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 in at-risk communities 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 Quality Assurance Plan
- Florida MIECHV Fiscal Policy Manual
- Florida MIECHV Supplemental Policies for Parents as Teachers LIA

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Policy 1: Model Fidelity

Florida MIECHV implements three evidence-based program models – Healthy Families Florida, Nurse-Family Partnership, and Parents As Teachers. LIAs are expected to maintain fidelity to the designated program model. LIAs must receive written approval from the program model for any adaptations to the model. LIAs must submit, or reference if previously provided, current written approval for implementation of the model and any adaptations with the execution of their MIECHV agreement.

Policy 2: Staff Support

2.1 Staff Recruitment and Retention

Given the high needs of enrolled families and the complexity of providing home visiting services, well-qualified staff are essential. LIAs must have a protocol with specific procedures in place for the recruitment and retention of staff. LIAs should ensure that employment requirements are in accordance with those of the program model.

2.2 Staff Orientation

LIAs must have a protocol with specific procedures in place for the orientation and training of staff. The plan should include both MIECHV and model-specific requirements.

2.3 Staff Supervision

High-quality supervision is a key component of evidence-based home visiting. LIAs are expected to meet all supervision requirements, as outlined by the program model.

Policy 3: Participant Eligibility, Recruitment, and Enrollment in MIECHV Services

3.1 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 program 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 policy 4.2 for additional information about serving families when children are removed after enrollment.

3.2 Recruitment

Recruitment must be on-going in order to maintain service to the contracted number of families. The Local Coordinated Intake and Referral (CI&R) process, or "Connect", will be used as the primary source for identifying potentially eligible program participants. If direct referrals are received, the CI&R staff should be notified of anyone enrolling that may also come through as part of the screening process. The program will participate as a referral agency within this infrastructure (e.g., attend meetings, provide data, etc.) to foster a coordinated screening and intake strategy for families in need of services.

3.3 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. While it may be appropriate to obtain a release of information for certain providers during the enrollment process, only those entities that will definitely be contacted should be included. LIAs must have a separate Release of Information form for obtaining consents to release information later during services (e.g. Early Steps, to refer for a low ASQ). Participants must not be asked to initial generic providers with a blank space that will be filled in later (for example, "pediatrician"). A specific entity/provider must be named when asking for consent, as well as the information that will be shared.

3.4 Re-Enrollment in MIECHV Services after Program Exit

At the discretion of the program supervisor, families may be eligible to re-enroll in the program if they meet re-enrollment policies. While each program model has specific guidance, the following offers an overview:

- PAT: Families who exit the program before completing two years of service may be eligible for re-enrollment with the **same target child** within 180 days of the program exit date. 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 or the target child is less than three months of age.

- NFP: Families who exit the program may be re-enrolled with the **same target child** up until that child's second birthday.

When deciding about re-enrollment, the supervisor and 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.
- Sustainability of other community programs to meet the family's needs.
- Reason(s) the family left the program previously, to what extent those reasons may still be present, and could those same reasons lead to disengagement once more.
- The amount of time the family has been out of service, since the program will be accountable for missing data that were required during the time the family was not receiving services.

To request the re-enrollment of a family, the following information must be included in an email to the MIECHV Data Manager/FLOHVIS Administrator:

- ✓ Participant/Primary Caregiver Case ID
- ✓ Specification of same or new target child
- ✓ Date of the first home visit back since dismissal
- ✓ Any details needed to determine re-enrollment eligibility

After a family is re-enrolled with the **same target child**, the following data collection and management steps should be completed:

- ✓ Update the necessary participant/child demographic fields.
- ✓ Complete a Household Profile and Child Wellness Update.
- ✓ Continue MIECHV data collection schedule based on the <u>first</u> date of enrollment.

<u>Skip any data collection due while the family was not enrolled in the program</u> (with the exception of the Intimate Partner Violence Assessment). 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 for services *may* be considered for re-enrollment with a **new target child**. The supervisor should contact the Data Manager and Program Director to discuss this possibility.

Policy 4: Engagement, Caregiver Changes, Family Retention, and Emergency Funds

4.1 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, partners, and other primary caregivers.

4.2 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 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 needs 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 Data Manager if that is the case.

4.3 Family Retention

If a family is missing home visits, the home visitor should actively employ and document strategies to re-engage the family in the program. Programs should use 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, 90 Days" at least monthly to identify participants disengaging from services.

4.4 Emergency Assistance and Participant Incentives

MIECHV funds may not be used to meet family emergency needs, such as food, rent, utilities, or any other form of cash assistance. LIAs must have a local policy in place detailing the usage of program incentives, if they use them. Incentives are items given for participation in activities and does not include items given to all participants. If providing a gift card as an incentive, LIAs must have a confirmation statement signed by the family stating that the card will not be traded for cash or used to purchase alcoholic beverages or tobacco products. LIAs may not provide incentives valued more than $50 per participant, unless they are donated. Safety items, such as car seats and pack n' plays, are not subject to the $50 limit.

In the occurrence of a public health emergency, temporary policies may be put in place with additional guidance as to how MIECHV funds can be spent. Temporary policies override the guidance in this document for the duration of the public health emergency or until the policy is revoked.

Policy 5: Intimate Partner Violence

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

LIAs must have a memorandum of understanding (MOU) with the certified domestic violence center(s) (DV) in their service area. The Department of Children and Families maintains a list of the certified DV centers here: https://www.myflfamilies.com/service-programs/domestic-violence/map.shtml. See policy 14.4 for a list of what should be included in an MOU.

5.2 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 two-day, virtual Intimate Partner Violence training. Staff can check for training events in the Learning Management System.

5.3 Screening for Intimate Partner Violence

LIAs should screen all participants within six months of enrollment. The screen should not be conducted on the initial visit, unless there are concerns. Screening 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 very young (nonverbal) children.

Information regarding available services should be shared with all participants, regardless of the screening outcome, unless it is unsafe to do so. Every participant with a positive screen should be offered a referral for IPV services, specifically to the local certified domestic violence center, as soon as possible and always 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.

5.4 Local Protocols and Referrals for IPV

LIAs must have a protocol with specific procedures in place for working with participants who are experiencing intimate partner 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 and those who disclose IPV outside of the screening process should be offered a referral to a certified domestic violence center within seven days. Referrals must be entered into FLOHVIS.

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. Home visitors with sufficient training should also invite the participant to discuss safety planning when the participant does not want to speak with a DV advocate.

5.5 Workplace Violence and Staff Safety

If a staff person discloses personal 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. 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 IPV may have on working with families experiencing IPV to determine the home visitor's capacity for working with those families.

LIA policies must 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 6: Child Development

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

LIAs 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 (e.g. FDLRS Child Find for children over 35 months). See policy 14.4 for a list of what should be included in a MOU.

6.2 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 should be entered in FLOHVIS. If a child has already been identified as having a delay and is currently receiving services to address the area of concern, do not complete that subscale on the screen. 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 that they have screened in those areas or indicates 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.

All results should be shared with the participant and anticipatory guidance on what to expect next, developmentally, should be provided. Also, it is best practice to share the results with the child's medical provider, childcare provider, and other providers, when the participant signs a release giving permission to do so.

6.3 Training on Developmental Screening

Staff must be trained on using the ASQ-3 prior to administering it. This training can be through a local provider, the program model, or 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. Completion of the training should be entered in the MIECHV LMS under local trainings.

6.4 Local Protocols, Developmental Promotion, and Developmental Screening Referrals

LIAs 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 must be entered in FLOHVIS.
For scores that fall below the cut-off, a referral to Early Steps (age 0-35 months) or FDLRS Child Find (age 36+ months) should 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.

If the child is already receiving services for a different domain, the home visitor should notify Early Steps (or other provider) that the child scored low in a new domain. This notification should be recorded in FLOHVIS as a new referral.

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

6.5 Developmental Surveillance

During every home visit, home visitors should ask participants 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.

6.6 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/caregiver 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 participant 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.

6.7 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): 3-9 months old, 15-21 months, 27-33 months old.
- DANCE (NFP): 1-3 months old, 8-10 months old, 15-17 months old, 21-23 months old.
- H.O.M.E. Inventory (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 7: Depression

7.1 Memorandum of Understanding with Mental Health Providers

LIAs 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/

See policy 14.4 for a list of what should be included in an MOU.

7.2 Training on Depression Screening

Staff must be trained on using the Edinburgh 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. Mothers and Babies training is not sufficient for this topic. 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.

7.3 Depression Screening

The EPDS should be administered to all participants within three months of enrollment for postnatal enrollments or within three months of delivery for prenatal enrollments. The tool should not 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.

7.4 Local Protocols and Referrals for Depression

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

Any participant with an EPDS score of 10 or greater is expected to receive a referral to a mental health specialist. A referral should be offered within seven days and recorded in FLOHVIS, even if the participant declines. If a participant's response to question #10 is anything other than "never", local procedures must include an immediate response, and a referral to a specialist must be provided and recorded in FLOHVIS.

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 or Nurse-Family Partnership Mental Health Intervention 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.

After referring participants for mental health treatment, it is important to follow-up on services, including but not limited to obtaining a release of information to communicate with the clinician when the participant consents. Several referrals may be needed before finding a good fit for the participant, and may also include a referral to a medical provider for medication. Uninsured participants may also be able to receive services from an infant mental health provider, which is billed under the child's insurance. The home visitor should encourage the participant to continue treatment until no longer needed. All referrals and the outcome of referrals, as well as Mothers and Babies modules and MHI delivered, should be entered in FLOHVIS. All EPDS administration dates and scores should be entered to track increases or decreases in symptoms.

7.5 Mothers and Babies

Home visitors must be trained prior to delivering the Mothers and Babies Course. After home visitors complete the Mothers and Babies training, the supervisor must email the MIECHV Data Manager to have their name added to the Mothers and Babies provider list before the first session is delivered.

When using Mothers and Babies as a preventative resource, it is recommended that the home visitor administer the Edinburgh (EPDS) prior to beginning Mothers and Babies sessions. For mothers who screen positive on the Edinburgh, Mothers and Babies can supplement counseling and/or medications, but it is not a replacement to specialized care. Referrals to these more intensive therapies is expected and documentation in FLOHVIS is required.

While it does not replace treatment for depression, completing at least one session of the Mothers and Babies Course is considered a completed depression referral (PM 17). A Referral TouchPoint for the referral to Mothers and Babies must be entered in FLOHVIS. The Mothers and Babies Session Date 1 should be used for Service received: Date service began.

7.6 Nurse-Family Partnership Mental Health Intervention

The Nurse-Family Partnership Mental Health Intervention (NFP-MHI) is a comprehensive Intervention of the NFP model grounded in research and developed in partnership with Nurse-Family Partnership nurses. The NFP-MHI enables the NFP Nurse-Home Visitor (NHV) to select various evidenced-based strategies to address the needs of a client experiencing depression. For participants who screen positive on the Edinburgh, the NFP Mental Health Intervention can supplement counseling and/or medications, but it is not a replacement to specialized care. Referrals to these more intensive therapies are expected and documentation in FLOHVIS is required.

When the NFP Mental Health Intervention is delivered as a direct follow-up action to a positive EPDS screen, a Referral TouchPoint for the referral to the NFP-MHI must be entered in FLOHVIS. The date of the first session completed after the positive screen should be used for Service received: Date service began. While it does not replace treatment for depression, the delivery of the NFP-MHI is considered a completed depression referral (PM 17).

Policy 8: Participant Tobacco Use and Referrals

8.1 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 should 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 should be offered within seven days. These answers and the referral must be recorded in FLOHVIS.

8.2 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. LIAs must have a local policy that details their referral process for tobacco cessation services.

Policy 9: Safe Sleep

9.1 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.

9.2 Promoting Safe Sleep and Training on Safe Sleep

Since MIECHV programs serve families during the period of greatest risk for 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. LIAs must have a local policy in place that details their procedures for educating caregivers on safe sleep practices. 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 10: MIECHV Data Requirements

10.1 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 FL MIECHV GroupSite share folders. LIAs must have a local policy that details their procedures for data collection and security.

10.2 Data Collection Training

All MIECHV staff must complete the MIECHV Data Collection Training as part of the new hire orientation process. For home visitors, the training must be completed before the first home visit is conducted. This training is an online, self-paced video that can be accessed at any time in the MIECHV LMS. Only after the training requirement is met, will the home visitor be added to the Approved Home Visitor list in FLOHVIS.

10.3 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 at least .25 FTE by the Florida MIECHV Initiative.
2) have signed consent forms that specify FAHSC, the model developer, Social Solutions, 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 Introduction to 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 end date is known, and no 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 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.

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.

Policy 11: Continuous Quality Improvement

11.1 Training on Continuous Quality Improvement

All MIECHV staff must receive CQI 101 and CQI 201 training that is provided by MIECHV within 12 months of hire. Each training is two hours long and provided virtually. Staff should also complete the Quality Improvement 101 class at https://www.nichq.org/ as an orientation, within 30 days of hire.

11.2 Participant Involvement in CQI

LIAs should make a concerted effort to involve participants in their CQI work. Participants can be included on the CQI team, provide guidance through surveys or focus groups, or participate in the PDSA tests. It is best practice to include a participant on the CQI team. Participants can also be involved in testing strategies and provide input on their effectiveness. Participants participating on the CQI team should be trained on the key concepts and principles of CQI.

11.3 CQI Team

LIAs must have a CQI team that meets at least monthly. The CQI team should include three to five members who fulfill the following roles:

- Lead/Facilitator
- Scribe
- Data Reporter

The team should include at least one home visitor, the person who is responsible for data, and a supervisor. Members of the CQI team should use recent data to inform PDSA testing and include participants whenever possible.

Policy 12: MIECHV Required Trainings

A well-trained staff contributes to achieving optimal benefits for families. In addition to training required by the model developers, Florida MIECHV requires staff be well-trained on several topics. Training received prior to hire or outside of MIECHV must be entered in the LMS under local trainings. The Florida MIECHV Local Implementing Agency Required Training Checklist is utilized by Florida MIECHV staff to assess completion of required trainings.

12.1 Ages and Stages Questionnaire

Home visitors and supervisors must be trained on using the ASQ-3. This training should take place prior to administering the tool. This training can be provided through a local trainer or the Florida Association of Healthy Start Coalitions. 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. Completion of the training should be entered in the MIECHV LMS under local trainings.

12.2 Continuous Quality Improvement

All MIECHV staff must receive CQI 101 and CQI 201 training that is provided by MIECHV within 12 months of hire. Staff can check for training events in the MIECHV LMS. Staff hired prior to 10/1/18, who received CQI training from another source, may be exempt from this requirement. Exemption status will be determined on a case-by-case basis.

Staff should also complete the Quality Improvement 101 class at https://www.nichq.org/ as an orientation, within 30 days of hire, if a CQI 101 training is not available within that timeframe.

12.3 Data Collection

All MIECHV staff must complete the MIECHV Data Collection Training as part of the new hire orientation process. For home visitors, the training must be completed before the first home visit is conducted. This training is an online, self-paced video that can be accessed at any time in the MIECHV LMS. Only after the training requirement is met, will the home visitor be added to the Approved Home Visitor list in FLOHVIS.

12.4 Edinburgh Postnatal Depression Scale

Home visitors and supervisors must be trained on using the Edinburgh Postnatal Depression Scale (EPDS). This training should take place prior to administering the tool. 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.

12.5 Health Insurance Portability and Accountability Act (HIPAA)
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 under Local trainings.

12.6 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 virtual Intimate Partner Violence training. Staff can check for training events in the MIECHV LMS.

12.7 Additional Required Data Trainings for FLOHVIS Users
All FLOHVIS Users must also complete the FLOHVIS Basic Training before gaining access to their live site. Full users must also complete the next scheduled FLOHVIS Data Entry Training.

Policy 13: Required Local Policies and Procedures

LIAs are required to have a complete local policies and procedures manual. It is important for staff to have a place to reference and the specifics for each required policy will vary by program. These procedures should be specific to the provider. A complete list of the policies and procedures required by Florida MIECHV can be found in the Florida MIECHV Local Implementing Agency Policy Checklist. LIAs should also include any policies and procedures required by their model developer.

Policy 14: Required Memorandums of Understanding

14.1 Local Early Steps Program and Other Providers of Developmental Services for Young Children
LIAs 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.

14.2 Mental Health Providers
LIAs 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/

14.3 Local Domestic Violence Center(s)
LIAs must have a memorandum of understanding (MOU) with the certified domestic violence center(s) (DV) in their service area. The Department of Children and Families maintains a list of the certified DV centers here: https://www.myflfamilies.com/service-programs/domestic-violence/map.shtml.

14.4 Required MOU Components
At a minimum, the MOUs 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
- Term in effect and review/renewal process

Florida MIECHV staff will determine if MOUs meet the minimum requirements using the Florida MIECHV Local Implementing Agency Memorandum of Understanding Checklist.

Policy 15: Adverse Incident Reporting

The Adverse Incident Report Form should be completed and emailed to MIECHVcontractmanager@fahsc.org and MIECHVprogrammanager@fahsc.org within one business day when a MIECHV caregiver/participant, target, or non-target child experiences an adverse incident. The form should be completed in the occurrence of:

- Child death,
- Child removal,
- Home Visitor initiating 911 call,
- Participant formal grievance,
- Participant/caregiver death,
- Participant suicidal attempt,
- Participant homicidal ideation or attempt,
- Or other serious incident.