HEALTH ACCESS: NURTURING DEVELOPMENT SERVICES, TOO

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Executive Summary

More than 15,000 babies are born in Kentucky every year to first-time parents. Many of these parents are ready to accept the new responsibilities of their new roles. Other parents, however, may face burdens of everyday life that affect how they are able to care for their new baby. These burdens – staying in school, finding employment, caring for the baby, assuring well-child visits, and making sure the child is immunized on time – all are situations for which the new parent may need a helping hand. The Health Access Nurturing Development Services (HANDS) program offers new families the tools for becoming the best parents possible.

Poor health behaviors, high teen pregnancy rates, substance abuse (including tobacco use), lack of preparation for child rearing, and lack of knowledge of the health care system may hamper a new parent. Kentucky's HANDS seeks to address these challenges for first time parents.

HANDS is part of Governor Paul Patton's Early Childhood Initiative, KIDS NOW, passed by the 2000 general Assembly. It is under-written by the Kentucky Tobacco Settlement. HANDS currently serves 4900 new families. The goal is to reach first-time parents in the Commonwealth. The mission statement reads: Kentucky's HANDS supports families as they build healthy, safe environments for the optimal growth and development of children. Goals of the program are positive pregnancy outcomes, optimal child growth and development, that children live in healthy, safe homes, and that families make decisions that enhance long term independence over meeting short-term or immediate needs. Early evaluation would indicate that the program is on its way to achieving goals. In HANDS families we have seen changes in rates of abuse when compared to comparable non-HANDS families and improved birth outcomes.

While first time, or new families, face a number of burdens, experience tells us families with subsequent births face many of the same burdens, as well as others that are unique to multiple child households. In addition, grandparents are taking on the nurturing role of families as parents return to their educational activities or the work force.

Therefore, the purpose of HANDS, Too is to propose that the benefits of the HANDS home visitation program for first time parents be expanded to all families. The proposal that follows will support the need and anticipated outcomes.

HEALTH ACCESS: NURTURING DEVELOPMENT SERVICES, TOO

Introduction/Background

Overview

Health Access: Nurturing and Development Services (HANDS) was established by the Kentucky Legislature in 2000. It is a program offered to Kentucky's first-time parents to support these families as they build healthy, safe environments for the optimal growth and development of children. Several local health departments piloted the program for two years before the Legislature enacted the program in statutes. Magoffin County Health Department began the program in July 2000 and Johnson County initiated services in April 2001. Health Access: Nurturing and Development Services, Too (HANDS, Too) is identical to the HANDS program except that HANDS, Too services are provided to other than first time parents and can be initiated to families with children under the age of two.

Purpose

The purpose of HANDS Too is to achieve the following:

Positive Pregnancy Outcomes
Optimal Child Growth and Development
Assure that children live in healthy, safe homes, and
Support families in making decisions that enhance long term independence

Significance

"The human capacities for love and learning are rooted in…the first eighteen months of life." (Selma Frailberg, Clinical Studies in Infant Mental Health).
HANDS and HANDS, Too are both rooted in brain research that over the past two decades that confirms that providing educational and support services to parents around the time of the baby's birth can significantly reduce the risk factors associated with child abuse; the earlier the intervention, the greater the likelihood of success. The U. S. Advisory Board on Child Abuse and Neglect recommends that the first, most important step in responding to the child abuse crisis is to focus on preventing it before it occurs by implementing a universal, voluntary, neonatal home visiting service for all new parents. (U. S. Advisory Board on Child Abuse and Neglect, U.S. Department of Health and Human Services, Creating Caring Communities; Blueprint for an Effective Federal Policy on Child Abuse and Neglect, September, 1991. Good home visitor program can cost as little as $2,000 - $3,000 per year. Welfare and service costs for at-risk families who do not receive early intervention can be as high as $40,000 per year.

Problem Statement

Both Magoffin and Johnson counties are rural poverty-stricken counties, where much of the population has been caught up in the cycle of poverty, inadequate education, teen

pregnancy, lack of opportunity, unemployment and under employment, and welfare dependency. The median family income according to the Census 2000 is $19,292 in Magoffin County and $24,052 in Johnson County, compared with Kentucky's $31, 730. In Magoffin County, over one-third of the population lives below the poverty level and close to one-half of the children live below poverty level. In Johnson County, one-forth of the population lives below the poverty level and one-third of the children live below poverty level. Unemployment rates in both counties are higher than the state average.

Data/Literature Review. A review of the literature is particularly dismal in regard to child abuse and neglect. In fact, Healthy Families America refers to child abuse and neglect in the U.S. as "a state of emergency." (U.S. Advisory Board on Child Abuse and Neglect, U. S. Department of Health and Human Services, Child Abuse and Neglect; Critical First Steps in Response to a National Emergency, August 1990. In 1991, over 2.6 million cases of suspected child maltreatment were reported. (NCPA, 50-State Survey, 1992.)

Significant characteristics of Magoffin and Johnson Counties families and their conditions compared with those of Kentucky as a state are quantified in the following indicator compilation:

	Kentucky	**Johnson County**	**Magoffin County**	**J/M**
Prenatal care in 1st trimester[o]	85.60%	83.80%	78.50%	81.15%
Teen mothers (15-17)[o1]	30.2	19.6	32.4	26
Teen mothers (under 15) [o1]	0.9	2.4	4.8	3.6
Teen mother (18-19) [o1]	93	121.1	149.8	135.45
Mother's level of ed. (<9 years) [o]	3.70%	4.40%	8.60%	6.50%
Mother's level of ed. (16+ years) [o]	19.70%	13.70%	6.20%	9.95%
High school grads not in school or working*	5	6	17	11.5
Child deaths*[2]	26	38	38	38
Child poverty*	23	35	42	38.5
Physical abuse reports (<5 years of age)*	28%	30%	44%	37%
Sexual abuse reports (<5 years of age)*	24%	20%	30%	25%

*2000 Kentucky KIDS COUNT data
[o]1999 Birth Statistics
[1]Rate per 1,000
[2]Average annual deaths per 1000,000 ages 1-14

Project Description

HANDS, Too is an expansion of the Commonwealth of Kentucky's HANDS Program, a family centered strengths based approach to services, designed to support families as they build healthy, safe environments for the optimal growth and development of children. Kentucky's HANDS program was developed after reviewing research-based home visitation nurturing programs throughout the nation, with the strongest and most positive aspects being incorporated into HANDS. HANDS, Too is an expansion of that program modeled after the original program.

The vision of HANDS, Too is that every child is wanted and cared for in a stimulating and nurturing environment. Additionally, the program adheres to the following assumptions:

- All families have strengths
- Families are responsible for their children
- Families are the primary decision makers regarding their children
- Communities recognize their roles in children's lives
- Communities recognize that all children must succeed
- Prevention and early intervention improve the community's well being
- Partnerships are vital to a successful program
- Health-related home visitation programs results in families with healthy, safe environments for the optimal growth and development of children

A family will begin the HANDS, Too Program by being screened using the Referral Record Screen (See Appendix I). Those families that screen positive will then receive a family risk assessment called the Parent Visit. This visit will focus on the different dynamics of the family such as the parents' childhood experiences, lifestyle behaviors, parenting experience, coping skills, current stresses, etc. The assessment is scored and if it is positive, the family is offered high intensive home visitation services, which will move them through the level of accomplishment system.

Provision is further made for some parents who screen negative to be offered low intensive home visitation services that will occur less often. Throughout the program, each family will move through the Parent Completion Levels (See Appendix II). This system helps to determine the frequency of home visits made to the family. A family that enters the program during the prenatal period will be placed on Level 1-Prenatal. After the birth of the baby, or if the family enters the program any time before the child is 2 years of age, these families will be moved or placed on Level 1. This means they will receive a weekly visit for a minimum of 60 days. Families will then move through the level system after they have completed 80% of the requirements for that level. The

family will be discharged when they have completed Level 4 or when the child transitions to Headstart at age 3.

HANDS, Too will provide families with structured home visits using the Growing Great Kids curriculum (See Appendix III). During the prenatal period, this curriculum focuses on prenatal health, psychosocial preparations for labor and delivery, newborn care, and newborn health and safety. After the birth of the baby, the curriculum shifts its focus to basic care, social and emotional development, cues and communication, physical and brain development, and play and stimulation. In addition to this curriculum, home visitors will use Ages and Stages Questionnaires to assist in the recognition of developmental delays. If delays are detected, referrals are made to the appropriate organization. Home visitors will also spend time with the family working on goals established during completion of the Family Service Plans.

In addition to the structured home visits made by the Family Support Worker, the family will receive quarterly professional home visits by a Registered Nurse or Social Worker. These visits are designed to assure that the family is receiving services and participating as intended by the program. They will also enable the program to change courses and implement other strategies where goals are being unmet or revised. This intense combination will allow the HANDS, Too Program to meet its planned goals and objectives.

The belief that these activities will lead to the desired outcomes is based upon programs' researched past performances, by professional literature, and best practices in the field. For instance, a Johns Hopkins Randomized Trial Study of Hawaii's Healthy Start program showed increased father involvement, more engagement in effective growth-fostering teaching of their infants, less poor mental health and less psychological aggression and neglectful behaviors towards their infants. A sampling of Healthy Families America outcomes includes enhanced parent-child relationships, including more appropriate expectations of the child (Georgia); a more nurturing environment (Maryland); and more positive parent child interactions (Arizona). Other important family outcomes include higher immunization rates, reduced pregnancy risk factors and improved prenatal care and healthy births.

Objectives

Objective I	Assure Positive Pregnancy Outcomes
Objective II	Assure Optimal Child Growth and Development
Objective III	Assure that Children live in Safe, Healthy Homes
Objective IV	Support families in Making Decisions that Enhance Long-Term Independence

Methodology

Objective I: Assure Positive Pregnancy Outcomes

Methodology: Within the first year of the program:

JCHD and MCHD will accept referrals from medical provides, other agencies, and outreach efforts
100 % of referrals will be screened
80% of referrals will screen positive
50% of positive screens will participate in program
50% of non-participators will receive other Health Department services
100% of participants will negotiate a Family Service Plan
Prenatal visits will be coordinated with 90% success rate
80% of participants will participate in the WIC Program
90% of participants will participate in the Family Planning Program
Post-partum appointments will be coordinated with 90% success rate

Objective II: Assure Optimal Child Growth and Development

Methodology: Within the first year of the program:

JCHD and MCHD will accept referrals from medical provides, other agencies, and outreach efforts
100% of referrals will be screened
80% of referrals will screen positive
50% of positive screens will participate in program
50% of non-participators will receive other Health Department services
100% of participants will negotiate a Family Service Plan
100% of all children will have a medical record
90% of all children will receive preventive health services
90% of all children will be immunized
100% of Family Service Plans will include children's needs and follow-up
70% of family caregivers will master content knowledge of development
100% of children will have developmental assessment
100% of children will be referred for additional services if appropriate
70% of fathers will be involved

Objective III: Assure that Children live in Safe, Healthy Homes

Methodology: Within the first year of the program:

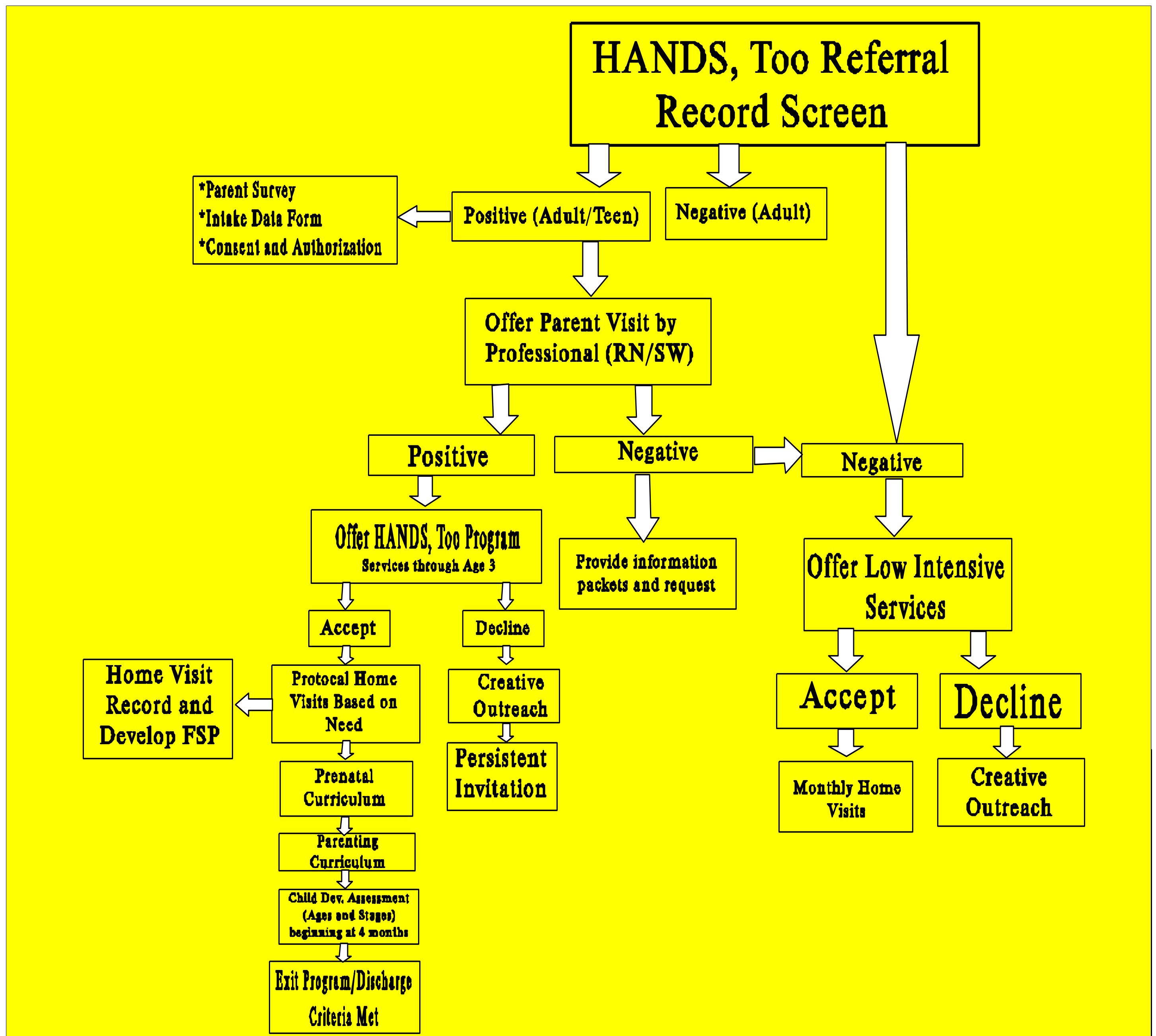
100% of homes will have safety checklist completion
100% of families will have risk assessment completion
100% of families will receive risk assessment feedback

Objective IV: Support families in Making Decisions that Enhance Long-Term Independence

Methodology: Within the first year of the program:

75% of families will participate in problem-solving engagement
Families will attain 75% of Family Service Plan goals
100% of families will receive social support intervention
100% of families will receive crisis support if appropriate
100% of families will receive emergency childcare if appropriate

The following flow chart depicts the process from referral to exit:



Resource Requirements / Strategies Used

I. Market HANDS, Too program in counties (providers, potential participants, community)
II. Assure a trained HANDS, Too program workforce
III. Provide services

The HANDS, Too program must be marketed to the community. A marketing plan must be formulated and begun prior to program implementation. Additionally, there must be assurance that there is a trained HANDS, Too program workforce before the program can be implemented. HANDS, Too workforce requirements are identical to the current HANDS workforce requirements. Currently, both MCHD and JCHD administer the program called **H**ealth **A**ccess: **N**urturing **D**evelopment **S**ervices (**HANDS**), offered statutorily to first time families and funded by tobacco settlement funds. Magoffin County Health Department began HANDS July 2000, and Johnson County Health Department began HANDS April 2001. These counties have trained professionals to immediately begin implementation of HANDS, Too. In addition to the Registered Nurses' or Social Workers' higher education and credentials required for their personnel positions and current HANDS program positions (Program Coordinator, Program Supervisor, Parent Visitor), they receive the following training:

Family Support Worker Core Training
Parent Visitor Core Training
Supervisor Training
Growing Great Kids Curriculum Training

Senior Community Outreach Workers (Family Support Workers) require either two years of college or two years of experience in the provision of social services, support services, or related duties or a combination of both.

To work with HANDS, Too families, these workers must have Family Support Worker Core Training. Additionally, both Registered Nurses/Social Workers and Senior Community Outreach Workers must have the following training:

Family Systems/Dynamics
Prenatal/Postpartum Care
Baby Care Basics
Infant Cues, States, Feeding
Communication Skills
Infant/Toddler Development
Using Community Resources
Working With Fathers
Domestic Violence
Substance Abuse

Mental Illness
Problem Solving/Crisis Intervention
Temperament and Discipline
Developmental Screen Training
Family Planning
Confidentiality and Ethics
Accident Prevention and Home Safety
Personal Health
Stress/Time Management
Family Visiting Safety
Program/Community Orientation
Values Clarification/Cultural Competency
Child Abuse/Neglect Dynamics and Child Protection Services

Additionally, resource requirements include budgeting needs as follows:

Program Coordination / Supervision
Home visit travel expenses
Printed materials for education
Computer/computer access for data entry
Office supplies
Training expenses for training specified above
Evaluation activities

The community has seen the need to implement this program for other than first time parents; however, due to limited funding, additional activities were deemed unaffordable. Plans were developed for Magoffin and Johnson Counties to participate in a pilot program for Kentucky to expand HANDS program services to other than first time families and to fund it with existing HANDS allocations through Tobacco Settlement funds. This project was supported by Kentucky Cabinet for Health Services officials and approval appeared imminent; disappointingly, however, it was determined that statutorily, the program was to be offered only to first time families, and current funding streams could not be utilized for this pilot expansion. This current proposal expands the HANDS Program to HANDS, Too, that is, to other than first time families.

Relevant data is as follows:

	All Births	Currently Served/Screened HANDS	Currently Unserved HANDS, Too Eligible
Johnson County	315	105	210
Magoffin County	209	70	139
Total	524	175	349

It is anticipated, based on experience with HANDS, that 80% of these families will screen positive. With 349 potential HANDS, Too families in the two counties, it is therefore anticipated that 279 will screen positive. Additionally, based on experience with HANDS, it is projected that 50% of those screening positive will accept services, which would result in a total of 140 families for HANDS, Too for Johnson and Magoffin Counties.

With Kentucky's projected budgetary need of $3000 per family for nurturing development home visitation services, a total annual budget of $420,000 would provide HANDS, Too services for Johnson and Magoffin Counties.

Essential Public Health Services

Magoffin County Health Department serves the population of Magoffin County and Johnson County Health Department serves the population of Johnson County. Both agencies are charged with completing assessments of the needs of the populations of the counties, developing plans according to the needs of the populations, and providing clinical and community services directed toward those needs, according to goals established in Healthy Kentuckians 2010 based upon Healthy People 2010 national goals. Families and individuals in Magoffin and Johnson Counties participate in the developing and implementing of these services by way of their participation in the needs assessment/ planning process. Their individual participation in and receipt of services is voluntary, but outreach practices of the Health Departments encourage the entire population of the counties to take advantage of the numerous services provided by the County Health Departments designed to make community health differences.

A goal in Healthy People 2010, Chapter 15, Injury and Violence Prevention, is Item 15–33, Reduce Maltreatment and Maltreatment Fatalities of children. In Healthy Kentuckians 2010, Objective 7.0 Injury/Violence Prevention specifically branches into 7.2 Reduce Child Deaths, 7.20/04S Reduce Child Maltreatment and 7.22 Reduce Physical Abuse, among other objectives. Under these objectives, Magoffin and Johnson County Health Departments administer many activities. HANDS, Too directly relates to injury and violence prevention. Additionally, the practice of public health provides an array of essential services that have been enumerated in public health textbooks universally.

Of the ten essential public health services, the following are included in HANDS, Too services:

Monitor Health
Inform, Educate, Empower
Mobilize Community Partnerships
Link to / Provide Care
Assure Competent Workforce
Evaluate

As the methodology utilized in implementation and provision of HANDS, Too is critiqued, the above-stated essential public health services are salient outcomes proposed for the program.

Results

The result of this Change Master Project has been the actual completion of the proposal to expand the HANDS nurturing services to other than first time families. While conducting research and data compilation for this proposal, Johnson and Magoffin County Health Departments and Department for Health Services Central Office personnel have searched for possible funding sources for this proposal. Magoffin County Health Department has submitted a proposal for HANDS, Too to Big Sandy Community Collaboration for Children, a KY Cabinet for Families and Children funding opportunity. Additional proposal submissions are planned for the counties individually and collaboratively.

Conclusions

Early evaluation would indicate that home visitation programs in Kentucky result in an improvement in child abuse and neglect incidents and improved pregnancy outcomes. It is anticipated that home visitation services to all families would result in similar outcomes.

Leadership Development Opportunities

The development of an intricate proposal through a group process has exposed the authors to a new look at some of the underlying need and potential outcomes associated with home visitation programs. With the diversity of perspectives of the individuals involved in the group, insight was gained into looking at the state as a whole and counties individually and collectively. Differences and similarities were seen and the group members were able to appreciate both. The group members are now much more knowledgeable and are therefore in a better position to advocate for home visitation services to all families.

APPENDIX I

HANDS, TOO REFERRAL RECORD SCREEN

Mother's Name __________________________ SS# __________________ Medicaid #__________________
Address ____ City __________________ Zip _________ County _______________ Phone: (____)___ ______________ Mother's Date of Birth ___ /___/___ Age ___
Father's Name _____________________________ EDC ____/____/_____ and/or Delivery Date ___/___/____

T=True, F=False, U=Unknown   Please fill in all questions-no blanks

Primary Risk Factors

___ 1. Marital status: Single, Separated, Divorced
___ 2. Partner unemployed
___ 3. Inadequate income or no info on source of income
___ 4. Unstable housing *(no home, questionable address, uncertain)*
___ 5. No phone
___ 6. Education under 12 years
___ 7. Inadequate emergency contacts *(no immediate family; no phone for emer contact)*
___ 8. Hx of, or current substance abuse *(excessive use of drugs or alcohol)*
___ 9. Late, none or poor compliance with prenatal care *(after 12 weeks)* (_________ month prenatal care began)
___10. Hx of abortion (____ elective ____ miscarriage)
___11. Hx of psychiatric care *(history of or active)*
___12. Abortion unsuccessfully sought or attempted *(during this pregnancy)*
___13. Relinquishment for adoption sought or attempted *(during this pregnancy)*
___14. Marital or family problems *(hx of family violence; discord among family/partner)*
___15. Hx of, or current depression *(self reported or staff reported)*

Other Concerns/ Needs

___ Tobacco Use/Secondary Use
___ Domestic Violence
___ Nutrition/WIC
___ Hx of childhood physical/sexual abuse
___ Teen parent
___ High Risk Infant (Medical)
___ Child Care
___ Other medical concerns: Specify:
____

Positive Screen =

1. ***Numbers 1, 9 or 12 are True***
2. ***Any two numbers are True***
3. ***There are 7 or more unknowns***

Referral Source: (Please Specify)

____Hospital __________________________ __________________
____OB/GYN __________________________
____Pediatrician _________________________ ____________________
____Health Department __________________ _____________
____Head Start _________________________

____ Self Referral
____Community Based Services
____Family Resource Center/School________________
____Family/Neighbor/Friend
____Church/Community Organization
____Other ___________________________________

Data collected by Public Health Staff _____Yes _____No

___ POSITIVE SCREEN ___ NEGATIVE SCREEN ___ REFUSED

COMPLETED BY: ______________________________ DATE:

HEALTH DEPARTMENT USE ONLY:

REASON FOR NO PARENT SURVEY WITH A POSITIVE SCREEN:
___ Refused ___Adoption ___No response ___CPS Status ___Infant Death
___Still Birth (Fetal Death) ___ Other (List) _________ ___Does Not Apply

___Enrolled in ***TEEN Monthly Home Visitation Program***

APPENDIX II

H A N D S, Too

Parent Completion LEVELS

Patient's Name: ____________________
Patient #: _____/_____/_____
Clinic #: ______________

Home Visitor responsibilities while Parent(s) is on LEVEL 1-P:	DATE
A. To make at least one home visit per month. The Home Visitor and Reviewer will determine the frequency of home visits during the prenatal period depending on the severity and complexity of problems needing attention prior to the birth of the baby and the parents' interest in participating in the program prenatally. Generally 2-4 home visits per month.	
B. To share information with the parent regarding all relevant aspects of prenatal care and fetal development.	
C. To encourage the parent to obtain prenatal medical care on a regular basis and will support the parent's efforts to obtain this care.	
D. If the parent enters the program prior to the ninth month of pregnancy, the home visitor will complete a FGS for the prenatal period and will write a new FGS with the family within six weeks of the baby's birth.	
E. To discuss family planning options with the parent(s).	
PARENT (S) REQUIREMENTS to move to LEVEL 1:	
A. Parent(s) will give birth to a baby and take that baby home to care for and parent.	

DATE OF PROMOTION TO LEVEL 1: ___/___/___ HOME VISITOR REVIEWER

Home Visitor's responsibilities while Parent(s) is on LEVEL 1:	DATE
A. Home Visitor to make at least one home visit per week for a minimum of 60 days. One group meeting can be substituted for a home visit if the Home Visitor participates in that group.	
B. Home Visitor to complete FGS with Reviewer and initiate FGS activities and updates every six months.	
C. Assessments required by program are complete: FGS, Ages and Stages, Childproofing Checklist and Child and Family Rating Scale.	
D. Home Visitor reports observations to Reviewer on a regular and "as needed" basis along with documented observations and interventions.	
E. Home Visitor to teach and conduct activities required by parent-child interaction curriculum.	
PARENT(S) REQUIREMENTS to move to LEVEL 2:	DATE
A. Parent(s) have maintained stability in the home with no crisis for 30 days, or responded appropriately to crisis with assistance of Home Visitor.	
B. Parent(s) keeps appointments or calls to reschedule 75% of the time.	
C. Parent(s) asks Home Visitor for help in problem solving as needed.	
D. Parent(s) expresses feelings/concerns to Home Visitor as appropriate.	
E. Parent(s) is responsive to parent-child interaction interventions.	
F. Parent(s) is able to identify at least one positive support network (other than Home Visitor).	
G. Parent(s) has a medical home and is attentive to the medical needs of the child.	

DATE OF PROMOTION TO LEVEL 2: ___/___/___ HOME VISITOR REVIEWER

Home Visitor's responsibilities while Parent(s) is on LEVEL 2:	DATE
A. Home Visitor is to make at least one home visit every other week and a telephone call in the week when no home visit is made.	
B. Home Visitor continues to observe and document status of parent and infant and consults with the Reviewer on a regular and "as needed" basis.	
C. Home Visitor updates FGS with family and implements FGS activities.	
D. Assessments required by program are complete: FGS, Ages and Stages, Childproofing Checklist and Child and Family Rating Scale.	
E. Home Visitor to continue to teach and conduct activities required by parent-child interaction curriculum.	
Parent(S) Requirements To Move To Level 3	DATE
A. Parent(s) have maintained stability in the home with no crisis for 30 days or responds appropriately to crisis with assistance of Home Visitor.	
B. Parent(s) regularly utilizes at least one other positive support network regularly.	
C. Parent(s) demonstrates effective problem solving skills in most situations.	
D. Parent(s) demonstrates positive parent-child interaction skills with guidance of Home Visitor.	
E. Parent(s) demonstrates reduction of one or more high risk factors.	
F. Parent(s) takes child to all scheduled Well-Child appointments and to medical home when sick.	
G. Child's immunizations are all up to date.	

DATE OF PROMOTION TO LEVEL 3: __/__/__ HOME VISITOR REVIEWER

Parent(S) Requirements To Move To Level 4	DATE
A. Parent(s) able to maintain stability in the home with no crisis for at least 30 days or responds appropriately to crisis independently.	
B. Parent(s) regularly utilizes at least two positive support networks other than Home Visitor.	
C. Parent(s) demonstrates regular use of effective problem solving skills.	
D. Parent(s) demonstrates ability to consistently utilize positive parent-child interaction skills.	
E. Parent(s) demonstrates significant reduction in changeable high risk factors on Parent Survey and no longer has a score of 25 or more.	
F. Parent(s) takes child to all scheduled Well-Child appointments and to medical home when sick.	
G. Child's immunizations are all up to date.	

DATE OF PROMOTION TO LEVEL 4: __/__/__ HOME VISITOR REVIEWER

Home Visitor responsibilities while Parent(s) is on LEVEL 4	DATE
A. Home Visitor is to make a home visit every three- (3) months and record observations/assessments until the child is two years of age.	
B. Home Visitor reports observations to Reviewer quarterly and on an "as needed" basis.	
C. Home Visitor to continue to review materials and conduct activities of parent-child interaction curriculum according to program requirements.	
D. Home Visitor is to monitor child's health and development. Also to make referrals and advocate for services needed to improve health, enhance development or treat delays.	
PARENT(S) responsibilities to REMAIN on LEVEL 4	DATE
A. Parent(s) have maintained stability in the home with no crisis or responds appropriately to crisis independently.	
B. Parent(s) regularly utilizes at least two positive support networks other than Home Visitor.	
C. Parent(s) demonstrates regular use of effective problem solving skills.	
D. Parent(s) demonstrates ability to consistently utilize positive parent/child interaction skills.	
E. Parent(s) takes child to all scheduled Well-Child appointments and to medical home when sick.	
F. Child's immunizations are all up to date.	

DATE OF DISCHARGE: __/__/__ HOME VISITOR REVIEWER

	DATE
A. New parent(s) who have not invited us to make home visits after 4 weeks of creative outreach, or who cannot be located. HOME VISITOR'S RESPONSIBILITIES: Home Visitor is to maintain creative outreach approach to attempt to build trust and engage parent(s) in program. Reviewer and home visitor will determine frequency and type of creative outreach to pursue. Parent(s) will remain on Level O for 2-3 months unless they become active participants and then are moved to Level 1.	
B. Parent(s) have been receiving regular outreach service for at least 3 months and are refusing services or continuously avoiding services. HOME VISITOR'S RESPONSIBILITIES: Home Visitor is to contact parent(s) at least once a month to inquire about parent(s)'s well being and attempt to schedule visits if appropriate. Case will be closed if parent(s) continues to refuse services for 2 to 4 months (at Reviewer's discretion).	
C. Parent(s) are temporarily out of service area for over 1 month and has informed workers. No contact by the Home Visitor is required. Parent(s) will resume former level status upon return unless Reviewer determines need for more intensive services.	

DATE OF ASSIGNMENT TO LEVEL 0: __/__/___ DATE OF PROMOTION TO LEVEL 1, 2, 3, 4 __/__/___

i Preface

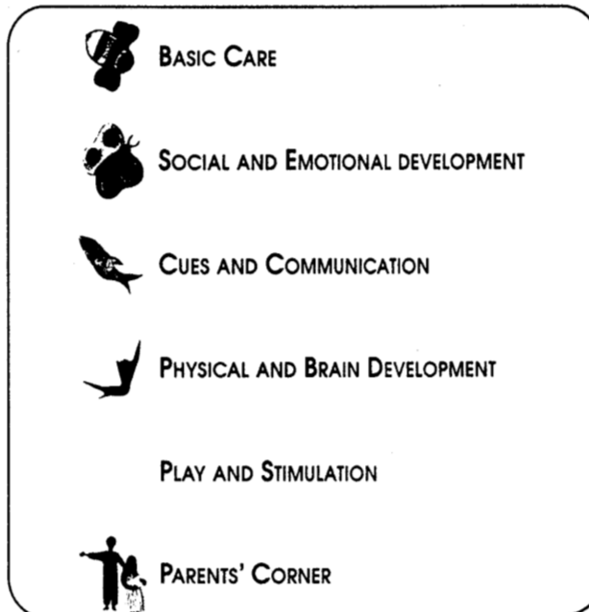
Introducing
Growing Great Kids™

As a newcomer to ***Growing Great Kids***™ you probably have some questions. These are some of the questions we thought you would like answered before you get started.

Beginning prenatally, ***Growing Great Kids***™ is a comprehensive curriculum that supports the development of nurturing and empathic parent-child relationships for 0 to 3 year olds. It does so by focusing on child development and health, provision of care, parenting concerns and the dynamics of parent-child and family relationships.

What Is?
Growing Great Kids™

For every three months of the child's development there are six modules, addressing:



Each of these modules is designed to support learning by anchoring the information in activities and interactive discussions.

In addition to the above, a Family Enhancement unit is included. This unit focus on family dynamics and growth within the family system.

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Why Use? Growing Great Kids™

Beginning prenatally, *Growing Great Kids*™ provides a "how to" guide for supporting parents and developing parenting competencies. It provides a structure for each home visit or group and takes the "guess work" out of what to do. *Growing Great Kids*™ puts difficult concepts into simple language by offering examples of words you could use, the "how to's", in the following areas:

- Building relationships with families that focus on program goals
- Growing parental empathy and nurturing relationships
- Doing activities that support childhood health, growth and development
- Gaining an understanding of parental/family values
- Communicating to facilitate open discussion and parental empowerment
- Sharing information about child development
- Making age appropriate toys from common household items
- Enhancing family relationships
- Extending families' support systems
- Addressing concerns and exploring solutions
- Cultivating motivation, critical thinking and problem solving skills
- Promoting parental self care and health

How Do You Use? Growing Great Kids™

Growing Great Kids™ is written to be inclusive of all family members and all of the individuals involved in raising a child. Adapting this curriculum to the cultures and communities you are working in will make it most effective. Utilizing community resources to expand upon information and extend the families' support system is recommended.

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How Do You Use? *Growing Great Kids*™

This curriculum can be used either during home visits or with parent groups. Depending upon the dynamics of the family or the size of the group, each module will take 1 to 3 visits/sessions to complete. The purpose of this curriculum is to integrate learning into parental practices and parental behavior. Being flexible and having fun will create an environment that will nurture learning.

For each curriculum, a set of master handouts is provided which includes parent/child activities and information pertinent to the modules, certificates of completion for parents and documentation records specific to each module. Some of these materials are also available in Spanish.

How Do You Learn To Use? *Growing Great Kids*™

Great Kids, Inc.
provides training and technical assistance in how to make this curriculum work for you. For information please call
1-800-906-5581

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