# Healthy Families America 120810

HFA is an intensive voluntary home visiting program model designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, substance abuse issues or are at-risk for child abuse and neglect and other adverse childhood experience. Specifically, it is for parents/caregivers of children ages birth to five years old. Home visit services may be initiated prior to the birth of a baby if they are assessed to be at high risk for abuse/neglect. Otherwise, if assessed to be at high risk at birth services should begin within three months. The goals of Healthy Families America (HFA) are:

•Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth

•Cultivate and strengthen nurturing parent-child relationships

•Promote healthy childhood growth and development

•Enhance family functioning by reducing risk and building protective factors

HFA is theoretically rooted in the belief that early, nurturing relationships are the foundation for life-long, healthy development. Building upon attachment, bio-ecological systems theories, and the tenets of trauma-informed care, interactions between direct service providers and families are relationship-based; designed to promote positive parent-child relationships and healthy attachment; services are strengths-based; family-centered; culturally sensitive; and reflective.

The HFA model is based upon 12 critical elements. These are:

1. Initiate services prenatally or at birth.
2. Use standardized screening and assessment tools to systematically identify and assess families most in need.
3. Offer services voluntarily and use positive, persistent outreach efforts to build family trust.
4. Offer services intensely and over the long-term, with well-defined criteria and a process for increasing or decreasing frequency of service.
5. Take into account the culture of families in the services offered such that staff understands, acknowledges, and respects cultural differences of families.
6. Focus on supporting the parent(s) as well as the child through services that cultivate the growth of nurturing, responsive parent-child relationships and promote healthy childhood growth and development.
7. Link all families to a medical provider to ensure optimal health and development and other services to meet their assessed needs.
8. Ensure Family Support Specialists have an adequate time to spend with each family to meet their needs and to plan for future activities.
9. Select service providers based on:
    a. Their personal characteristics
    b. Their willingness to work in, or their experience working with, culturally diverse communities
    c. Their knowledge and skills to do the job

10. Provide intensive training to service providers specific to their role to understand the essential components of family assessment, home visiting, and supervision.
11. Ensure service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families
12. Give service providers ongoing, effective supervision so they can develop realistic and effective plans to empower families.

| Only in- home setting where the child is/will be living is permitted. Any alternate locations must be approved in writing. | Unit= One day<br>90 units/90 days (3 months) |
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| Admission Criteria: | • Parent must be pregnant or parenting a newborn<br>• Service must be referred by BCF caseworker<br>• Child must remain in their home<br>• Children in DHHR custody who have returned home for a trial visit<br>• WV DHHR Prevention or Case Plan must be provided, or service cannot be authorized. A provider plan will not substitute this requirement.<br>• May also be used for children in foster care who are pregnancy and/or parenting. |
| Continued Stay: | Not Applicable |
| Discharge Criteria | • Goals have been accomplished<br>• Family/child is not participating<br>• No progress has been demonstrated<br>• Child enters DHHR Custody |
| Service Exclusions: | Targeted Case Management and other parenting education curricula. |
| Clinical Exclusions: | Parent is in active hospital or residential based treatment without the child(ren). |
| Documentation: | There must always be a permanent case record maintained in a manner consistent with applicable licensing regulations and agency record-keeping policies.<br><br>A case note must be completed within 15 days for each service event that includes<br>• Code or service name<br>• Summary of the intervention<br>• Client's response to the intervention<br>• Relation to the service plan<br>• Location where service occurred<br>• Duration |

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| | • Start/stop time<br>• Signature of the provider and his/her title or credentials<br><br>A copy of the current Safety Plan and the CPS Family Functioning Assessment and/or Protective Capacity Family Assessment must be present in the case record.<br><br>WV DHHR Prevention or Case Plan must be provided, or service cannot be authorized. A provider plan will not substitute this requirement.<br><br>A monthly progress summary must be completed and received by DHHR worker by the 10th day of the following month, a copy kept in the provider chart and one sent to the referring worker. DHHR Standard Form must be used. This monthly progress report must contain:<br>• A list of dates of service and the specific services rendered and/or attempts<br>• Overall summary of progress for the client/family receiving the service. Please include if family continues to benefit and/or the barriers to intervention<br>• Plan for further interventions<br>• Any identified unmet concrete or service needs<br>• Date and name of DHHR staff to which any new allegations of abuse/neglect were reported within the month |

Prerequisites/minimum qualifications:

Agencies must sign an affiliate agreement indicating they will adhere to the Essential Requirements to meet model fidelity.