**Purpose:** This document describes the criteria that new Welcome Baby sites must meet to demonstrate the extent that the program is being implemented as designed. It is critical to adhere to the fidelity criteria in order to maintain the quality of services replicate the program consistently and better interpret program outcomes.

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<tr>
<th>Fidelity Domain</th>
<th>WB Protocol</th>
<th>WB Fidelity Criteria</th>
<th>Indicator(s)</th>
<th>Reporting Frequency</th>
<th>Reporting Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Staff Qualifications</td>
<td>There are qualifications per position (see Appendix A below) for Program Management Staff (Project Director, Clinical Supervisor, Data &amp; Evaluation Manager, Outreach Specialist) and WB Home Visitation Staff (Parent Coaches, Hospital Liaisons, and RNs).</td>
<td>1. Staff must meet minimum requirements per key position.</td>
<td>1.1. Percent of staff meeting minimum requirements per position.</td>
<td>Annually</td>
<td>Interim – Survey program directors about staff qualifications Collect on Training Registration Form</td>
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<td></td>
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<td>2. All program staff must complete 100% of WB training topics within one year of hire.</td>
<td>2.1 Percent of staff (home visitors and supervisors) completing 100% of WB training topics within one year of hire.</td>
<td>Annually</td>
<td>LA Best Babies Network Training Registration and Attendance Database.</td>
</tr>
<tr>
<td>II. Staff Training</td>
<td>WB program staff must complete training in various topics (see Appendix B) below.</td>
<td>3. All Project Directors, Clinical Supervisors, RN’s Parent Coaches and Liaisons must complete CLE training within six months of hire.</td>
<td>3.1. Percent of key staff (Project Directors, Clinical Supervisors, RNs, Parent Coaches and Liaisons) completing CLE training within six months of hire.</td>
<td>Annually</td>
<td>Long term – Online training registration to be connected to access database.</td>
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<td></td>
<td>All Project Directors, Clinical Supervisors, RN’s Parent Coaches, and Liaisons must complete CLE training.</td>
<td>4. One PC supervisor oversees no more than 4 parent coaches.</td>
<td>4.1. Mean monthly number of parent coaches overseen by PC supervisor. 4.2. Percentage of supervisors at or below fidelity criteria.</td>
<td>New programs: twice a year for first year; then Annually</td>
<td>This may be able to be tracked in the database. Clinical supervisors are able to assign parent coach teams. Interim Plan-self report as part of quarterly reports to First 5 LA</td>
</tr>
<tr>
<td>III. Supervisory</td>
<td>Parent Coach Supervisors oversee no more than 4 parent coaches.</td>
<td>5. Welcome Baby Staff who conduct visits and assessments will receive one hour of individual reflective</td>
<td>5.1. Mean hours of one-on-one supervision per month for Welcome Baby Staff who conduct visits and assessments.</td>
<td>Quarterly</td>
<td>Interim – Tracking spreadsheet for clinical supervisor</td>
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<td>Requirements</td>
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<td>IV. Reflective</td>
<td>WB staff are supervised to model empathy, reflective</td>
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<td>Supervision</td>
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<td>Fidelity Domain</td>
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<td>communication and positive regard so parents can model that same behavior with their children.</td>
<td>supervision per week (4 per month) and 4 hours of group reflective supervision per month (two 2-hour sessions).</td>
<td>5.2 Percentage of Welcome Baby Staff who conduct visits and assessments receiving at least one hour of one on one supervision weekly.</td>
<td>Monthly</td>
<td>Interim – Tracking spreadsheet for clinical supervisor</td>
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<td>Fidelity Criteria</td>
<td>Indicator(s)</td>
<td>Reporting Frequency</td>
<td>Reporting Process</td>
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<td>5.3 Number of group reflective supervision meetings per quarter.</td>
<td>Quarterly</td>
<td>Interim – Tracking spreadsheet for clinical supervisor</td>
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<td>6. Home visitors are observed by a parent coach supervisor during a home visit at least four times per a year.</td>
<td>6.1 Percent of home visitors who are observed during a home visit four times a year.</td>
<td>Annually</td>
<td>Interim – Tracking spreadsheet for clinical supervisor</td>
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<tr>
<td>7. Parent coaches do not exceed more than 70 families.</td>
<td>7.1 Percent of home visitors above recommended caseload.</td>
<td>Monthly</td>
<td>Stronger Families Database: TBD Report</td>
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<td>8. Depending on the birth rate of the hospital, staff should strive to meet a certain threshold for number of visits: a. Parent Coach (PC) III (Supervisor): 20 visits/month b. PCs: 32 visits/month c. RNs: 32 visits/month d. Hospital Liaisons: 60 enrollments per month</td>
<td>8.1 Mean monthly home visits per position.</td>
<td>Monthly</td>
<td>Stronger Families Database TBD Report (Case load forecasting)</td>
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<td>8.2 Percentage of home visitors below suggested workload.</td>
<td>Monthly</td>
<td>Stronger Families Database TBD Report (Case load forecasting)</td>
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<td>8.3 Percentage of home visitors above suggested workload.</td>
<td>Monthly</td>
<td>Stronger Families Database TBD Report (Case load forecasting)</td>
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<td>9. All WB sites must develop and implement a prenatal recruitment plan that is updated annually. This plan must address reaching a % of</td>
<td>9.1 Percent of sites with a prenatal recruitment plan that has been updated no less than one year prior.</td>
<td>Monthly</td>
<td>Interim Plan-self report as part of annual reporting to First 5 LA since the indicator is asking for a prenatal</td>
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V. Home Visitor Caseloads

In order to provide quality services, parent coaches do not exceed a certain caseload at any one point in time.

V.1 Percent of home visitors above recommended caseload. Monthly

V.2 Percentage of home visitors below suggested workload. Monthly

V.3 Percentage of home visitors above suggested workload. Monthly

VI. Home Visitor Workloads

All WB home visitation staff should strive to meet a number of visits per month. These visits vary by level of staff and the birth rate of the hospital.

VI.1 Mean monthly home visits per position. Monthly

VI.2 Percentage of home visitors below suggested workload. Monthly

VI.3 Percentage of home visitors above suggested workload. Monthly

VII. Prenatal Recruitment and Enrollment

Outreach specialists make an effort to engage women within the eligible community and encourage them to enroll in WB.

VII.1 Percent of sites with a prenatal recruitment plan that has been updated no less than one year prior. Monthly

VII.2 Percentage of home visitors below suggested workload. Monthly

VII.3 Percentage of home visitors above suggested workload. Monthly

VII.4 Percentage of sites with a prenatal recruitment plan that has been updated no less than one year prior. Monthly

VII.5 Percent of sites with a prenatal recruitment plan that has been updated no less than one year prior. Monthly

VII.6 Percent of sites with a prenatal recruitment plan that has been updated no less than one year prior. Monthly
<table>
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<th>Fidelity Domain</th>
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<td></td>
<td></td>
<td>women giving birth in the hospital annually.</td>
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<td>recruitment plan with a target % of clients giving birth in the hospital annually.</td>
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<td>10. A minimum of 70% of eligible women offered the program prenatally should accept to be enrolled in WB.</td>
<td>10.1. Percent of clients who were offered the program prenatally who accepted to be enrolled in WB.</td>
<td>Monthly</td>
<td>Stronger Families Database: Outreach Enrollment Report (Dec. 2013)</td>
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<td>11. A minimum of 90% of mothers will be approached by the hospital liaison to enroll in WB.</td>
<td>11.1. Percent of eligible mothers who are approached to enroll in WB or Select Home Visiting Model (SHVM).</td>
<td>Monthly</td>
<td>Stronger Families Database: Hospital Tracking Report (Dec. 2013)</td>
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<td>12. A minimum of 40% of mothers approached by the hospital liaison will enroll in WB.</td>
<td>12.1. Percent of eligible mothers approached who enroll in WB or SHVM program.</td>
<td>Monthly</td>
<td>Stronger Families Database: Hospital Tracking Report (Dec. 2013)</td>
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<td>VIII. Hospital</td>
<td>Hospital Liaisons approach mothers who give birth at the hospital and encourage them to enroll into WB.</td>
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<td>Enrollment</td>
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<td>IX. Service Dosage</td>
<td>WB participants receive different service dosage based on their level of risk and whether they live within a Best Start community.</td>
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<td>13. Best Start participants enrolled prenatally in the first or second trimester will complete at least 6 visits.</td>
<td>13.1. Percent of Best Start participants enrolled prenatally in first or second trimester who complete 6 visits.</td>
<td>Monthly</td>
<td>Stronger Families Database: Engagement Point Tracking Report (Dec. 2013)</td>
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<td>15. Best Start participants enrolled at the hospital who are low to medium risk will complete at least 4 visits.</td>
<td>15.1. Percent of Best Start participants enrolled at the hospital who are low to medium risk who complete 4 visits.</td>
<td>Monthly</td>
<td>Stronger Families Database: Engagement Point Tracking Report (Dec. 2013)</td>
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<td>16. Non-Best Start participants enrolled at the hospital at high risk will receive at least two visits.</td>
<td>16.1. Percent of Non-Best Start participants enrolled at the hospital who are high risk and who receive two visits.</td>
<td>Monthly</td>
<td>Stronger Families Database: Engagement Point Tracking Report (Dec. 2013)</td>
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<td>X. Timing of</td>
<td>WB visits should occur during prescribed time periods prenatally and postnatally.</td>
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<td>Service Delivery</td>
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<td>17. The following visits must occur during these time periods:</td>
<td>17.1. Percent of visits that are within the recommended time period.</td>
<td>Monthly</td>
<td>Stronger Families Database: Engagement Point Tracking Report (Dec. 2013)</td>
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<td></td>
<td></td>
<td>• Prenatal home visit (up to 27 weeks)</td>
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<td>• Prenatal telephone</td>
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<tr>
<td>XI. Referrals to Community Services</td>
<td>Clients receive appropriate referrals to various services including to SHVM, WIC, food stamps, dental referral, etc.</td>
<td>assessment- by 32 weeks of pregnancy  • Prenatal home visit ( by 38 weeks of pregnancy)  • Postpartum hospital visit  • Postpartum Nurse home visit- within 7 days of discharge  • Post-NICU Discharge Nurse Home Visit if applicable one week after baby discharge  • Postpartum visit by 4 weeks of discharge  • Telephone assessment-by 2 months postpartum  • Postpartum visit: 4 months  • Postpartum visit: 9 months</td>
<td>18. Staff should ask clients if a referral was completed. This should happen every time a referral takes place.  18.1. Percent of referrals that were verified by staff as completed.</td>
<td>Monthly</td>
<td>Stronger Families Database: Referral Summary Report (TBD)</td>
</tr>
<tr>
<td>XII. Participant Perception of the Relationship</td>
<td>WB staff strive to build relationships with their clients founded upon mutual respect, trust and acceptance.</td>
<td>19. All staff are mentored and trained to build positive relationships with their clients</td>
<td>19.1. Percent of clients that report a positive relationship with their home visitor in the client exit survey.</td>
<td>Annually</td>
<td>Interim: Replicate client exit survey using online survey tool for each site’s data admin to complete. Potentially tracked in database: Client Satisfaction Summary Report (TBD) Mailed survey forms can be uploaded to database (link to client ID) Update client survey, strategize incentives for survey completion</td>
</tr>
<tr>
<td>XIII. Client Centered</td>
<td>WB staff promote a client- 20. All staff are mentored and trained to build positive relationships with their clients</td>
<td>20. Percent of home visitors that report a positive relationship with their home visitor in the client exit survey.</td>
<td>20.1. Percent of home visitors that report a positive relationship with their home visitor in the client exit survey.</td>
<td>Annually</td>
<td>Clinical Supervisory</td>
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### Welcome Baby Fidelity Framework

#### Approach

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<td>centered and strength-based model, which is a non-directive approach that values the client as the authority on her own experience and fully capable of fulfilling her own potential for growth. <strong>See Appendix C for WB Approach.</strong></td>
<td>trained to implement the client-centered approach during home visits.</td>
<td>meet WB fidelity criteria for the client centered approach.</td>
<td>Monthly</td>
<td>Stronger Families Database: TBD Report</td>
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#### XIV. Content of home visits

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<tr>
<th>Fidelity Domain</th>
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<th>Reporting Process</th>
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<td></td>
<td>The WB visit protocol includes recommended content for each visit (see Appendix D below)</td>
<td>21. Content should be covered at every visit while maintaining client centered approach</td>
<td>21.1. Mean percentage content covered across all visits</td>
<td>Monthly</td>
<td>Stronger Families Database: TBD Report</td>
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<td>21.2. Percent of visits in which planned content is delivered.</td>
<td>Monthly</td>
<td>Stronger Families Database: TBD Report</td>
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#### XV. Responsiveness of Provider

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<td></td>
<td>As a client-centered program, clients receive unplanned assistance if needed</td>
<td>22. Staff are responsive to the client's immediate needs but also adhere to the WB curriculum</td>
<td>22.1. Percent of visits involving unplanned assistance</td>
<td>Monthly</td>
<td>Stronger Families Database: TBD Report</td>
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<tr>
<td></td>
<td></td>
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<td>22.2. Percent of visits that are unplanned</td>
<td>Monthly</td>
<td>Stronger Families Database: TBD Report</td>
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<td></td>
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<td>22.3. Percent of home visitors who addressed an unplanned situation</td>
<td>Monthly</td>
<td>Stronger Families Database: TBD Report</td>
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</table>
Appendix A: Job Qualifications per Position

1. Project Director: Masters level in Public Health, Public Administration, Early Childhood Development, Social Work or nursing with experience in program implementation, and knowledge of maternal child health. At least seven years program and supervision experience, two years of experience in home visitation preferred, with preference for experience in making home visits to low income families. Recommended at least 5 years of experience working in maternal and child health.

2. Clinical Supervisor: Licensed Clinical Social Worker or Licensed Developmental Psychologist with two years of experience providing reflective supervision. At least two years of experience in maternal and child home visitation.

3. Outreach Specialist: Bachelor’s degree in child development, social work, psychology, human development, or a related field preferred; or Child Development Associate (CDA) certification or AA degree, plus direct experience. At least one year of experience in community outreach. Bilingual preferred.

4. Parent Coaches: Bachelor’s degree preferred in child development, social work, psychology, human development, public health education or related field, Child Development Associate (CDA) or AA degree with maternal and child health experience. At least one year of experience in maternal and child home visitation. Bilingual preferred.

5. Hospital Liaisons: BA degree in child development, social work, psychology, human development, public health or related field, and at least one year previous work experience in maternal and newborn health services. Background in conducting family assessments required. Bilingual preferred.

6. Registered Nurses: Public Health Nurse or RNs currently pursuing a PHN certification and will complete within one year of hire. At least one year of experience in maternal and newborn services with strong maternal and newborn clinical assessments skills. At least six months experience conducting home visits. Bilingual preferred.
Appendix B: Content of WB training

1. WB Framework and Orientation
2. Safety for Home Visitors & Self-defense
3. Bonding/Attachment
4. Motivational Interviewing
5. Enhancing Parental Understanding of Child Development: An Empathetic Approach
6. Brain and Infant Development
7. Preventive Care: Prenatal, Postpartum and Newborn Care
8. Childbirth Education
9. Family violence
10. Child abuse/Mandatory Reporting
11. HIPAA and Informed Consent
12. Perinatal Depression PHQ-9 Screening
13. Using the ASQ-3 to Communicate about Children’s Development
14. Milestones and Development: Expectations for Birth to 12 Months
15. Data collection and performance improvement
16. Cultural Competency
17. Reflective Practice
18. Welcome Baby Nurse Visit
19. Parent Coach Visit
20. Outreach and Communications: Keeping Our Language Consistent
21. Family Planning
22. Health Coverage for Pregnant Women and Newborns
23. Home Safety for Infants and Toddlers
24. Healthy Homes
25. Universal Risk Screening: Bridges for Newborns Screening
26. Life Skills Progression Training
27. Certified Lactation Educator Training Series (UCSD)
28. Stronger Families Database: Data Collection, Tracking and Reporting
Appendix C: Overall Welcome Baby Approach

Welcome Baby Approach

Welcome Baby believes that positive behavior change in health, well-being and parenting is learned and enhanced in the context of a relationship that is based in empowerment and empathy. This is done through a client-centered and strength-based model, which is a non-directive approach that values the client as the authority on her own experience and as fully capable of fulfilling her own potential for growth. Through the parallel process of Reflective Practice, Welcome Baby staff model empathy, reflective communication and positive regard to help parents receive the same experience of empathic connectedness that we want them to have with their infants and children.

The core principles of the Welcome Baby program are as follow:

- We value the science that promotes practices that enhance the brain, and the emotional, physical, and social development of infants and children.
- We believe the most important predictor of a child’s healthy growth and development is the healthy, secure attachment formed with a consistent, loving caregiver.
- We recognize that pregnancy and parenting can be a stressful, life-changing event, in addition to a joyous one.
- We believe in developing the self-awareness that allows us to support others in their own process of coping with stress.
- We believe in respecting and valuing each person’s life story and how that may influence their beliefs, opinions, actions and decisions.
- We practice and model an empathetic and connected form of communication: putting oneself in the place of the other person to imagine what they might be feeling, thinking, and what experiences they may be bringing into the interaction.
- We value respectful relationships through which all parties feel understood.
- We value diversity and the opportunity to learn from various perspectives.
- We believe in providing women and families with the information necessary for them to make their own informed decisions.

The essential strategies within this client-centered, strength-based approach that is promoted through the relationships are:

- Establishing trust and rapport with the client.
- Assessing the client/family’s needs, goals, values, culture and well-being by observation and exploration.
- Assessing level of family and community support (both emotional and concrete).
- Providing empathetic support and feedback to the client that allows her and her child to feel understood.
- Highlighting strengths of mother-child dyad to enhance and promote attachment.
- Providing education and support related to areas of need, concern, and interest using a client-centered approach.
- Demonstrating active listening skills by reflecting back the clients’ concerns and feelings.
- Promoting self-efficacy by acknowledging the client’s strengths.
- Discussing and reviewing accurate parenting information and appropriate expectations about infant behavior.
- Acknowledging and promoting behaviors that enhance parent-infant attachment and attunement, through observation, education and modeling.
- Modeling and promoting practices that enhance social, emotional, physical and intellectual (brain) development of infants and children.
- Demonstrating cultural competency by respecting individual family differences.
- Providing the client/family with needed referrals and follow-up.
- Raising issues that may be of concern for individual families and for the community at large about barriers and other issues faced in obtaining services.
Appendix D: Content of home visits (from visit protocols)

1) Up to 27 weeks prenatal visit:
   a. Meeting the client and developing rapport and trust
   b. Review of the Welcome Baby program and services
   c. Obtaining consent for services and explaining confidentiality
   d. Assessment of the client’s strengths and needs and identification of issues that may affect her health and her pregnancy utilizing a client-centered approach
   e. Assessment of social support and involvement of the secondary caregiver/baby’s father
   f. Screening for possible maternal depression
   g. Client-centered health education on topics such as self-care during pregnancy and fetal development
      i. Importance of prenatal visits
      ii. Fetal development
      iii. Attaching/bonding with baby in utero
      iv. Normal body changes during pregnancy
      v. Common pregnancy discomforts and how to alleviate them
      vi. Nutrition during pregnancy
      vii. Substances to avoid
      viii. Importance of good oral hygiene and dental visits
      ix. Kick counts
   h. Assessment of infant feeding plans and client-centered breastfeeding education
      i. Assessment of knowledge about childbirth and encouragement of childbirth preparation classes
   j. Education about pregnancy warning signs and preterm labor
   k. Provision of incentive
   l. Summarization of the visit and referral to any needed resources

2) Prenatal Telephone Assessment
   a. Continued development of rapport and trust with the client
   b. Assessment of current issues and follow-up on any issues and/or referrals from the previous visit
   c. Assessment of social support and involvement of the secondary caregiver/baby’s father
   d. Screening for possible maternal depression
   e. Encouragement of childbirth preparation classes
   f. Continued assessment of infant feeding plans and client-centered breastfeeding education
   g. Assessment of continuity of health coverage and prenatal care
   h. Summarization of the call and referral to any needed resources

3) Prenatal home visit: 28-38 weeks
   a. Continued development of rapport and trust with the client
   b. (If 1st visit) Review of the WB program and services
i. (If 1st visit) Obtain consent for services and explain confidentiality

c. Assessment of the client’s strengths and needs and identification of issues that may affect her health and her pregnancy utilizing a client-centered approach

d. Assessment of social support and involvement of the secondary caregiver/baby’s father

e. Screening for possible maternal depression

f. Client-centered health education on topics such as self-care during pregnancy and fetal development
   i. (If 1st visit) Importance of prenatal visits
      ii. Fetal development
      iii. Attaching/bonding with baby in utero
      iv. Normal body changes during pregnancy
      v. Common pregnancy discomforts and how to alleviate them
      vi. Nutrition during pregnancy
      vii. Substances to avoid
      viii. Importance of good oral hygiene and dental visits
      ix. Kick counts
      x. Other information based on client’s needs and interest

g. Assessment of infant feeding plans and client-centered breastfeeding

h. Assessment of self-efficacy related to breastfeeding and education on how to get started while at the hospital

i. Assessment of preparation for childbirth and client-centered education about labor and delivery

j. Education about pregnancy warning signs and preterm labor

k. Promotion of parent-child attachment, including skin-to-skin right after birth

l. Assessment of the client’s plan for the 1st weeks postpartum, including baby supplies, preparing siblings, help & support from others, etc.

m. Assessment of plans for contraception following the birth and family planning education

n. Assessment and client-centered education on home safety, including lead poisoning prevention, second-hand smoke, car seat safety, smoke detectors, and safe sleep/SIDS prevention.

o. Summarization of the visit and referral to any needed resources

p. Complete Life Skills Progression tool

4) Postpartum Hospital Visit

   a. Enrollment, consent, and orientation for new clients

   b. Universal Screening

   c. Assessment of social support and involvement of the secondary caregiver/baby’s father

   d. Screening for possible maternal depression

   e. Assessment and support with breastfeeding/infant feeding

   f. Observation of parent-infant interaction and education about bonding and secure attachment

   g. Assistance with newborn enrollment into health insurance

   h. Promotion of parent-child attachment, including skin-to-skin right after birth

   i. Review of car seat safety
5) **Nurse Home Visit within 3-7 days post-hospital discharge (Best Start and Non-Best Start)**
   a. Meeting the client and developing rapport and trust
   b. Review of the WB program and services (if enrolled in the hospital)
   c. Explaining confidentiality (if client enrolled in the hospital)
   d. Assessment and/or follow-up of the client’s issues, concerns or priorities
   e. Assessment of client’s birth experience
   f. Maternal assessment of postpartum recovery and education about warning signs, self-care and family planning
   g. Assessment of social support and involvement of the secondary caregiver/baby’s father
   h. Screening for possible maternal depression
   i. Assessment and support with breastfeeding/infant feeding
   j. Assessment and education about bottle feeding (for clients who are formula feeding)
   k. Observation of parent-infant interaction and education about bonding and secure attachment
   l. Physical assessment of the infant and education on newborn care
   m. Additional support for those clients who have a baby in the NICU due to prematurity, low birth weight and/or other medical complications
   n. Assessment of infant’s sleeping environment and education on safe sleeping
   o. Assessment and client-centered education on home safety
   p. Follow-up and reinforcement of well-baby visits and immunizations
   q. Summarization of the visit and referral to any needed resources

6) **Post-NICU Discharge Nurse Home Visit (if applicable) (Best Start and Non-Best Start)**
   a. Continued development of rapport and trust with the client
   b. Assessment of the client’s adjustment to having the baby at home
   c. Assessment of social support and involvement of the secondary caregiver/baby’s father
   d. Screening for possible maternal depression
   e. Assessment and support with breastfeeding
   f. Assessment and education about bottle feeding (for clients who are formula feeding)
   g. Observation of parent-infant interaction and education about bonding and secure attachment
   h. Physical assessment of the infant and education on newborn care
   i. Assessment of infant’s sleeping environment and education on safe sleeping
   j. Assessment of home safety
   k. Summarization of the visit and referral to any needed resources

7) **Postpartum Home Visit: 2-4 weeks (Best Start and Non-Best Start)**
   a. Meeting (if this the first visit between you and the client) or reconnecting with the client and ongoing development of rapport and trust
   b. Assessment of client’s strengths, needs, interests and priorities that may affect her health or her baby’s health using a client-centered approach
   c. Assessment of social support and involvement of secondary caregiver/baby’s father
   d. Screening for possible maternal depression
e. Assessment and support with breastfeeding/infant feeding
f. Support with return to work and child care plans, if appropriate
g. Observation of parent-infant interaction and education about bonding and secure attachment
h. Information and anticipatory guidance about infant’s development and behavior
i. Assessment of health insurance coverage for mother and infant
j. Follow-up on mother’s postpartum care, self-care and plans for family planning
k. Follow-up and reinforcement of well-baby visits and immunizations
l. Assessment and client-centered education on home safety, including infant’s sleeping environment and safe sleep
m. Summarization of the visit and referral to any needed resources
n. Complete Life Skills Progression tool

8) Telephone assessment: 2 months postpartum (Best Start)
   a. Reconnection with the client and ongoing development of trust and rapport
   b. Assessment of social support and involvement of the secondary caregiver/baby’s father
   c. Screening for possible maternal depression
d. Assessment and support with breastfeeding/infant feeding, including return to work and child care plan support
e. Assessment of health insurance coverage for mother and infant
f. Assessment of the client’s health and follow-up about postpartum visit, including family planning
g. Follow-up and reinforcement of well-baby visits and immunizations
h. Assessment of need for assistance with public benefits
   i. Summarization of the visit and referral to any needed resources

9) Non-Best Start: 2 month postpartum visit
   a. Reconnection with the client and assessment of current issues and priorities
   b. Assessment of social support and involvement of the secondary caregiver/baby’s father
c. Screening for possible maternal depression
d. Assessment and support with breastfeeding/infant feeding, including return to work and child care plan support
e. Assessment of parent-infant interaction and education about bonding and secure attachment
f. Information and anticipatory guidance about infant’s development and behavior
g. Assessment and client-centered education on home safety
h. Assessment of health insurance coverage for mother and infant
   i. Assessment of the client’s health, self-care, family planning, and follow-up about postpartum visit
   j. Follow-up and reinforcement of well-baby visits and immunizations
   k. Assessment of need for assistance with public benefits
   l. Summarization of the visit and referral to any needed resources

10) Postpartum Visit 3-4 months
    a. Reconnection with the client and assessment of current issues and priorities
    b. Assessment of social support and involvement of the secondary caregiver/baby’s father
c. Screening for possible maternal depression
d. Assessment and support with breastfeeding/infant feeding
e. Support with return to work or school and childcare plans, if appropriate
f. Assessment of parent-infant interaction and education about bonding and secure attachment
g. Developmental screening of infant
h. Information and anticipatory guidance about infant's development and behavior
i. Assessment of health insurance coverage for mother and infant
j. Follow up on mother's self-care and ongoing family planning
k. Follow-up and reinforcement of well-child visit and immunizations
l. Assessment and client-centered education on home safety including infant's sleeping environment and safe sleep
m. Summarization of the visit and referral to any needed resources

11) Post-Partum Visit: 9 months
   a. Reconnection with the client and assessment of current issues and priorities
   b. Assessment of social support and involvement of the secondary caregiver/baby's father
c. Screening for possible maternal depression
d. Assessment and support with breastfeeding/infant feeding
e. Support with return to work and child care plans, if appropriate
f. Assessment of parent-infant interaction and education about bonding and secure attachment
g. Developmental screening of infant
h. Information and anticipatory guidance about infant's development and behavior
i. Assessment of health insurance coverage for mother and infant
j. Follow-up and reinforcement of well-child visits and immunizations
k. Assessment and client-centered education on home safety, including infant's sleeping environment and safe sleep
l. Follow up on mother's self-care and ongoing family planning
m. Summarization of the visit and referral to any needed resources
n. Complete satisfaction survey
   o. Complete Life Skills Progression tool