2019 PROGRAM SPECIFICATION
Central Racine County Health Department

STANDARD PROGRAM: Family Connect Racine County Home Visitation Program

PROGRAM #: 511
TARGET POP: Youth and Family

YEAR: 2019 | UNITS: Actuals | CLIENTS: N/A | ALLOCATION: TBD

UNIT DEFINITION: Actual Expenses

GEOGRAPHICAL AREA TO BE SERVED: Racine County

DAYS/HRS OF SERVICE AVAILABILITY: Monday through Friday 8 AM to 4:30 PM

MINIMUM STANDARDS:

Provider must agree to comply with the following terms and conditions:

- Standard contract language
- Certification standards where applicable
- Fiscal and program reporting criteria
- Allowable Cost Policy
- Audit criteria
- Policies and procedures as defined in Racine County Human Services Department Contract Administration Manual
- Maintain adequate liability coverage
- Recognize that authorization for services is approved by Racine County Human Services Department.
- All informational materials (program descriptions, brochures, posters, etc.) must identify it as a RCHSD program through the use of a standardized RCHSD format provided by Racine County.
- The program must be identified as a RCHSD program in all public presentations and media contacts/interviews.

PROGRAM DESCRIPTION:

Family Connects Racine County

Family Connects is a nurse-based, short-term, evidence based home visiting model that works to support new parents caring for their newborn, offer physical assessments, address questions regarding newborn care, discuss parental concerns and assist with accessing community services and resources. Central Racine County Health Department (CRCHD), in partnership with Racine County Human Services (RCHSD) and United Way of Racine County (UWRC), will work to implement the Family Connects model as a pilot in Racine County. The program will be named Family Connects Racine County (FCRC). FCRC is complementary to other early childhood programming in Racine and adds to the continuum of home visiting services currently provided through the Racine County Home Visiting Network (RCHVN).

RCHVN collaborators include:

- Racine County Human Services Department
- United Way of Racine County
- Ascension-All Saints
- University of Wisconsin-Milwaukee Helen Bader School of Social Welfare

The addition of short-term home visiting services in Racine County is important as evidence has shown that all families with new babies need some form of support. Research conducted of the original Family Connects (known as Durham Connects at that time) demonstrated that 94% of families assessed had at least one need for specific education, recommendations or community service referrals. However, the majority of those families did not require long-term services. A recent retention analysis found that families participating in RCHVN long term home visiting services had average 6, 12, 24 and 36 month retention rates of 77%, 42%, 15% and 9% respectively. Many of these families terminated services early because they met their goals and/or felt that services were no longer needed. This trend was also observed in recent statewide Family Foundations Home Visiting data analysis. These data should not be interpreted to mean that long-term services are not beneficial nor desired. On the contrary, this suggests that the benefits of home visiting may have occurred early on in the process and only some of the families enrolled needed the longer term intervention. FCRC solves this problem by providing beneficial home visiting services to more families over a shorter duration of time while providing referrals for long-term home visiting services and other community resources for families who demonstrate need. This may work to improve retention rates in the long-term home visiting programs by ensuring that families with the highest need are being served. Finally, increasing the number of families being assessed through FCRC will result in the identification of family needs that would not have otherwise been identified, because they would not have qualified for other home visiting programs that target participants based on key demographics or other risk factors.

The success of the Family Connects model hinges on the premise that it is offered to all parents of newborns in a catchment area and is universal in nature. In addition, the program works best in communities where there are an abundance of community resources and ideally, a long term home visiting program. Racine County is fertile ground for this model to be implemented successfully, namely by having these necessary prerequisites in place, in large part through the work of RCHVN and partner agencies. In this way, FCRC acts as a systematic triage system that ensures families with newborns are provided with referrals tailored to their specific needs resulting in more efficient use of all community assets and resources. Finally, families who require ongoing home visiting services will be referred to the existing long-term home visiting programs based on assessment and need. As a result, the dollars invested in those services will be utilized more efficiently by serving the families with the highest need.

The long term vision for FCRC is that the program will be community-based with community ownership and ultimately seen as a standard of care for newborns/parents. As a result, more families will be connected to appropriate resources and ultimately have more opportunity for stronger families and better overall health and well-being. Finally, there is mounting evidence of the effectiveness of two-generation programs, such as this one, in preventing the deleterious effects of adverse childhood experiences (ACEs). Families in Racine County have higher levels of early childhood adversity than in other parts of Wisconsin. As a result, the intergenerational effects of ACEs are passed on from caregivers to their children which ultimately work to weaken family structures and results in decreased family health and well-being. These outcomes undermine efforts currently underway to improve educational attainment and build an educated workforce in Racine County. FCRC believes this cycle can be interrupted through programming that works to reduce this transmission by connecting families to the resources and education they need to provide an environment that allows for their children and families to thrive.

PROGRAM ELEMENTS:
The Family Connects model is “manualized” and has pre-developed: policies and procedures; standardized assessments; documentation forms; database; and quality assurance protocols. In addition, all families are assessed with the Family Support Matrix which evaluates family supports in 12 domains across four categories:

1. Healthcare
   - Maternal Health
   - Infant Health
   - Health Care Plans
2. Caring for infant
   - Child Care Plans
   - Parent-Child Relationship
   - Management of Infant Crying
3. Home safety
   - Household safety/material supports
   - Family and Community Safety
   - History with Parenting Difficulties
4. Parent support
   - Parent Well-Being
   - Substance Abuse
   - Parental Emotional Support

In addition to the Family Support Matrix, the home visit consists of additional assessments, education, anticipatory guidance and referrals. For example, the protocol includes screening for postpartum depression using the Edinburg Postpartum Depression Screening (EPDS); substance abuse using the CAGE; and personal safety and domestic violence using the Conflict Tactics Questionnaire.

PROGRAM ACTIVITIES:
The funding allocated in this specification will be used to support Public Health Nurse Home Visitors, a Supervisor, Clerical Support, a Data Specialist/Support, and required management oversight as well as external evaluators to ensure that FCRC provides direct services according to the model and becomes nationally accredited. The provider will engage in ongoing service implementation; work with local providers to ensure an adequate resource network is in place; adapt program policy and procedures to meet local needs; finalize and implement an evaluation plan with academic partners; and, send staff to ongoing training.

The Public Health Nurse Home Visitors will provide skilled public health nursing services under the direction of the Health Officer or designee. Consistent with the Family Connects model, nurses will be sought for the project who have the unique personal characteristics and experience required to conduct in home services, including: a) a strong desire and experience to work in a team environment and support families in the community; b) an ability to communicate effectively with others; c) previous experience in maternal/child health and home visiting; d) an appreciation for cultural differences in parenting; e) an ability to work collaboratively with a broad array of public and private providers to ensure that families have access to the services they need to ensure child safety, health and family well-being; and f) appreciation of the need for responsiveness and accountability.

JOB SUMMARY:
The Public Health Nurse Home Visiting positions provide public health nursing home visiting services and participate in public health programs that promote and maintain the health of individuals, families, groups and the community. These nurses provide public health nursing home visitation programs and services to promote health and prevent adverse birth and childhood outcomes. These staff will attend Family Connects training; follow the Family Connects home-visiting protocol; keep records of client observations and activities; document information for family assessments; establish a trusting relationship with families during home visits; engage the family to establish a family support plan with goals, objectives and activities that address family strengths and needs; utilize the Family Support Matrix to assess family needs in 12 domains of physical and psychosocial well-being; provide health and physical assessments of mother and baby in the home to determine well-being; facilitate referrals and connections to community agencies to support families; address questions about caring for the newborn(s); identify parents’ needs; identify community services or resources to meet those needs; apply working knowledge of parent-child interaction, child-maternal health, child development and child abuse/neglect to help families improve parenting skills; apply effective time-management and organizational skills; perform data collection and entry into the Family Connects database.

The nurses will meet regularly as a team to share information about the program, discuss challenges, share information on resources and conduct group case consultation as needed. Meetings will also provide opportunities to ensure the Family Connects model is being implemented with fidelity and troubleshoot any problems as they arise. Finally, the nurses along with the Family Connects project staff and other key stakeholders will identify gaps in critical community-wide resources with the goal of working toward increasing needed services locally.

SUPERVISION RECEIVED:

The Public Health Nurse Home Visitors will work under the direction of the Health Officer or designee. Close supervision is given at the beginning of work involving an extensive orientation program and a detailed evaluation of overall nursing performance. Once an employee demonstrates proficiency, s/he is expected to perform normal work assignments in accordance with established work procedures and departmental policies with a minimum amount of supervision and is expected to maintain a flexible work schedule. Supervisors will be available for staff consultation during hours of operation and when Supervisors are away from the office on vacation or training, back up supervision will be assigned.

EVALUATION OUTCOMES:

1. Provider will engage the Family Connects model developers for site certification (accreditation).
2. Provider will pay all required fees for model implantation.
3. Provider will engage in all planning activities as described by the Family Connects model.
4. Provider will implement the necessary policies and procedures required by the Family Connects model.
5. Provider will engage academic partners to finalize and implement an evaluation plan.
6. All project staff will receive the required Family Connects training
7. Provider will serve families according to the Family Connects model.
8. Provider will provide year-end standard Family Connects reports.

REPORTING REQUIREMENTS:

Client demographics must be tracked using the database provided by RCHSD. Demographics to be tracked include race, ethnicity, gender, age, the referral, start and end dates, census tracking, zip code and the marital status of the head of household as well as SACWIS individual and family identifiers. This report should also include the total served in the program to date.

Quarterly Evaluation Outcome and Demographic Reports reflecting the aforementioned criteria must be provided no later than 4/15/19, 7/15/19 and 10/15/19 to Racine County HSD Contract Compliance Monitor.

Annual Evaluation Outcome and Demographic Reports must be submitted to Racine County HSD Contract Compliance Monitor by 2/1/20.