# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>4</td>
</tr>
<tr>
<td>Purpose</td>
<td>5</td>
</tr>
<tr>
<td>Background, Framework</td>
<td>6</td>
</tr>
<tr>
<td>Principles</td>
<td></td>
</tr>
<tr>
<td><strong>HV Standard Area 1: Program Participation</strong></td>
<td>7</td>
</tr>
<tr>
<td>Eligibility</td>
<td></td>
</tr>
<tr>
<td>Recruitment</td>
<td></td>
</tr>
<tr>
<td>Program Participation</td>
<td></td>
</tr>
<tr>
<td><strong>HV Standard Area 2: Culturally Competent Service Delivery</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>HV Standard Area 3: Relationship-based Practices</strong></td>
<td>9</td>
</tr>
<tr>
<td>Reflective Supervision</td>
<td>10</td>
</tr>
<tr>
<td><strong>HV Standard Area 4: Family Goal-Setting</strong></td>
<td>10</td>
</tr>
<tr>
<td>Establishing goals with Families</td>
<td>11</td>
</tr>
<tr>
<td>Referrals and follow-Up</td>
<td></td>
</tr>
<tr>
<td>Community Resources &amp; Collaborations</td>
<td></td>
</tr>
<tr>
<td>Family Satisfaction Surveys</td>
<td></td>
</tr>
<tr>
<td><strong>HV Standard Area 5: Curriculum and Service Delivery Approach</strong></td>
<td>12</td>
</tr>
<tr>
<td>Required Components of Home Visits:</td>
<td>13</td>
</tr>
<tr>
<td>Prenatal Visits</td>
<td></td>
</tr>
<tr>
<td>Post-partum Visits</td>
<td></td>
</tr>
<tr>
<td>Visits with Families of Children up to Age 5 Years</td>
<td></td>
</tr>
<tr>
<td>Acknowledgement of Service Completion or Discontinuation</td>
<td>14</td>
</tr>
<tr>
<td>Program Evaluation</td>
<td></td>
</tr>
<tr>
<td><strong>HV Standard Area 6: Program Management Systems</strong></td>
<td>15</td>
</tr>
<tr>
<td>Planning</td>
<td>16</td>
</tr>
<tr>
<td>Organizational Management</td>
<td></td>
</tr>
<tr>
<td>Record Keeping – Client Records, Consent</td>
<td>17</td>
</tr>
<tr>
<td>Reporting</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Program-level Self-Assessment</td>
<td></td>
</tr>
<tr>
<td>Fiscal Management</td>
<td>18</td>
</tr>
<tr>
<td>Caseload Size</td>
<td></td>
</tr>
<tr>
<td>Safety Assurance</td>
<td></td>
</tr>
<tr>
<td>Ongoing Program Monitoring</td>
<td>19</td>
</tr>
<tr>
<td>Program Response to Findings of Non-Compliance &amp; Program Deficiencies</td>
<td>20</td>
</tr>
<tr>
<td>Special Conditions</td>
<td></td>
</tr>
</tbody>
</table>
Table of Contents - continued

<table>
<thead>
<tr>
<th>HV Standard Area 7: Staffing and Supervision</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Staff</td>
<td>20</td>
</tr>
<tr>
<td>Clinical Staff</td>
<td>21</td>
</tr>
<tr>
<td>Staff Training</td>
<td></td>
</tr>
<tr>
<td>Ongoing Professional Development</td>
<td>22</td>
</tr>
<tr>
<td>Supervisor/Supervisor Requirements</td>
<td>23</td>
</tr>
<tr>
<td>Reflective Supervision</td>
<td></td>
</tr>
<tr>
<td>Field Supervision</td>
<td></td>
</tr>
<tr>
<td>Administrative Supervision</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HV Standard Area 8: Community Engagement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration</td>
<td>25</td>
</tr>
<tr>
<td>Community Education</td>
<td></td>
</tr>
<tr>
<td>Community Advisory Committees</td>
<td>26</td>
</tr>
<tr>
<td>HV Standard Area 9: Data Management</td>
<td>26</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appendix A: Rationale and Research Support for New Mexico Home Visiting Program Standards</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix B: 18 Outcome Areas</td>
<td>28</td>
</tr>
<tr>
<td>Appendix C: Documentation Requirements – Client Record</td>
<td>47</td>
</tr>
<tr>
<td>Appendix D: Required Screening &amp; Assessment Tools and Frequency Schedule</td>
<td>48</td>
</tr>
<tr>
<td>Appendix E: DAP Note Examples (Data, Assessment, Plan)</td>
<td>53</td>
</tr>
<tr>
<td>Appendix F: Special Conditions</td>
<td>56</td>
</tr>
<tr>
<td>Appendix G: Client Assessment</td>
<td>58</td>
</tr>
</tbody>
</table>
INTRODUCTION

The New Mexico Home Visiting Accountability Act (2013, Chapter 118) requires that the Children Youth and Families Department (CYFD) establish a Home Visiting Program. This Act codifies activities that have been engaged in at CYFD for a number of years.

According to the New Mexico Home Visiting Accountability Act, "home visiting" means a program strategy that delivers a variety of informational, educational, developmental, referral and other support services for eligible families who are expecting or who have children who have not yet entered kindergarten, and that is designed to promote child well-being and prevent adverse childhood experiences. Home visiting provides a comprehensive array of services that promote parental competence and successful early childhood health and development by building long-term relationships with families and optimizing the relationships between parents and children in their home environments. The Act goes on to define a "home visiting program" as a program that uses home visiting as a primary service delivery strategy and offers services on a voluntary basis to pregnant women, expectant fathers and parents and primary caregivers of children from birth to kindergarten entry. Additionally, the Act defines what home visiting is not. Home visiting does not include provision of case management or a one-time home visit or infrequent home visits, such as a home visit for a newborn child or a child in preschool. For the purposes of this document and the Act, it does not include or home visiting that is provided as a supplement to other services; or services delivered through an individualized family service plan or an individualized educational program under Part B or Part C of the federal Individuals with Disabilities Education Act.

PURPOSE

The New Mexico Home Visiting Accountability Act goes on to define a “home visiting system” as providing universal, voluntary access, as well as providing a common framework for service delivery and accountability across all home visiting programs. Part of this definition includes “comprehensive home visiting standards that ensure high quality service delivery and continuous quality improvement”. The program standards described in this document are consistent with the requirements of the New Mexico Home Visiting Accountability Act.

The New Mexico Home Visiting Program Standards were developed by CYFD to articulate a specific set of expectations regarding how a Home Visiting Program should be implemented in the State of New Mexico. The Program Standards provide a common understanding of how home visiting services must be delivered to achieve positive, measurable outcomes for infants, toddlers and their families. The Program Standards are grounded in research that tells us “positive early experiences lay a foundation for healthy development” (Shonkoff - Center on the Developing Child - Harvard University. N.p., n.d. Web. 22 Sept. 2010).
BACKGROUND

History
In 2009, Governor Bill Richardson designated New Mexico’s Children, Youth and Families Department (CYFD) as the “lead agency” for Home Visiting. Rather than adopt a single existing model of Home Visiting, the CYFD led a process to review Home Visiting research and best practices to establish Long-term Outcomes and Program Standards that could provide a common framework of service delivery and accountability across all programs. These common Long-Term Outcomes and Program Standards allow the state to establish:

- Common performance measures
- Common data elements
- Common contractual obligations across all state-funded Home Visiting Programs

Community-based programs are encouraged to adopt a national model if they choose. Regardless, all programs are required to comply with the state’s Program Standards and corresponding Performance Measures based on the Long-term Outcomes identified in the Home Visiting Logic Model. As a result, the state is able to establish a statewide system of Home Visiting that is consistent and allows for the collection, aggregation and analysis of common data as are required by the New Mexico Home Visiting Accountability Act.

The New Mexico Home Visiting Program has chosen not to require that communities implement a specific model or approach to home visiting because:

- Existing national (evidence-based) models were each developed with a different focus, for a specific population, and for different reasons. For example, some focus more on pre-natal and/or post-natal maternal-child health and others on older children’s school readiness.
- Data clearly reveals that ALL children in New Mexico are at risk for myriad adversities (before birth to school entry). Existing national, evidence-based models vary in addressing all these risks from before birth to kindergarten entry.
- Recognizing the rich diversity of New Mexico’s communities, it is clear that the New Mexico Home Visiting Program must allow communities to establish community-specific home visiting programs that are responsive to their community’s unique cultural and linguistic heritage while consistently adhering to the Home Visiting Program Standards.

Framework
Consistent with the Act, the Program Standards are linked to the five Long-Term Outcomes identified in the Home Visiting Logic Model:

- Babies are born healthy
- Children are nurtured by the parents and caregivers
- Children are physically and mentally healthy and ready for school
- Children and families are safe
- Families are connected to formal and informal supports in their community
This has been accomplished by establishing performance measures for each Program Standard with corresponding assessments, as well as data-management and collection protocols.

The Program Standards are based on research and best practices as determined by the field. An annotated list of the Standards, with research and reference citations can be found in Appendix A. The Program Standards establish a high level of quality service delivery while being realistic and responsive to the diversity of each community served.

The New Mexico Home Visiting Program Standards are organized by nine overarching areas addressing:

1. Program participation,
2. Relationship-based practices,
3. Culturally competent service delivery,
4. Family and child goal setting,
5. Program management,
6. Staff qualifications,
7. Curriculum and service delivery,
8. Community engagement, and
9. Data management.

The Home Visiting Program Standards may be used in conjunction with other program standards as well as with State, Federal and local regulations, and are non-negotiable for programs that receive state funding.

**Principles**

The New Mexico Home Visiting Program implements home visiting as a strategy for the delivery of a variety of informational, educational, developmental, referral and other support services for eligible families who are expecting or who have children who have not yet entered kindergarten. The Home Visiting Program is designed to promote child well-being and prevent adverse childhood experiences. Home Visiting Program staff provide a comprehensive array of services that promote parental competence and successful early childhood health and development by building long-term relationships with families and optimizing the relationships between parents and children in their home environments.*

Home Visiting from this perspective is both a promotion- and prevention-level strategy. Providing Home Visiting services in the family home over an extended period of time provides the opportunity for services to be delivered in the “real world” of participating families. This real-life focus offers the potential for a better assessment and understanding of a family’s day-to-day realities. This understanding is critical for home visitors to build relationships, establish goals and support wellness across multiple domains (e.g. physical health, developmental competence, social and emotional well-being) for infants, young
children and their primary caregivers and families. The New Mexico Home Visiting Program is a voluntary, statewide system that is free and non-categorical.

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

**HV Standard Area 1:**

**Program Participation** — This standard determines target population, prioritization, recruitment requirements, periodicity, duration and intensity. Programs are required to be voluntary, free and universal.

1.1 Eligibility

1.1.a. The program has written protocols that guide program admission, length of stay, and discharge criteria.

1.1.b. The program’s written eligibility criteria is inclusive of: expectant mothers including expectant teens; parents/caregivers including teen parents of infants and young children birth to age five; and adoptive parents of infants and young children birth to age five.

1.1.c. The program procedures and practices ensure that priority admission occurs for families with children less than 36 months of age.

1.1.d. The program’s eligibility protocols define children who are in foster care as ineligible for this home visiting service.

1.1.e. The program’s eligibility protocols define services as “universally available” without guidelines that weigh risk or income eligibility (unless this is required by the program model, such as the Nurse-Family Partnership). Services are always provided at no cost to each family and are voluntary.

   1.1.e.i. The program has a defined, written procedure related to program admission for situations when the demand for services exceeds service capacity.

   1.1.e.ii. The program maintains documentation of the number of families not accepted for home visiting services and the reasons why this determination was made, and referrals made to other service programs (if applicable).

1.2 Recruitment: The program has a written recruitment plan that ensures early identification of pregnant women and families who may benefit from home visiting services and that ensures that all families have ready access to those services.

1.3 Program Participation

1.3.a. The program procedures and practices ensure a continuum of services is provided to families based on family preferences, needs, strengths and risk factors. Services are: flexible and designed to meet the needs of each family within their community; and in part based on the results of the required screening procedures which are administered according to a defined periodicity schedule.

1.3 b. If the program implements an evidence-based model or promising approach, program procedures and practices ensure that the program adheres to its responsibility to maintain model fidelity, within the context of the CYFD New Mexico Home Visiting Standards.

1.3.c. Program procedures and practices ensure that a maximum of 36 months of post-natal services are provided per enrolled family.
1.3.d. The program has written procedures regarding transition planning for all children leaving home visiting services.

1.3.e. Program procedures and practices ensure that expectations regarding attendance are based on the dosage determined on the family plan that has been developed with the family and is based on their needs while taking into account the results of the screening tools (See 5.2.b.).
   i. In order to continue to be served through the Program, families must maintain an attendance percentage of at least 80%. Justification for falling below 80% (such as illness, temporary absence of the area, etc) must be documented.
   ii. Program procedures and practices ensure that at least 70% of each home visitor’s time is spent in direct contact with families. Justification for falling below 70% (such as illness, temporary absence, families’ abilities to engage, etc.) must be documented.

1.3.f. Program procedures and practices ensure that transitioning planning occurs with families and is documented. Families may choose to leave home visitation services for a variety of reasons. Optimally, many families will leave when they have completed the program. For those families the discussion/transition plan might include:
   i. A portfolio that reflects the child’s development upon entry into the program and the child’s developmental skills as the family is ending services. This could include the most recent ASQ or ASQ:SE results, verbal videos that capture special moments with the family and/or celebrating the successes achieved by the family.
   ii. Discussion of where the family goes from here. This might consider the resources needed by the parents or the next services that will support the child. For children that may be enrolled in childcare or in an early learning environment, the discussion could include helping the family understand how to evaluate what a quality program is, how to handle adjustment issues with the child or other transition issues. A home visitor may choose to accompany a parent on a visit to another program to help support a smooth transition.

1.3.g. The program has written procedures for disenrollment of families under each of the following circumstances:
   i. Completion of program – must include transition plan (satisfaction survey must be completed)
   ii. Voluntary termination – must include written notification from families (satisfaction survey must be completed)
   iii. Procedures for disenrollment due to lack of participation: including process and documentation describing number of attempts to engage families, attempts for communication, notification of proposed action and action.
   iv. Timeline to replace families shall not exceed thirty (30) days from the disenrollment date.

**HV Standard Area 2:**
**Culturally Competent Service Delivery:** This standard specifies the service delivery practices necessary to work effectively with people from a variety of abilities, languages, identities, realities as well as ethnic, cultural, political, economic, and religious backgrounds. Culturally competent service delivery practices are implemented while taking into consideration the dynamics and structure of each family as they defined themselves.

2.1. The program ensures that each home visitor is trained and supported to use culturally sensitive and linguistically appropriate practices to communicate effectively, establish positive relationships with each family, and demonstrate respect for the uniqueness of each family’s culture.
2.2. Relationship-based, strengths-focused, and family-centered practices are central to culturally sensitive practices. Program practices recognize caregivers and families as:
   a. Capable of deciding what is important for their child and family; and
   b. The primary influencers of positive outcomes in their infants and very young children; and
   c. Full partners and collaborators in the development of their home visiting plan and services.

2.3. Program procedures, practices, and the materials used with families are applied in ways that are sensitive to the uniqueness of each family’s culture and ways of being. Accommodations are made as necessary to ensure that the cultural beliefs, values and practices of each family are honored when:
   a) Determining who is a member of the family and will receive services; and
   b) Conducting screening and assessments; and
   c) Providing information and support to each family; and
   d) Asking families to share sensitive information with program staff.

2.4. Program procedures and practices ensure that reflective supervision and/or reflective consultation is used to support cultural awareness and the delivery of culturally competent services.

**HV Standard Area 3:**
**Relationship-based Practices:** *This standard establishes the process, tools and strategies to focus on parent-child bonding and healthy emotional attachment and work with all members of the family who want to participate.*

3.1. Program procedures and practices ensure that Home Visitors engage in mutually respectful, goal-oriented partnerships with families to promote optimal parent-child relationships and family well-being.

3.2. Program procedures and practices ensure that Home Visitors are trained and supported to view “relationships” as the focus of the work. Awareness and use of parallel process is encouraged so that home visitors are aware of and able to focus on: the parent-child relationship; the home visitor-parent relationship; as well as their own relationship with their reflective supervisor. The qualities of each of these relationships are seen as central to and influencers of the other relationships.

3.3. Program procedures and practices ensure that each family is viewed as a “whole” and that all caregivers/family members who choose to participate are supported as needed to optimize the emerging caregiver-child relationships in ways that support optimal development of infants, toddlers and young children.

3.4. Program procedures and practices ensure that Home Visitors are trained and supported to use observations, screenings, and assessments to identify the emerging capabilities of the infant and very young child within a relationship context. Screening tools and procedures and use of curricula are consistent with this standard.

3.5. Program procedures and practices ensure that Home Visitors are trained and supported to recognize and intentionally reinforce each parent’s/caregiver’s strengths, emerging parenting competencies, and positive parent/caregiver interactions with infants and young children. Screening tools and procedures and use of curricula are consistent with this standard.
3.6. Program procedures and practices ensure that home visitors are trained and supported to help each parent:
   a. View their infant/young child as a unique person; and
   b. Increase awareness of all the factors (noticing, playing, holding, teaching, etc.) that constitute effective parenting for that child; and
   c. Experience pleasure from daily activities and interactions with their children. Screening tools, procedures and use of curricula are consistent with this standard.

3.7. Program procedures and practices ensure that Home Visitors are trained and supported to share with families an understanding and appreciation of process of developing relationships and that this process is specific to each unique dyad.

3.8. Program procedures and practices ensure that Home Visitors are trained and supported as they nurture the parents' relationship with one another, if one exists; alternatively, the home visitor helps the custodial parent manage appropriate contact with the non-custodial parent in ways that are consistent with the emotional and caregiving needs of the infant/young child.

3.9. **Reflective Supervision** (see 7.6.2.) Program procedures and practices:
   a. Ensure the provision of regular (minimum 2 hours each month), collaborative, reflective supervision for all home visitors regardless of educational level, professional licensure, or years of experience; and
   b. Support supervisors and home visitors as they regularly examine their own thoughts, feelings, strengths, and growth areas related to home visiting, as well as to understand their own capacities and needs as they relate to the capacities and needs of the families they serve.

**HV Standard Area 4:**
**Family Goal-Setting:** *This standard determines tools and usage of state approved screening processes, ongoing assessment and goal setting, referrals, follow ups and case management process.*

4.1. **Establishing Goals with Families:** Program procedures and practices ensure that home visitors are trained and supported to follow defined procedures for setting goals with families in ways that are consistent with CYFD’s long-term outcome targets.

4.1.a Program procedures and practices ensure that family goals are individualized and clearly reflect what each family hopes to accomplish for their child and themselves by participating in home visiting services.

4.1.b. Program procedures and practices ensure that each family/child goal is clearly linked to one of the 18 outcome areas defined by the CYFD Home Visiting Program. (See Appendix B)

4.1.c. Program procedures and practices ensure that the required screening tools are administered to each child/family according to the defined schedule and that the results are considered when setting goals with families.

4.1.d. Program procedures and practices ensure that the results of screenings are used as one of the key elements to develop the Family Plan. The plan must be developed with the family and must address the goals, dosage (frequency and intensity), services to be provided and discussions with families regarding the developmental status and needs of their child.
4.1. e. Program procedures and practices ensure that the Family Plan can be modified (dosage, intensity, goals, etc.) at any time according to the needs and ability of the family to participate.

4.2. Referral & Follow Up: Program procedures and practices ensure that appropriate referrals and follow-up occur on a regular basis while each family is receiving home visiting services.

4.2.a. All referrals are documented with special attention to the following:
   i. Mother has a primary care provider,
   ii. Child has a pediatrician;
   iii. If indicated by the Edinburgh Post/Perinatal Depression Scale (EPDS) cutoff score, it is documented that the mother is referred for behavioral health services;
   iv. If indicated by the Ages and Stages Questionnaire-3 (ASQ3) cutoff scores, it is documented that the child/family are referred to a Family Infant Toddler (FIT) Program service provider in the community;
   v. If indicated by the Woman Abuse Screening Tool (WAST) score, it is documented that the mother/family was referred for domestic violence services; and
   vi. When there is suspicion of child abuse or neglect, a referral to Child Protective Services is documented regardless of whether the home visitor made the referral or learned that someone else had made the referral while the family is receiving home visiting services.

4.2.b. Program procedures and practices ensure that the database is used to document that a child/family is already connected to one of the services listed above, even if there was no referral made by the Home Visiting Program. (See HV Standard Area 9: Data Management)

4.2.c. Program procedures and practices ensure that the database is used to document when an agency/program other than the Home Visiting program is conducting ASQ3 and ASQ:SE screens on the child enrolled.

4.2.d. Program procedures and practices ensure that if the child and family are also receiving early intervention services through the New Mexico Family Infant Toddler Program, any potentially detrimental impact on the family of a child with an identified delay or a diagnosed disability is be considered thoughtfully in deciding whether to discontinue use of the ASQ; if discontinued, the rationale for doing so is noted clearly in the client file and the database.

4.2.e. Program procedure and practices ensure that there are mechanisms and personnel in place to respond to immediate safety issues and identified risk factors as home visitors discover them.

4.3. Program procedures and practices ensure that follow-up occurs on each referral approximately one month after the date of referral. Follow-up is conducted to determine what action the family may have taken related to the referral. It is evident that the program uses this information to determine the disposition of the referral so that the referral status can be updated and the referral closed as appropriate.

4.4 Community Resources & Collaborations: The program has a written plan for cultivating and deepening relationships with providers of community resources and services that can help address the needs of the families served by the Home Visiting program. The plan describes how the Home Visiting Program collaborates to help develop an effective, community-based system of care that is responsive to the needs of the families they serve.
4.4.1. Program procedures and practices are in place to ensure that the home visitor identifies the other community organizations providing service to an enrolled family and takes steps to:

a. Reduce duplication of services and/or to organize a regular schedule of home visits by all involved agencies that is respectful of the parent(s)’ time and privacy; and

b. Coordinate the process used to address all family needs as well as the service requirements of the various agencies.

4.5. Family Satisfaction Surveys

4.5.1. Program procedures and practices ensure that a Family Satisfaction Survey is completed annually by each family and upon completion of services.

4.5.2. Program procedures and practices ensure that information obtained through Family Satisfaction surveys is analyzed and used for program planning and improvement.

HV Standard Area 5:
Curriculum and Service Delivery Approach: This standard defines the use of research-based curriculum or use of the curriculum of the evidence-based model or promising approach to home visiting the program has adopted.

5.1. Program procedures, practices and written materials describe which research-based curriculum materials or which curriculum from an evidence-based model or promising approach to home visiting is being implemented.

5.1.1. CYFD-approved research-based home visiting curricula include:

a. Partners for a Healthy Baby
b. Portage Project Growing: Birth to Three
c. Partners in Parenting Education (PIPE)

5.1.2. Evidence-based and promising practice models (which each have their own required curriculum) that are approved by CYFD include:

a. Parents as Teachers
b. Nurse-Family Partnership
c. First Born Program
d. Healthy Families America

5.1.3. Recommended supplemental training for home visit staff includes:

a. Circle of Security
b. Mind in the Making

5.1.4. Recommended Parenting Education programs include:

a. Triple P Parenting
b. Love and Logic
c. Birthing From Within (childbirth preparation)

5.2. Program procedures, practices, including staff training and support ensure that the model and/or curriculum materials are implemented to provide essential structure and content for the
parent education and support activities that are delivered through the home visiting program.

5.3. The program materials, procedures and practices demonstrate that home visitors are able to develop home visiting plans (Family Plans) that are family specific and needs-based and that engage families in a regularly scheduled, consistent frequency of home visits.

5.3.a. Program procedures and practices ensure the implementation of each Family Plan including the dosage prescribed and agreed to by each family. (See 1.3.e., 4.1.d., and 4.1.e.)

5.3.b. Program procedures define expectations regarding the rescheduling of home visits when families are unavailable for scheduled appointments or the home visitor needs to cancel a scheduled visit (See 1.3.e.).

5.4. Program procedures and practices ensure that if the program is implementing an evidence-based model or promising approach, the program is responsible for maintaining fidelity of implementation. (See 5.1)

5.5. Program procedures and practices ensure that service components are offered based on CYFD’s guidelines for screening and curricula use, in combination with each family’s needs, preferences, cultural/linguistic context, and risk factors.

5.5.a. Program procedures and practices ensure that Prenatal Home Visits include the following components:
   i. Support and assistance to access prenatal care that is consistently utilized and attends to the physical and emotional health care as needed and/or as requested by the pregnant woman/family;
   ii. Provision of active assistance to families in identifying informal support networks;
   iii. Provision of information on prenatal health care, newborn care (establishing medical home or health care), and infant/child development, including the importance of parent-infant interactions and earliest relationships
   iv. Screening for issues related to depression (Edinburgh Post/Perinatal Depression Screen) which helps guide subsequent home visits and potential referrals;
   v. Referral to Women, Infants and Children (WIC) nutrition program for qualified families; and
   vi. Referral to PE/MOSAA-Presumptive Eligibility/Medicaid on Site Application Assistance if appropriate.

5.5.b. Program procedures and practices ensure that Post-Partum Visits include the following components:
   i. Focus attention on parent/caregiver/child interactions, mutual competence, and parent/caregiver attributions;
   ii. Support and assistance to access post-partum care that attends to the physical, emotional and social well-being of the mother;
   iii. Screening for issues related to depression (Edinburgh Post/Perinatal Depression Screen) which helps guide subsequent home visits and potential referrals;
   iv. Assessment of any concrete needs the family is experiencing; and
   v. Other needs as identified by the family.

5.5.c. Program procedures and practices ensure that Home Visits for families with children up to age 5 include the following components:
   i. Focus attention on parent/caregiver attributions (parents assigning some quality or character
to their baby);
ii. Support and assistance to access pediatric health care as needed and as appropriate depending on age of baby;
iii. Assistance to families in identifying informal support networks;
iv. Referral and linkages to other needed or recommended health, developmental, mental health, community and educational supports for the child, caregiver and family as appropriate;
v. Screening for possible risk factors within the child, caregiver, and family (using, at a minimum, CYFD selected tools and measures), including home safety, developmental concerns in children, perinatal depression in mothers, domestic violence, and family social support;
vi. Development of safety plans with families presenting with issues of concern or high risk for family violence;
vii. Developmental guidance and parent-child interaction support based on a research based curriculum and/or the use of the New Mexico Early Learning Guidelines, to support and encourage the child’s development in all domains. This includes supporting parents/caregivers to:
• Talk with and read with their child, to build communication and literacy skills
• Provide a wide variety of age-appropriate toys and safe materials for exploration
• Encourage their child’s development of social skills including understanding their own feelings and the feelings of others and turn-taking
• Provide ample outdoor and indoor opportunities for active physical play
viii. Follow up and engagement in collaboration with other service providers families are working with and/or have been referred to for additional services; and
ix. Provision of appropriate referrals and follow up at the completion of Home Visiting services to appropriate community, educational, and other services and informal support networks. If family wishes, provide a plan for transition and follow up.

5.6. Program procedures and practices ensure that the Acknowledgement of Service Completion or Discontinuation is completed through face-to-face contact with a client (when possible) to complete a summary that addresses:
   a. Reason for discontinuation of services;
   b. Summary of services provided;
   c. Goals attained or not attained;
   d. A transition plan including recommendations and referrals; and
   e. Completion of client satisfaction questionnaire.

5.7. Program Evaluation: The program has specific procedures and practices that ensure that all requirements of the CYFD-defined evaluation process are being met:
   a. All screening tools are administered at the defined intervals and frequency; and
   b. The required database is used to collect and report the required data (Also see Standard Area 9: Data Management); and
   c. All data is entered into the database within 7 days of an activity; (Also see Standard Area 9: Data Management); and
   d. The results of screenings are used as one of the key elements for service planning, including which services are provided, frequency of home visits, and discussions with families regarding the developmental status and needs of their child.
HV Standard Area 6: Program Management Systems: This standard determines the systems that must be in place for planning, record keeping, reporting, communication, program-level self-assessment, ongoing monitoring, fiscal management, caseload size and caseload size management.

6.1. Planning - Program procedures and practices ensure that the program planning process focuses attention on the program’s most critical challenges and opportunities. These procedures and practices ensure that the program leaders have the opportunity to gain insight into the future direction of their agency's services and how their services affect the community served. The procedures and practices ensure that the planning process is used to determine specific program improvement, enhancement initiatives, and/or for staff development purposes.

6.1.a. The program has a written plan that includes provisions for:
   i. Ongoing recruitment,
   ii. Selection and enrollment of children and families,
   iii. Service delivery area,
   iv. Caseloads,
   v. Collaborative relationships and activities,
   vi. Expansion priorities, and
   vii. Development/revision of Home Visiting Implementation plans that identify short- and long-term goals for implementing quality services. The plan is be reviewed annually.

6.2. Organizational Management

6.2.1. Written policies address human resource issues, including staff hiring, pay, employee evaluation, absence from work, leave policies, professional development, and termination.

6.2.2. Written policies address travel to client homes for home visits, use of cell phones to be in contact with clients, and access to Internet and computers for use of the required electronic web-based data management system.

6.2.3. The program has clearly stated, written standards of conduct and a code of ethical conduct that the staff is trained and supported to follow.

6.2.4. The program has an organization chart that defined the flow of responsibility within the agency.

6.2.5. Written policies are in place to ensure that the program manager oversees all case-specific tasks of a home visitor who discontinues her employment with the program until a new home visitor is able to do so.

6.3. Recordkeeping

6.3.1 Client Records
6.3.1.a. Program procedures and practices ensure that CYFD requirements regarding use of electronic client files and documentation of required management elements in the provided data management system are met (See Standard Area 9: Data Management).

6.3.1.b. Program procedures and practices ensure that files are maintained regarding client/agency interaction from initial referral and admittance to the program through discharge. All home visiting services are documented in client files according to the requirements outlined in Appendix C.

6.3.1.c. Program procedures and practices ensure that client information and service provision activities are documented as required in the data system (See Standard Area 9: Data Management).

6.3.1.d. i. The program ensures that home visitors and other staff enter data accurately and on a timely basis, protecting the integrity and accuracy of the information.

6.3.1.d. ii. Program procedures and practices ensure that the Program Manager reviews electronic data on a regular, ongoing basis to identify missing, incomplete or inaccurate data.

6.3.1.d. iii. Program procedures and practices ensure that inaccuracies, inconsistencies or issues related to lack of timely data entry are corrected.

6.3.2. The agency provides suitable storage of and access to client records for three years after termination of the CYFD contract. After that time, procedures and practices are in place providing suitable disposal of client records.

6.4 Consent
6.4.1 Program procedures and practices ensure that specific consent is obtained before sharing any identified data with other service providers. Each consent form is used for a specified reason, a specifically identified provider and is time limited. Administrative supervision is implemented to ensure that new consents are secured as needed, based on time elapsed, provider need, and according to the specific consent policies of the organization and providers to whom the request is being made.

6.4.2. Program policies, procedures and practices ensure confidentiality of client information, written, verbal, and electronic, that are in accordance with the policies of the Health Information Portability and Accountability Act (HIPAA). Without specific written client consent, the release of Protected Health Information to agencies or funding sources other than CYFD may be a violation of state and federal regulations.

6.4.3. Program procedures and practices ensure that consent is obtained from every client allowing for data about their home visiting experiences to be maintained in the electronic client file system of CYFD. The consent form includes assurance that all data about the family used for reporting and/or evaluation purposes will be de-identified and aggregated, and that no identifying data will ever be made public. The consent form informs the client that records review is limited to specific agency staff providing the Home Visiting services to the family, the CYFD manager, and staff of the data management system.

6.5. Reporting – Program procedures and practices ensure the submission of Quarterly Reports in the required format on the 15th of October, January and April. Program procedures and practices ensure the submission of a Final Report, which is a retrospective of the year and is submitted by July 15.
6.6. Communication – There are written program procedures and processes that specify how communication will take place

6.6.1. Program procedures and practices ensure that the appropriate program staff participate in opportunities to stay updated about any changes made at state-and federal-levels, for example through quarterly meetings, “Ask the Manager” calls, written communication, etc.

6.6.1.a. Program procedures and practices ensure that this updated information is shared, as appropriate with:
   i. The agency’s governing body; and/or
   ii. Program staff; and/or
   iii. Parents/family members who are participating in the Home Visiting Program.

6.6.1.b. Program procedures and practices define how information is shared from the program-level to the State Program manager regarding and the Training and Technical Assistance system regarding:
   i. Program accomplishments; and
   ii. Program’s needs; and
   iii. Community issues affecting the home visiting program; and
   iv. Personnel changes; and
   v. Program status as required

6.7. Program-level Self-Assessment

6.7.1. Program procedures and practices ensure that the Program Manager conducts regular and frequent review of program activities. At least 10% of the cases must be reviewed every two weeks and 100% of the cases must have been reviewed by the end of the year. The procedures and practices include effective use of the data management system tools for self-monitoring at the case level and individual staff level, as well as at the program level (See Standard Area 9: Data Management).

6.7.2. Program procedures and practices ensure that the following elements are monitored:
   a. Enrollment;
   b. Caseloads;
   c. Number of visits received by each family;
   d. Completion of screening tools on required periodicity, and referrals for flagged risk-scores;
   e. Family goals established, and Home Visiting activities are related to helping families achieve their goals.

6.8. Fiscal Management

6.8.1. A financial management system is in place that ensures accurate payroll, taxes, and records of income and expenditures.

6.8.2. The agency/program has the policies, procedures and practices needed to accurately:
   a. Monitor expenditures against income; and
   b. Maintain steady cash flow across the 12-month contract periods.
6.8.3. Program procedures and practices ensure that the Program Manager reviews budget status at least monthly. The Program Manager develops and implements corrective plans if spending appears to be inconsistent with the planned budget in terms of amounts and/or rate of spending.

6.8.3.a. Program procedures and practices ensure that the monthly invoices with expenditure reports are submitted to CYFD as required. Submitted invoices accurately demonstrate a connection to the number of families served, hourly cost for the visit, as well as identified line item expenditures.

6.8.3.b. Program procedures and practices ensure that the Quarterly reports of “average cost per visit” are submitted as required to CYFD and that the Program Manager develops and implements corrective plans if per-visit costs exceed CYFD guidelines.

6.9. Caseload Size

6.9.1. The program has a written recruitment plan to ensure full enrollment.

6.9.2. Program procedures and practices ensure that the program hires adequate numbers of qualified personnel to be able to provide services at full enrollment.

6.9.3. Program procedures and practices ensure that staff caseloads are monitored closely and additional families are recruited when openings occur.

6.9.3.a. Program procedures and practices ensure that case loads are maintained on an ongoing basis consistent with the contractual obligation described between the program and CYFD.

6.9.3.a.i. Program procedures ensure that when families need more visits, approval is sought and received from the CYFD Home Visiting Manager. This allows flexibility to the programs while also ensuring contractual compliance.

6.9.4. Program procedures and practices ensure that the Program Manager works with staff to engage marginally involved families.

6.9.4.a. Program policies, procedures and practices ensure that when families are non-responsive, their case is “closed” to make room for new families to be served. These procedures and practices may include defining when other services may be suggested, and how the door may be left open for the family to come back to the program at a later date.

6.10. Safety Assurance

6.10.1. Program procedures and practices ensure that all staff, supervisors and consultants working in the program receive criminal record clearances through CYFD/Early Childhood Services as required by regulation.

6.10.2. Program procedures and practices ensure that all children, caregivers and families are screened for risk factors using specified tools according to the periodicity schedule defined by CYFD. Risk factors may be related to such issues as domestic violence, child abuse/neglect, substance abuse, or others.
6.10.2.a. Program procedures and practices ensure that when a safety risk is identified or suspected, the program: assesses immediate safety, refers to other community providers as appropriate; and supports linkages and collaboration with other needed services to minimize the risk.

6.10.2.b. Program procedures and supervisory practices ensure that when possible risk situations and safety issues are identified either via screening tools or more informal observation by the home visitor, the home visitor is provided the necessary support to proceed in the best way possible to ensure immediate safety and minimize risk.

6.10.2.c. Program procedures and practices ensure that home visitors are provided with appropriate supervision and consultative support to:

   i. Develop an initial plan with the family to define strategies for safety, when issues of risk or danger are evident; and

   ii. Develop and adhere to plans assuring the safety of the home visitor and consultant while they are engaged in the work of home visiting.

6.10.2.d. Program procedures and practices ensure that home visitors provide referrals and linkages for families to additional resources in their communities related to child/family safety.

6.11. **Ongoing Program Monitoring** - The CYFD Management Team will conduct ongoing monitoring of the Home Visiting Program. This monitoring will help the CYFD Program Management team assess the program’s operations and ensure that necessary steps are being taken to meet the Home Visiting Program Standards, contractual requirements, and the program’s goals, objectives, and activities. The monitoring plan also ensures that appropriate interventions and corrective actions with Home Visiting programs are taken in a timely manner, should they be necessary.

6.11.1. Program procedures and practices ensure that the program participates in and makes effective use of the ongoing program monitoring that is conducted by the CYFD Management Team.

   6.11.1.a. The program provides opportunities for the CYFD Management Team/Monitors to observe Home Visiting practices, services, training, interactions, etc.

   6.11.1.b. The program provides opportunities for the CYFD Management Team/Monitors to conduct interviews with the Home Visiting Managers, staff, participants, customers, community partners, etc.

   6.11.1.c. The program provides opportunities for the CYFD Management Team/Monitors to review documents, records, reports, billing, contracts, data, meeting minutes, etc.

6.11.2. Program procedures and practices ensure that the necessary Program Managers and staff are sufficiently aware of the CYFD-established Monitoring Framework, which indicates the methods utilized in the monitoring process, including: ongoing communication, monthly status meetings, desk reviews, announced scheduled visits and unannounced site visits.

6.11.3. The Program Manager is aware that the frequency and focus of visits and monitoring activities may be modified by the CYFD Management Team/Monitors as needed and noted on the Monitoring Report.
6.11.4. Program procedures ensure participation by appropriate staff in discussions with the CYFD Management Team/Monitors as they share all findings from the monitoring, including demonstration of quality practices, areas of compliance and non-compliance, as well as technical assistance provided. This information will also be noted on the Monitoring Report and will be shared within the program as appropriate to guide continuous improvement activities.

6.11.5. The program ensures that the appropriate program staff is available and participates in a meeting with the CYFD Home Visiting Program Manager to discuss the program status and progress. This meeting will result in the development/refinement of a Continuous Quality Improvement Plan to ensure the implementation of all applicable regulations and contractual agreements.

6.12. Program Response to Findings of Non-Compliance and Program Deficiencies

6.12.1. Program procedures ensure that findings of non-compliance and/or deficiency that result from the ongoing monitoring process are properly attended to.

6.12.2. Program procedures ensure that non-compliance/deficiency issues are resolved within the time periods specified in preliminary report of finding that is received at the conclusion of the monitoring visit.

6.12.3. Special Conditions

6.12.3.a. Program procedures and practices ensure that in the event that the program is placed under “Special Conditions” (See Appendix F) all programmatic, fiscal, and/or administrative decisions will be reviewed with and approved by the CYFD Home Visiting Program Manager or designee prior to action.

6.12.3.b. Program procedures support the appropriate program staff to work collaboratively with the Home Visiting Management Team to ensure that every child has equitable access to quality services while the Special Conditions are being addressed and resolved.

HV Standard Area 7:
Staffing and Supervision: This standard delineates the requirements for staff education level, experience and ongoing training, reflective practices, supervisory levels and professional development processes needed to fulfill their responsibilities.

7.1. Program Staff

7.1.a. Program procedures and practices ensure that the program is staffed by individuals suited to perform the core Home Visiting service components described in section 5.5. Programs may be staffed with a combination of degreed professionals and non-degreed professionals who have knowledge of pregnancy and the prenatal period, infant/toddler safety and health, early childhood development, early childhood mental health principles and practices, knowledge of community resources, and strong relationship-building skills.

7.1.b. Program staffing procedures ensure the existence of a Home Visiting team that is
multidisciplinary and composed of licensed/credentialed professionals who have knowledge in early childhood development and early childhood mental health as well as non-degreed professionals and/or specialists from other disciplines.

7.1.c. Program procedures and practices ensure that staff education and credentials are entered into the database and kept current throughout the term of employment for all home visitors, clinical and supervisory staff.

7.2. Clinical Staff

7.2.a. Program staffing procedures ensure that home visitors and families (as appropriate) have access to at least one Master’s level licensed mental health professional who is available for consultation when potential high risk situations, crises, and/or other clinical issues or concerns arise.

7.2.a.i. The program ensures that the mental health professional possesses the clinical training and experience needed to provide meaningful mental health consultation to home visitors.

7.2.a.ii. Program staffing patterns may also allow for the licensed mental health professional to provide brief direct support for a family if/when a clinical issue arises or needs prove beyond the scope or skill level for the primary home visitor.

7.3. Staff Training

7.3.a. Program procedures and practices ensure that home visiting program staff are trained to effectively implement the curriculum approach adopted, and/or the evidence-based home visiting model or promising approach used by the program.

7.3.a.i. Program procedures and practices ensure that they are in compliance with the pre-service and in-service training requirements of the evidence-based model or promising approach they are implementing.

7.3.b. The program provides documentation that all home visiting staff have been trained in the following topic areas: (See 7.3.e. addressing timing requirements):

- Relationship-based practice (addressed in Online Trainings: Foundations of Relationship-based Home Visiting)
- Pregnancy and Early Parenthood (addressed in Online Training: Child Development: A Family Story)
- Parent child interaction (addressed in Online Trainings: Foundations of Relationship-based Home Visiting)
- Infant/child growth and development (addressed in Online Training: Child Development: A Family Story)
- Community resources
- Use of all screening tools
- Documentation/data entry

7.3.c. Program practices and procedures ensure that supervisors support home visitors to integrate and implement information from trainings to help build skill and competence.
7.3.d. Program procedures and practices ensure that all online modules are viewed within 2 months of hire as part of ongoing staff orientation and that each staff member engages in follow-up discussion about each module with his/her supervisor.

7.3.e. Program procedures and practices ensure that the online trainings are used as an ongoing training tool according to program needs.

7.3.f. Program procedures and practices ensure that in addition to initial completion of all required modules by each staff member, the modules and or updates are reviewed at a minimum on an annual basis and are discussed during program staff meetings and/or during ongoing reflective supervision.

7.3.g. Program procedures and practices ensure that the program manager assesses staff needs, topics needing review and/or concepts needing more attention, and then works to make sure the appropriate modules are reviewed with the home visiting staff.

7.3.h. Program procedures and practices ensure that in addition to the topics included in 7.3.b., each home visitor is trained on the following:

i. The agency’s/program’s policies and procedures including standards of conduct, professional boundaries and code of ethics.

ii. The confidentiality/informed consent practices of all funding sources and collaborating agencies.

iii. Provisions and requirements of relevant federal and state laws including mandated reporting of child abuse and neglect.

iv. Personal safety when providing home visiting services.

7.3.i. Program procedures and scheduling ensure that home visiting staff, managers and supervisors participate in all trainings as scheduled by CYFD, or equivalent trainings such as those required by the evidence-based model in use by a program, or trainings identified on the staff member’s Professional Development Plan. This participation is documented in the database.

7.4. Ongoing Professional Development

7.4.1. Program policies, procedures and practices support continued professional development, including access to relevant higher education courses and degree programs.

7.4.2. Program procedures and practices ensure that each home visiting staff member completes a Professional Development Self-Assessment form to help identify his/her strengths and areas where additional training is needed.

7.4.3. Program procedures and practices ensure that each staff member uses the results of the Professional Development Self-Assessment and works with his/her Program Manager and/or Supervisor to develop a Professional Development Plan. The Plan is then used to guide the types of trainings pursued.

7.4.4. Each home visiting program staff member completes 10 hours of ongoing in-service training annually.

7.4.4.a. Each staff member’s ongoing in-service training is documented in the Home Visiting Data
7.5. Supervisor/Supervision Requirements

7.5.a Program procedures and practices ensure that Program Managers and/or the staff they designate to perform Reflective Supervision (supervisors) have a minimum of one year of supervisory experience and two years' work experience with the target population served through home visiting.

7.5.b. Program procedures and practices ensure that Program Managers and/or the staff they designate to perform Reflective Supervision (supervisors) are knowledgeable about pregnancy and prenatal issues, early childhood and family development (including social and emotional development), reflective practice, and family centered care.

7.6. Reflective Supervision

7.6.1. Program procedures and practices ensure that Program Managers and/or the staff/consultants they designate to perform Reflective Supervision are able to provide reflective supervision for all home visiting staff.

7.6.2. Program procedures and practices ensure that all home visiting staff receives a minimum of two hours per month of individual reflective supervision with a qualified supervisor (see 3.9).

7.6.3. Program procedures and practices ensure that if an individual serves a dual role in the program as both a direct service provider and a supervisor for other staff, that individual is provided with supervision from another qualified supervisor to support the home visiting work with families.

7.6.4. Program procedures and practices ensure that reflective supervision is provided individually and may be enhanced through group sessions.

7.6.4.a. Program procedures and practices ensure Reflective Supervision meetings are:

   i. Consistently scheduled; and

   ii. Conducted by a qualified practitioner who is trained and knowledgeable in early childhood development or early childhood mental health utilizing reflective practice principles.

7.6.5. Program procedures and practices ensure that supervision sessions are documented in the database.

7.6.6. Program procedures and practices ensure that Program Managers and/or the staff they designate to perform Reflective Supervision (supervisors) document their participation in reflective consultation and respond to evaluation questions related to their own reflective consultation experiences.

7.7. Field Supervision

7.7.1. Program procedures and practices ensure that Program Managers accompany their home visitors on family visits (field supervision) a minimum of:

   7.7.1.a. One time per year for seasoned staff; and
7.7.1.b. Twice a year for new staff; and
7.7.1.c. As needed, in addition to the minimum requirements for each staff member.

7.7.2. Program procedures and practices ensure that supervision content may include but is not limited to:
   7.6.a. Home visitor’s relationship with family;
   7.6.b. Home visitor’s balance of attention on: baby, mom or case management? Too much of one and not enough of another?;
   7.6.c. Home visitor’s attention to parent-child interaction and mutual competence;
   7.7.d. Home visitor’s ratio of “being with” and listening vs. directing and doing (i.e. home visitor supporting the parent/child interaction rather than playing with baby);
   7.7.e. Effective use of curriculum materials to provide supporting information about topics addressed, and providing the parent with ideas for enjoyable activities to do with their infant or young child.

7.7.3. A tool such as the Home Visit Rating Scale (HOVRS) may be used to guide field supervision observations and follow-up discussion and planning.

7.8 Administrative Supervision

7.8.1. Program procedures and practices ensure that Administrative Supervision is provided for all home visiting staff. This supervision includes quality assurance for services provided, adherence to all CYFD policies, and review of screening tools and results. Supervision sessions must be documented in the database.

7.8.2. Program procedures and practices ensure that Program Managers oversee the administration of screening tools to include the following:
   a. Review ASQ3 and ASQ: SE for cut off scores and ensure referrals are completed to appropriate services when indicated
   b. Review Edinburgh Post/Perinatal Depression Scale (EPDS) and ensure appropriate referrals were made and followed-up, as indicated by cut-off scores
   c. Review Woman Abuse Screening Tool (WAST) and ensure referrals are completed to appropriate domestic violence support and intervention services if indicated by cut-off scores
   d. Review the Social Support Index (SSI) and discuss with Home Visitor the interpretation and possible action plans
   e. Review Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) - and discuss with Home Visitor
   f. Review Maternal and Child Health form to ensure information has been gathered at the time of intake and then annually thereafter.
   g. Review Perinatal Questionnaire to ensure information has been documented within 2 months of a baby’s birth (for babies born during enrollment in the program).
   h. Review safety items using the drop-down list to ensure that training about safety issues has been provided, and safety concerns are being addressed.

7.8.3. Program procedures and practices ensure that as appropriate, the administrative review related to screening tools leads to more reflective dialogue between staff and supervisor around
how to approach issues of identified risk with a family and what referrals or additional services may be needed.

7.8.4. Program procedures and practices ensure that, as screening results are reviewed with supervisors, the need for consultation with the licensed mental health consultant on the team is considered. This consultation may assist with formulating a plan for dialogue with the family, referral strategies, or other more clinical issues that may arise as the result of actively screening for risk factors with families.

7.8.5. Program procedures and practices ensure that if the family’s needs are beyond the home visiting program’s scope of work, with parent consent, appropriate referrals to other resources are made and documented.

7.8.6. Supervision procedures and practices ensure that the screening results are used by home visiting staff as an integral part of service planning with families.

HV Standard Area 8: Community Engagement: This standard specifies requirements for programs to partner with agencies and groups that may work with the same families to ensure collaboration and avoid duplication, and to work with community partners to ensure each family’s access to the necessary continuum of family support services.

8.1. Collaboration - Program procedures and practices ensure effective collaboration with other entities that will result in increased quality service to families.

8.1.a. The program has a system for making referrals and tracking follow-up when the families are referred to other community services.

8.1.b. The program documents efforts to collaborate with local hospitals, the Women Infants and Children (WIC) Program, teen parent centers, OB-GYN practitioners, midwives, Primary Care Providers (PCPs), pediatricians and other entities that may have contact with their target population. These collaborative efforts provide opportunities to discuss and develop referral and networking processes that enhance service accessibility and quality for families.

8.2 Program managers/supervisors document participation in activities related to the continued development of the comprehensive New Mexico Home Visiting Program Standards Manual that is used by New Mexico Home Visiting Service agencies.

8.3. Community Education - the program documents participation in Community Education and development activities at the local and state levels to ensure awareness of home visiting services.

8.3.a. Community Education activities may include:

- Public awareness activities to promote community knowledge of the agency’s services and outreach to serve the target population.
- Advocacy, education, policy development and networking on behalf of the target population through formal systems.
- Consultation, education and training of other community service providers in the
community to increase inter-agency collaboration and maximize service provision to clients.

- Provision of presentations to educate, raise awareness, or provide information and materials related to early childhood development, maternal and infant care, infant social and emotional development including the importance of early attachments and factors that influence early brain development.

8.3.b. The program documents the provision of at least two community presentations each year that are designed to raise awareness of the importance of the early years.

8.3.c. The program documents dates, times, person performing community education activities, the number of attendees and a description of the activities in quarterly and annual reports.

8.4 Community Advisory Committees

8.4.1. The agency/program providing Home Visiting services documents regular participation with a community advisory committee, council or coalition. The committee may be an established community group concerned with family well-being, or may be a group convened by the Home Visiting agency/program.

8.4.2. If an agency serves multiple communities (or Counties), there is documentation that an agency representative participates with an advisory committee in each distinct community.

The goal of participating with a local advisory committee is that the home visiting program becomes an integral part of the community, able to more effectively serve the families and be responsive collaborators with existing community activities.

8.5. The program documents the steps they take to collaborate with other home visiting programs (if any) that serve families in the same community or geographical area. Collaboration may include working together on promotion and recruitment activities, and referring clients to one another as appropriate to best meet family needs.

HV Standard Area 9:

Data Management: This standard delineates the requirements for entering and utilizing data for program planning, program improvement and accountability.

9.1. Program procedures and practices ensure that the data management system provided by CYFD is used to support program planning, to contribute to State-level and community-level program evaluation/accountability, and for purposes of continuous quality improvement. (See Appendix C: Documentation Requirements)

9.1.a. The required database is used to collect and report the required data (see 5.7.b.)
9.1.b. All data is entered into the database within 7 days of an activity (see 5.7.c.)

9.2. Program procedures and practices ensure that data collection and reporting occurs to support compliance with the requirements of the New Mexico Home Visitation Accountability Act.
9.3. The funded agency ensures compliance with HIPAA requirements regarding electronic, verbal and written information (see 6.4).

9.4. The agency ensures that home visitors and other staff complete the training provided by CYFD in use of the data management system as soon as possible after hire.

9.5. Program procedures and practices ensure that client information and service provision activities are documented as required in the data system (see 6.3).

9.5.a. Program procedures and practices ensure that home visitors and other staff enter data accurately and on a timely basis, protecting the integrity and accuracy of the information (see 6.3).

9.5.b. Program procedures and practices ensure that the Program Manager reviews electronic data on a regular, ongoing basis to identify missing, incomplete or inaccurate data (see 6.3).

9.5.c. Program procedures and practices ensure the correction of inaccuracies, inconsistencies or issues related to lack of timely data entry (see 6.3).

9.6. Program procedures and practices ensure that the data is utilized for Continuous Quality Improvement, at the client, staff, and program levels.

9.7. Program procedures and practices ensure that Program Managers participate in training provided by CYFD to gain skill noticing discrepancies in data reports that lead the manager to investigate further, including working with individual staff to understand issues, to correct data-entry errors or omissions, and to improve service delivery.

9.8. Program procedures and practices ensure that the Program Manager informs the database team immediately when a home visitor leaves his/her employment with the program so access to that home visitor’s user account can be de-activated.

9.9. Program procedures and practices ensure that the database is used to document that a child/family is already connected to one of the services listed in 4.2.b, even if there was no referral made by the Home Visiting Program.

9.10. The program documents in the database the participation by home visiting staff, managers, and supervisors in all trainings provided by CYFD (see 7.3.i).

9.11. The program documents supervision sessions in the database (see 7.6.5 and 7.8.1)
Appendix A

Rationale and Research Support for New Mexico Home Visiting Program Standards

The Children Youth and Families Department (CYFD) requires that all programs comply with the state’s Program Standards and corresponding Performance Measures based on the Long-term Outcomes identified in the Home Visiting Logic Model. These requirements ensure that the state is able to establish a statewide system of Home Visiting that is based on community-specific needs and resources yet is consistent across programs and communities in order to allow for the collection, aggregation and analysis of common data.

This approach was necessary because:

- Existing national, evidence-based models were each developed with a specific focus, were usually developed for a specific population, and were developed to address different needs or priorities. For example, some focus more on pre-natal and/or post-natal maternal/child health, others on older children’s readiness for school, and still others on the prevention of child abuse and neglect. Data collection and program effectiveness measures for each of these models reflect the focus of that model and cannot be reasonably compared across program models; and
- Data clearly reveals that ALL children in New Mexico are at risk for myriad adversities (before birth to school entry). Existing models vary in addressing all these risks from before birth to kindergarten entry; and
- Recognizing the rich diversity of New Mexico’s communities, it is clear that the New Mexico Home Visiting Program must allow communities to establish community-specific home visiting programs that are responsive to their community’s unique cultural and linguistic heritage.

Meta-analyses and comprehensive literature reviews regarding home visitation research, best practice elements, and policies support this approach. In June 2012 John Kormacher of the Erikson Institute and a number of his colleagues with the support of the Pew Center on the States, published an important report related to assessing quality in home visiting programs. This report shared the findings of a study that was conducted to field test a comprehensive tool to measure program implementation of best practice elements in home visiting programs. To develop this tool, the researchers conducted a comprehensive review of the literature regarding best practice elements and what is known about which practices produce which outcomes for a specific population. These researchers noted that multiple home visiting models are often blended or braided to provide services to meet state and community needs.

An important part of the Kormacher, et al. study was to review a number of overarching reviews of best practice elements within home visitation or prevention programs (Daro, 2009; Nation et al., 2003; Paulsell, Avellar, Sama Martin, & Del Grosso, 2010; Weiss & Klein, 2006). They note that in two of these reviews (Paulsell et al., 2010 and Daro, 2009) evidence is cited from program evaluations showing specific program elements that relate to positive program outcomes. Kormacher and his colleagues found that among a number of national home visitation models (Parents As Teachers, Healthy Families America, Early Head Start, Even Start and Nurse Family Partnership) there are similar themes in terms of program vision, logic models and in quality indicators. It should be noted that the New Mexico Home Visiting Logic Model was developed using elements that were common across several national models and supportive of the five long-term outcomes established by the New Mexico Children’s Cabinet in 2008. The Kormacher, et al. 2012
report also notes that some best practice elements reflect a consensus or conventional wisdom within the field about aspects of program quality (e.g. program theory, use of assessment and screening tools), but have not necessarily been directly tested through research.

Additionally, the final report of a *Meta-Analytic Review of Components Associated with Home Visiting Programs* (James Bell Associates, May 2012 for the Pew Center on the States) noted that home visiting best practice recommendations either take the form of suggesting that evidence-based models be adopted in a “wholesale” way or as suggestions for particular approaches based on clinical impressions, for example recommending a particular schedule of home visits. The authors of this meta-analysis indicate that model ratings (i.e. “evidence-based” or “promising practices”) are important for guiding practitioners as they make decisions regarding whether or not to adopt a program model. At the same time, they note that any particular program model may not include the most effective combination of components to produce maximum results for a given population or community. The pertinent question seems to be how to best build the effectiveness of a program model or enhance models that may already be in operation: what elements (e.g., content, service delivery methods) in home visiting programs are the most likely to produce the desired outcomes? These finding are consistent with CYFD’s decision to allow programs/ communities that want to adopt a national, evidence-based or promising practice model to do so and require that all funded programs adhere to the New Mexico Home Visiting Program Standards regardless of the model or approach being used.

CYFD has determined that the New Mexico Home Visiting Program Standards may be used in conjunction with other program standards as well as State, Federal and local regulations, but are considered non-negotiable for programs that receive state funding. In this way, the New Mexico Home Visiting Program is considered “one program” regardless of the differences the community programs that are implementing home visiting services.

### The New Mexico Home Visiting Program Standards align with the Best Practice Elements Identified through the Summary Reviews

<table>
<thead>
<tr>
<th>Best Practice Elements Commonly Identified through Summary Reviews</th>
<th>New Mexico Home Visiting Program Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing of family enrollment in programs</td>
<td>Program participation (HV-1)</td>
</tr>
<tr>
<td>Frequency and length of services</td>
<td></td>
</tr>
<tr>
<td>Use of assessment and screening tools</td>
<td>Curriculum and service delivery (HV-5)</td>
</tr>
<tr>
<td>Family and child goal setting</td>
<td></td>
</tr>
<tr>
<td>Education and experience level of home visitors</td>
<td>Staffing and Supervision (HV-7)</td>
</tr>
<tr>
<td>Program theory of change</td>
<td>Relationship-based practice (HV-3)</td>
</tr>
<tr>
<td>Culturally-competent practice</td>
<td>Culturally-competent practice (HV-2)</td>
</tr>
<tr>
<td>Data management (HV-9)</td>
<td></td>
</tr>
<tr>
<td>Program management (HV-6)</td>
<td></td>
</tr>
<tr>
<td>Program resource networks</td>
<td>Community engagement (HV-8)</td>
</tr>
</tbody>
</table>

Findings from these and other published literature reviews and meta-analyses, and the available research were used to provide the rationale and research-base for the New Mexico Home Visiting Program Standards.

**HV-1 - Program Participation: Timing/Dosage**

This standard determines target population, prioritization, recruitment, periodicity, duration and intensity. The standard requires that the program to be voluntary, without charge to families, and universally available.

**Rationale:** Effective programs clearly identify for whom the service is intended, at what level of intensity the service is to be delivered, and for how long the service should be delivered in order to achieve the intended outcomes. With these clear parameters, effective programs must then define their recruitment and outreach strategies so that they reach the intended population. Methods for prioritizing service delivery to specific sub-sets of the identified population are also necessary when the service need and potential enrollment exceeds program capacity. Clarity regarding the intended “eligible” population as well as consistent messages regarding and implementation of any prioritization criteria are necessary for effective recruitment and referral networks. The NM Home Visiting Program is required to be voluntary, without charge to families, and universally available with the understanding that priorities must be set when community need exceeds program capacity. The intended outcomes and community needs assessment information are used to guide decisions regarding service prioritization.

**What the Research Tells Us**

As with much of the literature regarding home visiting research, findings are somewhat inconclusive about targeted program enrollment and program recruitment. This is significant when funding and policy decisions are being made regarding how to achieve the best outcomes for the greatest number of babies and families with the available resources. One study found when the target service population is clearly identified and the actual program participants reflect the target service population, program services are well matched to participants and the program is more efficacious (Nation et al., 2003 as cited in Korfmacher, et al, 2012). This is consistent with the New Mexico Home Visiting Program Standards.

Research is less conclusive however about targeted program enrollment. Sweet & Applebaum’s 2004 meta-analysis did find some evidence that targeted program enrollment improves program outcomes. However, this same meta-analysis was not able to disentangle the independent impact of targeted program enrollment from other program services. There seems to be a general consensus that intentionality and transparency regarding program recruitment and enrollment likely allows programs to be more effective. At the same time, according to the findings of the 2004 meta-analysis, there is limited research on the effects of program recruitment and enrollment on program service delivery or program outcomes (Sweet & Applebaum, 2004).

Two frequently cited “target” criteria are pregnant women and first time parents. Some program models (i.e. Nurse Family Partnership) require **prenatal enrollment.** The New Mexico Home Visiting Program encourages recruitment of pregnant women and prioritizing this population when indicated. As with other aspects of targeted enrollment, researchers have found it difficult to disentangle the effect of prenatal enrollment from other features of the program model (Sweet &
However, evidence is cited linking prenatal enrollment in program services to stronger parenting outcomes (Darо, 2009) and more positive birth outcomes (Lee et al., 2009; McCurdy, Gannon, & Darо, 2003 as cited in Korfmacher, et al., 2012). Research suggests that mothers with additional risk factors who might lack access to adequate health care and prenatal services may benefit most from beginning home visiting services prenatally or at birth (Darо, 2009 as cited in Korfmacher, et al., 2012).

Programs sometimes choose to prioritize first time mothers/parents in the belief that services are more likely to be effective with this population and/or that first time parents who receive home visiting services will be able to generalize their knowledge and experience to parenting subsequent children. This type of prioritization may be indicated when community service need exceeds program capacity. It should be noted that a 2013 Pew Center on the States brief indicates that at-risk mothers who already have children can benefit from home visiting as much as first-time mothers. This finding is worth considering given the high levels of risk among New Mexico mothers. The 2013 PEW Brief cites a 1999 randomized controlled evaluation of Healthy Start in Hampton, VA, through which researchers found mothers with at least one child prior to enrollment and their children benefited from the program as much as first-time mothers did on measures of infant health, parent-child interaction, and the home environment (Galano & Huntington, 1999 as cited in the 2013 PEW Charitable Trust Brief titled Expanding Home Visiting Research: New Measures of Success).

Several analyses of the available research also tell us that there is a strong relationship between child and family outcomes and families receiving a sufficient frequency and length of program services (Nievar, VanEgeren, & Pollard, 2010; Sweet & Applebaum, 2004). The research consistently suggests that families who complete more visits tend to show greater outcomes (Sweet & Applebaum, 2004). Programs lasting for a year or more with an average of four visits per month have been found to be more likely to demonstrate positive outcomes (Kahn & Morre, 2010 as cited in Kormacher, et al., 2012). A significant positive relationship between the frequency and length of services and child outcomes related to cognitive development, immunization rates and fewer childhood injuries has been demonstrated (Wagner, et al, 2001 as cited in Kormacher, et al., 2012).

In terms of duration or over how long a period of time the families participate in program services, longer enrollment significantly predicts parent support for language and literacy (Raikes et al., 2006 as cited in in Kormacher, et al., 2012). Roggman et al., 2008 (cited in Kormacher, et al., 2012) also found that parents who leave services before completion were observed as less supportive of their child’s play and had lower scores on the HOME observation (Home Observation for Measurement of the Environment, Caldwell & Bradley, 1984). The research also suggests that family retention rates and the intensity of services families receives relate to home visitors’ ability to effectively engage parents in program services (Allen, 2007; Roggman, et al., 2008 as cited in Kormacher, et al., 2012).

Korfmacher, et al. (2012), note that there is agreement in the home visiting field that home visiting programs can help facilitate continuity of care by developing transition plans with families. These plans are thought to provide parents with support in continuing to achieve their parenting goals even after they are no longer receiving home visiting services. Transition plans are likely to be especially important for families with higher needs who may benefit from a variety of community resources and services so that they can achieve or sustain progress on their goals (Golden, et al., 2011 as cited in Korfmacher, et al., 2012). The Korfmacher report indicates however that limited efforts have been made to explore the content and quality of transition plans within home visiting programs. The New Mexico Home Visiting Standards require that programs have procedures in place to ensure that transition plans are developed with each family served. This requirement is
consistent with general consensus in the field even if there is not specific research demonstrating the importance and effectiveness of this practice.

**HV-2. Culturally Sensitive Practices**

This standard specifies practices to work effectively with people from a variety of abilities, languages, and identities as well as ethnic, cultural, political, economic, and religious backgrounds.

**Rationale:** The rich diversity present among New Mexico families and communities makes it essential to provide services and supports that respect the culture, values, preferences, and needs of each family. Home visiting organizations and programs are expected to understand and address a multiplicity of cultures, languages, and values among the families with whom they partner.

**What the Research Tells Us**

According to the 2011 US Census, African Americans compose 13% of the US population and 2.5% of the NM population. The US Hispanic population has grown from 4.5% of the population in 1970 to 14.2% in 2011. In NM, nearly 47% of the population is Hispanic and just over 40% is White-non-Hispanic. The US population of Asian and Pacific Islanders from many different countries and cultures grew 72% from 1990 to 2000 yet remains low in NM at only 1.6% of our population. The Native American and Alaska Native population is also growing faster in the US than the general population—26% growth since 1990, with 10% of the NM population being Native American. 7% of NM’s population is under age 5 years and nearly 25% is under 18 years. Although NM’s foreign-born population is just under 10%, over 36% of New Mexicans over 5 years of age live in homes in which a language other than English is spoken.

Goode, et al., 2006 conducted a review of the evidence base for the impact of cultural and linguistic competence in health and mental health care on health outcomes and well-being and the costs and benefits to the system. They concluded that while the evidence shows great promise for the impact of culturally and linguistically competent interventions on physical and mental health outcomes and well-being, significant gaps remain, due largely to methodological issues. Current studies fall short in many areas, including: lack of definition and measurement of cultural and linguistic competence; designs that isolate effects of cultural and linguistic competence; and studies that address ultimate health outcomes of decreased incidence of disease, morbidity and mortality. In addition, few studies examined cultural and linguistic competence at the organizational and policy levels. Additionally, evidence to support the hypothesis that cultural and linguistic competence would result in decreased system costs is not currently present in the literature.

**Cultural Factors That Impact Home Visiting Service Delivery**

Given the diversity of New Mexico families, it is important to understand how cultural factors impact home visiting service delivery. Culture is an especially important consideration to home visiting services because it structures perceptions, shapes behaviors, and influences the way of life as it informs group members how to behave. Culture provides group members their identity. The growth and development of babies and toddlers is rooted within a cultural context, as are the early care practices of parents and caregivers (Brunson Day, 2006). Culture is described as an integrated pattern of human behavior which includes but is not limited to thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles relationships,
and expected behaviors of a racial, ethnic, religious, spiritual, social, or political group; and as the ability to transmit the above to succeeding generations; and as dynamic in nature. Cultural factors that reflect diversity among individuals and groups include, but are not limited to, language, national origin, tribal or clan affiliation, gender, age, education, literacy, socioeconomic status or class, sexual orientation and sexual identity, religious or spiritual beliefs, geographic or regional patterns, legal status, acculturation, and assimilation (Bronheim, S., Goode, T., & Jones, W., 2006). Cultural and Linguistic Competence in Family Supports. National Center for Cultural & Linguistic Competence, Georgetown University Center for Child and Human Development). Each of these factors effects home visiting service delivery.

Daro and her colleagues (2005) believe that culture is a strong factor in parenting choices and notions of appropriate parent-child interactions. Thus, it is essential that voluntary family support programs consider cultural relevance and sensitivity in hiring and training their direct service staff. They also note that an organization’s culture or values could determine the extent to which a home visitor actively engages participants or effectively draws on other community resources in meeting participant needs. At the same time, a parent’s perception of a home visiting program may be influenced by her perception of the organization offering the service. If an organization is perceived as embracing the values and norms of the community and respecting local culture, new parents may be more willing to enroll and remain in the program. Similarly, potential participants may view a family support program as less stigmatizing and more normative if the organization offering the service provides broad, generalized support to all local residents as opposed to targeted support for those experiencing a set of core problems (e.g., domestic violence, substance abuse, mental health issues).

The Healthy Families America (HFA) Essential Elements and Supporting Literature (Prevent Child Abuse 2001) notes that there is a consensus among social scientists that home visiting programs should provide culturally competent services. This publication notes that there is a long history of efforts to provide services to children and families that are sensitive and responsive to their needs and adaptive strengths. HFA cites information from Slaughter-Defoe (1994) indicating that “the success of the settlement house was due, at least in part, to the fact that service providers appreciated the families’ “indigenous language and cultures, specifically their behavioral norms, rituals, and routines, that is, their agreed-upon shared ways of behaving within constituted family and community groups.” (Slaughter-Defoe, 1994, p.175). This same HFA publication cites Bernstein, and his colleagues (1994), advising that home visitors work with families to search for the best strategy for their children in the context of understanding, as possible the family’s values related to child rearing and family life, critical elements of cultural transmission. These authors describe the essence of acceptance of cultural diversity as understanding that families have the right to choose to live their lives differently from the home visitor’s. They state, “We believe, however, that whatever the choice in an area of concern, it should result from parents sharing their perspective and programs sharing information – rather than the result of ignorance, habit, or personal history – without considering alternatives.” (Bernstein, Percansky, & Wechsler, 1994, p.16) HFA suggests that this type of exchange should be routine in any home visiting program so that there is ongoing and open dialogue regarding mutually established goals. Other authors note, “How staff members feel about each other, those they serve, and the program itself can have a very strong influence on program outcome.” For instance, when home visitors feel they have control over their work allowing them the flexibility to meet families’ needs, they have a better chance of fostering that same sense of empowerment in the families they serve. Stereotypes inevitably influence provider’s relationship with families, so home visitors must continuously be supported to examine their own beliefs.” (Kaplan & Girard, 1994 as stated by Slaughter-Defoe, 1993, p.179) and cited in Prevent Child Abuse
America (2001). This is an aspect of ongoing professional development and self-other awareness that is addressed through the NM Home Visiting Program Standards’ requirement that home visitors participate in regular reflective supervision.

Linguistic diversity

Census data indicate over 36% of New Mexicans over 5 years of age live in homes in which a language other than English is spoken. No data was found specific to the linguistic environment of very young children in New Mexico. Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires home visiting organizations and home visitors to respond effectively to the health and development literacy needs of the populations they serve. Home visiting organizations must have policy, structures, practices, procedures, and dedicated resources to support this capacity to respond effectively. This expectation is clearly stated in the New Mexico Home Visiting Program Standards.

HV-3. Relationship-based Practices

This standard establishes the process, tools and strategies to focus on parent-child bonding and healthy emotional attachment and work with all members of the family who want to participate.

Rationale:

“Nurturing begets nurturing. A caring, professional-parent/family relationship supports a caring, nurturing parent-child relationship.” (Bernstein, 2002-03, p.1). New Mexico home visiting programs keep the quality of the parent-child relationship central to all aspects of their work knowing that all intended outcomes are impacted by these essential relationships. In order to intentionally support system-wide relationship-based approaches, many of the practice and supervision requirements defined by the New Mexico Home Visiting Program Standards are based on the competencies outlined by the New Mexico Association for Infant Mental Health (NMAIMH) Competencies for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (http://www.nmaimh.org). Relationship-based practices as defined through the NMAIMH competencies are also referenced for professionals providing services through the New Mexico Family-Infant Toddler Program (IDEA, Part C), are addressed through Associate’s and Bachelor’s level education courses for family-infant service professionals, and are consistent with performance standards for Early Head Start.

Over the past 10 years, New Mexico has come far in our recognition that, central to the developmental and mental well-being of very young children are factors that are defined as “Infant Mental Health” (IMH). A Strategic Plan for Infant Mental Health in New Mexico (2003) defines infant mental health as “the psychological, social and emotional well being of infants and toddlers in relationship with their caregivers, environment and culture, and with respect for each child’s uniqueness.”

When viewed along a continuum of service levels from promotion, to prevention, to intervention and treatment, the New Mexico Home Visiting Program is a prevention-level service with IMH
principles at its core and is intended to be available to all families. At all levels of this continuum, the focus is not simply on the infant or on the parent, but on the relationship between the two. The New Mexico Home Visiting Program encourages parenting practices that benefit the infant’s social and emotional health and provides parents with information about where to go for support. “Prevention” is a distinct level of service from intervention and treatment levels that are being developed in New Mexico for children who are known to be struggling with identified behavioral/relational disturbances. Although IMH intervention and treatment services also typically involve home visits, the focus of this clinical work with parents and their infants or toddlers is to address a variety of mental health issues that are often evident in maladaptive behaviors and interactions between parents and their very young children.

What the Research Tells Us

We now have decades of research that tells us that mutually rewarding interactions are essential prerequisites for the development of healthy brain circuits and the development of increasingly complex skills (National Scientific Council on the Developing Child, 2007). Researchers remind us that relationships are can be described and understood as mutual, reciprocal interactions – the give-and-take or “serve and return” process that is similar to what is seen in games such as tennis and volleyball. These researchers describe how, in early childhood development, “serve and return” happens when young children naturally reach out for interaction through babbling, facial expressions, words, gestures, and cries, and adults respond by getting in sync and doing the same kind of vocalizing and gesturing back at them, and the process continues back and forth. These scientists note that the serve and return notion of interaction works best when it is embedded in an ongoing relationship between a child and an adult who is responsive to the child’s own unique individuality. The New Mexico Home Visiting Standards require an intentional and systematic focus on these very interactions and relationships.

In addition to the focus on nurturing parent-child relationships, the New Mexico Home Visiting Standards provide expectations regarding the quality of relationship between the home visitor and the parent/family. The parent-home visitor relationship has been found to be the strongest predictor of the intensity of program services received (Allen, 2007 as cited in Korfmacher, et al., 2012). Research tells us that the personal characteristics of home visitors impact the relationship quality between home visitors and parents, ultimately impacting program outcomes (Daro, 2000 as cited in Korfmacher, et al., 2012). Specifically, successful home visitors tend to hold non-judgmental views of families, are relationship-oriented, and work collaboratively with families to plan goals and implement activities (Daro, 2000; Hebbeler & Gerlach- Downie, 2002 as cited in Korfmacher, et al., 2012). Home visitor characteristics that influenced parental engagement in services, include: acceptance, sociability, perspective, balancing multiple roles, and the knowledge base needed to effectively refer families to outside resources (Wagner, Spiker, Gerlach-Downie, & Hernandez, 2000 as cited in Korfmacher, et al., 2012). This same report indicates that there is little direct research focused on the relationship between making referrals and program outcomes. Qualitative research conducted by interviewing parents found parents truly valued home visitors who were persistent, conscientious, and consistently followed through on delivering promised services and/or referrals (Brookes, Summers, Thornburg, Ispa, & Lane, 2003; Paris & Dubus, 2005 as cited in Korfmacher, et al., 2012). This same report indicates that there is little direct research focused on the relationship between making referrals and program outcomes. Qualitative research conducted by interviewing parents found parents truly valued home visitors who were persistent, conscientious, and consistently followed through on delivering promised services and/or referrals (Brookes, Summers, Thornburg, Ispa, & Lane, 2003; Paris & Dubus, 2005 as cited in Korfmacher, et al., 2012). Additionally, Paris and Dubus (2005) found that mothers in home visiting programs felt it was important that home visiting staff validated their feelings, recognized and affirmed their strengths as parents, and allowed mothers to feel connected and well cared for (Paris & Dubus, 2005 as cited in Korfmacher, et al., 2012). The New Mexico Home Visiting Program Standards
require careful attention to multiple levels of relationships: parent-child; home visitor-parent; and home visitor-reflective supervisor.

HV-4. Family Goal-Setting

This standard determines tools and usage of state approved screening processes, ongoing assessment and goal setting, referrals, follow ups and case management process.

Rationale

The New Mexico Home Visiting Program has chosen a comprehensive array of screening tools and processes to support programs as they work with families toward the outcomes in the logic model. The Program Standards require specific procedures and practices related to the administration of the screenings, as well as supervision of home visitors as they administer and use the results of the required screenings. The Standards require that the screening results be used collaboratively with families in discussions regarding child and family goal setting. This practice encourages home visitors and families to work together to understand how screening information can be used to inform service planning, to establish goals for progress on family-identified priorities, and to track that progress adjusting service strategies as needed. Collaborative family goal setting is an important strategy to help parents build a number of life skills.

What the Research Tells Us

Very little research specific to family goal setting was identified. A number of research publications refer to goal setting as an assumed aspect of home visiting programs. In fact, many national models include procedures for establishing service goals with families. Two articles cited in Korfmacher, et al. (2012) indicate that one characteristic of successful home visitors is collaborative planning with families to set goals (Daro, 2000; Hebbeler & Gerlach-Downie, 2002). These researchers note that successful home visitors also tend to hold non-judgmental views of families, are relationship-oriented, and work collaboratively with families to both plan goals and to implement activities. Each of these characteristics is highlighted, trained toward and supported through reflective supervision practices in the New Mexico Home Visiting Program.

Research specific to providing home visiting services to mothers with depression also mention differences in outcomes depending on whether the focus of the program is to support mother-identified goals or to more specifically address child development outcomes. Golden, et al. (2011) note that especially in programs that prioritize meeting the mother’s self-identified goals, home visitors may need help in understanding and being able to communicate to a mother how her depression might make achieving her goals more difficult despite her best efforts. Often trained and supported home visitors are in a good position to help mothers see that by treating the depression and reducing the symptoms, the mother will more likely be able to make the changes she wants to make and to reach her goals. These authors also noted that in the home visiting programs that focused more on child development than on the mother’s goals, home visitors were particularly receptive to information about the effect of maternal depression on babies and young children. Home visitors who had this information saw opportunities for engaging the mother in a conversation around depression. Duggan, et al. (2012) also recommend sensitive, collaborative goal setting with mothers experiencing depression.
In 2012, James Bell Associates conducted a study to examine the effectiveness of home visiting programs by determining which individual home visiting program components have the most power to improve key parent and child outcomes. These researchers used a component analysis employing meta-analytic techniques to synthesize the results of published evaluations of home visiting programs for pregnant women and families with children birth to age 3. They used characteristics of program content and service delivery to predict effect sizes on measures of key outcomes such as child and parent functioning, health, and well-being.

Interestingly, “goal setting” (meaning that the reviewed studies explicitly stated that “goal setting” was done with or taught to parents as a program component) was among the six of ten components that were found to result in significant negative coefficients. These researchers concluded that the presence of these six components was reliably associated with less successful programs in their meta-analysis. The six components associated with less successful programs were: Safe or Clean Home Environment, Promotion of Child’s Cognitive Development, Promotion of Child’s Language Development, Promotion of Child’s Socio-Emotional Development, Need for Social Support or Social Network, and Goal Setting.

Caution must be used in interpreting this finding. The authors themselves share, “. . . it would be inappropriate to claim that particular components or strategies caused program success or that the inclusion of other components led to less optimal outcomes. The results speak only to the extent to which certain components were consistently associated with greater differences between treatment and control/comparison groups on the parent and child outcomes examined in this study across a broad range of program content, delivery, and evaluation methodologies.” (Pew Center on the States, 2012, p. 53). They further caution, “non-significant outcomes should not be over-interpreted”.

HV-5. Curriculum and Service Delivery Approach

This standard defines the use of a specific research-based curriculum, a combination of curricula and approved home visiting models and the process for approval of a home visiting curriculum or model not listed under “approved curriculums and models” section.

Rationale:

During prenatal home visits New Mexico Home Visiting Programs are required to provide information on infant/child development, including developmental guidance using a recognized curriculum. Then during home visits provided after the baby is born and up to 36 months of age, they are required to provide developmental guidance and parent-child interaction support based on a research based curriculum. The approved curricula include: Partners for a Healthy Baby; Portage Project’s Growing: Birth to Three; and Partners in Parenting Education (PIPE). Using a research-based, recognized curriculum ensures that the families served through their home visiting program are receiving information and materials that have been developed through a process of rigorous study and research that ideally can offer evidence of effectiveness. Home visitors who use a curriculum benefit from years of work by a group of thoughtful practitioners and researchers who have combined their knowledge and talents and provided a resource that can be used with confidence to benefit families and their very young children. Practitioners who use the curriculum are drawing from a bank of collective wisdom (Epstein, 2008).
Approved Home Visiting Program models include: First Born, Parents as Teachers, Nurse-Family Partnership, and Healthy Families America. The New Mexico Home Visiting Program Standards along with the adopted curriculum give structure and content for the parent education and support delivered through home visiting services.

What the Research Tells Us:

The quality rating tool developed by Korfmacher, et al. (2012), considers a strong program model to be one that includes use of an evidence-informed model with a well-established curriculum that places consistent emphasis on the content areas of child development, child health and safety, and parent-child relationships. Home visits with more time spent on child focused activities and promotion of child development predict several program outcomes. Visits focused on promoting child development (relative to visits focused on other activities, such as paperwork, social support) significantly predict greater parental support for language development, higher overall scores for the quality of home learning environments, and higher child cognitive scores (Raikes et al., 2006 as cited in Korfmacher, et al., 2012). There is also research suggesting that mothers are more likely to be engaged in home visits when home visitors are discussing child development (Peterson, Luze, Esbaug, Jeon, & Kantz, 2007 as cited in Korfmacher, et al., 2012). In addition to focusing on child development, greater facilitation of positive parent-child interactions during home visits is related to: higher parental engagement, more secure attachment behaviors in children, and children’s age appropriate cognitive development (Knoche, Sheridan, Edwards, & Osborn, 2010; Roggman, Boyce, & Cook, 2009 as cited in Korfmacher, et al., 2012).

Epstein (2008) notes that use of a single, proven curriculum does not mean that the provided service is rigid. A good curriculum enables home visitors to build on the knowledge that already exists in the field, to add in their own experience and observations as well as the experiences and observations of the family, and then adapt what the home visitor does according to the needs and preferences of the child and family.

HV-6. Program Management Systems

This standard determines the systems for planning, program self-assessment, ongoing monitoring, record keeping, reporting, communication, fiscal management and caseload size and management.

Rationale:

The quality of home visiting services is dramatically affected by the competence and leadership of a program leader who plans, assesses, and modifies the program on a continuing basis. Implementation of sound and coherent management practices and procedures ensures that New Mexico Home Visiting Programs are able to support home visiting staff to provide high quality services to pregnant women and families with very young children. Successful programs have leaders who design and manage policies, procedures, and systems that comply with regulations, ensure quality-learning experiences for children and families, and maintain financial soundness. The program administrator is the individual responsible for planning, implementing, and evaluating an early care and education program. The role of the administrator covers both leadership and management functions.

Effective program management is also critical to relationships within the community as well as with
the families being served. Home visiting staff who are supported by effective administration and program management are able to focus their time and energy on providing families with high quality supports and services. This is especially true of programs that serve families who are experiencing multiple risks. In order for home visitors to be most effective with families who are struggling, they need to have confidence that, as home visitors, they are operating from a stable and secure base of operations within their programs.

What the Research Tells Us:

Effective program administration (such as leadership, work environment, supervision, and program monitoring) is generally recognized in the human service field as essential elements of program quality (Glisson, 2010; Durlak & DuPre, 2008 as cited in Kormacher, et al., 2012). However, there is little research on the impact of administrative aspects on home visiting program effectiveness and few measurement tools exist to address these issues.

Coffee-Borden and Paulsell (2010) cite studies that demonstrate that the organizational environment, supervision practices, and community partnerships directly affect home visitors’ capacity to effectively provide services to children and families and implement evidence-based programs with fidelity. These authors note that home visitors feel supported in their work with families when their organizations provide supportive internal policies and procedures and when positive attitudes exist among agency staff.

HV-7. Staffing and Supervision

This standard delineates the requirements for staff education level, experience and ongoing training, reflective practices, supervisory levels and professional development processes needed to fulfill their responsibilities.

Rationale: The effectiveness of the New Mexico Home Visiting Program is enhanced when home visitors have the knowledge, skills, experience, and personal characteristics needed to deliver the service as intended. Home visitor effectiveness is enhanced as program staff is provided ongoing professional development support through specialized training experiences that are directly relevant to the work requirements and populations served and are provided with regular reflective supervision. Likewise, the quality of program supervision is enhanced when supervisors are well qualified and provided with ongoing professional development relevant to their roles. Home visiting program supervisors can be more effective when they are provided with ongoing support to enhance their reflective supervision and program management skills.

What the Research Tells Us:

Research findings on staff education and professional experience are somewhat inconclusive and mixed. The Olds, et al. (2002) investigations of the Nurse-Family Partnership have shown that mothers visited by nurses tend to demonstrate greater benefits than mothers visited by paraprofessionals. However, Sweet & Appelbaum’s (2004) meta-analysis indicated that the impact of staff education and professional experience depends on the outcomes under consideration. For example, children with professional home visitors tended to demonstrate greater cognitive outcomes, however, children with paraprofessional home visitors tended to exhibit fewer signs of
neglect and abuse. While the findings for child and parent outcomes are mixed, there is some evidence to suggest that staff education and professional experience contributes to the staff member’s response to in-service trainings and to the ability to incorporate new knowledge into their work with families (Knoche, Sheridan, Edwards, & Osborn, 2010 as cited in Korfmacher, et al., 2012).

Daro, et al. (2003) found that staff professional experience positively correlated with the number of home visits the families completed. Beyond a general view that more is better, however, there are not established thresholds for how much education or experience is needed for home visitors to be most effective in their service delivery (Korfmacher, et al., 2012).

A published brief addressing early childhood mental health notes that the emotional and behavioral needs of vulnerable infants, toddlers, and preschoolers are best met through coordinated services that focus on their full environment of relationships, including parents, extended family members, home visitors, providers of early care and education, and/or mental health professionals. Mental health services for adults who are parents of young children would have broader impact if they routinely included attention to the needs of the children as well (In Brief: Early Childhood Mental Health, www.developingchild.harvard.edu).

Watson & Neilsen Gatti (2012) conducted a small study to explore how provision of reflective supervision supports early interventionists by decreasing burnout and increasing skills needed to work with diverse families. These authors noted that the home-based family workers (early interventionists) expressed joy, passion and fulfillment in their work. They also expressed increasing levels of stress as a result of working with complex and stressed families and their own feelings of inadequacy about their ability to fully meet the needs of the families they serve when also faced with program budget cuts and increasing paperwork demands. Study participants identified the need for supervision time to attend to critical aspects influencing their work including the influences of relationships and their feelings about their work with families and their young children. Reflective supervision was found to help participants recognize and use their feelings to inform them about their work rather than to interfere with the work as they faced the sometimes overwhelming needs of families.

**HV-8. Community Engagement**

This standard specifies requirements for programs to partner with agencies and groups that may work with the same families to ensure collaboration with community partners and avoid duplication, share responsibility for the healthy development of children and families in the program to ensure each family’s access to the necessary continuum of family support services.

**Rationale:** The New Mexico Home Visiting Program is designed so that home visiting services and supports are embedded within each community’s early childhood system of care. Programs providing home visiting services engage in strategic community needs assessment, planning and cross-agency relationships in order to develop effective referral networks, interagency communication, and a continuum of services and supports that work together to meet the needs of the pregnant women and families with very young children. Community engagement creates a safety net that ensures families in need who want to participate in services can do so without issues of duplicating services, programs competing for families to serve, or allowing gaps in community services that leave some families’ needs unmet.
What the Research Tells Us:

When home visiting staff have the knowledge base to refer families to outside resources as necessary, parents tend to be more engaged in program services (Wagner et al., 2000 as cited in Korfmacher, et al., 2012). Mothers in home visiting programs felt it was important that home visiting staff take the initiative in providing referrals and following through on services offered by checking back with families about referrals (Paris & Dubus, 2005; see also Brookes et al, 2003 as cited in Korfmacher, et al., 2012, p. 67). The 2013 PEW Brief titled: Expanding Home Visiting Research: New Measures of Success indicates that when adequate community infrastructure is in place, low cost, universal-access approaches to home visiting can provide short-term positive returns on investment by triaging families to the appropriate level of services. These authors conclude that when the necessary community infrastructure is in place, offering home visiting to all families regardless of risk effectively improves child and family outcomes and saves taxpayers money.

Research by Golden, et. al., (2011) note that good practice involves cross-program strategies (community engagement) such as linking home visiting services to medical and mental health treatment, connecting one-on-one services with group options and community resources, as well as referral networks into and when transitioning out of home visiting services. After looking at a wide range of the literature, Daro (as cited in Weiss and Klein, 2006) identifies links between home visiting and other community resources and supports as one of the key factors that contribute to positive effects to support program improvement.

HV-9. Data Management

This standard delineates the requirements for entering and utilizing data for program planning, program improvement and accountability.

Rationale: While different agencies may choose to implement different models or approaches to their provision of home visiting services within their communities, the New Mexico Home Visiting Program is a unified program with standard and consistent requirements for each implementing agency. These consistent standards and requirements, including specific data collection and utilization requirements are important for a number of reasons. All agencies that implement home visiting services are expected to collect and use this standard data to monitor and continuously improve the services they deliver to the families in their communities. Additionally, CYFD uses the data collected by all agencies that are implementing home visiting services to monitor and improve service delivery in each community and across the state. Implementing agencies may collect and report data in addition to what is required through the New Mexico Home Visiting Program Standards. However every agency implementing home visiting services must at a minimum collect the data required by the Standards so that cross-agency comparisons can be accurately made and so that consistent conclusions can be drawn regarding program service delivery and outcomes.

What the Research Tells Us:

The 2013 PEW Brief titled: Expanding Home Visiting Research: New Measures of Success (2013) notes that being truly evidence-based is an ongoing process that goes beyond model selection to include continual data monitoring, analysis, feedback, experimentation, and testing to improve quality and maximize outcomes for children and families. This brief indicates that findings from meta-analyses links specific program content with results and highlight the importance of
objectively monitoring and measuring the services and service quality that programs deliver.

Weiss & Klein (2006) consider use of data for program improvement to be the first step in maintaining service quality. They recommend that program expansion be tied to a transparent and effective system for collecting indicators of performance and using it to improve programs and outcomes. Daro’s (2006) findings indicate that the development of a quality home visiting system is reliant on use data for continuous service/program improvement. Daro notes that as use of home visiting as a service delivery strategy expands as part of state service systems, it becomes critical that home visiting programs build capacity for effective information systems that provide checks and balances to guide program quality and to achieve the desired outcomes.

This same finding was published by the Pew Center for the States’ Policy Framework to Strengthen Home Visiting Programs (2011). This publication states, “States can enhance the quality and effectiveness of their home visiting programs by articulating the purposes of the programs, coordinating home visiting resources with other early childhood programs, and establishing data collection and evaluation infrastructure to ensure ongoing program improvement. When adequately and carefully planned, these activities will put states in a stronger position to achieve improved outcomes . . . .” (pp. 4-5).
References


Appendix B

To assist families in selecting Goals, these 5 Long-Term Outcomes have been expanded by CYFD to include the following 18 outcome Areas:

1. Supportive relationships present
2. Family is safe
3. Attainment of education/employment
4. Appropriate health/medical care is received
5. Immunization plan of family is followed
6. Appropriate prenatal practices are in place
7. Subsequent pregnancy is planned and spaced
8. Emotional health is managed
9. Substance use is managed
10. Caregiver competence/confidence
11. Stable basic essentials are obtained
12. Positive relationships with children
13. Father is involved with child
14. Child well-being/readiness supported
15. Breastfeeding is provided for the baby
16. Healthy nutrition provided for child
17. Engaged in social/spiritual communities
18. Age appropriate expectations are met
Appendix C
DOCUMENTATION REQUIREMENTS – Client Record

CYFD requires maintenance of electronic client files

A. Documentation at Intake/Admission (to be maintained in individual file)
   · Determine if the client meets the eligibility criteria.
   · Intake begins the process of gathering information, which includes a complete social history.

   All referrals made to a program are captured by the program. Contact with prospective clients is documented in the database. Once the family signs the consent for services, the status of the case is changed to “admit” status. Referrals that do not accept the program are removed from the referral status.

   · Required forms include:
     o **Client Rights/Responsibilities/ Grievance Procedures**
     o **Client Release of Information** - specific consent is obtained before sharing any identified data with other service providers. Each consent form is used for a specified reason, a specifically identified provider and is time limited. Administrative supervision is implemented to ensure that new consents are secured as needed, based on time elapsed, provider need, and according to the specific consent policies of the organization and providers to whom the request is being made.
     o **Consents to Release Protected Health Information** - confidentiality of client information, written, verbal, and electronic is ensured by program procedures and practices in accordance with the policies of the Health Information Portability and Accountability Act (HIPAA). Without specific written client consent, the release of Protected Health Information to agencies or funding sources other than CYFD may be a violation of state and federal regulations.
     o **Consent Forms** – includes documentation of consent, or attempt to obtain consent of the client and/or parent/legal guardian for admission, evaluation, photo/video or research). Programs must use language approved by CYFD. Each consent form is used specifically for each identified provider, for a specified reason and is time limited. Programs must be vigilant to obtain new consent as needed.
     o All forms must be signed and dated by the family and /or parent or legal guardian, and agency staff. A separate Release of Information Form must be used for each request. Guardian must sign unless child has been emancipated.
     o **Consent Form Specific to Data Collection** – consent is obtained from every client allowing for data about their home visiting experiences to be maintained in the electronic client file system of CYFD. The consent form includes assurance that all data about the family used for reporting and/or evaluation purposes will be de-identified and aggregated, and that no identifying data will ever be made public. The consent form informs the client that records review is limited to specific agency staff providing the Home Visiting services to the family, the CYFD manager, and staff of the data management system.

   NOTE: The funded agency must ensure compliance with HIPAA requirements: electronic, verbal and written information.
B. Documentation of Appropriate Family and Infant/Toddler Goals

Document in client file including the database when the goals were achieved and if not achieved.

It is important to set goals with each family about what they hope to accomplish through working with the home visiting program, and to review progress regularly, noting when goals are accomplished. New goals should be developed as the family’s needs and interests change. The comprehensive information gathered through the use of the screening tools directly relate to families’ goals and to the 5 Long Term Outcomes:

- Babies are born healthy
- Children are nurtured by their parents and caregivers
- Children are physically and mentally healthy and ready for school
- Children and families are safe
- Families are connected to formal and informal supports in their communities

To assist families in selecting Goals, these 5 Long-Term Outcomes have been expanded by CYFD to include the following 18 outcome areas (same as Appendix A):

1. Supportive relationships present
2. Family is safe
3. Attainment of education/employment
4. Appropriate health/medical care is received
5. Immunization plan of family is followed
6. Appropriate prenatal practices are in place
7. Subsequent pregnancy is planned and spaced
8. Emotional health is managed
9. Substance use is managed
10. Caregiver competence/confidence
11. Stable basic essentials are obtained
12. Positive relationships with children
13. Father is involved with child
14. Child well-being/readiness supported
15. Breastfeeding is provided for the baby
16. Healthy nutrition provided for child
17. Engaged in social/spiritual communities
18. Age appropriate expectations are met

C. Documentation of Screening Tools

Required performance measurement tools and/or data collection must be completed with each family - please refer to periodicity grid (Appendix D).

D. Documentation of client progress through home visit records

“*What we are doing is what we are documenting.*”

Documentation must be thorough and complete. CYFD requires that documentation include objective descriptions of what was observed (seen and heard) so that if a chart is subpoenaed, all factual issues are stated and nothing is left out. This will support any action necessary to support the safety of children.

Documentation is written behaviorally and factually without interpretation and judgment/assessment of events.
Documentation may include but not limited to:
- Parent/child interactions
- Family Health
- Systems Issues
- Environmental Factors
- Social Supports
- Mental Health
- Strengths
- Concerns
- Curriculum
- Other

The progress notation shall be made in the database service entry screen and include date, time and duration of contact, type of service, indication of dropdown items checked and a narrative note based on the DAP (Data-Assessment-Plan) format (DAP examples are provided in Appendix E).

When a dropdown category is marked as a “concern”, there must be an entry made in the narrative section that describes the nature of the concern in more detail and within seven days. The dropdown items or “actions” are designed to be an integral part of the service note. They are used to provide more specific information about what was discussed during the home visit. In many cases, selecting an action item becomes self-explanatory as the documentation for that item. In other cases, selecting the dropdown may warrant a brief explanation or expansion in the DAP note. This may be especially evident when selecting an item from the “Parent-Child Interaction Observed” or “Parent-Child Interaction Discussed” boxes. The parent-child interactions will necessitate narrative to effectively describe what was observed and discussed.

The action items checked not only reflect what happened in the visit but also support the ongoing development of goals in the service plan. For example, if there is frequent discussion with the parents about particular safety issues, it suggests that safety may be relevant for addition as a service plan goal.

Action items also are “mapped” to the eighteen (18) identified outcome measures (Appendix A). The use of action codes serves as an indicator of activity that reflects on the extent of actions taken to support each outcome measure. This documentation will also support evaluation of home visiting services across New Mexico.

There is no requirement that every dropdown category get checked. The home visitor will check the items that were discussed or observed at that home visit. The parent-child observations and parent-child interactions addressed are required. If “concerns’ are checked, this should be explained in the DAP note along with tracking and updating family goals. The “D” part of DAP should always track/update goals and comment on concerns/issues noted in drop downs (DAP examples are provided in Appendix E).

The following is a brief description of the drop down areas: (Definitions are provided with each drop-down when using the data management system)
- Present at session: records who was at the home visitor (excluding the primary home visitor)
- Parent-Child Interaction Observation: describes what was seen by the home visitor. If the child was not present for some reason (including prenatal families) there would be no “observed” parent-child interaction.
Parent-Child Interaction Addressed: describes what was discussed with the parent regarding interactions observed.

Prenatal Supports: refers to various issues about the health of the mother and the unborn baby.

Nutrition/Feeding: includes items such as breastfeeding, nutrition of the infant/child as well as nutrition of the mother.

Child Growth and Development: includes a wide range of areas that pertain to the growth and development of the child.

Maternal/family health: family planning, mental health and substance use/abuse are among the categories of actions.

Home visiting curriculum: list of various curricula and other materials used in the particular visit.

E. Documentation of Supervisory Chart Reviews

Supervisors must review a minimum of 10% of all active client files (paper charts or electronically) every two weeks (files of high-risk families may need to be reviewed more often). It is expected that within one year, 100% of active client files have been reviewed.

File review includes:

- Review of services offered to the family
- Review of appropriateness and effectiveness of services provided
- Review of the intake, screening, progress notation and other pertinent information in file
- Review progress with regard to goals
- Reports of case staffing with supervisors and other involved professionals
- Developmental issues or concerns
- Developmental achievements that are age appropriate
- Parental/Caregiver concerns/developmental guidance given
- Review of referral documentation and follow-up (A referral would be documented when the resource addresses an item in the service plan or responds to a need identified in a home visit. If the family is already connected to other services, this information also needs to be documented in the database).

*Note: Written summary notations must include the date and signature of the supervisor and be placed in the client file (unless there is only an electronic file). The supervisor will log the chart review AND findings in the database within seven days of review. The CYFD case audit form will be used for this purpose when it becomes available to programs. When this occurs, the audit event will be reflected in the database.

F. Documentation of Service Completion or Discontinuation

It is important to document the reasons why families leave home visitation services. In addition, it is important for the home visitor to discuss with the family the process of transitioning from the program.

Documenting the transition plan: Families may choose to leave home visitation services for a variety of reasons. Optimally, many families will leave when they have completed the program. For those families the discussion might include:

1. A portfolio of where the child has been developmentally and prior to ending services. This could include the most recent ASQ or ASQSE results, verbal videos that capture special
moments with the family and/or celebrating the successes achieved by the family.

2. Discussion of where the family goes from here. This might consider the resources needed by the parents or the next services that will support the child. For children that may be enrolled in childcare or in an early learning environment, the discussion could include helping the family understand how to evaluate what a quality program is, how to handle adjustment issues with the child or other transition issues. A home visitor may choose to accompany a parent on a visit to another program to help support a smooth transition.

**Documenting the reason for ending services:**

Families may leave for reasons other than completing a program. It is important to document the reason, when known, so that a record is kept for the family. The home visitor should record the reason because it also allows the program to understand why families leave. This information might help the program develop strategies to support families in different ways if it would improve retention in the program.

**G. Documentation of staff qualifications/competencies**

Programs must maintain up-to-date records of staff education levels in the database. The workforce information maintained in the database allows contracting agencies and CYFD to plan for staff training opportunities, including in-service training, degree-bearing courses, financial aid approaches, and assistance for meeting endorsement/licensure milestones.

Training events must be documented in the database no later than seven days after the event or activity occurred.

Programs are also responsible for maintaining current information on staff competencies in the database.

Through reflective supervision and trainings focused on core competencies, CYFD supports and encourages home visitors becoming endorsed through the NMAIMH in order to create a standard for competence in the field.

**H. Documentation of Significant Events and Incident/Occurrence Reports.**

All Home Visiting agencies must have policies and procedures in place that address unusual occurrences and/or significant events that has threatened or could threaten the health, safety or welfare of the family or staff of the program.

All Home Visiting agencies must report these significant events to the CYFD Program Manager within 24 hrs. Documentation of any significant disciplinary action, health and safety issue, rules violation, or action involving liability may include but is not limited to:

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

**Suspected abuse or neglect must be reported to Protective Services Statewide Central Intake at 1-800-797-3260, and documented according to agency policy. It is recommended that programs contact local Protective Services to provide staff the necessary training/information about the reporting process. The report also requires documentation in the referral section of the database as a referral to Child Protective Services.**

**Appendix D**

The completion of the screening tools listed below is required as outlined in the periodicity grid on the following page. The required tools are:

1. Edinburgh Postnatal Depression Scale (EPDS)
2. Ages and Stages Questionnaire (ASQ3)
3. Ages and Stages Questionnaire: Social - Emotional (ASQ-SE)
4. Women Abuse Screening Tool (WAST)
5. Social Support Index (SSI)
6. Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)
7. Maternal Child Health Information
8. Peri-Natal Questionnaire
9. Social History
<table>
<thead>
<tr>
<th></th>
<th>Prenatal</th>
<th>Newborn</th>
<th>1 Week</th>
<th>6 Weeks</th>
<th>1 Month</th>
<th>2 Months</th>
<th>3 Months</th>
<th>4 Months</th>
<th>6 Months</th>
<th>8 Months</th>
<th>9 Months</th>
<th>10 Months</th>
<th>12 Months</th>
<th>14 Months</th>
<th>15 Months</th>
<th>16 Months</th>
<th>18 Months</th>
<th>20 Months</th>
<th>22 Months</th>
<th>24 Months</th>
<th>27 Months</th>
<th>30 Months</th>
<th>33 Months</th>
<th>36 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASQ3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Date &amp; initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ASQ-SE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Date &amp; initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EPDS</strong></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date &amp; initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date &amp; initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WAST</strong></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date &amp; initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MCH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date &amp; initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal Questionnaire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date &amp; initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Piccolo</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date &amp; initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ASQ3**
- Administer during 3rd trimester, and at 1 and 3 months postnatal. If enrolled after birth, score immediately. In the event a score is above cut-off, the EPDS will be administered monthly until score drops below cut-off

**EPDS**
- Prenatally, if possible. Otherwise, within 6 wks of enrollment and annually thereafter

**SSI**
- Within 6 wks of enrollment and annually thereafter

**WAST**
- To be completed within 2 months of baby’s birth

**MCH**
- Maternal & Child Health information is to be completed at intake and annually thereafter

**Perinatal Questionnaire**
- To be completed within 2 months of baby’s birth

**Piccolo**
- At entry and then every six months, along with the ASQ3. (Child must be at least 4 month old)
| Prenatal | Newborn | 1 Week | 6 Weeks | 1 Month | 2 Months | 3 Months | 4 Months | 6 Months | 8 Months | 9 Months | 10 Months | 12 Months | 14 Months | 15 Months | 16 Months | 18 Months | 20 Months | 22 Months | 24 Months | 27 Months | 30 Months | 33 Months | 36 Months |
|----------|---------|--------|---------|---------|---------|---------|---------|---------|---------|---------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Social History | Begins at intake – must be completed within 6 months | | | | | | | | | | | | | | | | | | | | | | |
| Date & initials | | | | | | | | | | | | | | | | | | | | | | | |
| Family Satisfaction Survey | Completed annually | | | | | | | | | | | | | | | | | | | | | | |
| Date & initials | | | | | | | | | | | | | | | | | | | | | | | |

- Screening tools may be used more frequently if and when the home visitor observations indicate the need for further information.

- ASQ - If an ASQ screening is missed, please complete as soon as possible rather than wait for the next scheduled date. In the case of a missed ASQ-3 or ASQ-SE, complete the questionnaire closest to the child’s current age; do not wait until the next scheduled date.

- EPDS - If an EPDS score is above cut-off (10), administer monthly until score is below is below cut-off.

- WAST – if there is a score that indicates concern for partner violence, continue with the 6 remaining questions and monitor monthly until concerns are mitigated.

- SSI – if there is a low score, monitor monthly until scores increase.

- The home visitor/supervisor discretion can be used to determine the appropriateness of using the ASQ3 for children referred to and enrolled in NM Family Infant Toddler Services (Part C).
Appendix E
Data – Assessment – Plan (DAP)
DAP Note: Examples

#1
**Data:** Mom and Dad both commented on 8 month-old baby’s difficulty with sleep both at night and naptime. Baby wakes at night every couple hours and will only go back to sleep when nursed. Mom rocks and holds baby to help him fall asleep during naptime during the day. Baby has not yet been able to fall asleep on his own. Parents report being exhausted. Dad states he is frustrated and wants to try letting baby cry before nursing immediately. Mom commented on how hard it is for her to hear baby cry, wanting to comfort him right away.

**Assessment:** Parents struggling to find common ground on supporting babies sleep routine. Both parents are able to express their feelings in relation to this issue. Baby appears healthy and there are no reports on any medical/physical reason that baby is waking so often.

**Plan:** Mom stated that she would start talking to other moms about their methods of helping their baby’s get to sleep other than rocking and nursing and discuss them with dad. At our next visit we will discuss her findings and assess where parents are in relation to approaching sleep differently.

- Since DAP notes are to capture parts of the home visit that pertain to the family goals or anything of concern, this note captured the conversation related to this family’s goal: Have Sam fall asleep on his own. Other aspects of the home visit are captured in drop downs.

#2
**Data:** After scoring 3 mo. ASQ & reviewing scores together with MOB, I told MOB that we will re-evaluate the gross motor part of evaluation in two weeks. MOB reports and I observed that when baby is on tummy she "sometimes" turns head side to side. When baby is on tummy, baby will not hold head up longer than 3 seconds. MOB also reported that when baby is on back, baby's head is straight & does not move from side to side. MOB also stated that while baby is on tummy her head still falls down instead of baby laying head down.

**Assessment:** MOB appears in tune with her child’s development and has observed motor concerns. She appears open to possible referrals and ongoing evaluations/assessments.

**Plan:** Re-evaluate gross motor section of ASQ3 in two weeks. Send scores to PCP &, if needed, will make a referral to local Early Intervention

- Since DAP notes are to capture parts of the home visit that pertain to the family goals or anything of concern, this note captured the conversation related to this family’s goal: During tummy time, Carly will look up at mom when she talks to her. Other aspects of the home visit are captured in drop downs.
#3

**Data:** During home visit, mom commented on how frustrated she is with potty training Juan. When I asked how she knew when he needs to go, she stated that she just makes him sit on the potty throughout the day when she remembers. While we were talking, Juan started wiggling and hid behind the sofa and so we began talking about the cues he gives that lets her know that he needs to go potty. We talked about other signs/cues he might give and how to help him read his own body.

**Assessment:** Mom wants Juan potty trained and is unclear about the cues he gives to let her know he needs to go. She appears open to learning more about Juan’s’ cues and responding to them.

**Plan:** Mom agreed to observe Juan more closely and start to see what cues he might give that lets her know to bring him to the potty. I will bring this conversation up again on our next visit on 3/2.

- Since DAP notes are to capture parts of the home visit that pertain to the family goals or anything of concern, this note captured the conversation related to this family’s goal: Potty train Juan. Other aspects of the home visit are captured in drop downs.

#4

**Data:** Mary mentioned concerns about her 5 month old baby’s feeding and weight gain. She’s been breast feeding comfortably yet baby is constantly eating at short spurts throughout the day and night. Mary states worry that she’s not producing enough milk for her baby and that she’s not gaining enough weight. During the visit, I witnessed baby nursing and falling asleep within 2 minutes of nursing, slept for 20 minutes then woke again and nursed for a few minutes.

Mary also mentioned that her husband lost his job and that he is around the house more these days. She said that she is worried he won’t get another job because he doesn’t seem to be looking for a new one.

**Assessment:** Baby appears to be feeding/nursing successfully (suck and swallow) yet feeds briefly and falls asleep constantly. Unsure if she is getting full before falling asleep. Baby appears healthy and petite. New stressors in the family with Mark losing his job.

**Plan:** Mary has a pediatrician appointment on Thursday and will talk to him about weight and growth. We will discuss other options of supplementing feedings and/or nursing and sleep routines. I will also follow up on how things are going with Mark’s job search.

- Since DAP notes are to capture parts of the home visit that pertain to the family goals or anything of concern, this note captured the conversation related to one this family’s goals which is “Kathy will nurse for longer periods of time before falling asleep” and the concern of father’s job loss. Other aspects of the home visit are captured in drop downs.
Appendix F

Special Conditions (See 6.12.3)

In situations where monitoring reveals multiple findings that do not conform to CYFD Home Visiting Program Standards with consideration given to both the number of non-complying items as well as the severity of one or more items as determined by CYFD, the Home Visiting Monitoring Team may determine that the program requires in-depth oversight. When this occurs, the program is placed under Special Conditions. This means that all programmatic, fiscal, and/or administrative decisions must be reviewed and approved by the Project Manager or designee prior to action.

Identification of Special Conditions and Process for Removal:
The Contractor will be notified in writing if special conditions are imposed by the CYFD Home Visiting Management Team. The notification will include the following items:

- Nature of the special conditions/restrictions
- Reasons for imposing them
- The corrective actions which must be implemented by the Contractors with regard to the special conditions before they will be removed
- Consequences for non-compliance with special conditions
- Time period for the correction of non-compliance
- Technical Assistance if applicable by the CYFD Home Visiting Management Team

Any or all of the following actions may be imposed in the event special conditions are attached to the contract:

- Requiring additional more detailed financial and/or program reports
- Performing additional project monitoring by the CYFD Home Visiting Management Team
- Requiring the Contractors to obtain technical or management assistance
- Establishing additional prior approvals
- Temporarily withholding cash payments pending correction of the non-compliance or deficiency
- Disallowing (that is, denying both use of funds and any applicable matching credit for) all or part of the cost of the activity or action not in compliance
- Suspending wholly or partly suspending or terminating the current contract
- Withholding further contracts for the project or program
- Taking any other remedies that may be legally available

Contractors placed under special conditions will be advised of the process for removal of the special conditions and timelines that must be met.

It is the commitment of the Home Visiting Management Team to work together with community programs, ensuring that every child has equitable access to quality services.