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.

Fidelity Domain	WB Protocol	WB Fidelity Criteria	Indicator(s)	Reporting Frequency	Reporting Process
I. Staff Qualifications	There are qualifications per position (see Appendix A below) for Program Management Staff (Project Director, Clinical Supervisor, Data & Evaluation Manager, Outreach Specialist) and WB Home Visitation Staff (Parent Coaches, Hospital Liaisons, and RNs).	1. Staff must meet minimum requirements per key position.	1.1. Percent of staff meeting minimum requirements per position.	Annually	Interim – Survey program directors about staff qualifications: Collect on Training Registration Form and *"Staff Qualifications and Training Log"* Long Term: build this into Stronger Families Database
II. Staff Training	WB program staff must complete training in various topics (see Appendix B in the Fidelity Framework) below.	2. All program staff must complete 100% of WB training topics within one year of hire.	2.1 Percent of staff (home visitors and supervisors) completing 100% of WB training topics within one year of hire.	Annually	LA Best Babies Network Training Registration and Attendance Database and: *"Staff Qualifications and Training Log"*
	All Project Directors, Clinical Supervisors, RN's Parent Coaches, and Liaisons must complete CLE training.	3. All Project Directors, Clinical Supervisors, RNs, Parent Coaches and Liaisons must complete CLE training within six months of hire.	3.1. Percent of key staff (Project Managers, Clinical Supervisors, RNs, Parent Coaches and Liaisons) completing CLE training within six months of hire.	Annually	Long-term – Online training registration to be connected to access database. *"Staff Qualifications and Training Log"*

Fidelity Domain	WB Protocol	WB Fidelity Criteria	Indicator(s)	Reporting Frequency	Reporting Process
III. Supervisory Requirements	Parent Coach Supervisors oversee no more than 4 parent coaches.	4. One PC supervisor oversees no more than 4 PCs.	4.1. Mean monthly number of parent coaches overseen by PC supervisor. 4.2. Percentage of supervisors at or below fidelity criteria.	New programs: twice a year for first year; then Annually	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 *FSOE Site Visit Organizational Chart Review and Program Manager Interview.*
IV. Reflective Supervision	WB staff are supervised to model empathy, reflective communication and positive regard so parents can model that same behavior with their children.	5. Welcome Baby Staff who conduct visits and assessments (HL, PC, PC Sup, RN, OS) will receive one hour of individual reflective supervision per week (4 per month) and 4 hours of group reflective supervision per month (two 2-hour sessions) at least 80% of the time. Outreach Specialists to receive reflective supervision from Program Manager or Clinical Supervisor. Data Managers and administrative staff to participate in group reflective supervision.	5.1. Mean hours of one-on-one supervision per month for Welcome Baby Staff who conduct visits and assessments. 5.2.	Quarterly	Interim – Tracking spreadsheet for clinical supervisor *FSOE Site Visit Document Review and Program Manager Interview.*
			5.2 Percentage of Welcome Baby Staff who conduct visits and assessments receiving at least one hour of one on one supervision weekly.	Monthly	Interim – Tracking spreadsheet for clinical supervisor. *FSOE Site Visit Document Review and Program Manager Interview.*
			5.3. Number of group reflective supervision meetings per quarter.	Quarterly	Interim – Tracking spreadsheet for clinical supervisor.

Fidelity Domain	WB Protocol	WB Fidelity Criteria	Indicator(s)	Reporting Frequency	Reporting Process
					FSOE Site Visit Document Review and Program Manager Interview.
V. Home Visitor Workloads	All WB home visitation staff should strive to meet a number of engagement points per month. These visits vary by level of staff and the birth rate of the hospital.	6. Depending on the <u>birth rate of the hospital</u>, staff should strive to meet a certain threshold for number of engagement points: a. Parent Coach (PC) III (Supervisor): 20 engagements/month 80% of the time b. PCs: 40 engagements/ month 80% of the time c. RNs: 40 engagements/ month 80% of the time d. Hospital Liaisons: 60 enrollments per month	6.1. Mean monthly engagement points per position. 6.2. Percentage of home visitors below suggested workload. 6.3. Percentage of home visitors above suggested workload.	Monthly Monthly Monthly	*Data will be abstracted from the SFDB during the LABBN Record Audit, using the Case Load Forecasting Report.*
VI. Prenatal Recruitment and Enrollment	Outreach specialists make an effort to engage women within the eligible community and encourage them to enroll in WB.	7. A minimum of 70% of eligible Best Start women offered the program prenatally should accept to be enrolled in WB.	7.1 Percent of clients who were offered the program prenatally who accepted to be enrolled in WB.	Monthly	*Update: SFDB Goal 1-7 report-Measure 2.*
VII. Hospital Enrollment	Hospital Liaisons approach mothers who give birth at the hospital and encourage them to enroll into WB.	8. Hospital Liaisons Enrollment Tiers: (See Appendix E): -Tier 1 - Monthly Birth Rate Average Under 100: 95% Approach Rate, 60% Enrollment Rate - Tier 2 – Monthly Birth Rate Average 101-230: 80%	8.1. Percent of eligible mothers who are approached to enroll in WB.	Monthly	*Hospital Cases Tab-Milestone Report by Agency for those sites with Hospital Data Feeds*

Fidelity Domain	WB Protocol	WB Fidelity Criteria	Indicator(s)	Reporting Frequency	Reporting Process
		Approach Rate, 60% Enrollment Rate -Tier 3 – Monthly Birth Rate Average Over 320: 75% Approach Rate, 60% Enrollment Rate 8. -Tier 4 - Monthly Birth Rate Average Over 450: 70% Approach Rate, 60% Enrollment Rate A minimum of 90% of mothers will be approached by the hospital liaison to enroll in WB.			
		9. See Tiers listed in number 8 and Appendix E.	9.1. Percent of eligible mothers approached who enroll in WB	Monthly	Stronger Families Database: *Hospital Cases Tab-Milestone Report by Agency for those sites with Hospital Data Feeds*
VIII. Service Dosage	WB participants receive different service dosage based on their level of risk and whether they live within a Best Start community.	10. Best Start participants enrolled prenatally in the first or second trimester will complete at least 6 engagements.	10.1. Percent of Best Start participants enrolled prenatally in first or second trimester that complete 6 engagements.	Monthly	Stronger Families Database: *Caseload Report-Detailed Download (only shows open cases)*
		11. Best Start participants enrolled prenatally in the third trimester will complete at least 5 engagements.	11.1. Percent of Best Start participants enrolled prenatally in third trimester who complete 5 engagements.	Monthly	As above
		12. Best Start participants enrolled at the hospital who are low to medium risk will complete at least 4 engagements.	12.1. Percent of Best Start participants enrolled at the hospital who are low	Monthly	As above

Fidelity Domain	WB Protocol	WB Fidelity Criteria	Indicator(s)	Reporting Frequency	Reporting Process
			to medium risk who complete 4 engagements.		
		13. Non-Best Start participants enrolled at the hospital at high risk will receive at least two engagements.	13.1. Percent of Non-Best Start participants enrolled at the hospital who are high-risk and who receive two engagements.	Monthly	As above
IX. Timing of Service Delivery	WB visits should occur during prescribed time periods prenatally and postnatally.	14. The following visits must occur during these time periods: • Prenatal home engagement (up to 27 weeks) • Prenatal home visit between 20-32 weeks of pregnancy • Prenatal home engagement (by 38 weeks of pregnancy) • Postpartum hospital engagement • 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 • Postpartum engagement: 2 months postpartum • Postpartum engagement visit: 4 months • Postpartum engagement: 9 months	14.1. Percent of visits completed within the recommended time period among those that are eligible for that engagement point	Monthly	Stronger Families Database: *LABBN SFDB Record Audit*
X. Referrals to Community Services	Clients receive appropriate referrals to various services including	15. Staff should ask clients if a referral was completed. This should happen every	15.1. Percent of referrals that were verified by staff as completed.	Monthly	Stronger Families Database:

Fidelity Domain	WB Protocol	WB Fidelity Criteria	Indicator(s)	Reporting Frequency	Reporting Process
	to WIC, food stamps, dental referral, etc.	time a referral takes place.			*LABBN SFDB Record Audit*
XI. Participant Perception of the Relationship	WB staff strive to build relationships with their clients founded upon mutual respect, trust and acceptance.	16. All staff are mentored and trained to build positive relationships with their clients	16.1. Percent of clients that report a positive relationship with their home visitor in the client exit survey.	Annually	Interim: Replicate client exit survey using online survey tool for each site's data admin to complete. Potentially tracked in database: *Client Satisfaction Survey & MCHA In-home observations*
XII. Family Centered Approach	WB staff promote a family-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. See Appendix C for WB Approach.	17. All staff are mentored and trained to implement the family-centered approach during home visits.	17.1. Percent of home visitors that meet WB fidelity criteria for the family-centered approach.	Annually	Staff Observation Tool *MCHA In-home observations*
		18. Home visitors are observed by a parent coach supervisor during a home engagement at least four times per a year.	18.1. Percent of home visitors who are observed during a home engagement four times a year.	Annually	Interim – Tracking spreadsheet for clinical supervisor *FSOE Site Visit Document Review and Program Manager Interview.*

Fidelity Domain	WB Protocol	WB Fidelity Criteria	Indicator(s)	Reporting Frequency	Reporting Process
					Stronger Families Database: TBD Report
XIII. Content of home visits	The WB visit protocol includes recommended content for each visit (see Appendix D below)	19. Content should be covered at every visit while maintaining client centered approach	19.1. Mean percentage content covered across all visits	Monthly	Stronger Families Database: TBD Report
			19.2. Percent of visits in which planned content is delivered.	Monthly	Stronger Families Database: *LABBN SFDB Record Audit*
XIV. Responsiveness of Provider	As a family-centered program, clients receive unplanned assistance if needed	20. Staff are responsive to the client's immediate needs but also adhere to the WB curriculum	20.1. Percent of visits involving unplanned assistance	Monthly	Stronger Families Database: *LABBN SFDB Record Audit*
			20.2. Percent of visits that are unplanned	Monthly	Stronger Families Database: *LABBN SFDB Record Audit*
			20.3. Percent of home visitors who addressed an unplanned situation	Monthly	Stronger Families Database: *LABBN SFDB Record Audit*

Appendix A: Minimum Required Preferred Job Qualifications per Position

1. Project Director: Masters level in Public Health, Public Administration, Early Childhood Development, Social Work or nursing with experience in community settings, and knowledge of maternal child health or Bachelor's degree in child development, social work, psychology, human development, public health or related field with at least ten years of program implementation and administrative supervision experience. At least seven years of program implementation and administrative supervision experience, and at least three years of experience working in maternal and child health.

2. Clinical Supervisor: Licensed Clinical Social Worker, Licensed Developmental Psychologist, or Licensed Marriage and Family Therapist or able to complete licensure within 6 months, with two years of experience providing reflective supervision. At least two years of experience in maternal and child home visitation and at least two years administrative experience as a supervisor.

3. Outreach Specialist: Bachelor's degree in child development, social work, psychology, human development, social studies, anthropology, human services, women's studies, marketing, communication or a related field preferred with at least one year of experience in community outreach, or Child Development Associate (CDA) certification or AA degree with at least 2 years direct experience and at least one year of experience in *community outreach.

4. Parent Coach Supervisor: Bachelor's degree in child development, social work, psychology, human development, public health education, social studies, anthropology, human services, women's studies or related field. At least two years of administrative experience supervising staff or completion of Supervisor Training (as approved by F5LA) within three months of hire. At least two years of experience in receiving Reflective Supervision and in home visiting in maternal and child health.

5. Parent Coach: Bachelor's degree preferred in child development, social work, psychology, human development, public health education, social studies, anthropology, human services, women's studies or related field with at least one year of experience in maternal and child home visitation, or Child Development Associate (CDA) or AA degree with maternal and child health experience and at least two years of experience in maternal and child home visitation. Bilingual preferred.

6. Hospital Liaison: BA degree in child development, social work, psychology, human development, public health, social studies, anthropology, human services, women's studies or related field, and at least one year previous work experience in maternal and newborn health services. Background in conducting standardized family assessments assessing family needs, risks and support services required.

7. Registered Nurse: BSN RN with Public Health Nurse certification or BSN RN 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.

8. Data and Evaluation Manager: Bachelor's degree in public health, biostatistics, biometrics, administration or related field. At least three years relevant experience in managing the research administration process and supervising staff; developing and implementing quality improvement plans; and managing database and systems for program management and outcomes. At least two years' experience conducing descriptive data analysis, summarizing data and creating reports.

*Definitions

Maternal and Child Health (MCH) Home Visiting: Defined as home visits with prenatal and/or postpartum moms with children 0-5 years old AND topics covered during home visit include child development and milestones, psychosocial, health related, parenting, education and/or breastfeeding.

Maternal and Child Health Community Outreach: Defined as working in the community with prenatal and/or postpartum moms with children 0-5 years old AND focusing on recruiting them into a MCH program and/or providing MCH related education/resources.

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 family-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 family-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 family-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 and collecting Authorization to Share Data for evaluation form
    d. Assessment of the client's strengths and needs and identification of issues that my affect her health and her pregnancy utilizing a family-centered approach
    e. Assessment of social support and involvement of the secondary caregiver/baby's father
    f. Screening for possible maternal depression
    g. Family-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 family-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. Introduce and explain program materials
    l. Summarization of the visit and referral to any needed resources
2) Prenatal home visit: 20-32 weeks
    a. (If 1st visit) Review of the WB program and services
        i. (If 1st visit) Obtain consent for services and explain confidentiality
    b. (If 1st visit) Family-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
    c. Continued development of rapport and trust with the client
    d. Assessment of current issues and follow-up on any issues and/or referrals from the previous visit
    e. Assessment of social support and involvement of the secondary caregiver/baby's father
    f. Screening for possible maternal depression
    g. Encouragement of childbirth preparation classes
    h. Continued assessment of infant feeding plans and family-centered breastfeeding education
    i. Assessment of continuity of health coverage and prenatal care
    j. 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 family-centered approach
    d. Assessment of social support and involvement of the secondary caregiver/baby's father

e. Screening for possible maternal depression
f. Family-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 family-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 family-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 family-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 following the visit

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
   j. Summarization of the visit referral for needed resources, WB postnatal program or Home Visiting Program as appropriate
   k. Referral to needed resources
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 family-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 my affect her health or her baby's health using a family-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 family-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 following the visit

8) Postpartum Visit 2 Months (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 family-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 family-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 family-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. Provide Certificate of completion
p. Complete Life Skills Progression tool following the visit

Appendix E: Content of home visits (from visit protocols)