepping away from the computer, even for a short period of time.