

**Initial Report on the  
Empowering Families of Milwaukee  
Home Visiting Program**

July 2005 — December 2006

Wisconsin Department of Health and Family Services  
Office of Policy Initiatives and Budget  
and  
Division of Public Health

August 2007

## **Initial Report on the Empowering Families of Milwaukee Home Visiting Program**

Empowering Families of Milwaukee (EFM) is a comprehensive community-based home visiting program operated by the City of Milwaukee Health Department. The program is funded for five years by the Wisconsin Department of Health and Family Services (DHFS). The City of Milwaukee Health Department was selected to implement the home visiting program through a competitive Request for Proposal process in July of 2005. Aurora Family Services was selected as a partner agency for the initial 18-month contract period based on its experience in providing home visiting services. This report provides an overview of program planning and initial implementation in the first 18 months of the program (July 2005 through December 2006).

Initiating a comprehensive home visiting program in Milwaukee is one of several approaches focused on eliminating racial and ethnic disparities in birth outcomes in the DHFS Healthy Birth Outcomes Initiative: Eliminating Racial and Ethnic Disparities.<sup>1</sup> Goals of EFM are to:

- Improve birth outcomes;
- Enhance family functioning;
- Support child health, safety and development; and
- Prevent child abuse and neglect.

Program strategies to achieve these goals include:

- Providing evidence-based home visiting services that are family-centered, family strength-based,

community-based and culturally competent.

- Outreach to identify women early in pregnancy and at the time of the infant's birth.
- Case management services to promote access to health and social service supports.
- Providing core services, including services such as nutrition education, breastfeeding support, education on safe sleep practices, support to access infant health exams and immunizations and referral and follow-up services for families as needed.

### **Target Population**

Pregnant women and women with infants up to two months old who reside in a six zip-code area in Milwaukee's central city are eligible to enroll in the EFM home visiting program if they are at risk for poor birth outcomes. The six zip-code area targeted by the program (53204, 53205, 53206, 53208, 53212 and 53233) has a high incidence of poverty, infant mortality, low birth weight, late entry into prenatal care, teen pregnancy, sexually transmitted diseases, lead poisoning, and child welfare reports.

### **Services**

Comprehensive home visiting services are provided by a three-member team that includes a public health nurse from the City of Milwaukee Health Department and social workers and community health workers from community-based agencies. Families receive services based on their level of need, and the program seeks to develop long-term relationships with clients. Services can be provided until the child is five years old, and families can continue to receive program services if they move from the targeted zip-code area to another area in the City of Milwaukee. Over the course of the five-year program, it is

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<sup>1</sup> The Department's Healthy Birth Outcomes Initiative is part of the Governor's Kids First Agenda which is designed to ensure that Wisconsin children are prepared for school and ready to succeed; safe; supported by strong, successful families; and healthy.

expected that approximately 700 families will have received services through EFM.

**Funding**

Federal temporary assistance for needy families (TANF) funds were used to fund the program for an initial 18-month period and will be provided for four subsequent 12-month periods.

Grant Period	Funding
<i>Initial 18-Month Project Period</i>	
July 1, 2005 through December 31, 2006	\$1,218,128
<i>Subsequent Four 12-Month Project Periods</i>	
CY 2007	\$812,085
CY 2008	\$812,085
CY 2009	\$812,085
CY 2010	\$812,085
<i>Total</i>	\$4,466,468

To help enrolled families achieve the outcomes specified in their care plans, at least \$150 of “flexible funds” must be provided each year for each family enrolled in the program.<sup>2</sup> As the contract agency, the City of Milwaukee Health Department is required to match all dollars designated as flexible funds at a rate of 50 percent. Two families received services through flexible funds in the initial months of the program.

Medicaid reimbursement is also available to support Medicaid prenatal care coordination (PNCC) or child care coordination (CCC) benefit services to families who are eligible for these services.<sup>3</sup> The EFM home visiting

<sup>2</sup> Flexible funds assist families to obtain goods or services that are needed immediately for family safety and functioning for which there is no other source of payment. They may also be used as incentives to enable key celebrations of family achievements such as a parent’s graduation from high school/GED program or securing a job.

<sup>3</sup> The Medicaid prenatal care coordination benefit provides medical, social, educational and other services to women at risk of adverse pregnancy outcomes. Services can be provided during pregnancy through the first 60 days

program billed Medicaid for PNCC or CCC services provided to approximately 60 percent of the clients served in the initial period of program operation.

**Program Partners**

A key strategy of the EFM home visiting program, and of the state’s Healthy Birth Outcomes Initiative, is partnering with community-based organizations.<sup>4</sup> Much of the activity during the initial 18 months of the program involved working with community partners to plan and implement the program.

**Program Partners Involved in Program Planning**

Key community partners involved in planning the EFM home visiting program included Aurora Family Services, the University of Wisconsin-Extension Office in Milwaukee County, and the Black Health Coalition. A coalition of public and private sector stakeholders was also created to assure a seamless system of care and to assure long-term sustainability of services to at-risk families.

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following delivery. The Medicaid child care coordination benefit provides services to assist the recipient and, when appropriate, the recipient’s family gain access to and coordinate medical, social, educational, vocational, and other services. Child care coordination benefit services are available to Medicaid recipients in Milwaukee County who receive an initial risk assessment within eight weeks following the birth of a child, or received Medicaid prenatal care coordination services if they receive the initial risk assessment within six months following delivery. Child care coordination services may be offered until the child’s seventh birthday.

<sup>4</sup> One of the goals of the Community and Evidence-Based Practices component of the state’s Healthy Birth Outcomes Initiative is to partner with trusted community-based organizations that serve disparately affected populations to develop, implement, and/or expand evidence-based and community-endorsed programs.

Contract agencies providing program development and administrative services included:

- Aurora Family Services which served as a partner in program start-up and implementation with the City of Milwaukee Health Department.
- The Parenting Network which developed program policies and procedures for the program. An initial policies and procedures manual prepared by the Parenting Network was published in September of 2006.<sup>5</sup>
- The Black Health Coalition which supported development and maintenance of the community coalition.
- Career Youth Development which provided workshops on violence awareness, cultural competence and AODA awareness and resources; targeted outreach; and participated in coalition meetings.
- The University of Wisconsin-Madison Department of Information and Technology which provided services to support data collection for program evaluation using DHFS' Secure Public Health Electronic Records Environment (SPHERE) public health information system.
- The University of Wisconsin – Madison Center for Cultural Diversity in Health Care which developed a process evaluation plan issued in December 2006. The UW process evaluation plan provides an evaluation framework;

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<sup>5</sup> Empowering Families of Milwaukee Program Policies & Procedures Manual, City of Milwaukee Health Department, September 2006.

recommendations for quality improvement, report, and data management; and a timeline for implementing the process evaluation.<sup>6</sup>

### **Program Partners Providing Services to Families in Program Development Period**

While the program design for EFM was being developed, the City of Milwaukee Health Department also contracted with community-based organizations for outreach and direct client services. This was done to provide services to the target population as soon as possible. Contract agencies included the Black Health Coalition, Career Youth Development, and Aurora Family Services. These agencies provided outreach, case management, or other supportive services to over 300 pregnant women, women with young children and teen parents.

The Black Health Coalition's Healthy Beginnings Program provided outreach and case management services to 30 pregnant women and women with children in the Milwaukee County Jail.

Career Youth Development provided outreach services and case management services, reaching 28 teen parents. Case management services focused on family support, education/employment skills, anger management, alcohol and other drug awareness and prevention, and civic engagement. The 28 teen parents received face-to-face visits and initial assessment services. They also received, or were referred to, services as needed based on their individual goals. Eight of the 28 teen

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<sup>6</sup> Staci T. Lowe, PhD, Gloria Johnson-Powell, MD, Wen-Jan Tuan, MS, and Abhik Bhattacharya, PhD, "Proposed Process Evaluation Plan Empowering Families of Milwaukee," December 29, 2006. University of Wisconsin-Madison, Center for the Study of Cultural Diversity in Healthcare (CDH), School of Medicine and Public Health.

parents were referred to and enrolled in EFM.

Aurora Family Services implemented a home visitation program, the New Parents Initiative, prior to the development of EFM. In Aurora's New Parents Initiative, parents assessed as high risk at the hospital after delivery are offered supportive home visits by a case manager. Case manager home visit services may be reimbursed through the Medicaid prenatal care coordination and child care coordination benefits. Almost all of the women served by the New Parents Initiative receive Medicaid-funded prenatal care coordination and/or child care coordination. Services include information on infant care, child development, linkage to needed services and monitoring of the parent's progress toward agreed-upon goals. Typically, families are served for less than a year.

During the development of EFM, the City of Milwaukee contracted with Aurora Family Services to provide services to families through Aurora's New Parents Initiative. Following is a summary of program activity through June 30, 2006.

#### *Enrollment and Program Services*

- In total, 278 women were served through June 30, 2006. This includes 123 women who received prenatal care coordination during their pregnancy and 155 women who received child care coordination services after delivery. The 123 women who received prenatal care coordination services received health education as a part of the prenatal care service. These women represented 83 percent of the 149 pregnant women enrolled in the New Parents Initiative. The 155 women receiving child care coordination services represented 50 percent of the 309 women with children who were enrolled. Women who were enrolled that did not

receive these services dropped out of the program for a variety of reasons.

- Twenty-three women, representing 15 percent of the 149 pregnant women enrolled in the program, were enrolled in the first trimester of their pregnancy
- The 278 women who were served were referred to a number of health and social service supports in the community. In total there were 484 referrals to community resources, an average of 1.7 referrals per woman.
- Thirty-eight percent of the 278 women served were enrolled in WIC as a result of receiving services from the New Parents Initiative. Slightly over half of these women were enrolled in WIC when they enrolled in the New Parents Initiative; the other women were enrolled in WIC after they began to receive prenatal care coordination benefit services.

#### *Birth Outcomes*

- Not smoking during pregnancy was identified as a goal in the care plans of 11 of the 123 pregnant women who received prenatal care coordination services. These women self-reported smoking during pregnancy, and six of them quit smoking.
- Two of the 123 pregnant women who received prenatal care coordination services initiated breast-feeding.
- The 123 pregnant women who received prenatal care coordination services were followed by the program throughout their pregnancies. There were no fetal deaths reported for these women. There were 13 births at or less than 37 weeks gestation, 6 births at or less than 2500 grams, and no infant deaths.

## ***Program Planning Process***

The planning process for EFM began with an extensive review of literature on evidence-based program models, effective home visiting programs, and evaluations of other home visiting programs operated in the City of Milwaukee target area.

The City of Milwaukee Health Department also developed 13 community profile maps identifying infant mortality density and distributions of the six zip-code target area. This information was used to select subcontractors for home visiting program services, target outreach, and manage staff and caseloads. It is expected that the mapping information will also be useful if the program reaches maximum capacity and needs to refer families to alternative programs/services.

EFM does not attempt to replicate a single home visiting model; it incorporates strategies and protocols from a number of key sources.

Reliance on Healthy Families America's "12 Critical Elements of Effective Home Visiting Programs," which represent research-based, field-tested qualities of effective home visitation, is an especially important aspect of the program:<sup>7</sup>

*"The success of EFM's home visitation model is contingent on: providing services at an adequate dosage and intensity; providing frequent and effective supervision to staff; and utilizing parenting and developmental resources with families. Historically, Milwaukee's home visitation programs have focused on case management services absent of these components. EFM will work with stakeholders to support staff actualizing the 12 critical elements with families."*

(City of Milwaukee Report on Contract Objective Attainment)

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<sup>7</sup> A copy of the 12 Critical Elements is in Appendix B.

All EFM home visitors are certified Parents as Teachers parent educators. This certification was supported by a two-year grant which the City of Milwaukee Health Department received from the Children's Trust Fund. This grant enabled the City of Milwaukee to implement the Parents as Teachers' model home visiting program and adopt the Parents as Teachers' "Born to Learn, Prenatal to 3 Years" curriculum.

To supplement the Parents as Teachers curriculum, EFM also requires home visitors to receive basic training on Prevent Child Abuse America/ Healthy Families America's prenatal training program, "Great Beginning, Start Before Birth." All EFM staff will be trained in Great Beginnings in July 2007.

In addition, EFM adopted the City of Milwaukee Health Department's "Nursing Standards of Practice." Client-focused practice standards are described for preconception through post partum care, for the care of high-risk infants, for children experiencing child abuse or neglect, and pre-school children.

Because EFM is intended to be integrated with the Wisconsin Medicaid prenatal care coordination and child care coordination benefits, it also incorporates the policies and procedures required by these Wisconsin Medicaid benefits.

## ***Initial Program Implementation***

The City of Milwaukee Health Department opened its central intake and referral system for EFM in September of 2006, three months before the initial 18-month project period ended. Following is a description of EFM and its initial implementation.

### **Selection of Program Partners to Provide Outreach and Home Visiting Services**

The City of Milwaukee Health Department is the lead agency for the public health

nursing component of EFM’s multi-disciplinary team. Through an RFP process in August of 2006, the City of Milwaukee Health Department selected community-based partners to provide program outreach and home visitation social work and community education services. Community agencies selected through this RFP process and their roles are shown in the following table.

**EFM Partner Community Agencies**

<b>Agency</b>	<b>Activity</b>
Black Health Coalition of Wisconsin	Outreach to pregnant women and women with infants in Milwaukee County Jail
Career Youth Development	Outreach to high risk teens
Children’s Service Society of Wisconsin	Case management and home visiting services provided by social workers and community health workers.
La Causa	
St. Vincent de Paul Society of Milwaukee	
The Parenting Network	
Aurora Family Service	

To ensure consistent application of the program across the various sites, the program uses centralized intake and Medicaid billing processes, and all subcontractors are required to employ the same policies and procedures. Monthly administrative and all staff meetings are held to provide a forum for communication and sharing of ideas among City of Milwaukee Health Department and community-based organization/agency staff.

**Program Staff**

EFM Program staff includes seven nursing staff positions in the City of Milwaukee Health Department as well as the equivalent of nine full-time social workers and community health workers from contract

agencies. Community health workers are required to have a high school diploma or GED; social workers and public health nurses are required to have Bachelor’s Degrees in social work or human services and nursing, respectively. Supervisors are required to have a Bachelor’s Degree and experience in human services or related fields. By the end of the initial contract period, staffing for the program was complete for all but one of the community-based contract agencies which was recruiting a part-time social worker.

Cultural, ethnic, racial, and linguistic characteristics are considered when matching parents to service providers. If necessary, skilled translators and materials are provided in the participant’s native language whenever possible.

Supervision is provided through individual weekly meetings for each full-time staff for a minimum of 1.5 to 2.0 hours. Supervision is also available for staff who must work evenings or weekends, by pagers or telephone for emergency consultation. The six program supervisors shadow home visits, review program documentation, provide guidance on use of curricula, and review caseloads.

**Outreach**

Implementing an effective outreach and referral system is critical to reaching the population targeted by EFM. The program’s Community Outreach Plan relies on community networks to facilitate referrals. Typically, the referral of a new family to the program is made to the Health Project Coordinator. After review, the Health Project Coordinator sends the referral to one of the five multi-disciplinary teams.

In the last quarter of 2006, the program received 237 referrals. Half of the referrals were received from two of the six targeted zip-code areas. Approximately 67 percent of the clients referred were African American; the remaining clients were white, Asian, American Indian, or other. Approximately

26 percent of the clients referred were Hispanic.

Referrals were received from a number of internal and external programs and partners. These included: programs of the City of Milwaukee Health Department, Medicaid Health Maintenance Organizations, Aurora Family Service's New Parents Initiative, Medical Assistance Outreach, Up Connection, Aurora Health Care hospitals and clinics, Milwaukee area WIC clinics, Milwaukee Women's Center, Career Youth Development, the Parenting Network, and Vincent Family Resource Center.

### **Intake**

A member of the multi-disciplinary team contacts interested families and schedules a face-to-face assessment. Efforts to contact families continue for 60 days although each site may conclude outreach before 60 days if parents have re-engaged in services, refused services, or moved from the area.

The program uses Medicaid risk assessment tools to determine the risk level of families. Additional resources used to identify family needs and strengths at enrollment include "Great Beginning, Start Before Birth" curriculum materials and the "Born to Learn, Prenatal to 3 Years" curriculum materials which will be implemented July 2007.

### **Home Visits**

One of the three members of the multi-disciplinary team usually conducts the initial and subsequent home visits. The public health nurse usually conducts home visits for prenatal clients. Family needs determine which team member is most appropriate to visit families after the child is born. During the home visit, the family and the home visitor work together to establish a plan with specific strategies to achieve the goals documented in the family's care plan. Families are provided crisis intervention services if needed and are linked to health

services and other community services that serve as protective factors.<sup>8</sup>

Home visits last approximately one hour, and, after birth, the infant/child typically must be present. The number of visits to families ranges from weekly or more frequent home visits to less than quarterly for the lowest intensity level. In 2006, the EFM referral and intake process used the risk factors identified upon referral to assign families to the appropriate home visitor. The home visitor and client then negotiated visit frequency, with the benchmark of at least two visits per month, based on family need and risk factors.

### **Caseload**

Each multi-disciplinary team is limited to a maximum of 60 families, and each individual team member is limited to 25 families at any given time. However, if all families assigned to a home visitor require weekly visits, the home visitor maximum is 12 families. Thus the active caseload could range from less than 200 to 400 families at a point in time depending on how frequently the families currently being served are scheduled to be visited by the program's 16 home visitors.

The EFM Program Management team has been working with a small group of staff to pilot a weighted caseload approach for roll-out in October 2007. It is expected that this weighted caseload approach will be used to manage EFM home visitation caseloads in the future.

### **Client Assessment and Reporting**

To ensure consistent assessment and reporting all subcontractors are required to administer the Ages and Stages and the

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<sup>8</sup> Services may include WIC; income support services; Early Intervention Program services; mental health, domestic violence and social services; alcohol and other drug abuse services; general health and dental services; GED or vocational training; fatherhood programs; childcare; and transportation.

Home Observation and Measurement of the Environment (HOME) standardized evaluation instruments and to record client assessments, services, and outcomes in SPHERE.

### **Program Monitoring and Evaluation**

In January of 2007, the City of Milwaukee issued a comprehensive report describing the program's attainment of the contract objectives specified for the initial program period.<sup>9</sup> DHFS is also planning an evaluation of EFM in cooperation with the City of Milwaukee Health Department. Information for this evaluation will be obtained from a number of sources including SPHERE and the internal ACCESS caseload management database the City of Milwaukee developed to improve data quality and facilitate service provision. Information on this evaluation will be available through the Healthy Birth Outcomes Initiative.

### **Training**

The DHFS Division of Public Health has an annual \$180,000 contract with the University of Wisconsin-Extension Milwaukee County to provide home visitor education and Medicaid training to home visitation workers in Milwaukee County. Through this contract, the UW-Extension trains EFM workers and workers providing Medicaid prenatal care coordination and child care coordination benefit services throughout Milwaukee County. TANF provides most of the funding for this training (\$100,000). Other funding sources are Medicaid (\$40,000) and general purpose revenue (\$40,000 match for Medicaid funds).

Approximately 300 supervisors and staff received professional development services

in CY 2006 through this contract. Training was provided for City of Milwaukee Health Department staff, for community-based organizations that are partners for EFM, and for other agencies providing home visiting services. Training specific to EFM focused on supervision and staff orientation, the core curriculum, and use of standardized evaluation instruments. UW Extension also provided training on a number of other topics such as poverty education and emotional intelligence.

In the first 18 months of the program, the state Division of Public Health and the City of Milwaukee Health Department also provided training. This training covered a variety of topics, including team building, use of SPHERE, program orientation, the "First Breath" smoking cessation program, violence prevention, alcohol and other drug abuse, and cultural competence.

### ***Preliminary Evaluation Findings***

Program enrollment began in the fall of 2006. By year's end, 78 households including 49 pregnant women, 29 women with infants, and 30 infants had been enrolled in the program. The rate of enrollment for this initial period was greater than would be expected given the belief that approximately 200 families would be served in the first 12 months of program operation.

Approximately 68 percent of the women served in the first 18 months of the program were African American, and 25 percent were Hispanic. Many were low-income; medical care for the majority of these women was covered by Medicaid or BadgerCare.

Typical services provided to clients included: prenatal, child and postpartum assessment; development of care plans and ongoing monitoring; health information on pregnancy, infant care, child growth and development, and parenting; healthy nutrition; social support; screening; and referral and follow-up.

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<sup>9</sup> Patricia Lee King, et al. "Milwaukee Comprehensive Home Visiting Program, 2006 Objective Attainment Report, Division of Public Health Contract Number 13677," City of Milwaukee Health Department, Maternal and Child Health Division, January 29, 2007

**Client Outcomes**

Information on client outcomes is available for the 63 pregnant women and women with infants who were actively enrolled in the program on December 31, 2006. It reflects the program’s efforts to enroll women early in pregnancy, retain clients, link families to supportive services in the community, and ensure that children receive preventive health services.

To support healthy birth outcomes, EFM seeks to enroll women early in their pregnancy. Early enrollment is desirable to impact women’s early and continuous prenatal care. In total, 49 pregnant women had been enrolled in the program by December 31, 2006. Six of these women exited the program after enrollment, and eight other women delivered babies while enrolled and transitioned to Medicaid child care coordination benefit services. Twelve (34 percent) of the remaining 35 pregnant women who were actively enrolled in EFM on December 31<sup>st</sup> were enrolled in their first trimester. This was very close to the contract expectation that 35 percent of the women enrolled would be in their first trimester.

Client retention is also an important goal of the program. Overall 63 (80 percent) of the 78 households that were enrolled in the program from September through December of 2006 were still enrolled in the program on December 31, 2006. The 15 clients who left the program included 12 pregnant women and three women with infants. Data indicate that six clients who left the program refused services/changed their mind after enrollment, two clients left the program due to fetal deaths, one client moved out of state, one client was followed by Aurora’s New Parents Initiative, and one client was involved in the Bureau of Milwaukee Child Welfare. The remaining four families were not interested in participating in EFM after their Public Health Nurse home visitors changed due to two nurses leaving the EFM team.

EFM seeks to link families with supportive resources in the community. By December 31, 2006, the program had referred 19 of the 63 families enrolled on December 31<sup>st</sup> to 24 other agencies for services. The services clients were referred to most often were prenatal medical services; child care; the Family Support Program; and WIC, the special Supplemental Nutrition Program for Women, Infants and Children. The City of Milwaukee tracks the outcomes of referrals, and this information will be included in the next report.

Receipt of preventive health services, such as childhood immunizations, is another key program goal, and the program documents children’s receipt of required immunizations. Children are also screened for developmental delays so they can be referred to special services if needed. Most of the infants in the initial months of program operation were too young to be due for their vaccinations or be screened for developmental delays. These outcomes will be evaluated in 2007.

**EFM Program Initial Implementation**  
(Through 12/31/2006)

<b>Referrals Received:</b>	237
African American	67%
Hispanic	26%
<b>Clients Served:</b>	78
African American	68%
Hispanic	25%
Pregnant when enrolled	63%
In 1 <sup>st</sup> trimester if pregnant when enrolled	34%
<b>Referred to Community Resources</b>	30%
<b>Client Retention</b> (Still enrolled at end of quarter)	81%

### ***Lessons Learned***

After the initial 18-month contract, EFM home visiting program management identified the following as lessons learned:

- Collaborative leadership, while building strong partner support for the new initiative, likely delayed implementation; taking the time to develop trust and arrive at common vision are necessary to have a successful program.
- Developing on-going referral sources requires establishing a trusting relationship and needs constant nurturing.
- Initial investments of time and resources into effective teambuilding prior to addressing roles and program context are critical to establishing effective teams across organizations and professional disciplines.
- Timing and context are critical with training of staff to ensure that the content is relevant and useful to their home visiting practice.

### ***Future Challenges***

Future challenges identified by the City of Milwaukee Health Department include ensuring model fidelity, delivering consistent services across sites, coordinating with providers and addressing system gaps.

## Appendix A. EFM Home Visiting Program Contract Objectives for 2006

1. By March 31, 2006, all written policies, procedures, protocols, and forms for the Milwaukee Comprehensive Home Visiting Program will be established by the City of Milwaukee Health Department.
2. By March 31, 2006, an outreach plan will be developed for the Milwaukee Comprehensive Home Visiting Program that addresses early identification strategies and a centralized intake and referral system to increase the number of families served by the Program within the first trimester of pregnancy or upon the infant's birth.
3. By March 31, 2006, all contractual relationships between the City of Milwaukee Health Department and its partner community-based organizations will be established to deliver minimum components of the Milwaukee Comprehensive Home Visiting Program for pregnant women and families with infants and children through age four years.
4. By December 31, 2006, all home visiting program staff of the Milwaukee Comprehensive Home Visiting Program will be trained by the University of Wisconsin-Milwaukee Extension utilizing curriculum designed for the Program.
- \*5. By December 31, 2006, 35% of pregnant women enrolled in the Milwaukee Comprehensive Home Visiting Program will receive applicable services within the first trimester of their pregnancy.
- \* 6. By December 31, 2006, 200 high risk pregnant women and families with children through age five years will receive services from the Milwaukee Comprehensive Home Visiting Program.  
[Baseline is that Aurora serves 143 families through PNCC and CCC. City of Milwaukee Health Department serves 21 families through PNCC.]
- \*7. By December 31, 2006, 200 pregnant women and young families enrolled in the Milwaukee Comprehensive Home Visitation

Program will receive case management services to promote access to health and social service supports.

8. By December 31, 2006, a written evaluation plan of key outcomes of the Milwaukee Comprehensive Home Visiting Program will be implemented by the City of Milwaukee Health Department in collaboration with its community partners.

\*9. By December 31, 2006, 40% of parent(s) of children enrolled in the Milwaukee Comprehensive Home Visiting Program will demonstrate use of preventive health services for their children at frequencies recommended according to accepted national standards.

[Baseline anticipates that Milwaukee Comprehensive Home visiting Program will enroll 100 families with young children during the initial contract period.]

\*10. By December 31, 2006, 50% of infants and children through five years of age enrolled in the Milwaukee Comprehensive Home Visiting Program will achieve their optimal milestones in development and early learning.

[Baseline anticipates that Milwaukee Comprehensive Home visiting Program will enroll 100 families with young children during the initial contract period.]

11. By March 31, 2006, community profiles that identify infant mortality density and distribution will be developed for case finding activities within the six zip code target area of the Milwaukee Comprehensive Home Visiting Program.

\* SPHERE is a data source for this objective.

## Appendix B—12 Critical Elements

Empowering Families of Milwaukee (EFM) employs Healthy Families America's 12 CRITICAL ELEMENTS that characterize quality programs to promote positive outcomes for pregnant women and parenting families. The elements are grounded in research from the field of home visiting and are incorporated in national model home visiting programs throughout the country. Additional information on the following 12 critical elements is available in Appendix A of Healthy Families of America's Site Development Guide (2000).<sup>10</sup>

1. Initiate services prenatally or at birth.
2. Use a standardized (i.e. consistent for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse, and parental history of abuse in childhood).
3. Offer services voluntarily and use positive outreach efforts to build family trust.
4. Offer services intensively (i.e., at least once a week) with well defined criteria for increasing or decreasing intensity of service and over the long term (i.e., three to five years).
5. Services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; staff and materials should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served.
6. Services should focus on supporting the parent(s) as well as supporting parent-child interaction and child development.
7. At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care,

etc. Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.

8. Services should be provided by staff with limited caseloads to assure that they have an adequate amount of time to spend with each family, meeting their unique and varying needs and planning for future activities. In many communities a home visitor will do best serving no more than 15 families on the most intense service level; in some communities the number may need to be significantly lower, for example, fewer than 10 families.
9. Service providers should be selected because of their personal characteristics (i.e., non-judgmental, compassionate, able to establish a trusting relationship, etc.), their willingness or experience working with culturally diverse communities, and their skills to do the job.
10. Service providers should have a framework based on education or experience for handling the variety of situations they may encounter when working with at-risk families. All service providers should receive basic training in areas such as cultural competency, substance abuse, child abuse reporting, domestic violence, drug-exposed infants, and services available in their community.
11. Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation ( i.e., identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building

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<sup>10</sup> HFA's site development guide is available at <http://www.healthyfamiliesamerica.org/publications/download.shtml>

upon family strengths, developing an individual family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, managing crisis situations, etc.).

12. Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference, and in order to avoid stress-related burnout.