FAMILY CONNECTS
NURSE HOME VISITS

Key Responsibilities of the Family Connects Organizational Home

Implementation of the Family Connects model requires creation and maintenance of an organizational structure that allows for full implementation of the core model components (*see page 3*). In order to accomplish these components, the selected organizational home must be able to perform specific activities / tasks including:

General Program Management

[Executive leadership, Human Resources Leadership, and Communications Staff]

- Leadership personnel management
- Oversight of all program operations & communication with the Family Connects national service office
- Communications management (website, marketing materials, etc.)

Personnel Management

[Executive / Program Leadership and Clinical Director]

- Manage clinical personnel (hiring, initial training/onboarding, professional development, etc.)
- Manage administrative ands support personnel (hiring, initial training/onboarding, professional development, etc.)
- Provide clinical supervision (group and individual)
- Perform quarterly quality assurance tasks per the Family Connects model requirements

Clinical & Support Services

[Clinical Director, Nurse Home Visitors, and Program Support Workers]

- Create and maintain core program material library (parent handouts, client incentives, etc.)
- Respond to client / parent inquiries for services (via email, web, and phone).
- Recruit program participants (in-person and via phone/web)
- Schedule integrated home visits according to program policy and procedure (as directed by Program Co-Directors and Director of Clinical Services)
- Provide integrated home visits according to standardized visit protocol, assessment of risk, and connection to community resources for identified needs
- Document clinical services provided (to be completed within 48 working hours of the home visit encounter)
- Document client connection to community resources via post visit calls or other client survey methods

Community Advisory Process / Stakeholder Engagement

[Community Resource Specialist]

- Inform the management of external communications (website, marketing materials, etc.).
- Create and maintain relationships with community resources / services
- Provide individual-case consultation regarding community resources to clinical personnel
- Market the program locally to referral sources, employers, newspapers, churches, childcare agencies, the public, etc.
- Create and maintain a local resource directory (Agency Finder) for use with clients by clinical and support staff
- Oversee the community advisory process for the Family Connects program

Data Validation & Reporting

[IT Management and FC Database Manager]

- Maintain Family Connects database
- Provide technical assistance for end users
- Generate weekly clinical activities report (standardized)
- Generate monthly community activities report (standardized)
- Provide data validation for all internal program reporting
- Provide data analysis for ad hoc reporting requests

Financial Management

[Financial Director, Executive Leadership, and Clinical Director]

- Manage funding streams through oversight of grants and contracts
- Report key financial performance indicators
- Provide financial documentation for reports as needed

Core Components of the Family Connects Model

THE COMMUNITY-WIDE APPROACH

The Family Connects program is community-based with community ownership, 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 neighborhoods.

In order to model the evidence-based Family Connects program, a community penetration of at least 60 to 70 percent of the *a priori* identified population is essential for the community level outcomes as demonstrated in the two program randomized controlled trials and for which the program is approved for MIECHV funding.

COMMUNITY ALIGNMENT FOR FAMILY CONNECTS IMPLEMENTATION

A Community Advisory Board (CAB) that includes consumers and community resources/stakeholders is required to align resources relevant to families with newborns. The CAB may be a part of an existing group for community services' coordination or developed specifically for the Family Connects local program.

Available community resources are compiled in a web based format and / or printed directory (the Agency Finder) and updated regularly. Regular review should include identifying gaps in community services as well as identifying new formal and informal community services that address family needs.

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 services, such and Medicaid and SNAP benefits (food stamps).

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

THE MODEL FOR NURSE HOME VISITS

The initial Family Connects home visit is scheduled as close to birth as possible. Scheduling at the birth hospital is one method used to accomplish universal service delivery. Other options may be explored for local differences in hospitals and communities.

The initial home visit (referred to as the Integrated home visit; IHV) occurs at approximately 3 weeks after birth/after the infant comes home to the family. The IHV generally requires 1 ½ to 2 hours and may be followed by 1 to 2 follow-up visits

Family Connects home visitors are Registered Nurses, providing health and psychosocial assessments of newborn, mother, and family.

The collaboration of a pediatrician or family medicine physician is needed for input and verification of the infant assessment and to be available for nurse questions about infants' and families' health needs.

Nurse visitors are trained in the family friendly high inference approach for assessing family needs and risk factors in 12 factors that reflect child and family health, caring for the infant, household safety and stability, and parental well-being. Rating and responding accordingly to family needs is documented by the *Family Support Matrix*, the home visit tool developed by Family Connects.

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

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

Family and nurse plan together for individualized connections to and recommendations for community resources and services.

As indicated clinically, the initial home visit can have one or more follow up visits/telephone calls to complete the assessments, allow for more direct supportive guidance, and ensure linkages to local services and resources. The primary goal of follow up is to support the connections to community resources.

In addition to the clinical follow up, a brief contact by phone or mailed survey is made regarding client satisfaction and successful linkage to referrals at one month after the family's case is closed.

The clinical team has weekly team meetings (case conference) for peer review of families seen during the preceding week.

Systematic quality assurance includes: protocol adherence, accurate assessment of family risks and needs, inter-rater reliability in rating the *Family Support Matrix* at a high >75% adherence and reliability level >.60 Kappa Cohen statistic.

Documentation of the home visit(s) and contacts with families and community services related to family needs in an electronic medical record is essential.

IMPLEMENTATION MONITORING AND DATA SHARE

The dissemination of the Family Connects model requires training and monitoring by the Family Connects International Office in Durham, North Carolina. The initial training and start up is spelled out by the office prior to the training contract and usually requires 12 to 18 months, after which yearly on and off site monitoring is used to verify continued implementation of model requirements.

Family Connects sites will document program implementation using the Family Connects International office JAVA-4 database, used for the site's formative evaluation as well as verification of implementation of the model by the central office.
A business agreement (BAA) is required to support quarterly share of (non-identified) data with the Durham office

AUXILLIARY/OPTIONAL COMPONENTS

In a community with few formal resources, identifying informal resources by examining local standards of care through interviews of clients and stakeholders is helpful for a complete list of available resources.

Some programs have elected to add a brief "pre-IHV visit" in the first week after hospital discharge to assist in specific issues such as feeding support or weight check. The early visit does not replace the 3-week *Family Support Matrix* assessment, and it is an optional addition for individual sites.

Funders may require and a program may elect individual supervision of the clinical staff guided by the tenets of reflective supervision.

Core competencies (including continuing education) are developed by the Family Connects International Office to guide local sites to provide ongoing education in relevant clinical areas.