

NEW MEXICO HOME VISITING  
PROGRAM STANDARDS  
2016-2017

cyfd



Children Youth & Families Department



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October, 2016

## Contents

THE NEW MEXICO HOME VISITING PROGRAM .....	4
Home Visiting Program Background.....	4
Level I Home Visiting – Prevention and Promotion.....	4
Level II Home Visiting – Targeted Interventions.....	5
Framework.....	5
Vision .....	5
Goals .....	5
Principles .....	6
Meeting the needs of the community .....	6
THE NEW MEXICO HOME VISITING PROGRAM LOGIC MODEL .....	7
PURPOSE.....	9
Overview.....	9
<i>HV Standard 1 – Program Participation.....</i>	<i>10</i>
1.1 Eligibility .....	10
1.2 Recruitment .....	11
1.3 Program Participation.....	11
1.4 Disenrollment & Transition.....	12
<i>HV Standard 2 – Culturally Sensitive and Relevant Practices – including supports for Dual Language Learners .....</i>	<i>13</i>
<i>HV Standard 3 – Relationship-based Practices: .....</i>	<i>14</i>
<i>HV Standard 4 – Family Goal-Setting.....</i>	<i>15</i>
4.1 Screenings and Assessments.....	15
4.2 Goal Setting.....	15
4.3 Referrals .....	16
4.4 Community Resources.....	16
<i>HV Standard 5 – Curriculum and Program Implementation (Service Delivery Approach) .....</i>	<i>17</i>
5.1 Curriculum.....	17
5.2 Curriculum and Model Fidelity .....	17
5.3 Intentional Home Visiting Practices.....	17

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<i>HV Standard 6 – Program Management Systems</i> .....	19
6.1 Organizational Management.....	19
6.2 Program Implementation .....	19
6.3 Recordkeeping – Client Records.....	19
6.4 Consent.....	20
6.5 Reporting .....	21
6.6 Communication .....	21
6.7 Fiscal Management.....	22
6.8 Caseload Size .....	22
6.9 Safety Assurance .....	22
6.10 Continuous Quality Improvement (Onda) .....	22
6.11 Ongoing Program Monitoring .....	23
<i>HV Standard 7 – Staffing and Supervision</i> .....	24
7.1 Program Staff and Qualifications .....	24
7.2 Clinical Staff.....	25
7.3 Staff Training.....	25
7.4 Ongoing Professional Development .....	26
7.5 Supervision Requirements .....	26
<i>HV Standard 8 – Community Engagement</i> .....	28
8.1 Collaboration .....	28
8.2 Community Education .....	28
8.3 Community Advisory Committees.....	28
Rationale and Research Support for New Mexico Home Visiting Program Standards.....	30

## THE NEW MEXICO HOME VISITING PROGRAM

The New Mexico Home Visiting Program is administered by the Children, Youth and Families Department, in accordance with the New Mexico Home Visiting Accountability Act (2013, Chapter 118). 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. 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 set forth by this Act.

### *Home Visiting Program Background*

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

The New Mexico Home Visiting Program has been identified on two interacting levels of service depending on the family/community needs.

- Level I Home Visiting – Prevention and Promotion
- Level II Home Visiting – Targeted Interventions

### *Level I Home Visiting – Prevention and Promotion*

The Level I New Mexico Home Visiting Program is a prevention-promotion program for families who are expecting, or have children under the age of five, these services are non-categorical, free and offered on a voluntary basis to families.

Level I Home Visiting means services that address the needs of the majority of children and their families served. Promoting safe nurturing relationships between young children and their care giver, and implementing strategies that prevent adverse childhood experiences and promote wellbeing (New Mexico Pyramid Partnership: A Framework for Social Emotional Well-Being of Infants, Young Children, and Families, <http://www.earlylearningnm.org/pyramid-framework-partnership>).

### *Level II Home Visiting – Targeted Interventions*

The birth of a new child can be a joyous occasion, but it may also be a very stressful change for the family. Research has demonstrated that when poverty results in an inability to meet basic needs, it has also been associated with serious negative outcomes including child neglect and abuse. When stress is chronic, as it is in situations of abuse, neglect, or extreme poverty, scientists have termed it “toxic” because its harmful influence on the developing brain is so great.

Level II – Targeted Home Visiting has been designed to support parents of children prenatal to age three, deal with the demands and stress of parenting while addressing improving the quality of the parent-child relationship and if needed, changing parent-child interaction patterns while being careful of not creating stigma or humiliation for participation. Level II Targeted Interventions Home Visiting Program provides services to families that are referred or identified during participation in the Home Visiting program in general to be at risk and/or in need of a higher level of intervention. This also includes targeting Early Childhood Investment Zones and communities at-risk due to: infant mortality, premature birth, low-birth-weight infants and other indicators of at-risk prenatal, maternal, newborn or child health; poverty; crime; domestic violence; high rates of high-school dropouts; substance abuse; unemployment; or child maltreatment.

## **NEW MEXICO HOME VISITING PROGRAM FRAMEWORK**

### Framework

The New Mexico’s theoretical framework is based in five research-based Long-Term Outcomes identified in the Home Visiting Logic Model:

- 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 community

### Vision

New Mexico families are supported to raise children who are healthy, happy and successful.

### Goals

1. Pregnant women experience improved prenatal health & babies experience improved birth outcomes;
2. Parents are available, responsive, attuned and appropriate with their infants and young children, supporting optimal social-emotional and cognitive development; and
3. Infants and young children to age five (5) experience optimal social-emotional and cognitive development so that they are prepared for school success.

### Principles

The New Mexico Home Visiting Program implements home visiting as a strategy for the delivery of services to families with children, prenatal to age five; services include; informational, educational, developmental, referral, and other supports. Home Visiting Program staff provide services to promote parental competence, and successful early childhood and development, by optimizing the relationships between parents and children in their home environment.

Home Visiting services are delivered in the “real world” of participating families, this focus offers the potential for a better assessment and understanding of a family’s day-to-day realities.

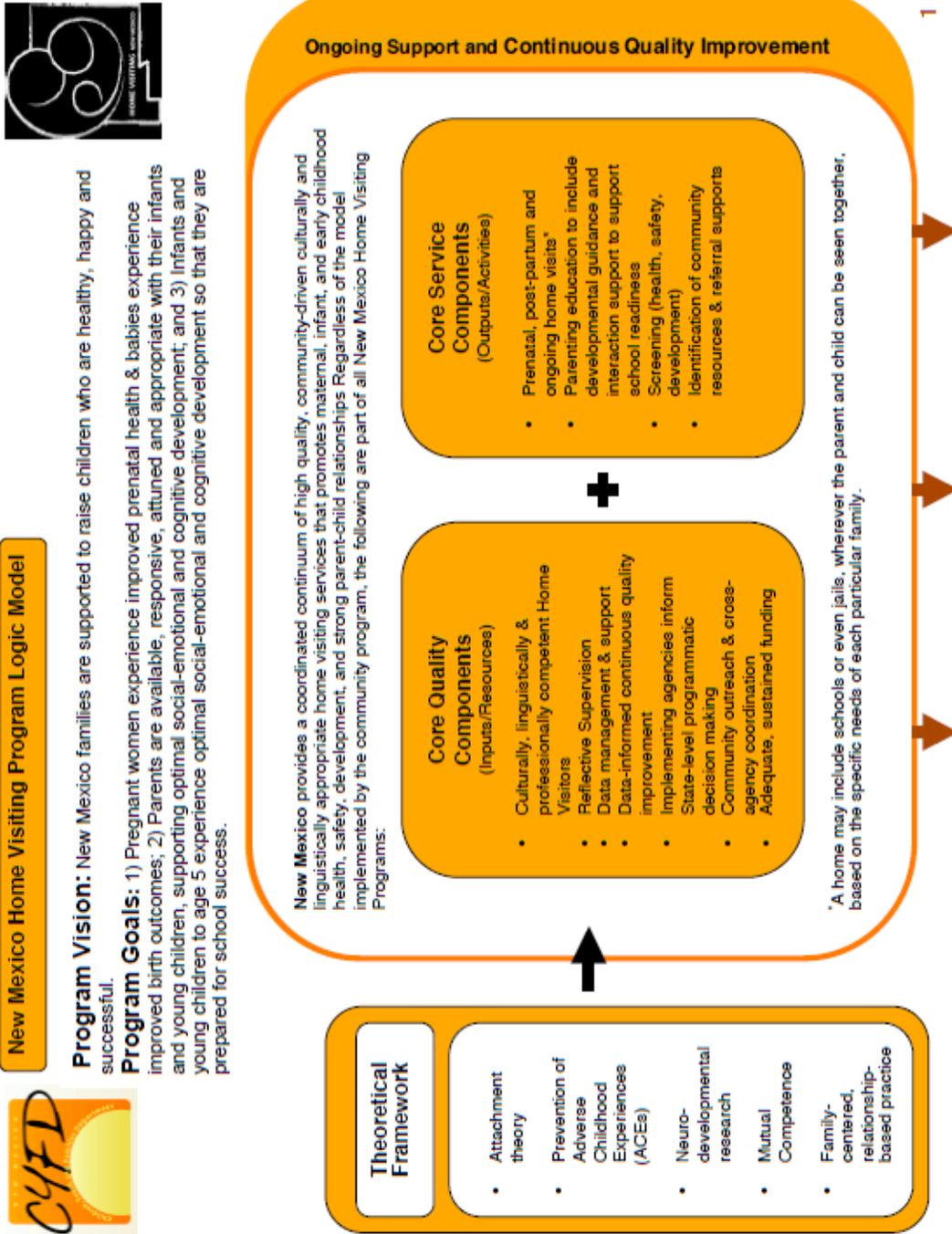
This understanding is critical for home visitors to build relationships, establish goals and support wellness across multiple domains (e.g. physical health, developmental competence, social and emotional well-being) for infants, young children and their primary caregivers and families.

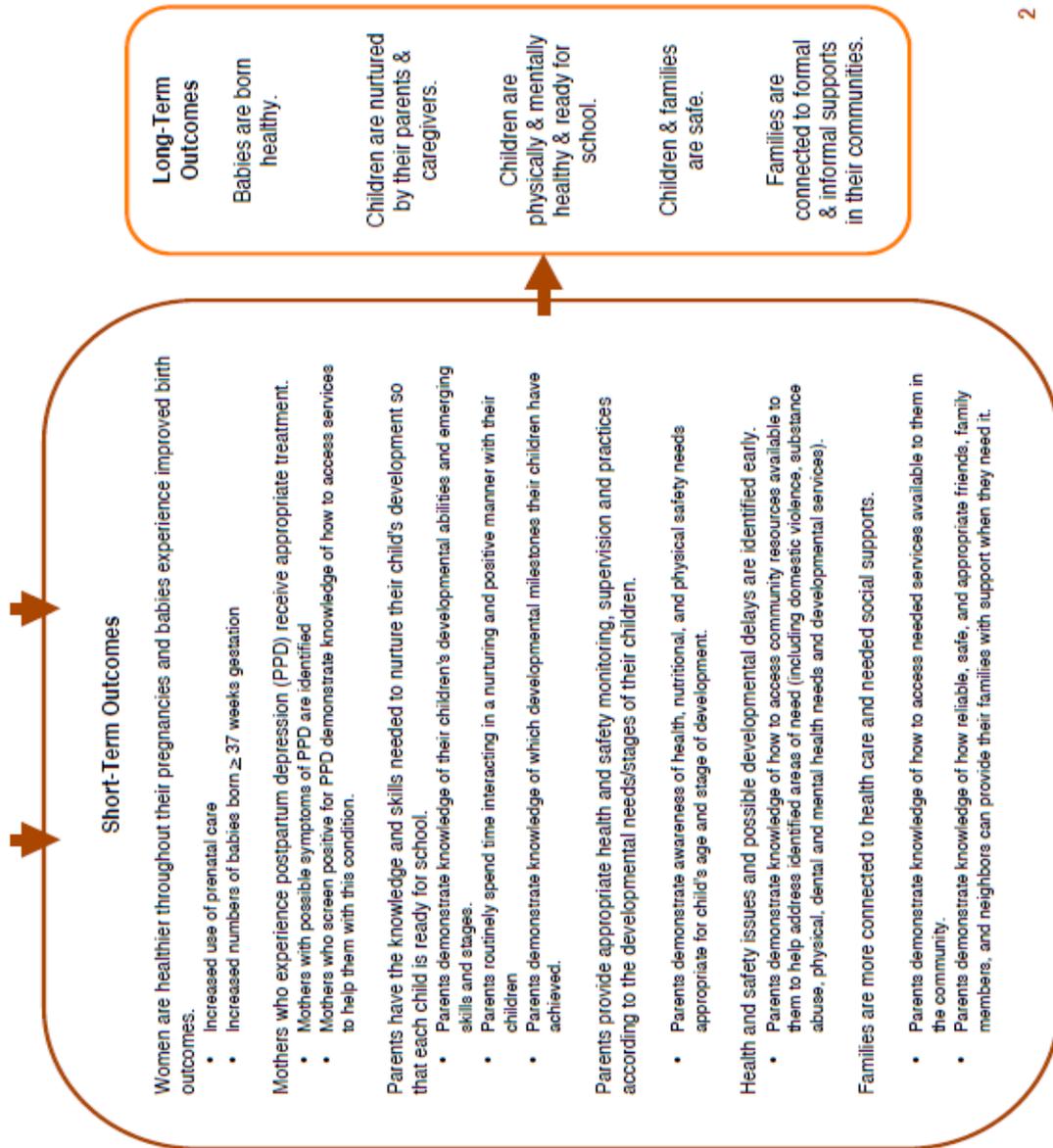
### Meeting the needs of the community

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**.

THE NEW MEXICO HOME VISITING PROGRAM LOGIC MODEL





## THE NEW MEXICO HOME VISITING PROGRAM STANDARDS

### *PURPOSE*

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 New Mexico Home Visiting Program Standards set a common framework for service delivery and build the foundation for accountability across all home visiting programs.

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).

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 **Home Visiting Program Standards** are non-negotiable for programs that receive CYFD funding at any Level and may be enhanced with other related standards. This includes: diverse program models, and other State, Federal and local regulations.

### Overview

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

1. Program participation,
2. Culturally sensitive & relevant practice,
3. Relationship-based practices,
4. Family goal-setting,
5. Curriculum and program implementation,
6. Program management systems,
7. Staffing and supervision,
8. Community engagement, and
9. Data management.

## IMPLEMENTATION STANDARDS

### *HV Standard 1 – Program Participation*

*This standard determines target population, prioritization, recruitment requirements and periodicity, duration and intensity for Home Visiting Levels I and II.*

#### **1.1 Eligibility**

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

1.1.b. The program's written eligibility criteria include families and children prenatal to age 5 as defined by model and funding source.

1.1.c. The program's eligibility protocols require consultation with CYFD Home Visiting Manager-Monitors for children/families involved with Protective Services, Juvenile Justice Services, or other Special Considerations.

1.1.d. The program's eligibility protocols define services as prevention and promotion program(as determined in this standards) . Services are always provided at no cost to each family and are voluntary.

1.1.e. The program has a defined, written procedure to determine selection criteria and waiting list systems for situations when the demand for services exceeds service capacity. Waiting list information must be submitted to CYFD.

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

In addition, for Level II programs:

II.- 1.1.a. Families are eligible for Level II services based on any one of the following criteria:

1. Referral- families referred from Child Protective Services (unsubstantiated cases), Juvenile Justice Services, Infant Mental Health Practitioners Special Considerations (such as incarceration, drug abuse, etc.) automatically meet Level II eligibility. This requires ongoing coordination with the referring agency.
2. Assessment- current Level I family cases that are considered high-risk, based on routine screenings/assessments, should be staffed by a multi-disciplinary team to determine best fit for services.

3. Critical Family Incident- in the event a critical incident occurs, a family who did not previously demonstrate risk factors on routine screenings/assessments may be transitioned to Level II services as appropriate
  - Items 2 and 3 require a Case Management Meeting including the HV Program Supervisor, Level I HV, Level II HV and with parental consent, any other agency involved.

## **1.2 Recruitment**

The program has an ongoing written recruitment plan that ensures early identification of pregnant women and families who may benefit from home visiting services. The recruitment plan must be updated and submitted at a minimum on a quarterly basis or as requested by the assigned program manager, utilizing the template provided by CYFD.

During the identification of families appropriate for Level I or Level II services, program recruitment plans cannot single out “high risk” families.

In addition, for Level II programs:

Recruitment Plan must include presentations, coordination and ongoing meetings with Protective Services, Juvenile Justice, Family Infant/Toddler Program, Drug Court, Child Care Providers, Hospitals, Law Enforcement, etc.

## **1.3 Program Participation**

1.3.a. The program procedures ensure 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. Implementing Infant Mental Health Practices.

1.3.b. The program procedures and practices ensure a continuum of services is provided to families based on family preferences, needs, strengths and risk factors.

1.3.c. 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 Program Standards.

1.3.d. Program procedures and practices ensure that each home visitor’s time is spent in direct contact (face-to-face) with families in their home. Justification for providing services in alternate locations must be documented.

1.3.e. Program procedures and practices ensure that contact time with families is at least 45 minutes to count as a completed home visit.

**1.4 Disenrollment & Transition**

1.4.a. The program has written procedures for disenrollment of families. Reasons for planned and unplanned disenrollment are documented.

1.4.b. Program procedures and practices ensure that transition planning occurs with families and is documented within the first 30 days. Before and after program participation Planned disenrollment must include a documented transition plan. Including notification to referral source, partnering agencies and follow up.

1.4.c. The timeline to replace families shall not exceed thirty (30) days from the disenrollment date. Justification will be provided for extenuating circumstances.

1.4.d. The program must consult with CYFD Home Visiting Program Manager-Monitors when special circumstances arise regarding family transition.

*HV Standard 2 – Culturally Sensitive and Relevant Practices – including supports for Dual Language Learners*

*This standard specifies the service delivery practices necessary to work effectively with people from a variety of abilities, languages, identities, and realities as well as ethnic, cultural, political, economic, and religious backgrounds. Culturally sensitive and relevant service delivery practices are implemented while taking into consideration the dynamics and structure of each family as they define themselves. In addition, practices must support enrolled children who are acquiring both the language of their family as well as the language of the larger community. These very young children are dual language learners (DLLs).*

2.1. When possible, home visitors should reflect the community they are serving, culturally, linguistically, ethnically, etc.

2.2. The program ensures that each home visitor is trained and supported to use culturally sensitive and linguistically appropriate practices to communicate effectively and demonstrate respect for the uniqueness of each family's culture.

2.3. Program procedures and the materials used with families are relevant to the population being served. Reasonable accommodations are made as necessary to support the individual culture and circumstances of families.

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 sensitive and relevant services (per Standard 7.5.a.). Implementing Infant Mental Health Practices.

2.5 Provide parents of children who are DLLs research-based guidance about the benefits of bilingualism and the important role of home language development. Information must be in a language they understand and must promote support and respect of the home language of each family and child participating in the Home Visiting Program to foster their wellbeing.

[http://www.beststart.org/resources/hlthy\\_chld\\_dev/BSRC\\_When\\_Families\\_Speak\\_fnl.pdf](http://www.beststart.org/resources/hlthy_chld_dev/BSRC_When_Families_Speak_fnl.pdf)

*HV Standard 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 are trained and supported to view relationships as the focus of the work. Ensure the Social-Emotional Needs of the child and family are supported.

3.2. Home visitors utilize required screenings, assessments and selected curricula that focus on strengthening the parent/caregiver-child relationship utilizing Infant Mental Health Principles.

3.3 Program's parent satisfaction survey will contain a measure to indicate if the family feels they have a positive relationship with their home visitor

3.4. Home visitors will receive regular ongoing **reflective supervision**. Sessions should include discussion about implementation of relationship-based practices (per Standard 7.5.a.).

#### *HV Standard 4 – Family Goal-Setting*

*This standard determines tools and usage of state approved screening processes, ongoing assessment and goal setting, referrals, follow ups and bridging to community resources.*

#### **4.1 Screenings and Assessments**

4.1.a. The completion of these screening tools is required, staff must be trained to fidelity by an approved trainer

1. Postnatal Depression Scale
2. Ages and Stages Questionnaire
3. Ages and Stages Questionnaire: Social /Emotional
4. Interpersonal Violence Screening Tool
5. Social Support Index (SSI)
6. Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)
7. Maternal Child Health Information
  - Peri-Natal Questionnaire
9. Social History
10. Any other tool as determined by CYFD

#### **4.2 Goal Setting**

Goals must be **established with each family** and be individualized and clearly reflect what each family hopes to accomplish for their child and themselves by participating in home visiting services.

4.1.a Based on identified needs and the Family Plan, the home visitor shall schedule visits accordingly. Plans must be reviewed and updated every month by the home visitor and/with the family.

4.1 b.. Family Services Plans (FSP) must be developed in a multidisciplinary team comprised, at a minimum, of the following members: Level I Home Visitor, Program Supervisor, Clinical Supervisor, and the Level II Home Visitor (when applicable), referral source (as applicable), If necessary, the CYFD Program Manager-Monitor may also be involved.

4.2.c. Programs ensure that, at a minimum, the following elements are used when developing goals in partnership with the family:

- i. Family input
- ii. Supporting the parent-child relationship

- iii. Results of screenings
- iv. Community supports
- v. Transition planning
- vi. Safety Plans as applicable
- vii. When applicable plans for coordination and alignment of services with other partnering and referral agencies (CPS, JJS, etc.)
- viii. When applicable, participation in the Early Intervention Individualized Family Services Plan development and implementation

4.2.d. Goals must be linked and identified as addressing one of the long-term outcomes:

- i. Babies are born healthy
- ii. Children are nurtured by the parents and caregivers
- iii. Children are physically and mentally healthy and ready for school
- iv. Children and families are safe
- v. Families are connected to formal and informal supports in their community.

### **4.3 Referrals**

4.3.a. Any **referrals** related to goals (or as a result of high risk scores on screens) require **follow up** which must be documented within first 30 days.

4.3.b. Any referrals related to high risk scores on screens or Level II referrals require a follow up within 5 business days.

### **4.4 Community Resources**

4.4.a. Programs collaborate with **community resources** to assist in meeting goals and addressing the needs of families. Service coordination with community partners must ensure non-duplication and alignment in a seamless matter.

4.4.b. As part of the quarterly reporting process provide a list of missing and non-accessible services in the community that have contributed to unsuccessful completion of referrals.

- i. Include description of efforts being made within the community to access the needed community services.
- ii. Specify barriers in accessing those services with recommendations for the state and the community.

4.5 The **family satisfaction survey** must include at least one question related to how the home visitor worked with the family to develop and/or achieve their goal. (See standard 6.10\_)

*HV Standard 5 – Curriculum and Program Implementation (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 Curriculum**

Each program will select and adhere to an approved curriculum/model.

5.1. a Specialized program curriculums that are tailored to community needs must be consulted on with CYFD Office of Child Development for approval.

5.1.b. The selected curriculum model must support the follow:

- i. prenatal visits
- ii. post-partum visits
- iii. visits with families of children up to age 5 years

**5.2 Curriculum and Model Fidelity**

5.2.a Each program will ensure that home visitors receive the training appropriate to the selected curriculum or model to ensure fidelity.

5.2.b. A home visitor staff must complete training on identified curriculum within the first 60 days of hire. Requests for extensions on training beyond 60 days must be approved by CYFD Home Visiting Program Manager/Monitor.

**5.3 Intentional Home Visiting Practices**

Home visitors are required to engage families in regularly scheduled home visits supported by the program’s infrastructure, procedures and practices.

5.3.a. Program procedures are practices ensure the following components occur during regularly scheduled home visits:

- i. Parent engagement
- ii. support parent-child relationship
- iii. support and assistance to access health care
- iv. referral and follow-up to formal and informal community resources
- v. screenings for possible risk factors
- vi. address safety concerns and high risk scores with families
- vii. provide developmental guidance
- viii. promote breast feeding as appropriate
- ix. ensure well child checks are up to date

5.4.b. Program procedures and practices ensure that when a safety risk is identified or suspected, the program takes the following actions: assesses immediate safety, refers to other community providers as appropriate, creates and documents family safety plan, supports linkages and collaboration with other needed services to minimize the risk and follows up referrals made to community resources within ten (10) calendar days.

5.5 For **planned service completion or discontinuation**, please see HV 1.4.

5.6 For **program evaluation**, refer to 6.10 and 6.11.

### *HV Standard 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 Organizational Management**

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

6.1.b. 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.

6.1.c. The program has clearly stated, written standards of conduct and a code of ethical conduct that the staff is trained and supported to follow. Including boundaries and use of personal devices for business purposes.

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

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

#### **6.2 Program Implementation**

6.2.b. Program must develop a Home Visiting Implementation plans that identify short- and long-term goals for implementing quality services in the following areas:

- i. Ongoing recruitment/retention
- ii. Enrollment of children and families
- iii. Service delivery area
- iv. Caseloads (see 6.8)
- v. Community collaboration

#### **6.3 Recordkeeping – Client Records**

6.3.a. Program procedures and practices ensure that electronic client files and documentation of required management elements are maintained in the provided data management system.

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

6.3.e Family Files. Programs must maintain Family Files onsite according to HIPAA (Health Insurance Portability and Accountability Act) requirements. Ensure that the Family Files include at a minimum the following information:

Cover: Confidentiality Page

Section I

1. Enrollment Information
2. Family plans
3. Progress Notes
4. Screenings, Referrals and Follow Ups
5. Transitions and Closure
6. Special Circumstances and Level II services

6.3.f. The agency provides suitable storage of and access to client records for three years after termination of services with family. After that time, procedures and practices are in place providing suitable disposal of client records. Files for Level II services must be kept for 5 (five) years.

6.3.g. In the event the agency or CYFD elects to terminate contract to provide home visiting services, client records are to be kept for seven (7) years.

#### **6.4 Consent**

6.4.a. Program policies, procedures and practices ensure confidentiality of client information in accordance with policies of the Health Information Portability and Accountability Act (HIPAA), including electronic protected health information (ePHI).

6.4.b. 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 Home Visiting Managers, and staff of the professional development and data management teams.

6.4.c. 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.

6.4.d. Programs will ensure training is provided to all program staff on HIPAA and electronic Protected Health Information.

6.4.e. A HIPAA Business Agreement will be place between the program and the data management system.

## **6.5 Reporting**

6.5.a. Program procedures and practices ensure the submission of Quarterly Reports in the required format on the 15<sup>th</sup> 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.

6.5.b. Any inaccuracies, inconsistencies or missing data revealed in the Quarterly Report will be addressed with an Action Plan [See Standard 6.11.b].

6.5.c Mandatory Reporting: All Home Visitor Service Providers and staff must report any and all suspected abuse, neglect or exploitation of children to the Children, Youth and Families Statewide Central Intake.

- i. In the report to the Statewide Central Intake, the reporter must identified his/herself as a Home Visiting Service Provider and whether the allegations involve a Home Visiting client or family.
- ii. After the mandated reporter reports the incident to Statewide Central Intake, the service provider shall notify the alleged abuse and/neglect to the assigned CYFD program manager within 24 hours of the report, utilizing the "Incident Report" format.

## **6.6 Communication**

6.6.a. Program procedures and processes are expected to specify how communication will take place and how updated information is shared, as appropriate with:

- The agency's governing body;
- Program staff;
- Parents/family members who are participating in the Home Visiting Program;
- CYFD Home Visiting Manager/Monitor

## **6.7 Fiscal Management**

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

6.7.b. The agency/program has the policies, procedures and practices needed to accurately:

- i. Monitor expenditures against income; and
- ii. Maintain steady cash flow across the 12-month contract periods.

6.7.c. Agency/program ensures that the monthly invoices with expenditure reports are submitted to CYFD as required.

i. Submit monthly invoices, by the 15<sup>th</sup> of each month, to: CYFD Home Visiting Manager/Monitor, CYFD/ECS/OCD, PO Drawer 5160, Santa Fe, New Mexico 87502-5160.

## **6.8 Caseload Size**

6.8.a The Caseload size may vary from 15 – 28 depending on the intensity of need and frequency of visits.

In addition, for Level II programs:

The caseload for a Level II Home Visitor shall not exceed 15 of Level II cases.

In the event a home visitor is providing both Level I and Level II service, the case load distributions shall not exceed the following parameters: cases shall not exceed 10 for Level II for a maximum combined (Level I and Level II) caseload of 20.

## **6.9 Safety Assurance**

Program procedures and practices establish safety protocols for home visiting staff, especially in regards to non-traditional hours.

## **6.10 Continuous Quality Improvement (Onda)**

6.10.a. Programs will participate in FOCUS that includes Self-Assessment and the Continuous Quality Improvement process (Onda) as outlined by CYFD, and in collaboration with Home Visiting Consultation Team and the data team, to improve program quality.

6.10.b. Family Satisfaction Surveys must be conducted annually, and/or at the end of service, and results should contribute to the program's continuous quality improvement.

### **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.

6.11.a. Monitoring will take place through the following processes:

- i. Data Review
- ii. Quarterly Reports- Review of submitted reports and follow-up discussions
- iii. Site Visits- On-site meetings with program manager may include interviews with home visiting staff and/or families, and records review of client files, fiscal files, and/or employee files.
- iv. Ongoing Communication- Regular phone calls and emails

#### **6.11.b. Program Response to Findings of Non-Compliance and Program Deficiencies**

Program management will ensure that appropriate interventions and corrective actions are implemented in a timely manner, should they be necessary.

- i. Action Plans are created in collaboration with the program manager, CYFD Home Visiting Manager/Monitor, and CYFD Home Visiting Supervisor to assist the program in prioritizing high need areas of contract non-compliance and setting appropriate timelines for completion of action items.
- ii. Corrective Action Plans are put into place when programs have significant areas of non-compliance that need that require immediate attention (Corrective Action Plans may result in contract amendments).

#### **6.11.c. Special Conditions**

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 Supervisor or designee prior to action.

## *HV Standard 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 and Qualifications**

7.1.a. Program procedures and practices ensure that the program hires adequate numbers of qualified personnel to provide services in order to meet contractual obligations.

- i. Ratios for Staffing: For every 20 families funded, programs must have, at minimum, One (1) full-time home visitor, and One (1) .25 FTE Program Manager to accurately meet the needs of the home visiting program.
- ii. The program must have a program manager/director housed within the same location. The Program Director must have at a minimum a Bachelor's Degree with at least three year experience working with infants, toddlers or expectant families.

7.1.b. 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 and prior to providing direct services.

7.1.c. Program procedures and practices ensure that the program is staffed by individuals who embrace the Home Visiting Philosophy and have the capacity to perform the core CYFD Home Visiting service components.

7.1.d. Program staffing procedures ensure the existence of a Home Visiting team that is multidisciplinary and who have knowledge in early childhood development and infant/early childhood mental health.

- i. Programs must hire degreed professionals who meet the qualifications as specified in the New Mexico Home Visiting Standards as part of their home visiting team; or non-degreed professionals that meet the following education path:
  - a. 50% of non-degreed personnel (or personnel in non-related field degree program) must obtain the Infant Family Studies Certificate with in two years of
  - b. 100% of non-degreed personnel (or personnel in non-related field degree program) must obtain the Infant Family Studies Certificate with in three years the implementation of these standards.

#### **In addition for Level II**

Level II Home Visitors must possess a Bachelor's Degree in one of the following areas: Social Work, Early Childhood Development, Marriage and Family Counseling, Infant Family Studies, or in a related field approved by your CYFD Program Manager-Monitor, and obtain Level I or higher Infant Mental Health Endorsement within two years of hire.

## 7.2 Clinical Staff

Program staffing procedures ensure that home visitors have access to at least one Master's level licensed mental health professional that is available for consultation when potential high risk situations, crises, and/or other clinical issues or concerns arise. Within two years of hiring/contracting the individual must obtain their Infant Mental Health Endorsement Level II or higher

## 7.3 Staff Training

7.3.a. Program managers ensure the appropriate program staff participate in opportunities to stay updated about any changes made at state-and federal-levels. Opportunities include, but are not limited to: Quarterly Meetings, Ask the Manager Calls and written information.

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.b. The program maintains documentation that all home visiting staff are trained, at a minimum, in the following **topic areas**:

- Relationship-based Practice
- Pregnancy and Early Parenthood
- Parent-child Interaction
- Infant/child Growth and Development
- Community Resources (Domestic Violence, Substance Abuse, WIC, Housing, SSI, TANF, and other social supports available in the community)
- Use of all required screening tools
- Documentation/Data Entry
- Provisions and requirements of relevant Federal and State Laws including mandated reporting of child abuse and neglect
- HIPPA and Confidentiality
- CYFD Organization and Practices (Juvenile Justice Services, Protective Services, Early Childhood Services, and Behavioral Health)
- Other Trainings as required by CYFD

In addition, for Level II programs:

Level II Home Visitors must have a clear understanding of program requirements and regulations for referring/partnering agencies.

#### **7.4 Ongoing Professional Development**

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

7.4.b. Program procedures and practices ensure that each home visiting staff member completes a professional development self-assessment to help identify his/her strengths and areas where additional training and support are needed, and develop a plan accordingly.

7.4.c. Non-degreed home visiting staff (Para-professionals) must work toward the completion of the following degree path:

- i. 100% of non-degreed personnel (or personnel in non-related field degree program) must obtain the Infant Family Studies Certificate within three years of hire
- ii. 50% Obtain an Associate's Degree within 2 years;
- iii. 25% Obtain a Bachelor's Degree within 4 years of hire with the home visiting program.

7.4.d. Program manager must submit annual staffing reports to the CYFD Home Visiting Manager/Monitor indicating staff progress on meeting professional qualifications.

#### **7.5 Supervision Requirements**

Program procedures and practices ensure home visiting staff receives supervision from an experienced and licensed and/or credentialed supervisor with knowledge of the following areas: pregnancy and prenatal issues, early childhood and family development (including social and emotional development), reflective practice, and family centered care.

- i. Program practices and procedures ensure that supervisors support home visitors to integrate and implement information from trainings to help build skill and competence.

##### **7.5.a. Reflective Supervision**

- i. Program procedures and practices ensure that reflective supervision is provided individually at a minimum of two times per month and enhanced through group sessions, as appropriate.
- ii. Program procedures and practices ensure Reflective Supervision meetings are:
  - consistently scheduled (a minimum of 2 hours/month); and
  - conducted by a qualified practitioner who is trained and knowledgeable in infant/early childhood mental health utilizing reflective practice principles.

### 7.5.b. Field Supervision

- i. Program procedures and practices ensure that supervisors accompany their home visitors on family visits (field supervision) a minimum of:
  - one time per year for home visiting staff with 1 or more years experience as a home visitor;
  - twice a year for new home visitors with less than one year experience; and
  - as needed, in addition to the minimum requirements.

### 7.5.c. Administrative Supervision

- i. 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 requirements, data and case audits.
- ii. In addition to supervision requirements listed above, administrative supervisors or a designated staff member, must have experience with data management systems.
- iii. Program procedures and practices ensure that the program conducts regular and frequent review of program activities. At least 10% of the cases must be reviewed every month 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).

## *HV Standard 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**

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

8.1.b. The program documents efforts to collaborate with local agencies or programs that provide services to young children and families to enhance service accessibility.

8.1.c. Programs document efforts to prevent duplication of services when more than one CYFD funded home visiting program is providing services to the same community area(s). Programs must collaborate to create a plan of action when it is discovered that more than one program is providing services to the same family.

### **8.2 Community Education**

8.2.a. The program documents participation in community education and development activities at the local and state levels to ensure awareness of home visiting services [See Standard 6.2].

8.2.a. The program documents the provision of quarterly community presentations each year that are designed to raise awareness of home visiting services and the importance of the early years.

### **8.3 Community Advisory Committees**

The agency/program providing services documents regular participation with a community advisory committee, council or coalition.

In addition, for Level II programs:

The program has an up-to-date community resource manual to utilize as a reference when family's need or request additional services.

The program has clearly written protocols to follow for the referral process.

Provide quarterly presentations to community partners.

### **HV Standard 9 – Data Management**

*All CYFD contracted providers must use the NM CYFD Home Visiting Database. As required by the New Mexico Home Visiting Accountability Act, this is utilized for program accountability that includes evaluation, continuous quality improvement and compliance that may affect current and future funding.*

9.1. The funded agency ensures compliance with HIPAA requirements regarding electronic, verbal and written information.

9.2. Within 45 days after receiving a fully executed home visiting contract, the program must be setup in the NM CYFD Home Visiting Database. It is the program's responsibility to work with the Home Visiting Database Team.

9.3. 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. Data management includes data entry, monitoring, reporting and analysis.

9.4. All CYFD required data must be entered into the NM CYFD Home Visiting Database within 5 days of an activity.

9.5. Program procedures and practices ensure that the program manager reviews electronic data on a regular, ongoing basis to identify and correct missing, incomplete or inaccurate data.

9.6. Program procedures and practices ensure that the program manager informs the database team within 24 hours when a home visitor leaves his/her employment with the program so access to that home visitor's user account can be de-activated.

## 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 Korfmacher, 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 findings 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 to 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.

### **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 & Appelbaum’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 & Applebaum, 2004; Korfmacher, et al., 2012). However, evidence is cited linking prenatal enrollment in program services to stronger parenting outcomes (Daro, 2009) and more positive birth outcomes (Lee et al., 2009; McCurdy, Gannon, & Daro, 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 (Daro, 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 & Appelbaum, 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 and Relevant 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. Theses 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). 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 Program Implementation (Service Delivery)**

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](http://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).

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## **Appendix B**

To assist families in selecting goals, it may be useful to consider the following **18 outcomes** 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 in the following areas:

- A. Documentation at Intake/Admission (to be maintained in individual file)
- B. Documentation of Appropriate Family and Child Goals
- C. Documentation of Screening Tools
- D. Documentation of client progress through home visit records
- E. Documentation of Supervisory Chart Reviews
- F. Documentation of Service Completion or Discontinuation
- G. Documentation of staff qualifications/competencies
- H. Documentation of Significant Events and Incident/Occurrence Reports.

## **Appendix D**

### **Required Screenings and Assessment Tools and Frequency Schedule**

All required screening tools must be completed at the periodicity specified by CYFD.

## **Appendix E**

### **Progress Notes**

Home visitors are required to complete a progress note for each visit.

## **Appendix F**

### **Special Conditions**

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.

## **Appendix G**

### **Home Visiting Glossary**

<b>Attachment</b>	An emotional bond between a parent/primary caregiver and infant that develops over time and as a result of positive care-seeking behaviors (e.g., crying, smiling, vocalizing, grasping, reaching, calling, following) and responsive care giving (e.g., smiling, talking, holding, comforting, caressing). A special form of emotional relationship. Attachment involves mutuality, comfort, safety and pleasure for both individuals in the relationship.
<b>Attributions</b>	Assigning some quality or character to a person or thing.
<b>Attunement</b>	The ability to read and respond to the communicated needs of another. This involves synchronous and responsive attention to the verbal and non-verbal cues of another.
<b>Children’s Protective Services</b>	A state-wide system to prevent or treat the abuse and neglect of children within the New Mexico Children, Youth and Families Department.
<b>Collaborate</b>	Work willingly with other direct service providers, parents, community agencies, faculty, and other professionals to obtain, coordinate, and research services that effectively nurture infants and families.
<b>Collateral Contacts</b>	Sources that provide additional information to support or reinforce the assessment/evaluation and treatment of clients.

**Community Collaboration** Participation with other community entities to address the health and well-being of the community as a whole.

**Community Priorities** Issues identified through community collaboration that are paramount to provide positive affects to the health and well-being of the community.

**Competency Guidelines** Describe specific areas of expertise, responsibilities and behaviors that are required to become endorsed through the New Mexico Association of Infant Mental Health (NMAIMH). There are 4 levels of endorsement: Level 1 (Infant Family Associate), Level 2 (Infant Family Specialist), Level 3 (Infant Mental Health Specialist), and Level 4 (Infant Mental Health Mentor). Areas of expertise, very generally described here, include theoretical foundations; law, regulation and policy; service systems; direct service skills; working with others; communicating; reflection; and thinking.

**Consultation** An opportunity for professionals to meet regularly with an experienced infant mental health professional to examine thoughts and feelings in relationship to work with infants, young children, and families.

**Contingency/Contingent Interactions** An adult’s response that is directly related to an infant or young child’s behavior or actions and vice versa.

**Co-regulation** The reciprocal maintenance of psychophysiological homeostasis within a relationship in terms of the physiological and emotional states. In the infant, the parent-child dyad is crucial in regulating both of these.

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<b>Cultural Sensitivity</b>	Unbiased knowledge of the family’s culture and language which is an integral part of all efforts to deliver services. Beliefs and practices are identified which include, but are not limited to, family organization and relational roles (traditional and nontraditional), spirituality, and understanding of ethnically related stressors such as acculturation, poverty, and discrimination.
<b>Developmental Guidance</b>	Offering individualized guidance to parents about their children’s developmental requirements, while focusing on the capacities of the child and the primary caregiver.
<b>Early Intervention</b>	Services that begin prior to pregnancy, during pregnancy or at any time during the first three years of the child’s life.
<b>Empathy</b>	Empathy is an ability to understand and feel what another person is feeling, not in a physical sense, but in an emotional sense. The expression "put yourself in someone else's shoes" is actually a description of empathy. This helps to understand other's situations, perspectives, and problems much better.
<b>Engagement Cues</b>	Engagement means that the infant wants to engage or attract the attention of her caregiver – in other words, she is ready for interaction. Some familiar cues are smiling, looking at, and reaching out to another.

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<b>Epigenetics</b>	Epigenetics is the study of heritable changes in gene expression or cellular phenotype caused by mechanisms other than changes in the underlying DNA sequence. These include factors in the life of the mother and father prior to conception that would influence chromosomal proteins and therefore impact the genetic expression in their offspring.
<b>Family</b>	At least one parent, caregiver, guardian, or custodian of the infant or young child involved in the home visiting program.
<b>Family Centered</b>	Looking at the family as a whole. The aim is to support/partner with the family in service of the infant or young child.
<b>Family-Centered Practice</b>	The professional's ability to focus on the child(ren) within the context of the family and to respect the family's strengths and needs as primary.
<b>Frustration</b>	Victor Bernstein defines this as ' <i>your agenda being different than their agenda</i> '.
<b>Human Services/Related Degree(s)</b>	Include but are not limited to Social Work, Sociology, Counseling, Human Services, Criminology/ Criminal Justice, Public Administration, Educational Counseling, Education, Nursing and Health Education.

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<b>Infant Mental Health</b>	An interdisciplinary field dedicated to promoting the social and emotional well-being of all infants, very young children, and families within the context of secure and nurturing relationships. Infant mental health services support the growth of healthy attachment relationships, reducing the risk of delays or disorders and enhancing enduring strengths.
<b>Informal Networks</b>	Informal networks refer to the parents' resources and access to family, friends and/or neighbors who may assist them emotionally, financially, with transportation, as in well as in other areas of potential need.
<b>Mirror Neurons</b>	Neurons in the brain of one individual that respond to the firing of neurons in the brain of another individual.
<b>(MIS) Database</b>	Management Information System is an electronic tracking system for clients and service delivery.
<b>Mutual Competence</b>	Mutually competent interactions are interactions which enable both the parent and child to feel secure, valued, understood, successful, and happy and enjoy learning together.
<b>Newborn Care</b>	Care that is provided to the mother and infant including medical, emotional, and psychological aimed at maintaining and enhancing the health and well-being of the infant. Newborn is considered 0-4 weeks and an infant is considered birth to 1 year of age.
<b>NM Association for Infant Mental Health Endorsement Process</b>	A process that supports the development and recognition of infant and family professionals within an organized system of culturally sensitive, relationship-focused practice that promotes infant mental health.

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<b>Parallel Process</b>	Parallel Process is a way of modeling interactions, behaviors, attitudes, and possible responses exemplifying how these factors are incorporated into all aspects of home visiting. For example: Home visitor who are treated with dignity and respect will more likely apply these same values in their interactions with families.
<b>Performance Measure</b>	A quantitative or qualitative indicator used to assess the outcome or result of a program/or service.
<b>Prenatal Care</b>	Prenatal care refers to care that is provided to the mother during pregnancy. This includes medical, emotional, and psychological care, aimed at maintaining and enhancing the health of the unborn child, as well as the mother.
<b>Reciprocity</b>	The situation where an action by one individual is returned by an action by the recipient. This 'give and take' arrangement is usually mutually agreed upon, implicitly if not explicitly.
<b>Reflective</b>	Self-aware, able to examine one's professional and personal thoughts and feelings in response to work within the infant and family field.
<b>Reflective Functioning</b>	Reflective functioning is the capacity to have one's own thoughts and feelings as well as the capacity to think about another person's thoughts and feelings.
<b>Reflective Practice</b>	Able to examine one's thoughts and feelings related to professional and personal responses within the infant and family field.

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<b>Relationship-based Practice</b>	Values early developing relationships between parents and young children as the foundation for optimal growth and change; directs all services to nurture early developing relationships within families; values the working relationship between parents and professionals as the instrument for therapeutic change; values all relationship experiences, past and present, as significant to one's capacity to nurture and support others.
<b>Reflective Supervision</b>	<p>A learning experience in which a professional meets regularly with an experienced infant/early childhood mental health professional to examine professional and personal thoughts and feelings in relationship to work in the infant/early childhood and family field.</p> <p>Face-to-face, group or individual supervision of home visiting staff by a supervisor who meets relevant experience in reflective practice. The supervisor promotes the development of skills and responsibility in the delivery of home visiting services.</p>
<b>Related Field</b>	An allied mental health field or counseling related field including social work, guidance and counseling, mental health, psychology, family studies, marriage and family therapy, family sciences, rehabilitation counseling, counselor education, or social anthropology.
<b>Relevant Experience</b>	Significant and demonstrable experience in providing services to the target population.
<b>Resiliency</b>	The capacity to be confident, competent and caring despite significant risk factors throughout childhood. (e.g. develop social competence, problem-solving skills, capacity to reflect, autonomy and a sense of purpose.)

**Self-regulation**

The ability to control and manage the effects of intense feelings. Emotional regulation is influenced by many factors including culture, temperament, and life experiences.

**Service Collaboration**

Participation with other community entities to benefit the health and well-being of children and families in the target population.