Contents

Standard 7-1.B

(from Best Practice Standards 2014-2016 effective through 12/31/2016)

7-1. Participating Target Children have a medical/health care provider to assure optimal health and development.

[**7-1.A** relates to site policy for linking all target children to medical/health care provider(s).]

7-1.B Target children have a medical/health care provider.

Intent: *A medical home is crucial to the health and optimal development of the child. In addition to being a vital resource for ongoing preventive health and wellness guidance, and medical interventions as needed, a medical home plays a crucial role child abuse prevention as it allows another professional consistent access to the family to provide support and monitoring for the well-being of the child.*

7-1.B		RATING INDICTORS
3	-	Ninety-five percent (95%) through one hundred percent (100%) of target children have a medical/health care provider.
2	-	Eighty percent (80%) through ninety-four percent (94%) of target children have a medical/health care provider.
1	-	Less than eighty percent (80%) of target children have a medical/health care provider.

☺ Tip: For target children who currently do not have a medical/health care provider, be sure to indicate the reasons why and clearly document attempts/steps taken to link these children.

☺ Tip: It is also important to indicate if families are on Creative Outreach and current information is unavailable.

☺ Tip: Sites are also encouraged to document the current medical/health care provider for all participating family members (children other than target children and adults) – see standard 7-3.

Using PIMS to Provide Evidence of Compliance

The report **PIMS18B: Linkage to Medical Providers for Participating Children** addresses this standard. Remember that as with most affiliation standards, you may need to support the quantitative data from PIMS reports with a narrative interpretation.

Report **PIMS18B** will provide a list of participants and their children, with the children's medical providers. Medical provider names are taken from the birth records and from **Child History** records, if any exist. If there is no medical provider entered for a child, the report will show a dash in the field. **PIMS18B** will also indicate the date of the first pediatric referral for a child, when there is a referral record for the target child. A print-out of the referral records can be used as evidence of the program's efforts to connect a child or participant to a medical provider.

Tips for Monitoring PIMS Data Related to Standard

Sites will want to make sure that all children have medical provider information entered in the birth record. Sites will also want to regularly monitor the child's current medical provider, and to update that information in the **Child History** record should the child change doctors.

The clinic name or pediatric practice name can be entered in the PIMS records instead of the physician's name, if the physician's name is not known.

How to Run this Report

1. From the **Reports** screen, select **Standard Reports**.
2. For target children, select **Category** "Child Outcomes" and **Report** "Linkage to Medical Providers for Participating Children".
3. Under **Report Parameters**, choose **Case Status** "Currently presumed active" and a data cut-off date of today. The percentage of children or parents with a medical provider is shown on the last page.
4. To generate a hard copy of the family's referral records, go to the participant's **Home** form. Click on **Referrals** and double click on the record you wish to view; for example, a referral for the target child's medical home. Click on the **Print** button to display a printer-friendly version of the record.

Example

File Export View Window

Healthy Families (1L000')

PIMS18B: Linkage to Medical Providers For Participating Children

Participants Active at Any Time Between 1/1/04 and 6/30/04 (n = 36)

Target Children Only (n = 35)

HFA Credentialing Standard 7-1B

Group filter not applied

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Participant Name	Pregn. ID	Child Name	Pediatrician's Name	Clinic	1st Ped. Referral
Maxwell, Jasmine	A	Maxwell, Moon	Hu, Dr.	--	
Newton, Hannah	A	Newton, James	---	--	1/20/2003
Osborne, Chelsea	A	Osborne, Paul	Hu, Dr.	--	
Tate, Yvette	A	Tate, Keira	Chicago, Dr.	--	

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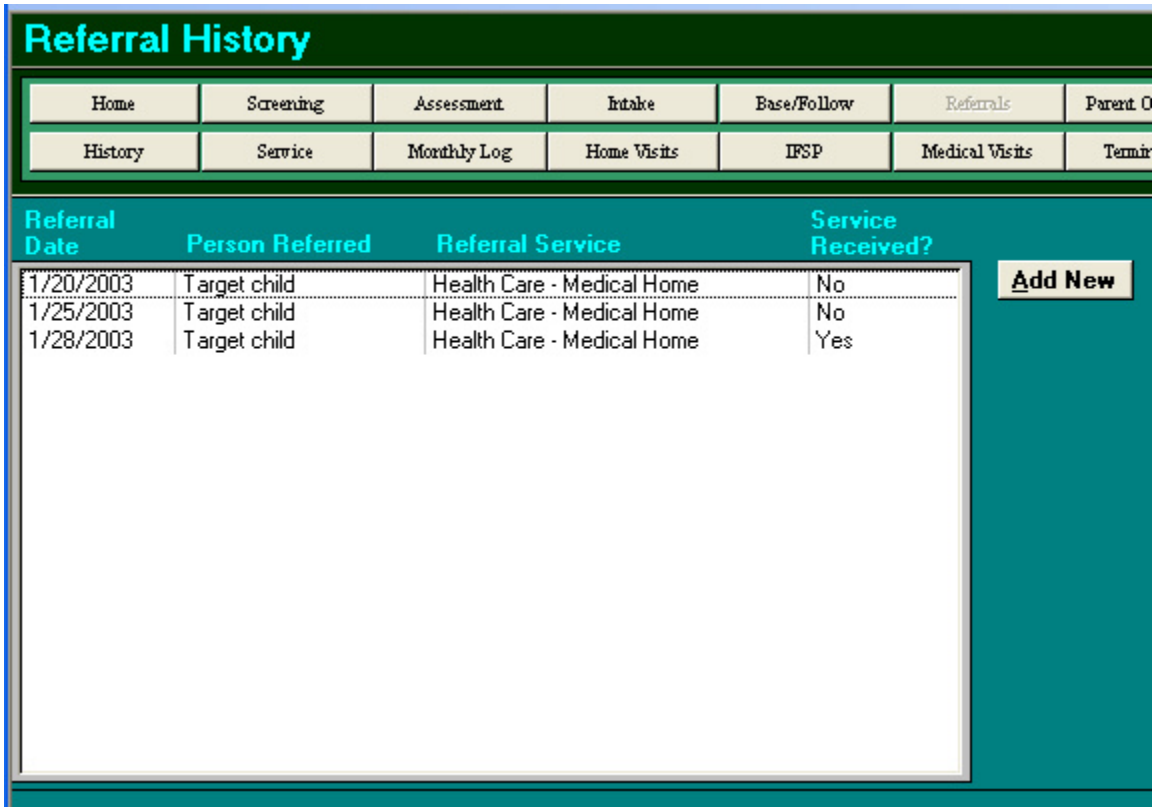
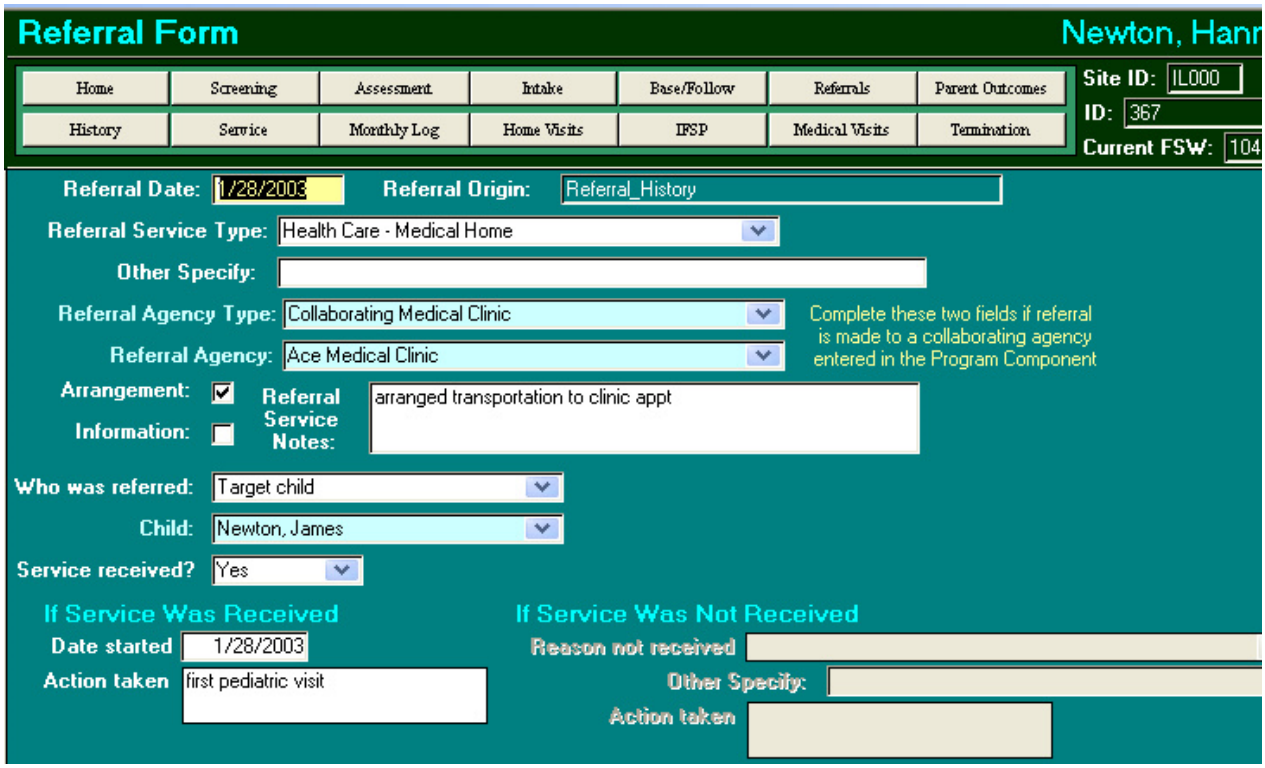
Participant Name	Pregn. ID	Child Name	Pediatrician's Name	Clinic	1st Ped. Referral
Bailey, Mildred	A	Bailey, Allyn	Doctor,	--	
Cannon, Patty	A	Cannon, Paulit	Howe, Justin	--	7/1/2003
Chase, Latasha	A	Chase, Cleotilde	Doctor,	--	

In the above example, participant Hannah Newton's child does not initially have a pediatrician. However, there was a referral from the program to a medical provider for the child soon after his birth on 1/16/03. Looking at the referral records below, we see that the worker made at least three

referrals to a medical provider for the child within a few weeks of his birth before an appointment was completed. It is important for sites to document all attempts to connect children to medical providers.



Individual referral records can be printed by opening the desired record and using the **Print** button to create a printer-friendly version.


Referral Form
Newton, Hann
Home
Screening
Assessment
Intake
Base/Follow
Referrals
Parent Outcomes
History
Service
Monthly Log
Home Visits
IFSP
Medical Visits
Termination
Site ID: IL000
ID: 367
Current FSW: 104
Referral Date: 1/28/2003
Referral Origin: Referral_History
Referral Service Type: Health Care - Medical Home
Other Specify:
Referral Agency Type: Collaborating Medical Clinic
Referral Agency: Ace Medical Clinic
Complete these two fields if referral is made to a collaborating agency entered in the Program Component
Arrangement:
Information:
Referral Service Notes:
arranged transportation to clinic appt
Who was referred: Target child
Child: Newton, James
Service received? Yes
If Service Was Received
Date started 1/28/2003
Action taken first pediatric visit
If Service Was Not Received
Reason not received
Other Specify:
Action taken

Standard 7-2

(from Best Practice Standards 2014-2016 effective through 12/31/2016)

7-2. The home visitor promotes and educates families regarding the importance of immunizing their children, tracks the receipt of immunizations, and follows-up with parents when immunization appointments are missed. Participating Target Children are up-to-date on immunizations.

[**7-2.A** Relates to site policy on monitoring immunizations.]

7-2.B The site ensures that immunizations are up-to-date for target children. **Please note:** the percentage should not include children whose permanent health conditions or family beliefs preclude immunizations; however, evidence of these exceptions must be documented in the family file.

Intent: *All children are immunized at regular health care visits, beginning at birth. Some children may be ill or have other reasons preventing them from receiving immunizations according the identified immunization schedule. Therefore, children may not necessarily receive their immunizations on time; however, it is essential to keep them up-to-date.*

Sites track immunization information differently. Some choose to collect the information from the parent/care giver and document it on the site's tracking sheets, and others solicit periodic updates from the medical providers themselves indicating whether or not the child is up-to-date or current. Therefore, sites are encouraged to clearly indicate how they receive the information used to determine if target children have up-to-date immunizations.

Please Note: *To be up to date at age one, the target child will have received all scheduled immunizations through six months of age. To be up to date at age two, the target child will have received all scheduled immunizations through 18 months of age.*

7-2.B		RATING INDICATORS
3	-	Ninety percent (90%) through one hundred percent (100%) of target children have up-to-date immunizations at one year of age and at two years of age.
2	-	Eighty percent (80%) through eighty-nine percent (89%) of target children have up-to-date immunizations at one year of age and at two years of age.
1	-	Less than eighty percent (80%) of target children have up-to-date immunizations at one year of age and at two years of age.

☺ Tip: For target children, who are not currently up-to-date, be sure to indicate the reasons why and clearly document attempts/steps taken to obtain immunizations for these children.

☺ Tip: It is also important to indicate if families are on Creative Outreach and currently no information is available.

☺ Tip: The Center for Disease Control has an interactive immunization scheduler available online.

Using PIMS to Provide Evidence of Compliance

The reports listed below address this standard. Remember that as with most affiliation standards, you may need to support the quantitative data from PIMS reports with a narrative interpretation.

- **PIMS19G: Immunizations Required at Age One and Two** lists each target child and his/her immunization schedule with completion dates, the child's age at the latest home visit, the maximum date by which the immunizations should have been completed, and a calculation of percentage of immunizations completed by the maximum date.
- **PIMS19H: Immunizations Required at Age One and Two Summary** lists a summary of completion rates for each child and the site as a whole.

Tips for Monitoring PIMS Data Related to Standard

For the report to yield useful data, sites will want to update children's immunization data regularly, both in the client chart and in PIMS. Make sure that the immunization schedule entered into the site definitions corresponds to one of the generally accepted immunization schedules stated in Standard 7-2 above.

Use **PIMS19G** to generate immunization records for all children. Sites will want to ensure that PIMS data is current with children's medical records. **Use PIMS19H** show the number and percentage of children who are 100% completed with immunizations.

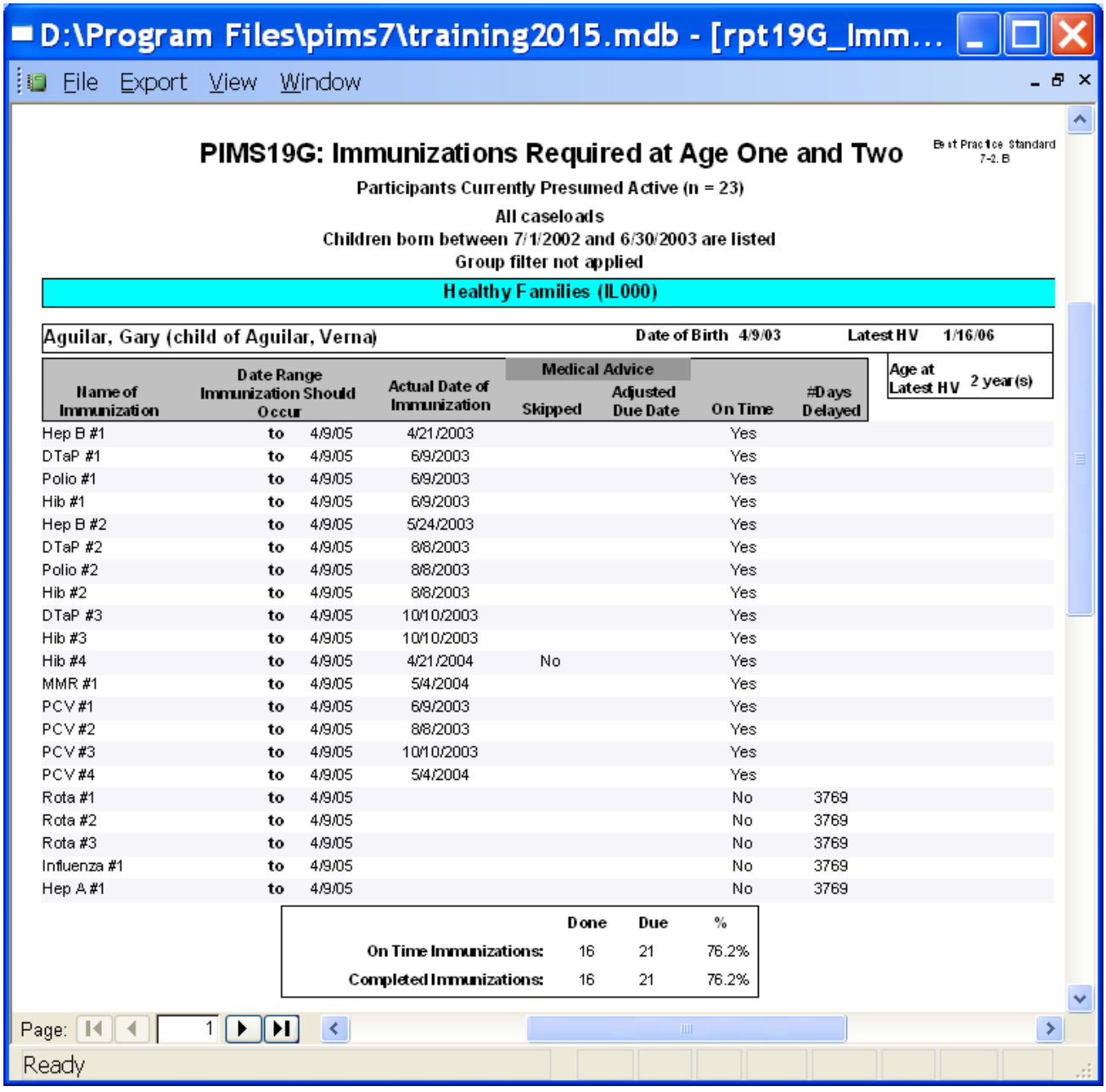
Immunizations skipped on medical advice. Children may have an adjusted schedule due to illness, availability of vaccines, and other reasons. In these cases, on the child's immunization record, check the box "Skipped" and enter an adjusted due date, if appropriate. Skipped immunizations that have an actual date of administration entered will be counted as "not skipped."

How to Run these Reports

5. From the **Reports** screen, select **Standard Reports**.
6. Select **Category** "Child Outcomes" and **Report** "Immunizations Required at Age One and Two" or "Immunizations Required at Age One and Two Summary".
7. Report Parameters: select **Case Status** "Currently presumed active".
    - Note: **PIMS19G** will list immunizations due before the date of latest home visit, i.e. the most recent home visit. For participants on creative outreach (Level X), **PIMS19G** may not display all of the child's actually completed immunizations; you will want to note these families in your accompanying narrative, as well as any children who are not up to date due to medical advice.

Example 1

The example below shows the first page of **PIMS19G**, illustrating Gary Aguilar's immunization record and percentages of on-time and completed required immunizations. Gary was born on 4/9/2003, and was two years old at the time of the last completed home visit; therefore, he had until 4/9/2005 to complete all immunizations due by 18 months.



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File Export View Window

PIMS19G: Immunizations Required at Age One and Two

Best Practice Standard 7-2.B

Participants Currently Presumed Active (n = 23)

All caseloads

Children born between 7/1/2002 and 6/30/2003 are listed

Group filter not applied

Healthy Families (IL000)

Aguilar, Gary (child of Aguilar, Verna) Date of Birth 4/9/03 Latest HV 1/16/06

Age at Latest HV 2 year(s)

Name of Immunization	Date Range Immunization Should Occur		Actual Date of Immunization	Medical Advice Skipped	Medical Advice Adjusted Due Date	On Time	#Days Delayed
Hep B #1	to	4/9/05	4/21/2003			Yes	
DTaP #1	to	4/9/05	6/9/2003			Yes	
Polio #1	to	4/9/05	6/9/2003			Yes	
Hib #1	to	4/9/05	6/9/2003			Yes	
Hep B #2	to	4/9/05	5/24/2003			Yes	
DTaP #2	to	4/9/05	8/8/2003			Yes	
Polio #2	to	4/9/05	8/8/2003			Yes	
Hib #2	to	4/9/05	8/8/2003			Yes	
DTaP #3	to	4/9/05	10/10/2003			Yes	
Hib #3	to	4/9/05	10/10/2003			Yes	
Hib #4	to	4/9/05	4/21/2004	No		Yes	
MMR #1	to	4/9/05	5/4/2004			Yes	
PCV #1	to	4/9/05	6/9/2003			Yes	
PCV #2	to	4/9/05	8/8/2003			Yes	
PCV #3	to	4/9/05	10/10/2003			Yes	
PCV #4	to	4/9/05	5/4/2004			Yes	
Rota #1	to	4/9/05				No	3769
Rota #2	to	4/9/05				No	3769
Rota #3	to	4/9/05				No	3769
Influenza #1	to	4/9/05				No	3769
Hep A #1	to	4/9/05				No	3769

	Done	Due	%
On Time Immunizations:	16	21	76.2%
Completed Immunizations:	16	21	76.2%

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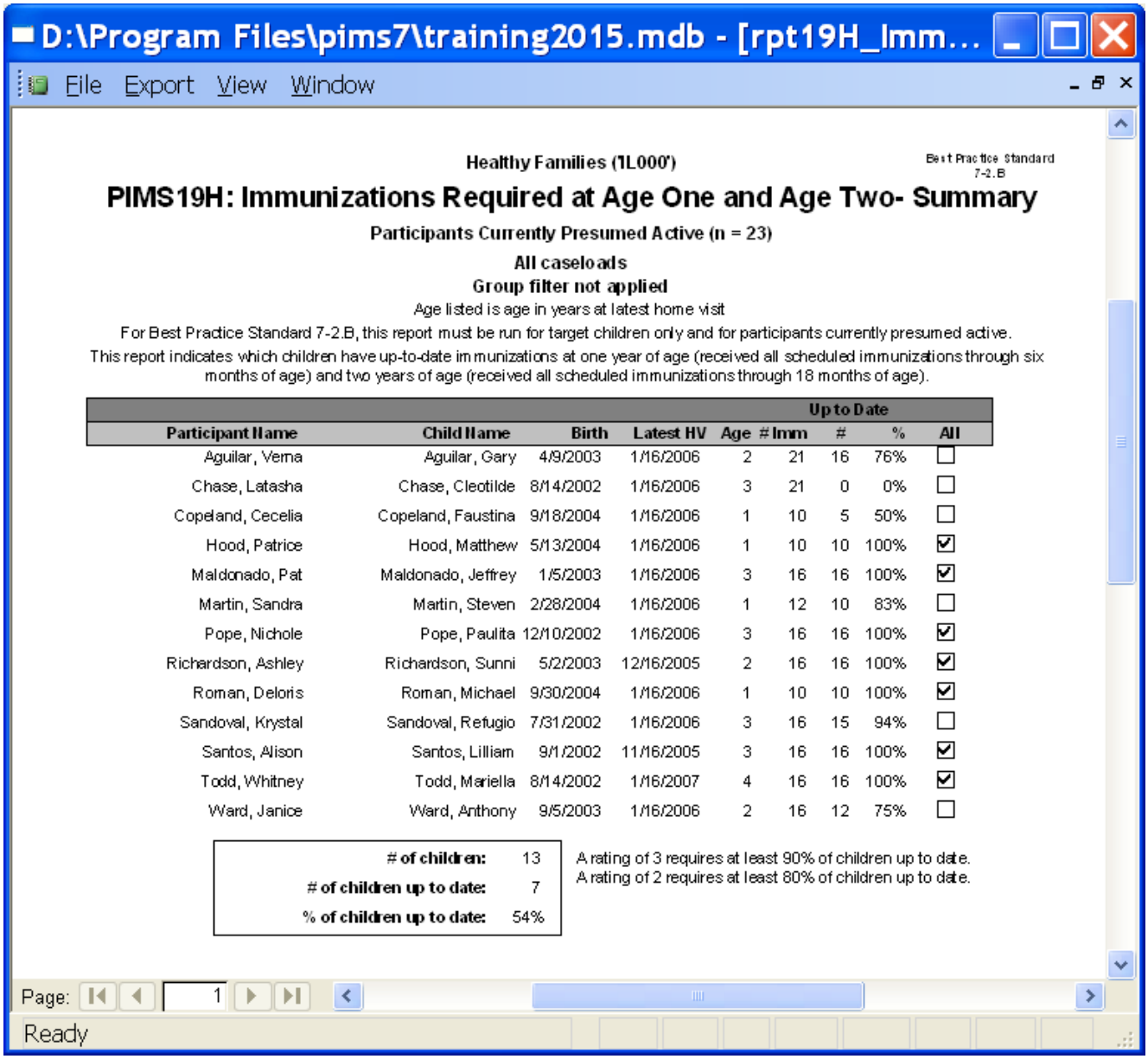
Example 2

The example below for **PIMS19H** shows the site has 54% of children up to date with immunizations, which does not meet the standard.



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File Export View Window

Healthy Families (1L000)

Best Practice Standard 7-2.B

PIMS19H: Immunizations Required at Age One and Age Two- Summary

Participants Currently Presumed Active (n = 23)

All caseloads

Group filter not applied

Age listed is age in years at latest home visit

For Best Practice Standard 7-2.B, this report must be run for target children only and for participants currently presumed active.

This report indicates which children have up-to-date immunizations at one year of age (received all scheduled immunizations through six months of age) and two years of age (received all scheduled immunizations through 18 months of age).

						Up to Date		
Participant Name	Child Name	Birth	Latest HV	Age	# Imm	#	%	All
Aguilar, Verna	Aguilar, Gary	4/9/2003	1/16/2006	2	21	16	76%	☐
Chase, Latasha	Chase, Cleotilde	8/14/2002	1/16/2006	3	21	0	0%	☐
Copeland, Cecelia	Copeland, Faustina	9/18/2004	1/16/2006	1	10	5	50%	☐
Hood, Patrice	Hood, Matthew	5/13/2004	1/16/2006	1	10	10	100%	☑
Maldonado, Pat	Maldonado, Jeffrey	1/5/2003	1/16/2006	3	16	16	100%	☑
Martin, Sandra	Martin, Steven	2/28/2004	1/16/2006	1	12	10	83%	☐
Pope, Nichole	Pope, Paulita	12/10/2002	1/16/2006	3	16	16	100%	☑
Richardson, Ashley	Richardson, Sunni	5/2/2003	12/16/2005	2	16	16	100%	☑
Roman, Deloris	Roman, Michael	9/30/2004	1/16/2006	1	10	10	100%	☑
Sandoval, Krystal	Sandoval, Refugio	7/31/2002	1/16/2006	3	16	15	94%	☐
Santos, Alison	Santos, Lilliam	9/1/2002	11/16/2005	3	16	16	100%	☑
Todd, Whitney	Todd, Mariella	8/14/2002	1/16/2007	4	16	16	100%	☑
Ward, Janice	Ward, Anthony	9/5/2003	1/16/2006	2	16	12	75%	☐

# of children:	13
# of children up to date:	7
% of children up to date:	54%

A rating of 3 requires at least 90% of children up to date.
A rating of 2 requires at least 80% of children up to date.

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Ready

Standard 7-3

(from Best Practice Standards 2014-2016 effective through 12/31/2016)

7-3. Families are connected to services in the community on an as needed basis.

[**7-3.A** Relates to site policy on providing linkages to health care and other community resources.]

7-3.B Home visitors provide information, referrals, and linkages to available health care and health care resources for all participating family members.

Intent: *Sites are encouraged to provide information, referrals and linkages for all participating family members including the target child. Information could include a variety of topics that may benefit all participating members (i.e., smoking cessation support groups, free health clinics for adults, immunization clinics, flu shots, nutritional classes, etc.). Health care information includes the importance of dental care as well as referrals linking families to preventive services for dental care, as appropriate. Additionally, home visitors share information regarding the benefits to families for spacing pregnancies. Site staff are knowledgeable of health care resources within the community and be able to appropriately provide referrals and linkages to members. It is recommended that sites only provide information, referrals and linkages when necessary, (i.e., when a pregnant mother needs assistance connecting to prenatal care, or when parents or siblings have health concerns and are without a medical care provider). Therefore if a family is currently receiving necessary services/care, there may be no need for further provision of the above-mentioned services.*

7-3.B RATING INDICATORS

3 - Evidence indicates that home visitors provide information, referrals and linkages to all participating family members on available health care and health care resources, when necessary.

2 - Past instances were found when home visitors did not provide information, referrals and linkages to all participating family members on available health care and health care resources, when necessary; however, recent practice indicates this is occurring.

1 - Insufficient evidence exists to suggest that home visitors are providing information, referrals and linkages to all participating family members on available health care and health care resources, when necessary.

☺ Tip: Sites may want to consider documenting health care resource referrals associated with this standard, in the same way other community resource referrals are documented for standards 7-3.C and 7-3.D.

7-3.C The site connects families to appropriate referral sources and services in the community as needed.

Intent: *Families benefit by accessing community agencies and services that can support the family in accomplishing goals or overcoming challenges they may be experiencing. Families may be reluctant to access additional services, and home visitors are one way to bridge the gap. Home visitors should be familiar with the community agencies and the services they provide to be sure families are referred appropriately. Sites are encouraged to provide referrals as often as needed. Additionally, while there may be services to refer the family to within the community, it does not mean they are necessarily appropriate or needed by the family. Therefore not all families require referrals.*

7-3.C		RATING INDICATORS
3	-	Evidence indicates families are linked to additional services in the community on an as needed basis.
2	-	Past instances were found when families needing additional services were not connected to appropriate services in the community, as needed; however, recent practice indicates this is now occurring.
1	-	There is insufficient evidence to indicate families are linked to additional services in the community on an as needed basis.

7-3.D. The site tracks and follows up with the family, and/or service provider (if appropriate) to determine if the family received needed services. Follow-up with referral sources will require signed informed consent (see GA-5.B).

7-3.D		RATING INDICATORS
3	-	The site has a method for tracking and following-up on referrals of families to other community services as needed and evidence indicates the site is tracking and following up on referrals.
2	-	Past instances were found when tracking and follow-up did not occur; however, recent practice indicates this is now occurring.
1	-	Either the site does not have a method or the site has a method but there is insufficient evidence to indicate that tracking and follow-up is occurring.

☺ Tip: Sites are encouraged to track all of the referral resources provided and the family's utilization of those services over the course of services in one place for easy monitoring.

☺ Tip: Periodically, sites may want to review any trends pertaining to families ability to access particular services in the community. Doing so can assist with the ongoing assessment of community needs and identification of gaps in service availability.

Using PIMS to Provide Evidence of Compliance

Reports **PIMS18A** and **PIMS18C** show a list of medical homes for participants and fathers, respectively. If participants or fathers have no medical home listed, the report will also show if a referral to a medical home has been provided.

Sites can use PIMS to record and track the status of all family referrals for health care and other resources through the **Referrals** records. The following can be used to provide evidence of linkages to resources:

- **PIMS21: Referral Information** provides a list of participants who have referral records in the date range specified.
- Participant Referral Records can be printed to show more detailed information about the referrals.

For information on reporting on medical homes for children, see the tip sheet for Standard 7-1.B.

Remember that as with most accreditation standards, you may need to support the quantitative data from PIMS reports with a narrative interpretation.

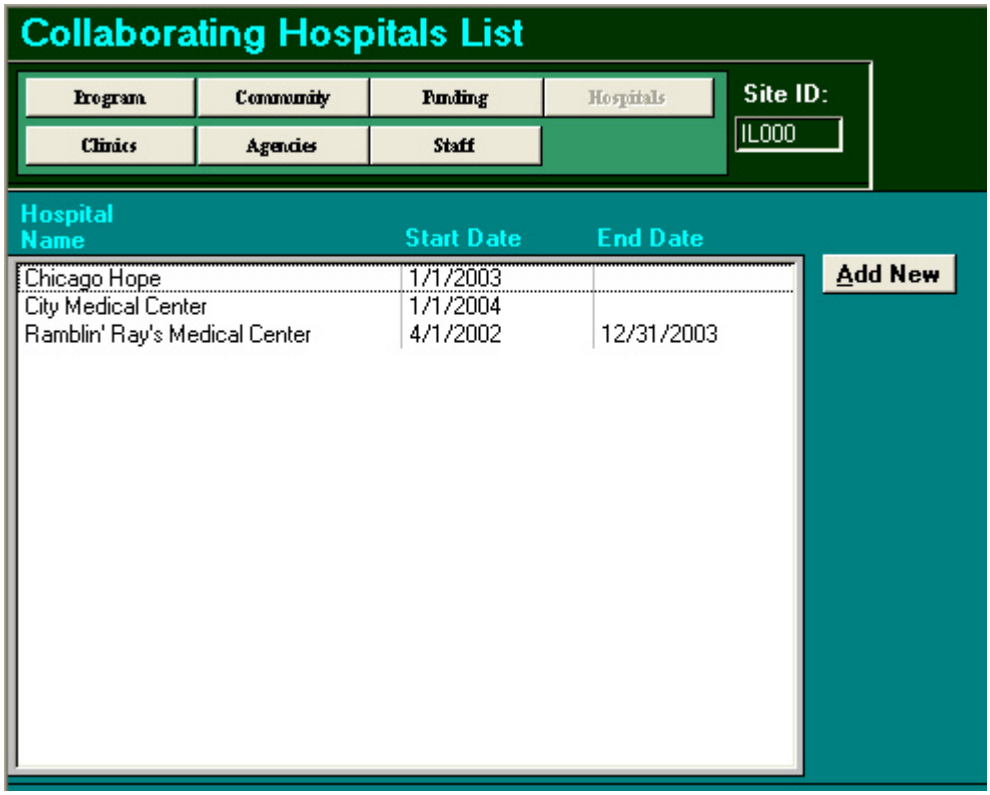
Tips for Monitoring PIMS Data Related to Standard

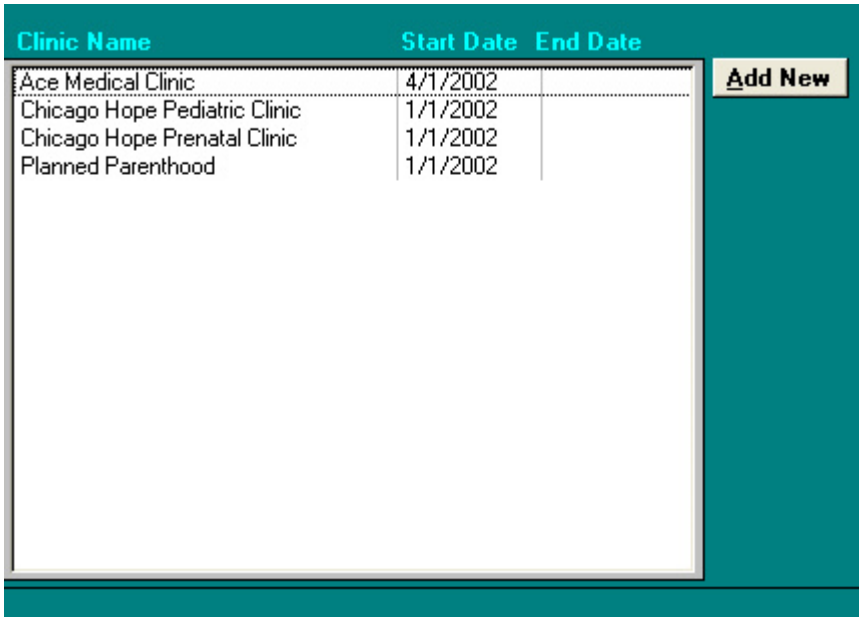
- Sites will want to keep their lists of collaborating hospitals, clinics and other agencies current in the Program Management section of PIMS so that these resources will be available in drop-down menus in **Referrals** records.
- Sites will want to create a mapping of local resources to the general referral categories included in the PIMS **Referrals** record, and to ensure that staff use it consistently when entering data. See below for a sample mapping table.
- Make sure that participants and partners have a medical home recorded in PIMS. Participant medical homes are entered on the **Intake Record**; subsequent changes are recorded in the Participant **History** records. Partner medical homes are entered in the **Partner Initial Demographics** form.
- For PIMS21 to yield useful data, make sure that **Referral** records are updated regularly with the status of the referral: *service received* (yes, no, unknown), *reason not received*, and *action taken*. For clarity, sites can use the "Referral Service Notes" box on the Referrals record to record the specific service, and the family member referred (other than the mother, target child, father, or current partner). For example, if an older sibling needed a dentist, select category "Health Care", in the Note box enter "University Hospital Dental Clinic: older child needs dentist for dental caries", and select "other members of household" for who was referred.

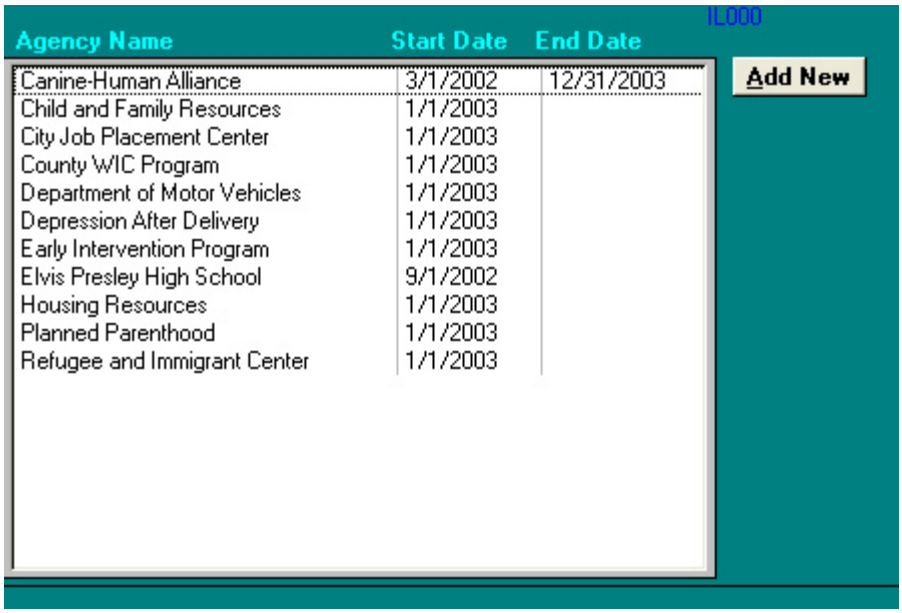
Entering Community Resources in PIMS

It is important to keep PIMS **Program Management** data current for community resources. These include collaborating hospitals, clinics, and other agencies. This information should be entered soon after the PIMS data base is created and updated regularly. Agencies entered in PIMS create the drop-down menus in the **Referrals** records.

From the main menu, select **Program Data Entry**. On the **Site/Program Search Menu**, double-click on your site. On **Site/Program Information Entry**, select **Hospitals**, **Clinics**, or **Agencies** to enter or update information on community resources.





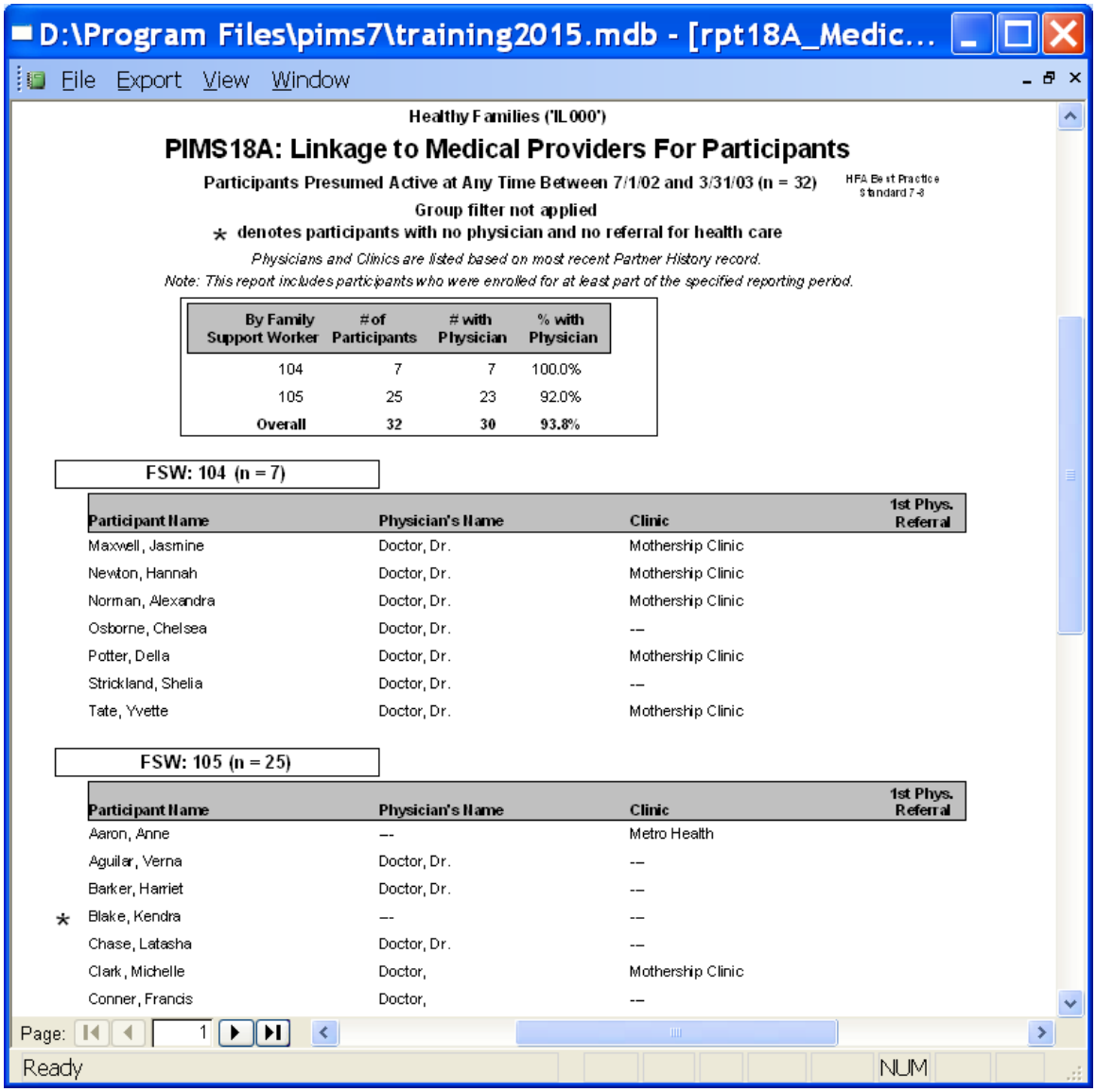


How to Run these Reports

8. From the **Reports** screen, select **Standard Reports**.
9. For **PIMS18A** and **PIMS18C**, select **Category** "Family Outcomes" and **Report** "Linkage to Medical Providers for Participants" or "Linkage to Medical Providers for Fathers". Choose participant status of "currently presumed active" and a cut-off date of today.

Example 1 – Participant Medical Home

In the example below, Kendra Blake does not have a medical home, and there is no referral record indicating that a linkage was attempted. The site would want to ensure that, at a minimum, a referral to a medical home had been made and that it was recorded in PIMS.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File Export View Window
Healthy Families ('IL000')
PIMS18A: Linkage to Medical Providers For Participants
Participants Presumed Active at Any Time Between 7/1/02 and 3/31/03 (n = 32)
HFA Best Practice Standard 7-8
Group filter not applied
* denotes participants with no physician and no referral for health care
Physicians and Clinics are listed based on most recent Partner History record.
Note: This report includes participants who were enrolled for at least part of the specified reporting period.
By Family Support Worker | # of Participants | # with Physician | % with Physician
104 | 7 | 7 | 100.0%
105 | 25 | 23 | 92.0%
Overall | 32 | 30 | 93.8%
FSW: 104 (n = 7)
Participant Name | Physician's Name | Clinic | 1st Phys. Referral
Maxwell, Jasmine | Doctor, Dr. | Mothership Clinic
Newton, Hannah | Doctor, Dr. | Mothership Clinic
Norman, Alexandra | Doctor, Dr. | Mothership Clinic
Osborne, Chelsea | Doctor, Dr. | --
Potter, Della | Doctor, Dr. | Mothership Clinic
Strickland, Shelia | Doctor, Dr. | --
Tate, Yvette | Doctor, Dr. | Mothership Clinic
FSW: 105 (n = 25)
Participant Name | Physician's Name | Clinic | 1st Phys. Referral
Aaron, Anne | -- | Metro Health
Aguilar, Verna | Doctor, Dr. | --
Barker, Harriet | Doctor, Dr. | --
* Blake, Kendra | -- | --
Chase, Latasha | Doctor, Dr. | --
Clark, Michelle | Doctor, | Mothership Clinic
Conner, Francis | Doctor, | --
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Ready
NUM

Example 2 – Participant Referrals by Individual for Date Range

In the example below, referrals are summarized by participant for the date range 1/1/2003 to 12/31/2003.

Healthy Families ('IL000')

PIMS21: Referral Information

HFA Credentialing Standards 7-3, 7-4

Includes all referrals between 1/1/2003 to 12/31/2003 (n = 61 referrals)

Group filter not applied

Referral Date	Person Referred	Type of Referral	Referral Service Notes	Received	Received Date	Action Taken	If Not Received, Reason Not Received
Aguilar, Verna (n = 10 referrals)							
2/18/03	Mother of child	Health Care - General		No			Participant changed mind about service
2/25/03	Mother of child	Health Care - General		No			Participant changed mind about service
3/4/03	Mother of child	Health Care - General		No			Participant changed mind about service
3/11/03	Mother of child	Health Care - General		No			Participant changed mind about service
3/17/03	Mother of child	Health Care - General		No			
3/18/03	Mother of child	Health Care - General		No			Participant changed mind about service
5/15/03	Mother of child	Counseling and Support Services		Yes	6/1/2003	screening and counseling	
5/28/03	Mother of child	Health Care - General		Yes	5/30/2003		
6/27/03	Mother of child	Health Care - General		Yes	6/27/2003		
10/1/03	Target child	Health Care - Medical Home	Wantped to rule out illness, injury, etc.	Yes			
Bailey, Mildred (n = 2 referrals)							
4/17/03	Mother of child	Nutrition Service		Yes	5/9/2003		
9/15/03	Mother of child	Counseling and Support Services		Yes	9/15/2003	immediate phone screening and appointment	

Example 3 – Printout of Participant Referral Records

To print a specific participant referral, click on the **Referrals** button from the **Home** form, open the desired **Referral** record, and click on the **Print** button at the bottom of the page.

Healthy Families

Referral Record

Aguilar, Verna - 359 *Printed: 6/18/2014 3:21:53 PM*

Referral Date:	5/15/2003
Referral Service:	Counseling and Support Services
Other Specify:	
Referral Agency Type:	Non-Hospital Collaborating Agency
Referral Agency:	Depression After Delivery
Arrangement: ☑ / Information: ☐	Referral Service Notes:
Who was referred:	Mother of child
Child:	
Service received?	Yes
if received, date started	6/1/2003
Actiontaken:	screening and counseling
if not received, reason	
Other Specify:	

Sample Mapping of Local Community Resources to PIMS Referrals Record Categories

PIMS Category	Community Resource
Health Care	Anytown Prenatal Clinic Planned Parenthood City Hospital Emergency Room University Hospital Dental Clinic Town Health Department
Nutrition Services	County WIC Interfaith Food Pantry Weight No More
Public Assistance	County Welfare Agency Board of Social Services County Housing Authority Medicaid Office
Family and Social Support	Hometown Breastfeeding Mothers Mothers of Twins Club Best Dads Meetings Child and Family Resources Family Enrichment Program Council on Homeless Prevention
Employment, Training, and Education	GED Program High School Diploma Program One-Stop Center County Employment and Training Program Work Force Literacy Volunteers of American ESL Classes
Counseling and Support Services	Hospital Substance Abuse Program Al-Anon Abuse Ceases Today (ACT) Program Marriage Counseling Depression After Delivery Domestic Violence Shelter
Other Services	Agency transportation Library Story Time for Tots Salvation Army Day Care Center Early Intervention Program Emergency Utility Assistance Spanish-American Credit Union

Standard 7-4

(from Best Practice Standards 2014-2016 effective through 12/31/2016)

7-4. The site has policy and procedures for strengthening families by addressing challenging issues such as substance abuse, intimate partner violence, developmental delay in parents, and mental health concerns, and practice indicates that this policy is being implemented.

Intent: *Healthy Families sites serve many families who are struggling with issues such as substance abuse, intimate partner violence, developmental delay in parents, depression, and other mental health challenges some of which may be caused by early childhood trauma such as child abuse, as well as other trauma, along with multiple stressors in their lives such as financial, housing, lack of education, and poor self-esteem to list a few. In order to address these challenges, site staff must form healthy relationships with parents, apply a strength-based empowerment approach that includes being honest when parents are responding to their environment in ways that may cause harm to themselves and their children, accepting families where they are, without judgment or bias, building on parental competencies and focusing on the experience versus trying to establish "right or wrong". These principles are core HFA components.*

Home visitors are not counselors or therapists. Their most important role as it relates to substance abuse, intimate partner violence, and mental health challenges is to support the parent(s) to become "treatment ready" by:

- *Providing honest feedback with parents' permission*
- *Pointing out discrepancies between stated values and actual behavior*
- *Providing an atmosphere of safety and acceptance*
- *Encouraging forward thinking (i.e. assist parent in developing a vision of what they want)*
- *Providing information and referrals*
- *Using motivational interviewing (when trained on this technique)*
- *Utilizing reflective supervision to receive support and prevent burnout*

It is important for home visitors to help parents recognize the importance of the parent-child relationships and the impact of untreated depression and/or other mental health issues. Research clearly demonstrates that untreated disorders and past trauma can have serious consequences for early learning, social competence and lifelong health.

[**7-4.A** Relates to site policy for addressing challenging issues.]

7-4.B Program staff addresses challenging issues such as substance abuse, intimate partner violence, developmental delay in parents, and mental health needs by actively focusing on building protective factors.

7-4.B		RATING INDICATORS
3	-	The site follows its policy related to addressing challenging issues such as substance abuse, intimate partner violence, developmental delay in parents, and mental health by actively focusing on building protective factors.
2	-	Past instances were found when the site did not follow its policy to address challenging issues such as substance abuse, intimate partner violence, developmental delay in parents, and mental health by actively focusing on building protective factors; however, recent practice indicates this is now occurring.
1	-	There is insufficient evidence to indicate that the site follows its policy to address challenging issues as listed in the above rating indicators.

☺ Tip: Sites are encouraged to track all conversations with families that indicate staff is addressing challenging issues. Additionally, for easier monitoring, sites should document in one place all linkages/referrals to community services and the family's utilization of those services over the course of services.

Pre-site Evidence to Submit

From the HFA Self-Study Tables of Evidence: "Submit assessment tools used to assess substance abuse, intimate partner violence, mental health, etc. as well as linkage/referral form used to track referrals and follow-up to referrals which clearly indicates families' utilization of or lack of utilization of those services."

Using PIMS to Provide Evidence of Compliance

Refer to tip sheet for Standard 7-3 for information on how to enter site-specific information on agencies, and on how to generate reports and participant referral records for pre-site evidence.

Sites will also want to make sure conversations about challenging issues are documented in the PIMS **Home Visit** form so they can be reviewed during the site visit. The site may want to submit a sample Home Visit form highlighting the section "Review of Topics Identified in Parent Survey or Subsequent Visits"; this is described in the tip sheet for standard 6-1.C.

Standard 7-5.B

(from Best Practice Standards 2014-2016 effective through 12/31/2016)

7-5.B The site conducts depression screening with all enrolled mothers. If enrolled prenatally the screening will be completed at least once during the prenatal period, and for all families at a minimum of at least once postnatally before the baby is 3 months of age.

Intent: *Depression screening should be conducted at various points is time both prenatally and postnatally. Depression screens should still be completed when families are in treatment to assure that treatment is meeting the needs of the family. If the caregiver is not the biological mother, depression screening may be appropriate but is not required. If the mother refuses and/or the family is enrolled when the baby is older than 3 months, they are not counted within the cohort.* ***Please note:*** *Prenatal screenings do not exempt post-natal screening.*

7-5.B	RATING INDICATORS
3	- All mothers are screened using a standardized and validated depression screen/tool at least once prenatally (when enrolled prenatally) and at least once postnatally within 3 months of the baby's birth. The site also conducts depression screens for subsequent births.
2	- All mothers were not screened using a standardized and validated depression screening tool at the frequency required in the standard, however, recent practice indicates this is now occurring with all target pregnancies/births.
1	- Any of the following: the site does not use the standardized depression screen/tool, and/or the standardized depression screen/tool is not used within the timeframes required in the standard; or there is no recent practice to demonstrate that all mothers are now being screened.
Note:	**This is a Sentinel Standard**

☺Tip: According to several *Perinatal Care Position Statements,* depression screening is recommended to occur twice during the prenatal period (when families are enrolled in the program early in their pregnancy), and at 6 weeks, 3 months, and 1 year following the birth of the baby.

☺Tip: Ideally, if multiple providers are involved, home visitors will coordinate with others to reduce duplicate screening. In such cases, a written consent must be on file in the participant record and the program must be in receipt of a copy to show that the screening was done. Even more importantly, the site needs copy on file in order to make and track any necessary follow-up referrals/interventions for the family.

☺ Tip: Even if another the site copies of screens done at birth, re-screening is strongly recommended. Best practice would be to re-screen between at 6 weeks and 3 months postpartum.

☺ Tip: Depression screenings are not intended to be used as formal diagnostic tools. Screening tools are used to determine the need for a more intensive evaluation by a licensed mental health clinician.

Using PIMS to Provide Evidence of Compliance

Report **PIMS63: Depression Screening** addresses this standard and mirrors the HFA spreadsheet provided. Remember that as with most affiliation standards, you may need to support the quantitative data from PIMS reports with a narrative interpretation.

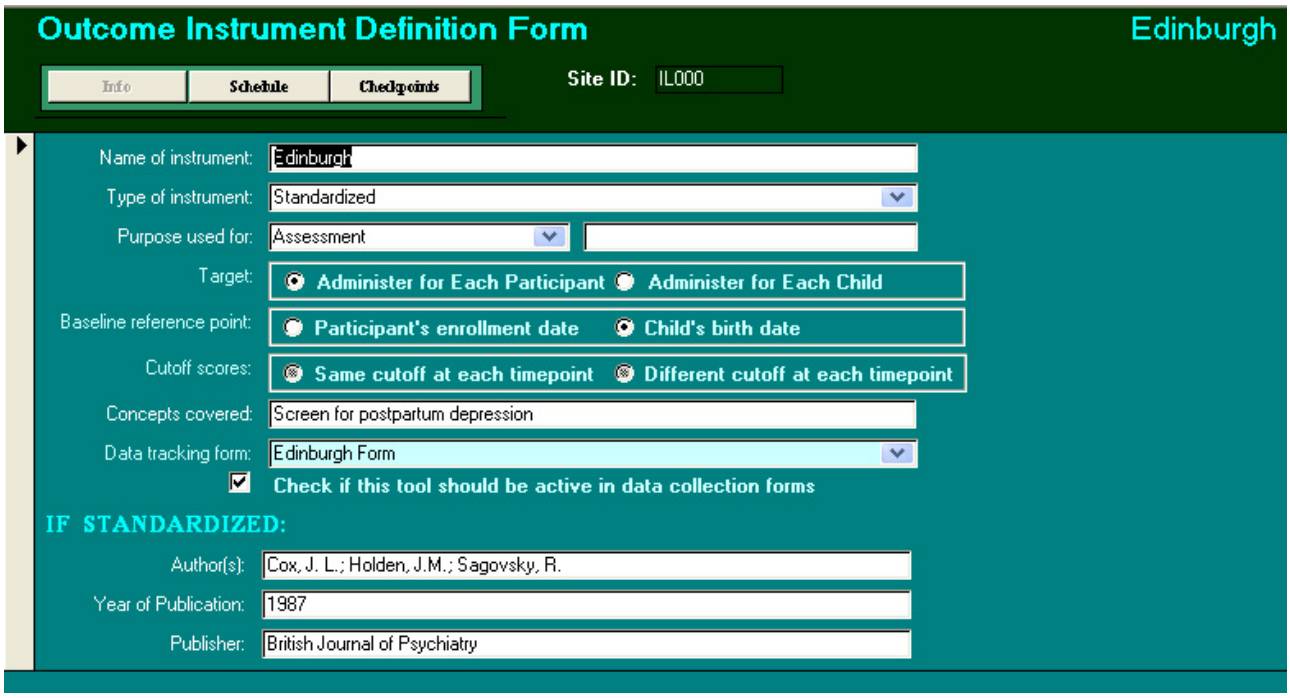
Tips for Monitoring PIMS Data Related to Standard

Sites will want to make sure that all depression screening records are entered for each enrolled mother.

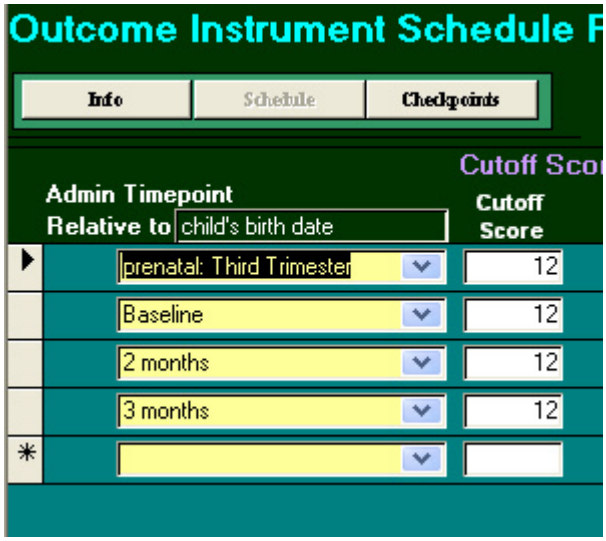
Entering Parent Outcome Instruments in PIMS

It is important to keep PIMS **Site Definitions** data current for outcome instruments. These include instruments for both parent and child evaluations. This information should be entered soon after the PIMS data base is created and updated as needed. Instruments entered in PIMS create the drop-down menus in the **Child Outcomes** and **Parent Outcomes** records.

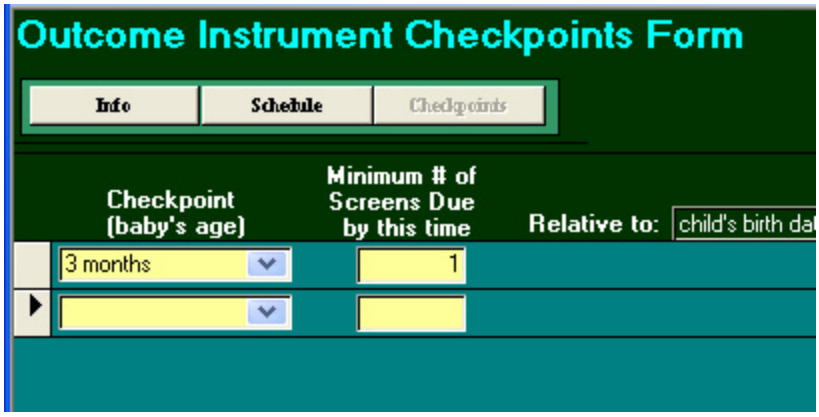
From the main menu, select **Site Definitions** and then **Outcome Instruments**. The **Outcome Instruments List** will open. If there is not a screening tool for depression listed, you will need to add a new record. The example below is for the Edinburgh Postpartum Depression Screen. Note that the depression screen is administered for each participant based on the child's birth date. There is a PIMS form available for tracking data specific to the Edinburgh; therefore, that data collection form is chosen as active.



Next, set the schedule on which the depression screen will be administered by clicking on the **Schedule** button. In the example below, the site has chosen to screen one time prenatally, at birth (baseline), two months, and three months.



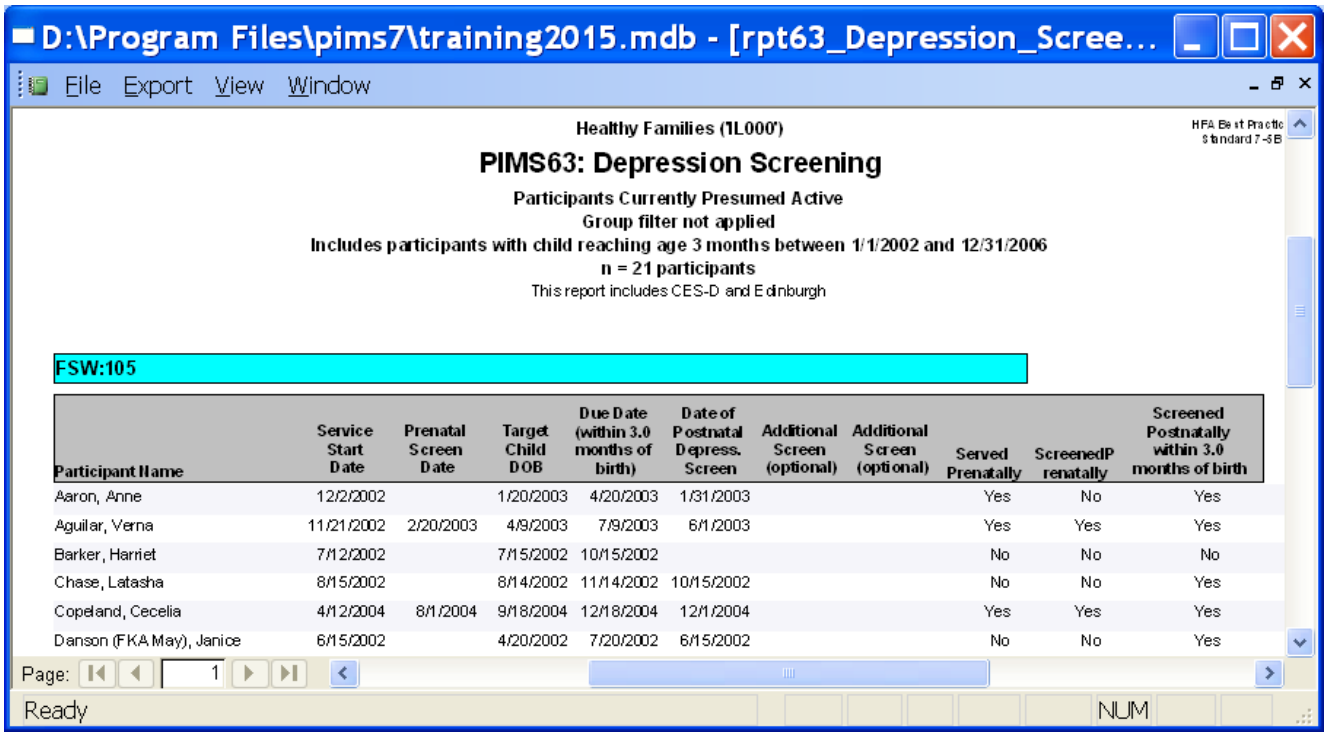
Next, click on the Checkpoints button to indicate the minimum number of screens to be administered by what age. In the example below, the site will conduct a minimum of one depression screening by the time the child is 3 months old.



How to Run this Report

10. From the **Reports** screen, select **Standard Reports**.
11. Select **Category** "Family Outcomes" and **Report** "Depression Screening".
12. Choose a date range of target children which includes the birth date of the oldest child of current participants, and a cut-off date of today. Select Case Status filter of "Currently presumed active".

Example



Participant Name	Service Start Date	Prenatal Screen Date	Target Child DOB	Due Date (within 3.0 months of birth)	Date of Postnatal Depress. Screen	Additional Screen (optional)	Additional Screen (optional)	Served Prenatally	ScreenedPrenatally	Screened Postnatally within 3.0 months of birth
Aaron, Anne	12/2/2002		1/20/2003	4/20/2003	1/31/2003			Yes	No	Yes
Aguilar, Verna	11/21/2002	2/20/2003	4/9/2003	7/9/2003	6/1/2003			Yes	Yes	Yes
Barker, Harriet	7/12/2002		7/15/2002	10/15/2002				No	No	No
Chase, Latasha	8/15/2002		8/14/2002	11/14/2002	10/15/2002			No	No	Yes
Copeland, Cecelia	4/12/2004	8/1/2004	9/18/2004	12/18/2004	12/1/2004			Yes	Yes	Yes
Danson (FKA May), Janice	6/15/2002		4/20/2002	7/20/2002	6/15/2002			No	No	Yes

In the example above, participants Aguilar and Copeland enrolled prenatally and have received both prenatal and postnatal depression screens. Participant Aaron enrolled prenatally but was only screened postnatally. Participant Barker enrolled postnatally but did not receive a screen within three months of the baby's birth.

Standard 7-5.C

(from Best Practices Standards 2014-2016 effective through 12/31/16)

7-5.C Referral and follow-up on referrals occur for mothers, whose depression screening scores are elevated and considered to be at-risk of depression unless already involved in treatment (based on the tool's scoring criteria).

7-5.C		RATING INDICATORS
3	-	Mothers with an elevated depression screening score are referred (with consent) for further evaluation/treatment and follow-up unless already involved in treatment.
2	-	Past instances were found when the site did not ensure all mothers with an elevated depression screening score were referred (with consent) for further evaluation/treatment and follow-up unless already involved in treatment; however, recent practice indicates this is now occurring.
1	-	Any of the following: mothers with an elevated depression screening score are not referred for further evaluation/treatment and/or there is no follow-up on those who are referred.

Using PIMS to Provide Evidence of Compliance

The report **PIMS63A: Depression Followup** addresses this standard. Remember that as with most accreditation standards, you may need to support the quantitative data from PIMS reports with a narrative interpretation.

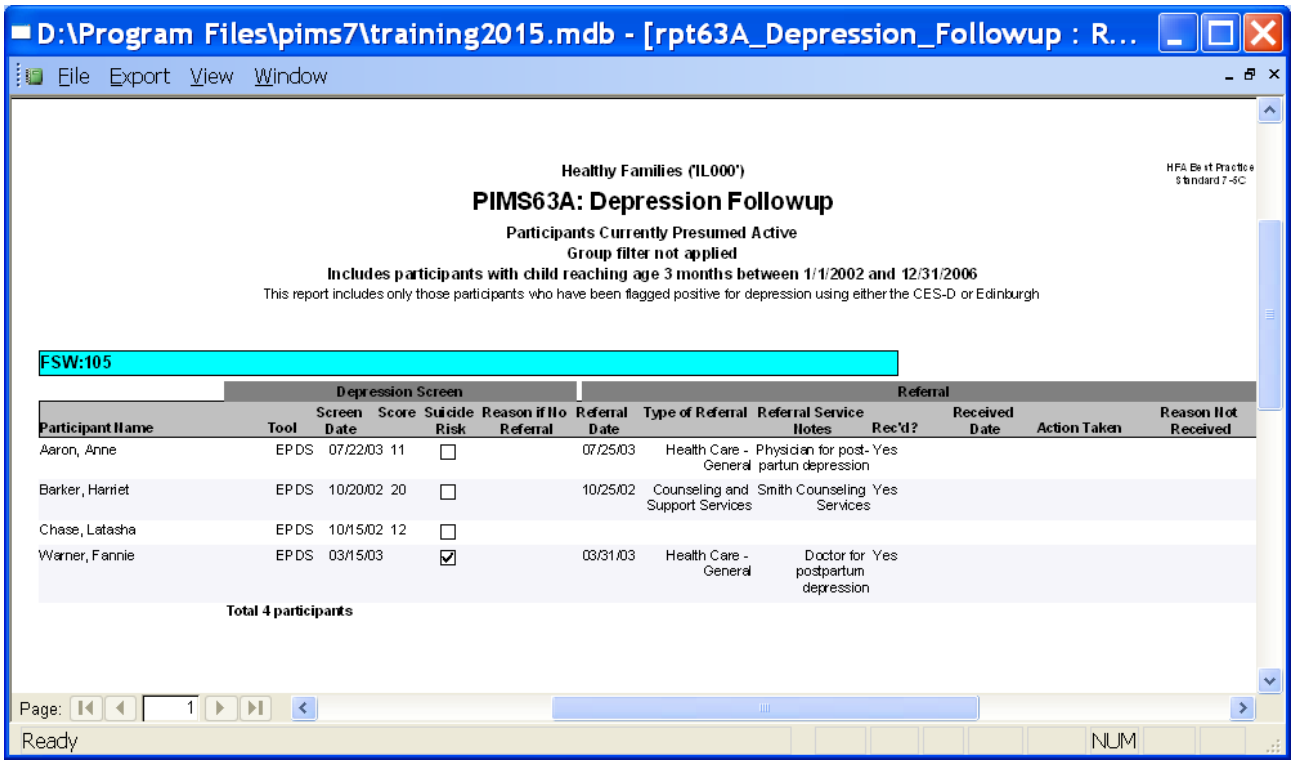
Tips for Monitoring PIMS Data Related to Standard

Sites will want to ensure that, for mothers receiving referrals for depression screening follow-up, referral records have been entered into PIMS, and that referral outcomes have been recorded as appropriate.

How to Run this Report

13. From the **Reports** screen, select **Standard Reports**.
14. Select **Category** “Family Outcomes” and **Report** “Depression Followup”
15. Choose a date range of target children which includes the birth date of the oldest child of current participants, and a cut-off date of today. Select Case Status filter of “Currently presumed active”.

Example



In the above example, four mothers had elevated depression screen scores or otherwise exhibited risks. Aaron, Barker and Warner were referred to medical or counseling services and received those services. Chase was not referred to services; the site would want to check if this was accurate or that additional referral information needs to be entered in PIMS.

Standard 7-5.D

(from Best Practices Standards 2014-2016 effective through 12/31/16)

7-5.D Those who administer the depression screen/tool have been trained in the use of the tool before administering it, and supervisors also receive this training.

Intent: Please Note: *When a collaborative partnership results in another provider completing the depression screen and providing copy to the Healthy Families provider, the HFA site does not need to monitor training of non-HFA staff in administering the screen. However, HFA sites are required in these situations to ensure that HFA staff receive depression screen training to ensure understanding of administration guidelines and referral protocols regardless of whether they administer the screen or not, as they need to be able to interpret and act on the results.*

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7-5.D	RATING INDICATORS
3 -	All staff using the tool, and their supervisors, have been trained in its use before administering it or supervising staff who are administering it.
2	-Past instances were found when training of direct services staff and supervisors was not received until after staff had administered tool, however these staff have since been trained, and recent practice indicates the site is now ensuring all staff receives training prior to the first administration.
1	-Evidence exists to indicate that staff administer the tool prior to being trained and/or supervisors have not received this training.

Using PIMS to Provide Evidence of Compliance

The report **PIMS45: Staff Training on Instruments** addresses this standard. Remember that as with most accreditation standards, you may need to support the quantitative data from PIMS reports with a narrative interpretation.

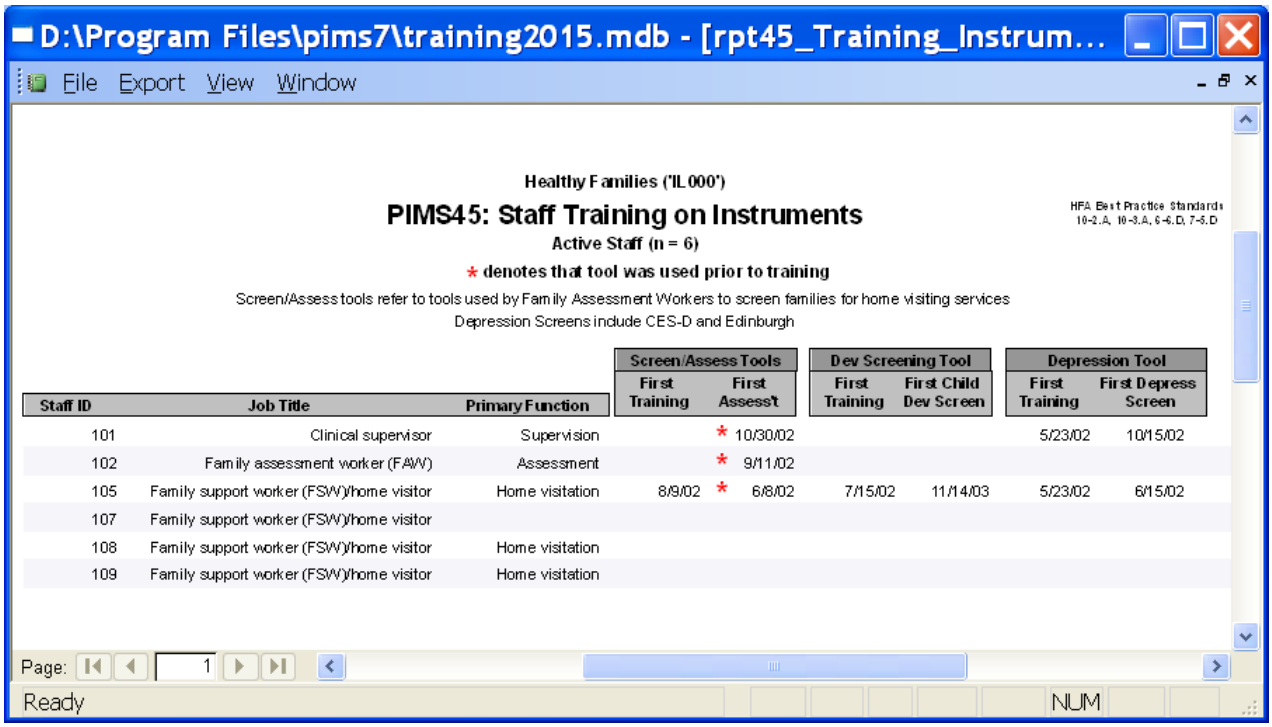
Tips for Monitoring PIMS Data Related to Standard

Sites will want to make sure that staff training records are complete. Make sure that for training on the depression screening tool, the appropriate box has been checked off in the training record.

How to Run this Report

16. From the **Reports** screen, select **Standard Reports**.
17. Select **Category** “Program and Staff” and **Report** “Staff Training on Instruments”.
18. Choose Case Status filter of “Currently presumed active”.

Example



Staff ID	Job Title	Primary Function	Screen/Assess Tools: First Training	Screen/Assess Tools: First Assess't	Dev Screening Tool: First Training	Dev Screening Tool: First Child Dev Screen	Depression Tool: First Training	Depression Tool: First Depress Screen
101	Clinical supervisor	Supervision		* 10/30/02			5/23/02	10/15/02
102	Family assessment worker (FAW)	Assessment		* 9/11/02				
105	Family support worker (FSW)/home visitor	Home visitation	8/9/02	* 6/8/02	7/15/02	11/14/03	5/23/02	6/15/02
107	Family support worker (FSW)/home visitor							
108	Family support worker (FSW)/home visitor	Home visitation						
109	Family support worker (FSW)/home visitor	Home visitation						

In the above example, staff 101 and 105 both received training in the depression tool before administering it for the first time.