CRITICAL COMPONENTS

CRITICAL COMPONENTS OF THE FAMILY CONNECTS HOME VISITING PROGRAM

The Family Connects approach has a number of program components, some of which are critical for communities that wish to replicate the model. The key components are listed and described below as those essential for implementation to be distinguished from those activities that may be selected as auxiliary to the program. These "critical components" are necessary for replicating the model as an evidence-based program derived from the evaluation studies of the Family Connects model in Durham, North Carolina. Other program components may be included in dissemination locations as important options, auxiliary resources, or those that address specific local needs. All of the components listed below, critical and auxiliary, are active in the current Durham Connects program in Durham, North Carolina.

CRITICAL COMPONENTS FOR THE FAMILY CONNECTS MODEL ARE:

The Connects program is community-based with a sense of ownership and commitment to the program from community members and other stakeholders, and it is seen as part of the continuum of care for newborns and their parents in the community.

- The program is designed for **universal community coverage;** all families with newborns in a catchment area are eligible, whether region, state, city, or neighborhood.
- **Registered nurses** are the Family Connects home visitors, providing health and psychosocial assessments of newborn, mother, and family.
- The Integrated Home Visit includes a **systematic assessment** (Family Support Matrix) of family strengths, risks, and needs.
- **Supportive guidance** is spelled out in the protocol and provided by home visitors at all visits (e.g., back to sleep, the benefits of tummy time).
- Nurse visitors are trained to provide **systematic education** in response to parent queries and nurse observation in areas of possible difficulties in adapting to the newborn (e.g., breastfeeding, support for "baby blues," and others).
- The family and nurse plan together for **individualized "connection"** with community resources and services. (Rather than simply providing referrals, the nurse actively connects and links the family with the services.)
- As indicated clinically, the initial home visit can have one or more **follow up visits**/telephone calls to complete the assessments and to ensure linkage to local services and resources. The goal of follow up is to support the community resource linkage but not to become "case management." Follow up visits also allow for additional assessment of family risk, and more direct intervention, such as weighing the infant having feeding difficulties, continuing to assess postpartum depression, and so forth.
- A direct link between Family Connects and the local **Department of Social Services** is essential to facilitate the family's ease of access to and knowledge about eligible benefits, such as Medicaid eligibility, SNAP benefits (food stamps), and others.
- Systematic **quality assurance** is critical and includes: protocol adherence, accurate assessment of family risks and needs, inter-rater reliability in rating the Family Support Matrix, and consumer satisfaction.
- The clinical team has regularly scheduled individual supervision and/or team meetings for **supervision and peer collaboration.**
- **Documentation** for the medical record of the home visit(s) and contacts with families and community referrals is essential.

OPTIONAL OR AUXILIARY COMPONENTS RECOMMENDED AND MAY INCLUDE:

- Scheduling the initial home visit at the birth hospital is the first choice method in order to accomplish universal service delivery.

with few formal resources, identifying informal resources by examining local standards of care through interviews of clients and stakeholders may be helpful. Referrals to these resources should be documented with outcomes reported back to agencies to strengthen community systems.

- A Community Advisory Board (CAB) that includes consumers and community resources/stakeholders is strongly advised.
- Electronic documentation of 1) program penetration of the targeted community and 2) child and family outcomes, when feasible, will assist with marketing the program, creating a locally sustainable model, and fundraising.
- Family Connects programs seek to identify gaps in needed community services for families, to document them, and to work to address these gaps.

FAMILY CONNECTS

NURSE HOME VISITS

INTRODUCTION TO THE MODEL
CONSIDERATIONS FOR DISSEMINATION

Thank you for your interest in the Family Connects nurse home visiting program. We provide here a brief description of the program background and implementation.

Please review with your community collaborators; and if there is interest and funding available for implementing the program as well as training and certification as Family Connects, please contact us. We will discuss together what is needed in your community to address your local goals, funding, and timeline.

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I. THE FAMILY *CONNECTS* PROGRAM

Introduction

Family *Connects* is a model for a community-based program to support new parents in caring for their newborn(s) with a nurse home visit early in the postpartum period. The nurse will provide physical assessments of the mother and the baby, address questions about caring for the newborn, discuss parents' needs at this happy and vulnerable time, and help them access community services or resources that match their needs. Family *Connects* also works to identify family resources that are critical but not available in the community, with the goal of working toward increasing needed services locally.

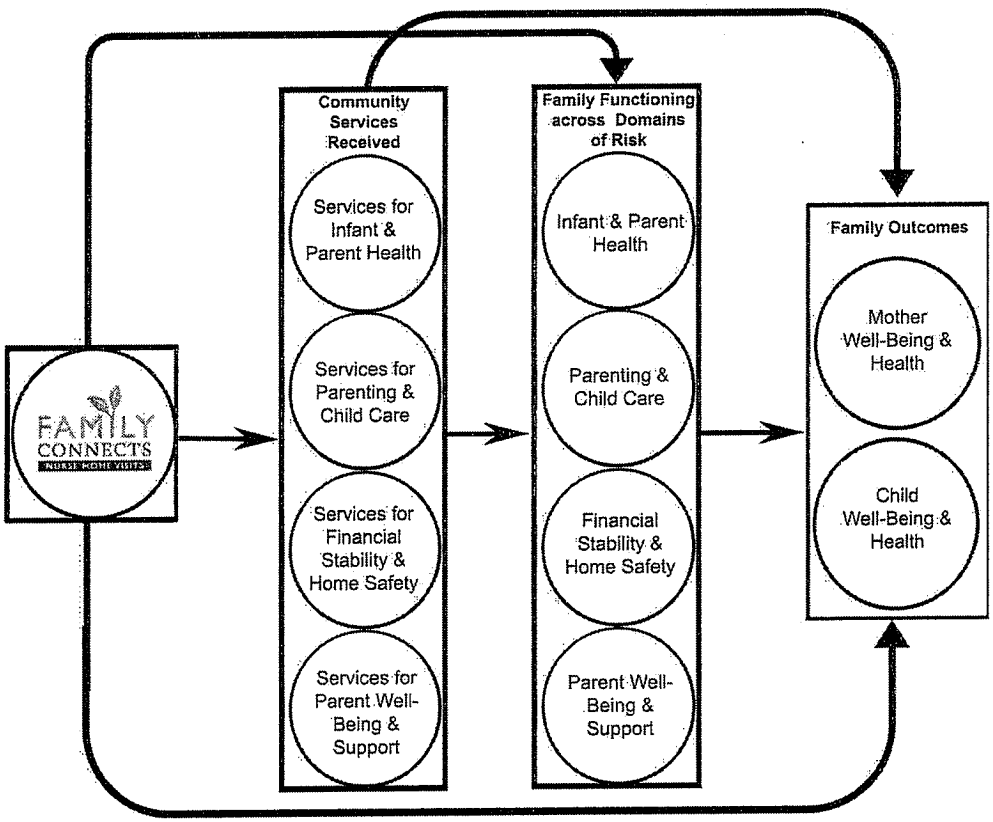
The aim of the Family *Connects* home visit is to engage with the family and, with the family, to celebrate the arrival of the newborn. We acknowledge that caring for a newborn can be a joyful but also challenging job involving parents losing sleep, having unanswered questions about their own health or that of the baby, and needing support for their new role. We know that any community has services and resources that a parent may not know about or may not know how to contact. In these ways, we use the Family *Connects* program to connect to the family and to link family members to resources that support this period of new parenting.

Program Background and Logic Model

The Family *Connects* model was developed within the context of the Durham Family Initiative, funded by the Duke Endowment in 2002, with the primary goal of reducing community rates of child maltreatment (K. Dodge, Principle Investigator). The universal community-level approach involves a theory-driven and evidence-based assessment of child and family strengths and needs that is provided in an informal and family-friendly manner. The underlying assumption is that all families with newborns need support, and offering services to all families is the only way to improve health and wellbeing for an entire community. Family *Connects* also has a rigorous approach to the evaluation of program performance, fidelity to the home visit protocol, community penetration, and benefits for family recipients.

The logic model above depicts the Family *Connects* theory of change for infants and families. Nurse home visits and assessments provide supportive guidance, address specific needs by education about infant and postpartum maternal issues, and facilitate connections to individually matched community resources and services. Increased connections to the community, in turn, promote family functioning child and family wellbeing over time.

Figure 1. The Family *Connects* Logic Model



Family Assessment

The program is linked to a high inference assessment of family strengths, risks, and needs. The nurse visitor engages with the family in a friendly and supportive dialogue while assessing and rating 12 factors within four domains (see Figure 1). These factors are known to be associated with maternal and child health and wellbeing and, when identified, provide opportunities for prevention and intervention. The *Family Support Matrix* is the tool used to addresses family health needs, childcare and the parent-child relationship, household needs and safety, and parenting support. The home visitor rates

each of the 12 factors as: (1) no risk/needs at this time, supportive guidance provided; (2) needs and concerns addressed by education and demonstration during visit; (3) family issues best addressed by linkage with community resources; and (4) urgent need(s) requiring immediate intervention.
Each factor comes with a set of queries to use during the assessment, as needed, and supportive guidance to deliver for each domain/factor.

Figure 2. Domains and Factors in the Family Support Matrix Assessment

Support for Health Care

- Factor 1-Maternal Health
- Factor 2-Infant Health
- Factor 3-Health Care Plans

Support for Caring for the Infant

- Factor 4-Child Care Plans
- Factor 5-Parent and Child Relationship
- Factor 6-Management of Infant Crying

Support for a Safe Home

- Factor 7-Household Safety/Material Supports
- Factor 8-Family and Community Safety
- Factor 9-History with Parenting Difficulties

Support for Parents

- Factor 10-Maternal Wellbeing
- Factor 11-Substance Abuse
- Factor 12-Maternal Emotional Support

II. CRITICAL COMPONENTS OF THE FAMILY CONNECTS PROGRAM

The Family *Connects* approach has a number of program components, some of which are critical for communities that wish to replicate the model. The key components are listed and described below as those essential for implementation to be distinguished from those activities that may be selected as auxiliary to the program. These "critical components" are necessary for replicating the model as an evidence-based program derived from the evaluation studies of the Family *Connects* model in Durham, North Carolina. Other program components may be included in dissemination locations as important options, auxiliary resources, or those that address specific local needs. All of the components listed below, critical and auxiliary, are active in the current Durham *Connects* program in Durham, North Carolina.

Critical (essential) components for the Family *Connects* model with comments from the Durham, North Carolina experience are:

- The *Connects* program is community-based with a sense of ownership and commitment to the program from community members and other stakeholders, and it is seen as part of the continuum of care for newborns and their parents in the community.

Lessons Learned: Durham *Connects*
The original project in Durham was developed by Duke University's Center for Child and Family Policy, the Center for Child & Family Health, and the Durham County Department of Public Health in collaboration with community leaders: Durham's Department of Social Services, the Durham County Commissioners, and the Duke University Medical Center, Departments of Obstetrics and Pediatrics. These community leaders signed a memorandum of agreement to align community resources with identified birth-family needs. The program became a part of the local system of care in close liaison with birthing hospitals and pediatric primary care, and all families of Durham County resident newborns are entitled to the program.

- The program is designed for universal community coverage; all families with newborns in a catchment area are eligible, whether region, state, city, or neighborhood.

Lessons Learned: Universal Implementation
By providing funds for community implementation of evidence-based home visiting programs, the Patient Protection and Affordable Care Act of 2010 heightened the need for programs implemented at scale in community settings. Although evidence supports the positive impact of home visiting programs targeted to high-risk groups when these programs are implemented with small study samples, scaling up implementation of the same programs can result in declined participation and retention rates, decreased implementation fidelity, and demands for adequate

community resources that exceed community capacity.

Family *Connects* is a short-term, universal, and relatively inexpensive postnatal nurse home visiting program designed to provide a brief assessment of child and family health and wellbeing, intervention and education to all families through "supportive guidance" from home visiting nurses, and then, connections with community resources based on individualized assessments of family needs. This short-term universal program addresses many family needs that would not necessarily be identified by a program that targets demographic or situational risk factors only. All families need support at this time, but not all families need the two to three years of weekly services that are typical in many home visiting interventions. During the initial randomized controlled trial of the *Connects* program, 94% of families seen were assessed to have one or more needs for specific education, recommendations, or community services. All families benefit from the supportive guidance provided by Family *Connects* nurses.

- Registered nurses are the Family *Connects* home visitors, providing health and psychosocial assessments of newborn, mother, and family.

- The Integrated Home Visit includes a systematic assessment (*Family Support Matrix*) of family strengths, risks, and needs.

- Supportive guidance is spelled out in the protocol and provided by home visitors at all visits (e.g., back to sleep, the benefits of tummy time).

- Nurse visitors are trained to provide systematic education in response to parent queries and nurse observation in areas of possible difficulties in adapting to the newborn (e.g., breastfeeding, support for "baby blues," and others).

- The family and nurse plan together for individualized "connection" with community resources and services. (Rather than simply providing referrals, the nurse actively connects and links the family with the services.)

Lessons Learned: Community Services for Those Who Need Them
The Family *Connects* model does not replace more intensive two- and three-year home visiting programs for those families that need and choose them, such as Healthy Families America and Nurse Family Partnership. Rather, the short-term home visits serve as a universal screening and triage approach to ensure optimal matching and follow-through of families with other community services. In this way, families have access to what they need and to the programs and services to

which they agree. Only families with identified needs for more intense and more expensive programs receive them, resulting in cost efficient programming.

- As indicated clinically, the initial home visit can have one or more follow up visits/telephone calls to complete the assessments and to ensure linkage to local services and resources. The goal of follow up is to support the community resource linkage but not to become "case management." Follow up visits also allow for additional assessment of family risk, and more direct intervention, such as weighing the infant having feeding difficulties, continuing to assess postpartum depression, and so forth.

- A direct link between Family *Connects* and the local Department of Social Services is essential to facilitate the family's ease of access to and knowledge about eligible benefits, such as Medicaid eligibility, SNAP benefits (food stamps), and others.

- Systematic quality assurance is critical and includes: protocol adherence, accurate assessment of family risks and needs, inter-rater reliability in rating the *Family Support Matrix*, and consumer satisfaction.

- The clinical team has regularly scheduled individual supervision and/or team meetings for supervision and peer collaboration.

- Documentation for the medical record of the home visit(s) and contacts with families and community referrals is essential.

<u>Optional or auxiliary components recommended and may include:</u>

- Scheduling the initial home visit at the birth hospital is the first choice method in order to accomplish universal service delivery. Other options may have to be explored based on differences in hospitals and communities.

- Available community resources should be documented online or in an electronic database and updated regularly. In a community with few formal resources, identifying informal resources by examining local standards of care through interviews of clients and stakeholders may be helpful. Referrals to these resources should be documented with outcomes reported back to agencies to strengthen community systems.

- A Community Advisory Board (CAB) that includes consumers and community resources/stakeholders is strongly advised.

- Electronic documentation of 1) program penetration of the targeted community and 2) child and family outcomes, when feasible, will assist with marketing the program, creating a locally sustainable model, and fundraising.

Lessons Learned: Evaluation of Durham *Connects*
Durham *Connects* was piloted at the population level prior to evaluation by a randomized controlled trial (RCT) (1 July 2009 – 31 December 2010). Findings from the RCT are found in journal articles referenced in Appendix B. Any Family *Connects* program will develop its own approach to formative and summative evaluation, both of which are needed for ongoing and sustainable quality improvement. Using administrative and/or individually collected data about child and family outcomes may also assist in claiming funding for local program sustainability. For the 18 month trial, Dodge and colleagues (2013) reported a community participation rate of 69% for families of eligible newborns, and nurses maintained an average of 84% fidelity to the Durham *Connects* home visit protocol. By age 6 months, those eligible for the program had more family community connections, better positive parenting behavior, lower rates of maternal anxiety, higher quality home environments, and decreased emergency medical care for the infants, which resulted in estimated healthcare savings of $3.02 for every $1.00 in program costs. The evaluation of Durham *Connects* at infant age 12 and 24 months indicated continued cost avoidance for child emergency care (i.e., emergency department, urgent care, inpatient hospitalization).

- Family *Connects* programs seek to identify gaps in needed community services for families, to document them, and to work to address these gaps.

Summary of Program Goals

There are several goals, or connecting steps, involved in Family *Connects*; they are:

1) A nurse visitor, program support worker, or member of the hospital staff visits all new parents in the hospital after delivery to describe the program and to schedule an initial home visit with a Family *Connects* nurse. All residents in the program service area are eligible. Any community may explore alternate and combined methods for scheduling the home visit, including a website for self-referral, working with medical care practices, and advertising.

2) The nurse home visitor conducts the initial home visit, referred to here as the Integrated Home Visit. The visit is designed for the home visiting nurse to make a connection with the family, assess health and psychosocial wellbeing, respond to a

range of questions about postpartum and newborn care, and plan for connections in the community to provide support for the family.

3) One or two follow up home visits or telephone contacts for families are scheduled, as needed, to provide further education, assessment, and/or to help secure family connections to community resources and supports identified during the initial visit.

4) Nurse visitors make appropriate contacts as needed to link the family to community organizations. At times, the work involves researching what is available in the community for a specific family need.

5) A follow up telephone call (the Post-Visit Connection; PVC) is completed one month after the nurse closes the case. A program support worker discusses the visit with the parent and evaluates the success of referrals to community services as well as consumer satisfaction.

III. THE ROLE OF FIDELITY AND QUALITY ASSURANCE

Family *Connects* aims to be a universal home visiting program for all newborns in a designated geographic area and to be disseminated to other cities and other states. In order to continue to show implementation success and outcomes effectiveness, it is important that all clinical providers participate in monthly or quarterly assessments of adherence to the home visit protocol and the testing inter-rater reliability on rating on the *Family Support Matrix.*

Fidelity to the protocol is assessed by dyadic visits during which a supervisor (or peer) participates by checking off critical items required for the IHV (using a Fidelity Checklist). The goal is at least 75% adherence to the visit protocol, which provides information about the extent to which the visit reflects the exiting evidence base and also provides a forum for supervision and education in conducting the visit. We have learned that peer feedback and recommendations are very helpful in creating a culture of openness and competency. After the visit, both visitors complete the *Family Support Matrix,* and inter-rater agreement is calculated. As a part of quality assurance, there are quarterly audits of important protocol items, for example, information required for Medicaid billing.

IV. DISSEMINATION AND REPLICATION OF THE EVIDENCE-BASED MODEL

Family *Connects* dissemination follows the training models in use at the Center for Child & Family Heath in Durham, North Carolina, including Learning Communities, Learning Collaboratives, and/or a cascading model of implementation of the evidence-based protocol.

Recipients may choose a range of input from the Durham-based team, depending on community readiness and needs. Although the specifics of model dissemination will be individually negotiated depending on what the new site already has and what is needed, all critical components of the *Connects* model must be incorporated into the new site in order to be considered a *Connects* (evidence-based) program. Additionally, in securing funding for *Connects* program implementation, consideration should be given both to costs associated with the initial training and consultation required to replicate the model (variable depending on the site), as well as the per family cost to implement the program for the catchment area (approximately $500-$700 per birth for all program staff and services).

V. REFERENCES FOR THE FAMILY *CONNECTS* EVALUATION

Dodge, K.A., Goodman, W.B., Murphy, R.A., O'Donnell, K., Sato, J., & Guptill, S. (2013). Implementation and randomized controlled trial evaluation of universal postnatal nurse home visiting. *American Journal of Public Health*. Available online at: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301361

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Alonso-Marsden, S., Dodge, K.A., O'Donnell, K.J., Murphy, R.A., Sato, J.M., & Christopoulos, C. (2013). Family risk as a predictor of initial engagement and follow-through in a universal nurse home visiting program to prevent child maltreatment. Child Abuse & Neglect, 37, 555-565