

# **ATTACHMENT I**

## **Healthy Start Program Model**

Healthy Start (HS) is a statewide, voluntary home visiting program that promotes family strengthening, child health and safety, and positive parent-child relationships. The program consists of two components, Early Identification (EID) and Home Visiting (HV).

The EID component of the program provides screenings and assessments to identify prenatal women and families “at risk” for child maltreatment, developmental delay and sub-optimal health.

The HV component provides culturally appropriate support services to the family to reduce the identified high-risk factors/stressors, which may lead to child abuse/maltreatment. The service is provided to the family in their natural environment and is voluntary until the child reaches three years of age.

HS utilizes a paraprofessional model. Home visitors are paraprofessionals who work with a team consisting of a supervisor, clinical specialist (CSp), and a child development specialist (CDS). HV services include screenings/assessments for possible delays and referrals for early intervention services. In addition, the program provides child development and parenting information, problem solving skills, and links families with appropriate community resources. The program also identifies families in need of services to address substance abuse, mental health issues and domestic violence.

The 2006 report to the Legislature for SCR 227 HS Advisory Task Force delineated the following goals for the program:

- Reduction in child abuse and neglect
- Increasing family self sufficiency
- Reduction of stressors and risk to children
- Improved child adjustment and achievement

### **Early Identification Services**

EID Services are initiated at various points of entry for the mother, i.e. hospitals with maternity facilities, prenatal facilities (OB/GYN offices), Women, Infant, and Children Clinic (WIC) clinics, community health centers, Public Health Nursing services and Department of Education Grads Programs.

The EID screens and assessments are completed with the families within 24 to 48 hours following the birth of their infants. Eligibility for home visiting services is determined by: 1) The Kempe Family Stress Checklist (see attachment A) with a score of 30 or higher, or 2) In some cases the EID supervisor may consider other factors related to the health and safety of the infants not addressed or identified by the Kempe Family Stress Checklist and may recommend home visiting services for the families. The EID providers complete written reports which include information related to the families’ risk factors. These reports are forwarded to the agency, which will provide the Home Visiting Services. This timeframe provides the family with appropriate and timely services upon the mother/infant’s discharge from the hospital. The families of infants hospitalized in

the Neonatal Intensive Care Unit shall be screened and assessed once the infants are transitioned to the Intermediate Care Unit.

The referral to HV services includes appropriate data entry into the MCHB data base system – Child Health Early Intervention Record System. (CHEIRS).

### **Home Visiting Services**

HV services are provided by a team minimally consisting of a Family Support Worker (FSW), CSp, CDS, and a Supervisor. The focus of the home visiting services is to reduce the families' risk factors and increase the families' self sufficiency.

Direct Services will include:

1. Accept and process referrals from Healthy Start EID providers or other community referral sources. Staff shall identify and assess risk factors based on 1) EID screens and assessments (e.g. Kempe Family Stress Checklist) and/or 2) assessments of the families completed by a professional staff. Based on the EID and/or families' assessments the families are assigned appropriate team members to provide services. The team members shall include, but is not limited to, the CSp, CDS, Supervisor, and FSW.
2. Provide intake services. Staff member shall contact the families within 48 hours of referrals to arrange face-to-face meetings with families in their natural environment. Meeting with families and appropriate staff member(s) shall include, but are not limited to, a discussion regarding HS services via a team approach, family's rights, and completion of forms and consents. Staff member(s) shall assess current and relevant risk factors with the families, in a sensitive manner using EID assessments as a reference to assist families to identify their strengths, concerns/priorities, and aspirations. The intake process shall include building trust, rapport, and engagement with family members.
3. Deliver home visitation services. Home visits are conducted in the families' natural environment by the HS team member(s), in accordance with the IFSP, in a seamless, cohesive manner where all disciplines involved communicate with one another regarding their relationship to the family.
  - Promote:
    - early and on-going prenatal care;
    - positive parent-child relationship and parenting;
    - family strengthening by addressing family violence, substance abuse and mental health issues;
    - father involvement;
    - positive child health development by encouraging oral health, utilizing the medical home, promoting a safe home environment, and encouraging well child care and immunization;
    - positive child social emotional and physical development;
    - problem-solving skills and communication skills;
    - development of a support system for the families;

- positive-decision making and develop/enhance coping skills, and self-sufficiency; and
- family planning
- Conduct:
  - ASQ and ASQ-SE on all children;
  - NCAST Teach scale
  - HOME scale
- Identify, assess, and monitor children with developmental concerns and provide interventions, referrals and care coordination as appropriate, (i.e., children receiving services from other Part C providers) by the CDS.
- Identify, assess, and monitor the health care needs that affect the child and/or family by the HS team and provide consultation and interventions to families.
- Provide:
  - child development, parent training, and family planning information and materials.
  - crisis prevention information and/or counseling to families and interventions to families dealing with ongoing crisis.
  - families with referral to community resources.
  - services to engage families who are not actively participating with HS services. Efforts to engage families who are not participating with HS services shall not exceed three months.
  - families information on age appropriate, non-violent discipline strategies.

4. Participate in the Comprehensive Development Evaluation (CDE) process. Children who have developmental concerns (i.e. two standard deviation on the ASQ, parent, staff, or doctor concerns, and/or exposure to substance abuse in utero) shall within 45 days of parental consent:

- receive a timely CDE to determine eligibility for additional early intervention services; and
- complete an IFSP meeting to include additional early intervention services as needed.

IDEA, Part C requires that the CDE be conducted by a multidisciplinary team consisting of two or more professionals from two or more disciplines. CDE must be conducted by qualified staff, who are trained on appropriate methods and procedures utilizing a state-approved diagnostic tool (e.g. Hawaii Early Learning Profile (HELP), Batelle, and/or the Early Intervention Learning Profile). Staff shall participate in conducting a CDE, writing CDE report, and on-going monitoring of the child's developmental status. The care coordinator shall participate in the CDE process, including and not limited to the Comprehensive Developmental Assessment (CDA).

5. Develop an Individual Family Support Plan (IFSP). The IFSPs shall be developed jointly in accordance to IDEA, Part C with the family and appropriate qualified personnel involved in the provision of services to the family. Appropriate personnel

may include, but are not limited to the FSW, CSp, CDS, Supervisor, and other community agencies.

The IFSP shall address and document the families' risk factors/stressors. In some cases families may decline to have their risk factors/stressors documented on the IFSP. However documentation of services to address these risk factors/stressors shall be included in the families' case notes.

The initial IFSP shall be completed within 45 calendar days of referral to Healthy Start home visiting program. The IFSP shall be reviewed every 6 months, or earlier, and within 12 months of the initial IFSP.

6. Ensure care coordination services are provided to families. The care coordinator is responsible to ensure that services delivered by appropriate staff and agencies are coordinated and delivered in a timely manner. Services shall include but are not limited to: assist families in identifying strengths and resources they have within the family; assist the family to identify concerns/needs they have about their child and themselves; facilitate and participate in the development, review, and evaluation of the IFSP; support the family in being active participants through the IFSP process; coordinate and monitor service delivery; when appropriate, assist and coordinate the CDE and transition process consultation.
7. Assess and monitor families identified with issues of family violence, substance abuse and mental health. Clinical specialists shall be responsible to provide "treatment readiness" counseling services and referrals to families until existing community resources can accommodate the families.
8. Support FSWs with professional services within the program in assessing, planning, providing resource information and delivering interventions to families. FSW shall receive weekly reflective supervision to enhance their knowledge and skills, address FSW's attitudes that are essential for effective job performance, monitor boundaries, and address safety issues.
9. Interventions and Approaches to Address Risk Factors and Child Development: The team is to utilize an MCHB approved tool to guide and support them in providing culturally and age appropriate services to the families.
10. Transdisciplinary services: Team is to provide services utilizing the transdisciplinary model when appropriate. The model is a method of service delivery in which all team members shall assess and plan for services. Team members shall allocate responsibilities of services to families based on their needs rather than discipline specific roles and duties.
11. Provide group activities to support child's and families' outcomes on the IFSP. Team to develop and implement group activities based on the families' needs.
12. Family Progress Worksheet. Team to complete a Family Progress Worksheet (FPW)

which monitors the families' progress related to the risk factors documented on the IFSP or identified by the family. *(This tool requires editing to correlate to the AAPI – Inappropriate expectations, Low level of empathy, Strong belief in value of corporal punishment, Reverses family roles, Restricts power-independence.)*

13. Complete a Pre and Post Test for every family engaged in HS services. All families who are receiving HS services shall complete the Adult-Adolescent Parenting Inventory (AAPI) upon entry into the program, and prior to exiting the program. *(This tool still in piloting stage.)*

### **Hawaii Healthy Start Training**

Healthy Start home visiting staff shall attend MCHB required trainings. Trainings include but are not limited to:

Intensive Role Specific Training for:

Family Assessment Workers

Family Support Workers

Clinical Supervisors

Clinical Specialists

Child Development Specialists

Ongoing Trainings providing current information related to working with at risk families.

Early Intervention Services Orientation

## **MCHB SUPERVISOR MODEL**

The role of the supervisor is to be responsible for the overall functioning and productivity of the team. The Healthy Start team may consist of a Clinical Specialist, a Child Development Specialist, and Family Support Workers. The supervisor's duties may include but are not limited to: assess the families' risk factors, assign cases to Healthy Start teams, conduct quality assurance duties (including fiscal management), and completing MCHB required reports (Quarterly, OSEP, Felix, Variance), ensure timely provision of services, e.g. screens, assessments, and IFSPs.

### **Supervisor Responsibilities:**

1. Review all EID screens and referrals.
2. Assign families to the Healthy Start team based on the team's caseload and intensity of families' needs.
3. Ensure the team's billable units are accurately documented and entered into CHEIRS.
4. Ensure the team members have completed required trainings
5. Provide guidance and support to the HS team members
6. Complete MCHB required reports, e.g. Quarterly Reports, OSEP reports, and Felix Reports, Variance.
7. Attend MCHB quarterly meetings.

## **MCHB CHILD DEVELOPMENT SPECIALIST MODEL**

The role of the Child Development Specialist (CDS), as part of the Healthy Start team, is to identify, assess, and monitor children with developmental concerns and provide interventions, referrals, and care coordination as appropriate. The CDS will support families of children with developmental concerns by coordinating the CDE, attending the IFSP and DOE meetings.

### **Child Development Specialist Responsibilities:**

1. Review EID referrals to screen for children who may be at risk for developmental delays, such as prenatal substance exposure, mental health issues, and bonding/attachment concerns.
2. Identify and assess children who are at risk for developmental delay(s).
3. CDS services may include but are not limited to:
  - a. attend the initial home visit with the FSW to assess children and families' needs and concerns.
  - b. be the care coordinator for the families whose children have a developmental delay, which includes developing an IFSP with families and/or participating and facilitating the IFSP meeting.
  - c. assess FSW's abilities to address the children's developmental concerns and the families' ability to support their children's development.
  - d. support FSW and families in implementing strategies through mentorship (e.g., role playing, training and guidance).
  - e. consult with team members regarding the families progress on the IFSP.
  - f. provide individualized counseling specific to the needs to the families and FSW.
  - g. refer families to appropriate community agencies
  - h. participate in the comprehensive developmental evaluations process.
  - i. conduct or participate in ongoing monitoring of the children's developmental status.
  - j. provide services to the children who are receiving early intervention therapeutic services as a transdisciplinary member of the IFSP team
4. CDS services will be provided in a seamless, cohesive manner with other team members.
  - a. CDS services will be included in the initial consent for HS services.
  - b. CDS documentation will be a part of the families' case files.
  - c. CDS will collaborate with team members to develop and participate in group activities for families.
  - d. CDS will provide trainings for staff.
5. Attend quarterly MCHB meetings.

## **MCHB CLINICAL SPECIALIST MODEL**

The role of the Clinical Specialist (CSp), as part of the Healthy Start team, is to identify, assess, and provide services to families who are at risk for child maltreatment due to domestic violence, mental health issues, and substance abuse. The purpose of the CSp services is to enhance the families' functioning which will support the optimal growth and development of their children. CSp responsibilities include, but are not limited to, care coordination, home visits, referrals to community agencies, consultations with team members and families, training to families and staff, and treatment readiness. Treatment readiness services may be short term interventions to prepare family members for further and more intensive treatment services.

### **Clinical Specialist Responsibilities:**

1. Review all EID referrals assigned to the team.
2. Assess families' risk factors and determine families who are in need of CSp services.
3. The CSp services may include but are not limited to:
  - a. attend the initial home visit with the FSW to assess families' needs and concerns.
  - b. be the care coordinator for families who are assessed as requiring CSp assistance, which includes developing an IFSP with the families and/or participating and facilitating the IFSP meeting.
  - c. assess FSW's abilities to address the families' risk factors and implement the strategies.
  - d. support FSWs in implementing strategies through mentorship (e.g., role playing, training and guidance).
  - e. consult with team members regarding the family's progress on the IFSP.
  - f. monitor families' progress by visiting families in their natural environment.
  - g. provide individualized counseling specific to the needs to the families in their natural environment.
  - h. refer families to appropriate community agencies to successfully complete therapeutic services.
4. CSp services will be provided in a seamless, cohesive manner with other team members.
  - a. CSp services will be included in the initial consent for HS services.
  - b. CSp documentation will be a part of the families' case files.
  - c. CSp will participate in the reflective supervision of the FSW on the identified CSp cases.
  - d. CSp will collaborate with team members to develop and participate in group activities for families.
  - e. CSp will provide trainings for staff.
5. Attend quarterly MCHB meetings.

## **MCHB FAMILY SUPPORT WORKER MODEL**

The role of the Family Support Worker (FSW), as part of the Healthy Start team, is to (1) provide education to strengthen parent skills and parent-child relationships and (2) support families through home visits, engaging families at risk for child maltreatment, and development of relationships based on a strengths-based model. FSW will receive support and guidance through the Healthy Start professional team members.

### **Family Support Worker Responsibilities:**

1. Contact families to schedule a visit with the family.
2. Consult with the professional members of the team to develop approaches to address the family's risk factors.
3. Foster a supportive relationship with the family.
4. Provide services to meet the needs of culturally diverse families.
5. Participate in staff meetings and child team meetings to provide current information on the family's status to decrease their risk factors
6. Document home visits
7. Communicate on a regular basis with the professional team members of family's needs/concerns.
8. Communicate with the professional team members regarding significant family observations, e.g. safety issues regarding the child, mental health and/domestic violence issues, or substance abuse issues.
9. Participate and support families in the CDE process with guidance from the CDS.
10. Support families transitioning to other programs.
11. Update the IFSP Review for children not receiving early intervention therapeutic services
12. Attend and participate in all IFSP meetings.
13. Implement MCHB approved curriculum.
14. Refer families to community agencies, such as DHS or Community Clearinghouse.
15. Implement strategies on the IFSP with guidance from the professional members on the team.
16. Conduct MCHB approved developmental screens and NCAST scales.
17. Encourage families who are not actively participating with HS services for three months before exiting the program.

## **Rating Scale for Family Stress Checklist**

The purpose of the rating scale is to assist FAWs in objectively completing the Family Stress Checklist. The Family Stress Checklist questions should be scored as follows: 0 = Normal, 5 = Mild, and 10 = Severe. The Rating Scale is copyrighted by the Hawaii Family Support Center (formerly the Hawaii Family Stress Center).

### **#1: Parent Beaten or Deprived as Child**

#### **(0) – Normal**

- a) No corporal punishment.
- b) Spankings (less than six times ever with hand, belt, stick, etc., which left no bruises).
- c) Received consistent nurturing.

#### **(5) – Mild (rate as 5 if one or more applies)**

- a) Spankings, more than six times, no bruises.
- b) Received intermittent nurturing.
- c) Witnessed physical abuse of sibling.
- d) Witnessed spousal abuse of parents.

#### **(10) – Severe (rate as 10 if one or more applies)**

- a) Severe beatings, including bruising.
- b) Raised by more than two families.
- c) Raised by one or more families, but with no nurturing parent model.
- d) Bizarre psychological abuse (i.e., made to eat in garage or doghouse).
- e) History of running away from home.
- f) Constantly scapegoated as "black sheep" of family.
- g) History of sexual abuse.
- h) Removed from home or abandoned.
- i) Raised in family where one or both parents are alcoholics or drug addicted.
- j) "Don't remember" their childhood.

### **#2: Parent with Criminal/Mental Illness/Substance Abuse**

#### **(0) – Normal**

- a) No arrests or one time mild offense (i.e., teenage shoplifting or stealing a car). Do not include any crime against a person.
- b) No drug use.
- c) One time experimental use of any drug.
- d) No alcohol use or occasional use up to one drink per day if this is not seen as problem by family (if seen as a problem rate as Mild).
- e) Occasional drunkenness up to once per month if not seen as a problem by family (if seen as a problem, rate as Mild).
- f) Never required psychiatric care.

**(5) – Mild (rate as 5 if one or more applies)**

- a) More than one minor traffic violation or record of one minor juvenile or adult crime (speeding, minor theft).
- b) Any drug use more than once (rate as Severe any drug use during pregnancy).
- c) Drinking regularly with more than one drink per day or drunkenness more than once a month (if seen as a problem, rate as Severe).
- d) History of or currently seeing psychiatrist/psychologist for minor life crisis (i.e., counseling to improve life, rather than therapy for psychiatric problem).
- e) Parent demonstrates ongoing rehabilitation (for more than two years) but with history of:
  - 1. Multiple mild offenses/arrest;
  - 2. Crime against a person (i.e., assault and battery, armed robbery);
  - 3. Prison term;
  - 4. Heavy drug use;
  - 5. Alcoholism or heavy drinking; or
  - 6. Mental hospitalization or long-term psychiatric care.

**(10) – Severe (rate as 10 if one or more applies)**

- a) Chronic pattern of criminal activity.
- b) Current or recent prison term (within last two years), driving under influence of alcohol or history of theft, burglary, felonies, prostitution.
- c) Chronic heavy use of any drug, including marijuana.
- d) History of recurrent episodes of heavy drug use, even if not currently using (i.e., heroin addict, now reformed, but who has repeatedly reformed and returned to heroin in the past).
- e) Any drug use at any time during pregnancy whether pregnancy known or not.
- f) Current chronic heavy drinking/alcoholism.
- g) History of recurrent episodes of alcoholism, even if presently "dry."
- h) Any drinking/drug use, regular or occasional, which results in violent episodes.
- i) Current indications and/or diagnosis of psychosis (i.e., medication prescribed by psychiatrist or history of hospitalization).
- j) Chronic pattern of psychiatric problems.
- k) History of diagnosed schizophrenia or sociopathic behavior.

**#3: Parent Suspected of Abuse in the Past**

**(0) – Normal**

**(5) – Mild (rate as 5 if one or more applies)**

- a) Official report of mild abuse; children not placed in foster care or removed from home.
- b) Chronic use of illicit drugs with children present but not where parents are "out of it."
- c) Abuse suspected, but not confirmed.

**(10) – Severe (rate as 10 if one or more applies)**

- a) Official report of serious abuse/death.
- b) Mysterious death of sibling.
- c) Children placed in foster care/removed from home.
- d) Child allowed to use any illicit drug (ever).
- e) Child present with adult using any substance where parent is unable to care for child due to intoxication.
- f) Child abuse suspected in previous marriage for either parent.

**#4: Low Self-Esteem, Social Isolation, Depression, No Lifelines**

**(0) – Normal**

- a) Close to at least one family member (i.e., sees regularly and/or can and does call on them for serious problems).
- b) Happy and content with life at present.
- c) Sees and enjoys other people regularly.
- d) Parent can name more than one lifeline and will actually use them.
- e) Parent has phone and transportation.

**(5) – Mild (rate as 5 if two or more apply)**

- a) Not close to family, with no hostility.
- b) Discontent with life, but sees this as temporary.
- c) Sees and enjoys other people at least once a week.
- d) Parent can name one lifeline only and will actually use it.
- e) Parent has no phone with none available and/or no transportation.
- f) Not high school graduate.
- g) Parent demonstrates difficulty in coping with life stresses.
- h) Late prenatal care (automatic 5).
- i) Unemployed, not seeking work.

**(10) – Severe (rate as 10 if one or more applies)**

- a) Not close to family, with hostility.
- b) Very unhappy or depressed with life and sees this as permanent, or does not see immediate end to situation.
- c) Rarely sees other people with little or no enjoyment.
- d) Parent can name no lifeline.
- e) Parent can name a lifeline, but will not actually use it.
- f) Parent will not "burden" anyone with problems; feels has to handle by self.
- g) Parent unable to cope with life stresses (i.e., current drug, alcohol, or criminal activity).
- h) History of childhood abuse and/or neglect without resolution.
- i) History of lifestyle (i.e., prostitution) or expressions of low self-esteem.
- j) No prenatal care.
- k) Chronically unemployed. Unable to keep job.

## **#5: Multiple Crises or Stresses**

### **(0) – Normal**

- a) Parent can name nothing that is stressful.
- b) Parents argue occasionally, but soon resolve without violence and do not see this as problem (if seen as problem, rate as Mild).
- c) Finances are not a big problem for family although they may not have "enough" money.

### **(5) – Mild (rate as 5 if two or more apply or if one listed under Severe applies)**

- a) Parents argue frequently without violence, and do not see this as problem (if seen as problem, rate as Severe).
- b) Parents argue occasionally without violence but see this as stressful.
- c) Finances are "tight" but parent feels he/she can "manage."
- d) Recent loss of loved one who did not serve as lifeline.
- e) Recent change of job, with history of good work stability.
- f) Recent move, but previously in one place more than one year.
- g) Living situation seen as inadequate, but not stressful by family.
- h) One separation with no current threat of divorce.
- i) Multiple crises with which parent demonstrates good coping and does not feel overwhelmed.

### **(10) – Severe (rate as 10 if two or more apply)**

- a) Parents constantly in conflict with or without violence.
- b) One parent very afraid of other parent.
- c) Finances cause much stress to parent.
- d) Chaotic lifestyles with continual crises which parent feels unable to handle.
- e) Multiple separations and/or threat of divorce (end of relationship).
- f) Recent loss of loved one who served as lifeline.
- g) Frequent job changes.
- h) Frequent moves.
- i) Living situation seen as stressful by parents (i.e., temporary, overcrowded, conflicts).
- j) Any other stress parent mentions which is constantly present in his/her life and with which he/she is unable to cope or does not see hope of escape.

## **#6: Violent Temper Outburst**

### **(0) – Normal**

- a) No violence.
- b) Yelling, screaming, leaving when angry.

**(5) – Mild (rate as 5 if one or more applies)**

- a) Parent throws things when angry, but not at people.
- b) Parent pushes or gives slaps when angry (not more than once in past two years).

**(10) – Severe (rate as 10 if one or more applies)**

- a) Parent hits or kicks when angry to leave lasting marks (i.e., bruises, black eye).
- b) Parent has history of violent behavior to others (i.e., assault, murder).
- c) Parent throws things at people.
- d) Parent breaks up house in uncontrollable rage.
- e) One parent is afraid of violence in spouse, though no history of violence.
- f) Parent afraid he/she may lose control.

**#7: Rigid and Unrealistic Expectations of Child**

**(0) – Normal**

- a) No information, but shows concern (i.e., has books, plans to ask doctor).
- b) Expects walking between 9 to 15 months, but will not worry until 15 months.
- c) Expects toilet training to begin at 1½ to 2 years.
- d) Will pick up crying baby or expresses concern regarding possible illness.
- e) Shows concern for physical and emotional need of baby.

**(5) – Mild (rate as 5 if one or more applies)**

- a) Any expectations of walking earlier than above, but without rigidity (i.e., this is not essential to parent).
- b) Any expectations of toilet training earlier than above, but without rigidity, as in "a".
- c) Any expectations of walking/toilet training unreasonably beyond normal (i.e., walking at four years) may be indications of parent unwilling to or unable to detect serious development lags.
- d) Worries about spoiling the baby, but tolerant of normal annoying behavior.
- e) Will let baby cry for up to ½ hour, but expresses concern for needs of baby.
- f) Fear of being unsuccessful parent.

**(10) – Severe (rate as 10 if one or more applies)**

- a) Any rigid expectation of walking or toilet training earlier than above (i.e., this is very important to parent).
- b) Intolerance of normal annoying behavior or excessively concerned about spoiling.
- c) Parent says he/she or spouse cannot stand crying baby and will become angry with same.
- d) Parent expresses no concern for needs of baby.
- e) Parent will not check on or be concerned regarding baby crying longer than ½ hour.
- f) Parent feels that infants and children intentionally misbehave out of malice and must be dominated to ensure "respect."
- g) Parent has no information, and has no plans to acquire information.

## **#8: Harsh Punishment of Child**

### **(0) – Normal**

- a) None for infant.
- b) Physical punishment not used or used as secondary strategy to withdrawal of privileges and "time out." When the child is punished physically no implements (spoon, paddle or stick) are used.

### **(5) – Mild (rate as 5 if one or more applies)**

- a) Yelling at infant.
- b) For older children, use of physical punishment, no implements used or bruises.

### **(10) – Severe (rate as 10 if one or more applies)**

- a) Physical punishment used for infant.
- b) Shaking of baby.
- c) Implements used on older children. Physical punishment leaves bruises.
- d) Parent was abused as child and sees this as justified or as the right way to discipline.

## **#9: Child Difficult and/or Provocative as Perceived by Parents**

### **(0) – Normal**

- a) Not present.
- b) Child's behavior viewed as normal part of growth process.

### **(5) – Mild (rate as 5 if one or more applies)**

- a) Baby is wakeful, colicky, irritable, or so perceived by parents.
- b) Baby seen as sometimes difficult, but positives also mentioned.

### **(10) – Severe (rate as 10 if one or more applies)**

- a) Baby's behavior seen by parents as provocative (i.e., "He wants to make me angry so he cries").
- b) Baby seen as having no good points.
- c) Baby is constantly difficult, or so perceived by parents.
- d) Baby seen as deserving of physical punishment.

## **#10: Child Unwanted or At Risk for Poor Bonding**

### **(0) – Normal**

- a) Baby is very much wanted, whether planned or unplanned.
- b) Parent displays warmth when talking about baby.
- c) Child rearing looked upon as positive life change.

**(5) – Mild (rate as 5 if one or more applies)**

Baby is wanted but is premature.

Parent initially wanted abortion or adoption, but now feels positive with changes being made in lifestyles to accommodate new addition to family.

Unmarried parents.

Prolonged separation from parents (i.e., longer than one week).

**(10) – Severe (rate as 10 if one or more applies)**

- a) Baby is unwanted (i.e., not coming at good time in parent's life and parent unsure if able to handle situation).
- b) Baby must have certain characteristics if parent is going to love it (i.e., certain sex, looks, personality, etc.).
- c) Parent is not the natural father of baby, whether or not he states that wants baby.
- d) Baby seen as burden on lifestyles.
- e) No positive statements made about pregnancy or child rearing.
- f) Baby with many medical problems and/or physical deformities.
- g) Expects baby to patch up relationship; makes FOB responsible; baby has to love parents.

# **ATTACHMENT J**

## Healthy Start Training Catalog

CODE	Title of Training	Major Learning Area	Length	Cost	Frequency	Priority	
HS100	Foundation Training: 2 Days	<ul style="list-style-type: none"> <li>- Dynamics Child Abuse &amp; Neglect</li> <li>- Nurturing Principles and Practices</li> <li>- Fathers Services</li> </ul>	12 hrs	1	1	1	2 x a year
HS101	Families in Progress: Part 1	<ul style="list-style-type: none"> <li>- Addressing Difficult Issues</li> <li>- Linking EID Assessments to the Home Visit</li> </ul>	6 hrs	1	3	1	Quarterly
HS102	Families in Progress: Part 2	<ul style="list-style-type: none"> <li>- IFSP Creating a Vision</li> <li>- Relationships in Development</li> <li>- Change Agent</li> </ul>	6 hrs	1	3	1	Quarterly
HS 105	FSW Core Training: 4 days : FSW 5 days: Supervisor	<ul style="list-style-type: none"> <li>- Program Overview and Rationale</li> <li>- Enhancing Family Functioning</li> <li>- Promoting Positive Parent Child Relationship</li> </ul>	32 hrs- FSW	1	3	3	Quarterly
			38 hrs-Sup	3	1	3	2 x a year
HS 106	EID Core Training 4 days: EID Worker 5 days: Supervisor	<ul style="list-style-type: none"> <li>- Program Overview</li> <li>- Role Specific Training for the FAW and FAW Supervisor</li> </ul>	32 hrs- FSW	3	1	3	2 x a year
			38 hrs-Sup	3	1	3	2 x a year
HS 107	CORE Training Clinical Supervision	<ul style="list-style-type: none"> <li>- Employee Selection</li> <li>- Supervising the 'Home Visitor Model'</li> </ul>	6 hrs			1	2 x a year
HS 108	CORE Training: 2 days Clinical Specialist	<ul style="list-style-type: none"> <li>- Role Clarification</li> <li>- Developmental Framework for assessment &amp; intervention</li> <li>- Case review and consultation</li> </ul>	12 hrs			1	2 x a year
HS 109	Supervising HV/FSW in Family Dynamics	<ul style="list-style-type: none"> <li>- Developmental model for Parent Child Interaction</li> <li>- Supervising framework regarding Family Dynamics and Change</li> </ul>	6 hrs			1	2 x a year

1 - MANDATORY TRAINING REQUIRED WITHIN FIRST 6 MONTHS    2-MANDATORY TRAINING REQUIRED WITHIN FIRST 12 MONTHS    3- RECOMMENDED ONGOING/ADDITION TRAINING

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10/06; 02/07

### Healthy Start Training Catalog

CODE	Title of Training	Major Learning Area	Length of Training	Instructor	FSW hrs	ED	OS	OS	OS	OS	OS	OS
HS 110	Baby Care Basics	- Baby Care & Health & Safety	6 hrs	Cristina Nealon	1	3	1				1	2 x a year
HS 111	Early Childhood Development: Part 1	- Overview of Development	6 hrs	Cristina Nealon	1	3	1				1	2 x a year
HS 112	Early Childhood Development: Part 2	- Development ( 0-12 months)	12 hrs	Cristina Nealon	2	2					2	2 x a year
HS 113	Early Childhood Development: Part 3	- Development (12-36 months)	12 hrs	Cristina Nealon	2	2					2	2 x a year
HS 114	Substance Abuse: Part 1	- Overview of Substance Abuse Dynamics	6 hrs	Cristina Nealon	1	2	1	1			1	2 x a year
HS 115	Substance Abuse: Part 2	- Family System - Denial - 6 stages of change	6 hrs	Cristina Nealon	2	3	2	2			2	2 x a year
HS 116	EIS Refresher	- IN DEVELOPMENT	4 hrs	TBD	3	3	3	3			3	TBD
HS 117	FSW CORE Training Part 2	- Follow up to CORE FSW	6 hrs	Cristina Nealon	2		3	3			3	2 x a year
HS 118	Family Violence: Part 1	-Domestic Violence/Relationships - DV and Trauma - Overview of Crisis Intervention	6 hrs	Barbara Naki	1	1	1				1	2 x a year
HS 119	Family Violence: Part 2	- Role of the Home Visitor - Application/Intervention	3 hrs	Barbara Naki	2	3	2	2			2	2 x a year
HS 120	Leadership Development for Sr. HV's/FSW's	- Role Clarification - Leadership - Attitudes/Skills/Knowledge	6 hrs	TBD	3	3						TBD
HS121	Supervisor Training: Part 2	- IN DEVELOPMENT	6 hrs								2	TBD
HS 122	Administering the ASQ	- Overview of ASQ & calculations - Score and overall section - ASQ-SE	6 hrs	Cristina Nealon	1		1				1	2 x a year

1 - MANDATORY TRAINING REQUIRED WITHIN FIRST 6 MONTHS    2-MANDATORY TRAINING REQUIRED WITHIN FIRST 12 MONTHS    3- RECOMMENDED ONGOING/ADDITION TRAINING

### Healthy Start Training Catalog

CODE	Title of Training	Major Learning Areas	Length of Training	Instructor Name	SW ID#	CDL ID#	Class Size	Class Start	Class End	Director Name	Frequency
HS 124	Mental Health: Part 1	- Paradigms of MH & Psychopathology - Social-Emotional Development	6 hrs	Linda Fox Barbara Naki	1	1	1	1	1		TBD
HS 125	Mental Health: Part 2	- In Development	6 hrs	Linda Fox Barbara Naki	2	2	2	2	2		TBD
HS 126	Maternal & Family Health	- Family Planning/Nutrition - Post Partum Depression	3 hrs	Cristina Nealon	1	1	1	1	1		2 x a year
HS 127	Culturally Relevant Programs for Families	- Creating Culturally Relevant Services.	3 hrs	Barbara Naki	1	1	1	1	1		2 x a year
HS 128	Nurturing Principles & Practices	- Disciplined /Behavior - Consequences/Choices/Attitudes/Skill & Knowledge	3 hrs	Barbara Naki	1	1	3	3	1		2 x a year
HS 129	Working with Teens	- Brain Development - Understanding Adolescents - Case Study &Resources	6 hrs	Cristina Nealon	2	2	3	3	2		Quarterly
HS 130	Boundaries & Ethics Part 1	- Personal Safety - Defining Ethics - Setting Boundaries	3 hrs	Barbara Naki	1	1	1	1	1		2 x a year
HS 131	Boundaries and Ethics Part 2	- Practical Application in the field	6 hrs	Cristina Nealon	2	2	2	2	2		Quarterly
HS 132	Documentation: Part 1	- Principles and Practices	3 hrs	TBD	1	1	1	1	1		TBD
HS 133	Documentation: Part 2	- Application By Discipline - Team Documentation	6 hrs	TBD	2	2	2	2	2		TBD
HS 134	Documentation: Part 3	- Review and Practice	3 hrs	TBD	3	3	3	3	3		TBD

1 - MANDATORY TRAINING REQUIRED WITHIN FIRST 6 MONTHS    2-MANDATORY TRAINING REQUIRED WITHIN FIRST 12 MONTHS    3- RECOMMENDED ONGOING/ADDITION TRAINING

## Healthy Start Training Catalog

CODE	Title of Training	Major Learning Areas	Length of Training	Instructor	FSW/HWT	ED	GDs	Clinical Specialist	Supervisor/Managers	Administrative Support	Availability/Feeling
HS 135	Perinatal Loss	- In Development	4 hrs	Linda Fox	3	3	3	3	3		TBD
HS 136	Crisis Intervention	- Theories and Practice	6 hrs	TBD	3	3	3	3	3		TBD
HS 137	Stress Management/ Burnout Prevention	- Techniques for self and group care - Burnout prevention	6 hrs	TBD	3	3	3	3	3		TBD
HS 138	Addressing Difficult Issues: Part 2	- In Development	3 hrs	TBD	2		2	2	2		
HS139	Understanding the Effects of Childhood Trauma	- Helping the FSW/HW understand the role of the Clinical Specialist	3 hrs	Barbara Naki							
HS140	Living in the World of Abuse and Neglect	- Enhanced healthy start and the role of the Clinical Specialist	3 hrs	Barbara Naki							

1 - MANDATORY TRAINING REQUIRED WITHIN FIRST 6 MONTHS    2-MANDATORY TRAINING REQUIRED WITHIN FIRST 12 MONTHS    3- RECOMMENDED ONGOING/ADDITION TRAINING

# **ATTACHMENT K**

# FORM A - PEOPLE TO BE SERVED

ORGANIZATION: \_\_\_\_\_  
 PROGRAM/SERVICE: Enhanced Healthy Start Services  
 SITE(S): \_\_\_\_\_

<b>PEOPLE TO BE SERVED</b>	<b>Annually</b>
1. # of families receiving CWS with a child referred at 0-90 days of age	
2. # of families receiving CWS with a child referred at 91 days to one year of age	
3. # of families receiving CWS with a child referred at one year of age to three years of age	
4. # of families receiving FSS with a child referred 0-90 days of age	
5. # of families receiving FSS with a child referred at 91 days to one year of age	
6. # of families receiving FSS with a child referred at one year of age to three years of age	
7. # of families receiving VCM with a child referred at 0-90 days of age	
8. # of families receiving VCM with a child referred at 91 days to one year of age	
9. # of families receiving VCM with a child referred over one year of age	
10. # of families from basic Healthy Start services with a child referred at 0-90 days of age	
11. # of families from basic Healthy Start services with a child referred at 91 days to one year of age	
12. # of children (in families) served	

# FORM B – SERVICE ACTIVITIES

ORGANIZATION: \_\_\_\_\_

PROGRAM/SERVICE: Enhanced Healthy Start Services

SITE(S): \_\_\_\_\_

<b>SERVICE ACTIVITIES</b>	<b>Annually</b>
1. # of family assessments completed within seven days of referral.	8
2. # of individualized service plans developed with and agreed to by families within 45 days of referral for home visiting.	8
3. # of referrals to community resources for: a. substance abuse b. domestic violence/intimate partner abuse c. mental health/maternal depression d. health problems e. early intervention services f. family planning g. other (please list)	8

# FORM C - OUTCOMES

ORGANIZATION: \_\_\_\_\_  
PROGRAM/SERVICE: Enhanced Healthy Start Services  
SITE(S): \_\_\_\_\_

<b>OUTCOMES</b>	<b>Annually</b>
1. % of families that have no new report of abuse/neglect during the time of Enhanced Healthy Start Services.	90%
2. % of families that have no new confirmed report of abuse/neglect during the time of Enhanced Healthy Start Services.	100%
3. % of families that have no new confirmed report of abuse/neglect six months after case closure by Enhanced Healthy Start and CWS or FSS.	100%
4. % of families regularly participating in services to which they have been referred.	95%
5. % of families with reduced risk factors measured at six months as compared to the initial measurement.	90%
6. % of families expressing satisfaction with Enhanced Healthy Start Services.	90%