Department of Children and Families
Division of Family and Community Partnerships
Office of Early Childhood Services
Annex A Instructions – Nurse-Family Partnership

IMPORTANT: The completed contract renewal materials are to be sent to the DCF contract administrator coordinating the contract renewal process. In addition, please provide a copy and electronic version of both the completed **Annex A** and **Annex B** documents for all DCF (i.e., DCP&P, DFCP, and CBCAP funded) Home Visitation (HV) grants (i.e. Healthy Families-TIP, Nurse-Family Partnership, Parents As Teachers, Home Instruction for Parents of Preschool Youngsters.) to the designated DFCP Office of Early Childhood Services (OECS) Home Visitation program specialist assigned to review your contract.

Annex A – Section 2 Program Information

Section 2.1 Program Name and Service Delivery Information

Complete the designated forms as described in the general Annex A instructions.

Section 2.2 Program Description

The program description now provides a standard narrative for the specific HV models and underscores essential contract requirements for grantees. Please cut and paste this information into your agency's Annex A, as appropriate. Please be sure that you are aware of all DCF recommendations and requirements as a funded HV grantee. Read this template language carefully and add agency specific information, as requested.

Section 2.2 #1 Provide a Brief Program/Component Description and its Purpose

The Nurse-Family Partnership (NFP) model is an evidenced-based home visitation program (EBHV) that provides in-home health and parenting education, and supportive services to at-risk low income, first-time pregnant women and their families. NFP identifies eligible families through a systematic screening and assessment process conducted during pregnancy. Families enrolled in the program are offered intensive, long-term home visitation services from pregnancy to age two. Services are strengths-based and rely on parent/family input and active involvement. Participation in NFP is voluntary.

Specially trained nurse home visitors educate families on important issues that impact on the health and well-being of the mother/parents and infant. Nurse home visitors follow a standard set of written guidelines issued by the NFP National Service Office (NSO) for pregnancy, infancy and toddlerhood; and a core parenting curriculum, Partners in Parenting Education. Home visits help parents/families to develop protective factors in five domains (program content areas):

1. My Health (Personal Health)–nutrition, exercise, tobacco/alcohol/other drug use, mental health.
2. My Home (Environmental Health)–healthy and safe homes, work, schools and neighborhoods.
3. My Life (Life Course Development)–childbirth planning, education and finding employment.
4. My Child/Taking Care of My Child (Maternal/Parental Role)–promoting infant/toddler health, development and security.
5. My Family & Friends (Family & Friends)–healthy supportive relationships to meet family/childcare needs.

In adddition, home visitors work within all domains to link families with available health, social services, and other resources that will help to address family needs.

All DCF funded sites must adhere to the NFP model elements and program guidelines set forth by the the national office and operate under the terms of their contracts with NFP. The NFP Model Elements provide a framework for program development, implementation, and quality assurance; and are closely aligned with the *NJ Standards for Prevention*. The NFP model is strengths-based and emphasizes the importance of focusing on the *Protective Factors* in its work with families. New NFP implementing agencies will particpate in the introduction training session developed by NSO for administrative staff. Implementation partners in NJ include the NSO Regional Program Developer and the designated NSO Nurse Consultant for New Jersey. Program staffing, supervision and training must be in keeping with the NFP program standards as set forth in the contract between the implementing agency, DCF and the NSO.

All programs are expected to adhere to conceptual, practice and administrative standards as set forth in the *Standards for Prevention Programs: Building Success through Family Support* developed by the New Jersey Task Force on Child Abuse and Neglect. Grantee program and administrative staff are expected to have knowledge of *the Protective Factors Framework.*

Section 2.2 #2 Target Populations
NFP is available to families from pregnancy up to age two. Criteria for enrollment is limited to pregnant women in the first or second trimester of pregnany (no later than 28 weeks gestation).

Potential clients are screened for a varitety of risk factors, including but not limited to first-time live birth (includes women with a prior miscarriage or fetal death), teen pregnancy, low income, unstable housing, social isolation, depression, substance use, domestic violence and other indicators that place an infant/child at risk of abuse and neglect.

Section 2.2 #3 Service Delivery
EBHV programs are designed to promote the protective factors that support the health and well being of pregnant women, parents/families and their infants and young children. Nurse home visitors work closely with families to develop a trusting relationship with the goals of improving prenatal health, child health and development, and economic self-sufficiency. Nurse home visitors assess parent/family strengths and promote a better understanding of the essential role of the parent (mothers, fathers and other responsible caregivers) in providing a nurturing, healthy and safe environment for their children. A major focus of NFP is the prevention of child maltreatment. To this end, the program addresses key factors that are known (evidence-based) to contribute to child neglect and abuse--prenatal health, infant/child health, child growth and development, parenting skills/anticipatory guidance, parent-child bonding and interaction, early learning/school readiness, family/social support and adult relationships, education/employment, and linkages to needed treatment services, childcare and/or other community resources. As described elsewhere in this section, home visits are the key service delivery vehicle, and home visitors must adhere to the recommended schedule of visits to ensure that participating families benefit from the full impact of the program.

Documentation and Data Collection: NFP sites are required to record visit information and track specified data using the web-based NFP data collection and reporting system that has been designed to keep track of family characteristics, needs, services provided, and progress toward accomplishing national objectives. DCF funded NFP sites have access to various data summary reports from the NSO data system. DCF expects sites to use these reports to provide helpful feedback to staff, monitor performance and improve quality of services. To ensure accurate monthly, quarterly, and annual report data, EBHV sites must enter all documentation into the NSO data system by the 5th of the month for the previous month.

SPECT Data System: DCF collaborates with the NJ Dept. of Health (DOH) and Family Health Initiatives (FHI) in regards to the Single Point of Entry Client Tracking data system (SPECT). The SPECT data system is utilized by prenatal providers, Central Intake, EBHV sites, and other core programs and partners. To ensure accurate monthly, quarterly, and annual report data, EBHV sites must enter all documentation into the SPECT database by the 10th of the month for the previous month.

DCF has established a standard quarterly report that is inclusive of a set of performance indicators for all EBHV programs supported by the department (refer to the attached word file, *EBHV Quarterly Progress Reporting Form*). These HV Objectives include three areas of focus--1) process, 2) impacts and 3) outcomes. Grantees are required to collect, review and analyze program performance data to continually improve program effectiveness and promote quality services for participating families, and then report to DCF on a quarterly basis.

Quarterly Service Reports: All programs are required to send quarterly report data to the designated DCF contract administrator and DFCP HV Program Specialist—using the following standard reporting periods: (The following is the program is the program year for collecting the data required. It may not reflect your contract/fiscal year)

- July 1st to September 30th
- October 1st to December 31st
- January 1st to March 31st
- April 1st to June 30th
- Quarterly reports are due no later than 15 days after the report end date and should accompany the agency's submission of its quarterly *Report of Expenditures*.

Continuous Quality Improvement (CQI): CQI is an essential aspect of service delivery. Funded agencies must demonstrate progress in meeting established program targets. The purpose of continuous quality improvement planning is to ensure that DCF funded programs are effective in reaching and supporting families, and helping families to achieve these core program objectives. Through this process, grantees identify areas for performance improvement to reach optimal levels of program functioning.. **Refer to Section 2.2–subsection #8 for CQI components and timeline.**

CQI is initiated throughout the program year and as needed, based on the following guidelines:

a. Target Process / Level of Service (LOS) Measures (Table A)—Chronic underperformance (i.e. over 3-months) in any of the indicators in Table A-LOS, Enrollment, Discharges, Expected Visits and Retention. *Note: Retention is a challenge both nationally and statewide, but it is important to continue to strive to meet national and state standards. DCF and NSO will work collaboratively with sites to strengthen performance in this area over the next few years.*
b. Performance Objectives and Performance Measures (Table B)—Chronic underperformance (over 6 months) in five or more areas Objectives-WIC enrollment, primary care providers, well visits, etc.

All grantees should strive to reach the above mentioned measures and benchmarks; however, we recognize that there may be variability across target populations and target communities. As part of the CQI process, programs respond to the underperformance as part of the quarterly report. Underperformance in any area is reviewed and addressed. If a program is placed on corrective action for underperformance, additional program data reports maybe requested more frequently. Revisions to mandated data reporting requirements for the federally legislated Maternal, Infant, and Early Childhood (MIEC) HV benchmarks will be issued in collaboration with all HV partners and will be required to track and be submitted by the program.

Note: These targets continue to undergo review and analysis. DCF HV program staff may make further refinements to specific targets, or additional indicators, after this analysis is complete.

The CQI process will include input/consultation from all HV partners-- consultation with the regional NFP developer, NSO nurse consultant, grantee, DCF and other essential partners. CQI processes will be reviewed on a regular basis.

Evaluation and Research Study: All DCF funded evidence-based HV grantees must participate in the statewide evaluation and research study being conducted by Johns Hopkins University and any other approved research projects in response to funding requirements. All DCF funded EBHV programs must notify EBHV Program Manager and/or Program Specialist of their participation in any additional research/evaluation studies.

Section 2.2 #4 Service Delivery Method
NFP services are provided to participating families primarily in the home setting. At times, visits may be conducted in an alternate mutually agreed upon setting, e.g. after school, work or community setting. Visits must be able to accommodate the participant's schedule and may be provided at alternate mutually agreed upon times, i.e. early morning, early evening or on a weekend day.

Referrals and Linkages:
HV program staff are encouraged to link families with additional resources that provide services in the target community, including other DFCP programs (e.g., Family Success Centers, School-Linked Services, DV support, Strengthening Families childcare providers, etc.), as appropriate. In addition, grantees shall routinely review and update exisiting entries in state, county and local resource networks and directories, e.g. DFCP's online directory or NJ's 2-1-1 Partnership

Database, to ensure complete, accurate and up-to-date information for families and professionals trying to locate HV services.

Local Community Advisory Board:
HV grantees shall establish and/or maintain alignment with the local County Council for Young Children (CCYC) to form an active advisory board.

The advisory board must be an organized active body, which meets at least quarterly to advise/govern the activities of planning, implementation, and assessment of program services. This includes but is not limited to a review of program practices, policies, quarterly/annual performance measures, Continuous Quality Improvement (CQI) efforts, providing input and timely recommendations with respect to program strengths, areas of growth, and improvement. HV grantees are encouraged to integrate and/or develop this advisory role within the broader perinatal and/or early childhood community.

The HV grantee Program Supervisor/Manager (or other program representative) and the advisory board must work as an effective team in the planning and developing of program policies and procedures.

HV grantees must also identify at least one parent/caregiver from each FTE home visitor to invite to the advisory board and collaborate with the CCYC lead agency and/or members to encourage and facilitate parent/caregiver participation.

HV grantees must provide documentation of advisory board activities, have available meeting notes, and attendance records during site visits or as requested. HV grantees must also refer to the DCF Policy and Procedure: Advisory Boards

Section 2.2 #5 Access to Services
Generally, NFP services are provided in the participant's home. There are no physical limitations that preclude enrollment or participation.

Pregnant women and parents are screened by prenatal care providers, health care providers or other community agencies. HV sites are expected to be active partners with the local Central Intake (CI) and comply with the business agreements set forth, to ensure easy linkages for eligible pregnant women/parents and families. DFCP HV staff will help to facilitate these relationships with CI, as needed.

Once a family is referred to the program they receive an initial contact from the program within three working days and are scheduled for an initial home visit for a nursing assessment and eligible families are offered enrollment into the program.

Families that decline or are ineligible for servcies are provided with resource information about available/ suitable community services and supports, and are assisted with any essential referrals. Based upon local Business Agreements/Rules, programs should provide a status report and re-route these families back to central intake for links to alternate services, as appropriate.

Families that meet program eligibility and agree to participate in the program are enrolled and visits are conducted by the assigned nurse home visitor. Visit frequency is determined by the nurse based on the phase of care and the families' needs. Visit guidelines are as follows:

Prenatal - during 1st month of enrollment	Weekly (4 visits)
Prenatal - end of 1st month to delivery	Every other week (8-10 visits)
Infant - from birth to six weeks of age	Weekly (6 visits)
Infant-Toddler - age 8 weeks to 21 months	Every other week (40 visits)
Toddler - age 21 months to 24 months (age 2)	Monthly (3-4 visits)

Families that are enrolled but inactive, i.e. missed three or more consecutive scheduled visits or are lost-to-care, will continue to receive outreach for at least three months.

The nurse and the parent/family collaborate in goal planning (pregnancy, parenting, infant/child, family sustainability). Ongoing progress is documented and new goals are established over the course of home visits. The nurse will assist participating families with referrals for health, social service, child care or other community supports as needed and mutually agreed upon.

The nurse will assist participating families with referrals for health, social services, child care or other community supports, as needed.

Staffing/Caseload Requirements:
- Each full-time (1.0 FTE) nurse home visitor carries a caseload of 25 active families.
- At least a half-time (0.5 FTE) supervisor is designated for four (4) full-time nurses.

Note: A nurse supervisor employed full-time and carrying a 0.5 FTE caseload is required to carry a minimum caseload of 5 families (maximum of 10 families).

Discharge Process: Ideally a participant remains enrolled in NFP until the child has reached age two and the family has achieved specified health and well-being performance indicators. For a variety of reasons, families may withdraw from the program earlier. Sites are required to track length of participation, reasons for discharge and progress in reaching specified goals and objectives.

Section 2.2 #6 Catchment Area/Neighborhood
Grantees provide services in the homes of participating families. The catchment area for this site is _____ (specify for your agency). *Remember DCF funded NFP programs are county wide.*

Section 2.2 #7 Emergency/After-Hours Contact
Client and staff safety is an important concern in home visitation programs. All program staff are required to undergo background checks. Field staff carry cell phones and are instructed to remain in regular contact with the office during the course of the day.

In the event of any staff or client emergency _____ (briefly summarize key safety policies for your agency).

Emergency contacts for this agency are: _____ (complete this for your agency).

Section 2.2 #8 Unduplicated Clients (Annual Report)
In compliance to NSO/NFP, all sites must submit the NFP Implementing Agency Annual Plan/Quality Improvement Planning report to NSO within the appropriate timeframe. In addition, NFP Implementing Agencies must submit the most recent plan to DCF within 90 days of the end of the contract period. This report shall be submitted to both the contract administrator and DFCP HV Program Specialist.

Furthermore, DFCP/OECS requires the Quarterly Report/Year-End Report to be submitted 15 days after the end of the report period. The Year-End Report should include explanations why a program may not be reaching a particular objective and what is the plan to make improvements.

It is recognized by DCF that collection, analysis and reporting of data for these objectives is an ongoing process. As previously, adjustments to performance measures may still be needed and will include the federal MIECHV benchmarks. Adjustments will be made by DCF in consultation with NFP partners, as indicated.

> *NOTE: As noted above in Section 2.2-subsection #3, programs are still required to submit quarterly reports on an ongoing basis during the year.*

Section 2.3 Performance Outcomes
In lieu of the standard Annex A Section 2.3 form, NFP programs are to submit the 3-page HV Performance Outcome Form. Grantees must use the NFP template for this form (posted on the DCF website) and insert projected numbers in the blanks (specifically in Objectives 1, 2a and 2b) where indicated for the upcoming year.

Section 2.4 Program Personnel Information Sheet
Please complete all of the information as requested in the general instructions. Be sure to include the first and last name of the employee and educational credentials of HV staff.

IMPORTANT: HV grantees must provide a breakdown of staff roles and specify the percentage (FTE and estimated hours per week) of time allocated for each worker in the specified HV roles, i.e. Program Manager, Supervisor, Nurse Home Visitor and Data Entry/Program Support. Use the column titled Functional Job Duties to itemize core functions/role with an estimate of the average number of hours per week (e.g., administrative support – ETO data entry and program support 10 hours per week).

Section 2.5 Level of Service
A monthly contracted level of service chart is to be completed for each program/component, if applicable. One program might require several LOS forms to be completed which can be downloaded from the website. This will be indicated to you by the Contract Administrator and/or in the renewal/award letter.

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Annex A Instructions – Nurse-Family Partnership

The information on this form is usually utilized as a reference/source document when completing reporting forms during the contract term, when required by DCF.

Service Type: Per service dictionary, contact your contract administrator (i.e. individual counseling, residential placement, legal assistance, transportation)

Description of Unit Measurement: Indicate what is being used as the measurement for monthly Contracted Level of Service (CLOS), (i.e. beds, rides, sessions, hours)

Number of Contracted Slots/Units: Numbers should reflect unduplicated service counts. Unduplicated service counts refers to the practice of counting a customer receiving services only once within a service cycle.

Refer to Annex B 2 and or Renewal/Award Letter for this number. (i.e. # of beds, # of rides, # of sessions, # of hours)

Annualized Units: Equivalent to the Annual Total under Column 3 on chart.

Column 1: Select Month from drop down menu. Month 1 should reflect 1st month of Contract.

Column 2: Indicate Actual Number of Expected Days of Service or Units Per Month.

Column 3: Indicate total Contracted LOS per month, this could be 'Days of Service' multiplied by Number of Contracted Slots/Units per month or equivalent to number listed in Column 2.

Annual Totals: This number will equal annualized number of units to be contracted per program type.