






# PTS-HFI Best Practice Standards

## Initial Engagement/Screening & Assessment














| Principle   | Practice   | Benchmark   | Documentation<br>Hard Copy Files |
|---|--|---|----------------------------------|
| <p>IE1 - By targeting pregnant and parenting teens, programs can effectively address child abuse, neglect, and other poor outcomes for teens, as well as their young children in a community.</p> <p><i>BPS = Best Practice Standard</i></p>  | <p>IBTI programs target services for pregnant and parenting teens, ages 13-19 at intake, their children, and their families.</p> <p>Exceptions can be made with prior approval from the Ounce. In programs that serve women of all ages, teens should be given priority.</p> | 100% of participants are age 19 or younger at intake.                                 | Participant Files                |
| <p>IE2 - Programs are more likely to recruit and retain long-term participants when they initiate services prenatally or immediately after birth in order to form a trusting connection with new parents, and establish the program as a source of support and information.</p> <p><i>(BPS 1-2.A)</i></p> | <p>A - For programs using assessments to determine eligibility: programs complete assessments before the child is age two weeks.</p>   | Programs complete 80% of assessments prenatally or before the child is age two weeks. | Participant Files                |
|   | <p>B - For programs using screenings to determine eligibility: programs complete screenings before the child is age two weeks.</p>   | Programs complete 80% of screenings prenatally or before the child is age two weeks.  | Participant Files                |
|   | <p>C - For programs using screenings to determine eligibility: programs complete assessment with 45 days of enrollment.</p>  | Programs complete 80% of assessments within 45 days of enrollment.                    | Participant Files                |
|   | <p>D - Programs initiate Home Visiting before the child is age three months.</p> <p>Exceptions can be made with prior approval from the Ounce.</p>   | Programs initiate Home Visits before the child is age three months 100% of the time.  | Case Notes<br>Participant Files  |

| Principle  | Practice   | Benchmark   | Documentation<br>Hard Copy Files               |
|--|--|---|--|
| <p>IE3 - Screening and assessment of family needs focuses on systematic identification of those families most in need of services, and identifies the presence of key factors associated with an increased risk of child maltreatment and other poor childhood outcomes.</p> <p><i>(BPS 1-1.A)</i></p> | <p>A - Programs use the Kempe Family Stress Checklist (Kempe) or a locally adapted assessment tool as the uniform method for early identification of potential participants. With approval from the Ounce, programs may implement alternative methods of identifying participants, while continuing to use the Kempe as a service-planning tool.</p> | <p>100% of programs assess potential participants using the Kempe or an IBTI approved tool.</p>   | <p>FAW Files<br/>Participant Files</p>         |
|  | <p>B - Programs clearly define their target population and maintain annual tracking of the number births and other demographic characteristics within that population to ensure that they screen 100% of the potential participants.</p>   | <p>Site has a description of its target population and how the current target population was decided upon including the relevant and up to date community data that was used in the decision making. Both the description and data utilized are comprehensive and up to date within last two years.</p> | <p>Program Abstract</p>                        |
|  | <p>C - Programs refer families that assess as high-risk to all other applicable services in the community if the program is full.</p>  | <p>100% of programs assess families' risk levels and refer to other services as needed.</p>   | <p>FAW Files</p>                               |
| <p>IE4 - Assessment of family needs occurs in an atmosphere of mutual respect and informed consent.</p>  | <p>A - Programs conduct positive and persistent outreach for target families and those who screen or assess as high-risk to encourage their voluntary participation in the program.</p>  | <p>100% of programs use positive outreach to engage potential participants.</p>   | <p>FAW Files<br/>Supervisory Documentation</p> |











| Principle  | Practice   | Benchmark   | Documentation<br> Hard Copy Files  |
|--|--|---|---|
| IE4 - Assessment of family needs occurs in an atmosphere of mutual respect and informed consent.   | B - Programs maintain up-to-date signed IBTI consents for services with all participants involved.   | 100% of participant files contain up-to-date, complete, and signed Ounce consent forms.   |  Participant Files   |
|  | <p>C - Staff members obtain signed consent prior to any intake or assessment interview, and entry of participant information into OunceNet and/or Visit Tracker. Refusal to sign a consent form for entry of their information into OunceNet or Visit Tracker does not preclude a family from services.</p> <p>Programs that receive MIECHV funding from the Ounce must also utilize the MIECHV consent form for all participants assigned to MIECHV funded staff.</p> | Programs enter data into OunceNet and/or Visit Tracker only after obtaining prior written consent 100% of the time.             |  Participant Files   |
| IE5 - Programs are most effective when they use intake and assessment information about family characteristics, background, history, and current functioning to plan services. | Staff members who assess families or gather intake data share that information with Home Visitors, Doulas, and Parent Group Service Coordinators.  | 100% of staff members who complete intakes or assessments share intake information or assessment results with the service team. |  Program Narrative<br> Team Meeting Notes |














# PTS-HFI Best Practice Standards

## Home Visiting

| Principle   | Practice   | Benchmark  | Documentation<br> Hard Copy Files   |
|---|--|--|--|
| <p>HV1 - Home Visiting is the core family support and early childhood education service provided by IBTI programs for pregnant and parenting teens and their children.<br/>(BPS 4-1.B, 4-2.A, 4-3.A, 4-4.A)</p> | <p>A - Home Visits take place on a schedule determined in partnership with the family, diminishing in intensity as family needs change.</p>  | <p>Programs assign 100% of families to a service intensity level.</p>  | <ul style="list-style-type: none"> <li> Participant Files</li> <li> Program Narrative</li> </ul>   |
|   | <p>B - Home Visitors conduct Home Visits weekly for the first six months of the baby's life with visit frequency beyond that time planned in accordance with HFI guidelines for participant level changes.</p>   | <p>100% of participants receive weekly Home Visits for the first six months of their baby's life.</p>  | <ul style="list-style-type: none"> <li> Case Notes</li> <li> Level Change Form</li> <li> Supervisory Documentation</li> </ul>                 |
|   | <p>C - Each family's progression to a new level of service, as identified on level change criteria, is reviewed by the family, home visitor, and supervisor. This review serves as the basis for the decision to move the family from one level of service to another.</p>                                   | <p>100% of participant level changes are documented in participant files. It is recommended that programs use the HFA Level Change Form.</p> | <ul style="list-style-type: none"> <li> Case Notes</li> <li> Participant Files</li> <li> Supervisory Documentation</li> </ul>              |
|   | <p>D - Programs offer services to families for a minimum of three years after the birth of the baby.</p>   |  | <ul style="list-style-type: none"> <li> Policy and Procedure Manual</li> </ul>  |
|   | <p>E - Programs ensure that families planning to discontinue or close from services have a well thought out transition plan. Transition planning begins six months prior to participant exit. The elements of the programs transition plan are articulated in the program's Policy and Procedure Manual.</p> |  | <ul style="list-style-type: none"> <li> Case Notes</li> <li> Policy and Procedure Manual</li> <li> Supervisory Documentation</li> </ul> |

| Principle   | Practice  | Benchmark  | Documentation<br>📁 Hard Copy Files                  |
|---|---|--|---|
| <p>HV2 - Home Visiting is of sufficient intensity to impact program outcomes.<br/><i>(BPS 4-2.B Sentinel Standard, 6-5.A,B)</i></p>   | <p>A - Home Visits last between 1.0 and 1.5 hours.</p>  | <p>80% of Home Visits last between 1.0 and 1.5 hours.</p>  | <p>📁 Case Notes</p>                                 |
|   |   | <p>95% of completed Home Visits take place in the home.</p>  | <p>📁 Case Notes</p>                                 |
|   | <p>B - Programs complete Home Visits with all participants at the expected level of frequency for each family.</p>  | <p>Home Visitors complete 75% of expected Home Visits per service intensity level.</p>   | <p>📁 Case Notes</p>                                 |
|   | <p>C – Programs use an evidence-informed curriculum to guide service delivery.</p> <p>Programs are not expected to adhere to this standard until a list of approved curricula is provided by HFA.</p> | <p>75% of families receive at least 75% of the appropriate number of home visits based upon the individual level of services to which they are assigned.</p> | <p>📁 Case Notes</p>                                 |
|   |   | <p>Programs submit the name of their chosen curriculum in their Program Abstract for Ounce approval.</p>   | <p>📁 Program Abstract<br/>📁 Program Narrative</p>   |
| <p>HV3 - Home Visits are parent-child focused, and responsive to the health and development needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship.<br/><br/><i>(BPS 6-3.A., 6-3.B Sentinel Standard, 6-4.A, 6-4.B)</i></p> | <p>A - Programs routinely address and promote positive parent-child interaction, attachment and bonding, and the development of nurturing parent-child relationships.</p>                             |  | <p>📁 Case Notes<br/>📁 Supervisory Documentation</p> |
|   | <p>B – Home visitors routinely assess, address, and promote positive child interaction, attachment, and bonding with all families, utilizing CHEEERS on all home visits.</p>                          |  | <p>📁 Case Notes<br/>📁 Supervisory Documentation</p> |








| Principle   | Practice  | Benchmark  | Documentation<br> Hard Copy Files   |
|-------------|---|--|--|
| (BPS 6-4.C) | C - Programs have policies and procedures for strengthening families by addressing challenging issues such as substance abuse, intimate partner violence, developmental delays in parents, and mental health concerns. Practices indicate that the policies are being implemented.                            |  |  Case Notes<br> Policy & Procedure Manual<br> Supervisory Documentation |
|             | D - Programs utilize home safety checklists with families on a routine basis.   | Home safety checklists are implemented with families within 45 days of the first completed home visit. Home Visitors are encouraged to use the checklists more frequently if needed to address concerns with families.   |  Case Notes<br> Participant Files  |
|             | E - Home Visitors discuss the risks of smoking and provide smoking cessation information to participants who smoke. Materials may also be provided to family members who smoke, if interested.  |  |  Case Notes   |
|             | F - Home Visitors discuss the risks of alcohol use during pregnancy and provide materials about alcohol and pregnancy to participants as needed.  |  |  Case Notes   |
|             | G - Home Visitors plan and structure each visit to enable parents to understand their child's stages of development, develop age-appropriate expectations, develop successful communication and enjoyable interaction with their child, and develop parental interest and pride in their child's development. | 90% of participants complete a maternal efficacy questionnaire within 30 days of the first home visit and every six months thereafter during program enrollment. Programs are only expected to implement maternal efficacy questionnaires for the target child. Programs that receive MIECHV <b>only</b> funding from the Ounce are not required to implement the maternal efficacy questionnaire. |  Case Notes<br> Participant Files  |

| Principle   | Practice   | Benchmark   | Documentation<br> Hard Copy Files  |
|---|--|---|---|
| <p>HV3 - Home Visits are parent-child focused, and responsive to the health and development needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship.</p> <p><i>(BPS 6-6.B Sentinel Standard)</i></p> | <p>H - Home Visitors encourage parents to read to their children.</p>  |   |  Case Notes<br> Program Narrative                 |
|   | <p>I - Home Visitors share information about the benefits of breastfeeding and about risks of HIV transmission via breastfeeding.</p>  | <p>Home Visitors document discussions with participants about breastfeeding in case notes.</p>                            |  Case Notes  |
|   |  | <p>75% of participants initiate breastfeeding.</p>  |  Child Intake  |
|   | <p>J - Home Visitors use medically accurate materials in discussing HIV with participants.</p>   |   |  Case Notes<br> Participant Files                 |
|   | <p>K - Home Visitors use universal precautions during work with infants and toddlers.</p>  |   |  Supervisory Documentation<br> Team Meeting Notes |
|   | <p>L - All participating children, up to age six, receive developmental screening at the following ages: three, six, nine, and 12 months, and every six months from age one through six. Programs emphasize parental involvement in the screening process.</p> | <p>95% of children have two documented screenings for developmental delay in the first year of life.</p>                  |  Participant Files   |
|   |  | <p>95% of children have one documented screening for developmental delay in the second year of life.</p>                  |  Participant Files   |
|   |  | <p>96% of enrolled children will have one documented screening for developmental delay during the third year of life.</p> |  Participant Files   |
|   |  | <p>90% of children are up-to-date with expected developmental screenings.</p>   |  Participant Files   |










| Principle  | Practice   | Benchmark   | Documentation<br>📁 Hard Copy Files  |
|--|--|---|---|
| <p>HV3 - Home Visits are parent-child focused, and responsive to the health and development needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship.</p>  | <p>M - Programs track children who are suspected of having a developmental delay, follow through with appropriate referrals, and follow up to determine if services were received.</p>   | <p>Programs follow up on 85% of referrals related to suspected developmental delays to determine if services were received.</p>   | <p>📁 Case Notes<br/>📁 Participant Files<br/>📁 Supervisory Documentation</p> |
|  | <p>N - Community-Based FANA (FANA) trained Home Visitors engage pregnant participants in the prenatal FANA activities designed for their infant’s gestational age, and engage postpartum participants in postnatal FANA activities during their infant’s first month of life.</p> <p>Programs that <b>only</b> receive MIECHV funding from the Ounce are not required to implement FANA.</p> | <p>Home Visitors implement prenatal FANA activities a minimum of every other week during the last trimester of pregnancy and engage postpartum participants in postnatal FANA activities at least once within the baby’s first month of life.</p> | <p>📁 Case Notes<br/>📁 Program Narrative</p>                                 |
|  | <p>O - Home Visitors fully complete written documentation of Home Visits within 72 hours of each visit, and complete related data entry within one week of the Home Visit.</p>   |   | <p>📁 Case Notes<br/>📁 Program Narrative<br/>📁 Supervisory Documentation</p> |
| <p>HV4 - In a manner respectful of each participant’s cultural and religious beliefs, Home Visitors engage participants in discussions around the potential impact of subsequent births with the goal of supporting participants in making informed and intentional decisions.</p> | <p>A - Home Visitors provide all participants with information and support regarding delay of subsequent births, effective family planning, including birth control and abstinence (as the only 100% protection from risk), and protection from STIs, including HIV/AIDS, using medically accurate curricula and materials.</p>  | <p>80% of participants delay subsequent birth during program involvement.</p> <p>(delay = 2 year interval between births)</p> <p>This benchmark does not apply to programs that receive MIECHV <b>only</b> funding from the Ounce.</p>            | <p>📁 Case Notes</p>   |













| Principle  | Practice   | Benchmark  | Documentation<br>Hard Copy Files        |
|--|--|--|---|
| <p>HV4 - In a manner respectful of each participant’s cultural and religious beliefs, Home Visitors engage participants in discussions around the potential impact of subsequent births with the goal of supporting participants in making informed and intentional decisions.</p> | <p>B - Home Visitors update participant information on contraceptive use at a minimum of every six months.</p>   | <p>100% of participants have contraception information updated in OunceNet at a minimum of every six months.</p>   | <p>Participant Files</p>                |
| <p>HV5 - Home Visitors build and sustain relationships with participating teens and their children that promote health, self-sufficiency, development of a social support network, and responsible decision-making.<br/><i>(BPS 7-1.B, 7-2.B)</i></p>                              | <p>A - Home Visitors assist and support teens to return to school and obtain safe, high-quality childcare.</p>   | <p>75% of participants who should be enrolled in high school or equivalent educational services are enrolled during the course of program involvement. This benchmark does not apply to programs that receive MIECHV <b>only</b> funding from the Ounce.</p> | <p>Case Notes<br/>Participant Files</p> |
|  |  | <p>100% of participants have education status information updated in OunceNet a minimum of every six months.</p>   | <p>Participant Files</p>                |
|  | <p>B - Home Visitors link participating children and parents to a medical provider for routine health care, well-child care, and timely immunizations.</p> | <p>96% of target children have completed the 3-2-2 immunization series by age 12 months.</p>   | <p>Participant Files</p>                |
|  |  | <p>90% of target children have completed the 4-3-3-1 immunization series by age 24 months.</p>   | <p>Participant Files</p>                |
|  |  | <p>98% of target children have two well-child visits in the first year of life (by age 12 months).</p>   | <p>Participant Files</p>                |
|  |  | <p>97% of target children have one well-child visit in the second year of life (by age 24 months).</p>   | <p>Participant Files</p>                |
|  |  | <p>90% of target children have one well-child visit in the third year of life (by age 36 months).</p>  | <p>Participant Files</p>                |

| Principle   | Practice   | Benchmark   | Documentation<br> Hard Copy Files  |
|---|--|---|---|
| <p>HV5 - Home Visitors build and sustain relationships with participating teens and their children that promote health, self-sufficiency, development of a social support network, and responsible decision-making.</p> | <p>B - Home Visitors link participating children and parents to a medical provider for routine health care, well-child care, and timely immunizations.</p>   | <p>90% of target children are up-to-date with immunizations and well-child visits.</p>  | <p> Participant Files</p>  |
|   |  | <p>92% of target children have a documented primary care provider.</p>  | <p> Participant Files</p>  |
| <p>HV6 - Programs conduct Home Visits in a manner that supports the successful completion of personal and program goals as described in the Family Goal Plan. (BPS 6-2.B, 6-2.C) 2-2.A</p>                              | <p>A - Home Visitors develop a Family Goal Plan with each participant within 45 days of the first completed Home Visit, and every six months thereafter. Home Visitors and parents review and update the plans on a regular basis. The plans accurately reflect the progress of each family toward the completion of their goals and address parent and child needs, strengths, capacities, and challenges. Home Visitors structure both the plan and Home Visits to support the parent's strengths.</p> | <p>90% of participant files contain up-to-date Family Goal Plans.</p>   | <p> Participant Files</p>  |
|   | <p>B - Home Visitors address issues identified in the initial assessment in Home Visits.</p>   | <p>Site has policy and procedure regarding the following: assessment criteria and documentation of assessment narratives that assess for the presence of factors that could contribute to increased risk factors for child maltreatment or other adverse childhood experiences. The policy and procedure identify who completes the narrative and the timeframe for completion.</p> | <p> Case Notes<br/>  Participant Files<br/>  Supervisory Documentation</p> |












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| HV6 - Programs conduct Home Visits in a manner that supports the successful completion of personal and program goals as described in the Family Goal Plan. | C - Home Visitors update participant outcome information related to employment, medical home, transience, and WIC status in OunceNet at a minimum of every six months.  | Home Visitors update 100% of participant outcome information in OunceNet at a minimum of every six months.   | 📁 Participant Files  |
|  | D - Home Visitors update child outcome information related to childcare and father involvement in OunceNet at a minimum of every six months.  | Home Visitors update 100% of child outcome information in OunceNet at a minimum of every six months. This standard applies to the target child only. Home Visitors do not need to track this data on non-target children.  | 📁 Participant Files  |
|  | E - Home Visitors update questions regarding the participants' level of engagement and the Home Visitor's level of concern about the participant at six-month intervals.  | Home Visitors update 100% of participant patterns every six months.  | 📁 Participant Files  |
|  | F - Home Visitors update child feeding information in OunceNet according to the following schedule: at birth, six weeks, six months, and one year. For participants who are breastfeeding after one year, Home Visitors update child feeding information at 18 months and two years, if applicable. | 100% of children have up-to-date feeding information in OunceNet. This standard applies to the target child and any subsequent children.   | 📁 Participant Files  |
| HV7 - Programs provide Home Visits in a manner that respects the family and cultural values of each participant.   | A - Programs offer services on a voluntary basis, using positive and persistent outreach efforts to build family trust and retain overburdened families in the program.   |  | 📁 Case Notes<br>📁 Participant Files<br>📁 Staffing Notes<br>📁 Supervisory Documentation |
|  | B - Home Visitors and Supervisors encourage the support and involvement of fathers, grandparents, and other primary caregivers.   | Case notes and other program documentation reflect the program's encouragement of and support for the involvement of fathers and other family members. This includes documentation of all family members participating in Home Visits and efforts made to engage the father. | 📁 Case Notes<br>📁 Supervisory Documentation  |












| Principle   | Practice  | Benchmark   | Documentation<br> Hard Copy Files   |
|---|---|---|--|
| <p>HV7 - Programs provide Home Visits in a manner that respects the family and cultural values of each participant.</p>   | <p>C - Programs select and implement materials and curricula in a way that builds upon strengths inherent to each family’s cultural beliefs. The program’s materials reflect the language, ethnicity, and customs of the families served.</p> | <p>Programs identify at least one home visiting curriculum in their Program Abstract. Home Visitors document the use of this curriculum in case notes.</p>  | <ul style="list-style-type: none"> <li> Program Abstract</li> <li> Program Narrative</li> </ul>  |
| <p>HV8 - Programs utilize reflective practice and Infant Mental Health strategies to promote parent-child relationships and strengthen parenting practices.</p> <p>Programs that receive MIECHV <b>only</b> funding from the Ounce are not required to participate in DTSP.</p> | <p>A - Developmental Training and Support Program (DTSP) trained Home Visitors utilize home videos of routine activities, observation, inquiry, and reflection as key intervention strategies during Home Visits.</p>                         | <p>DTSP trained Home Visitors videotape 75% of their participants at least twice per year.</p>  | <ul style="list-style-type: none"> <li> Case Notes</li> </ul>   |
|   | <p>B - Home Visitors use the Parent/Child Observation Guide (PCOG) or Mutual Competency Grid (MCG) to review videos internally as part of staff development and participant service planning.</p>   | <p>Home Visitors document subsequent discussions of videos using the PCOG or MCG in case notes for videotaped families.</p>   | <ul style="list-style-type: none"> <li> Participant Files</li> </ul>  |
|   |   | <p>Home Visitors and Supervisors review videotapes of families within the program as part of staff development or service planning. Home Visitors and Supervisors document this review accordingly.</p> | <ul style="list-style-type: none"> <li> Participant Files</li> <li> Supervisory Documentation</li> <li> Team Meeting Notes</li> </ul> |
|   | <p>C - Programs keep signed videotaping consent forms on file and use videos only for the stated purpose.</p>   |   | <ul style="list-style-type: none"> <li> Participant Files</li> </ul>  |

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|--|---|---|---|
|  | D - Home Visitors incorporate issues raised or discussed in review of the tapes (including the PCOG or MCG) into the Family Goal Plan.  |   |  Family Goal Plan<br> Staffing Notes<br> Supervisory Documentation   |
| <p>HV9 - Due to the high incidence of depression among the population served by IBTI programs, and because maternal depression can significantly impair the parent-child relationship, programs make efforts to identify maternal depression as early as possible and to help depressed participants access services.<br/>(BPS 7-5A.)</p> <p>Programs that receive MIECHV <b>only</b> funding from the Ounce are not required to implement maternal depression screenings.</p> | A - Programs have policies and procedures for administration of a standardized depression screen/tool that specify how and when the tool is to be used with all families participating in the program and assure that all staff who administer the tools are fully trained. |   |  Policy and Procedure Manual   |
|  | B - Referral and follow-up on referrals occurs for mothers whose depression screening scores are elevated and considered to be at-risk of depression, based on the tool's scoring criteria, unless already involved in treatment.   |   |  Case Notes<br> Participant Files<br> Policy and Procedure Manual<br> Supervisory Documentation |
|  | C - Programs administering the Edinburgh Postpartum Depression Scale to participants enter the results of these scales into OunceNet.   | Unless programs reach another agreement with IBTI, Home Visitors screen 100% of consenting active participants prenatally and twice postpartum (at 4-6 weeks and 6 months). |  Participant Files   |

# PTS-HFI Best Practice Standards







## Doula

| Principle   | Practice  | Benchmark  | Documentation<br> Hard Copy Files   |   |
|---|---|--|--|---|
| D1 - Programs are more likely to recruit and retain long-term participants when they initiate services prenatally or immediately after birth in order to form a trusting connection with new parents, and establish the program as a source of support and information. | Programs initiate Doula services at the beginning of the third trimester of pregnancy.  | Programs enroll 80% of Doula participants by the seventh month of pregnancy.     |  Participant Files<br> Program Narrative |   |
| D2 - Doula Home Visits are of sufficient intensity to impact program outcomes.  | Doula Home Visits last between 1.0 and 1.5 hours.   | 80% of Doula Home Visits last between 1.0 and 1.5 hours.                         |  Case Notes   |   |
| D3 - Doula Home Visits are parent-child focused and responsive to the health and developmental needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship.  | A - Doulas plan and structure each visit to enable parents to understand each stage of prenatal development, understand and develop enjoyable prenatal and postpartum interaction with their child, and develop parental interest in their child's development. |  |  Case Notes<br> Participant Files        |   |
|   | B - Doulas share information about the benefits of breastfeeding and about risks of HIV transmission via breastfeeding, using medically accurate materials.   | Doulas document discussions with participants about breastfeeding in case notes. |  |  Case Notes  |
|   |   | 75% of participants initiate breastfeeding.                                      |  |  Participant Files   |
|   | C - Doulas use universal precautions in work with infants and toddlers.   |  |  |  Supervisory Documentation<br> Team Meeting Notes |
|   | D - Doulas discuss the risks of smoking during pregnancy and provide smoking cessation materials to participants who smoke. Materials may also be provided to family members, if interested.  |  |  |  Case Notes  |

| Principle   | Practice   | Benchmark   | Documentation<br> Hard Copy Files   |
|---|--|---|--|
| <p>D3 - Doula Home Visits are parent-child focused, and responsive to the health and developmental needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship.</p>  | <p>E - Doulas discuss the risks of alcohol use during pregnancy, and provide materials about alcohol and pregnancy to participants as needed.</p>  |   |  Case Notes   |
|   | <p>F - Community-Based FANA (FANA) trained Doulas engage pregnant participants in the prenatal FANA activities designed for their infant's gestational age, and engage postpartum participants in postnatal FANA activities during their infant's first month of life.</p>   | <p>Doulas implement prenatal FANA activities a minimum of every other week during the last trimester of pregnancy, and engage postpartum participants in postnatal FANA activities at least once within the baby's first month of life.</p> |  Case Notes<br> Program Narrative  |
|   |  | <p>Doulas attend FANA training and complete FANA certification within one year of hire.</p>   |  Supervisory Documentation<br> Training Records  |
|   | <p>G - Doulas fully complete written documentation of Doula Home Visits within 72 hours of each visit and complete related data entry within one week of the visit.</p>  |   |  Case Notes<br> Program Narrative<br> Supervisory Documentation |
| <p>D4 - In a manner respectful of each participant's cultural and religious beliefs, Home Visitors engage participants in discussions around the potential impact of subsequent births with the goal of supporting participants in making informed and intentional decisions.</p> | <p>Doulas provide all participants with information and support regarding the delay of subsequent births, effective family planning, including birth control and abstinence (as the only 100% protection from risk), and protection from STIs, including HIV/AIDS, using medically accurate curricula and materials.</p> |   |  Case Notes   |
| <p>D5 - Programs conduct Doula Home Visits in a manner that supports the successful completion of personal and program goals as described in the birth plan.</p>  | <p>Doulas develop a birth plan with each participant. This plan may serve as the participants' first Family Goal Plan.</p>   | <p>90% of Doula participants have an up-to-date birth plan.</p>   |  Participant Files  |












| Principle   | Practice  | Benchmark   | Documentation<br>📁 Hard Copy Files  |
|---|---|---|---|
| D6 - Programs conduct Doula Home Visits in a manner that supports the successful completion of personal and program goals as described in the birth plan.   | Doulas update child feeding information in OunceNet at birth and at six weeks.  | 100% of children have up-to-date feeding information in OunceNet. This standard applies to the target child and any subsequent children.  | 📁 Participant Files   |
| D7 - Programs provide Doula Home Visits in a manner that respects the family and cultural values of each participant.   | A - Programs offer Doula services on a voluntary basis, using positive and persistent outreach efforts to build family trust, and retain overburdened families in the program.  |   | 📁 Case Notes<br>📁 Participant Files<br>📁 Program Narrative<br>📁 Staffing Notes<br>📁 Supervisory Documentation |
|   | B - Doulas encourage the support and involvement of fathers, grandparents, and other primary caregivers.  | Case notes and other program documentation reflect the Doula's encouragement of and support for the involvement of fathers and other family members. This includes documentation of all family members participating in Doula Home Visits, who is at the birth, and any efforts the Doula makes to engage the father. | 📁 Case Notes<br>📁 Supervisory Documentation   |
|   | C - Doula programs select and implement materials and curricula in a way that builds upon strengths inherent to each family's cultural beliefs. The program materials reflect the language, ethnicity, and customs of the families served.      |   | 📁 Program Abstract<br>📁 Program Narrative   |
| D8 - Doulas provide intensive, specialized services in order to improve the perinatal health of mother and baby, support parent-child attachment, and improve the family's social-emotional experience of labor and delivery. | During the last trimester of pregnancy, program participants receive additional direct services provided through the Doula program. These include prenatal education support, advocacy with medical providers, and preparation of a birth plan. | Doulas complete 80% of Doula Home Visits at the contracted level.   | 📁 Case Notes<br>📁 Program Abstract<br>📁 Program Narrative   |



| <b>Principle</b>   |   | <b>Practice</b>   | <b>Benchmark</b>  | <b>Documentation</b> |
|--|---|---|---|----------------------|
| <p>D9 - Doulas provide intensive, specialized services in order to improve the perinatal health of mother and baby, support parent-child attachment, and improve the family's social-emotional experience of labor and delivery.</p>                   | <p>A - Doula support and advocacy includes 24-hour availability for attendance during labor and delivery. Doulas provide continuous support from the point of active labor through recovery, with respect to agency policy, backup procedures, and the overall well-being of both the mother and the Doula.</p> | <p>75% of Doula participants have a Doula-attended birth.</p> | <p> <b>Hard Copy Files</b></p> <p> Participant Files</p> <p> Program Narrative</p> |                      |
|  | <p>B - Doula programs have established written protocols that outline procedures when Doulas go to the hospital, when Doulas call and utilize backup, and what communication is expected between the Doula and the Doula Supervisor while the Doula is at the birth.</p>  |   | <p> Program Files</p>  |                      |
| <p>D10 - Doula services provide a supportive relationship that addresses the emotional work of the adolescent's emerging role as mother and her developing attachment to her child. Doula services nurture the mother so she can nurture the baby.</p> | <p>Doulas support the young parent's self-determination while encouraging prenatal care, initiation of breastfeeding while promoting emotional availability and engagement with her developing newborn.</p>   |   | <p> Case Notes</p> <p> Participant Files</p>   |                      |

# PTS-HFI Best Practice Standards

## Prenatal Groups












| Principle  | Practice  | Benchmark  | Documentation<br> Hard Copy Files   |
|--|---|--|--|
| <p>PRE1 - Prenatal Group sessions challenge thinking and emphasize decision making about issues that affect the relationship between the parent and their unborn child. Prenatal Group activities provide opportunities for positive peer interaction.</p> | <p>A - A portion of the Prenatal Group session focuses on the sharing of experiences and ideas of group members.</p>  |  |  Group Plans  |
|  | <p>B - A wide variety of activities and approaches is encouraged to bridge the range of learning and social skills of group members (i.e., games, videos, role-playing, guest speakers, recreational events, and community service projects).</p> | <p>Prenatal Group documentation reflects the activities and approaches used in Prenatal Group sessions.</p>                |  Group Plans  |
|  | <p>C - Curricula and other materials used in Prenatal Group should be culturally competent and focused on common prenatal issues (programs must discuss the use of supplemental non-prenatal focused curricula with IBTI Program Advisor).</p>    | <p>Prenatal Group macro and micro plans identify the topics, curricula, and materials used in Prenatal Group sessions.</p> |  Group Plans<br> Program Abstract<br> Program Narrative   |
|  | <p>D - Planning of Prenatal Group sessions reflects the input of participants, site staff, and birth plans.</p>   |  |  Group Evaluations<br> Group Plans<br> Team Meeting Notes |
|  | <p>E - Staff members use group meeting records, informal feedback, parent evaluations, and their own observations to improve Prenatal Group sessions.</p>   |  |  Process Notes<br> Supervisory Documentation   |

| Principle   | Practice  | Benchmark  | Documentation<br>📁 Hard Copy Files                                    |
|---|---|--|---|
| <p>PRE2 - Prenatal Groups enhance the intensity and focus of Home Visits with pregnant participants by promoting integration of services. Through integration, these interventions offer more intense and diverse services that increase the chance of achieving IBTI desired outcomes.</p> | <p>A - Prenatal Group facilitators provide all participants with information and support regarding nutrition, the female reproductive system, the process of normal labor, routine hospital practices, basic newborn care, normal newborn behaviors, feeding methods including breastfeeding and formula preparation, and the normal physiological changes of the immediate postnatal period.</p> |  | <p>📁 Group Plans<br/>📁 Quarterly Narrative – Group Topic Calendar</p> |
|   | <p>B - Prenatal Group facilitators cover the risks of HIV transmission through breastfeeding, using medically accurate materials.</p>   |  | <p>📁 Group Plans<br/>📁 Quarterly Narrative – Group Topic Calendar</p> |
|   | <p>C - Prenatal Group facilitators encourage participants to identify a medical home for their child and share information regarding well-child care and immunizations.</p>   |  | <p>📁 Group Plans<br/>📁 Quarterly Narrative – Group Topic Calendar</p> |
|   | <p>D - Prenatal Group facilitators encourage and support teens to return to school and provide information on identifying safe, high-quality childcare.</p>   |  | <p>📁 Group Plans<br/>📁 Quarterly Narrative – Group Topic Calendar</p> |
| <p>PRE3 - Prenatal Groups promote prenatal attachment and bonding by promoting and facilitating a healthy relationship between mother and unborn child, thus helping the parent develop emotional availability for the baby.</p>  | <p>A part of each Prenatal Group meeting has activities that encourage connections and positive interactions between the parent and unborn child.</p>   | <p>Each Prenatal Group session has a documented parent-child activity.</p> | <p>📁 Group Plans</p>  |


















| Principle  | Practice   | Benchmark  | Documentation<br>📁 Hard Copy Files   |
|--|--|--|--|
| <p>PRE4 - Prenatal Groups are an ongoing service strategy. The duration of the group is long enough to sustain relationships that promote trust and goal attainment.</p>       | <p>A - Prenatal Group membership and facilitators are as consistent as possible.</p>   |  | <ul style="list-style-type: none"> <li>📁 Program Abstract</li> <li>📁 Group Plans</li> </ul>  |
|  | <p>B - Each Prenatal Group meets for a minimum of 1 ½ hours as part of a six-to-eight week session.</p>  |  | <ul style="list-style-type: none"> <li>📁 Program Abstract</li> <li>📁 Group Plans</li> </ul>  |
|  | <p>C - Programs hold a minimum of 24 Prenatal Group sessions during the fiscal year.</p>   | <p>Programs hold 90% of planned Prenatal Group sessions.</p> | <ul style="list-style-type: none"> <li>📁 Program Abstract</li> <li>📁 Quarterly Narrative – Group Topic Calendar</li> </ul>                                   |
|  | <p>D - Prenatal Group documentation includes micro plans, attendance, and process notes for each session.</p>  |  | <ul style="list-style-type: none"> <li>📁 Group Plans</li> </ul>  |
|  | <p>E - Individuals responsible for planning Prenatal Groups submit macro plans on a quarterly basis to their IBTI Program Advisor.</p>   |  | <ul style="list-style-type: none"> <li>📁 Macro Plans</li> </ul>  |
|  | <p>F - Prenatal Group arrangements include a nutritious meal or snack.</p>   |  | <ul style="list-style-type: none"> <li>📁 Program Abstract</li> <li>📁 Group Plans</li> </ul>  |
|  | <p>G - Programs complete a written evaluation plan for Prenatal Group services that includes a procedure for gathering feedback from Group participants.</p>                                       |  | <ul style="list-style-type: none"> <li>📁 Group Evaluations</li> <li>📁 Group Plans</li> <li>📁 Policy and Procedure Manual</li> <li>📁 Process Notes</li> </ul> |
| <p>PRE5 - Prenatal Groups enable pregnant women, their partners, and families to achieve a healthy pregnancy, optimal birth outcome, and positive adaptation to parenting.</p> | <p>These groups promote transition to ongoing program services such as Home Visiting and Parent Groups for both enrolled participants and those not yet actively enrolled in the IBTI program.</p> |  | <ul style="list-style-type: none"> <li>📁 Group Plans</li> </ul>  |

# PTS-HFI Best Practice Standards

## Parent Groups\*

| Principle   | Practice  | Benchmark  | Documentation<br> Hard Copy Files   |
|---|---|--|--|
| <p>PAR1 - Parent Group sessions challenge thinking and emphasize decision making about issues that affect the relationship between parent and child. Parent Group activities provide opportunities for positive peer interaction.</p>                           | <p>A - A portion of the Parent Group session focuses on the sharing of experiences and ideas of group members about various topics, such as parenting, family planning, health care, career exploration, education, housing, and childcare.</p>   |  |  Group Plans  |
|   | <p>B - A wide variety of activities and approaches are encouraged to bridge the range of learning and social skills of group members (i.e., games, videos, role-playing, guest speakers, recreational events, and community service projects).</p>  | <p>Parent Group plans reflect activities and approaches used in Parent Group sessions.</p>         |  Group Plans  |
|   | <p>C - Topics, curricula, and other materials used in Parent Group sessions are culturally competent and focused on parenting issues (programs must discuss use of supplemental non-parenting focused curricula with the IBTI Program Advisor).</p>   | <p>Parent Group plans identify topics, curricula, and materials used in Parent Group sessions.</p> |  Group Plans<br> Program Abstract<br> Program Narrative   |
|   | <p>D - Planning of Parent Group sessions reflects the input of participants, site staff, and Family Goal Plans.</p>   |  |  Group Evaluations<br> Group Plans<br> Team Meeting Notes |
| <p>PAR2 - Parent Groups enhance the intensity and focus of the Home Visits with pregnant and parenting teens. Through integration, these interventions offer more intense and diverse services that increase the chance of achieving IBTI desired outcomes.</p> | <p>A - Parent Group facilitators provide all participants with information and support regarding the delay of subsequent births, effective family planning, including abstinence, (as the only 100% protection from risk) birth control, and protection from STIs, including HIV/AIDS. Curricula and materials used are medically accurate.</p> |  |  Group Plans<br> Quarterly Narrative – Group Topic Calendar  |

| Principle   | Practice   | Benchmark   | Documentation<br>📁 Hard Copy Files                                   |
|---|--|---|--|
| <p>PAR2 - Parent Groups enhance the intensity and focus of the Home Visits with pregnant and parenting teens. Through integration, these interventions offer more intense and diverse services that increase the chance of achieving IBTI desired outcomes.</p> | <p>B - Parent Group facilitators encourage participants to maintain a medical home for their child and follow up on routine well-child care and immunizations.</p>                   |   | <p>📁 Group Plans<br/>📁 Quarterly Narrative: Group Topic Calendar</p> |
|   | <p>C - Parent Group facilitators encourage and support teens to return to school and obtain safe, high-quality childcare.</p>  |   | <p>📁 Group Plans<br/>📁 Quarterly Narrative: Group Topic Calendar</p> |
|   | <p>D - Parent Group facilitators provide information on unintentional injury prevention, including Shaken Baby Syndrome, home safety, and poison prevention.</p>                     |   | <p>📁 Group Plans<br/>📁 Quarterly Narrative: Group Topic Calendar</p> |
|   | <p>E - Home Visiting participants are the primary target audience of IBTI Parent Group Services.</p>   | <p>100% of Parent Group participants are actively engaged in Home Visits.</p>   | <p>📁 Group Roster<br/>📁 Participant Files<br/>📁 Staffing Notes</p>   |
| <p>PAR3 - Parent Groups are parent-child focused, as well as responsive to the parent and child's developmental and environmental needs.</p>  | <p>A - A part of each Parent Group meeting has activities that encourage successful communication and enjoyable interaction between parent and child, and between group members.</p> | <p>Each Parent Group session has a documented parent-child activity.</p>  | <p>📁 Group Plans</p>   |
|   | <p>B - A portion of the meeting allows parents to meet apart from children.</p>  |   | <p>📁 Group Plans</p>   |
|   | <p>C - Childcare arrangements ensure safety and consistency in caregivers. Programs must provide adequate screening and supervision of childcare providers.</p>                      | <p>Programs screen 100% of childcare providers in the same manner as paid staff. This includes all legally permissible background checks, criminal history records, and civil child abuse and neglect registries.</p> | <p>📁 Group Plans<br/>📁 Program Narrative</p>                         |
| <p>PAR4 - Parent Groups are an ongoing service strategy. The duration of the group must be long enough to sustain relationships that promote trust and goal attainment.</p>   | <p>A - Each Parent Group must meet a minimum of forty times per fiscal year, optimally on a weekly basis.</p>  | <p>Programs hold 90% of planned Parent Group sessions.</p>  | <p>📁 Program Abstract</p>  |

| Principle   | Practice  | Benchmark   | Documentation<br> Hard Copy Files   |
|---|---|---|--|
| <p>PAR4 - Parent Groups are an ongoing service strategy. The duration of the group must be long enough to sustain relationships that promote trust and goal attainment.</p> | <p>B - Parent Group membership and facilitators are consistent.</p>   | <p>Parent Group participants are required to attend 75% of Parent Group sessions.</p>   |  Group Plans<br> Program Abstract  |
|   | <p>C - Parent Group plans address content areas in-depth over several weeks through various topics.</p>   |   |  Group Plans<br> Quarterly Narrative – Group Topic Calendar  |
|   | <p>D - Parent Group Service Coordinators submit 10-week macro plans on a quarterly basis to their IBTI Program Advisor.</p>                                       |   |  Macro Plans  |
|   | <p>E - Parent Group documentation includes group micro plans, attendance, and post-group process notes for each session.</p>                                      |   |  Group Plans  |
|   | <p>F - Optimal Parent Group size is six to twelve participants.</p>   | <p>Each Parent Group maintains an average attendance of at least five participants.</p>   |  Program Abstract   |
|   | <p>G - Parent Group arrangements include a nutritious meal or snack and transportation to and from group.</p>   |   |  Group Plans<br> Program Abstract<br> Program Narrative   |
|   | <p>H - Programs complete a written evaluation plan for Parent Group services that includes a procedure for gathering feedback from Parent Group participants.</p> |   |  Group Evaluations<br> Group Plans<br> Policy and Procedure Manual<br> Process Notes |
|   | <p>I - Staff members use Parent Group meeting records, informal feedback, parent evaluations, and their own observations to improve Parent Group sessions.</p>    |   |  Process Notes<br> Supervisory Documentation   |
|   | <p>PAR5 - Programs provide Parent Groups in consideration of, and as a support to each participant’s family and cultural values.</p>                              | <p>A - Parent Groups provide support for the involvement of fathers, other primary caregivers, and extended family members (i.e., periodic family nights, grandparent events, and fathers’ nights).</p> |  |

| Principle   | Practice  | Benchmark   | Documentation<br>📁 Hard Copy Files  |
|---|---|---|---|
| PAR5 - Programs provide Parent Groups in consideration of, and as a support to each participant's family and cultural values.   | B - It is optimal that staff members (volunteer and paid) reflect the cultural values and strengths of the participants' community.   |   | 📁 Program Files   |
| PAR6 - All other Parent Groups maintain a primary focus on parenting and target achievement of one or more of the IBTI program goals. These groups are time-limited, and target a specific population other than first-time pregnant and parenting teens. Examples include but are not limited to prenatal groups, school-based groups for pregnant and parenting teens, play groups, co-parenting teen couples' groups, grandparent groups, and father's groups. | A - Other Parent Groups provide a variety of activities for participants prior to and with the goal of formal enrollment in the IBTI program.   |   | <ul style="list-style-type: none"> <li>📁 Group Plans</li> <li>📁 Program Abstract</li> <li>📁 Program Narrative</li> <li>📁 Quarterly Narrative Report – Group Topic Calendar</li> </ul> |
|   | B - Other Parent Groups enhance current group services for enrolled participants or these groups may support or enhance those directly involved with a current participant and child actively enrolled in the IBTI program. |   | <ul style="list-style-type: none"> <li>📁 Group Plans</li> <li>📁 Program Abstract</li> <li>📁 Program Narrative</li> <li>📁 Quarterly Narrative Report – Group Topic Calendar</li> </ul> |
| PAR7 - The specialized curriculum known as Heart to Heart is an enhancement to Parent Groups that focuses on child sexual abuse prevention and enhancement of parent-child relationships.   | A - Programs implement Heart to Heart in one ongoing Parent Group during the fiscal year if indicated in the Program Abstract. Programs may add additional Heart to Heart groups with Ounce approval.                       |   | <ul style="list-style-type: none"> <li>📁 Program Abstract</li> <li>📁 Program Narrative</li> </ul>   |
|   | B - Programs utilize Heart to Heart co-facilitators according to the program design.  | Programs identify two Heart to Heart co-facilitators in the Program Abstract. | <ul style="list-style-type: none"> <li>📁 Group Plans</li> <li>📁 Program Abstract</li> <li>📁 Training Records</li> </ul>   |
|   | C - In order to implement Heart to Heart in a manner that ensures cohesiveness and trust within the group, programs limit Heart to Heart enrollment.  | Programs enroll Heart to Heart participants by the third session.             | <ul style="list-style-type: none"> <li>📁 Group Roster</li> </ul>  |




















| Principle  | Practice  | Benchmark  | Documentation<br>Hard Copy Files   |
|--|---|--|--|
| <p>PAR7 - The specialized curriculum known as Heart to Heart is an enhancement to Parent Groups that focuses on child sexual abuse prevention and enhancement of parent-child relationships.</p> | <p>D - Programs plan and implement a Heart to Heart graduation ceremony as the group's closing activity.</p>  | <p>To be eligible to participate in the Heart to Heart graduation ceremony, participants cannot miss more than two sessions.</p>   | <p>Group Roster</p>  |
|  |   | <p>Heart to Heart trained Home Visitors can implement group sessions during Home Visits to allow Heart to Heart group members to participate in graduation. Programs cannot count this towards group attendance in OunceNet.</p> | <p>Case Notes</p>  |
|  | <p>E - Heart to Heart facilitators ensure the completion of a Community Service Project involving group participants and community residents or service providers as part of curriculum implementation.</p>   | <p>Programs document the Community Service Project in the Fourth Quarter Narrative Report.</p>   | <p>Group Plans<br/>Quarterly Narrative Report</p>                                |
|  | <p>F - Prior to Heart to Heart implementation, each program:</p> <ol style="list-style-type: none"> <li>1) Designates a clinical consultant to provide support for Heart to Heart facilitators during program implementation,</li> <li>2) Identifies clinical treatment resources (such as a sexual assault center) for participants who disclose abuse,</li> <li>3) Provides verification of an up-to-date child abuse reporting protocol</li> <li>4) Completes a Heart to Heart Support and Intervention Plan.</li> </ol> |  | <p>Child Abuse Reporting Protocol<br/>Program Abstract<br/>Program Narrative</p> |

\*Programs that receive MIECHV **only** funding from the Ounce are not required to adhere to these standards.

# PTS-HFI Best Practice Standards














## Infant Mental Health\*

| Principle   | Practice   | Benchmark | Documentation<br> Hard Copy Files   |
|---|--|-----------|--|
| <p>IMH1 - Infant Mental Health (IMH) services are relationship-focused interventions designed to strengthen, but not replace the core family support strategies of Home Visiting and Parent Groups.</p> | <p>A - Programs target IBTI participants for IMH services.</p>   |           |  Participant Files  |
|   | <p>B - Clinically trained, Masters level or above (LCPC, LCSW, PhD), practitioners provide IMH services. Programs provide access to professional-level supervision for IMH practitioners.</p>  |           |  Program Abstract<br> Program Narrative  |
|   | <p>C - Programs base IMH services on an assessment of individual and family needs, with a plan for duration and intensity of contact with the family. Programs also orient and integrate IMH services into the overall outcomes of the program. Not all participants will require clinical services.</p> |           |  Case Notes<br> Participant Files<br> Program Abstract<br> Program Narrative<br> Staffing Notes<br> Supervisory Documentation |
|   | <p>D - Programs offer IMH services in a variety of formats, and offer parents the opportunity to explore and reflect on thoughts and feelings that the presence of their baby awakens.</p>   |           |  Participant Files<br> Program Narrative<br> Quarterly Narrative Report   |
|   | <p>E - IMH services include consultation with program staff.</p>   |           |  Program Abstract<br> Program Narrative<br> Staffing Notes<br> Team Meeting Notes  |











\*Only programs that receive funds specifically for Infant Mental Health are required to adhere to these standards.

# PTS-HFI Best Practice Standards

## Program Structure & Governance










| Principle   | Practice   | Benchmark  | Documentation<br> Hard Copy Files  |  |
|---|--|--|---|--|
| SG1 - IBTI programs have the greatest chance of outcome achievement when services are of sufficient intensity, and linked to specific strengths, needs, and risk factors of the target group. | A - Programs clearly identify and define their target population and the planned intensity of services, including frequency and duration of contact.   | 100% of programs use the HFI level system to determine frequency of Home Visits.                     |  Program Abstract<br> Program Narrative |  |
|   | B - Programs use income guidelines to determine eligibility for program services.  | 100% of enrolled participants are below 185% of the Federal poverty level or receiving WIC services. |  Income Eligibility Documentation  |  |
|   | C - Short-term services such as community education, Prenatal Group, and Doula are offered to participants under the following conditions: <ul style="list-style-type: none"> <li>• Services enhance the program’s profile in the community as a collaborator and provider of specialized teen parent services.</li> <li>• Participants are teen parents.</li> <li>• No more than 20% of Doula participants receive short-term Doula services.</li> <li>• For short-term Doula Services, participants transition to ongoing family support or home visiting programs offered by community partners.</li> <li>• The majority of participants attending Prenatal Group have an active IBTI enrollment status.</li> </ul> |  |  Program Abstract  |  |
|   |  |  |   |  Program Abstract   |
|   |  |  | Programs enroll 80% of Doula participants in Home Visiting services.  |  Participant Files<br> Program Abstract<br> Program Narrative           |
|   |  |  |   |  Participant Files<br> Program Narrative<br> Quarterly Narrative Report |
|   |  |  |   |  Group Roster   |

| Principle  | Practice   | Benchmark  | Documentation<br>Hard Copy Files                       |
|--|--|--|--|
| <p>SG1 - IBTI programs have the greatest chance of outcome achievement when services are of sufficient intensity and linked to specific strengths, needs, and risk factors of the target group.</p>  | <p>D - Programs offer creative outreach under specified circumstances for a minimum of three months for each family before discontinuing services.</p>   |  | <p>Participant Files<br/>Supervisory Documentation</p> |
|  | <p>E - Programs comprehensively analyze, at least annually, acceptance and retention rates of participants. Programs also address how they might increase their acceptance rate based on the analysis of those refusing services in comparison to those accepting services. See Glossary of Terms (Section A8) for definitions of acceptance and retention rate.</p> | <p>100% of programs measure and analyze their acceptance and retention rates on an annual basis, and provide completed documentation of this analysis to the Ounce.</p>  | <p>Program Files</p>                                   |
|  | <p>F- Programs track trends and changes in their target population and adjust their program plans as indicated.</p>  | <p>100% of programs document trends or changes in their target population.</p>   | <p>Program Abstract<br/>Quarterly Narrative Report</p> |
|  | <p>G - Program funding and in-kind support (i.e., facility space) is sufficient to providing services to the target population.</p>  |  | <p>Program Budget<br/>Program Budget Narrative</p>     |
| <p>SG2 - The relationship between the staff person and the participant is primary to the delivery of quality services. The quality and intensity of that relationship affects the participant's initial engagement, ongoing participation, and retention in the program.<br/>(8-1.B)</p> | <p>A - Programs maintain full enrollment.</p>  | <p>Program enrollment is at least 85% of program capacity (see page 176 for details). Home Visitors with caseloads of 25 are at the maximum point capacity (i.e., 26 points) regardless of the actual point value of the caseload.</p> | <p>Program Abstract</p>                                |
|  | <p>B - In order to ensure staff capacity to develop meaningful relationships with participants and deliver quality services, no caseload for a full-time Home Visitor exceeds 25 participants, regardless of the point values of the caseload.</p>   | <p>100% of staff caseloads have 25 or fewer participants.</p>  | <p>Program Abstract</p>                                |

| Principle   | Practice  | Benchmark  | Documentation<br> Hard Copy Files   |
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| SG2 - The relationship between the staff person and the participant is primary to the delivery of quality services. The quality and intensity of that relationship affects the participant's initial engagement, ongoing participation, and retention in the program. | C - Parent Group Coordinators are responsible for group facilitation, session planning and implementation, record keeping, group arrangements, volunteer recruitment, orientation, training, and supervision.<br><br>This practice does not apply to programs that receive MIECHV <b>only</b> funding from the Ounce. | A ratio of .25 FTE per group is required.  |  Program Abstract   |
|   | D - Supervisors have relationships with participants and gather satisfaction surveys annually to ensure responsiveness to participant needs.  | Programs complete annual satisfaction surveys with a response rate of at least 25% of actively enrolled participants.<br><br>This benchmark does not apply to programs that receive MIECHV <b>only</b> funding from the Ounce. |  Program Files  |
| SG3 - Delivery of relationship-based services to participants and their children begins with the nature of the relationship between the staff in the program.<br><i>(12-1A, 12-1.B, 12-3.A)</i>   | A - Staff members receive ongoing training and regularly scheduled supervision. Staff members meet individually with a Supervisor on a weekly basis.  | Each staff member receives 46 individual supervisions per fiscal year.   |  Program Abstract<br> Program Narrative<br> Supervisory Documentation |
|   | B - Supervisors and Program Managers receive regular, on-going supervision which holds them accountable for the quality of their work, and provides them with skill development and professional support.   | Supervisors and Program Managers receive the level of supervision consistent with what is indicated in the Program Abstract.   |  Program Abstract<br> Program Files<br> Supervisory Documentation     |
|   | C - Doula programs ensure regular perinatal clinical support of Doulas and Doula Supervisors with face-to-face sessions that take place a minimum of once a month on site.  | Programs hold 75% of expected clinical support sessions.   |  Clinical Support Notes   |








| Principle  | Practice  | Benchmark   | Documentation<br>📁 Hard Copy Files  |
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| SG3 - Delivery of relationship-based services to participants and their children begins with the nature of the relationship between the staff in the program.<br><br><i>(BPS 12-1.D)</i>   | D - Programs base supervision on a process of reflection, stepping back from the work to explore the how's and why's of staff's actions and the impact of the work on that staff person.  |   | 📁 Supervisory Documentation   |
|  | E - Supervisors conduct observations of staff's direct work with families in Home Visits and Groups two times per year.   |   | 📁 Supervisory Documentation   |
|  | F - A minimum ratio of full-time supervisor to staff of 1:6 is expected. A ratio of 1:5 is optimal.   |   | 📁 Program Abstract  |
| SG4 - Programs have a Director to supervise staff, promote and provide for coordination of services across components, and build collaboration in the community. This coordination is necessary to maximize the use of program and community resources and to provide integrated services for pregnant and parenting teens and their children. | Programs have a 100% FTE Program Director. This person is responsible for program oversight (planning, implementation, and evaluation) and ensuring the coordination and integration of service components.<br><br>This practice does not apply to programs that receive MIECHV <b>only</b> funding from the Ounce. |   | 📁 Program Abstract  |
| SG5 - Where programs receive funding for Home Visiting and other services such as Groups, Doulas, or IMH, they integrate these services in a manner that allows participants to experience the unique benefits of each strategy and the combined effects of all.   | A - Home Visiting participants are the primary target audience of IBTI Group Services.<br><br>This practice does not apply to programs that receive MIECHV <b>only</b> funding from the Ounce.  | 100% of Parent Group participants are actively engaged in Home Visiting.  | 📁 Group Rosters<br>📁 Participant Files<br>📁 Staffing Notes<br>📁 Supervisory Documentation |
|  | B - Staff in all service components share information relevant to participants' progress in order to keep services responsive and promote continuity. Programs hold monthly team meetings to coordinate and integrate services to participants.   | Programs hold 75% of expected team meetings.<br><br>This benchmark does not apply to programs that receive MIECHV <b>only</b> funding from the Ounce. | 📁 Program Abstract<br>📁 Program Narrative<br>📁 Team Meeting Notes                         |




| Principle   | Practice  | Benchmark | Documentation<br>Hard Copy Files   |
|---|---|-----------|--|
| <p>SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards.</p> | <p>A - All staff members participate in the appropriate Healthy Families America training specific to their role within the program within six months of their date of hire.</p>  |           | <p>Supervisory Documentation<br/>Training Records</p>  |
|   | <p>B - Staff members have written staff development plans, and Supervisors plan to release staff from their duties to attend training that supports their work.</p>   |           | <p>Supervisory Documentation<br/>Training Records</p>  |
|   | <p>C - Staff members receive basic and ongoing training in key areas they encounter in their work with families.</p>  |           | <p>Training Records</p>  |
|   | <p>C.1 - The following topics should be covered within three months of hire:</p> <ul style="list-style-type: none"> <li>• Sleeping,</li> <li>• Feeding/breastfeeding,</li> <li>• physical care of baby,</li> <li>• Crying/comforting baby,</li> <li>• Home safety,</li> <li>• Shaken Baby Syndrome,</li> <li>• SIDS,</li> <li>• Seeking medical care,</li> <li>• Well-child visits/immunizations,</li> <li>• Seeking appropriate childcare,</li> <li>• Car seat safety,</li> <li>• Failure to thrive,</li> <li>• Family planning,</li> <li>• nutrition,</li> <li>• Prenatal/postnatal healthcare</li> </ul> |           | <p>Quarterly Narrative Report<br/>Staff Development Plans<br/>Supervisory Documentation<br/>Training Records</p> |





| Principle   | Practice   | Benchmark | Documentation<br> Hard Copy Files   |
|---|--|-----------|--|
|   | <ul style="list-style-type: none"> <li>• Prenatal/postpartum depression and Warning signs for when to call doctor.</li> </ul>  |           |  |
| <p>SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards.</p> | <p>C.2 - The following topics should be covered within six months of hire:</p> <ul style="list-style-type: none"> <li>• Language/literacy development,</li> <li>• Physical/emotional development,</li> <li>• Identifying developmental delays,</li> <li>• Brain development,</li> <li>• Supportive attachment,</li> <li>• Positive parenting strategies,</li> <li>• Discipline,</li> <li>• Parent-child interaction,</li> <li>• Working through difficult relationships,</li> <li>• Stress/time management,</li> <li>• Personal safety,</li> <li>• Burnout prevention,</li> <li>• Ethics,</li> <li>• Crisis intervention,</li> <li>• Emergency protocols,</li> <li>• Promotion of positive mental health,</li> <li>• Signs of mental health issues,</li> <li>• Depression,</li> <li>• Working with families with mental health issues, and</li> <li>• Referral resources.</li> </ul> |           | <ul style="list-style-type: none"> <li> Quarterly Narrative Report</li> <li> Staff Development Plans</li> <li> Supervisory Documentation</li> <li> Training Records</li> </ul>         |
|   | <p>C.3 - The following topics should be covered within twelve months of hire:</p> <ul style="list-style-type: none"> <li>• Etiology of child abuse and neglect,</li> <li>• Working with survivors of abuse,</li> <li>• Life skills management,</li> <li>• Engaging fathers,</li> <li>• Multi-generational families,</li> <li>• Teen parents,</li> <li>• Relationships,</li> <li>• HIV/AIDS,</li> </ul>   |           | <ul style="list-style-type: none"> <li> Quarterly Narrative Report</li> <li> Staff Development Plans</li> <li> Supervisory Documentation</li> <li> Training Records</li> </ul> |















| Principle   | Practice   | Benchmark  | Documentation<br>📁 Hard Copy Files   |
|---|--|--|--|
|   | <ul style="list-style-type: none"> <li>• Working with diverse cultures/populations</li> <li>• Culture of poverty</li> <li>• Values clarification</li> </ul>  |  |  |
| <p>SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards.</p> | <p>D - Programs ensure that all staff members are oriented to child abuse, neglect indicators and reporting requirements prior to direct work with families.</p>                                   |  | <ul style="list-style-type: none"> <li>📁 Quarterly Narrative Report</li> <li>📁 Staff Development Plans</li> <li>📁 Supervisory Documentation</li> <li>📁 Training Records</li> </ul> |
|   | <p>E - Programs train and certify staff in the appropriate developmental screening tool within the first six months of hire.</p>   |  | <ul style="list-style-type: none"> <li>📁 Supervisory Documentation</li> <li>📁 Training Records</li> </ul>  |
|   | <p>F - Doulas complete IBTI approved training in addition to other Doula certification. Participation in ongoing in-service training is required.</p>  | <p>Doulas attend the FSW track of HFA Integrated Strategies training within the first six months of their hire date, and attend the first available Doula Basic training in relationship to their hire date.</p> | <ul style="list-style-type: none"> <li>📁 Supervisory Documentation</li> <li>📁 Training Records</li> </ul>  |
|   | <p>G - Doulas and Doula Supervisors attend a DONA approved Birth Doula Training.</p>   | <p>Doulas and Doula Supervisors complete DONA training within three months of hire.</p>  | <ul style="list-style-type: none"> <li>📁 Supervisory Documentation</li> <li>📁 Training Records</li> </ul>  |
|   | <p>H - Programs follow and annually review with staff their policy governing appropriate procedures for addressing child abuse and neglect in alignment with state law.</p>                        |  | <ul style="list-style-type: none"> <li>📁 Program Files</li> <li>📁 Supervisory Documentation</li> <li>📁 Team Meeting Notes</li> </ul>   |
| <p>SG7 - All IBTI services are responsive to the culture of the families served.</p>  | <p>A - Programs select staff for their experience and expertise in working with the community and families served by the program, including an understanding of language, customs, and values.</p> |  | <ul style="list-style-type: none"> <li>📁 Program Files</li> </ul>  |











| Principle  | Practice   | Benchmark  | Documentation<br> <b>Hard Copy Files</b>   |
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|  | B - Programs train staff annually on the specific cultural needs of their participants and target community.   |  |  Team Meeting Notes<br> Training Records              |
| SG7 - All IBTI services are responsive to the culture of the families served.  | C - Programs implement a review of cultural competency that addresses curricula and other materials, training, and service delivery every other year. This review includes input from participants and staff in all areas.   | 100% of programs conduct a cultural competency every other year. |  Cultural Competency Review results<br> Program Files |
| SG8 - Programs select staff and volunteers in a manner that ensures they are willing to work with high-risk families; such as those in which domestic violence or substance abuse may be a concern.<br>(BPS 9-1.A) | A - Screening and selection of program managers includes consideration of characteristics including but not limited to: <ul style="list-style-type: none"> <li>• Solid understanding of and experience in managing staff</li> <li>• Administrative experience in human services or related field including experience in quality assurance and improvement and site development</li> <li>• Master's degree in public health or human services administration or fields related to working with children and families or Bachelor's degree with three years of relevant experience</li> </ul> |  |  Personnel Files<br> Policy and Procedure Manual  |





| Principle  | Practice  | Benchmark | Documentation<br> Hard Copy Files   |
|--|---|-----------|--|
|  | <p>Program Managers hired prior to July 1, 2014 should have at least a Bachelor's degree. Criteria above apply to staff hired starting July 1, 2014.</p>  |           |  |
| <p>SG8 - Programs select staff and volunteers in a manner that ensures they are willing to work with high-risk families, such as those in which domestic violence or substance abuse may be a concern.<br/> <i>(BPS 9.1.B)</i></p> | <p>B - Screening and selection of supervisors includes all but is not limited to:</p> <ul style="list-style-type: none"> <li>• Master's degree in human services or fields related to working with children and families, or Bachelor's degree with three years relevant experience,</li> <li>• Solid understanding of and/or experience in supervising and motivating staff, as well as providing support to staff in stressful work environments,</li> <li>• Knowledge of infant and child development and parent-child attachment,</li> <li>• Experience with family services that embrace the concepts of family-centered and strength-based service provision,</li> <li>• Knowledge of maternal-infant health and dynamics of child abuse and neglect,</li> <li>• Experience in providing services to culturally diverse communities/families,</li> <li>• Experience in home visitation with strong background in birth to three prevention services,</li> </ul> |           | <ul style="list-style-type: none"> <li> Personnel Files</li> <li> Policy and Procedure Manual</li> </ul> |

| Principle  | Practice  | Benchmark | Documentation<br> Hard Copy Files   |
|--|---|-----------|--|
|  | <ul style="list-style-type: none"> <li>• Infant mental health endorsement level III or IV (if available),</li> <li>• Experience with reflective practice preferred.</li> </ul> <p>Supervisors hired prior to July 1, 2014 should have at least a Bachelor's degree. Criteria above apply to staff hired starting July 1, 2014.</p>  |           |  |
| <p>SG8 - Programs select staff and volunteers in a manner that ensures they are willing to work with high-risk families, such as those in which domestic violence or substance abuse may be a concern.</p> | <p>C - Staff members are open to flexible schedules that allow for connecting with participants who are not available during traditional work hours.</p>  |           |  Supervisory Documentation  |
| <p><i>(BPS 9-1.C)</i></p>  | <p>D - Screening and selection of direct service staff, volunteers, and interns that perform the same function include consideration of personal characteristics including but not limited to:</p> <ul style="list-style-type: none"> <li>• Minimum of high school diploma or equivalent</li> <li>• Ability to establish trusting relationships</li> <li>• Acceptance of individual differences</li> <li>• Experience and willingness to work with the culturally diverse populations that are present among the site's target population</li> <li>• Knowledge of infant and child development</li> <li>• Open to reflective practice</li> <li>• Infant mental health endorsement level I or II preferred (if available)</li> </ul> |           |  Personnel Files<br> Policy and Procedure Manual |

| Principle   | Practice  | Benchmark | Documentation<br>📁 Hard Copy Files  |
|---|---|-----------|---|
| <p>SG9 - The programs relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community, and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families. <i>(BPS GA-1A)</i></p> | <p>A - Programs have a broadly-based advisory/governing group which serves in an advisory or governing capacity in the planning, implementation, and evaluation of program related activities.</p>  |           | <ul style="list-style-type: none"> <li>📁 Advisory Group Agendas</li> <li>📁 Advisory Group Minutes</li> <li>📁 Program Files</li> </ul> |
| <p>SG9 - The programs relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community, and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families.</p>                    | <p>B - Community partners identified as referral sources for screening, assessment, and program intake match the program’s target population and meet any specific HFI requirements.</p>  |           | <ul style="list-style-type: none"> <li>📁 Program Files</li> <li>📁 Program Narrative</li> </ul>  |
|   | <p>C - To ensure a regular flow of referrals for screening or intake, programs develop and maintain relationships with other community organizations that come into routine contact with pregnant and parenting teens, including but not limited to schools, health clinics, social service agencies, and child welfare programs.</p> |           | <ul style="list-style-type: none"> <li>📁 Program Narrative</li> <li>📁 Team Meeting Notes</li> </ul>                                   |

| Principle   | Practice  | Benchmark   | Documentation<br> Hard Copy Files   |
|---|---|---|--|
|   | D - The site monitors the number of families in the target population that are identified/referred through its system of organizational relationships, and develops strategies to increase the percentage screened/identified.                              |   |  Program Files  |
|   | E - Programs obtain and maintain written linkage agreements through routine communication with collaborating organizations.   |   |  Program Abstract<br> Program Files<br> Program Narrative |
|   | F - Doula programs develop written linkage agreements (whenever possible) with any hospital(s) where Doulas provide labor and delivery support to guarantee access of Doulas for attending births.  |   |  Program Abstract<br> Program Files<br> Program Narrative |
| SG9 - The program's relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community, and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families.<br>(BPS 7-3.A) | G - Program interns and volunteers, when utilized, are subject to the same screening processes programs use with paid staff. In addition, volunteers receive the same training and quality of supervision as would a paid staff person with similar duties. | Programs screen 100% of program interns and volunteers in the same manner as paid staff. This includes all legally permissible background checks, criminal history records, and civil child abuse and neglect registries. |  Program Files<br> Program Narrative   |
|   | H - To ensure comprehensive services for families once enrolled, programs develop and maintain knowledge of working relationships with service providers that address needs beyond the scope of IBTI services.  |   |  Community Resource Directories<br> Team Meetings Notes  |

| Principle  | Practice  | Benchmark   | Documentation<br> Hard Copy Files  |
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|  | These include but are not limited to schools, alternative and vocational education, housing, financial assistance, health services, nutritional programs, recreational programs, mental health, early intervention, substance abuse, domestic violence services, and childcare. |   |   |
|  | I - Programs track and follow up with families and service providers, if appropriate, to determine if the families received needed services. Follow-up with service providers requires signed informed consent.   |   |  Program Files<br> Policy and Procedure Manual        |
|  | J - Release of information forms used for referrals should be specific to the referral agency and time limited.   |   |  Participant Files<br> Policy and Procedure Manual |
| SG10 - Programs are aware of and sensitive to participants' experiences of services.   | Programs contact participants who drop out to gather information for quality improvement. Each program has a procedure for participant exit interviews that helps determine the impact of the program.  |   |  Exit Interview Forms<br> Program Files           |
| SG11 - Programs participate in evaluation activities to determine the effectiveness of services.   | Programs cooperate with Ounce research and evaluation efforts. This includes obtaining informed consent in writing from participants in order to link names, addresses, and telephone numbers to participant identification numbers.  |   |  Participant Files   |
| SG12 - Effective programs maintain complete records of service activities to allow for planning, to track progress, and to demonstrate accountability. | A - Programs maintain participant files with up-to-date information about service intensity, service content, and participant progress.   | 100% of program staff participates in OunceNet and/or Visit Tracker training. |  Participant Files<br> Training Records           |

| Principle | Practice  | Benchmark   | Documentation<br> Hard Copy Files |
|-----------|---|---|--|
|           | <p>Programs utilize OunceNet and/or Visit Tracker and cooperate with all elements of data collection, training, and reporting information as required by IBTI.</p>  |   |  |
|           | <p>B - Programs enter information regarding a breakdown of time spent on various components into OunceNet as part of each Home Visit's documentation.</p>   |   |  Participant Files                |
|           | <p>C - Programs ensure that all OunceNet computers are equipped with up-to-date virus protection software.</p>  | <p>100% of OunceNet computers have up-to-date and functional virus protection software.</p> |  Program Files                    |
|           | <p>D - Programs adopt and implement policies that restrict and control downloading and installation of files or software to computers used for OunceNet access. See page 125 for specific information on what should be restricted on OunceNet computers.</p> |   |  Program Files                    |