Disclaimer: This Policy and Procedure is a DRAFT for feedback and is not active at this time.

100-60 CONTRACTED CASELOAD CAPACITY

PURPOSE

To establish and ensure California Home Visiting Program (CHVP) local health jurisdictions (LHJs) reach and maintain a caseload of enrolled families that aligns with the selected home visiting model and California Department of Public Health (CDPH)/CHVP expectations.

POLICY

CDPH/CHVP LHJs are required to reach and maintain a full caseload of participant families for each evidence-based home visiting (EBHV) program they are implementing with federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) funding and State General Funding (SGF) for EBHV. This number is called the Contracted Caseload Capacity (CC).

BACKGROUND

CDPH/CHVP acknowledges that there is time needed for program start up before reaching a full caseload capacity and that there is a continual flow of families with diverse needs into and out of the program. These are taken into consideration in this policy and the procedures for setting, maintaining, and monitoring CC.

CDPH/CHVP works closely with the CHVP-funded EBHV model developers to determine a ratio of home visitor full time equivalent (FTE) to program participants that meets model fidelity requirements and is reasonable and responsive to local needs for flexibility in serving families with varying levels of acuity.

As part of the Annual Funding Agreement (AFA) process, CDPH/CHVP Program Consultants (PCs) will collaborate with their assigned LHJs to determine the CC for each EBHV model and funding source, using the procedure below. The CC will be indicated on the final AFA Approval Letter and be used to guide goal setting, provide technical assistance, and support LHJs via the Extra Support Plan (ESP) process, if needed. Newly funded local programs or those that are expanding with CHVP funding, have 18 months from initial AFA approval to reach the CC.

CDPH/CHVP is transitioning from the current Home Visitor Personnel Cost Method to the new Enrollment Slot Method, which will algin the CC with the families reported to MIECHV.

PROCEDURE

I. CDPH/CHVP PCs will work with LHJs to determine a CC for each MIECHV and/or SGF EBHV funded EBHV model during the annual CHVP AFA process. If an LHJ has an agreement or approval from the EBHV model for an FTE/participant ratio that varies from the standard ratios, CDPH/CHVP will honor that agreement. LHJs should provide verification of the approval to their CDPH/CHVP PC during the determination process or at the time of a request for change of CC. Agreements with EBHV models and reductions to CC are subject to annual reassessment. If you have any questions about contracted Caseload Capacity, please contact your PC and assigned research scientist (RS).

   A. Newly funded LHJs or those that are expanding with CHVP funding have 18 months from initial AFA approval to reach the CC.

   B. LHJs interested in implementing a model approved adaptation/enhancement must work with the model and PC to determine CC.

   C. CDPH/CHVP reserves the right to request additional information or justification for CC at any time.

   D. CDPH/CHVP reserves the right to require LHJs to adjust CC at any time to align with CHVP funding, home visitor FTE, CDPH/CHVP SOW requirements, evidence-based model requirements, recommendations and/or all other CDPH/CHVP program and reporting requirements.

   E. For more information on model specific requirements for CC, please see reference section below.

II. LHJs may request a change to their CC outside of the annual CDPH/CHVP AFA process, via e-mail to their CHVP PC.

   A. When the LHJ subcontracts to another agency to deliver home visiting services, the LHJ is responsible for initiating a change request.

III. After the 18-month initial program implementation period allowed to reach CC, LHJs that fall below 85% of their CC for three consecutive months, as measured by the CHVP monthly caseload will meet with their CDPH/CHVP PC to create an Extra Support Plan (ESP). Please see the CHVP Extra Support Plan Policy for further information.

   A. Monthly caseload is measured by the number of families enrolled in an LHJ's EBHV program, by funding source (MIECHV or SGF EBHV), on the last day of each monthly reporting period and is reflected in monthly historic caseload graphs. (See definitions below)

i. CDPH/CHVP will produce monthly historic caseload graphs for each LHJ by funding source and EBHV model and will provide them via their password protected CHVP SharePoint site.

ii. PCs and LHJs will review the historic caseload graphs monthly to monitor CC.

B. For questions regarding a timeframe for reaching or maintaining CC after the 18- month initial program implementation period, please reach out to your CDPH/CHVP PC for assistance.

IV. LHJs must ensure proper documentation of funding source(s) for each family enrolled in the program, using model-specific data collection forms/systems and follow the *Program and Data Requirements* in the CDPH/CHVP Enrollment Policy and Procedures.

A. LHJs must use the *Enrollment Slot Method* to identify SGF-funded families at enrollment (see definition below).

i. LHJs must identify certain family enrollment slots as SGF-funded and assign families to these slots at enrollment based on the contracted caseload capacity at annual AFA approval.

B. LHJs must ensure efforts are taken to minimize changes in a family's assigned enrollment slot to promote stability and consistency in provision of services. This includes shifts in assigned funding slots between, MIECHV, SGF EBHV, or other funding sources.

i. There are some circumstances that may warrant a temporary change in a family's assigned funding slot (i.e. home visitor medical leave or temporary vacancies). In these instances, the LHJ must provide continued data collection and reporting on these families.

C. For the purposes of monitoring CC, families would only count toward one CDPH/CHVP funding source.

V. LHJs must adhere to all MIECHV and SGF EBHV scope of work (SOW) requirements related to CC, including:

A. Develop and sustain relationships with appropriate agencies to obtain home visiting participant referrals.

B. Develop a referral triage process for incoming home visiting participants.

VI. LHJs who are implementing a new model or model enhancement may work with their PC to establish a mechanism to report CC to CHVP.

VII. LHJs must maintain fidelity to selected home visiting model as well as all model requirements and recommendations related to CC and home visitor/participant ratios. CDPH/CHVP makes every effort to establish caseload capacity expectations that support model fidelity. Please reach out to your CDPH/CHVP PC if you have questions or concerns.

DEFINITIONS

- *Contracted Caseload Capacity* is the number of participant families an LHJ is expected to serve at any given time. This number takes into consideration multiple factors, including the home visiting model being impl`emented, budgeted home visitor FTE, and acuity of the service population.
- *Monthly Caseload* is defined by the number of families who were continuing from the previous month and those who are enrolled during the monthly reporting period.
- *Historic Caseload Graphs* provide CHVP-funded LHJs a visual representation of their program or model- specific monthly caseload data. The chart provides the monthly caseload in comparison to their overall contracted caseload capacity and a threshold for 85% of their caseload capacity.
- Information on new enrollments and dismissals during the month are also provided. This report provides LHJs with two-years of caseload data through the end of the reporting month.
- *Enrollment Slot Method*: Families are designated as SGF families or MIECHV families based on the slot they are assigned to at enrollment. Using this methodology, recipients identify certain slots as MIECHV funded or SGF funded and assign families to these slots at enrollment. The number of slots devoted to a funding source will be relative to home visitor FTE devoted to that funding source.
    - For example: For a home visitor who is 0.50 FTE SGF and 0.50 FTE MIECHV, half of their slots would be SGF and half would be MIECHV.

REFERENCES

- CDPH/CHVP Scopes of Work
- CDPH/CHVP ESP Policy and Procedure
- Nurse Family Partnership Model Element 12
- NFPx Guidance
- Healthy Families America (HFA) Best Practice Standards (BPS) 4-2 and 8-1
- HFA Child Welfare Protocol
- PAT Supervisor's Handbook, Sample Policies & Procedures, Services Provided to Families Policy
- Health Resources & Services Administration (HRSA), Office of Management and Budget (OMB) No. 0906-0016 Form 4 – Section A.1