FY25 Start Early-HFI Best Practice Standards
Initial Engagement/Screening & Assessment

Principle	Practice	Benchmark	Documentation
IE1 - By using weighted eligibility and targeting families with the highest need, programs can effectively address child abuse, neglect, and other poor outcomes. *BPS = Best Practice Standard*	A - HV&DN programs provide services for pregnant and parenting individuals, prioritizing adolescents at intake.		Participant Files DataPoints Quarterly
	B - Programs use a weighted eligibility system in addition to any other model requirements to determine program eligibility. Programs ensure that funder specific priority populations are part of the weighted eligibility criteria.		
IE2 - Programs are more likely to recruit and retain long-term participants when they initiate services prenatally or immediately after birth in order to form a trusting connection with new parents and establish the program as a source of support and information. *(BPS 1-2.A, 2-1.C)*	A - Programs initiate Home Visiting before the child is age three months.	Programs initiate Home Visits before the child is age three months 100% of the time.	Case Notes Participant Files

Principle	Practice	Benchmark	Documentation
IE3 - Screening and assessment of family needs focuses on systematic identification of those families most in need of services and identifies the presence of key factors associated with an increased risk of child maltreatment and other poor childhood outcomes. *(BPS 1-1.A)*	A - Programs use the Family Resource and Opportunities for Growth (FROG) as the uniform method for early identification of potential participants.	100% of programs assess potential participants using the FROG.	Participant Files DataPoints Quarterly
	B - Programs clearly define their target population and maintain annual tracking of the number births and other demographic characteristics within that population to ensure that they screen 100% of the potential participants.	Program has a description of its target population and how the current target population was decided upon including the relevant and up to date community data that was used in the decision making. Both the description and data utilized are comprehensive and up to date within last two years.	Program Abstract
	C - Programs refer families that assess as high-risk to all other applicable services in the community if the program is full.	100% of programs assess families' risk levels and refer to other services as needed.	
IE4 - Assessment of family needs occurs in an atmosphere of mutual respect and informed consent.	A - Programs conduct outreach activities for target families and those who screen or assess as high-risk to encourage their voluntary participation in the program.	100% of programs use outreach activities to engage potential participants.	Supervisory Documentation
	B - Programs maintain up- to-date signed Start Early consents for services with all participants involved.	100% of participant files contain up-to-date, complete, and signed Start Early consent forms.	Participant Files

Principle	Practice	Benchmark	Documentation
IE4 - Assessment of family needs occurs in an atmosphere of mutual respect and informed consent.	C - Staff members obtain signed consent prior to any intake or assessment interview, and entry of participant information into DataPoints. Refusal to sign a consent form for entry of their information into DataPoints does not preclude a family from services.	Programs enter data into DataPoints only after obtaining prior written consent 100% of the time.	Participant Files
	D - Database systems that are used to maintain accurate demographic and programmatic information are up to date.		Healthy Families America Site Tracker (HFAST) DataPoints
IE5 - Programs are most effective when they use intake and assessment information about family characteristics, background, history, and current functioning to plan services. *(BPS 6-1)*	A - Staff members who assess families or gather intake data share that information with Home Visitors, Doulas, Parent Group Service Coordinators, and Program Supervisors.	100% of staff members who complete intakes or assessments share intake information or assessment results with the service team.	Program Narrative Supervision Notes
	B - Re-enrolled families should open with same eligible target child, when continued eligibility applies.	100% of families are re-enrolled with eligible target children, when eligibility applies.	DataPoints Participant Files
	C - HFA Service Plan is to be discussed monthly with families on the most intensive levels.	100% of families who have received an assessment will have a service plan to address risks and stressors completed by the Home Visitor and Supervisor. The Service Plan is to be developed within 2 weeks of the completion of the FROG.	Supervision notes

FY25 Start Early-HFI Best Practice Standards
Home Visiting

Principle	Practice	Benchmark	Documentation
HV1 - Home Visiting is the core family support and early childhood education service provided by HV&DN programs for pregnant and parenting individuals and their children. *(BPS 4-1.B, 4-2.A, 4-3.B, 4- 4.A)*	A - Home Visits take place on a schedule determined in partnership with the family, diminishing in intensity as family needs change.	Programs assign 100% of families to a service intensity level.	Participant Files Program Narrative
	B - Home Visitors conduct Home Visits weekly for the first six months of the baby's life with visit frequency beyond that time planned in accordance with HFA guidelines for participant level changes.	100% of participants receive weekly Home Visits for the first six months of their baby's life.	Case Notes HFA Level Change Form Supervisory Documentation
	C - Each family's progression to a new level of service, as identified by level change criteria, is reviewed by the family, home visitor, and supervisor. This review serves as the basis for the decision to move the family from one level of service to another.	100% of participant level changes are documented in participant files. Programs are required to use the HFA Level Change forms and are encouraged to use the HFA Celebration Forms to acknowledge participant progress	Case Notes Participant File Supervisory Documentation
	D - Programs offer services to families for a minimum of three years after the birth of the baby. Accelerated services are acceptable when level change criteria are met.		Policy and Procedure Manual

Principle	Practice	Benchmark	Documentation
HV1 - Home Visiting is the core family support and early childhood education service provided by HV&DN programs for pregnant and parenting individuals and their children.	E - Programs ensure that families planning to discontinue or close services have a well thought out transition plan. Transition planning begins six months prior to participant exit. The elements of the programs transition plan are articulated in the program's Policy and Procedure Manual.		Case Notes Policy and Procedure Manual Supervisory Documentation
	F – Transition plans are developed in conjunction with the family and completed plans include the participant's signature.		
HV2 - Home Visiting is of sufficient intensity to impact program outcomes. *(BPS 4-2.B, 6-4)*	A - Home Visits last between 1.0 and 1.5 hours. In certain circumstances, visits between 45 minutes and one hour are acceptable.	80% of Home Visits last between 1.0 and 1.5 hours. All visits, including virtual visits, should be at least 45 minutes. Two shorter visits in the same day can be combined in DataPoints to be counted as one visit, provided the total time is at least 45 minutes.	Case Notes DataPoints
		Home visits take place in the home or virtually depending upon family needs. Virtual visits should be documented accordingly in DataPoints and programs should have established policies and procedures for implementation of virtual visits.	Case Notes Policy & Procedure Manual
	B - All elements of a home visit are required for virtual visits, including a parent- child activity.		Case Notes
	C - Programs complete Home Visits with all participants at the expected level of frequency for each	Home Visitors complete 75% of expected Home Visits per service intensity level.	Case Notes DataPoints

Principle	Practice	Benchmark	Documentation
	family.		
HV2 - Home Visiting is of sufficient intensity to impact program outcomes. *(BPS 4-2.B, 6-4)*	D – Programs use an evidence- informed curriculum to guide service delivery.	Programs submit the name of their chosen curriculum in their Program Abstract	Program Abstract Program Narrative
HV3 - Home Visits are parent-child focused, and responsive to the health and development needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship. *(BPS 6-3.A., 6-3.B&E Essential Standard, 6-4.A, 6- 4.B&C)*	A - Programs routinely address and promote positive parent-child interaction, attachment and bonding, and the development of nurturing parent-child relationships.		Case Notes Supervisory Documentation
	B – Home visitors assess, address, and promote positive child interaction, attachment, and bonding with all families, utilizing CHEERS on all home visits.	100% of parent child activities are documented using CHEERS on every home visit except when administering the FROG or the CCI.	Case Notes Supervisory Documentation
	C - Programs have policies and procedures for strengthening families by addressing challenging issues such as substance abuse, intimate partner violence, developmental delays in parents, and mental health concerns. Practices indicate that the policies are being implemented.		Case Notes Policy & Procedure Manual Supervisory Documentation
	D - Programs utilize home safety checklists with families on a routine basis.	Home safety checklists are implemented with families within 45 days of the first completed home visit. Home Visitors are encouraged to use the checklists more	Case Notes Participant Files

Principle	Practice	Benchmark	Documentation
		frequently if needed to address concerns with families.	
HV3 - Home Visits are parent-child focused, and responsive to the health and development needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship. *(BPS 6-4 A, B, C)*	E - Home Visitors discuss the risks of smoking and provide smoking cessation information to participants who smoke. Materials may also be provided to family members who smoke, if interested.	100% of participants have information regarding tobacco use during pregnancy entered into Datapoints at intake.	Case Notes DataPoints
		100% of participants have information regarding current tobacco use within 30 days of the first home visit and every six months thereafter for the duration of program enrollment. Information should be updated if status changes during program involvement.	
	F - Home Visitors discuss the risks of alcohol use during pregnancy and provide materials about alcohol and pregnancy to participants as needed.	100% of participants have information regarding alcohol consumption during pregnancy entered into DataPoints at intake.	Case Notes
	G - Home Visitors plan and structure each visit to enable parents to understand their child's stages of development, develop age- appropriate expectations, develop successful communication and enjoyable interaction with their child, and develop parental interest and pride in their child's development.		Case Notes Participant Files

Principle	Practice	Benchmark	Documentation
	H - Home Visitors encourage parents to engage in language development activities with their children.		Case Notes Program Narrative
HV3 - Home Visits are parent-child focused, and responsive to the health and development needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship. *(BPS 6-4B)*	I - Home Visitors share information about the benefits of breastfeeding and about risks of HIV transmission via breastfeeding.	Home Visitors document discussions with participants about breastfeeding in case notes	Case Notes
		75% of participants initiate breastfeeding.	Child Intake
	J - Home Visitors use medically accurate materials in discussing HIV with participants.		Case Notes Participant Files
	K - Home Visitors use universal precautions during work with infants and toddlers.		Supervisory Documentation Team Meeting Notes
	L - All participating children, up to age five, receive developmental screening at the following ages: four, six, nine, and 12 months, every six months from age one through age five. Programs emphasize parental involvement in the screening process.	85% of all children are up to date with expected developmental screenings.	Participant Files
		80% of children ages 9, 18, 24 and 30 months have at least one on time developmental screening.	Participant Files
	M - All participating children, up to age five, receive social emotional screenings at the following ages (in months): two, six, 12, 18, 24, 30, 36, 48, and 60.	85% of children are up to date with expected social emotional screenings.	Participant Files

Principle	Practice	Benchmark	Documentation
	N - Programs track children who are suspected of having a developmental delay, follow through with appropriate referrals, and follow up to determine if services were received.	Programs follow up on 85% of referrals related to suspected developmental delays to determine if services were received.	Case Notes Participant Files Supervisory Documentation
	O - Community-Based FANA (FANA) trained Home Visitors engage pregnant participants in the prenatal FANA activities designed for their infant's gestational age, and engage postpartum participants in postnatal FANA activities during their infant's first month of life.	Home Visitors implement prenatal FANA activities a minimum of every other week during the last trimester of pregnancy and engage postpartum participants in postnatal FANA activities at least once within the baby's first month of life.	Case Notes Program Narrative
	P - Home Visitors fully complete written documentation of Home Visits within 72 hours of each visit, and complete related data entry within of the Home Visit.		Case Notes Program Narrative Supervisory Documentation
	Q - Parent Child interactions will be observed using the CHEERS Check-In tool. The CHEERS check-in tool is to be completed twice a year through age 36 months and then yearly in subsequent years.		Participant Files
HV4 - In a manner respectful of each participant's cultural and religious beliefs, Home Visitors engage participants in discussions around the potential impact of subsequent births with the goal of supporting participants in making informed and intentional decisions.	A - Home Visitors provide all participants with information and support regarding delay of subsequent births, effective family planning, including birth control and abstinence (as the only 100% protection from risk), and protection from STIs, including HIV/AIDS, using medically accurate curricula and materials.	80% of participants delay subsequent birth during program involvement. (delay = 2 year interval between births)	Case Notes

Principle	Practice	Benchmark	Documentation
	B - Home Visitors update participant information on contraceptive use at a minimum of every six months.	100% of participants have information regarding contraceptive use and STI prevention updated in DataPoints at a minimum of every six months.	Participant Files
HV5 - Home Visitors build and sustain relationships with participating parents and their children that promote health, self-sufficiency, development of a social support network, and responsible decision- making. *(BPS 7-1.B, 7-2.B)*	A - Home Visitors assist and support parents to return to school and obtain safe, high-quality childcare.	75% of participants who should be enrolled in high school or equivalent educational services are enrolled during the course of program involvement.	Case Notes Participant Files
		100% of participants have education status information updated in DataPoints a minimum of every six months.	Participant Files
	B - Home Visitors link participating children and parents to a medical provider for routine health care, well-child visits, and timely immunizations.	90% of target children are up to date with immunizations and well-child visits.	Participant Files
		80% of target children have received their last well- child visit, based on the American Academy of Pediatrics schedule. The schedule can be found here: https://www.healthychildre n.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx	Participant Files

Principle	Practice	Benchmark	Documentation
	C – Home Visitors support and encourage birthing persons in accessing post-partum care.	85% of birthing persons who enroll prenatally or within 30 days of delivery receive a postpartum visit within 8 weeks of delivery date.	DataPoints Participant Files
HV6 - Programs conduct Home Visits in a manner that supports the successful completion of personal and program goals as described in the Family Goal Plan. *(BPS 6-2.B, 6-2.C) 2-2.A*	A - Home Visitors develop a Family Goal Plan with each participant within 45 days of the first completed Home Visit, and every six months thereafter. Home Visitors and parents review and update the plans on a regular basis. The plans accurately reflect the progress of each family toward the completion of their goals and address parent and child needs, strengths, capacities, and challenges. Home Visitors structure both the plan and Home Visits to support the parent's strengths.	90% of participant files contain up-to-date Family Goal Plans. 100% of Family Goal Plans are signed by the participant.	Participant Files
	B - Home visitors will set goals with the family around: parent child interaction, parent self-sufficiency and child development.	90% of participant files contain up-to-date Family Goal Plans that reflect parent child interaction, parent self-sufficiency and child development.	Participant Files

Principle	Practice	Benchmark	Documentation
HV6 - Programs conduct Home Visits in a manner that supports the successful completion of personal and program goals as described in the Family Goal Plan. *(BPS 6-2.B, 6-2.C) 2-2.A*	C - Home Visitors address issues identified in the initial assessment in Home Visits.	Programs have policies and procedures regarding assessment criteria and documentation of assessment narratives that assess for the presence of factors that could contribute to increased risk factors for child maltreatment or other adverse childhood experiences. Policies and procedures identify who completes the narrative and the timeframe for completion.	Case Notes Participant Files Supervisory Documentation
HV6 - Programs conduct Home Visits in a manner that supports the successful completion of personal and program goals as described in the Family Goal Plan. *(BPS 6-2.B, 6-2.C) 2-2.A*	D - Home Visitors update participant outcome information related to employment, medical home, and WIC status in DataPoints at a minimum of every six months.	Home Visitors update 100% of participant outcome information in DataPoints within 30 days of the first completed home visit and then at a minimum of every six months for the duration of program enrollment.	Participant Files
	E – Home Visitors update participant outcome information related to transience in DataPoints at a minimum of every three months.	Home Visitors update 100% of transience information in DataPoints at intake within 30 days of the first completed home visit and then at a minimum of every three months for the duration of program enrollment.	Participant Files
	F - Home Visitors update child outcome information related to childcare and father involvement in DataPoints at a minimum of every six months.	Home Visitors update 100% of child outcome information in DataPoints at intake or within 30 days of the child's birth and then at a minimum of every six months for the duration of program enrollment. This standard applies to the target child only. Home Visitors do not need to track this data on non-target children.	Participant Files

Principle	Practice	Benchmark	Documentation
	G - Home Visitors update child feeding information in DataPoints according to the following schedule: at birth, six weeks, six months, and one year. For participants who are breastfeeding after one year, Home Visitors update child feeding information at 18 months and two years, if applicable.	100% of children have up- to-date feeding information in DataPoints. This standard applies to the target child, if born during program enrollment, and any subsequent children.	Participant Files
HV7 - Programs provide Home Visits in a manner that respects the family and cultural values of each participant.	A - Programs offer services on a voluntary basis, using positive and persistent outreach efforts to build family trust and retain overburdened families in the program. The home visitor will embrace cultural humility in their approach to working with families from a place of self-awareness, understanding that each family has a unique culture and that our own culture and values can impact our interactions with families.		Case Notes Participant Files Staffing Notes Supervisory Documentation
	B - Home Visitors and Supervisors encourage the support and involvement of fathers, grandparents, and other primary caregivers.		Case Notes Supervisory Documentation

Principle	Practice	Benchmark	Documentation
	C - Programs select and implement materials and curricula in a way that builds upon strengths inherent to each family's cultural beliefs. The program's materials reflect the language, ethnicity, and customs of the families served.	Programs identify at least one home visiting curriculum in their Program Abstract. Home Visitors document the use of this curriculum in case notes.	Program Abstract Program Narrative
HV8 - Due to the high incidence of depression among the population served by HV&DN programs, and because maternal depression can significantly impair the parent-child relationship, programs make efforts to identify maternal depression as early as possible and to help depressed participants access services. *(BPS 7-5A.)*	A - Programs have policies procedures for administration of a standardized depression screen/tool that specify how and when the tool is to be used with all families participating in the program and assure that all staff who administer the tools are fully trained.	Home Visitors screen 100% of consenting active participants prenatally and twice postpartum (at 4-6 weeks and 6 months). This standard applies to target children and subsequent births.	Policy and Procedure Manual Participant File DataPoints
		85% of participants are screened for maternal depression within three months of delivery, when enrolled prenatally or within three months of enrollment, when enrolled postnatally	DataPoints

FY25 Start Early-HFI Best Practice Standards

Doula

Principle	Practice	Benchmark	Documentation
D1 - Programs are more likely to recruit and retain long-term participants when they initiate services prenatally or immediately after birth in order to form a trusting connection with new parents, and establish the program as a source of support and information.	Programs initiate Doula services at the beginning of the third trimester of pregnancy.	Programs enroll 80% of Doula participants by the seventh month of pregnancy.	Participant Files Program Narrative
D2 - Doula Home Visits are of sufficient intensity to impact program outcomes.	A - Doula Home Visits last between 1.0 and 1.5 hours.	80% of Home Visits last between 1.0 and 1.5 hours. All visits, including virtual visits, should be at least 45 minutes. Two shorter visits in the same day can be combined in DataPoints to be counted as one visit, provided the total time is at least 45 minutes. Home visits take place in the home or virtually depending upon family needs. Virtual visits should be documented accordingly in DataPoints and programs should have established policies and procedures for implementation of virtual visits.	Case Notes

Principle	Practice	Benchmark	Documentation
D2 - Doula Home Visits are of sufficient intensity to impact program outcomes.	B - Programs complete Doula Home Visits with all participants at the expected level of frequency for each family.	Doulas complete 80% of expected Doula home visits	Case Notes Program Abstract
D3 - Doula Home Visits are parent-child focused and responsive to the health and developmental needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship.	A - Doulas plan and structure each visit to enable parents to understand each stage of prenatal development, understand and develop enjoyable prenatal and postpartum interaction with their child, and develop parental interest in their child's development.		Case Notes Participant Files
	B - Doulas share information about the benefits of breastfeeding and about risks of HIV transmission via breastfeeding, using medically accurate materials.	Doulas document discussions with participants about breastfeeding in case notes.	Case Notes
		75% of participants initiate breastfeeding.	Participant Files
	C - Doulas use universal precautions in work with infants and toddlers.		Supervisory Documentation Team Meeting Notes
	D - Doulas discuss the risks of smoking during pregnancy and provide smoking cessation materials to participants who smoke. Materials may also be provided to family members, if interested.	100% of participants have information regarding tobacco use during pregnancy entered into DataPoints at intake and in case notes.	Case Notes
		100% of participants have information regarding current tobacco use within 30 days of the first home visit. Information should be updated if status changes during program involvement.	Case Notes

Principle	Practice	Benchmark	Documentation
D3 - Doula Home Visits are parent-child focused and responsive to the health and developmental needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship.	E - Doulas discuss the risks of alcohol use during pregnancy, and provide materials about alcohol and pregnancy to participants as needed.	100% of participants have information regarding alcohol consumption during pregnancy entered into DataPoints at intake and in casenotes.	Case Notes
	F - Community-Based FANA (FANA) trained Doulas engage pregnant participants in the prenatal FANA activities designed for their infant's gestational age, and engage postpartum participants in postnatal FANA activities during their infant's first month of life.	Doulas implement prenatal FANA activities a minimum of every other week during the last trimester of pregnancy, and engage postpartum participants in postnatal FANA activities at least once within the baby's first month of life. These activities are documented in datapoints and in case notes.	Case Notes Program Narrative
D4 - In a manner respectful of each participant's cultural and religious beliefs, Home Visitors engage participants in discussions around the potential impact of subsequent births with the goal of supporting participants in making informed and intentional decisions.	Doulas provide all participants with information and support regarding the delay of subsequent births, effective family planning, including birth control and abstinence and protection from STIs, including HIV/AIDS, using medically accurate curricula and materials.	100% of participants have information regarding contraceptive use and STI prevention entered into DataPoints and in the case note within 30 days of the first home visit. Information should be updated if status changes during program enrollment.	Case Notes
D5 - Programs conduct Doula Home Visits in a manner that supports the successful completion of personal and program goals as described in the birth plan.	Doulas develop a birth plan with each participant. This plan may serve as the participants' first Family Goal Plan.	90% of Doula participants have an up-to-date birth plan.	Participant Files
D6 - Programs conduct Doula Home Visits in a manner that supports the successful completion of personal and program goals as described in the birth plan.	Doulas update child feeding information in DataPoints at birth and at six weeks.	100% of children have up- to-date feeding information in DataPoints. This standard applies to the target child, if born during program enrollment, and any subsequent children.	Participant Files

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

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

FY25 Start Early-HFI Best Practice Standards
Prenatal Groups

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

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

Principle	Practice	Benchmark	Documentation
PRE4 - Prenatal Groups are an ongoing service strategy. The duration of the group is long enough to sustain relationships that promote trust and goal attainment.	A - Prenatal Group membership and facilitators are as consistent as possible.		Program Abstract Group Plans
	B - Each Prenatal Group meets for a minimum of 1 ½ hours as part of a six-to- eight week session.		Program Abstract Group Plans
	C - Programs hold a minimum of 24 Prenatal Group sessions during the fiscal year. Virtual group services are permissible in conjunction with or separate from in person group services. Virtual groups should be documented in DataPoints and programs should have established policies and procedures for implementation of virtual group sessions.	Programs hold 90% of planned Prenatal Group sessions.	Program Abstract
	D - Prenatal Group documentation includes micro plans, attendance, and process notes for each session.		Group Plans
	E - Individuals responsible for planning Prenatal Groups submit macro plans on a quarterly basis to their HV&DN Program Advisor.		Macro Plans
	F - Prenatal Group arrangements include a nutritious meal or snack.		Program Abstract Group Plans
	G - Programs complete a written evaluation plan for Prenatal Group services that includes a procedure for gathering feedback from Group participants.		Group Evaluations Group Plans Policy and Procedure Manual Process Notes

Principle	Practice	Benchmark	Documentation
PRE5 - Prenatal Groups enable pregnant persons their partners, and families to achieve a healthy pregnancy, optimal birth outcome, and positive adaptation to parenting.	These groups promote transition to ongoing program services such as Home Visiting and Parent Groups for both enrolled participants and those not yet actively enrolled in the HV&DN program.		Group Plans

FY24 PTS-HFI Best Practice Standards
Parent Groups*

Principle	Practice	Benchmark	Documentation
PAR1 - Parent Group sessions challenge thinking and emphasize decision making about issues that affect the relationship between parent and child. Parent Group activities provide opportunities for positive peer interaction.	A - A portion of the Parent Group session focuses on the sharing of experiences and ideas of group members about various topics, such as parenting, family planning, health care, career exploration, education, housing, and childcare.		Group Plans
	B - A wide variety of activities and approaches are encouraged to bridge the range of learning and social skills of group members (i.e., games, videos, role- playing, guest speakers, recreational events, and community service projects).	Parent Group plans reflect activities and approaches used in Parent Group sessions.	Group Plans
	C - Topics, curricula, and other materials used in Parent Group sessions are culturally competent and focused on parenting issues (programs must discuss use of supplemental non-parenting focused curricula with the HV&DN Program Advisor).	Parent Group plans identify topics, curricula, and materials used in Parent Group sessions.	Group Plans Program Abstract Program Narrative
	D - Planning of Parent Group sessions reflects the input of participants, site staff, and Family Goal Plans.		Group Evaluations Group Plans Team Meeting Notes

Principle	Practice	Benchmark	Documentation
PAR2 - Parent Groups enhance the intensity and focus of the Home Visits with pregnant and parenting teens. Through integration, these interventions offer more intense and diverse services that increase the chance of achieving HV&DN desired outcomes.	A - Parent Group facilitators provide all participants with information and support regarding the delay of subsequent births, effective family planning, including abstinence, (as the only 100% protection from risk) birth control, and protection from STIs, including HIV/AIDS. Curricula and materials used are medically accurate.		Group Plans
	B - Parent Group facilitators encourage participants to maintain a medical home for their child and follow up on routine well-child visits and immunizations.		Group Plans
	C - Parent Group facilitators encourage and support adolescents to return to school and obtain safe, high-quality childcare.		Group Plans
	D - Parent Group facilitators provide information on unintentional injury prevention, including Shaken Baby Syndrome, home safety, and poison prevention.		Group Plans
	E - Home Visiting participants are the primary target audience of HV&DN Parent Group Services.		Group Roster Participant Files Staffing Notes
PAR3 - Parent Groups are parent-child focused, as well as responsive to the parent and child's developmental and environmental needs.	A - A part of each Parent Group meeting has activities that encourage successful communication and enjoyable interaction between parent and child, and between group members.	Each Parent Group session has a documented parent- child activity.	□ Group Plans

Principle	Practice	Benchmark	Documentation
PAR3 - Parent Groups are parent-child focused, as well as responsive to the parent and child's developmental and environmental needs.	B - A portion of the meeting allows parents to meet apart from children.		Group Plans
	C - Childcare arrangements ensure safety and consistency in caregivers. Programs must provide adequate screening and supervision of childcare providers.	Programs screen 100% of childcare providers in the same manner as paid staff. This includes all legally permissible background checks, criminal history records, and civil child abuse and neglect registries.	Group Plans Program Narrative
PAR4 - Parent Groups are an ongoing service strategy. The duration of the group must be long enough to sustain relationships that promote trust and goal attainment.	A - Each Parent Group must meet a minimum of forty times per fiscal year, optimally on a weekly basis.	Programs hold 90% of planned Parent Group sessions.	Program Abstract
	B - Parent Group membership and facilitators are consistent.	Parent Group participants are required to attend 75% of Parent Group sessions.	Group Plans Program Abstract
	C - Parent Group plans address content areas in-depth over several weeks through various topics.		Group Plans
	D - Parent Group Service Coordinators submit 10- week macro plans on a quarterly basis to their HV&DN Program Advisor.		Macro Plans
	E - Parent Group documentation includes group micro plans, attendance, and post-group process notes for each session.		Group Plans
	F - Optimal Parent Group size is six to twelve participants.	Each Parent Group maintains an average attendance of at least five participants.	Program Abstract
	G - Parent Group arrangements include a nutritious meal or snack and transportation to and from group.		Group Plans Program Abstract Program Narrative

Principle	Practice	Benchmark	Documentation
PAR4 - Parent Groups are an ongoing service strategy. The duration of the group must be long enough to sustain relationships that promote trust and goal attainment.	H - Programs complete a written evaluation plan for Parent Group services that includes a procedure for gathering feedback from Parent Group participants.		Group Evaluations Group Plans Policy and Procedure Manual Process Notes
	I - Staff members use Parent Group meeting records, informal feedback, parent evaluations, and their own observations to improve Parent Group sessions.		Process Notes Supervisory Documentation
	J – Virtual group services are permissible in conjunction with or separate from in-person group services. Virtual groups should be documented accordingly in DataPoints and programs should have established policies and procedures for implementation of virtual group sessions.		Program Abstract Group Plans
PAR5 - Programs provide Parent Groups in consideration of, and as a support to each participant's family and cultural values.	A - Parent Groups provide support for the involvement of fathers, other primary caregivers, and extended family members (i.e., periodic family nights, grandparent events, and fathers' nights).		Group Plans Program Narrative
	B - It is optimal that staff members (volunteer and paid) reflect the cultural values and strengths of the participants' community.		Program Files

Principle	Practice	Benchmark	Documentation
PAR6 - All other Parent Groups maintain a primary focus on parenting and target achievement of one or more of the HV&DN program goals. These groups are time-limited and target a specific population other than first-time pregnant and parenting teens. Examples include but are not limited to prenatal groups, school-based groups for pregnant and parenting teens, play groups, co-parenting teen couples' groups, grandparent groups, and father's groups.	A - Other Parent Groups provide a variety of activities for participants prior to and with the goal of formal enrollment in the HV&DN program.		Group Plans Program Abstract Program Narrative
	B - Other Parent Groups enhance current group services for enrolled participants or these groups may support or enhance those directly involved with a current participant and child actively enrolled in the HV&DN program.		Group Plans Program Abstract Program Narrative
PAR7 - The specialized curriculum known as Heart to Heart is an enhancement to Parent Groups that focuses on child sexual abuse prevention and enhancement of parent-child relationships.	A - Programs implement Heart to Heart in one ongoing Parent Group during the fiscal year if indicated in the Program Abstract. Programs may add additional Heart to Heart groups with HVDN approval.		Program Abstract Program Narrative
	B - Programs utilize Heart to Heart co-facilitators according to the program design.	Programs identify two Heart to Heart co-facilitators in the Program Abstract.	Group Plans Program Abstract Training Records
	C - In order to implement Heart to Heart in a manner that ensures cohesiveness and trust within the group, programs limit Heart to Heart enrollment.	Programs enroll Heart to Heart participants by the third session.	Group Roster

Principle	Practice	Benchmark	Documentation
PAR7 - The specialized curriculum known as Heart to Heart is an enhancement to Parent Groups that focuses on child sexual abuse prevention and enhancement of parent-child relationships.	D - Programs plan and implement a Heart to Heart graduation ceremony as the group's closing activity.	To be eligible to participate in the Heart to Heart graduation ceremony, participants cannot miss more than two sessions.	Group Roster
		Heart to Heart trained Home Visitors can implement group sessions during Home Visits to allow Heart to Heart group members to participate in graduation. Programs cannot count this towards group attendance in DataPoints.	Case Notes
	E - Heart to Heart facilitators ensure the completion of a Community Service Project involving group participants and community residents or service providers as part of curriculum implementation.		Group Plans
	F - Prior to Heart to Heart implementation, each program: Designates a clinical consultant to provide support for Heart to Heart facilitators during program implementation, Identifies clinical treatment resources (such as a sexual assault center) for participants who disclose abuse, Provides verification of an up-to-date child abuse reporting protocol Completes a Heart to Heart Support and Intervention Plan.		Child Abuse Reporting Protocol Program Abstract Program Narrative

FY24 PTS-HFI Best Practice Standards
Infant Mental Health*

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

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

FY24 PTS-HFI Best Practice Standards
Program Structure & Governance

Principle	Practice	Benchmark	Documentation
SG1 - HV&DN programs have the greatest chance of outcome achievement when services are of sufficient intensity, and linked to specific strengths, needs, and risk factors of the target group. *(BPS 4-1.A)*	A - Programs clearly identify and define their target population and the planned intensity of services, including frequency and duration of contact.	100% of programs use the HFA level system to determine frequency of Home Visits.	Program Abstract Program Narrative
	B - Programs use a weighted eligibility system, in addition to any other model requirements, to determine eligibility for program services. Programs ensure that funder specific priority populations are part of the weighted eligibility criteria. Where slots are available, programs provide services to child welfare involved families regardless of income or other risk factors.	100% of enrolled participants are below 400% of the Federal poverty level (https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines). Priority should be given to participants with incomes below 200% FPL. Participants between 200% and 400% FPL must be in one of the Early Learning Council's Priority populations (https://www2.illinois.gov/sites/OECD/Events/Documents/Priority%20Populations%20updated%202021.pdf) or experiencing at least one other risk factor. Scores on the weighted eligibility form should be used to prioritize enrollment.	

Principle	Practice	Benchmark	Documentation
SG1 - HV&DN programs have the greatest chance of outcome achievement when services are of sufficient intensity, and linked to specific strengths, needs, and risk factors of the target group.	C - Short-term services such as community education, Prenatal Group, and Doula are offered to participants under the following conditions: Services enhance the program's profile in the community as a collaborator and provider of specialized adolescent prenatal and parent services.		Program Abstract
	No more than 20% of Doula participants receive short-term Doula services.	Programs enroll 80% of Doula participants in Home Visiting services.	□ Participant Files □ Program Abstract □ Program Narrative
		Where short-term participants are served by a non-Start Early funded home visiting program, programs provide data on the number served in the Program Quarterly Narrative report.	
	• For short-term Doula Services, participants transition to ongoing family support or home visiting programs offered by community partners.		Participant Files Program Narrative Quarterly Narrative Report
	• The majority of participants attending Prenatal Group have an active HV&DN enrollment status.		Group Roster
	D - Programs offer creative outreach under specified circumstances for a minimum of three months for each family before discontinuing services.		Participant Files Supervisory Documentation

Principle	Practice	Benchmark	Documentation
SG1 - HV&DN programs have the greatest chance of outcome achievement when services are of sufficient intensity, and linked to specific strengths, needs, and risk factors of the target group.	E - Programs comprehensively analyze, at least annually, acceptance and retention rates of participants. Programs also address how they might increase their acceptance rate based on the analysis of those refusing services in comparison to those accepting services. See Glossary of Terms (Section A8) for definitions of acceptance and retention rate.	100% of programs measure and analyze their acceptance and retention rates according to the following schedule: • Programs with more than 50 families enrolled in services over a 2 year period complete analysis annually • All program sizes complete analysis every two years.	Program Files
		Documentation of this analysis is provided to HV&DN upon request. The measurement of retention should be at various rates (6 mo., 12 mo., etc.) and across multiple timeframes.	Program Files
	F- Programs track trends and changes in their target population and adjust their program plans as indicated.	100% of programs document trends or changes in their target population, provides a written plan when proposing changes to the target population and includes a data source.	Program Abstract Quarterly Narrative Report
	G - Program funding and in- kind support (i.e., facility space) is sufficient to providing services to the target population.		Program Budget Program Budget Narrative
	H - Programs are to maintain a standard operating procedure manual to guide staff in their work.	Manuals are to be updated and reviewed with program staff annually.	Program Manual

Principle	Practice	Benchmark	Documentation
SG2 - The relationship between the staff person and the participant is primary to the delivery of quality services. The quality and intensity of that relationship affects the participant's initial engagement, ongoing participation, and retention in the program. *(8-1.B, GA-2.A)*	A - Programs maintain full enrollment.	Program enrollment is at least 85% of program capacity.	Program Abstract
	B - In order to ensure staff capacity to develop meaningful relationships with participants and deliver quality services, no caseload for a full-time Home Visitor exceeds 25 participants, regardless of the point values of the caseload.	Caseload maximum is 24 points (of any combination of levels) or 25 families. Agencies that have a 37.5 hour work week or less have a maximum caseload of 22 points.	□ Program Abstract
	C - Parent Group Coordinators are responsible for group facilitation, session planning and implementation, record keeping, group arrangements, volunteer recruitment, orientation, training, and supervision.	A minimum ratio of .25 FTE per group is required.	Program Abstract
	D - Supervisors have relationships with participants and gather satisfaction surveys annually to ensure responsiveness to participant needs.	Programs complete annual satisfaction surveys with a response rate of at least 25% of actively enrolled participants.	Program Files
SG3 - Delivery of relationship-based services to participants and their children begins with the nature of the relationship between the staff in the program.	A - home visitors and doula's receive ongoing training and regularly scheduled supervision. Staff members meet individually with a Supervisor on a weekly	Each staff member receives 46 individual supervisions per fiscal year.	Program Abstract Program Narrative Supervisory Documentation

Principle	Practice	Benchmark	Documentation
(12-1A,12-1.B, 12-3.A)	basis for 1.5 hours of reflective supervision.		
SG3 - Delivery of relationship-based services to participants and their children begins with the nature of the relationship between the staff in the program. *(12-1A,12-1.B, 12-3.A)*	B - Supervisors and Program Managers receive regular, on-going supervision which holds them accountable for the quality of their work, and provides them with skill development and professional support.	Supervisors and Program Managers receive the level of supervision consistent with what is indicated in the Program Abstract and includes discussion of all families at least once per month, regardless of service level.	Program Abstract Program Files Supervisory Documentation
	C - Doula programs ensure regular perinatal clinical support of Doulas and Doula Supervisors with face-to-face sessions that take place a minimum of once a month on site.	Programs hold 75% of expected clinical support sessions.	Clinical Support Notes
	D - Programs base supervision on a process of reflection, stepping back from the work to explore the how's and why's of staff's actions and the impact of the work on that staff person.	Supervision frequency; consistent with what is indicated in the Program Abstract, where all families regardless of the level are discussed and documented at least monthly.	Supervisory Documentation
	E - Supervisors conduct observations of staff's direct work with families in Home Visits and Groups two times per year.		Supervisory Documentation
	F - A minimum ratio of full- time supervisor to staff of 1:6 is expected. A ratio of 1:5 is optimal.		Program Abstract
SG4 - Programs have a Director to supervise staff, promote and provide for coordination of services across components, and build collaboration in the community. This coordination is necessary to maximize the use of program and community resources and to provide	Programs have a 100% FTE Program Director. This person is responsible for program oversight (planning, implementation, and evaluation) and ensuring the coordination and integration of service components.		Program Abstract

Principle	Practice	Benchmark	Documentation
integrated services for pregnant and parenting teens and their children.			
SG5 - Where programs receive funding for Home Visiting and other services such as Groups, Doulas, or IMH, they integrate these services in a manner that allows participants to experience the unique benefits of each strategy and the combined effects of all.	A - Home Visiting participants are the primary target audience of HV&DN Group Services.	100% of Parent Group participants are actively engaged in Home Visiting.	Group Rosters Participant Files Staffing Notes Supervisory Documentation
	B - Staff in all service components share information relevant to participants' progress in order to keep services responsive and promote continuity. Programs hold team meetings a minimum of 1x per month to coordinate and integrate services to participants.	Programs hold 75% of expected team meetings.	Program Abstract Program Narrative Team Meeting Notes
	C – In addition to team meetings, programs conduct regularly scheduled case staffings. A case staffing is a regular meeting held with direct and supervisory staff to discuss services and issues related to a particular participant's status and progress. This may include the IEMHC.	Case staffings should be held, at minimum, on a quarterly basis.	Program Abstract Program Plan Case Staffing Notes
SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards.	A - All staff members participate in the appropriate Healthy Families America training specific to their role within the program within six months of their date of hire. Program managers hired after January 1, 2018 are required to attend HFA		Supervisory Documentation Training Records Program supervisors utilize the HFA Training log to track Home Visitor training throughout employment

Principle	Practice	Benchmark	Documentation
	Implementation Training.		
SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards.	B - Staff members have written staff development plans, and Supervisors plan to release staff from their duties to attend training that supports their work.		Supervisory Documentation Training Records
	C - Staff members receive basic and ongoing training in key areas they encounter in their work with families. See Appendix G4 for a complete list of subject matter trainings required for each position.		Training Records
	D - Prior to direct work with families, programs ensure that all staff members are oriented to: • to child abuse, neglect indicators and reporting requirements • the principles of ethical practice • site's curriculum materials • policy and operating procedures • data collection forms and processes • site's relationship with other community resources • issues of confidentiality • issues related to boundaries • issues related to staff safety		Quarterly Narrative Report Staff Development Plans Supervisory Documentation Training Records
	E - Programs train and certify staff in the		Supervisory Documentation

Principle	Practice	Benchmark	Documentation
	appropriate developmental screening tool within the first six months of hire .		Training Records
SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards.	F - Doulas complete HV&DN approved training in addition to other Doula certification. Participation in ongoing in-service training is required.	Doulas attend the FSW track of HFA Integrated Strategies training within the first six months of their hire date, and attend the first available Doula Basic training in relationship to their hire date.	Supervisory Documentation Training Records
	G - Doulas and Doula Supervisors attend a DONA approved Birth Doula Training.	Doulas and Doula Supervisors complete DONA training within three months of hire.	Supervisory Documentation Training Records
	H - Programs follow and annually review with staff their policy governing appropriate procedures for addressing child abuse and neglect using defined criteria that is in alignment with state law.	100% of the time the site supervisor or agency manager is immediately notified when abuse or neglect is suspected.	Program Files Supervisory Documentation Team Meeting Notes
SG7 - All HV&DN services are responsive to the culture of the families served.	A - Programs select staff for their experience and expertise in working with the community and families served by the program, including an understanding of language, customs, and values.		Program Files
	B - Programs train staff annually on the specific cultural needs of their participants and target community.		Team Meeting Notes Training Records
	C - Programs implement a sensitivity review of cultural practices that addresses curricula and other materials, training, and service delivery every other year. This review includes input from participants and	100% of programs conduct a cultural competency survey every other year. The program gathers information to reflect on and better understand issues impacting staff	Cultural Humility Review Program Files

Principle	Practice	Benchmark	Documentation
	staff in all areas.	and families served. The program develops and implements an equity plan and reviews this plan annually.	
SG8 - Programs select staff and volunteers in a manner that ensures they are willing to work with high-risk families; such as those in which intimate partner violence or substance abuse may be a concern. *(BPS 9)*	A - See Appendix G4 for a complete list of subject matter trainings required for each position.	100% of programs use Start Early competencies to create annual professional development plans for staff.	Personnel Files Policy and Procedure Manual
	B - Program Managers hired prior to July 1, 2014 should have at least a Bachelor's degree. Criteria above apply to staff hired starting July 1, 2014.		Personnel Files Policy and Procedure Manual
	C - Staff members are open to flexible schedules that allow for connecting with participants who are not available during traditional work hours.		Supervisory Documentation
SG9 - The programs relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community, and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families. *(BPS GA-1A)*	A - Programs have a broadly-based advisory/governing group which serves in an advisory or governing capacity in the planning, implementation, and evaluation of program related activities.		Advisory Group Agendas Advisory Group Minutes Program Files
	B - Community partners identified as referral sources for screening,		□ Program Files Program Narrative

Principle	Practice	Benchmark	Documentation
	assessment, and program intake match the program's target population and meet any specific HFA requirements.		
SG9 - The programs relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community, and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families.	C - To ensure a regular flow of referrals for screening or intake, programs develop and maintain relationships with other community organizations that come into routine contact with pregnant and parenting adolescents, and other new parents including but not limited to schools, health clinics, social service agencies, and child welfare programs.		Program Narrative Team Meeting Notes
	D - The site monitors the number of families in the target population that are identified/referred through its system of organizational relationships, and develops strategies to increase the percentage identified and screened.		□ Program Files
	E - Programs obtain and maintain written linkage agreements through routine communication with collaborating organizations.		Program Abstract Program Files Program Narrative
	F - Doula programs develop written linkage agreements (whenever possible) with any		Program Abstract Program Files Program Narrative

Principle	Practice	Benchmark	Documentation
	hospital(s) where Doulas provide labor and delivery support to guarantee access of Doulas for attending births.		
SG9 - The program's relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community, and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families.	G - Program interns and volunteers, when utilized, are subject to the same screening processes programs use with paid staff. In addition, volunteers receive the same training and quality of supervision as would a paid staff person with similar duties.	Programs screen 100% of program interns and volunteers in the same manner as paid staff. This includes all legally permissible background checks, criminal history records, and civil child abuse and neglect registries.	Program Files Program Narrative
	H - To ensure comprehensive services for families once enrolled, programs develop and maintain knowledge of working relationships with service providers that address needs beyond the scope of HV&DN services. These include but are not limited to schools, alternative and vocational education, housing, financial assistance, health services, nutritional programs, recreational programs, mental health, early intervention, substance abuse, intimate partner violence services, and childcare.		Community Resource Directories Team Meetings Notes
	I - Programs track and follow up with families and service providers, if appropriate, to determine if the families received needed		Program Files Policy and Procedure Manual

Principle	Practice	Benchmark	Documentation
	services. Follow-up with service providers requires signed informed consent.		
	J - Release of information forms used for referrals should be specific to the referral agency and time limited.		Participant Files Policy and Procedure Manual
SG10 - Programs are aware of and sensitive to participants' experiences of services.	A – Programs have established policies and procedures that allow for virtual service delivery, based upon the needs of the family and the staff. Policies and procedures should include, but are not limited to, the elements outlined in the final State funder COVID-19 Guidance for Home Visiting, CI, and Doula programs		Program Files Policy and Procedure Manual
	B – Programs ensure that all platforms used for virtual service delivery are secure and have policies and procedures in place to ensure participant safety and confidentiality during visits and groups.		Policy and Procedure Manual
	C - Programs contact participants who drop out to gather information for quality improvement. Each program has a procedure for participant exit interviews that helps determine the impact of the program.		Exit Interview Forms Program Files
SG11 - Programs participate in evaluation activities to determine the effectiveness of services.	Programs cooperate with Start Early research and evaluation efforts. This includes obtaining informed consent in writing from participants in order to link names, addresses, and telephone numbers to participant		Participant Files

Principle	Practice	Benchmark	Documentation
	identification numbers.		
SG12 - Effective programs maintain complete records of service activities to allow for planning, to track progress, and to demonstrate accountability.	A - Programs maintain participant files with up-to- date information about service intensity, service content, and participant progress. Programs utilize DataPoints and cooperate with all elements of data collection, training, and reporting information as required by Start Early.	100% of program staff participates in DataPoints training.	Participant Files Training Records

FY24 Start Early PTS-PAT Best Practice Standards
Initial Engagement/Screening & Assessment

Principle	Practice	Benchmark	Documentation
IE1 - By using weighted eligibility and targeting families with the highest need, programs can effectively address child abuse, neglect, and other poor outcomes. *ER = Essential Requirement*	A - HV&DN programs provide services for pregnant and parenting individuals, prioritizing adolescents at intake.	Enrolled participants are to be eligible to receive at least two years of services with children between prenatal and kindergarten entry.	Participant Files
	B - Programs use a weighted eligibility system in addition to any other model requirements to determine program eligibility. Programs ensure that funder specific priority populations are part of the weighted eligibility criteria.		Participant Files Policy and Procedure Manual
	C - Programs have written recruitment plans that identify approaches and settings in which to recruit the families they are designed to serve.	A written recruitment plan that identifies recruitment approaches and settings that have been in effect for at least three months **or** if the affiliate participates in a centralized intake system, documentation that describes the centralized intake system is needed	Policy and Procedure Manual Program Files
IE2 - Programs are more likely to recruit and retain long-term participants when they initiate services prenatally or immediately after birth in order to form a trusting connection with new parents, and establish the program as a source of support and information.	A - Programs provide informational materials that give a clear picture of what families can expect from PAT services.		□ Program Files

Principle	Practice	Benchmark	Documentation
IE2 – Programs are more likely to recruit and retain long-term participants when they initiate services prenatally or immediately after birth in order to form a trusting connection with new parents and establish them as a source of support and information.	B - Programs use informational materials and recruitment strategies that reflect the languages and cultures of the populations to be served.		Program Files
	C – Whenever possible, programs initiate services prenatally or within six months of the child's birth to ensure adequate support for parents during this period of critical child development and initial relationship between parents and child.	Programs enroll participants within six months of the birth of the child 90% of the time.	Policy and Procedure Manual
	D – Families that must be placed on a waiting list or are not eligible for services are connected to appropriate resources at the time of intake.		Program Files Policy and Procedure Manual
	E – As part of enrollment, the parent(s) and Parent Educator discuss and sign a mutual participation agreement that includes explanations of at least the following: the program's services expectations for participation by the family; and, record keeping, data collection activities, and use of data.	100% of participant files contain a signed mutual participation agreement.	Participant Files Policy and Procedure Manual

Principle	Practice	Benchmark	Documentation
IE3 – Screening and assessment of family needs focuses on systematic identification of those families most in need of services and identifies the presence of key factors associated with an increased risk of child maltreatment and other poor childhood outcomes.	A – Programs clearly define their target population and maintain annual tracking of the number births and other demographic characteristics within that population to ensure that they screen 100% of the potential participants.	100% of programs define their target population and track the number of births.	□ Program Abstract
	B – Programs that assess a family with multiple stressors refers that family to all other applicable services in the community if the program is full.	100% of programs assess their families' risk level and refer to other services. At least 75% of families will receive at least 75% of the required number of visits.	Program Files
	C – Program chooses two outcomes to measure parenting skills, practices, capacity, or stress assessment from the list of PAT approved tools.	At least 75% of eligible families participate in assessment of parenting skills, practices, capacity or stress using a PAT approved tool.	Participant Files
		At least 90% of families will be assessed using a PAT approved tool in one or more of the following areas: Parent and Family Health/Well-Being, Child Development or Child Health/Well-Being.	Participant Files
IE4 – Assessment of family needs occurs in an atmosphere of mutual respect and informed consent.	A - Programs conduct positive and persistent outreach for target families and those who screen or assess as high-risk to encourage their voluntary participation in the program.	100% of programs use positive outreach to engage potential participants.	Supervisory Documentation
	B – Programs maintain up to date signed Start Early consents for services with all participants involved.	100% of participant files contain an up-to-date, complete and signed Start Early consent forms.	Participant Files

Principle	Practice	Benchmark	Documentation
IE4 – Assessment of family needs occurs in an atmosphere of mutual respect and informed consent.	C – Staff members obtain signed consent prior to any intake or assessment interviews and entry of participant information into DataPoints. Refusal to sign a consent form for entry of their information into DataPoints does not preclude a family from services.	Programs enter data into DataPoints only after obtaining prior written consent 100% of the time.	Participant Files
	D – Programs have client rights and confidentiality policies and procedures to ensure family privacy.		Participant Files Policy and Procedure Manual
IE5 – Family-centered assessment is a mechanism to get to know and genuinely understand the family, to recognize factors that promote family resilience and well-being, and to facilitate goal setting with the family. *(PAT ER 8)*	A – Program staff members complete and document a family-centered assessment within 90 days of enrollment, and then at least annually thereafter, using an assessment that addresses the PAT required areas (parenting, family relationships and formal and informal support systems, parent educational and vocational information, parent general health, parent/child access to medical care, including health insurance coverage, adequacy and stability of income for food, clothing, and other expenses, adequacy and stability of housing).	Family centered assessment was conducted using a PAT approved method. The use of the Family-Centered Assessment Synthesis Record is required when not using one of the four approved tools. At least 75% of families enrolled more than 90 days, had an initial Family- Centered Assessment completed within 90 days of enrollment. At least 75% of families that received at least one personal visit had completed a Family-Centered Assessment in the program year.	Participant Files
	B - Program staff members maintain a relationship- based, non-judgmental and culturally responsive approach to conducting family-centered assessment and goal setting.		Supervisory Documentation

Principle	Practice	Benchmark	Documentation
IE5 – Family-centered assessment is a mechanism to get to know and genuinely understand the family, to recognize factors that promote family resilience and well-being, and to facilitate goal setting with the family. *(PAT ER 8)*	C - Program staff members have the training and support necessary to complete the family- centered assessment according to the program's procedures.		Supervisory Documentation Training Files
IE6 - Programs are most effective when they use intake and assessment information about family characteristics, background history, and current functioning to plan services.	Staff members who assess families or gather intake data share that information with Parent Educators, Doulas, and Parent Group Service Coordinators.	100% of staff members who complete intakes or assessments share intake information or assessment results with the service team.	Program Narrative Team Meeting Notes

FY24 Start Early PTS-PAT Best Practice Standards
Personal Visits

Principle	Practice	Benchmark	Documentation
PV1 - Personal Visits are the core family support and early childhood education services provided by HV&DN programs for pregnant and parenting teens and their children. *(PAT ER 1)*	A - Programs offer services to families for a minimum of three years after the birth of the baby. Whenever possible, participants are to be enrolled prenatally or by six months.		Policy and Procedure Manual
	B - Assignment of families to Parent Educators takes into consideration several key factors, including the family's primary language and Parent Educator experience with particular family backgrounds and characteristics.		Supervisory Documentation
	C - Personal Visits take place on a schedule determined in partnership with the family, diminishing in intensity as family needs change. Programs complete at least bi-monthly visits to each family during the program year. Risk factors are to be documented.	Programs assign 100% of families to a service intensity level.	Participant Files Policy and Procedure Manual Program Narrative
	D - Referrals/requests for services are responded to within 3 business days and face to face contact occurs within 1 week of the family agreeing to a visit.		Participant File Personal Visit Record Policy and Procedure Manual

Principle	Practice	Benchmark	Documentation
PV1 - Personal Visits are the core family support and early childhood education services provided by HV&DN programs for pregnant and parenting teens and their children. *(PAT ER 1)*	F - Parent Educators address all three areas of emphasis (parent-child interaction, developmental centered parenting, and family well- being) in Personal Visits, including when addressing a family's immediate needs or a crisis situation.		Personal Visit Record Policy and Procedure Manual Supervisory Documentation
PV2 - Personal Visits are of sufficient intensity to impact program outcomes. *(PAT ER 6)*	A - Personal Visits last between 1.0 and 1.5 hours. In certain circumstances, visits between 45 minutes and one hour are acceptable.	80% of Personal Visits last between 1.0 and 1.5 hours. All visits, including virtual visits, should be at least 45 minutes. Two shorter visits in the same day can be combined in DataPoints to be counted as one visit, provided the total time is at least 45 minutes.	Personal Visit Record
		Personal visits take place in the home or virtually depending upon family needs. Virtual visits should be documented accordingly in DataPoints and programs should have established policies and procedures for implementation of virtual visits.	Personal Visit Record
		Parent Educators complete 75% of expected Personal Visits per service intensity level.	
	B - All elements of a Personal Visit are required for virtual visits, including a parent-child activity.		Personal Visit Record
	C - Parent Educators monitor Personal Visit and Group participation rates, and uses a variety of strategies to address engagement of families in services.		Program Files

Principle	Practice	Benchmark	Documentation
PV2 - Personal Visits are of sufficient intensity to impact program outcomes. *(PAT ER 6)*	D - All new Parent Educators attend the Foundational and Model Implementation training before delivering PAT services.	100% of Parent Educators have attended the required PAT Trainings before delivering PAT Foundational and Model Implementation Curriculum	Personal Visit Record Program Abstract Training Records
PV3 - Personal Visits are parent-child focused and responsive to the health and developmental needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship. *(PAT ER 10)*	A - Parent Educators help families recognize and expand upon their existing strengths and protective factors.		Personal Visit Record Supervisory Documentation
	B - During each Personal Visit, Parent Educators partner, facilitate, and reflect with families.		Personal Visit Record
	C - Programs have policies and procedures for strengthening families by addressing challenging issues such as substance abuse, intimate partner violence, developmental delays in parents, and mental health concerns. Practices indicate that the policies are being implemented.		Case Notes Policy & Procedure Manual Supervisory Documentation
	D - Parent Educators use the foundational visit plans and planning guide from the foundational curriculum to design and deliver Personal Visits to families.	Parent Educator's plan for each visit, documenting the planning process in a Foundational Personal Visit Plan, or Personal Visit Planning Guide.	Participant Files
	E - Parent Educators discuss each child's emerging development with the parents, incorporating parent and Parent Educator observations.		Participant Files Personal Visit Record Supervisory Documentation

Principle	Practice	Benchmark	Documentation
PV3 - Personal Visits are parent-child focused and responsive to the health and developmental needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship. *(PAT ER 10)*	F - Programs utilize home safety checklists with families on a routine basis.	Home safety checklists are implemented with families within 45 days of the first completed home visit at a minimum. Parent Educators are encouraged to use the checklists more frequently if needed to address concerns with families.	□ Participant Files
	G - Parent Educators discuss the risks of smoking and provide smoking cessation information to participants. Materials may also be provided to family members who smoke, if interested.	100% of participants have information regarding current tobacco use within 30 days of the first home visit and every six months thereafter for the duration of program enrollment. Information should be updated if status changes during program involvement.	Case Notes
	H - Parent Educators discuss the risks of alcohol use during pregnancy, and provide materials about alcohol and pregnancy to participants as needed.		Case Notes
	I - Parent Educators encourage parents to engage in language development activities with their children.		Personal Visit Record Program Narrative
	J - Parent Educators share information about the benefits of breastfeeding and about risks of HIV transmission via breastfeeding.	Parent Educators document discussions with participants about breastfeeding in PVRs.	Personal Visit Record Policy and Procedure Manual
		75% of participants initiate breastfeeding.	Participant Files
	K - Parent Educators use medically accurate materials in discussing HIV with participants.		Case Notes Participant Files
	L - Parent Educators use universal precautions in work with infants and toddlers.	Programs are responsible for the training of staff around universal precautions	Supervisory Documentation Team Meeting Notes

Principle	Practice	Benchmark	Documentation
PV3 - Personal Visits are parent-child focused and responsive to the health and developmental needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship. *(PAT ER 10)*	M - Community-Based FANA (FANA) trained Parent Educators engage pregnant participants in the prenatal FANA activities designed for their infant's gestational age, and engage postpartum participants in postnatal FANA activities during their infant's first month of life.	Parent Educators implement prenatal FANA activities a minimum of every other week during the last trimester of pregnancy and engage postpartum participants in postnatal FANA activities at least once within the baby's first month of life.	Personal Visit Record Program Narrative
	N - Parent Educators monitor and record children's achievement of developmental milestones, using the PAT milestones.	Parent Educators review and update (as applicable) the Milestones record, for each enrolled child, after each visit.	Developmental Milestones Participant Files
	O - Personal Visits are documented no more than two workdays after the visit, using the Personal Visit Record. Related data entry is completed within one week of the Personal Visit.		Personal Visit Record Program Narrative Supervisory Documentation
	P – Home Visitors support and encourage birthing persons in accessing post-partum care.	85% of birthing persons who enroll prenatally or within 30 days of delivery receive a postpartum visit within 8 weeks of delivery date.	DataPoints Participant Files
PV4 - In a manner respectful of each participant's cultural and religious beliefs, Home Visitors engage participants in discussions around the potential impact of subsequent births with the goal of supporting participants in making informed and intentional decisions.	A - Parent Educators provide all participants with information and support regarding the delay of subsequent births, effective family planning, including birth control and abstinence (as the only 100% protection from risk), and protection from STIs, including HIV/AIDS, using medically accurate curricula and materials.	80% of participants delay subsequent birth during program involvement. (delay = 2-year interval between births).	Personal Visit Record
	B - Parent Educators update participant information on contraceptive use at a minimum of every six	100% of participants have contraception information updated in DataPoints at a minimum of every six	Participant Files

Principle	Practice	Benchmark	Documentation
	months.	months.	
PV5 - Programs conduct Personal Visits in a manner that supports the successful completion of personal and program goals as described in the Family Goal Plan. *(PAT ER 9)*	A - Parent Educators assist and support adolescents to return to school and obtain safe, high-quality childcare.	75% of participants who should be enrolled in high school or equivalent educational services are enrolled during the course of program involvement.	Participant Files Personal Visit Record
		100% of participants have education status information updated in DataPoints at a minimum of every six months.	Participant Files
	B - Parent Educators develop a Family Goal Plan with each participant within 45 days of the first completed Personal Visit and at least every six months thereafter. Parent Educators and parents review and update the plan on a regular basis. A progress note should be entered when the goal status changes or at least monthly. New Goals Records are created when they are set. Plans accurately reflect the progress of each family toward their goals, and address parent and child needs, strengths, capacities, and challenges. Parent Educators structure both the plan and the Personal Visits to support the parent's strengths.	90% of participant files contain an up-to-date Family Goal Plan.	Participant Files
		100% of Family Goal Plans are signed by the participant.	

Principle	Practice	Benchmark	Documentation
PV5 - Programs conduct Personal Visits in a manner that supports the successful completion of personal and program goals as described in the Family Goal Plan.	C – Parent Educators will set goals with the family around parent-child interaction, parent self-sufficiency and child development.		Participant Files
PV5 - Programs conduct Personal Visits in a manner that supports the successful completion of personal and program goals as described in the Family Goal Plan.	D - Parent Educators update participant outcome information related to employment, medical home, and WIC status in DataPoints at a minimum of every six months.	Parent Educators update 100% of participant outcome information in DataPoints within 30 days of the first completed Personal Visit and then at a minimum of every six months, for the duration of program enrollment.	Participant Files
	E – Parent Educators update participant information related to transience in DataPoints at a minimum of every three months.	Parent Educators update 100% of participant transience information in Datapoints within 30 days of the first completed Personal Visit and then at a minimum of every three months, for the duration of program enrollment.	Participant Files
	F - Parent Educators update child outcome information related to childcare and father involvement in DataPoints at a minimum of every six months.	Parent Educators update 100% of child outcome information in Datapoints at a minimum of every six months. This standard applies to the target child only. Parent Educators do not need to track this data on non-target children.	Participant Files
	G - Parent Educators update questions regarding the participants' level of engagement and the Parent Educator's level of concern about the participant at six month intervals.	Parent Educators update 100% of participant patterns every six months.	Participant Files

Principle	Practice	Benchmark	Documentation
	H - Parent Educators update child feeding information in DataPoints according to the following schedule: at birth and at six weeks, six months, and one year. For participants who are breastfeeding after one year, Parent Educators update child feeding information at 18 months and two years, if applicable.	100% of children have feeding information updated in DataPoints. This standard applies to the target child, if born during program enrollment, and any subsequent children.	Participant Files
PV5 - Programs conduct Personal Visits in a manner that supports the successful completion of personal and program goals as described in the Family Goal Plan.	I - Programs ensure that families planning to discontinue or close services have a well thought out transition plan. The program will use the PAT transition form and Family Service Record and Exit Summary within 30 days of closing. Transition planning begins six months prior to participant exit. The elements of the programs transition plan are articulated in the program's Policy and Procedure Manual.		Case Notes Policy and Procedure Manual Supervisory Documentation
	Transition plans are developed in conjunction with the family and completed plans include the participant's signature.		Participant Files
PV6 - Programs provide Personal Visits in a manner that respects the family and cultural values of each participant.	A - Programs offer services on a voluntary basis, using positive and persistent outreach efforts to build family trust and retain overburdened families in the program		Participant Files Personal Visit Record Staffing Notes Supervisory Documentation

Principle	Practice	Benchmark	Documentation
	B - Parent Educators individualize Personal Visits in response to a family's culture, languages spoken in the home, needs, interests, and learning styles.		Participant Files Personal Visit Record Supervisory Documentation
PV6 - Programs provide Personal Visits in a manner that respects the family and cultural values of each participant.	C - Parent Educators and Supervisors encourage the support and involvement of fathers, grandparents, and other primary caregivers.	PVRs and other program documentation reflect the encouragement of and support for the involvement of fathers and other family members. This includes documentation of all family members participating in the Personal Visit and efforts made to engage the father.	Personal Visit Record Supervisory Documentation
	D - Parent educators use the Parent Educator Resources, Toolkit, and Parent Handouts from the PAT curriculum to share research-based information with families.		Personal Visit Record
	E - Parent educators connect families to resources that help them reach their goals and address their needs. The program uses the PAT resource connection form to track resource connections and their outcome.	At least 60% of the families that received at least one personal visit were connected by their parent educator to at least one community resource in the program year. The outcome of the referral is tracked in Datapoints.	Personal Visit Record
	F - Programs select and implement materials and curricula in a way that builds upon strengths inherent to each family's cultural beliefs. The program's materials reflect the language, ethnicity, and customs of the families served.		Program Files

Principle	Practice	Benchmark	Documentation
PV7 - Due to the high incidence of depression among the population served by HV&DN programs, and because maternal depression can significantly impair the parent-child relationship, programs make efforts to identify maternal depression as early as possible, and to help depressed participants access services.	A - Programs have policies and procedures for administration of a standardized depression screening tool that specify how and when the tool is to be used with all families participating in the program, and assure that all staff who administer the tools are fully trained.		Case Notes Participant Files Policy and Procedure Manual Supervisory Documentation Training Records
	B - Referral and follow-up on referrals occurs for mothers whose depression screening scores are elevated and considered to be at-risk of depression, based on the tool's scoring criteria, unless already involved in treatment.		Case Notes Participant Files Policy and Procedure Manual Supervisory Documentation
	C - Programs administering the Edinburgh Postpartum Depression Scale to participants enter the results of these scales into DataPoints.	Parent Educators screen 100% of consenting active participants prenatally and twice postpartum (at four to six weeks and six months). This standard applies to target children and subsequent births.	Participant Files
		85% of participants are screened for maternal depression within three months of delivery, when enrolled prenatally, or withing three months of enrollment, when enrolled postnatally.	

FY24 PTS-PAT Best Practice Standards

Doula

Principle	Practice	Benchmark	Documentation
D1 - Programs are more likely to recruit and retain long-term participants when they initiate services prenatally or immediately after birth in order to form a trusting connection with new parents and establish the program as a source of support and information.	Programs initiate Doula services at the beginning of the third trimester of pregnancy.	Programs enroll 80% of Doula participants by the seventh month of pregnancy.	Participant Files Program Narrative
D2 - Doula Personal Visits are of sufficient intensity to impact program outcomes.	A - Doula Personal Visits last between 1.0 and 1.5 hours.	80% of Home Visits last between 1.0 and 1.5 hours. All visits, including virtual visits, should be at least 45 minutes. Two shorter visits in the same day can be combined in DataPoints to be counted as one visit, provided the total time is at least 45 minutes. Home visits take place in the home or virtually depending upon family needs. Virtual visits should be documented accordingly in DataPoints and programs should have established policies and procedures for implementation of virtual visits.	Personal Visit Record

Principle	Practice	Benchmark	Documentation
D3 - Doula Personal Visits are parent-child focused and responsive to the health and development needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship.	A – Doulas help families recognize and expand upon their existing strengths and protective factors.		Personal Visit Record Supervisory Documentation
	B – Doulas plan and structure each visit to enable parents to understand each stage of prenatal development, understand and develop enjoyable prenatal and postpartum interaction with their child, and develop parental interest in their child's development.		Participant Files Personal Visit Record
	C - Doulas address three areas of emphasis (parent- child interaction, development centered parenting, family well- being) in Personal Visits, including when addressing a family's immediate needs or a crisis situation.		Personal Visit Record Supervisory Documentation
	D - Doulas share information about the benefits of breastfeeding and about risks of HIV transmission via breastfeeding, using medically accurate curricula and materials.	Doulas document discussions with participants about breastfeeding in PVRs.	Personal Visit Record
	E - Doulas use universal precautions in work with infants and toddlers.		Supervisory Documentation Team Meeting Notes
	F - Doulas discuss risks of smoking during pregnancy with all participants and provide smoking cessation materials to participants who smoke. Materials may also be provided to family members,		Case Notes
	G - Doulas discuss the risks of alcohol use during pregnancy and provide materials about alcohol and pregnancy to all participants.		Case Notes

Principle	Practice	Benchmark	Documentation
D3 - Doula Personal Visits are parent-child focused and responsive to the health and development needs of parents and their children. The visit design promotes secure attachment and a healthy parent-child relationship	H - Community-Based FANA (FANA) trained Doulas engage pregnant participants in the prenatal FANA activities designed for their infant's gestational age and engage postpartum participants in postnatal FANA activities during their infant's first month of life.	Doulas implement prenatal FANA activities a minimum of every other week during the last trimester of pregnancy and engage postpartum participants in postnatal FANA activities at least once within the baby's first month of life.	Personal Visit Record Program Narrative
		Doulas attend FANA training and complete FANA certification within one year of hire.	Supervisory Documentation Training Records
	I - Personal Visits are documented no more than two working days after the visit. Related data entry is completed within one week of the Personal Visit.		Personal Visit Record Policy and Procedure Manual Program Narrative Supervisory Documentation
D4 - In a manner respectful of each participant's cultural and religious beliefs, Doulas engage participants in discussions around the potential impact of subsequent births with the goal of supporting participants in making informed and intentional decisions.	Doulas provide all participants with information and support regarding the delay of subsequent births, effective family planning, including birth control and abstinence (as the only 100% protection from risk), and protection from STIs, including HIV/AIDS, using medically accurate curricula and materials.		Personal Visit Record
D5 - Programs conduct Doula Personal Visits in a manner that supports the successful completion of personal and program goals as described in the birth plan.	Doulas develop a birth plan with each participant. This plan can serve as the participant's first Family Goal Plan.	90% of Doula participants have an up-to-date birth plan.	Participant Files
D6 - Programs provide Doula Personal Visits in a manner that respects the family and cultural values of each participant.	A - Programs offer Doula services on a voluntary basis, using positive and persistent outreach efforts to build family trust and retain overburdened families in the program.		Participant Files Personal Visit Record Program Narrative Staffing Notes Supervisory Documentation

Principle	Practice	Benchmark	Documentation
D6 - Programs provide Doula Personal Visits in a manner that respects the family and cultural values of each participant.	B - Doulas encourage the support and involvement of fathers, grandparents, and other primary caregivers.	PVRs and other program documentation reflect the encouragement of and support for the involvement of fathers and other family members. This includes documentation of all family members participating in the Personal Visit, who is at the birth, and efforts the Doula makes to engage the father.	Personal Visit Record Supervisory Documentation
	C - Doulas certified in the Foundational curriculum use the curriculum to deliver Doula Personal Visits with a focus on child development and parent-child interaction.		Personal Visit Record Program Abstract
	D - Doulas use the Parent Educator Resources, Toolkit, and Parent Handouts from the PAT curriculum to share research-based information with families.		Personal Visit Record
D7 - Doulas provide intensive, specialized services in order to improve the perinatal health of mother and baby, support parent-child attachment, and improve the family's social-emotional experience of labor and delivery.	A - During the last trimester of pregnancy, participants receive additional direct services provided by the Doula program. These will include prenatal education, support, advocacy with medical providers, and preparation of a birth plan.	Doulas complete 80% of Doula Personal Visits at the expected frequency.	Personal Visit Record Program Abstract Program Narrative
	B - Doula support and advocacy includes 24-hour availability for attendance during labor and delivery. Doulas provide continuous support from active labor through recovery, with respect to agency policy, backup procedures, and the overall well-being of	75% of Doula participants have a Doula attended birth.	Participant Files Program Narrative

Principle	Practice	Benchmark	Documentation
	both mother and Doula.		
D7 - Doulas provide intensive, specialized services in order to improve the perinatal health of mother and baby, support parent-child attachment, and improve the family's social-emotional experience of labor and delivery.	C - Doula programs have established, written protocols that outline procedures for when Doulas go to the hospital, when Doulas call and utilize backup, and what communication is expected between the Doula and the Doula Supervisor while the Doula is at the birth.		Program Files
D8 - Doula services provide a supportive relationship that addresses the emotional work of the participants emerging role as parent and their developing attachment to their child. Doula services nurture the parent so that they can nurture the baby.	Doulas support the parent's self-determination while encouraging prenatal care, and the initiation of breastfeeding, and promoting emotional availability and engagement with her developing newborn.	75% of participants initiate breastfeeding.	Participant Files Personal Visit Record

FY24 PTS-PAT Best Practice Standards
Screening

Principle	Practice	Benchmark	Documentation
S1 - Programs provide developmental screening and referral services to all enrolled families to identify developmental delays and refer families to appropriate early intervention services. *(PAT ER 14)*	A - It is essential that programs complete formal screening (developmental, and the health record) at least annually for all eligible children.	At least 95% of children receive a complete developmental screening within 90 days of enrollment or birth within the program.	Annual Individual Service Record Health Record Participant Files Policy and Procedure Manual
	B - All children, up to age three, of the family receiving services have a completed child health record at intake and annually thereafter.	100% of children, up to age three, have a completed child health record at intake and annually thereafter.	Annual Individual Service Record Health Record Participant Files Policy and Procedure Manual
	C - Programs have procedures for child developmental screening, rescreening, and referral.		Policy and Procedure Manual Program Files
	D - Prior to screening, parents receive information about the purpose of the screening, how the screening is completed, and what they can expect after the screening is completed.		Participant Files
	E - Screening is conducted with sensitivity to the languages spoken in the home and the family's cultural background.		Participant Files
	F - All participating children, up to age five, receive developmental screening at the following ages: four, six, nine, and 12 months, and every six months from age one through age five. Programs emphasize parental involvement in the screening process.	85% of children are up to date with expected developmental screenings.	Participant Files DataPoints

Principle	Practice	Benchmark	Documentation
S1 - Programs provide developmental screening and referral services to all enrolled families to identify developmental delays and refer families to appropriate early intervention services.	F - All participating children, up to age five, receive developmental screening at the following ages: four, six, nine, and 12 months, and every six months from age one through age five. Programs emphasize parental involvement in the screening process.	80% of children ages 9, 18, 24 and 30 months have at least one on time developmental screening.	Participant Files
	G - All participating children, up to age 60 months, receive social emotional screening at the following ages: two, six, 12, 18, 24, 30, 36, 48, and 60.	85% of target children receive social emotional screening at the recommended intervals.	Participant files
	H - Screening incorporates parent observations of the child.		Participant Files
	I - Parent Educators share parenting strategies and parent-child activities tied to developmental screening results.		Participant Files Personal Visit Record Supervisory Documentation
	J - Parents receive verbal and written summaries of all developmental screening results.		Participant Files Policy and Procedure Manual
	K - Programs track children who are suspected of having a developmental delay, follow through with appropriate referrals, and follow up to determine if services were received.	Programs follow up on 85% of referrals related to suspected developmental delays to determine if services were received.	Participant Files
		95% of children delayed are referred to early intervention services.	Participant Files
S2 - Programs work with participants to help them establish medical and dental homes for their children and help them obtain routine preventive care.	A - Parent Educators ensure that parents and children link to a medical provider for routine health care, well-childcare, and timely immunizations.	90% of target children are up-to-date with immunizations and well-child visits.	Health Record Participant Files

Principle	Practice	Benchmark	Documentation
S2 - Programs work with participants to help them establish medical and dental homes for their children and help them obtain routine preventive care.	A - Parent Educators ensure that parents and children link to a medical provider for routine health care, well-childcare, and timely immunizations.	80% of target children have received their last well-child visit, based on the American Academy of Pediatrics schedule. The schedule can be found here: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx	Health Record Participant Files
S3 - Parent Educators maintain proper documentation of screening data and share this information with parents.	Completed screening results are maintained as part of the family file.	At least 75% of children receive a completed Child Health Record by seven months of age or within 90 days of enrollment.	Participant Files Policy and Procedure Manual
		At least 75% of children have the Child Health Record updated annually each program year.	Participant Files Policy and Procedure Manual
S4 - Parent Educators promote proper child development by utilizing rescreening and follow-up procedures.	When indicated by screening results, re-screening is done or the Parent Educator provides a resource connection for further assessment.		Participant Files Policy and Procedure Manual

FY24 PTS-PAT Best Practice Standards
Prenatal Groups

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

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

Principle	Practice	Benchmark	Documentation
PRE4 - Prenatal Groups are an ongoing service strategy. The duration of the group is long enough to sustain relationships that promote trust and goal attainment.	A - Prenatal Group membership and facilitators are as consistent as possible.		Program Abstract Group Plans
	B - Each Prenatal Group meets for a minimum of one and a half hours as part of a six-to eight-week session		Program Abstract Group Plans
	C – Virtual group services are permissible in conjunction with or separate from in-person group services. Virtual groups should be documented accordingly in DataPoints and programs should have established policies and procedures for implementation of virtual group sessions. Programs hold a minimum of 24 Prenatal Group sessions during the fiscal year.	Programs hold 90% of planned Prenatal Group sessions.	Program Abstract Group Plans
	D - Prenatal Group documentation includes micro plans, attendance, and process notes for each session.		Group Plans
	E - Individuals responsible for planning Prenatal Groups submit macro plans on a quarterly basis to their HV&DN Program Advisor.		Macro Plans
	F - Prenatal Group arrangements include a nutritious meal or snack.		Program Abstract Group Plans
	G - Programs complete a written evaluation plan for Prenatal Group services that includes a procedure for gathering feedback from Group participants.		Group Evaluations Group Meeting Record Group Plans Policy and Procedure Manual

Principle	Practice	Benchmark	Documentation
PRE5 - Prenatal Group services enable pregnant persons, their partners, and families to achieve a healthy pregnancy, optimal birth outcome, and positive adaptation to parenting.	These groups promote transition to ongoing program services such as Personal Visits and Parent Group services for both enrolled participants and those not yet actively enrolled in the HV&DN program.		□ Group Plans

FY24 PTS-PAT Best Practice Standards
Parent Groups

Principle	Practice	Benchmark	Documentation
PAR1 - Parent Group sessions challenge thinking and emphasize decision making about issues that affect the relationship between parent and child. Parent Group activities provide opportunities for positive peer interaction.	A - A portion of the Parent Group connection focuses on the sharing of experiences and ideas of group members about various topics, such as parenting, family planning, health care, career exploration, education, housing, and childcare.		Group Plans
	B - A wide variety of activities and approaches is encouraged to bridge the range of learning and social skills of group members (i.e., games, videos, role- playing, guest speakers, recreational events, and community service projects).	Parent Group plans reflect activities and approaches used in Parent Group sessions.	Group Plans
	C - Topics, curricula, and other materials used in Parent Group connections are culturally competent and focused on parenting issues (programs must discuss use of supplemental non-parenting focused curricula with HV&DN Program Advisor).	Parent Group plans identify topics, curricula, and materials used in Parent Group sessions.	Group Plans Program Abstract Program Narrative
	D - Planning of Parent Group connections reflects the input of participants, site staff, and goal plans.		Group Evaluations Group Plans Team Meeting Notes
	E - Parent Educators facilitate a welcoming group connection environment, opportunities to build social connections and experiences that promote empowerment		Group Plans

Principle	Practice	Benchmark	Documentation
	and leadership.		
PAR2 - Parent Groups enhance the intensity and focus of the Personal Visits with pregnant and parenting individuals. Through integration, these interventions offer more intense and diverse services that increase the chance of achieving HV&DN desired outcomes.	A - Parent Group facilitators provide participants with information and support regarding the delay of subsequent births, effective family planning, including abstinence (as the only 100% protection from risk), birth control, and protection from STIs, including HIV/AIDS. Curricula and materials used are medically accurate.		Group Plans Quarterly Narrative – Group Topic Calendar
	B - Parent Group facilitators encourage participants to maintain a medical home for their child and follow up on routine well-child visits and immunizations.		Group Plans Quarterly Narrative – Group Topic Calendar
	C - Parent Group facilitators encourage and support adolescents to return to school and obtain safe, high-quality childcare.		Group Plans Quarterly Narrative – Group Topic Calendar
	D - Parent Group facilitators provide information on unintentional injury prevention, including Shaken Baby Syndrome, home safety, and poison prevention.		Group Plans Quarterly Narrative: Group Topic Calendar
	E - Personal Visit participants are the primary target audience of HV&DN Parent Group Services.		Group Roster Participant Files Staffing Notes Supervisory Documentation

Principle	Practice	Benchmark	Documentation
	F - Program staff monitors Personal Visit and Group Connection participation rates and uses a variety of strategies to address engagement of families in services.		Program Files Group Documentation
PAR3 - Parent Group services are parent-child focused, as well as responsive to the parent and child's developmental and environmental needs.	A - A part of each Parent Group connection has activities that encourage successful communication and enjoyable interaction between parent and child, and between group members.	Each Parent Group session has a documented parent-child activity.	Group Plans
	B - A portion of the Parent Group connection allows parents to meet apart from children.		Group Plans
	C - Childcare arrangements ensure safety and consistency in caregivers. Programs provide adequate screening and supervision of childcare providers.	Programs screen 100% of childcare providers in the same manner as paid staff. This includes all legally permissible background checks, criminal history records, and civil child abuse and neglect registries.	Group Plans Program Narrative
PAR4 - Parent Groups are an ongoing service strategy. The duration of the group must be long enough to sustain relationships that promote trust and goal attainment.	A - Parent Group membership and facilitators are consistent.	Parent Group participants are required to attend 75% of group connections to remain enrolled in groups.	
	B - Parent Group plans address content areas in-depth over several weeks through various topics.		
	C - Parent Group Coordinators submit 10-week macro plans to their HV&DN Program Advisor on a quarterly basis.		

Principle	Practice	Benchmark	Documentation
	D - Parent Group documentation includes group micro plans, attendance, and post-group process notes for each Group Connection.		Group Plans Group Connection Planner and Record
PAR4 - Parent Groups are an ongoing service strategy. The duration of the group must be long enough to sustain relationships that promote trust and goal attainment. *(PAT ER 13)*	E - Each Parent Group meets a minimum of forty times per fiscal year, optimally on a weekly basis.	Programs hold 90% of planned Parent Group connections.	Program Abstract
	F - Optimal Parent Group size is six to twelve participants.	Each Parent Group maintains an average attendance of at least five participants.	Program Abstract
	G - Parent Group arrangements include a nutritious meal or snack and transportation to and from group.		Group Plans Program Abstract Program Narrative
	H - Group Connections are offered at times and locations convenient for family members.		Group Plans
	I - The facilities, locations, and materials used are appropriate for the format and size of the program's Group Connections.		Group Plans
	J – Virtual group services are permissible in conjunction with or separate from in-person group services. Virtual groups should be documented accordingly in DataPoints and programs should have established policies and procedures for implementation of virtual group sessions.		Program Abstract Group Plans
	K - Staff members use group meeting records, informal feedback, parent evaluations, and their own observations to improve Parent Group		Group Meeting Record Supervisory Documentation

Principle	Practice	Benchmark	Documentation
	connections.		
PAR5 - Programs provide Parent Groups in consideration of and as a support to each participant's family and cultural values.	A - Parent Groups provide support for the involvement of fathers, other primary care givers, and extended family members (i.e., periodic family nights, grandparent events, and fathers' nights).		Group Plans Program Narrative
	B - It is optimal that staff members (volunteer and paid) reflect the cultural values and strengths of the participants' community.		Program Files
	C - Programs use parents as a resource to identify topics for, plan, and facilitate Parent Group Connections.		Group Plans Program Narrative
PAR6 - All other Parent Groups maintain a primary focus on parenting and target achievement of one or more of the HV&DN program goals. These groups are time-limited and target a specific population other than first-time pregnant and parenting teens. Examples include but are not limited to prenatal groups, school- based groups for pregnant and parenting teens, play groups, co-parenting teen couples' groups, grandparent groups, and father's groups.	A - Other Parent Groups provide a variety of activities for participants prior to and with the goal of formal enrollment in the HV&DN program.		Group Plans Program Abstract Program Narrative

Principle	Practice	Benchmark	Documentation
	B - Other Parent Groups enhance current group services for enrolled participants, or these groups may support or enhance those directly involved with a current participant and child actively enrolled in the HV&DN program.		Group Plans Program Abstract Program Narrative
PAR7 - The specialized curriculum known as Heart to Heart is an enhancement to Parent Groups that focuses on child sexual abuse prevention and enhancement of parent-child relationships.	A - Programs implement Heart to Heart in one ongoing Parent Group during the fiscal year if indicated in the Program Abstract. Programs may add additional Heart to Heart groups with Start Early approval.		Program Abstract Program Narrative Quarterly Narrative
	B - Programs utilize Heart to Heart co-facilitators according to the program design.	Programs identify two Heart to Heart co-facilitators in the Program Abstract.	Group Plans Program Abstract Training Records
	C - In order to implement Heart to Heart in a manner that ensures cohesiveness and trust within the group, programs limit Heart to Heart enrollment.	Programs enroll Heart to Heart participants by the third session.	Group Roster
	D - Programs plan and implement a Heart to Heart graduation ceremony as the group's closing activity.	To be eligible to participate in the Heart to Heart graduation ceremony, participants cannot miss more than two sessions.	Group Roster
	E - Programs plan and implement a Heart to Heart graduation ceremony as the group's closing activity.	Heart to Heart trained Parent Educators can implement group sessions during Personal Visits to allow Heart to Heart group members to participate in graduation. Programs cannot count this towards group attendance in DataPoints.	Personal Visit Record

Principle	Practice	Benchmark	Documentation
	F - Heart to Heart facilitators ensure the completion of a Community Service Project involving group participants and community residents or service providers as part of curriculum implementation.		Groups Plans
PAR7 - The specialized curriculum known as Heart to Heart is an enhancement to Parent Groups that focuses on child sexual abuse prevention and enhancement of parent-child relationships.	G - Prior to Heart to Heart implementation, each program must: designate a clinical consultant to provide support for Heart to Heart facilitators during program implementation identify clinical treatment resources (such as a sexual assault center) for participants who disclose abuse; provide verification of an up-to-date child abuse reporting protocol; and complete a Heart to Heart Support and Intervention Plan.		Child Abuse Reporting Protocol Program Abstract Program Narrative

FY24 PTS-PAT Best Practice Standards
Infant Mental Health*

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

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

FY25 Start Early -PAT Best Practice Standards

Program Structure & Governance

Principle	Practice	Benchmark	Documentation
SG1 - HV&DN programs have the greatest chance of outcome achievement when services are of sufficient intensity and linked to specific strengths, needs, and risk factors of the target group.	A - Programs clearly identify and define their target population, planned intensity of services, including f frequency and duration of contact, and program goals and objectives.	100% of programs use the level system to determine frequency of Personal Visits.	Program Abstract Program Narrative
	B - Programs use a weighted eligibility system, in addition to any other model requirements, to determine eligibility for program services. Programs ensure that funder specific priority populations are part of the weighted eligibility criteria. Where slots are available, programs provide services to child welfare involved families regardless of income or other risk factors.	100% of enrolled participants are below 400% of the Federal poverty level (https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines). Priority should be given to participants with incomes below 200% FPL. Participants between 200% and 400% FPL must be in one of the Early Learning Council's Priority populations (https://www2.illinois.gov/sites/OECD/Events/Documents/Priority%20Populations%20updated%202021.pdf) or experiencing at least one other risk factor. Scores on the weighted eligibility form should be used to prioritize enrollment.	

Principle	Practice	Benchmark	Documentation
SG1 - HV&DN programs have the greatest chance of outcome achievement when services are of sufficient intensity and linked to specific strengths, needs, and risk factors of the target group.	C - Short-term services such as community education, Prenatal Group, and Doula are offered to participants under the following conditions: • Services enhance the program's profile in the community as a collaborator and provider of specialized teen parent services.		
	• No more than 20% of Doula participants receive short-term Doula services.	Programs enroll 80% of Doula participants in long-term home visiting services.	Participant Files Program Abstract Program Narrative
		Where short-term participants are served by a non-Start Early funded home visiting program, programs provide data on the number served in the Program Quarterly Narrative report.	Participant Files Program Narrative Quarterly Narrative Report
	• For short-term Doula Services, participants transition to ongoing family support or home visiting programs offered by community partners.		Participant Files
	• The majority of participants attending Prenatal Group have an active HV&DN enrollment status.		Group Rosters
	E – It is recommended that programs offer creative outreach under specified circumstances for a minimum of three months for each family before discontinuing services.		Participant Files Supervisory Documentation

Principle	Practice	Benchmark	Documentation
SG1 - HV&DN programs have the greatest chance of outcome achievement when services are of sufficient intensity and linked to specific strengths, needs, and risk factors of the target group.	F - Programs comprehensively analyze, annually, acceptance and retention rates of participants. Programs also address how they might increase their acceptance rate based on the analysis of those refusing services in comparison to those accepting services. See Glossary of Terms (Section A8) for definitions of acceptance and retention rate.	100% of programs measure and analyze their family enrollment, service intensity, acceptance, retention, and attrition rates on an annual basis.	Policy and Procedure Manual Program Files
	G - Programs track trends and changes in their target population and adjust their program plans as indicated.	100% of programs document trends or changes in their target population.	Program Abstract Quarterly Narrative Report
	H - Program funding and in- kind support (i.e., facility space) is sufficient to provide services to target population.		Program Budget Program Budget Narrative
	I - Programs work to maintain or strengthen its funding on an ongoing basis.		Program Budget Program Budget Narrative Program Files
	J - Program design and staffing is informed by community needs.		Program Files

Principle	Practice	Benchmark	Documentation
SG2 - The relationship between the staff person and the participant is primary to the delivery of quality services. The quality and intensity of that relationship affects the participant's initial engagement, ongoing participation, and retention in the program. *(PAT ER 13)*	A - Programs maintain full enrollment.	Program enrollment is at least 85% of the program's capacity.	Program Abstract
	B - In order to ensure staff's capacity to develop meaningful relationships with participants and deliver quality services, no caseload for a full-time Parent Educator exceeds 25 participants, regardless of the point values of the caseload. Parent Educators in their first year of service maintain no more than 18 families.	Caseload maximum is 24 points (of any combination of levels) or 25 families. Agencies that have a 37.5 hour work week or less have a maximum caseload of 22 points.	Program Abstract
	C - Full time 1st year parent educators complete no more than 48 visits per month during their first year, and full-time parent educators in their second year and beyond complete no more than 60 visits per month)		Program Abstract
	D - Parent Group Coordinators are responsible for group facilitation, session planning and implementation, record keeping, group arrangements, and volunteer recruitment, orientation, training, and supervision.	A ratio of .25 FTE per group is required.	Program Abstract Program Narrative
	E - Supervisors have relationships with participants and gather satisfaction surveys annually to ensure responsiveness to participant needs.		Program Files

Principle	Practice	Benchmark	Documentation
SG2 - The relationship between the staff person and the participant is primary to the delivery of quality services. The quality and intensity of that relationship affects the participant's initial engagement, ongoing participation, and retention in the program. *(PAT ER 13)*	F - At least annually, programs gather and summarize feedback from families about the services they have received, using the results for program improvement.	Programs complete annual satisfaction surveys, with a response rate of at least 25% of actively enrolled participants.	Program Files
	A - Staff members receive ongoing training and regularly scheduled supervision. Staff members meet individually with a Supervisor on a weekly basis. Supervisors document the number of hours spent in supervision for each staff member.	Each staff person receives 46 individual supervisions per fiscal year.	Program Abstract Program Narrative Supervisory Documentation
	B - Supervisors maintain a record of supervision with each Parent Educator as well as documentation of staff meetings.		Supervisory Documentation
	C - Doula programs ensure regular perinatal clinical support of Doulas and Doula Supervisors with face-to-face sessions that take place a minimum of once a month.	Programs hold 75% of expected clinical support sessions.	Clinical Support Notes
	D - Supervisors and Program Managers receive regular, on-going supervision which holds them accountable for the quality of their work, and provides them with skill development and professional support.	Supervision frequency consistent with what is indicated in the Program Abstract, where all families regardless of the level are discussed and documented at least monthly.	Program Abstract Program Files Supervisory Documentation

Principle	Practice	Benchmark	Documentation
SG2 - The relationship between the staff person and the participant is primary to the delivery of quality services. The quality and intensity of that relationship affects the participant's initial engagement, ongoing participation, and retention in the program. *(PAT ER 13)*	E - Programs base supervision on a process of reflection, stepping back from the work to explore the how's and why's of staff's actions and the impact of the work on that staff person.		Supervisory Documentation
	F - Supervisors observe new Parent Educators delivering one Personal Visit, one Screening, and one Group Connection within six months after PAT training and again at one year. Feedback from the observations is provided to the Parent Educator.	Feedback is documented on the observation form and in supervision documentation.	Policy and Procedure Manual Supervisory Documentation
SG3 - Delivery of relationship-based services to participants and their children begins with the nature of the relationship between the staff in the program. *(PAT ER 4)*	G - Parent Educators in their second year of employment and beyond are observed by the Supervisor or lead Parent Educator delivering a Personal Visit and provided with written and verbal feedback at least annually. Supervisors use the PAT Personal Visit observation form to record observations of Parent Educators on Personal Visits.	100% of home visitors are observed by the Supervisor at least two times per year. Documentation of the observation is found on the observation form and in supervision notes.	Supervisory Documentation
	H - The Supervisor observes at least one Group Connection quarterly, and reviews corresponding planning/delivery documentation and evaluations for each.		Supervisory Documentation
	I - A minimum ratio of full- time supervisor to staff of 1:6 is expected. A ratio of 1:5 is optimal.	The number of Parent Educators assigned to the supervisor is adjusted proportionally when the Supervisor is not full-time.	Program Abstract

Principle	Practice	Benchmark	Documentation
SG3 - Delivery of relationship-based services to participants and their children begins with the nature of the relationship between the staff in the program. *(PAT ER 4)*	J - Individual, reflective supervision covers and documents case discussion, including individualized service delivery and provides opportunities to address at least the following: roles, ethics, and boundaries; professional development; self-care; and, data management driven practice.		Supervisory Documentation
SG4 - Programs have a Director to supervise staff, promote and provide for coordination of services across components, and build collaboration in the community. This coordination is necessary to maximize the use of program and community resources and to provide integrated services for parents and their children.	A - Programs have a 100% FTE Program Director. This person is responsible for program oversight, (planning, implementation, and evaluation) and ensuring the coordination and integration of service components.		Program Abstract
	B - Programs hire well-qualified Supervisors who have at least the following: At least a bachelor's degree in early childhood education, social work, health, psychology or a related field At least five years of experience working with families and young children Strong interpersonal skills Commitment to reflective supervision, data collection, and continuous quality improvement		Policy and Procedure Manual

Principle	Practice	Benchmark	Documentation
SG4 - Programs have a Director to supervise staff, promote and provide for coordination of services across components, and build collaboration in the community. This coordination is necessary to maximize the use of program and community resources, and to provide integrated services for parents and their children.	C - Supervisors attend, at a minimum, the three-day Foundational training and the two-day PAT Model Implementation training before supervising Parent Educators.	100% of Supervisors have attended the required PAT Trainings before delivering PAT Foundational and Model Implementation Trainings.	Training Records
	D – The Supervisor of the Parent Educator accesses a minimum of 10 hours of professional development each year.		Training Records
SG5 - Where programs receive funding for Personal Visiting and other services such as Groups, Doulas, or IMH, they integrate these services in a manner that allows participants to experience the unique benefits of each strategy and the combined effects of all.	A - Personal Visit participants are the primary target audience of HV&DN Group Services.	100% of Parent Group participants are actively engaged in Personal Visits.	Group Rosters Participant Files Staffing Notes Supervisory Documentation
	B - Staff in all service components shares information relevant to participants' progress in order to keep services responsive and promote continuity. Programs hold monthly team meetings to coordinate and integrate services to participants.	Programs hold 75% of expected team meetings.	Program Abstract Program Narrative Team Meeting Notes
	C – In addition to team meetings, programs conduct regularly scheduled case staffings. A case staffing is a regular meeting held with direct and supervisory staff to discuss services and issues related to a particular participant's	Case staffings should be held, at minimum, on a quarterly basis.	Program Abstract Program Plan Case Staffing Notes

Principle	Practice	Benchmark	Documentation
	status and progress.		
SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards.	A - Staff members have written staff development plans, and Supervisors plan to release staff from their duties to attend training that supports their work.		Supervisory Documentation Training Records
	B - Programs ensure that all staff members are oriented to child abuse and neglect indicators and reporting requirements prior to direct work with families.		Quarterly Narrative Report Staff Development Plans Supervisory Documentation Training Records
	C - Staff members receive basic and ongoing training in key areas they encounter in their work with families. These include child and adolescent development; forming and maintaining an effective helping relationship; child abuse and neglect; intimate partner violence; substance abuse; maternal and child health; caregiver well-being; diversity, inclusion and equity; parent-child attachment; and community resources.		Supervisory Documentation Training Records

Principle	Practice	Benchmark	Documentation
SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards. *(PAT ER 8)*	D - To be eligible for recertification, Parent Educators complete a minimum of 20 hours of competency-based professional development and training per year	100% of affiliate Parent Educators are up-to-date with their certification.	Supervisory Documentation Training Records
	E - Programs train and certify staff in the appropriate developmental screening tool within the first six months of hire.		Policy and Procedure Manual Supervisory Documentation Training Records
	F - Programs follow and annually review with staff their policy governing appropriate procedures for addressing child abuse and neglect in alignment with state law.	100% of the time the site supervisor or agency manager is immediately notified when abuse or neglect is suspected.	Policy and Procedure Manual Program Files Supervisory Documentation Team Meeting Records
	G - Parent Educator caseloads allow sufficient time for all responsibilities, including: assisting with recruitment efforts; assisting with Group Connections; Personal Visits, including time for planning, travel, and record keeping; facilitating resource connections; data collection and documentation; professional development; and, supervision and staff meetings		Supervisory Documentation

Principle	Practice	Benchmark	Documentation
SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards. *(PAT ER 7)*	I - Programs have access to a licensed mental health professional that provides consultation to program staff members regarding their work with families.		Team Meeting Records
	J - Parent educators obtain competency-based professional development and training and renew certification with the national office annually.		Policy and Procedure Manual
	K - Shadowing, mentoring, observation, and training specific to the Parent Educator's role and responsibilities occur throughout the Parent Educator's first year. Shadowing follows completion of Foundational and Model Implementation (FAMI) training and must include one Personal Visit, one Group Connection, and one child screening. Observation occurs within six months of completion of FAMI training and again at one year. A new Parent Educator is observed conducting at least one Personal Visit, one screening, and one Group Connection and is provided with feedback.	100% of home visitors are observed and receive written and verbal feedback from the supervisor. This feedback is documented in the supervision notes and on the observation form.	Policy and Procedure Manual Supervisory Documentation

Principle	Practice	Benchmark	Documentation
SG6 - Staff knowledge, skills, and support are essential to the delivery of quality services. Reflective supervision demonstrates an investment in staff development in addition to the monitoring of staff activities. Programs implement reflective supervision as described earlier in these standards.	L - Programs prepare staff before they attend PAT training by, at a minimum: reviewing the Affiliate Plan, Model Components, Essential Requirements, and login process for needed resources; and, having Parent Educators shadow at least one Parent Educator delivering a Personal Visit.		Policy and Procedure Manual Supervisory Documentation
	M - Doulas complete HV&DN approved training in addition to other Doula certification. Participation in ongoing and in-service training is required.	Doulas attend the three-day PAT Foundational training and the two-day PAT Model Implementation training within the first six months of hire, and attend the first available Doula Basic training in relationship to their hire date.	Supervisory Documentation □ Training Records
	N - Doulas and Doula Supervisors attend a DONA approved Birth Doula Training.	Doulas and Doula Supervisors complete DONA training within three months of hire.	Supervisory Documentation □ Training Records
SG7 - All HV&DN services are responsive to the culture of the families served.	A - Programs select staff for their experience and expertise in working with the community and families served by the program, including an understanding of language, customs, and values.		□ Program Files
	B - Parent educators take language and culture into consideration when connecting families to resources.		□ Participant Files □ Personal Visit Record Supervisory Documentation
	C - Programs train staff annually on the specific cultural needs of their participants and target community.		□ Team Meeting Notes □ Training Records

Principle	Practice	Benchmark	Documentation
SG8 - Programs select staff and volunteers in a manner that ensures they are willing to work with high-risk families, such as those in which intimate partner violence or substance abuse may be a concern.	A - Staff members are open to flexible schedules that allow for connecting with participants who are not available during traditional work hours.		Policy and Procedure Manual Supervisory Documentation
	B - Staff and volunteers have experience or education related to parenting, family support, and child development.		□ Program Files □ Program Narrative
	C - Programs hire Parent Educators that reflect the languages and cultures of the families being served.		□ Program Files
	D - Staff members demonstrate the capacity to form positive trusting relationships through clear communication and acceptance of differences in values, beliefs, and practices.		Supervisory Documentation

Principle	Practice	Benchmark	Documentation
SG8 - Programs select staff and volunteers in a manner that ensures they are willing to work with high-risk families, such as those in which intimate partner violence or substance abuse may be a concern. *(PAT ER 2)*	E - The program's interview process for Parent Educators includes, but is not limited to: providing a job description that includes clearly defined qualifications and responsibilities; assessing for effective communication and interpersonal skills and qualities (e.g., conscientious, empathic, accepting, sociable, able to balance multiple roles, perspective, good judgement, personal ethics, and willingness to learn and intervene; and shadowing a Parent Educator delivering a Personal Visit.		□ Program Files
	F - Programs hire Parent Educators with minimum of a high school diploma or GED and two years previous supervised work experience with young children or parents.		Policy and Procedure Manual □ Program Files
	G - Program interns and volunteers, when utilized, are subject to the same screening processes programs use with paid staff. In addition, volunteers receive the same training and quality of supervision as would a paid staff person with similar duties.	Programs screen 100% of program interns and volunteers in the same manner as paid staff. This includes all legally permissible background checks, criminal history records, and civil child abuse and neglect registries.	Policy and Procedure Manual □ Program Files □ Program Narrative

Principle	Practice	Benchmark	Documentation
SG9 - The program's relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community, and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families.	A - Community partners identified as referral sources for screening, assessment, and program intake match the program's target population and meet any specific PAT requirements.		□ Program Files □ Program Narrative
	B - To ensure a regular flow of referrals for screening or intake, programs develop and maintain relationships with other community organizations that come into routine contact with pregnant and parenting adolescents and other new parents, including but not limited to schools, health clinics, social service agencies, and child welfare programs.		□ Program Narrative □ Team Meeting Notes
	C - The site monitors the number of families in the target population that are identified/referred through its system of organizational relationships, and develops strategies to increase the percentage screened/identified.		□ Program Files

Principle	Practice	Benchmark	Documentation
SG9 - The program's relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families. *(PAT ER 16)*	D - When possible programs obtain and maintain written linkage agreements through routine communication with collaborating organizations. Informal agreements are acceptable when written agreements are not possible.		□ Program Abstract □ Program Files □ Program Narrative
	E - Doula programs develop written linkage agreements (whenever possible) with any hospital(s) where Doulas provide labor and delivery support to guarantee access of Doulas for attending births.		□ Program Abstract □ Program Files □ Program Narrative
	F - To ensure comprehensive services for families once enrolled, programs develop and maintain knowledge of and working relationship with service providers that address needs beyond the scope of HV&DN services. These include but are not limited to schools, alternative and vocational education, housing, financial assistance, health services, nutrition programs, recreational programs, mental health, early intervention, substance abuse, intimate partner violence services, and childcare.		Community Resource Directories □ Team Meeting Notes

Principle	Practice	Benchmark	Documentation
SG9 - The program's relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families. *(PAT ER 16)*	G - Parent educators are well-informed about how families can access resources.		□ Program Files □ Team Meeting Notes
	H - An up-to-date resource network directory is available, covering at least the following resources: medical care; mental health care; social services; and, educational services		Community Resource Directory Policy and Procedure Manual □ Program Files
	I - Parent Educators connect families to resources that help them reach their goals and address their needs. Parent Educators connect families to resources that help them reach their goals and address their needs. These resources are tracked on the resource connection sheet. Home visitors or Doula's follow up on all resource connectiosn until the family is connected or has determined that the referral is not useful any longer.		□ Participant Files □ Personal Visit Record Policy and Procedure Manual Supervisory Documentation
	J - Parent Educators help families prepare for connecting with a resource.		Case Notes Supervisory Documentation

Principle	Practice	Benchmark	Documentation
SG9 - The program's relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families.	K - Programs track and follow up with families and service providers, if appropriate, to determine if the families received needed services. Follow-up with service providers requires signed Release of Information which must be updated regularly.		Participant Files
	L - Release of information forms used for referrals should be specific to the referral agency and specific time.		Participant Files Policy and Procedure Manual
	M - Parent Educators consult with other organizations serving the family to coordinate services and optimally support the family.		Participant Files Personal Vision Record Policy and Procedure Manual Staffing Notes Supervisory Documentation
	N - Parent Educators follow up with families about the outcomes of recommended resource connections, addressing barriers as applicable		Participant Files Policy and Procedure Manual
	O - Families are asked for feedback regarding their experiences with recommended resources.		Program Files Supervisory Documentation Team Meeting Notes

Principle	Practice	Benchmark	Documentation
SG9 - The program's relationship with the community is critical to supporting participant success. Effective programs link to services and organizations throughout the community and programs actively participate in relevant service networks, support effective referral relationships, and maintain visibility in the community as a source of support for families.	Q - Programs have an advisory committee that meets at least once every six months. The advisory committee can be part of a larger committee, community network, or coalition as long as the group includes a regular focus on the PAT program.	A minimum of two advisory committee meetings are to be conducted twice a year with a larger committee, community network, or coalition as long as the group includes a regular focus on the PAT affiliate.	Advisory Board Minutes Policy and Procedure Manual Program Files
	R - The advisory committee includes involvement of program personnel, community service providers, families who have received or are receiving PAT services, and community leaders.	At least annually, data on program services and outcomes are shared with the staff, advisory committee, and other stakeholders, identifying strengths and areas of service that could be improved.	Program Files Advisory Board minutes
	S - Programs take an active role in community wide planning for early childhood comprehensive services.		Program Files Team Meeting Notes
SG10 - Programs are aware of and sensitive to participants' experiences of services.	A – Programs have established policies and procedures that allow for virtual service delivery, based on the needs of the family and the staff. Policies and procedures should include, but are not limited to, the elements outlined in the final State funder COVID-19 Guidance for Home Visiting, CI, and Doula programs		Program Files Policy and Procedure Manual
	B – Programs ensure that all platforms used for virtual service delivery are secure and have policies and procedures in place to ensure participant safety and confidentiality		Policy and Procedure Manual

Principle	Practice	Benchmark	Documentation
	during visits and groups.		
SG10 - Programs are aware of and sensitive to participants' experiences of services.	C - Programs contact participants who drop out to gather information for quality improvement. Each program has a procedure for participant exit interviews that helps determine the impact of the program.		Exit Interview Forms Program Files
SG11 - Programs participate in evaluation activities to determine the effectiveness of services.	A - Programs cooperate with the Start Early research and evaluation efforts. This includes obtaining informed consent in writing from participants in order to link names, addresses, and telephone numbers to participant identification numbers.		Participant Files
	B - Data on program services are shared with the advisory committee and other stakeholders at least annually.		Policy and Procedure Manual Program Files
	C - Program staff uses information about implementation on an ongoing basis to identify strengths and issues, and make improvements.		Program Files Team Meeting Notes
	D - Programs measure outcomes for the families served.		Policy and Procedure Manual Program Files
	F - Programs have written process for continuous quality improvement.	Program staff engage as a team in continuous quality improvement using recognized CQI methods.	Program Files Team Meeting Notes

Principle	Practice	Benchmark	Documentation
SG12 - Effective programs maintain complete records of service activities to allow for planning, to track progress, and to demonstrate accountability. *(PAT ER 17)*	A - Programs maintain participant files with up-to- date information about service intensity, service content, and participant progress. Programs utilize DataPoints and cooperate with all elements of data collection, training, and reporting information as required by Start Early.	100% of program staff participates in DataPoints training.	Participant Files Training Records
SG12 - Effective programs maintain complete records of service activities to allow for planning, to track progress, and to demonstrate accountability. *(PAT ER 17)*	B - Programs have written policies and procedures that address at least the following: intake and enrollment; services provided to families, including family-centered assessment, goal setting and review of progress, Personal Visits, Group Connections, child screening and rescreening, referral and resource connections, and follow up; family engagement; transition planning and exit; confidentiality; data collection and documentation of services; orientation and training for new staff; supervision and professional development; and, Parent Educator safety.	Programs have written policies and procedures within two years of beginning PAT implementation.	Policy and Procedure Manual
	C - The affiliate annually reports data on service delivery and program implementation through the APR; affiliates use data in an ongoing way for purposes of continuous quality improvement, including participating in the	100% of programs submit the required documentation for annual recertification to the PAT National Center by August 15 of each year.	Policy and Procedure Manual □ Program Files

Principle	Practice	Benchmark	Documentation
	Quality Endorsement and Improvement Process every five years.	Programs are to participate in the Quality Endorsement and Improvement Process every five years or when selected by the PAT National Center, unless a deferral is provided by national office	□ Program Files
SG12 - Effective programs maintain complete records of service activities to allow for planning, to track progress, and to demonstrate accountability. *(PAT ER 17)*	D - Programs maintain an efficient and comprehensive system of service documentation, data collection, and reporting that includes at least the following: Family Intake Record; consent for services; Foundational plans and Personal Visit Planning Guides; Milestones record for each enrolled child; Family Information records; Child Information record for each enrolled child; Parent/Guardian Information record for each enrolled child; Family-Centered Assessment Synthesis records or tools approved by PAT*; developmental screening results and child health records; goals record; resource connections record; Permission to Exchange Information; transition plan; and Family Service record and Exit Summary. *LSP, Family Map, North Carolina Family Assessment Scale for General Services, Mid America Head Start Family Assessment		Annual Individual Service Record Annual Summary of Services □ Enrollment Record □ Exit Record □ Health Record Policy and Procedure Manual □ Program Files □ Screening Recommendations

DHS Addendum

The following standards apply to programs who are recipients of DHS-MCHV funds through their Start Early contract

1. Program policies and procedures-
    A. Maintain written local program policies and procedures that are consistent with the program standards set by one of the four home visiting models noted above.
    B. Review and incorporate all policies and procedures found on the igrow Illinois website, including those related to breastfeeding, safe sleep, child welfare, substance use issues, cultural and linguistic responsiveness,=(/ and dual enrollment.
    C. For educational institutions, assure compliance with the Family Educational Rights and Privacy Act (FERPA).
2. Reflective supervision and reflective practice
    A. Utilize Infant/Early Childhood Mental Health Consultation (IECMHC) as described in the Illinois model for IECMHC on the Governor's Office of Early Childhood Development (GOECD) IECMHC webpage: https://www2.illinois.gov/sites/OECD/Pages/Illinois-Infant-Early-Childhood-Mental-Health-Consultation.aspx. To find a consultant, use the Illinois registry of IECMH Consultants: https://registry.ilgateways.com/find-consultants.
3. Program capacity
    A. Programs must have a plan in place for maintaining continuity of services to home visiting families if their home visitor is on extended leave or leaves the agency.
4. Screening, enrollment, and coordinated intake
    A. Participate in the local All Our Kids (AOK) Network, Integrated Referral and Intake System (IRIS), or other coordinated intake and referral initiative, where such a system exists. (If there is no such initiative in your program's geographic area, this requirement does not apply to your program.)
    B. Engage in community public awareness and outreach activities to support program enrollment.
    C. Avoid dual enrollment in more than one intensive home visiting program.
    D. Avoid waitlisting families when there are open home visiting slots offered by another local program (for example, by establishing referral partnerships with the other program).
5. Community systems development and cross-program referrals
    A. Dedicate a portion of a designated staff member's time to participate regularly as a member of at least one local community collaboration to support the goals and principles defined in the 2021 Joint Statement on Community Systems, Coordinated Intake, and IRIS.
    B. Share with the collaboration available, relevant, aggregated program data that contribute to community needs assessment, setting a common agenda, or other local initiatives.
    C. Promote shared messaging and materials from the collaboration among families and staff.
    D. Participate in at least one local collaboration initiative, such as developmental screening tracking using the ASQ-Enterprise, or the use of the Integrated Referral and Intake System (IRIS).
    E. Assist participating families in connecting with Early Intervention (EI), using the protocols and forms developed by the Illinois Chapter, American Academy of Pediatrics.
    F. Assist participating families in connecting with medical providers and with ancillary services such as mental health services, the Women, Infant, and Children (WIC) program, and intimate partner violence services, with support from the Department.
6. Quality assurance and program improvement
    A. Implement a plan for quality assurance, as specified by the home visiting model.
    B. Participate in Continuous Quality Improvement (CQI) efforts offered by the contractor.

7. Family voice
    A. Regularly incorporate input from home visiting families to improve program quality, as specified by the home visiting model.
    B. Invite families to participate in local collaborations and advisory bodies.