Family Resource Center Guidebook

July 2018

FIRST 5 STANISLAUS

Stanislaus County Community Services Agency

Building Foundations for the Future

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Introduction

In 2005, the Stanislaus County Children and Families Commission and the Community Services Agency formed a collaboration to fund a network of family resource centers throughout Stanislaus County. The collaboration marked a unique opportunity for family resource centers to provide differential response and family support activities throughout the county. To date, the family resource center/differential response initiative has been an overwhelming success at supporting families countywide.

The process of developing and implementing the family resource center/differential response initiative has taken a bottoms-up approach, giving all resource centers the opportunity to participate in program planning and development. Representatives from family resource centers have worked to develop goals, activities, and outcomes. The efforts of the centers have resulted in recognition across the state of California, with several California counties attempting to replicate the efforts and results of the family resource centers in other parts of the State.

This guidebook should serve as a tool for the family resource centers in the areas of operations and reporting. The book contains definitions, examples of activities, and methodologies for tracking data. Information contained in this book applies only to funding provided through the joint Community Services Agency/Children and Families Commission family resource center initiative. Any data or information provided by the family resource centers should only reflect activities directly supported by the funding initiative.

The Children and Families Commission's Vision is:

All of Stanislaus County's children will thrive in supportive, safe, nurturing, and loving environments; are healthy, eager, and ready learners; and become productive well-adjusted members of society.

The Community Services Agency's Adult, Child and Family Services Division's Vision is:

Every adult and child lives in a safe, stable, permanent home nurtured by healthy families and strong communities.

Case Management

I. Definition/Activities

A. Case management shall be defined as a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a family's needs through communication of available resources to promote quality cost-effective outcomes.

B. Activities surrounding case management may consist of the following:

1. Assessment of the family's situation (health, social, education, employment, or basic needs). Assessment shall be defined as the process of identifying, selecting, designing, collecting, analyzing, interpreting, and using information to determine a family's needs. Essentially, assessment is an integral part of the family resource center determining the most effective way to work with a specific family.

    a) Intake: Each center shall use an intake document or welcome form to use with families to get a "snapshot" of needs or concerns.

    b) Family Development Matrix (FDM): The FDM should be administered to all families who express interest in 3 or more services. The intended use of the FDM is for case management and is used to measure engagement. FDMs should not be used for simple assessments. If you feel it is appropriate for someone with fewer needs, you may use it. The start of gathering FDM data can begin at intake meeting, but is not designed to be completed at first intake meeting unless the family wants to complete it then.

2. Centers will enter data from the FDM into the database. FDM surveys can be closed in the database without completion and still be counted if client disengages.

3. A first FDM assessment will be processed within 30 days of a family's intake. A first FDM assessment shouldn't be done at the family's intake appointment or first contact unless the family expresses a desire for the assessment.

4. Every DR, Family Reunification (FR-aftercare), and Family Maintenance (FM-aftercare) family should receive an FDM.

5. A second FDM assessment will be processed within 60 days of the family's initial assessment. Subsequent FDMs can be performed at 60 day intervals.

6. Identification of the needs or problems of the family.

7. Identification of the family's desired outcomes or goals.

8. Development of a service plan with the family to reach identified goals (may use the empowerment plan from FDM).

9. Participation in carrying out the service plan by linking the family with services that will help the family to obtain identified outcomes and goals (referring, informing, or arranging services).

10. Assist the family in accessing the services (make appointments, arrange for interpreter, follow up on referrals).

11. Consult with families and service providers about the effectiveness of the services and progress toward goals.

12. Assist the family in time of crisis to plan for and access needed assistance.

13. Periodic reassessment of the family's situation

14. Periodic review of the empowerment plan with the family to evaluate whether it needs changes (implement changes if necessary).

II. Tracking (Assessment)

A. Time Studies: Staff time studies should be completed on a daily basis. Staff administering any assessments and intake forms as described above should record his/her time under differential response (DR) or after care (AC) if the client was referred by Child Welfare. Time spent assessing non-Child Welfare clients (ages 0-5 only) should be recorded under family resource center (FRC).

B. Case Counts: Case counts for administration of assessments should be counted under differential response (DR) or after care (AC). Case counts for administration of assessments for non-Child Welfare referred clients should be counted under family resource center (FRC). Counts should be provided for each child in the family, not the number of adults. Additionally, each family should only be counted once per month. Case counts should not be provided for administration of an intake form.

    1. Example: A family of five referred by Child Welfare (Father, mother, child (12), child (6), child (2)) receives an assessment. The number of case counts would be 3, recorded under DR or AC.

C. SCOARRS (Scorecards): Children associated with the parents completing the assessment should be recorded on the scorecards (see example above).

III. Tracking (Case Management)

A. Time studies: Time studies should be completed on a daily basis by staff. Staff administering case management activities and attending Multi-Disciplinary Team (MDT) meetings should count his/her time under DR or AC. Staff administering case management activities for non-Child Welfare clients should count his/her time under FRC.

B. Case counts: A family may be counted under the case management category (case counts, time studies) once contact with the family is attempted. Counts should reflect the number of children associated with the family, and each family should only be counted one time each month. The charge should be made to DR or AC if referred by Child Welfare. If the client is non-Child Welfare referred and age 0-5, the count should be made to FRC.

C. Scorecards: A family may be counted on scorecards for case management once an assessment has been completed. The scorecards should reflect the number of children associated with the family, not the number of parents. FDM continues to be counted for engagement. However, additional SCOARRS indicators are no longer tied to client receiving an FDM assessment. FDM first engagement outcome percentage is 40% and second engagement outcome percentage is 30%. The engagement factor will be calculated by dividing the number of FDMs by the number of clients who respond to engagement attempts.

    1. Example: A family of three is being case managed for three consecutive months. The family includes a mother and twin 4 year olds. The number reflecting this family would be two. Additionally, the family would only be counted on the scorecard 1 time.

D. Client data sheets: All differential response and after care families should be included on the client data sheet when the referral is received. Non-Child Welfare response families should be tracked as well. Names should never be removed from the client data sheet.

Mental Health

I. Definition/Activities

A. For the purposes of the family resource centers, mental health (MH) refers to services designed to improve the self-perceptions, social perceptions, and the ability to meet and handle the demands of life in families with children 0-5. Mental health services provided through family resource centers should strengthen a family's ability to balance daily problems with appropriate coping skills.

B. Mental health services provided through the family resource center may include mental health assessments, referrals, group therapy, individual counseling (with a mental health professional), family therapy, treatment planning, depression screenings, and substance abuse support. Individual counseling should only occur with individuals not eligible for Medi-Cal or Healthy Families.

1. Depression Screenings: Each center will use the screening tool provided from the Commission (currently the Burns depression screening tool). All case managed caregivers with children 0-5 should be screened.

II. Tracking

A. Time Studies: Staff time studies should be conducted on a daily basis. Staff time for administering depression screenings or providing direct mental health services should be time studied under family resource center (FRC). Coordination and supervision of MH activities should be time studied to FRC.

B. Case Counts: Case counts for depression screenings and direct mental health services should be counted under family resource center (FRC). Counts should reflect the number of children associated with the caregiver receiving services. Each family should be counted one time each month for mental health services received.

C. Scorecards: Data reported on the scorecards should reflect the number of children 0-5 whose caregivers were screened for depression and referred to mental health resources.

Parent Education

I. Definition/Activities

A. Parent education in family resource centers refers to an organized, programmatic effort to improve the child-rearing knowledge and skills of a family system or a child care system. A parent education program is designed to improve an individual's parenting skills.

B. Activities offered through parent education programs at the family resource centers may include: structured, curriculum based parenting programs, group support for parents, or focused one-on-one parent education sessions. *Parent education is not an unstructured one-on-one time with a parent on a specific topic or crisis. This would be considered case management.*

II. Tracking

A. Time studies: Staff time studies should be conducted on a daily basis. Staff time including preparation, clean up and facilitation of parent education activities should be time studied to differential response (DR), after care (AC) or family resource center (FRC). If majority of the class is DR referred clients, time should be allocated to DR. If majority of the class is AC referred clients, time should be allocated to AC. If majority of the clients are non-Child Welfare,

time should be allocated to FRC. The same methodology should be used if the center has a subcontract. The subcontractor should time study to the appropriate cost pool that represents the clients in attendance. Additionally, if the center is subcontracting for parent education, subcontracted staff time should only be time studied to DR, AC, or FRC for direct involvement in developing the parent education program. Coordination and supervision of parent education activities should be time studied to DR, AC, or FRC.

B. Case counts: Case counts for parent education should be provided for the number of children associated with parents participating in parent education activities under FRC or DR who are not reported as case managed. Families should only be counted one time per month.

    1. Example: A parent attends a 3-week parenting class. The parent has 4 children (ages 7, 6, 5, 2). The case counts for the month would be 4 (if the class spanned across 2 months there would be 4 case counts for each month).

C. Scorecards: Case counts should be provided for each child whose caregiver participated in the class (in the 0-5 section, track DR, AC and FRC children and caregivers). In the section for 6-17, please track only DR and AC referred caregivers and their children.

    1. Example: A caregiver attends an 8-week long class that crosses over 2 quarters. The caregiver would be counted 1 time only. If the caregiver is FRC and has a 2, 5, 6, and 7-year old, the scorecard count would be 2 for the children (the 2 and 5 year old) and 1 for the caregiver and it would only be accounted for in the 0-5 section.

       If the caregiver has a 5, 7, and 10 year old, and is DR referred, the scorecard count would be split between the 0-5 section (1 count) and the 6-17 section (2 counts) for the children. The caregiver would be counted 1 time in the 0-5 section and 1 time in the 6-17 section.

School Readiness

I. Definition/Activities

A. School readiness activities provided through the family resource centers are defined as activities supporting and preparing an individual child for his/her educational experience. Activities that could support the preparation of a child for his or her educational experience include adult literacy services for the caregivers to read to the child.

B. School readiness activities may include: specific school readiness groups, developmental screenings, reading activities, adult literacy services, math activities, science activities, or social-emotional activities.

II. Tracking

A. Time studies: Staff time studies should be conducted on a daily basis. Staff time including lesson planning, group planning, preparation, and facilitation of specific school readiness groups, administration of and referrals related to developmental screenings, and school readiness events should be time studied to family resource center (FRC). Coordination and supervision of school readiness activities should be time studied under FRC.

B. Case counts: Case counts for school readiness should be provided for the number of children directly participating in school readiness activities. Children should only be counted once per month on the case counts.

C. Scorecard: Data on the scorecard should reflect caregivers with children 0-5 who report receiving school readiness information from the center, number of developmental screenings,

and referrals related to developmental screenings. Each caregiver should be counted one time. Developmental screenings should be counted only once on the scorecard.

1. Example: If a child is receiving a developmental screening every 3 months, the child should only appear on the scorecards 1 time.

III. Surveys

A. Each center shall survey all caregivers with children 0-5 in order to determine if the caregiver received school readiness information. The survey is a self-report, and can be a written survey, in person, or via telephone.

General Outreach

I. Definition/Activities

A. General outreach refers to the distribution of information to a targeted population (families with children 0-5), coordination of and participation in community events (without a health focus) with the purpose of bringing in families with children 0-5 to the resource center.

B. Examples of general outreach activities include: door-to-door outreach, community events, presentations at events, or preparation time for events. General outreach is considered a direct activity with clients or potential clients.

II. Tracking

A. Time studies: Staff time studies should be conducted on a daily basis. Staff time including planning, attending, and conducting outreach activities should be time studied to family resource center (FRC).

B. Case counts: Case counts for general outreach should reflect the number of children 0-5 at the events and should be included in GO/HRO. In the case of large events, an estimate of the number of children is acceptable.

Health Related Outreach

I. Definition/Activities

A. Health related outreach refers to the distribution of information to a targeted population (families with children 0-5), coordination of and participation in community events (with a health focus) with the purpose of bringing in families with children 0-5 to the resource center and disseminating health information.

B. Examples of health related outreach includes health and safety fairs, car seat education, health focused events, health assessments, and health insurance enrollments. Health related outreach is considered a direct activity to clients or potential clients.

II. Tracking

A. Time studies: Time studies should be conducted on a daily basis. Staff time including planning and attending health related activities, health insurance enrollment, administering health assessments, and conducting health-related outreach activities should be time studied to family resource center (FRC).

B. Case counts: Case counts for health related outreach should reflect the number of children 0-5 at the events and should be counted under GO/HRO. In the case of large events, an estimate of

the number of children is acceptable. For health insurance enrollment, case counts should be provided for the number of children 0-5 associated with the family. In the case of a pregnant woman with no other children, the case count would be 1.

C. Scorecards: Data in the scorecard should reflect the health insurance enrollments. Health insurance enrollments should be counted in the scorecards when the family completes a health insurance enrollment application. It is not necessary to follow up in order to determine if the family successfully obtains insurance.

Administration

I. Definition/Activities

A. Administration refers to non-direct hours spent on complying with the CFC / CSA contract.

B. Examples of administration include attending meetings, supervision of staff, time compiling invoices, data collection and tracking, and time completing reporting requirements of contracts.

General Time Study Guidelines

I. Definition/Activities

A. Supervisors should allocate their time based on the type of employees they are supervising.

B. Trainings should be time studied to the cost pool it most represents.

C. All hours should be reflected on the time study.

D. Hours not spent on FRC should be shown in the Non-FRC (Non-CFC/CSA FRC funded activities) line.

E. Non-allocable hours including: holiday, vacation, sick, paid time off; should be shown on the non-allocable line.

F. Non-allocable hours should be charged based on the percentage of the FRC hours time studied for each employee. (Example: If an employee takes a vacation day for 8 hours and time studies 50% of their time to the FRC, then 4 hours could be charged).

Mandated Contractual Reporting

A. The FRC shall report **quarterly** to Commission and CSA staff using SCOARRS forms and Program Statistical reports for PSSF and CAPIT (specified in Exhibit E of the Contract) or other forms provided by the Commission or CSA.

B. FRC shall enter demographic data into a Commission approved database/spreadsheet a minimum of once a **quarter**.

C. FRC shall submit all **quarterly** forms (reports) referenced above according to the following schedule:

- Quarter 1 (July – September): October 31
- Quarter 2 (October – December): January 31
- Quarter 3 (January – March): April 30
- Quarter 4 (April – June): July 31

D. FRC shall submit all **quarterly** forms (reports) or other reporting via e-mail to the following:

- CFC Reports, CFCReports@stancounty.com
- CSA Reports, CSAReport@stancounty.com

E. FRC shall submit a Differential Response Client Data Sheet **monthly** via e-mail to DRClientData@stancounty.com.

F. FRC shall conduct a customer satisfaction survey using the provided form during the **second and fourth quarters** of the Fiscal Year.

1. FRC will compile and report survey results by January 31 (for Quarter 2) and July 31 (for Quarter 4).

G. FRC shall submit to Commission and CSA staff an **annual report** in the format provided by the Commission or CSA.

H. FRC shall develop and conduct an employee satisfaction survey **annually**.

1. FRC shall compile and report the survey results into the program's annual report as described in the contract.

Glossary

Assessment: Assessment is the process of identifying, selecting, designing, collecting, analyzing, interpreting, and using information to determine a family's needs. Essentially, assessment is an integral part of the family resource center determining the most effective way to work with a specific family.

Case Counts: Case counts represent the units of service provided. Case counts are recorded on the monthly invoice and reflect services provided to families served through the center. Case counts are recorded by the number of children (under the age of 18) in the family. The invoice should reflect the number of service units per month provided to families (case counts do not carry over month-to-month).

Case Management: Case management shall be defined as a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a family's needs through communication and available resources to promote quality cost-effective outcomes.

Children 0-5: Children ages 0 through 5 are eligible for services funded by the Commission. A child is eligible until he/she turns 6 years old. If a child turns 6 after the first of the month, the child may continue to receive services through the end of the month.

Children 0-17: Children ages 0-17 are eligible for DR services through the Community Services Agency funding if there is a CSA referral.

Contact: Contact is defined as an attempt made to reach out to the family and receiving any sort of response (verbal, non-verbal) in writing or in person.

Cost Pools: Categories of service on the invoice where the case counts are recorded and expenses are distributed to based on time studies. Cost pools on the invoices are as follows:

DR	Differential Response *Allowable Activities: Case Management and Parent Education*

AC	After Care *Allowable Activities: Case Management and Parent Education*
FRC	Family Resource Center *Allowable Activities: Parent Education, School Readiness, Mental Health, General Outreach, Health Related Outreach*
AD	Administration
Non-FRC	Non CFC/CSA FRC funded activities

General Outreach: The distribution of information to a targeted population, coordination of and participation in community events (without a health focus) with the purposes of bringing in families to the resource center.

Health Related Outreach: The distribution of information to a targeted population, coordination of and participation in community events (with a health focus) with the purpose of bringing in families to the resource center and disseminating health information.

Mental Health: Mental health refers to services designed to improve the self-perceptions, social perceptions, and the ability to meet and handle the demands of life in families. Mental health services provided through family resource centers should strengthen a family's ability to balance daily problems with appropriate coping skills.

Parent Education: An organized, programmatic effort to improve the child-rearing knowledge and skills of a family system or a childcare system. A parent education program can be followed to improve an individual's parenting skills.

School Readiness: Activities supporting and preparing an individual child for his/her educational experience.

Subcontractor: Contracted services paid for through the FRC grant. Subcontractors should report data and time studies to the FRC paying for the services.