100-60 CONTRACTED CASELOAD CAPACITY

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

PURPOSE

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

POLICY

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

BACKGROUND

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

CDPH/CHVP works closely with the three CHVP-funded EBHV model developers – Health Families America (HFA), Nurse-Family Partnership (NFP), and Parents As Teachers (PAT) – to determine a ratio of home visitor full time equivalent (FTE) to program participants that meets model fidelity requirements and is reasonable and responsive to local need for flexibility in serving families with varying levels of acuity.

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

In addition to determining the CC, CDPH/CHVP PCs will work with MIECHV-funded LHJs to determine the MIECHV Maximum Service Capacity (MSC). CDPH/CHVP's federal funder, Health Resources and Services Administration (HRSA), sets the policy for MSC, which is that LHJs designate all families as MIECHV that are served by home visitors for whom at least 25 percent of their personnel costs

(salary/wages including benefits) are paid for with MIECHV funding. This is commonly referred to as "the 25% Personnel Cost Rule". The MSC is indicated on the AFA approval letter for all MIECHV funded LHJs and is related to the number of participants CDPH/CHVP reports to the HRSA.

PROCEDURE

I. CDPH/CHVP PCs will work with LHJs to determine a CC for each MIECHV and/or SGF EBHV funded EBHV model during the annual CHVP AFA process, using the follow model specific home visitor FTE/participant ratios.

EBHV Model	CHVP-funded home visitor FTE as indicated on the budget/Participant ratio
HFA	• 1FTE/12 Participants for home visitors with less than 24 months tenure • 1FTE/16 Participants for home visitors with more than 2 years tenure
NFP	• 1FTE/25 Participants
PAT	• 1FTE/15 Participants for staff with less than 12 months tenure • 1FTE/20 Participants for staff with more than 1 year tenure

A. If an LHJ has an agreement or approval from the EBHV model for an FTE/participant ratio that varies from the standard ratios listed above, CDPH/CHVP will honor that agreement. The LHJ should provide verification of the approval to their CDPH/CHVP PC during the contracted caseload determination process or at the time of a request for change of CC. Agreements with EBHV models and reductions to CC are subject to annual reassessment.

B. Newly funded local programs or those that expanding with new CHVP funding, have 18 months from initial AFA approval to reach the CC.

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

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

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

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

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

A. Monthly active caseload is measured by the number of families actively enrolled in an LHJ's EBHV program, by funding sources (MIECHV or SGF EBHV), at the end of each monthly reporting period and is reflected in monthly Historic Caseload Graphs. (see definitions in the REFERENCES section of this policy)

1. CHVP will produce Historic Caseload Graphs monthly for each LHJ by funding source and EBHV model and will provide them to LHJs via their password-protected CHVP SharePoint site.

2. PCs will review the Historic Caseload Graphs monthly.

IV. LHJs that receive MIECHV funding for EBHV will also have a MIECHV Maximum Service Capacity (MSC) for each MIECHV-funded EBHV model. This number will be determined during the annual AFA process and will be indicated on the AFA approval letter. CDPH/CHVP reports this number to HRSA during regular performance reporting.

V. LHJs must ensure proper documentation of funding source(s) for each family enrolled in the program, using model-specific data collection forms/systems and following the *Program and Data Requirements* within the CHVP Enrollment Policy and Procedures. * See FIGURE 1.

1. LHJs must use the *Home Visitor Personnel Cost Method* to identify HRSA Maternal Infant and Early Childhood Home Visiting (MIECHV)-funded families at enrollment (see definition under the definitions section of this P&P).

a. LHJs must designate families as MIECHV-funded at enrollment, if at least 25% of a home visitor's personnel costs are paid with MIECHV funding.

2. LHJs must use the *Enrollment Slot Method* to identify SGF-funded families at enrollment (see definition under the Definitions section of this P&P).

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

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

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

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

VI. LHJs must adhere to all MIECHV and SGF EBHV SOW requirements related to caseload capacity, including the following:

1. Develop and sustain relationships with appropriate agencies to obtain home visiting participant referrals
2. Develop a referral triage process for incoming home visiting participants

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

REFERENCES

- CHVP Scopes of Work
- CHVP ESP Policy and Procedure
- Nurse Family Partnership (NFP) Model Requirements and Recommendations
- NFP Model Element 12
- Healthy Families America (HFA) Model Requirements and Recommendations
- Healthy Families America Best Practice Standards (BPS) 4-2 and 8-1
- Parents as Teachers Model Requirements and Recommendations
- Health Resources & Services Administration (HRSA), Office of Management and Budget (OMB) No. 0906-0016 Form 4 – Section A.1

DEFINITIONS

Contracted Caseload Capacity is the number of participant families an LHJ is expected to serve at any given time. This number takes into consideration multiple factors, including the home visiting model being implemented, budgeted home visitor FTE, and acuity of the service population.

Monthly Active Caseload is defined by the number of families who were continuing from the previous month and those who are enrolled during the monthly reporting period.

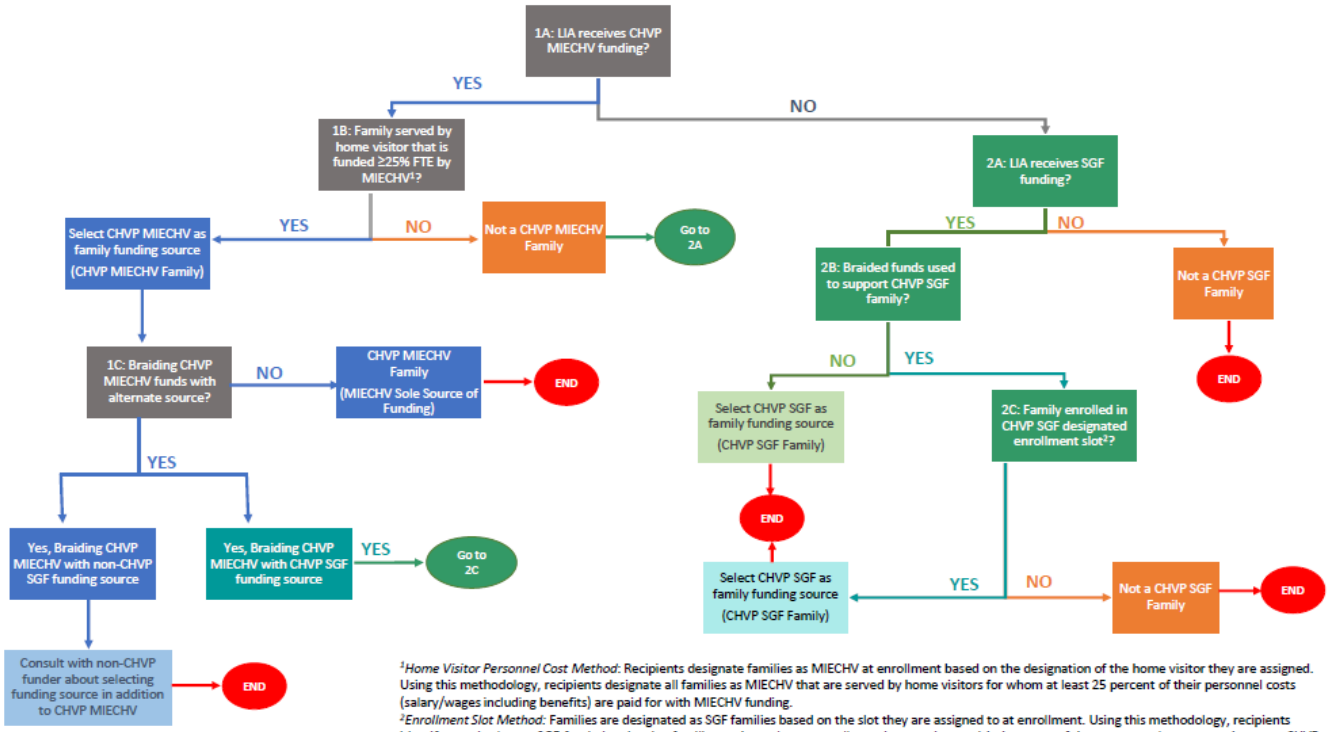
Historic Caseload Graphs provide CHVP-funded LHJs a visual representation of their program or model-specific monthly caseload data. The chart provides the monthly active caseload in comparison to their overall contracted caseload capacity and a threshold for 85% of their caseload capacity. Information on new enrollments and dismissals during the month are also provided. This report provides LHJs with three-years of caseload data through the end of the reporting month.

Personnel Cost Method: LHJs designate families as MIECHV at enrollment based on the designation of the home visitor they are assigned. Using this methodology, LHJs designate all families as MIECHV that are served by home visitors for whom at least 25 percent of their personnel costs (salary/wages including benefits) are paid for with MIECHV funding.

Enrollment Slot Method: LHJs designate families as SGF families based on the slot to which they are assigned at enrollment. Using this methodology, LHJs identify certain slots as SGF-funded and assign families to these slots at enrollment.

Maximum Service Capacity: The highest number of households that could potentially be enrolled at the end of the monthly reporting period if the program were operating with a full complement of hired and trained home visitors. Note: The maximum service capacity is equivalent to the caseload of family slots approved by HRSA

- FIGURE 1. PROCESS FOR DEFINING CHVP FUNDED FAMILIES



[1]*Home Visitor Personnel Cost Method:* Recipients designate families as MIECHV at enrollment based on the designation of the home visitor they are assigned. Using this methodology, recipients designate all families as MIECHV that are served by home visitors for whom at least 25 percent of their personnel costs (salary/wages including benefits) are paid for with MIECHV funding.
[2]*Enrollment Slot Method:* Families are designated as SGF families based on the slot they are assigned to at enrollment. Using this methodology, recipients identify certain slots as SGF-funded and assign families to these slots at enrollment in accordance with the terms of the contractual agreement between CHVP and the LIA regardless of the percentage of the slot funded by SGF.