N-MIECHV IMPLEMENTATION GUIDE

This guide is intended to take you step by step through the implementation of a new Healthy Families in America program.

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VIDEOS

A series of videos were produced in 2022 to aid all programs in education and outreach. They are short, easy to understand, and provide the answers to the most common questions about home visiting programs. All are found on YouTube and are available for use at any time. The intended audience are potential client families, partners, and resources.

1. N-MIECHV: What Is Home Visiting? (describes the program as a whole)

2. N-MIECHV: Home Visitors Are Partners in Family Resilience (Client testimonial in English)

3. N-MIECHV: Bilingual and Bicultural Home Visitors Meet Families Where They Are (Client testimonial in Spanish with subtitles in English)

4. N-MIECHV: What a Home Visit Looks Like (describes/shows a home visit)

5. Nebraska Child & Family Services – (Describes how N-MIECHV works with child welfare, featuring the first family enrolled under the

N-MIECHV LEADERSHIP TEAM

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- Responsibilities: federal grant writing/reporting, budgets, writing subawards, subrecipient monitoring, network communication and Open Mic calls, training and technical assistance

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Anna Burbach, Health Surveillance Specialist
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- Responsibilities: overseeing administration of the MIECHV grant, federal point of contact for Nebraska Dept. of Health and Human Services (NDHHS)

PREPARING FOR YOUR AWARD

1. **Creating an "address" in the NDHHS billing system so you can be paid!**
   This gives us information on who you are and gets the payments to the correct organization.
   a. Provide NDHHS a W9 form/ACH form with a voided check or ACH form from your bank.
   b. NDHHS will set up direct deposit- this is more secure and consistent than paper checks.
   c. NDHHS will assign you an Address Book Number—a unique number that we use to send payments to your account.

2. **Discussing the expectations and requirements of the N-MIECHV program**
   The N-MIECHV Program Manager and other members of the team will meet with you and your staff to discuss the requirements of the program, including reporting, Continuous Quality Improvement, training, your approved service area, goals for service delivery, on-going monitoring, subrecipient monitoring for the grant, and technical assistance. Each of these topics are discussed in other sections of this guide.

3. **Deciding on Scope and Scale**
   How big or how small do you want the program to be? The number of direct service providers (home visitors actually conducting visits) will determine the expected caseload of families to be served in a budget period, based on model fidelity.

4. **Creating your budget**
   This will be discussed in greater detail in the section: Creating Your Budget: Tips and Categories

A BRIEF HISTORY OF THE N-MIECHV PROGRAM

2008 The Nebraska State Legislature allocates $600,000 annually for "nurse home visiting services." The allocation was managed by the Division of Children and Family Services and benefitted three independent programs offering nurse home visiting services.

2010 The Health Resources and Services Administration (HRSA) awards an annual $1,000,000 to NDHHS Division of Public Health, in the form of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant authorized through the Affordable Care Act.

2010 NDHHS conducts a Needs Assessment to identify seventeen (17) "Priority" counties; those whose county-level data shows that the population may be at higher risk of poor lifespan health outcomes, which can lead to child maltreatment. HRSA requires that MIECHV funding must be directed to areas that can benefit the most.

2011 The Panhandle Public Health District health department becomes the first N-MIECHV site, or Local Implementing Agency (LIA) in Nebraska.

2012 The Nebraska State Legislature raises the allocation to $875,000/year. The benefitting programs continue to be managed by the Division of Children and Family Services.

2013 – 2014 Community planning takes place, and two more MIECHV-funded LIAs are added in the Lincoln and Omaha health departments.

2014 The Nebraska State Legislature raises the annual allocation to $1,100,000 and the language is changed from "nurse home visiting" to "evidence-based home visiting" to align with the federal MIECHV program. Administration of the state-funded programs is moved to the Division of Public Health, and the decision is made to hold those sites to the same standards as the federal MIECHV program as best practice. NDHHS issued an RFP (Request for Proposal) resulting in three (3) new LIAs and expanding the existing program in Lincoln.

2015 – 2018 The MIECHV program was removed from the Affordable Care Act in 2015 and put into the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA) or the "Doc Fix" legislation. In 2018, MIECHV was reauthorized as part of the Bipartisan Budget Act.

2014 – 2020 N-MIECHV administers three (3) federally funded and three (3) State funded home visiting programs. Funding is stable and consistent. NDHHS receives approximately $1,200,000 per year from MIECHV, and $1,100,000 per year from the Legislature, but is only able to submit data to HRSA for the three federally funded LIAs.

2019 NDHHS, Division of Children and Family Services receives the Family First Prevention Services Act (FFPSA) grant funds. Healthy Families America model of evidence-based home visiting is listed as "well supported" on the federal clearinghouse. Knowing that Public Health already had existing HFA programs, DCFS approached N-MIECHV with an idea for partnership, including access to Temporary Assistance for Needy Families (TANF) funding for the next 5 years. This allowed for a huge expansion of services and the addition of another LIA. The plan is for up to four more LIAs over the next 5 years.

2020 Updated Needs Assessment identifies 31 "priority counties." 1st braided subawards utilizing MIECHV, SGF, TANF, and FFPSA funds. This allows us to report on the data for all the LIAs rather than only 3. MIECHV allows us to count the entire caseload of any home visitor that is at least 0.25 FTE supported by MIECHV funds, so this becomes a requirement of the budgets from the LIAs moving forward.

2020-2021 Expansion of existing sites to serve 300 more families and in more priority communities, adding one program site that had been operating an HFA program independent to the N-MIECHV network.

2022 - 2023 Community Planning took place in central parts of the state to create up to 4 or 5 new programs utilizing TANF funds. One new program site opened, serving a 9-county service area in the middle of the state. The 2022 federal reauthorization authorized an additional $500,000 in MIECHV dollars, which N-MIECHV uses to bring all the new sites onto the federal data system.

2023 – 2024 N-MIECHV added 5 new sites, adding slots for an additional 400 families in 9 additional priority counties.

SUMMARY OF N-MIECHV PROGRAM REQUIREMENTS

The N-MIECHV program is very strengths-based and supportive; we are much more involved than "typical" state programs. It's our job to ensure fidelity to the model and report all the data to the federal MIECHV program. Most importantly, it is our responsibility to make sure you have absolutely everything you need to be successful!

1. The federal MIECHV program is complex and evolving. Our commitment to you is **TRANSPARENCY and COMMUNICATION.**

2. MIECHV Requirements include:
   a. Voluntary participation
   b. Individual assessment
   c. Well-trained, competent staff
   d. High quality supervision
   e. Strong organizational capacity
   f. Appropriate linkages and referral networks
   g. Fidelity to the approved model
   h. Priority for serving high-risk populations

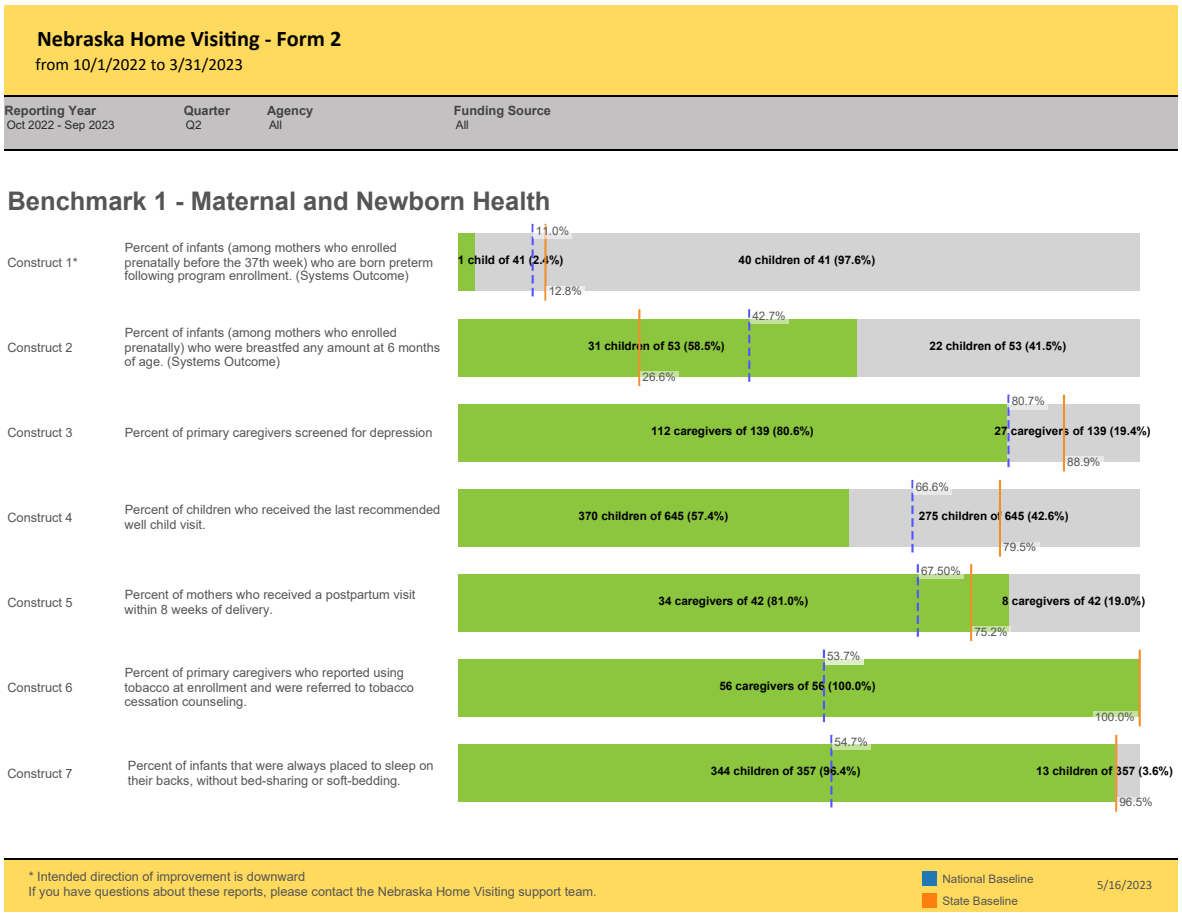
3. Target Population (primary caregiver with one or more):
   a. Primary residence in priority county
   b. Low income (250% of federal poverty level)
   c. Under 21 years
   d. Involvement in child welfare, or suspected child maltreatment
   e. Substance use
   f. Use of tobacco in the home
   g. Exposure to violence
   h. Low Student Achievement
   i. Children with disabilities or developmental delays
   j. Member of the Armed Forces with history of multiple deployments

4. N-MIECHV collects local-level data on 19 measures through an approved case management system. We do not have a contract with the developers of your case management system, YOU do. This is discussed in more detail further in this guide in the section: Data – Benchmarks, Measures, and Tools (pg. 20. **The N-MIECHV Benchmark Plan is included in the index (15).*

N-MIECHV Benchmarks and Measures At-A-Glance

Maternal and Child Health • Preterm Birth • Breastfeeding • Depression Screening • Well-Child Visits • Postpartum Care • Tobacco Use	**Childhood Injuries, Child Abuse and Maltreatment, and Reduction of Emergency Department Visits** • Safe Sleep • Child Injury • Child Maltreatment	**School Readiness and Achievement** • Parent-Child Interaction • Early Language and Literacy Activities • Developmental Screening • Behavioral Concern Inquiries
Crime and Domestic Violence • Intimate Partner Violence Screening	**Family Economic Self-Sufficiency** • Primary Caregiver Education • Continuity of Health Insurance	**Coordination and Referrals** • Completed Depression Referrals • Completed Developmental Referrals • Intimate Partner Violence Referrals

5. N-MIECHV contracts with Kansas University Center for Public Partnerships and Research (KU-CPPR or KU) to collect the site-level data (your contract with Datatude, Inc. includes sending the data to KU), analyze it and put it together into easy-to-read data reports. The reporting system is called Data Application and Integration Solutions for the Early Years or DAISEY—we call them DAISEY reports or Form 2. **How to Read a DAISEY Report is included in the index (2).*



6. The federal MIECHV program requires that N-MIECHV report aggregate (combined) data for all the LIAs annually in October. Every 3 years, we are required to prove that we have made improvements on 4 out of 6 of the benchmarks.

7. **Continuous Quality Improvement** is a required part of the MIECHV program. We have a State CQI Team that has representatives from each of the LIAs. Who is a participant in the CQI team is up to you, and it can change. Most sites have at least two participants, and it turns over every couple of years. The CQI Team member is responsible for leading local CQI team meetings and ensure that we receive the appropriate documentation. Each LIA is expected to participate in at least the State CQI project, have regular CQI meetings, and document the changes, challenges, and successes. CQI is DATA DRIVEN. Your team may engage in a 2nd CQI project based on your own data and the story that data tells about your site. This is discussed in more detail in the section: *Continuous Quality Improvement (pg. 24).*
   a. N-MIECHV provides annual CQI refresher training for all home visitors.
   b. Each LIA needs to report progress with documentation to N-MIECHV quarterly.

8. **Monthly Check-in calls** are required, along with a monthly check in call report. LIA Coordinator/Manager and Supervisors are invited to the regularly scheduled calls. These can be flexible as conflicts arise, and every once in a while, we'll ask you to just send the check in call report instead of meeting. On these calls we'll go over enrollment, home visit completion rates, challenges, successes, training needs, CQI and/or data updates, etc.
   a. The check in call report form is included in the index (3).

9. **Participation in monthly Open Mic calls** is optional but encouraged. It is a regularly scheduled call for all coordinators, managers, and supervisors to get updates on the program, federal requirements, and other topics of interest. Participants have the chance to ask questions, raise awareness about an accomplishment or a challenge, and just talk to other people who are doing the same job. The goal of the calls is to create a network of support for LIAs.

10. There are **monthly Direct Service Open Mic calls** as well. These are for direct service providers to do the same—create relationships and a network of people in the same position across the state. Generally, supervisors, coordinators, and managers do not attend. The N-MIECHV Program Specialist will facilitate these calls.

11. MIECHV is funded by the Health Resources and Services Administration (HRSA). HRSA often communicates special requests or projects that we need to pass along to the LIAs, such as completion of the Home Visiting Budget Assistance Tool (HV-BAT). N-MIECHV will communicate any other requirements, including deadlines, as early as possible via email, open mic calls, check in calls, etc. Don't hesitate to reach out to us with any questions or concerns.

CREATING YOUR BUDGET: TIPS & CATEGORIES

1. **General Guidance:**
   a. Creating a budget using the funding numbers that N-MIECHV provides. We BRAID funding from several sources—federal MIECHV dollars, State General Funds allocated for evidence-based home visiting, and federal TANF dollars. Your budget will have different columns for each funding source and a TOTAL column. New programs often have specific funding sources & not everyone will have all of them. N-MIECHV will tell you exactly how much you have in which funding source.
   b. For the totals, use whole numbers.
   c. N-MIECHV runs on the FEDERAL FISCAL YEAR, which is October through September.
      a. **Q1: Oct. 1 – Dec. 31**
      b. **Q2: Jan. 1 – Mar. 31**
      c. **Q3: Apr. 1 – Jun. 30**
      d. **Q4: Jul. 1 – Sep. 30**
   d. If your program is starting mid-federal fiscal year, your first period of performance will be whatever it takes to get you on the federal fiscal year schedule. For example, if you are starting August 1st, your first award will be a 14-month award, or Aug. 1 – Sep. 30.

2. **Personnel:**
   a. Who will lead your program? A Program Manager? Program Coordinator? Supervisor(s)? What are the individual roles? Will one person serve as both a manager and supervisor? How much FTE (what percentage of their job) will be dedicated to the home visiting program? Will they have other responsibilities within the agency?
   b. How many direct service providers/home visitors will the program have? The expected caseload is based on model fidelity—the Healthy Families America (HFA) model puts a limit on the number of families any one home visitor may serve, as demonstrated in the Best Practice Standards. (You will gain access to the HFA Best Practice Standards once your affiliation is complete.)
   c. If you are receiving federal MIECHV funds, a minimum of 25% (0.25 FTE) of the direct service providers' salary, benefits, and associated indirect costs must go to federal MIECHV funds FIRST. This allows us to count their entire caseload on the federal MIECHV data system. This applies to any staff that is seeing clients, so if a supervisor is expected to carry a small caseload, include them in the 25%.
   d. Supervisors often carry a 2-5 family caseload, but it's really up to you. A supervisor's job has many responsibilities. It may be best to leave only the clients with the most complex needs or those that are on higher levels for their caseload.
   e. Managers generally do NOT see clients directly, unless there are special circumstances that "need a manager's touch."
   f. The recommendation from N-MIECHV is that your direct service providers make a THRIVING wage—they should not qualify for the resources they refer to their clients. Turnover will be minimized if they're not worried about paying rent or their bills. The recommendation is to start at $18/hr. (This is not a requirement, but a recommendation based on state and national-level professional wage discussions and is specific to the Midwest. Your organization may have policies that are different.)
   g. You may want to include a small percentage of time for a financial or fiscal person. Generally they don't need more than 0.05 – 0.10 FTE.

3. **Benefits:**
   This is based on what your organization offers its employees. N-MIECHV does not have a specific recommendation of benefits.

4. **Training:**
   There are many training requirements in an N-MIECHV program, including both for the federal MIECHV and the national HFA programs. Specific requirements are discussed later in this guide under the section: Required Training (pg.23 – 24). In creating the training section of the budget, you should include:
   a. HFA core training is required for ALL staff (managers and supervisors included.) There are TWO core trainings: Foundations for Family Support (FFS) and Family Resilience and Opportunities for Growth (FROG). Healthy Families America sets their own rates for new staff, although N-MIECHV will usually have a current cost estimate they can share with you.
   b. Curriculum training is required for all direct service providers and supervisors.
   c. HFA Supervisor training is required for supervisors, managers, and coordinators. This includes Supervisor CORE: Relationships and Reflection and FROG Supervisors.
   d. HFA Implementation Training for Managers and/or Coordinators should be included in your budget, but it is recommended that this not take place for at least 6 -9 months after starting your program. It's very intense, very complex, and extremely informative, but it will make a lot more sense if your "feet are wet" and you are very familiar with the ins and outs of the program first.

5. **Travel:**
   a. Budget in conferences and/or specific trainings that will include commercial fares, lodging, and meals.
   b. Mileage for visits when using personal vehicles.
   c. Agency transportation for visits—gas, insurance, maintenance.

6. **Equipment:** (These are "bigger" items that generally are useable for 5 years or longer.)
   a. Budget for a good printer/copier/fax.
   b. Setting up your office (desks, chairs, cube walls, filing cabinets, etc.)
   c. Electronic equipment such as computers/laptops and monitors, plus an iPad, or tablet, work cell phones, and internet hot spots for every home visitor.

7. **Supplies:** (These are generally single-use items, like office supplies).
   a. Budget for recruitment/outreach supplies (fliers, brochures, rack cards, etc.)
   b. Outreach and incentives—things you use within the program that are offered to parents and families. This is also discussed in more detail in section: Client Incentives (pg. 33).
   c. Curriculum materials and ASQ3/ASQ-SE2 materials.

8. **Contractual:**
   a. Each site is required to use Datatude, Inc. for the FamilyWise case management system.
   b. Affiliation fees with Healthy Families America national.
   c. A company to conduct background checks.
   d. N-MIECHV recommends having a Zoom account or another virtual meeting platform for virtual home visits when necessary.
   e. N-MIECHV recommends having a DocuSign account for electronic signatures for clients and community partners.

9. **Indirect Cost rate:**
   a. Documentation of the indirect cost rate is required. You may use a NDHHS-approved, federally approved, de minimus rate, or only direct costs (a percentage of "overhead" based on the number of employees in each program) with no indirect rate.
   b. You must provide N-MIECHV with your current IDC documentation any time it changes.

EXECUTING YOUR SUBAWARD

1. The N-MIECHV Program Manager will write the subaward based on your budget, discussions, and model requirements. Each of the subawards across the state have the exact same specifications and requirements; the Local Implementing Agency (LIA—that's YOU) may have a draft of the subaward at the time of submission to NDHHS Procurement for approvals.

2. One of our tenants of administration is TRANSPARENCY for all our subrecipients. You should not be wondering what's going on, or what requirements are written into your subaward as you are waiting. Many of our LIAs need to be able to do "pre-work" with insurance or their Boards. This way you can begin review in your organization.

3. There are several layers of approval for the subawards at NDHHS.
   a. Programmatic Review:
      N-MIECHV Program Manager writes the award and submits it to the team supervisor, then unit administrator for review and suggested edits. This will include ensuring all required elements are accurate. Once approved, the award goes on to the NDHHS Procurement office.
   b. Procurement reviews:
      Review of the subaward is completed by Contract Management staff, Legal staff, and Grants Accounting staff. These staff review the required NDHHS elements finalized in detail, and double-check that all the accounting codes are correct, period of performance dates are accurate, that the grant information matches and is appropriate for the grant's requirements, and that all awards and budgeted expenses added together do not exceed the amount of funds available in the grant.

This is a complex process that has several people looking at specific parts to ensure that all the information is 100% accurate for our subrecipients. NDHHS strives for award approvals to be completed within a reasonable time, and before the start date written in the award, but if issues are identified at any part, it can temporarily halt the process. Delays happen for many reasons, so it is reasonable to expect a period of 30-60 days for full review, start to finish. Never fear—your N-MIECHV Program Manager and team are tracking the process and will alert you to delays or if there is anything needed from you.

Specific subaward elements are discussed in another section of this guide: *Elements of the Subaward (pg. 11).*

4. Once all reviews are complete, the subaward will be sent out for signature via DocuSign. Your organizational signatory will sign it, and then it is sent to the appropriate NDHHS signatory. Most of the time this is the Division of Public Health Director. Our DPH Director will try to make sure the award is counter-signed in a timely manner. Once it is complete or "fully executed" you will be sent a copy for your own records.

5. During the time of review and approval, the subrecipient may not be able to put staff time/effort or begin incurring expenses against the award before it is fully executed. The LIA organization will be able to decide if you can begin planning and/or work toward implementation of the program, potentially to be supported by other funds. This may include things such as contacting HFA for affiliation information, signing a lease agreement for office space and/or ordering office furniture, beginning recruitment for staff, or conducting community outreach meetings to assemble your advisory committee among other things. Follow your organizational policy.

6. The “start date” of the award is not necessarily the start date written in the award as the beginning of the period of performance. The subaward states in Section 1: DURATION, subsection 1.1: TERM, “This subaward is in effect from **the date of full execution or the beginning of the period of performance, whichever is later…” This means that it is the date the award is fully executed (the date counter signed by NDHHS) OR the start date written into the award, whichever is last.** Your N-MIECHV Program Manager will be able to guide you in which costs, if any, incurred before the date the award is active, is reimbursable according to the grant and NDHHS allowability guidelines.

ELEMENTS OF THE SUBAWARD

At NDHHS, we use federal and state funds for many, many things, in the form of SUBAWARDS or CONTRACTS. A subaward is used when NDHHS acts as a “Pass-Through Entity” of federal funds to carry out a federal Program in an “assistance-based” relationship and is responsible for monitoring the activities of the subrecipient. A contract for services is used when NDHHS is receiving services that are ancillary (additional or secondary) to the federal program, such as consultation work, like with our contract with the Kansas University Center for Public Partnerships and Research.

For N-MIECHV, the goal is the improvement of the future workforce and the prevention of child maltreatment through the implementation of an evidence-based home visiting programs. NDHHS is the pass-through entity of federal funds, and we definitely provide technical assistance and monitoring, so the appropriate contractual relationship is a SUBAWARD. This outlines exactly what the service looks like, the expectations, and the amount of collaboration or involvement of the state team. Your subaward also requires the N-MIECHV state team to do subrecipient monitoring, to ensure to our federal funders that the money is being used for exactly the purposes it’s supposed to be.

NDHHS has many common elements in all subawards and contracts, including standardized template language that the N-MIECHV program typically cannot change. There are several pages of legal language that protects not only NDHHS, but the subrecipient, and the general public. Most of the time this takes the form of addendum, such as Addenda A: General Terms – Subaward, Addenda B: NDHHS Insurance Requirements, and Addenda C: HIPAA Business Associate Agreement Provisions. (Note: not all addenda are included in all awards.)

The rest of the subaward language is developed by N-MIECHV and is specific to each LIA.

1. Period of Performance: The period of time that the subrecipient can bill for services. As discussed previously, this is going to be as closely matched to the federal fiscal year as possible. The N-MIECHV Program Manager is able to exercise a personal preference to how often a subaward is either written as a new award or is renewed. In N-MIECHV, the evidence-based home visiting programs are complex, ever-evolving, and require a tremendous amount of work to prepare, train staff, and implement the program—with the heaviest expenses in the first year. As long as the funding is available and the LIA is performing to expectations, the award is going to

be renewed. N-MIECHV will work intensively with any program that is under-performing and has set up the monitoring and communication system as such that you will never "not know" about concerns about performance. We are going to do everything in our power to help you be successful!

2. Termination: Either NDHHS or the LIA can terminate a subaward with a minimum of 30 days' notice.

3. Payment Structure:
   a. N -MIECHV will reimburse actual costs on a quarterly basis. (Exceptions can be made for a monthly reimbursement if necessary—please talk with the N-MIECHV Program Manager.)
   b. LIAs must use the standardized invoice and programmatic report forms developed by N-MIECHV. The invoices cannot be submitted without both forms.
   c. LIAs must send general ledger detail with the invoices. This is not the level of detail as copies of receipts and timecards, but it should have enough detail to show that the expenditures are federally allowable, allocable, and reasonable. For instance, if an LIA uses a single account for internet/wifi, and it is split between programs within the organization, we want to be able to see how this is split and how the amount on the N-MIECHV invoice is determined.
   d. Anything purchased with federal funds must comply with the Code of Federal Regulations (CFR). General ledger detail must list what was purchased—not just "supplies" but what kind of supplies? We need to be able to determine if all costs are federally allowable. The CFR is available online. The N-MIECHV Program Manager is very familiar with allowable and unallowable costs, and your organizational finance person should be as well. When in doubt—ASK BEFORE YOU PURCHASE. We'll give you the appropriate guidance.
   e. Invoices are due 30 days after the end of the first three quarters, and 45 days after the end of the fourth quarter.
      - Q1: Oct. 1 – **Dec. 31 INV. DUE Jan. 31st**
      - Q2: Jan. 1 – **Mar. 31 INV. DUE Apr. 30th**
      - Q3: Apr. 1 – **Jun. 30 INV. DUE Jul. 31st**
      - Q4: Jul. 1 – **Sep. 30 INV. DUE Nov. 15th**
   f. This is explained in further detail in the section: Invoicing/Billing (pg. 25).

4. Budget Changes: The subrecipient can move up to 10% of the total award in the budget as needed without state approval. If there is more than that, you have to make a written request to the N-MIECHV Program Manager. It must be approved before a quarterly invoice can be submitted.

5. Project Description: This is the part that is specific to you as the LIA and to N-MIECHV. It outlines everything that is required and expected on both our parts. The highlights:
   a. **Enrollment target** or the minimum number of families we expect you to serve.
      This is determined by the model limitations on caseload, the number of direct service providers (home visitors) at the most intense level of service, or visits occurring once a week for about an hour. The N-MIECHV team will provide further guidance and help you determine the differences in intensity of services based on different levels of progress, and how "served" is defined according to model fidelity (ie: "active," "enrolled," "on Creative Outreach", etc.)
      This number of families served is the minimum number of families served over the period of performance. It is going to take some time to build up to it, and the N-MIECHV team understands that. There are also attrition rates that we'll both monitor, and times that you'll be under that number. We want you to work hard to get to and maintain that number and will work with you to get there. If there are concerns about slow or low enrollment or high attrition, we'll talk about it on check in calls, offering technical assistance as necessary.

b. **Description of Service Area**
This is going to include the entire area in which you can provide services to families. The main focus is going to be on priority counties as determined by the most recent N-MIECHV Needs Assessment. What this means is that we want you to target your outreach efforts in the priority counties, but you may serve any family in your service area.

c. **Model Fidelity**
You must be affiliated with the national model at the onset of your program and become accredited in the model within three years of implementation

d. **Reflective Supervision**
Supervisors must be trained in Reflective Supervision and provide both clinical and reflective supervision according to HFA model fidelity to each direct service staff on a weekly basis. Managers must provide reflective and clinical supervision to the supervisors on a weekly basis as well.

e. **Data Collection**
You must accurately and consistently collect the data for your program according to the requirements of the federal MIECHV program, using a reliable, approved case management system. You will receive training on this.

f. **Continuous Quality Improvement (CQI)**
You must participate in CQI activities, both in your program locally, and with the State CQI team. You will receive training on this, and more information is included in the section: Continuous Quality Improvement (pg. 31).

g. **Communication and Contact**
You must maintain contact and communication with the N-MIECHV team on a regular basis and participate in subrecipient monitoring activities.
Monthly check in calls are required. This is a time to touch base on numbers, accomplishments, challenges, training, staffing, and find out how the N-MIECHV team can best support you. There is a standardized check in call report form that each LIA will submit before the call on the PRIOR month's activities. **Monthly Check In Report Form (3) is included in the index..*
N-MIECHV uses the network managers as an advisory committee and will often call for ad hoc meetings to discuss what's going on in the network, at the State or Federal level.
N-MIECHV has a monthly **Open Mic call with LIA managers and supervisors**. Participation is not required but strongly encouraged. N-MIECHV also has a monthly **Direct Service Open Mic call** for home visitors. Here, direct service providers have the opportunity to connect with others statewide who are doing the same job. They ask questions, share stories, celebrate accomplishments, and share challenges. Managers and supervisors typically don't participate in these calls.

h. **Subrecipient Monitoring Site Visits**
On odd years, we will conduct an in-person programmatic site visit. On even years, we will conduct a desk review/audit of financials. You will receive all the information needed prior to these visits. Transparency—no surprises.

i. **Operational and Business Plan**
Submission of an Operational and Business Plan will be required within 60 days of the execution of the subaward. This is going to look a lot like your affiliation application with HFA—it will outline your plan for staffing, space, budgeting, outreach, advisory committee, and general implementation of the program. N-MIECHV does not have a template for this.

j. **Child Welfare Protocol**
You must have an approved Child Welfare Protocol plan with the HFA national office and accept enrollments from families involved in child welfare. We will discuss the Child Welfare Protocol and partnering with the local child welfare offices in another section of this guide: *Healthy Families America Model of Evidence-Based Home Visiting (pg. 14).*

6. Performance Measures:
    a. Collect the data using an approved case management system.
    b. Keep all records (paper or electronic) for a minimum of 5 years past the period of performance.
    c. Make sure supervisors are monitoring individual direct service staff documentation and data entry to ensure completeness.

The rest of the subaward is DHHS responsibilities, DHHS template language, the budget, performance measures required (benchmark data plan), and the amounts with the funding source for your own reporting purposes.

Read the subaward thoroughly and carefully. If you have ANY questions or concerns, reach out to the N-MIECHV Program Manager.

HEALTHY FAMILIES AMERICA

Healthy Families America model of evidence-based home visiting is the program you will be implementing. You must contact the national office for MODEL AFFILIATION.

Healthy Families America

Our regional contact is Lenny Rivota: lrivota@preventchildabuse.org;
(312) 934-2601 (prefers email)

Lenny Rivota, M.S
Bilingual Training and TA Specialist
33 N. Dearborn St. Suite 2300
Chicago, IL 60602

She (or any of the national office staff) can help direct you on getting your affiliation application squared away. There are several classifications for the program. If your service area incorporates only one county or community, you are a **Single Site**. If your program will serve several counties (as most of our programs do) you are a **Multi-County Single Site.**

The HFA model is a positive, strengths-based program. They will offer training, technical assistance, and guidance in filling out the Affiliation Application, then meet with you to talk about your plan. Once you have your affiliation, you will gain access to the Best Practice Standards (everything you need to know about implementing the model to fidelity) and the Learning Management System (LMS) of online training modules.

The HFA enrollment window with families is narrow. It is an accreditation standard that 80% of your enrolled families must be enrolled either prenatally or within the first 90 days after the birth of the target child. This is intentional because we can make the greatest impact with families that have not yet learned poor habits, and when the target child is very young.

Along with your HFA Affiliation, you need to have an approved Child Welfare Protocol. This is specific to serving families involved in child welfare and is a condition of the award. The Child Welfare Protocol (CWP) widens the window of enrollment to the first 24 months of age when a family is REFERRED BY child welfare. It will require a formal Memorandum of Understanding between your program and the local child welfare office.

- NOTE: You can serve child welfare-involved families without an approved CW plan if they are pregnant or parenting a newborn 3 months of age or younger.
- You should be meeting with the local child welfare team or staff on a regular basis—some places have a high staff turnover rate and in order to stay top-of-mind, you need to develop a relationship, so you get consistent referrals.
- Education to the child welfare staff is going to be very important. HFA programs are voluntary, and a judge cannot mandate participation. We also take the privacy and HIPAA rights of our families very seriously—all of our CW participants must give us permission to share ANYTHING about their progress or goals with their child welfare caseworker.
- We are mandated reporters of suspected child abuse and/or neglect. That means if any home visiting staff see or hear anything indicating that a child either is or could potentially be in danger in the home, you must make a report to the **Child Welfare Hotline: 800-652-1999**. Follow your internal policy and procedures.

You will be working toward your national HFA **ACCREDITATION** in the first three (3) years after affiliation. This is an intense site review by national HFA Peer Reviewers ensuring that you are operating the model to fidelity. It starts with a self-study and ends with a 4-day visit from the peer reviewers. Then the results are discussed with the national accreditation review board. Again, HFA is a positive, strengths-based program. They will work with you to gain your accreditation and are not punitive. The Best Practice Standards are developed for accreditation—everything you need is in there. They will tell you exactly how to achieve the best of the standards, including intent, tips & tricks, and helpful hints.

Case Management System

As mentioned, each LIA must report the required data elements utilizing an approved case management system. N-MIECHV prefers a system called FamilyWise developed by Datatude, Inc. (We have a relationship with Datatude that allows us to automatically accept downloads of individual site data, eliminating the need for the LIAs to manually input all of the data into a flat file to send to us.) N-MIECHV has created a FamilyWise screenshot manual to help LIAs know how/where/why to enter the data for each of the benchmarks.

You will need to execute a contract with Datatude, Inc. for the data system. The cost is based on the number of users—the manager, supervisor(s), and all direct service staff must have access.

Datatude, Inc. will provide training on the use of FamilyWise.

- Datatude, Inc:
  Kristin Cotter Mena, Ph.D., IMH-E® (IV)
  President
  kcmena@datatudeinc.com
  888-675-2622x103
  713-440-7976x103

* The FamilyWise Screenshot Manu*al (4) and Form 2: Description of Missing Data (5) are included in the index.*

Curriculum

Next you will choose your curriculum. If the model is HOW you talk to parents & the approach you take, the curriculum is what you talk to parents about at each visit. You must choose an approved evidence-based curriculum:

- Growing Great Kids (Prenatal – age 5)
- Parents As Teachers (Prenatal – age 5)
- Partners for a Healthy Baby (Prenatal – age 3)
- Nurturing Parents – Nurturing Skills for Families (Birth - 5)
- PIPE Curriculum (Birth - 5)
- Baby Talk (Birth-5)

You may choose whichever curriculum is best for your community. Most of our program sites choose Growing Great Kids from Great Kids, Inc. but N-MIECHV does not have a formal recommendation. Different curriculums have different pros and cons, such as supplemental information availability (specific to preschool, substance use, or prenatal) and some require that you order all the materials from them, versus being able to duplicate or copy materials.

You will need to purchase curriculum materials for each direct service provider, and supervisors and managers must also receive the training. It is strongly recommended that you also purchase at least one set of the curriculum materials in whatever language is available that your client community speaks. Most commonly this is Spanish.

Your curriculum vendor will provide training for your staff.

Required Training

MIECHV and HFA require a lot of training for home visitors, managers, and supervisors. Generally speaking, home visitors complete between 90-100 hours of professional development annually. Some trainings have a cost associated with them, some are provided by N-MIECHV staff or are included in the HFA Affiliation costs and are available in the HFA Learning Management System (LMS). Trainings that are *highlighted* in red have an associated, separate cost.

ALL STAFF:

1. N-MIECHV HFA Orientation- by N-MIECHV Program Manager

2. HFA Stop Gap Training: Foundations for Family Support (FFS) – LMS
   *** Stop Gap is required if the staff member has not completed core training prior to seeing families.***

3. HFA Core Training- Provided by HFA National Office
   a. Foundations for Family Support (FFS)
   b. Family Resilience and Opportunities for Growth (FROG)
   *** FROG Training is only required IF a staff member is going to be conducting FROG surveys.***

4. Curriculum Training – provided by your curriculum vendor

5. Data Training – online interactive modules on the Answers 4 Families Classroom (developed by N-MIECHV)

6. Continuous Quality Improvement – by N-MIECHV

7. Tools
    a. **Child Development**: Ages & Stages Questionnaire and ASQ-Social/Emotional (ASQ3 and ASQ-SE2)
        i. *** This tool must be purchased separately through* Brookes Publishing.
        ii. A single set for the program site can be used; recommended Starter Kits for both the ASQ3 and the ASQ-SE2.
        iii. Free, online training is available on the Brookes Publishing website OR
        iv. N-MIECHV can provide training.
    b. **Maternal Depression:** Center for for Epidemiological Screening – Depression (CES-D)
        i. Written instructions are included. Designed for the client to fill out on their own.
        ii. Maternal Depression module available in HFA LMS
        iii. *Tool and instructions are included in the index (6).*
    c. **Substance Use:** - UNCOPE (the acronym is based on the first letter of each question.)
        i. Designed for the client to fill out on their own.
        ii. *The tool and a script developed by another site to guide the initial conversation, are included in the index (7).*
    d. **Parent-Child Interaction:** (CHEERS Check In) - Validated HFA parent-child interaction observation tool.
        i. HFA offers training in LMS
    e. **Intimate Partner Violence:** (IPV) Relationship Screener.
        i. The validated tool is the "STaT: 3 Question Screener", however it can be fulfilled by the similar questions in the FROG survey or another validated IPV screener (such as the Hit/Injured/Threatened/Scared, or HITS screener) AS LONG AS the 3 questions are answered in the case management system..
        ii. *Another program site developed a script with the 3 questions in a "Relationship Screener" that is more user-friendly, included in the index (8).*
        iii. IPV module available in HFA LMS
        iv. ***See the section in this guide on Benchmarks, Measures, and Tools*.
    f. **Safe Sleep:** NE Safe Sleep Environmental Checklist.
        i. *Tool and written instructions are included in the index (9).*
    g. **Home Safety: Home Safety Checklist**
        i. Developed by a program site in collaboration with the Nebraska Safe Kids Program
        ii. *Tool and written instructions are included in the index (10).*

8. **Healthy Families America Wrap-Around Training** – available in the HFA LMS
    a. **3-month** wrap-around training (within 3 mo of hire)
    b. **6-month** wrap-around training (within 6 mo of hire)
    c. **12-month** wrap-around training (within 12 mo of hire)
    d. *A full list of HFA Required Training, including Wrap-Around trainings is included in the index (11).*

9. **ANNUAL** training – HFA provides training modules in the Learning Management System, but this can also be achieved through NE DHHS or any other source.
    a. Child Abuse & Neglect including mandated reporting
    b. Diversity, equity, inclusion, & belonging
    c. Continuous Quality Improvement refresher
    d. Minimum of 15 hours in relevant training opportunities – unique to each HV's needs, interests, and staying up to date on recent advances in the field

10. **Strongly Recommended**
    a. HFA Facilitating Change or any other Motivational Interviewing training

SUPERVISORS/MANAGERS: This is IN ADDITION TO the trainings listed above.

1. Supervisor Stop Gap for FFS- in the HFA LMS
2. FROG Supervisor – in the HFA LMS
3. HFA Supervisor Core: Relationships and Reflection
4. *Facilitating Attuned Interactions (FAN) Training* through the Center for Reflective Practice at the University of Nebraska-Lincoln. **FAN training description is in the index (12).*

MANAGERS: This is IN ADDITION TO all trainings listed above.

1. HFA Implementation Training

INVOICING/BILLING

1. Invoices are to be completed on a quarterly basis (unless other arrangements have been made.) They are due within 30 days past the last day of federal fiscal quarters 1, 2, 3, and 45 days after the 4th quarter.
   a. **Q1: Oct 1 – Dec 31 Due by Jan 31**
   b. **Q2: Jan 1 – Mar 31 Due by Apr 30**
   c. **Q3: Apr 1 – Jun 30 Due by July 31**
   d. **Q4: Jul 1 – Sept 30 Due by Nov 15**

2. Invoices must use the **standardized programmatic reporting** forms and **standardized invoicing forms** provided by N-MIECHV.
   a. *Both of these forms are included in the index (13 & 14).*

3. Invoices must also include the **general ledger detail** for the months of reporting that show what was purchased. These invoices may be reviewed by both N-MIECHV and TANF programs separately.
   a. Please note: In the general ledger detail, you must list what was purchased. Simply putting "supplies" will not be acceptable. We are looking for allowability for federal expenses.
   b. Expense allowability is based on the Code of Federal Regulations.
   c. If you're ever unsure whether an expense is allowable under federal grants, *Please ASK before spending.*

Advisory committee

Each LIA will need to develop an advisory board for their program. With a program that went through community planning, it's easy to use the people invited to those meetings. Otherwise, you will invite local early childhood stakeholders—anyone that could be a potential referral source, or representatives from any organization that sees families or pregnant women.

Suggestions:

- Representatives from any other home visiting programs in the area, such as Sixpence and/or Head Start.
- Healthcare providers from the local clinic(s) and hospitals
- Pediatricians, family medicine practitioners, OB/GYNs
- Representatives from WIC
- Representatives from public and private schools
- Representatives from local health department
- Representatives from child welfare
- Representatives from Medicaid/Medicare eligibility offices
- Representatives from local businesses that cater to families, or are large employers in the area
- Representatives from local cultural hubs, esp. if there is a large population of community members in that culture
- FAMILY MEMBERS ** *These can be current or former participants in the program, or any other member of the community.*

Your advisory committee/board must meet a minimum of quarterly and in-person or virtual meetings are acceptable. It's not just about reporting out, you should involve your advisory committee members in programmatic and data activities. For example, outreach, increasing referrals, review of data reports, continuous quality improvement projects, resources for client families, and coordination between members for the benefit of the community. N-MIECHV recommends you send reminders to members ahead of meetings and send notes after meetings to maintain excellent communication.

Policy & procedures

Each LIA will develop a full Policy and Procedure Manual for your program. This should include individual local organizational policies, as well as the policies required by both HFA and the federal MIECHV program. The HFA requirement for accreditation includes developing your policy and procedure manual based on the most current HFA Best Practice Standards. Many of the policy requirements for MIECHV overlap the HFA requirements.

For the MIECHV requirements, you must have policies on:

1. Outreach, recruitment, and retention of client families
2. Voluntary nature of the program
3. Eligibility of families, including target populations in your community to ensure you are serving the families that are most in need of support. This aligns with the federal program target population.
4. Recruitment, training, and retention of high-quality staff
5. Enrollment, re-enrollment, and prevention of dual enrollment
6. Transitioning a family from one HFA program to another (ie: moving out of the area)
7. Use of incentives
8. Virtual home visits
9. Screening and referrals to the most appropriate community resources
10. Client satisfaction and grievances
11. Provision of high-quality supervision, including both clinical and reflective supervision
12. Fiscal policies, including policy on using either company or personal vehicles for home visits
13. Data entry and reporting
14. Others will be communicated by the N-MIECHV Leadership Team as necessary

N-MIECHV's Policy and Procedure manual is posted on the N-MIECHV Website.

DATA – BENCHMARKS, MEASURES, and TOOLS

The federal MIECHV program requires data collection on 6 benchmarks and 19 measures. N-MIECHV has developed an *online training module* for all home visiting staff to complete. Every subaward also includes a copy of the benchmark performance plan that explains exactly what is collected, how it is collected, and at what level.

1. You will receive reports of the analyzed data on a quarterly basis for both your own site and for the state network.

2. You will also receive a list of missing data for each construct, and which family (personal health information is de-identified by assigning each family a number) is missing that piece.

3. Each fall, N-MIECHV must submit annual performance data to our federal partners and will work to ensure that your data is as complete as possible.

4. On the check in call after the quarterly reports go out, we will discuss your data, pointing out highlights and going over areas for improvement.

5. The most important thing is that you understand your data and how it affects our network and our state.

6. The N-MIECHV Health Surveillance Specialist is available at any time for technical assistance.

SIX BENCHMARK AREAS

1. Maternal and Infant Health

2. Childhood Injuries and Child Maltreatment

3. School Readiness and Achievement

4. Crime and Domestic Violence

5. Family Economic Self-Sufficiency

6. Coordination of Community Supports and Referrals

The N-MIECHV program must demonstrate improvement in 4 out of 6 of the benchmark areas every three years as a condition of the federal MIECHV funding. Data collection and reporting is vitally important and begins with the LIAs' service to individual families. **The Nebraska-MIECHV Benchmark Plan is included in the index (15).*

BENCHMARK 1: MATERNAL AND NEWBORN HEALTH

Construct 1: Pre-Term Birth (Systems Outcome)
Percent of infants among mothers who enrolled prenatally before the 37th week of gestation who are born pre-term following program enrollment.

Construct 2: Breastfeeding (Systems Outcome)
Percent of infants among mothers who enrolled prenatally who were breastfed any amount at 6 months of age.

Construct 3: Depression Screening
Percent of parent/primary caregivers who are screened for depression using a validated tool within 3 months of delivery (for those enrolled prenatally) or within 3 months of enrollment (for those enrolled postpartum).
REQUIRED TOOL: Center of Epidemiological Studies Depression Scale (CES-D)

Construct 4: Well Child Visit
Percent of children who received the last recommended well child visit based on the American Academy of Pediatrics (AAP) schedule. *This schedule is in the index (16).

Construct 5: Post Partum Care
Percent of mothers enrolled prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery.

Construct 6: Tobacco Cessation Referrals
Percent of parent/primary caregivers who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling within 3 months of enrollment.

Construct 7: Safe Sleep
Percent of infants that are always placed to sleep on their backs, without bed-sharing or soft bedding.
OPTIONAL TOOL: Nebraska Safe Babies Safe Sleep Environmental Checklist

BENCHMARK 2: CHILD INJURIES, ABUSE, NEGLECT, AND MALTREATMENT AND EMERGENCY DEPARTMENT VISITS

Construct 8: Child Injury (Systems Outcome)
Rate of injury-related visits to the Emergency Department among children enrolled.

Construct 9: Child Maltreatment (Systems Outcome)
Percent of children with at least 1 investigated case of maltreatment (abuse, neglect) within the reporting period.

BENCHMARK 3: SCHOOL READINESS AND ACHIEVEMENT

Construct 10: Parent-Child Interaction
Percent of parent/primary caregivers who receive an observation of caregiver-child interaction by the home visitor using a validated tool.
REQUIRED TOOL: CHEERS Check In Tool (CCI)

Construct 11: Early Language and Literacy Activities
Percent of children with a family member who reported that during a typical week they read, told stories, and/or sang songs with their child every day.

Construct 12: Developmental Screening
Percent of children with a timely screen for developmental delays using a validated parent-completed tool.

REQUIRED TOOL: Ages and Stages Questionnaire, ed. 3 (ASQ3) and Ages and Stages Questionnaire Social-Emotional, ed. 2 (ASQ-SE2) *Materials must be purchased through Brooke's Publishing. Recommended: Starter Kits for both the ASQ3 & ASQ-SE2. One kit per program site, although you may want to purchase one in any language represented in your community. Most commonly this is Spanish.

The TIMING of conducting the ASQ screens is very important! If they are not done in the appropriate period of time based on the child's age, they will not "count" as complete in the data. ** The timing schedule for conducting ASQ is included in the index (17).*

Construct 13: Behavioral Concerns

Percent of home visits where parent/primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning.

BENCHMARK 4: CRIME OR DOMESTIC VIOLENCE

Construct 14: Intimate Partner Violence (IPV) Screening

Percent of parent/primary caregivers enrolled who are screened for IPC within 3 months of enrollment using a validated tool.

- The validated tool is the "3 Question Screener." This no-real-name screening tool can be fulfilled by the similar questions in the FROG survey (which adapts the IPV portion of the Behavior Risk Factor Surveillance System (BRFSS) or another validated IPV screener (such as the HITS tool) AS LONG AS those 3 questions are answered in the case management system.
- A program site has developed a "Relationship Screener" that asks these questions in a more detailed, less intimidating way. It is included in the index (7).

REQUIRED TOOL: 3 Question IPV Tool

1) **Afraid:** Considering your current partners or friends, or any past partners or friends, is there anyone who is making you feel unsafe now?
2) **Police:** In the past year, have the police ever been called to your home because of a fight or argument, no matter who was fighting or who was at fault?
3) **IPV:** Thinking back over the past year, on any occasion, were you hit, slapped, kicked, raped, or otherwise physically hurt by someone you know or knew intimately, such as a spouse, partner, ex-spouse or partner, boyfriend, girlfriend, or date?

BENCHMARK 5: FAMILY ECONOMIC SELF-SUFFICIENCY

Construct 15: Primary Caregiver Education (Systems Outcome)

Percent of parent/primary caregivers who enrolled without a high school (HS) degree or equivalent who subsequently enrolled in, maintained continuous enrollment in, or completed HS or equivalent during their participation.

Construct 16: Continuity of Insurance Coverage (Systems Outcome)

Percent of parent/primary caregivers who had continuous health insurance coverage for at least 6 consecutive months.

BENCHMARK 6: COORDINATION AND REFERRALS FOR OTHER COMMUNITY RESOURCES AND SUPPORTS

Construct 17: Completed Depression Referrals

Percent of parent/primary caregivers referred to services for a positive screen for depression (Construct 3) who receive one or more service contacts.

Construct 18: Completed Developmental Referrals

Percent of children with positive screens for developmental delays (Construct 12) who receive referral information to developmental resources.

Construct 19: Completed Intimate Partner Violence Referrals

Percent of parent/primary caregivers with positive screens for IPV (Construct 14) who receive referral information to IPV resources.

Continuous Quality Improvement (CQI)

Continuous quality improvement is an important component of the N-MIECHV programs; it is relevant and involves every staff person in the home visiting program, as well as families! It is our goal to create a culture of quality in each program and throughout the state network. Every LIA must participate in the State CQI team, but it doesn't have to be a manager or supervisor—direct service providers are welcome. The State CQI Plan is based on the collective data for all sites, and although every LIA must participate, they are able to choose the method and project that means the most to their individual site.

CQI is all about data—what story is your data telling? What story do you wish it to tell? N-MIECHV provides CQI training, technical assistance, the tools, and facilitates the State CQI meetings quarterly. The most commonly used CQI tools are the Fishbone Diagram, and the Plan-Do-Study-Act Cycle. *Blank forms for both of these tools are included in the index (18).*

LIAs should use their own data and priorities within their own team to work on other CQI projects that are meaningful to them.

Each of the LIAs submit the notes from internal CQI meetings, tools completed, and updates on their CQI projects quarterly to the N-MIECHV Program Specialist.

Outreach

Outreach for your program is essential to success! LIAs develop and nurture relationships with the local organizations in the community to send referrals—this includes anyone that sees pregnant women or families with infants. These always include local clinics, hospitals, OB/GYNs, pediatricians, DHHS, schools, daycares, churches, WIC offices, housing, food pantries, and for sure local businesses especially if they employ or cater to families. You need to "reach out" to these community partners and ensure they know about your program and will send you referrals!

The Federal Code of Regulations (CFR) does not allow federal funds to be used for "advertising" or "marketing", so you need to be creative with your outreach methodology.

- Create a brochure and/or a rack card that you can leave with partners to give to families.
- Fliers/Posters that are eye-catching, simple and bring the most important details to the forefront, encouraging families to find out more.
- Develop an "elevator speech" with input from your direct service staff. When someone asks randomly about home visiting or "what do you do?" make sure everyone can give simple, factual, and effective information.
- Go out into the community to present on your program, like at lunch and learns, staff meetings, or other educational opportunities.
- GO MORE THAN ONCE! You have to continue to meet with partners on a regular basis—two or three times a year to stay top-of-mind and to make sure new employees know who you are.
- Invite key partners to join your staff meetings and ask to join theirs. This is especially true with local NDHHS Child Protective Services staff.
- Invite partners to join your advisory committee.

- Have booths/participate in community events. Include a fun, short, easy parent-child activity that will draw in kids and lead parents to come find out more.
- ASK YOUR PROGRAM PARTICIPANTS to share their experiences with others! There is no better advertising than word-of-mouth.
- If someone sends a referral, send them a note telling them thank you and how much difference they are making in that person's life. If the client family says it's okay, you might even want to give an update that they enrolled.
- Be creative! Be consistent and be present. Oh, and take donuts. Everybody loves donuts.

CLIENT INCENTIVES

You can use incentive items for clients based on enrollment, needs, or outreach. These may include everything from diapers/wipes, breastfeeding support supplies (like breast pads, lanoline cream, milk storage bags), books, developmentally appropriate toys, home safety devices (like outlet plugs or roller devices for miniblind cords), formula, even feminine hygiene products or laundry detergent. All of these items have a place in providing safe, healthy, developmentally appropriate care and can be a huge incentive for engaging or continuing in services.

The *Code of Federal Regulations* allow programs to put their logo on certain incentives, such as a diaper bag, but it must be the specific HFA program, NOT a general organizational logo. For example, you can put the local health department's logo on there, but it must be accompanied by the Healthy Families America program logo/name.

Many programs have a "welcome baby" gift when families agree to meet with the program the first time. This might include a small package of diapers and wipes, a rattle or plushy, a board book, and of course information on the program. It may be just what the program needs to get their foot in the door.

Unfortunately, some disadvantaged families have experience with enrolling in programs just for the "free stuff." They may be jaded from fully participating and reaping the true benefits of a great program. To combat this, LIAs set up a system where clients can EARN points or "Baby Bucks" to use in the incentive "store" as they are making progress toward their goals and the benchmarks. For example, every time they keep a scheduled visit, take their child in for a well-child check, get an immunization, join a socialization event, or do a parent-child activity outside of a visit, they can earn a certain number of points. Points add up and eventually that family can "purchase" incentive items from the store.

LIAs must keep careful track of what items are purchased, and what items are distributed to families. All incentive items must be appropriate for a pregnant or parenting family and should NOT be available for the staff to use. This tracking system must include a date/time and who received it. Programs must keep track of inventory as well.

There are special times and circumstances when client families might receive incentives or gifts, like for a child's first birthday, for a major accomplishment such as meeting a big goal or graduating from the program. There are also times when the safety of the child must come first, and the family might receive a car seat or a Pack-N-Play for a safe sleep environment. You may also use incentives such as grocery or gas cards/transportation vouchers for emergencies. The key is to track carefully, and even though you might be helping a family out of a tight spot, you're teaching them to prepare better for it next time, not just rely on your program.

Many of our LIAs have incentive stores and programs with established rules and procedures. Reach out to the network to find out more!

Mileage/travel

Home visiting is all about meeting families where they are, and getting to know them in the environment they are most comfortable in—their home. There is going to be a certain amount of driving or travel involved for each visit. You need to decide if direct service staff will be using **company vehicles** or **personally-owned vehicles** for travel.

If you have company vehicles, there must be a policy/procedure on use including travel limits, expectations of keeping track of mileage, fuel, and ensuring that each person with permission to use it has appropriate defensive driving training and a clean record. If the vehicle is ONLY used for the HFA program, all expenses for that vehicle, such as purchase price, gas, maintenance, tires, etc. are allowable expenses for the HFA program. However, if the company vehicles are also available to other organizational employees, a reasonable process of deciding how much of the costs are allocated to the HFA program must be in place and documented. For example, if an organization has 10 employees, each of them approved to use the vehicles, across 3 programs, 33% of the expense of maintenance and upkeep of the vehicles should be allocated to the HFA program. You may also use a system of actual mileage and base the expenses on how many miles are driven. It's up to you—again, when in doubt, ASK.

Staff equipment/supplies/shirts

Home visitors use the internet on home visits for many different purposes, such as sharing videos, filling out forms, translation services, or looking up resources. They should each have a lightweight but reliable iPad, tablet, or laptop, with a hot spot or "portable" internet capability (for those times when the family does not have wifi or are in a rural area without wifi available), with protective covers. These devices should have your case management software downloaded for documentation purposes.

In the office, each staff member should also have either a laptop or desk top computer with the documentation software, a work cell phone, and other essential office supplies. A work bag to take all the parts of the curriculum or activity is very important—this should be large enough to hold the necessary materials and made of something that is easy to clean and disinfect. Some staff have even created "seats" out of 5-gallon buckets and cushions to carry their things and have a place to perch at the same time.

Each home visitor should also consider carrying lice and/or bedbug spray, wet wipes, and hand sanitizer.

Home visitor dress is something all sites need to consider. Home visitors are non-judgmental and want to develop a trusting relationship with the family. Many of our clients are living in poverty and are worried about how they appear to anyone new. First impressions count!

In order to meet families where they are, staff should dress professionally, but casually. Clean, no rips or holes, minimal jewelry, and comfortable shoes. In home visiting, we don't want to appear "superior," but strike a balance with clean, comfortable, and modest appearance. Many of our program sites opt for casual pants/slacks or jeans and "uniform" shirts, like polos, t-shirts, or sweatshirts with the HFA program logo. Many organizations have specific policy/procedures about staff appearance or dress code.

Uniform shirts are federally allowable IF they are specific to the HFA program, and not to the organization as a whole. For example, they must have the HFA logo/name on them and not just the name of the health department or non-profit organization.

Make sure your program has a good, quality copier/printer/fax machine available to all home visiting staff. (Many health care providers will only use fax when sending anything with personal health information, such as a referral.) This machine will be used constantly and one with a maintenance plan is essential.

FAMILY FIRST PREVENTION SERVICES ACT (FFPSA) GRANT

Each N-MIECHV LIA has the opportunity to receive additional funding in the form of an FFPSA contract with the Division of Children and Family Services (DCFS or child welfare department.) The FFPSA grant is a federally-funded prevention services grant, designed to keep children out of the foster care system, and families together at home. In order to qualify for this funding, the LIA must have an approved HFA Child Welfare Protocol. The contract will allow LIAs to bill DCFS for engaging and enrolling families that are referred by the local NDHHS child welfare team (Child Protective Services caseworker(s)) and that have completed what DCFS calls a "green phone referral" form for that client family.

The N-MIECHV Leadership team engages the FFPSA Program Manager and Program Specialist to provide training and technical assistance in working with the caseworkers and families involved in child welfare.

When a client family is referred by child welfare, the caseworker will reach out to the HFA program to make the referral and the HFA program will reach out to the client family. It is important to note that home visitors must assure the client that the rules and responsibilities of HIPAA laws are strictly followed—the program is VOLUNTARY and home visitors will NOT be allowed to discuss any part of the client's goals or progress without their express permission in the form of a written Release of Information (ROI). Home visitors are also NOT responsible to supervise visits between a parent and child. We work TOGETHER with the client and the caseworker to provide the most appropriate services to the family.

An FFPSA contract is optional. The FFPSA team has worked with the N-MIECHV team and developed an internal (NDHHS) Memorandum of Understanding (MOU) to provide the necessary data requirements for the federal reporting, so the LIAs are not responsible for any additional data collection or reporting for the FFPSA grant. The reimbursement to the LIAs is a UNIT RATE developed by DCFS, designed to cover the expenses for engagement/outreach, planning, visits, drive time, documentation, and case review in supervision.

The FFPSA unit rate is TIERED for distance, so the LIA must report to the FFPSA program (through the data portal) the address of the client. The distance is measured from the HFA office to the client's house. The LIA is responsible to inform DCFS any time that changes. DCFS will train the LIAs how to use the reimbursement software.

There are rules about when you can use two different sources of federal funding—you may not bill BOTH sources for the same work, called “Double Dipping.” The LIAs must put a policy/procedure in place to track the time spent working with child welfare-involved clients that are being billed to the FFPSA contract, and that time must be DEDUCTED from the invoices to the N-MIECHV subaward. The simplest way to do this is to calculate a percentage of time/effort of the home visitor based on how many families they are serving. For example, if a home visitor has a caseload of 12 families, and 3 of them are child welfare-involved (designated as “CW” or “CWP” families), then 25% of that person’s salary should be billed to FFPSA and 75% of it should be billed to N-MIECHV. Another method is to clock in/out or record the actual time spent by the home visitor in serving a CW family.

If an LIA chooses to have an FFPSA contract, it is considered “additional income” to the program. The N-MIECHV subaward covers the entire cost of the program, so any FFPSA dollars that are billed are considered in addition to or over and beyond the award. The FFPSA/N-MIECHV partnership is complex—when in doubt, call the N-MIECHV Program Manager!

** The FFPSA negotiated daily rate is included in the index (19).*

When can we start seeing families?

There are rules about when you are able to begin serving families, and training that must take place before that can happen. HOWEVER, don’t be afraid to start recruiting! N-MIECHV and the HFA network will help you know what to do, I promise!!

Once you have your HFA Affiliation, and all staff have completed BOTH the HFA Orientation offered by N-MIECHV, and the HFA online “Stop Gap” module in the Learning Management System, you can begin active outreach with community partners and start enrolling families. Of course, you must have all your paperwork (brochures, ROIs, enrollment forms, case management system) in place, but the orientation and stop gap trainings are enough to get you started.
There is nothing that is going to prepare you better than getting in there and creating relationships! Part of the HFA Stop Gap training includes shadowing existing home visitors. Many of our new programs will contact more experienced programs in our network and ask to come out and SHADOW their home visitors, supervisors, and/or managers for a day or two prior to seeing families.

TIMELINE

This is an approximate, suggested timeline for implementation of a new program site. Every site is different, and some challenges cannot be anticipated. The key is working with the N-MIECHV team to individualize for YOUR needs. (This timeline is NOT reflective of the HFA training schedule because their timeline doesn't begin until affiliation is complete.)

0 – 3 MONTHS:

1. Complete paperwork to become a vendor or subrecipient of an NDHHS award.
2. Decide on size, scope, geographical service area, program vehicles, and curriculum.
3. Create advisory committee and get commitments from community partners who will serve.
4. Create the budget.
5. Contact Healthy Families America to begin the affiliation process. Decide on a formal name for the program.
6. The subaward with NDHHS is fully executed.
7. Contract for your case management system.
8. Contract for your curriculum.
9. Managers/Supervisors complete HFA Orientation training with N-MIECHV.
10. Managers/Supervisors complete the HFA Stop Gap training in the Learning Management System.
11. Set up the office environment and purchase the necessary materials for staff including computers, work cell phones, and internet hot spots.
12. Hire direct service staff.
13. Set up date/time for monthly check in calls.
14. Join monthly Manager/Supervisor Open Mic calls.

3 – 6 MONTHS:

1. Direct service staff complete HFA Orientation and HFA FFS Stop Gap training.
2. Creating program materials like referral forms, enrollment forms, outreach materials, brochures, etc.
3. Contact Brookes Publishing to purchase the ASQ3 and ASQ-SE2 materials.

4. Acquire and become familiar with all the N-MIECHV required data tools; some require completion of additional training.

5. Complete training on the case management system by the vendor – PRACTICE!

6. ALL staff complete data training online modules.

7. ALL staff complete HFA Core trainings: Foundations for Family Support (FFS) and Family Resilience and Opportunities for Growth (FROG). *Only staff that will be conducting the FROG are required to complete FROG training.

8. Supervisors and direct service staff complete curriculum training by the vendor.

9. Contact another established program site to set up some shadowing visits.

10. Complete the Child Welfare Protocol application/plan with HFA.

11. Start to purchase incentive materials for clients and establish how your "store" will work as well as tracking.

12. Start to develop your policy/procedure manual.

13. Direct service staff join monthly Direct Service Open Mic calls.

14. BEGIN OUTREACH IN THE COMMUNITY

6 – 9 MONTHS:

1. ALL staff Complete Continuous Quality Improvement (CQI) training offered by N-MIECHV.

2. Begin wrap around training found in the HFA Learning Management System

3. Managers and Supervisors complete HFA Supervisor Core: Relationships and Reflection training through HFA

4. Have your first advisory committee meeting!

5. OUTREACH, OUTREACH, OUTREACH

6. Start enrolling families!

9 – 12 MONTHS:

1. Managers complete HFA Implementation Training.

2. OPTIONAL: Managers and Supervisors enroll in FAN Training- Reflective Supervision

3. OPTIONAL: ALL staff enroll in motivational interviewing training or Facilitating Change through HFA.

ACRONYM DICTIONARY

AAP:	American Academy of Pediatrics
ASQ3:	Ages and Stages Questionnaire, edition 3 (developmental screening tool)
ASQ-SE2:	Ages and Stages Questionnaire – Social/Emotional, edition 2 (social/emotional developmental screening tool)
CCI:	CHEERS Check In (Parent-Child Interaction observation tool)
CQI:	Continuous Quality Improvement
CWP:	Child Welfare Protocol (families enrolled under the Child Welfare Protocol may also be referred to as “CW” families)
DAISEY:	Data Application and Integration Solutions for the Early Years (data analysis system developed by Kansas University)
DCFS:	Division of Children and Family Services (child welfare)
DPH:	Division of Public Health
FFPSA:	Family First Prevention Services Act Grant
FFS:	Foundations for Family Support (HFA core training)
FROG:	Family Resilience and Opportunities for Growth (HFA core training)
FTE:	Full Time Equivalent (percentage of staff time/effort based on a 40-hour work week)
HFA:	Healthy Families America (model of evidence-based home visiting)
HIPAA:	Health Insurance Portability and Accountability Act (federal health information privacy law)
HRSA:	Health Resources and Services Administration (federal administration partner)
IPV:	Intimate Partner Violence (domestic violence or relationship violence)

KU-CPPR or KU:	Kansas University Center for Public Partnerships and Research (data analysis vendor)
LIA:	Local Implementing Agency
LMS:	Learning Management System (Healthy Families America training system)
MIECHV:	Maternal, Infant, and Early Childhood Home Visiting Program (federal level)
MOU:	Memorandum of Understanding (legal agreement between two organizations or agencies describing their relationship)
NDHHS:	Nebraska Department of Health and Human Services
N-MIECHV:	Nebraska-Maternal, Infant, and Early Childhood Home Visiting Program
ROI:	Release of Information (permission from the client family to talk about their personal health information or situation)
SGF:	State General Funds
TANF:	Temporary Assistance for Needy Families Grant

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