RACINE HEALTHY BABIES INITIATIVE ANNUAL REPORT

Reporting Period:
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REPORTING PERIOD: JULY 1, 2020 TO JUNE 30, 2021

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Introduction

Infant mortality rate is an internationally recognized indicator of the health of a community. From 2005 through 2009 and again from 2014 through 2016, African Americans in the City of Racine had an infant mortality rate that was three times the rate for white infants during the same time period. This health disparity reflects the fact that African American women in Racine suffer from disproportionate rates of premature births, low birth weight babies, and ultimately, fetal and infant mortality. The Racine Healthy Babies funding was established through Wisconsin State Statute 253.16 to address this disparity and improve birth outcomes.

The Racine Healthy Babies (RHB) funding is received by Racine County from the City of Racine. Through an intergovernmental agreement, Racine County administers the subcontract and provides leadership to the program funded by RHB. These funds have been utilized by Racine County primarily to fund Public Health Nurse Home Visitors for RHB program implementation as a complement to RCHVN.

Racine County Home Visiting Network (RCHVN)

Racine County Home Visiting Network (RCHVN) was initially developed from a grant obtained through the Wisconsin Department of Children and Families, called Family Foundations (FF). RCHVN provides the operational structure for home visitation in Racine County and now includes funding from both FF and RHB. It is not possible to provide a report on one of these funding sources without acknowledging the other. While both funding sources have differing primary target groups, these groups do overlap. However, as the Racine Healthy Babies funding was added into the RCHVN, procedures were developed to ensure that the families enrolled in the RHB and FF programs could be identified separately for home visitation and reporting purposes.

RCHVN utilizes the Healthy Families America (HFA) model to provide strength-based home visitation services to pregnant women with the goal of providing services through at least the child's third year of life. HFA is an evidence-based model and requires an accreditation process for all sites. The RCHVN vendor, Central Racine County Health Department (CRCHD), successfully completed the accreditation process in September of 2015 and is an HFA accredited program. As a part of the HFA model, CRCHD initially chose to use the evidence-based Parents as Teachers (PAT) curriculum, as a number of long-standing programs within Racine County used PAT within their programs and saw success in engagement, retention and outcomes. However, as the result of an evaluation which demonstrated high levels of adverse childhood experiences (ACEs) in Racine County, CRCHD switched to the evidence-based Growing Great Kids (GGK) curriculum. The GGK curriculum offers additional value for HFA home visiting services by accounting for factors related to early adversity and the effects that it has on parenting skills. In addition, GGK is inherently strong in promoting positive parent child interaction and is aligned with HFA best practice standards.

RCHVN utilizes a centralized intake system established through Family Foundations and is the central hub for processing all referrals into the Network. Referrals are currently routed to CRCHD to determine eligibility into RCHVN. Once referrals are received, a CRCHD supervisor reviews the referral information and determines whether they are eligible for either of the two RCHVN funding sources, with priority going to RHB. If they are found eligible, the supervisor assigns the referral to a RHB Public Health Nurse Home Visitor.

If a family is not eligible for service under RCHVN, CRCHD refers them to an alternate program. RCHVN has 11 partner programs that also provide services to families within Racine County. These partner agencies include: Professional Services Group, Ascension All Saints Medical Home, Ascension All Saints Centering Pregnancy, Health and Nutrition Services, Inc. (WIC), Racine Unified School District, Racine County Family Resource Network, Family Connects Racine County, Higher Expectations, and Racine County Human Services Department. CRCHD is responsible to follow-up with these partner referrals to ensure the partner agency has made contact and that services have commenced. CRCHD also has regular contact with referral agencies for outreach and engagement purposes. Again, while these RCHVN centralized intake activities are not funded by RHB, they play an integral role in how RHB providers operate.

Project Requirements and Outcomes

In 2020, a novel coronavirus (SARS-CoV-2), also known as COVID-19, was detected in Wisconsin. In May of 2020, the subcontractor notified Racine County who notified DHS that in-person services were being temporarily stopped or dramatically scaled back due to the public health crisis. Visits initially were halted due to statewide Safer at Home orders and then subsequently due to the HFA model requirements and the need to repurpose staff to address the pandemic. However, participants were offered virtual home visits during the 2020-2021 funding cycle as time allowed. The subcontractor staff worked to develop strong mechanisms for remote home visits as the pandemic unfolded. Racine County and the subcontractor worked hard to support families in these unprecedented times. *Racine County and the subcontractor did not meet all grant requirements for the contract year because the City of Racine and Racine County faced one of the highest COVID-19 case rates locally, statewide and nationally.*

Specific outcomes and directives were identified in the early stages of this project. The 27 consumer specific outcomes measures and results are presented in Attachments A and D. Other requirements were identified in ***Exhibit II, Contract between the Division of Public Health, Department of Health Services and the City of Racine for Reducing Fetal and Infant Mortality and Morbidity "Racine Healthy Babies"*** and are described below, with corresponding outcome information.

With the COVID-19 pandemic as the backdrop, specific Exhibit II RHB Program requirements and accompanying outcomes are as follows:

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1. Program Requirements

- **Requirement #1:** Healthy Families America (HFA) is the evidence-based home visiting model that will be used for the services provided under this contract, and HFA affiliation is required.
  Outcome #1: The RCHVN vendor utilizes the HFA model and is fully accredited by HFA. The vendor was officially accredited in October 2015 and remains in good standing with the model.

- **Requirement #2:** Collaboration with the Racine agencies and programs providing similar and complementary services is required, to maximize the use of these funds, and to meet the requirement that 90% of the funds be used for direct services to clients.
  Outcome #2: RCHSD monitors the contracts and assists in developing the vendor budget to ensure that 90% of the RHB funds are used for direct service. The RCHVN vendor for the DCF Family Foundations funding and the RHB funds is CRCHD, ensuring close collaboration between the service provision of the two funding streams.

- **Requirement #3:** Vendors must establish memoranda of understanding with these and other similar organizations, to assure a coordinated and comprehensive program of services is implemented, as intended by Wis Stats 253.16.
  Outcome #3: RCHVN has developed an MOU with local home visiting providers (CRCHD, RCHSD and Ascension All Saints) to ensure a coordinated approach to service delivery. Additionally, RCHVN has relationships with 11 partner agencies to ensure comprehensive service delivery. These partner agencies include: Professional Services Group, Ascension All Saints Medical Home, Ascension All Saints Centering Pregnancy, Health and Nutrition Services, Inc. (WIC), Racine Unified School District, Racine County Family Resource Network, Family Connects Racine County, Higher Expectations, and Racine County Human Services Department.

- **Requirement #4:** The vendor must establish or participate in a Stakeholder's Advisory Group, to help guide the work of this project, including participation in planning, review of services and activities, and recommendations for program changes. The advisory group must include active participation by community members.
  Outcome #4: RCHVN has convened quarterly Stakeholders meetings since October of 2014. *Stakeholder meetings were suspended beginning March 2020 due to the COVID-19 pandemic and will restart in the next grant cycle.* Prior to COVID-19, these meetings have been well attended by partnering agencies and served as a platform to advance policy within RCHVN. A former RCHVN program recipient was recruited to serve on the Stakeholder's Advisory Group during this grant cycle and attended the quarterly meetings beginning in July 2017. HFA requires an Advisory Group as well and having this ongoing Stakeholders meeting satisfies the requirements of both RHB and HFA.

- **Requirement #5: Flexible Funds**. An annual allocation of up to $250.00 per family enrolled in the program must be identified and made available as flexible funds to assist enrolled families achieve outcomes specified in their care plan.
  Outcome #5: The RCHVN vendor requests use of flexible funds for families enrolled appropriately. This is monitored by Racine County Human Services Department (see Attachment C for details).

- **Requirement #6: Risk Criteria.** Vendors must initiate services and maintain a caseload of 30-40 families, according to the following risk criteria:
  a. **Level 1:** Pregnant African American women who have had a previous preterm birth, low birth weight birth, fetal or infant death (death after 20 weeks gestation through the first year of life).
  b. **Level 2:** African American pregnant or parenting (within the first 60 days of life) women who do not meet the criteria for Level 1.
  c. **Level 3:** Pregnant or parenting (within the first 60 days of life) women of all other racial and ethnic groups who have had a previous preterm birth, low birth weight birth, fetal or infant death (death after 20 weeks gestation through the first year of life) or who have 4 of the 28 risk factors for the Medicaid Prenatal Care Coordination benefit.

  Outcome #6: In the past year, the vendor continued to build staff capacity and continued to provide service to 16 families that met one of the three risk levels and 87.5% were African American (see Attachment B). *This caseload requirement was not met due to the COVID-19 pandemic but the risk levels were met.*

- **Requirement #7: Policies –** Written policies and procedures specify the maintenance of case records to assure adequate protection of families' confidentiality in accordance with state and federal privacy laws including those in Title XIX, the Health Insurance Portability and Accountability Act (HIPPA).
  Outcome #7: The RCHVN vendor has developed a policy and procedure manual for RHB and for the HFA accreditation process. The manual incorporates the 12 Critical Elements and all other required elements for RHB home visitation including policies and procedures related to maintenance of case records. The vendor has active internal policies to ensure compliance with HIPAA.

- **Requirement #8 Collaboration:** Vendors are required to collaborate with the health care providers for each woman including the state-contracted HMO's to provide support to medical prenatal care, including any Centering Pregnancy and Centering Parenting programs, and group educational sessions to enhance health care for women during the pre-conception and inter-conception periods.
  Outcome #8: RCHVN staff regularly collaborates with each participant's primary health care provider to ensure continuity of care. Staff assist, when necessary, clients accessing the appropriate health care system. RCHVN utilizes all available resources within Racine County to ensure supportive health care services are available for all

program recipients, including Ascension All Saints Centering Pregnancy program. RCHVN additionally collaborates with partner agencies to ensure that this occurs. These partner agencies include: Professional Services Group, Ascension All Saints Medical Home, Health and Nutrition Services, Inc. (WIC), Racine Unified School District, Racine County Family Resource Network, Family Connects Racine County, Higher Expectations, and Racine County Human Services Department.

- **Requirement #9 Medical Home:** All families have established a medical home to ensure that their infant receives regular and preventive health care services.
  Outcome #9: RCHVN staff encourages and supports all program participants to identify and enroll with a primary health care provider to ensure continuity of care over the long-term. Vendors assist families in securing an appropriate provider.

- **Requirement #10 Coordination:** Vendors are required to coordinate services with service providers that care for women and their families in Racine to improve referrals for supportive services, such as hospitals and NICU's, other home visiting programs, WIC, Food Share, child care subsidy program, family violence, mental health and substance abuse services, programs from the Department of Workforce Development (e.g., W-2 and Child Care), the Department of Public Instruction and the Racine Unified School District, Racine County Human Services, faith-based organizations, housing, economic assistance and others.
  Outcome #10: RCHVN staff collaborates and coordinates all available and appropriate resources within Racine County to ensure supportive services are available for all program recipients. RCHVN has partner agencies to ensure that needed and supportive referrals to support women and their families are provided and well-coordinated. These partner agencies include but are not limited to: Professional Services Group, Ascension All Saints Medical Home, Ascension All Saints Centering Pregnancy, Health and Nutrition Services, Inc., Racine Unified School District, Racine County Family Resource Network, Family Connects Racine County, Higher Expectations, and Racine County Human Services Department (including Division of Economic Support, Behavioral Health Services, Youth and Family, etc.), and other community organizations.

- **Requirement #11 Resources:** Identify resources that address the unique cultural issues of families served.
  Outcome #11: As stated above, RCHVN participates and collaborates with a number of diverse Racine agencies and entities to ensure that we are able to identify and help families to access services that are diverse and culturally competent.

- **Requirement #12 Access:** Provide access to interpreter services and materials in the primary language of families residing in the targeted zip codes.
  Outcome #12: RCHVN has staff that speaks Spanish and access to interpreter services. Important documents, as well as brochures and posters used to advertise the RCHVN, are in Spanish and English.

- **Requirement #13 Networks:** Program establishes networks with other community resources for future employee recruitment of home visitors.
  Outcome #13: As stated above, RCHVN has close working relationships with a multitude of partner agencies

2. BadgerCare Plus/Medicaid Enrollment, PNCC billing and use of GPR funds

- **Requirement #1:** Program staff must ensure that women enrolled in the program for preconception, prenatal and postnatal services, who lack insurance or are the recipients of BadgerCare Plus/Medicaid, have access to services.
  Outcome #1: RCHVN staff ensures that women who are enrolled in the program have access to services for preconception, prenatal and postnatal services through direct interventions and education by the program staff as well as through referrals and collaboration with partner agencies. Women not eligible for RCHVN services are referred to partner agencies in order to ensure their needs are being met, including access to BadgerCare Plus/Medicaid and other programs for preconception, prenatal or postnatal services.

- **Requirement #2:** Program staff must assist women with early enrollment into BadgerCare Plus/Medicaid, PNCC and CCC (for those eligible), and any voluntary programs of pregnancy support for those not eligible for BadgerCare Plus/Medicaid.
  Outcome #2: RCHVN staff ensures all women not covered by insurance upon enrollment or at any time during program service, have applied for BadgerCare Plus/Medicaid in order to maximize their prenatal care. Women not eligible for RCHVN services are referred to partner agencies in order to ensure their needs are being met, including access to BadgerCare Plus/Medicaid and PNCC and other programs of pregnancy support.

- **Requirement #3:** Eligibility for BadgerCare Plus/Medicaid is not a requirement for participation in this program. However, if a mother or child is BadgerCare Plus/Medicaid eligible, then billing Medicaid may be maximized as appropriate.
  Outcome #3: RCHVN has expressed concerns to DHS regarding PNCC billing requirements and whether the program services and documentation align with and meet the guidelines as set by the State. RCHVN requested that we be able to suspend billing until the State provides a revised Medicaid PNCC Online Handbook that aligns with evidence-based models and addresses billing requirement concerns. DHS approved the temporary suspension of this activity on March 24, 2014.

- **Requirement #4:** Prenatal and postnatal home visits for the mother may be funded by the general purpose revenue (GPR) funds provided through this contract. However, if any prenatal or postnatal services provided to BadgerCare Plus/Medicaid eligible

women are covered services under Medicaid through the PNCC benefit or otherwise, then Medicaid may be billed and if billed, then GPR funds may not be used.
Outcome #4: The RCHVN vendor has nominally billed BadgerCare Plus/Medicaid for prenatal services for this program year. As stated above, RCHVN has expressed concerns to DHS regarding the PNCC billing requirements and whether the program services and documentation align with and meet the guidelines as set by the State (see above).

- **Requirement #5:** Home visiting services for infants through 12 months of age may be funded by these GPR funds. However, the case management portion of home visiting services provided to BadgerCare Plus/Medicaid eligible children (up to age two) are covered services under Medicaid through the CCC benefit and Medicaid may be billed and if billed then GPR funds may not be used.
  Outcome #5: With the temporary suspension of PNCC billing, RCHVN partners have not explored billing under the CCC benefit. The contract monitor, along with the vendor, will look at this possibility or targeted case management billing as soon as PNCC concerns are addressed.

3. Staffing model, supervision of staff and training requirements

- **Requirement #1:** The staffing model for this program must include a registered nurse who meets the qualifications of a public health nurse, as specified in Wis. Stat. s.250.06(1), and/or a social worker.
  Outcome #1: All home visitation staff are public health nurses who meet the qualifications of a public health nurse, as specified in Wis. Stat. s.250.06(1). The RCHVN vendor under the RHB funds meets or exceeds all expectations in selecting staff whose education and/or experience enable them to handle working with dynamic families. The vendor hires staff with demonstrated education or life experience(s) related to the practice of positive parenting, enhancing appropriate child development, and knowledge of community resources as evidenced by resumes and interview questionnaires. The vendor advertises for applicants with education and/or experience working with children and their families.

- **Requirement #2:** Home Visiting staff should have knowledge of community resources and educational or experiential background in child development, and parent support.
  Outcome #2: The RCHVN vendor staff has significant knowledge regarding community resources. Additionally, our partnership with RCHSD and the Racine County Family Resource Network assures a wide array of service availability for the families served in RCHVN.

- **Requirement #3:** Home Visiting staff must be able to work with diverse family structures and meet varying needs.
  Outcome #3: RCHVN meets all the requirements for staffing, cultural competency, training, and supervision. Staff has been trained in a wide variety of family diversity topics, including but not limited to the following: role of culture in parenting; breastfeeding in the African American community; child development and health; language development; and trauma-informed care.

- **Requirement #4:** At least 25% of staff should reflect the target population.
  Outcome #4: Direct service staff reflect the target population. RCHVN is confident that it has selected appropriately prepared staff that is skilled and experienced in working with diverse communities. The vendor uses the required criteria to hire staff as evidenced by interview questionnaires. The vendor establishes networks with other providers for staff recruitment, including community groups.

- **Requirement #5:** Home Visiting staff training should include all training recommended for HFA. Additional training should include those areas identified in the PNCC manual. All trainings should be culturally competent.
  Outcome #5: Professional staff will have received all or some of the listed trainings in the course of their professional education. Supervisors and staff regularly meet to identify additional training needs. This is conducted on an ongoing basis. *Training needs were delayed during the grant cycle due to the COVID-19 pandemic response.*
  RCHVN has set minimal training requirements that include:
    - Integrated Strategies for Home Visitation (ISHV-HFA Training)
    - ASQ-3 and ASQ-SE
    - HOME Inventory
    - Great Beginnings
    - Growing Great Kids
    - Mandatory Reporter Training (SCAN-MRT)
    - HFA online training modules
    - Reflective Supervision for Supervisors
    - Abuse Assessment Screening (AAS)
    - Edinburgh Postpartum Depression Screening
    - Perceived Stress Scale
    - Local Resources
    - Safe Sleep
    - Shaken Baby Syndrome
    - Case Management Skills

  Additionally, staff has trained on: role of culture in parenting; breastfeeding in the African American community; home safety, infant care; infant nutrition; child development and health; language development; and trauma-informed care

- **Requirements # 6 and 7:** Vendors will maintain a written training plan on cultural awareness and competency. In addition, vendors will provide training and curriculum that enhances services to cultural groups and reflects knowledge of the needs of the population served, including education and employment.
  Outcomes #6 and 7: The RCHVN vendor maintains training plans according to HFA standards that address cultural awareness and competency. The vendor has a Cultural Competency Plan that has been approved by HFA as part of the accreditation process.

- **Requirement #8:** Home Visiting staff will review all screening tools for cut off scores and assure referrals are made to services when appropriate.
  Outcome #8: The RCHVN vendor's supervisors utilize a screening algorithm to determine if women meet the eligibility requirements for RHB home visitation. In addition, the RCHVN vendor utilizes the PNCC Questionnaire for every new enrollment to identify family strengths as well as BadgerCare Plus/Medicaid PNCC billing eligibility. The RCHVN vendor home visitors utilize the required HFA Parent Survey for an in-depth assessment of strengths, needs and background of the mother/family and future baby expectations. The home visitors utilize practice standards that ensure referrals and/or additional services are provided when a screening (such as an ASQ-3, ASQ:SE, or Edinburgh Postpartum Depression Screen) is completed and the score is below the cut off. In addition, all staff utilize the Growing Great Kids goal-setting criteria.

- **Requirement #9:** Home Visiting staff will have access at all times to a supervisor for urgent consultation.
  Outcome #9: Vendor supervisors are available to staff for any urgent consultation. Additionally, all vendor staff are aware of the Crisis Services Line and 2-1-1.

- **Requirement # 10:** Vendor supervisors will assess staff training needs on a continual basis, and create training plans to meet those needs.
  Outcome #10: Supervisors and staff regularly meet to identify additional training needs. This is conducted on an ongoing basis. Additionally, training completed by staff is documented. *Training needs were delayed during the grant cycle due to the COVID-19 pandemic response.*

- **Requirement #11:** Vendor supervisors will provide reflective supervision sessions on a monthly basis or at the frequency prescribed by HFA.
  Outcome #11: RCHVN vendor supervisors have all received training in reflective supervision and utilize these practices with program staff. Vendor supervisors meet with each home visitor weekly for supervision and schedule, at minimum, quarterly home visits with staff, as outlined in the HFA model. Supervisors ensure compliance and consistency in the implementation of this program. Supervisors did not provide reflective supervision at the HFA required frequency due to the COVID-19 pandemic response.

- **Requirement #12:** Vendor supervisors will ensure that all evaluation materials are completed and entered into data bases as required in a timely manner.
  Outcome #12: Vendor supervisors ensure that all data is entered in a timely fashion in accordance with the data entry policy and procedures created by RCHVN. *Evaluation material data entry was delayed during the grant cycle due to the COVID-19 pandemic response.*

- **Requirement #13:** Vendor supervisors will ensure home visitors are implementing the curriculum prescribed by the model employed.
  Outcome #13: Regular staff meetings are held by the RCHVN vendor to ensure continuity and consistency across the program. Vendor supervisors meet with each home visitor weekly for supervision and schedule quarterly home visits with staff. Supervisors ensure compliance and consistency in the implementation of the program curriculum and as detailed above. *Weekly supervision was irregular and supervisor home visits were not implemented during the grant cycle due to the COVID-19 pandemic response.*

- **Requirement #14:** Supervisors will review status of acquisition of medical home of clients.
  Outcome #14: Vendor supervisors review this as a part of case file reviews and staff supervision.

- **Requirement #15:** Program holds monthly staff meetings that promote service provision and program accountability.
  Outcome #15: Monthly staff meetings are held by the RCHVN vendor to ensure continuity and consistency across the program. *Monthly staff meetings were delayed during the grant cycle due to the COVID-19 pandemic response.*

- **Requirement # 16:** Supervisors must review active files every quarter.
  Outcome #16: RCHVN vendor supervisors review active files as required.

- **Requirement #17:** The County will be required to consult with DPH on basic training that will be available in Racine at minimal cost. Training will be provided in areas including, but not limited to: pregnancy-related nutrition and health; strength-based family support; normal child growth and development; cultural competency; poverty; issues of adult mental health, substance abuse and domestic violence; child abuse and neglect and the effects of same on adults; issues faced by drug-exposed infants; and available supportive community resources.
  Outcome #17: RCHSD has been in contact with DPH staff to ensure all components of this training program are met.

4. Outreach and Engagement

- **Requirement #1:** Vendor work plans must include an outreach plan about how to promote engagement and referral into the Racine Healthy Babies program, to community networks and families that employ creative, culturally appropriate outreach methods for identification of families to promote early entry into medical care and prenatal care coordination services.
  Outcome #1: RCHVN promotes outreach and engagement to ultimately link families into the RHB program through the work of the vendor agency and home visiting staff. HFA requires the use of positive persistent outreach for families who are difficult to engage and has a process by which RHB home visitors follow to meet this requirement. Outreach and engagement activities include but are not limited to: follow up on each referral that meets eligibility for RHB, positive persistent outreach for families to encourage their engagement in services, and a "Creative Outreach" period for families who were enrolled in services but are not availing themselves for visits. *RCHVN was not able to provide direct outreach at the home during the grant cycle due to the COVID-19 pandemic.*

- **Requirement #2**: Vendors are expected to collaborate with similar programs and agencies within Racine to maximize the potential and effectiveness of outreach programs to reduce fetal and infant mortality and morbidity.
  Outcome #2: RCHVN collaborates with all home visiting programs in Racine County as well as healthcare providers, schools, WIC, Workforce Development, RCHSD, and other partners as noted previously for program referrals.

- **Requirement #3:** Outreach materials reflect the voluntary program policy and all the relevant provisions within the approved Policy and Procedure Manual.
  Outcome #3: RCHVN outreach brochures and materials emphasize the voluntary nature of the program. Posters and brochures are in English as well as Spanish and were distributed around the entire community with contact information for the program.

5. Evaluation

- **Requirement #1:** Vendor will enroll the majority of women during pregnancy and the family may choose to continue with services until the child reaches his/her first birthday (second birthday for CCC services for BadgerCare Plus/Medicaid-eligible children).
  Outcome #1: RCHVN enrolls the majority (93.8%) of women and families served during pregnancy and services continued, as desired, through at least the child's first birthday.

- **Requirement #2:** Performance will be measured to determine the program's effectiveness and results, using a combination of process and outcome objectives.
  Outcome #2: Please see the 27 indicators in Attachment A for measurements of performance. *Of note, not all indicators could be assessed through virtual visits during the COVID-19 pandemic.*

- **Requirement #3:** Additional outcome performance measures may be implemented at the time of contract renewal negotiations and on a bi-annual basis.
  Outcome #3: Additional outcome performance measures are detailed in #6 of Exhibit II. *Of note, not all indicators could be assessed through virtual visits during the COVID-19 pandemic.*

- **Requirement #4:** Program evaluation will include process and outcome measures that will require data collection, data entry, quality control, running reports, and analysis. Confidentiality must be assured, and all staff must be trained and supervised to assure that the evaluation is successfully executed.
  Outcome #4: Please see the 27 indicators in Attachment A for measurements of performance. Vendor staff that collect, collate and report on data for RCHVN are aware of and practice all confidentiality rules and guidelines and assure appropriate implementation of these rules and guidelines. *Of note, not all indicators could be assessed through virtual visits during the COVID-19 pandemic.*

- **Requirement #5:** Vendors will collect data for each participant enrolled and over time as required for the attached "Indicators for the Evaluation of the Racine Healthy Babies Home Visiting Program." DPH will determine when sufficient data is collected to determine a baseline for purposes of measuring future performance. DPH will notify the vendors when a baseline is established and at what point in time the vendors' performance will be measured to determine improvement.
  Outcome #5: Data from the 2012-2013 report has been identified as the base line data for RCHVN, per DPH.

- **Requirement #6:** In addition to the attached "Indicators for the Evaluation of the Racine Healthy Babies Home Visiting Program," the following data that are to be collected and reported include:
  a. The number and percent of women by risk criteria categories, enrolled by trimester of pregnancy
  b. Caseload retention
  c. Client contacts per pregnant woman or family enrolled
  d. Medicaid reimbursement
  e. Use of flexible funds

  Outcome #6: Please see Attachments B and C for this information.

6. Maximize and leverage additional resources, including Medicaid reimbursement.

- **Requirement #1:** Vendors may be required to bill Medicaid for PNCC and CCC covered services as appropriate. All reimbursement is to be reinvested in the home visiting program.
  Outcome #1: RCHVN has expressed concerns to DHS regarding our PNCC billing requirements and whether the program services and documentation align with and

meet the guidelines as set by the State. RCHVN requested that we be able to suspend billing until the State provides a revised Medicaid PNCC Online Handbook that aligns with evidence-based models and addresses billing requirement concerns. DHS approved the temporary suspension of this activity on March 24, 2014.

- **Requirement #2:** The general purpose revenue funds are to be leveraged to bring additional funds and resources into the community to support the purpose of the program. Processes will require effective billing for eligible BadgerCare Plus/Medicaid services and use of reimbursements to enhance program services. The program should be in a strong position to apply for federal Healthy Start funding or other federal or state funding when the opportunity comes available again. This overall evaluation process improves the program's capacity to determine effectiveness of selected strategies and report regularly using consistent data elements for measurement over time.
  Outcome #2: RCHVN continues to explore alternative avenues to leverage additional funding for this program.

7. Evaluation and Reports

- **Requirement #1:** Required Quarterly Reports:
  a. Quarterly caseload reports.
  b. Quarterly basic program reports, including demographics.

  Outcome #1: In addition to this report, quarterly "Racine Healthy Babies Quarterly Reports" are given out at the Stakeholder Advisory Group and include caseload reports and other data reports with demographics. Any changes to components #1 through #6 are documented; otherwise the Annual Report reflects all current practice. *Of note, data could not be run at normal intervals during the COVID-19 pandemic.*

- **Requirement #2:** Required Annual Report:
  An annual report must be prepared and submitted to the City, DHS, the legislature, and the governor, annually by July 30th. The annual report will include yearly summary of the progress made for each of the components #1 through #6 as well as a report on the data in relation to the attached "Indicators for the Evaluation of the Racine Healthy Babies Home Visiting Program."
  Outcome #2: In addition to this report, please see all attachments, including Attachment A for the "Indicators for the Evaluation of the Racine Healthy Babies Home Visiting Program". Please note that many of the indicators represent small sample sizes. As a result, small fluctuations in the numerator or denominator may result in large changes in percentage calculations. *Of note, the caseload for the grant cycle was lower than normal due to the COVID-19 pandemic, and not all indicators could be assessed through virtual visits during the COVID-19 pandemic.*

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Attachment A: Racine Healthy Babies Indicators

Indicator 1. Engagement in Program	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Average week of pregnancy by which mothers engage in home visiting services	19	20	24	22	24	23	19	18	25
Sum of Weeks	703	437	668	217	661	569	439	184	124
Women Enrolled Prenatally	37	22	28	10	27	25	23	10	5

Indicator 2. Referral for Tobacco Use at Enrollment	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Percentage of primary caregivers who reported using tobacco at enrollment and were referred to tobacco cessation counseling/services within 3 months of enrollment	-	-	-	-	-	100%	100%	50%*	0%
Women newly enrolled in the program who reported using tobacco and receiving a referral for tobacco cessation counseling/services within 3 months	-	-	-	-	-	4	1	1	0
Women newly enrolled in the program who reported using tobacco at enrollment	-	-	-	-	-	4	1	2	0
This was a new indicator for the 2017-2018 Program Year **1 of 2 women declined a referral.*									

Indicator 3. Postpartum Medical Visit	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Percentage of women enrolled prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks of delivery	-	-	-	-	-	80%	50%*	63%^	0%+
Women enrolled prenatally and giving birth, or within 30 days after delivery who receive a postpartum visit with a healthcare provider	-	-	-	-	-	16	7	10	0
Women enrolled prenatally and giving birth, or enrolled within 30 days after delivery	-	-	-	-	-	20	14	16	1
This was a new indicator for the 2017-2018 Program Year **13 of 14 women had a postpartum medical visit; however, 6 of the women had the visit after 8 weeks of delivery.* *^12 of 16 women had a postpartum medical visit; however, 2 of the women had the visit after 8 weeks of delivery.* *+1 of 1 woman had a postpartum medical visit; however, she had the visit after 8 weeks of delivery.*									

Indicator 4. Birth Spacing Information	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Percentage of women served by the program, enrolled prenatally, who receive information about birth spacing at least once prior to child birth	74%	83%	75%	56%*	57%^	76%+	93%	100%	100%
Women receiving birth spacing information	17	15	12	5	8	16	14	13	1
Women enrolled prenatally	23	18	16	9	14	21	15	13	1

**7 of 9 women received birth spacing information; however, two of the women received this information after the birth of the baby.*
^13 of 14 women received birth spacing information; however, 5 of the women received this information after the birth of the baby.
+21 of 21 women received birth spacing information; however, 5 of the women received this information after the birth of the baby.

Indicator 5. Postpartum Depression Screening	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Percentage of women who are screened for depression using the Edinburgh Postnatal Depression Scale (EPDS) within 3 months of enrollment (if not enrolled prenatally) or within 3 months of delivery (if enrolled prenatally)	-	-	-	-	-	88%*	94%	82%	0%^
Women screened for depression with EPDS	-	-	-	-	-	22	16	14	0
Women served by the program who were eligible to receive the EPDS	-	-	-	-	-	25	17	17	1

The indicator changed for the 2017-2018 Program Year
**23 of 25 women were screened for depression using the EPDS; however, 1 of the women was screened after 3 months of delivery.*
^1 of 1 woman was screened for depression using the EPDS; however, she was screened after 3 months of delivery.

Indicator 6. Breastfed at Any Amount at 6 Months	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Percentage of infants born to women enrolled prenatally who were breastfed any amount at 6 months of age	-	-	-	-	-	89%	77%	33%	0%
Infants with any breastfeeding, measured at 6 months of age	-	-	-	-	-	8	10	2	0
Infants who were born to women enrolled in the program prenatally with a 6 month Child Health & Wellness Assessment	-	-	-	-	-	9	13	6	0

This was a new indicator for the 2017-2018 Program Year

Indicator 7. Children's Health Exam	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of children who received the last recommended well child visit based on the American Academy of Pediatrics schedule	-	-	-	-	-	87%	94%	69%*	36%^
Children who received the last recommended well child visit	-	-	-	-	-	34	48	29	4
Children of mothers served by the program	-	-	-	-	-	39	51	42	11
This was a new indicator for the 2017-2018 Program Year **9 of the 42 children are missing a Child Health & Wellness Form due to COVID-19, Creative Outreach or Discharge.* *^6 of the 11 children are missing a Child Health & Wellness Form due to COVID-19, Creative outreach or Discharge.*									

Indicator 8. Continuous Insurance Coverage - Mother	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of women served by the program with continuous health insurance coverage for at least 6 consecutive months	-	-	-	-	-	95%	96%	64%*	60%^
Women with continuous health insurance coverage for at least 6 consecutive months	-	-	-	-	-	35	43	18	3
Women enrolled in program	-	-	-	-	-	37	45	28	5
This was a new indicator for the 2017-2018 Program Year **9 of the 28 women are missing a second Caregiver Demographic Form due to COVID-19, Creative Outreach or Discharge.* *^2 of the 5 women are missing a second Caregiver Demographic Form due to COVID-19, Creative Outreach or Discharge.*									

Indicator 9. Health Insurance-Child	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of children served by the program with BadgerCare Plus/Medicaid or other health insurance coverage	100%	98%	100%	100%	100%	95%	100%	95%	91%
Children with health insurance coverage	18	41	29	30	37	40	51	40	10
Children served by the program	18	42	29	30	37	42	51	42	11

Indicator 10. Healthy Families Parenting Inventory (HFPI)	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of mothers served by the program who receive an observation of parent-child interaction by the home visitor using the Healthy Families Parenting Inventory (HFPI)	-	-	-	-	-	86%	100%	46%*	17%^
Mothers who receive the HFPI	-	-	-	-	-	30	35	18	1
Mothers served by the program that were eligible to receive the HFPI	-	-	-	-	-	35	35	39	6
This was a new indicator for the 2017-2018 Program Year **21 of the 39 women are missing an HFPI due to COVID-19, Creative Outreach or Discharge.* *^5 of the 6 women are missing an HFPI due to COVID-19, Creative Outreach or Discharge.*									

Indicator 11. Shaken Baby Syndrome (SBS) Information	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of mothers served by the program, who gave birth during the program year, or were enrolled during the postpartum period, that received information on SBS within 60 days of delivery	-	-	-	-	-	79%*	92%	60%^	100%
Mothers served by the program that received information on SBS within 60 days postpartum	-	-	-	-	-	19	12	3	1
Mothers served by the program who enrolled prenatally and gave birth during the program year, or were enrolled during the postpartum period						24	13	5	1
The indicator changed for the 2017-2018 Program Year **24 of 24 women received information on shaken baby syndrome; however, 5 of the women received the information after 60 days of delivery.* *^5 of 5 women received information on shaken baby syndrome; however, 2 of the 5 women received the information prenatally or after 60 days of delivery.*									

Indicator 12. Parental Emotional Well Being	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of newly enrolled mothers served by the program administered the Perceived Stress Scale (PSS) within 90 days of enrollment	-	-	-	-	-	88%*	96%+	100%	100%
Mothers administered the Perceived Stress Scale within 90 days of enrollment	-	-	-	-	-	23	22	10	2
Mothers served by the program	-	-	-	-	-	26	23	10	2
The indicator changed for the 2017-2018 Program Year **24 of 26 women were administered the PSS; however, 1 of the women was screened after 90 days of enrollment.* *+23 of 23 women were administered the PSS; however, 1 of the women was screened after 90 days of enrollment.*									

Indicator 13. Child's Growth and Development: ASQ-3	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of children with a timely screen for developmental delays using the 6 month ASQ-3	-	-	-	-	-	82%*	81%+	64%^	33%#
Children with a timely screen for developmental delays using the 6 month ASQ-3	-	-	-	-	-	14	13	9	1
Children that were eligible to be screened for developmental delays using the 6 month ASQ-3	-	-	-	-	-	17	16	14	3

This was a new indicator for the 2017-2018 Program Year

**17 of 17 children were screened for developmental delays using the 6 month ASQ-3; however, 3 of the children were screened after the eligibility period.*
+15 of 16 children were screened for developmental delays using the 6 month ASQ-3; however, 2 of the children were screened after the eligibility period.
^5 of the 14 children are missing a 6 month ASQ-3 assessment due to COVID-19, Creative Outreach or Discharge.
#2 of the 3 children are missing a 6 month ASQ-3 assessment due to COVID-19, Creative Outreach or Discharge.

Indicator 14. Child's Growth and Development: ASQ-SE	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of children with a timely screen for social emotional development using the 6 month ASQ-SE 2	-	-	-	-	-	100%	100%	100%	50%*
Children with a timely screen for social emotional development using the 6 month ASQ-SE 2	-	-	-	-	-	16	19	12	1
Children that were eligible to be screened for social emotional development using the 6 month ASQ-SE2	-	-	-	-	-	16	19	12	2

This was a new indicator for the 2017-2018 Program Year

**1 of the 2 children is missing a 6 month ASQ-3 assessment due to COVID-19, Creative Outreach or Discharge.*

Indicator 15. Healthy Birth Weight	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of infants born to women enrolled in the program prenatally weighing less than 2500 grams	21%	11%	13%	0%	13%	10%	31%*	8%	100%
Infants born <2500 grams to mothers enrolled prenatally	4	2	2	0	2	2	5	1	1
Infants born to mothers enrolled prenatally	19	18	16	9	15	20	16	13	1

*Of the babies born <2500 grams, the mean birth weight is 2330 grams.

Indicator 16. Gestational Age	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of infants born to women enrolled prenatally born before 37 weeks gestation	16%	11%	13%	0%	0%	10%	25%*	0%	100%
Infants born <37 weeks to mothers enrolled prenatally	3	2	2	0	0	2	4	0	1
Infants born to mothers enrolled prenatally	19	18	16	9	15	20	16	13	1
*Of the babies born < 37 weeks, the mean gestational age is 35 weeks.									

Indicator 17. Intimate Partner Violence Screening	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of newly enrolled mothers served by the program screened for intimate partner violence (IPV) using a validated tool within 6 months of enrollment	-	-	-	-	-	100%	100%	100%	N/A*
Newly enrolled mothers who were screened for IPV using a validated tool within 6 months	-	-	-	-	-	24	23	20	N/A
Newly enrolled mothers in the program for at least 6 months	-	-	-	-	-	24	23	20	N/A
This was a new indicator for the 2017-2018 Program Year **No assessments were due for newly enrolled mothers at the time of this report.*									

Indicator 18. Postpartum Depression Follow Up	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of mothers referred for services for a positive EPDS screen who receive one or more service contacts	-	-	-	-	-	0%*	8%+	0%^	N/A#
Mothers who receive a referral for services for a positive EPDS screen who receive one or more service contacts within 60 days of the referral	-	-	-	-	-	0	1	0	N/A
Mothers who receive a referral for a positive EPDS	-	-	-	-	-	6	12	2	N/A

This was a new indicator for the 2017-2018 Program Year

**Of the 6 mothers who were offered a referral following a positive EDPS, all 6 did not follow through on the referral. All of the mothers continued to receive ongoing support from their home visitor.*

+*Of the 12 mothers who were offered a referral following a positive EDPS, 11 did not follow through on the referral. All of the mothers continued to receive ongoing support from their home visitor.*

^*Of the 2 mothers who were offered a referral following a positive EDPS, 2 did not follow through on the referral. All of the mothers continued to receive ongoing support from their home visitor.*

#*No assessments were due for newly enrolled mothers at the time of this report.*

Indicator 19. Child's Growth and Development: ASQ-3	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of children with positive screens for developmental delays using the ASQ-3 who receive services within 60 days of the screening	-	-	-	-	-	100%	100%	100%	100%
Children with positive screens for developmental delays who receive services within 60 days of the screening	-	-	-	-	-	7	5	10	3
Children with positive screens for developmental delays	-	-	-	-	-	7	5	10	3
This was a new indicator for the 2017-2018 Program Year									

Indicator 20. Intimate Partner Violence (IPV) Follow Up	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of mothers with positive screens for IPV who receive a referral for IPV resources	-	-	-	-	-	57%*	88%+	0%^	0%#
Mothers with a positive screen for IPV who receive a referral for IPV resources	-	-	-	-	-	4	7	0	0
Mothers with a positive screen for IPV	-	-	-	-	-	7	8	5	3
This was a new indicator for the 2017-2018 Program Year **3 of 7 women did not receive a referral for IPV resources because a referral was not indicated.* *+1 of 8 did not receive a referral for IPV resources because a referral was not indicated.* *^5 of 5 women were offered a referral for IPV resources but declined.* *#3 of 3 women did not receive a referral for IPV resources because they were already receiving services, declined a referral and/or had a safety plan in place.*									

Indicator 21. Behavioral Concerns	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of home visits where primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning	-	-	-	-	-	99.7%	100%	100%	100%
Home visits where primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning	-	-	-	-	-	393	869	250	24
Number of home visits	-	-	-	-	-	394	869	250	24
This was a new indicator for the 2017-2018 Program Year									

Indicator 22. Primary Caregiver Education	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of mothers without a high school degree or equivalent who subsequently enrolled in, maintained continuous enrollment in, or completed high school or equivalent	-	-	-	-	-	65%	75%	30%	0%
Mothers without a high school degree or equivalent who subsequently enroll in, maintain continuous enrollment in, or completed high school or equivalent	-	-	-	-	-	13	15	3	0
Mothers without a high school degree or equivalent upon enrollment	-	-	-	-	-	20	20	10	4
This was a new indicator for the 2017-2018 Program Year									

Indicator 23. Child Injury	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Rate per 1000 of injury-related visits to the Emergency Department since enrollment among children enrolled in the program	-	-	-	-	-	0	0	48	0
Children with an injury-related Emergency Department visit	-	-	-	-	-	0	0	2	0
Children enrolled in the program						39	51	42	5
This was a new indicator for the 2017-2018 Program Year									

Indicator 24. Safe Sleep	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of infants who are always put to bed on their backs, without bedsharing	-	-	-	-	-	42%*	38%	21%	0%
Infants always put to bed on their backs, without bedsharing	-	-	-	-	-	14	15	6	0
Infants enrolled in the program	-	-	-	-	-	33	39	29	7

This was a new indicator for the 2017-2018 Program Year

**RCHVN is currently working on a state-wide continuous quality improvement project to increase the percent of infants always placed to sleep in a safe sleep environment. The current state-wide baseline for this indicator is 19%, and the project aim is 30%. Although Racine Healthy Babies participants currently exceed the State's goal, home visitors and supervisors will continue to engage in quality improvement to increase the likelihood that participants engage in safe sleep practices consistently.*

Indicator 25. Children with Primary Care Provider	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of infants enrolled with a primary care provider	-	-	-	-	-	97%	100%	100%	100%
Infants with a primary care provider	-	-	-	-	-	34	39	36	7
Infants enrolled in the program	-	-	-	-	-	35	39	36	7
This was a new indicator for the 2017-2018 Program Year									

Indicator 26. Early Language and Literacy Activities	**2012-2013**	**2013-2014**	**2015-2014**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of children with a family member who reported that during a typical week he/she read, told stories, and/or sang songs with their child every day	-	-	-	-	-	56%*	75%[+]	60%^	18%[#]
Children read to on a daily basis	-	-	-	-	-	22	38	25	3
Children enrolled in the program	-	-	-	-	-	39	51	42	11

This was a new indicator for the 2017-2018 Program Year

**34 of the 39 children (87%) have a family member who reported that during a typical week he/she read, told stories, and/or sang songs with their child at least 3 times a week.*

+48 of the 51 children (94%) have a family member who reported that during a typical week he/she read, told stories, and/or sang songs with their child at least 3 times a week

^31 of the 42 children (74%) have a family member who reported that during a typical week he/she read, told stories, and/or sang songs with their child at least 3 times a week. 9 of the 42 children are missing an assessment during the reporting period due to COVID-19, Creative Outreach, or Discharge.

#6 of the 11 children are missing an assessment during the reporting period due to COVID-19, Creative Outreach or Discharge.

Indicator 27. Adverse Childhood Experiences	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**
Percentage of mothers served by the program who received a Childhood Experiences Survey within 90 days of enrollment	-	-	-	69%[†]	89%[++]	84%*	95%	100%	100%
Mothers that received the CES within 90 days of enrollment	-	-	-	9	16	21	20	9	3
Mothers served by the program	-	-	-	13	18	25	21	9	3

This was a new indicator for the 2015-2016 Program Year

†Of the 4 not counted in this measure, 1 had the CES after the 90-day timeframe. The remaining 3 clients either refused assessment or were unavailable for assessment at the end of the program year.

++Of the 2 not counted in this measure, both had the CES after the 90-day timeframe.

**Of the 4 not counted in this measure, 1 had the CES after the 90-day timeframe. The remaining 3 clients were unavailable for assessment.*

Attachment B: RHB Enrollment, Risk Level, Trimester, Retention and Client Contact

Table 1: Racine Healthy Babies Enrollments^

Dates: 7/1/2020 - 6/30/2021	#	%
Women Enrolled at Beginning of Period	**11**	**-**
Women Enrolled During Period	**5**	**-**
Total Women Served During Period	**16**	**-**
Women Pregnant Upon Enrollment	**15**	**93.8%**

^ The caseload requirement was not met due to the COVID-19 pandemic.

Table 2: RHB Risk Levels*

RHB Mothers Enrolled	#	%
Level 1	**0**	**0.0%**
Level 2	**14**	**87.5%**
Level 3	**2**	**12.5%**
Total	**16**	**100%**

*Definitions:
Level 1: Pregnant African American women who have had a previous preterm birth, low birth weight birth, fetal or infant death (death after 20 weeks gestation through the first year of life).
Level 2: African American pregnant or parenting (within the first 60 days of life) women who do not meet the criteria for level 1.
Level 3: Pregnant or parenting (within the first 60 days of life) women of all other racial and ethnic groups who have had a previous preterm birth, low birth weight birth, fetal or infant death (death after 20 weeks gestation through the first year of life) or who have 4 of the 28 risk factors for the Medicaid Prenatal Care Coordination benefit.

Table 3: RHB Trimester of Enrollment (Prenatal Only)

RHB Enrollment by Trimester	#	%
1st Trimester	**2**	**13.3%**
2nd Trimester	**10**	**66.7%**
3rd Trimester	**3**	**20.0%**
Total	**15**	**100%**

Table 4: RHB Enrollment Duration

RHB Women Served During the Program Year	#	%
0-3 Months	**7**	**43.7%**
4-6 Months	**4**	**25.0%**
7-9 Months	**2**	**12.5%**
10-12 Months	**3**	**18.8%**
13-18 Months	**0**	**0.0%**
19-24 Months	**0**	**0.0%**
>24 Months	**0**	**0.0%**
Total	**16**	**100%**

Table 5: RHB Demographics for Women Enrolled

Race	**#**	**%**
African American/Black	**14**	**87.5%**
White	**2**	**12.5%**
Asian	**0**	**0.0%**
American Indian/Native Alaskan	**0**	**0.0%**
Hawaiian/Pacific Islander	**0**	**0.0%**
Other	**0**	**0.0%**
Multi-Racial	**0**	**0.0%**
Total	**16**	**100%**
Ethnicity	**#**	**%**
Hispanic	**1**	**6.3%**
Non-Hispanic	**15**	**93.7%**
Total	**16**	**100%**
Age at Enrollment	**#**	**%**
12-17 Years	**0**	**0.0%**
18-21 Years	**3**	**18.8%**
22-44 Years	**13**	**81.2%**
Total	**16**	**100%**

Table 6: Types of Contacts with Families

Client Contacts	**n**	**%**
Total # Home Visits Due	**26**	
Total # of visits completed	**28**	**107.7%***
Total # of No Shows	**3**	
Total # of Cancelled Visits	**9**	
Total Contacts/Attempts	**40**	

***Percentages are of visits due**

Table 7: Activities by Family

Family	2020-2021 Activities*	Total Activities†	Days Enrolled‡
1	0	47	1114
2	8	55	1162
3	6	42	1035
4	0	30	619
5	0	21	511
6	0	17	647
7	1	27	651
8	3	14	593
9	0	12	456
10	1	12	429
11	0	4	170
12	2	2	77
13	4	4	160
14	7	7	98
15	3	3	49
16	1	1	12

***2020-2021 Activities include only home visits. Clients with no home visits during the 2020/2021 report year were on required creative outreach at the beginning of the report year.**

† Total Activities include face to face encounters from 2020-2021 and previous program years.

‡ Days Enrolled includes the total number of days the family was enrolled in services which may have started in a prior program year.

Attachment C: Medicaid Reimbursements and Flexible Spending Reports

Table 1: PNCC Medicaid Reimbursements

	Total
Number of PNCC Clients	0
Medicaid Reimbursements	$0

Table 2: Central Racine County Health Department Flexible Spending Summary

Total Flexible Spending Fund Distributions	**$ 0**

Indicators for the Evaluation of the Racine Healthy Babies Home Visiting Program 2020-2021

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
1. Average week of pregnancy by which mothers engage in home visiting services and receive a prenatal assessment. (Sum of week of pregnancy by which mothers engage in home visiting services and receive a prenatal assessment) / total # of women enrolled during pregnancy	Database	Decrease in the average week of pregnancy by which a mother is enrolled in home visiting services.	This measure will be collected at enrollment for women enrolled prenatally. Subsequent pregnancies during the enrollment will be excluded from this measure.
2. Percentage of primary care givers who reported using tobacco at enrollment and were referred to tobacco cessation counseling/services within 3 months of enrollment: (100 x # of women newly enrolled in the program who reported using tobacco and receiving a referral for tobacco cessation counseling/services within 3 months) / total # of newly enrolled women who reported using tobacco at enrollment	Database	Increase in the percentage of newly enrolled women using tobacco upon enrollment who receive a referral for tobacco cessation counseling/services within 3 months of enrollment, compared to baseline.	This measure will be collected for all mothers at enrollment. Receipt of referral will be assessed and a plan of action completed within 90 days.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
3. Percentage of women enrolled prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks of delivery: (100 x # of women enrolled prenatally and giving birth, or within 30 days after delivery who receive a postpartum visit with a healthcare provider) / total # of women enrolled prenatally and giving birth, or enrolled within 30 days after delivery	Database	Increase in the percentage of who receive a postpartum visit with a healthcare provider, compared to baseline.	This measure will be collected for all mothers enrolled prenatally and giving birth during the program year, or enrolled within 30 days after delivery, who receive a postpartum visit with a healthcare provider with 8 weeks of delivery.
4. Percentage of mothers served by the program, enrolled prenatally, who receive information about birth spacing at least once prior to child birth. (100 x # of women served by the program, enrolled prenatally, who receive information on birth spacing at least once prior to birth of the child) / total # of women served by the program who are enrolled prenatally, who have given birth.	Database	Increase or maintain the percentage of mothers served by the program, who are enrolled prenatally, who receive information about birth spacing at least once prior to the birth of the child, compared to baseline.	This measure will be collected for all mothers served by the program, who are enrolled prenatally and have given birth during the reporting period.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
5. The percentage of women who are screened for depression using the Edinburgh Postnatal Depression Scale (EPDS) within 3 months of enrollment (if not enrolled prenatally) or within 3 months of delivery (if enrolled prenatally): (100 x # of women eligible for EPDS) / total # of women served by the program who were eligible to receive the EPDS	Database	Increase or maintain in the percentage of women served by the program, who are screened for depression postpartum using the EPDS, compared to baseline.	This measure will be collected for all women served by the program who receive the EPDS within 3 months of enrollment (if enrolled prenatally) or within 3 months of birth (if enrolled postpartum).
6. The percent of infants born to women enrolled prenatally who were breastfed any amount at 6 months of age: (100 x # of infants with any breastfeeding, measured at 6 months of age) / total number of infants who were born to women enrolled in the program prenatally with a 6 child health and wellness assessment	Database	Increase or maintain the percentage of infants born to women enrolled in the program prenatally who were breastfed at any time, measured at 6-months of age.	This measure will be collected for all children who were born to mothers served by the program and enrolled prenatally. Child Health & Wellness Form should be completed at 1 month and 3, 6, 9, 12, 18, 24, 30, 36, 48 and 60 months. The Child Health & Wellness Form may be conducted more often. This measure will utilize data from the 6 month assessment.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
7. Percentage of children who received the last recommended well child visit based on the American Academy of Pediatrics schedule: (100 x number of children who received the last recommended well child visit) / total # of children of mothers served by the program	Database	Increase in the percentage of children who received the last recommended well child visit, compared to baseline.	This measure will be collected for all children. Child Health & Wellness Form should be completed at 1 month and 3, 6, 9, 12, 18, 24, 30, 36, 48 and 60 months. The Child Health & Wellness Form may be conducted more often. This measure will use the most recent assessment.
8. Percentage of women served by the program with continuous health insurance coverage for at least 6 consecutive months: (100 x # of women with continuous health insurance coverage for at least 6 consecutive months) / total # of women enrolled in program	Database	Increase or maintain the percentage of women served by the program continuous health insurance coverage, compared to baseline.	This measure will be collected for all women enrolled.
9. Percentage of children served by the program with BadgerCare Plus/Medicaid or other health insurance coverage: (100 x # of children with BadgerCare Plus/Medicaid/other health insurance coverage) / total # of children enrolled in program	Database	Increase or maintain the percentage of children served by the program with health insurance or Medicaid.	This measure will be collected for all children enrolled.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
10. Percent of mothers served by the program who receive an observation of parent-child interaction by the home visitor using the Healthy Families Parenting Inventory (HFPI): (100 x # of mothers who receive the HFPI) / total # of mothers served by the program that were eligible to receive the HFPI	Database	Increase or maintain the percentage of women served by the program who receive an observation of parent-child interaction using the Healthy Families Parenting Inventory (HFPI). The HFPI assesses the following domains: social support, problem solving, depression, personal care, mobilizing resources, commitment to parental role, parent/child behavior, home environment and parenting efficacy.	This measure will be collected for all currently enrolled women with children. In addition, it will be collected at program entry (for new postpartum enrollments) or after the birth of the baby (for new prenatal enrollments).
11. Percentage of mothers served by the program, who gave birth during the program year, or were enrolled during the postpartum period, that received information on shaken baby syndrome within 60 days of delivery: (100 x # of mothers served by the program that received information on shaken baby syndrome within 60 days postpartum) / total # of mothers served by the program who enrolled prenatally and gave birth during the program year, or were enrolled during the postpartum period.	Database	Increase or maintain the percentage of mothers who have received health teaching on shaken baby syndrome within 60 days of delivery, compared to baseline.	This measure will be collected for all mothers in the program who were enrolled prenatally and gave birth during the program year, or were enrolled during the postpartum period. Only shaken baby education provided within 60 days of delivery will be counted toward this measure.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
12. Percentage of newly enrolled mothers served by the program administered the Perceived Stress Scale within 90 days of enrollment: (100 x # of mothers administered the Perceived Stress Scale within 90 days of enrollment) / total # of mothers served by the program	Database	Increase or maintain the percentage of newly enrolled mothers administered the Perceived Stress Scale within the first 90 days of enrollment, compared to baseline.	This measure will be collected only for newly enrolled women within 90 days of enrollment, then subsequent assessments as needed.
13. Percentage of children with a timely screen for developmental delays using the 6 month ASQ-3: (100 x # of children with a timely screen for developmental delays using the 6 month ASQ-3) / # of children that were eligible to be screened for developmental delays using the 6 month ASQ-3	Database	Increase or maintain the percentage of children with a timely screen for developmental delays using the 6 month ASQ-3.	This measure will use all ASQ-3 screenings conducted with the family during the reporting period. ASQ screenings are conducted at the following months of the child's age: 2, 4, 6, 9, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 60. This measure will assess timeliness based on the 6 month ASQ-3.
14. Percentage of children, with a timely screen for social emotional development using the 6 month ASQ-SE 2: (100 x # of children with a timely screen for social emotional development using the 6 month ASQ-SE 2) / # of children that were eligible to be screened for social emotional development using the 6 month ASQ-SE 2	Database	Increase or maintain the percentage of children with a timely screen for social emotional developmental, with an ASQ-SE 2 score indicating a potential concern, who received a referral for additional intervention services.	This measure will use all ASQ-SE 2 screenings conducted with the family during the reporting period. ASQ-SE 2 screenings are conducted at the following months of the child's age: 6, 12, 18, 24, 30, 36, 48 and 60. This measure will assess timeliness based on the 6 month ASQ-SE 2.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
15. Percentage of infants born to women enrolled in the program prenatally born weighing less than 2,500 grams: (100 x # of infants born weighing less than 2,500 grams) / total # of infants born to women enrolled in the program prenatally	Database	Decrease in the percentage of infants born to women enrolled in the program prenatally born weighing less than 2,500 grams, compared to baseline.	This measure will be collected only for infants born to mothers enrolled prenatally. Child Health & Wellness Form should be completed at 1 month and 3, 6, 9, 12, 18, 24, 30, 36, 48 and 60 months. The Child Health & Wellness Form may be conducted more often. This measure will use the 1 month assessment.
16. Percentage of infants born to women enrolled prenatally born before 37 weeks of gestation: (100 x # of infants born before 37 weeks of gestation) / total # of infants born to women enrolled in the program prenatally	Database	Decrease in the percentage of infants born to women enrolled prenatally served by the program born before 37 weeks of gestation, compared to baseline.	This measure will be collected only for infants born to mothers enrolled prenatally. Child Health & Wellness Form should be completed at 1 month and 3, 6, 9, 12, 18, 24, 30, 36, 48 and 60 months. The Child Health & Wellness Form may be conducted more often. This measure will use the 1 month assessment.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
17. Percentage of newly enrolled mothers served by the program who are screened for intimate partner violence (IPV) using validated tool within 6 months of enrollment: (100 x # of newly enrolled mothers who were screened for IPV using a validated tool within 6 months) / total # of newly enrolled mothers in the program for at least 6 months	Database	Increase or maintain the percentage of mothers served by the program who are screened for IPV using the Abuse Assessment Screen within 6 months of enrollment, compared to baseline.	This measure will be collected for newly enrolled mothers served by the program. The activity date will be compared with the enrollment date to determine if the IPV screening was conducted within 6 months of enrollment.
18. Percentage of mothers referred for services for a positive EPDS screen who receive one or more service contacts: (100 x # of mothers who receive a referral for services for a positive EPDS screen who receive one or more service contacts within 60 days of the referral) / total # of mothers receiving a referral for a positive EPDS screen	Database	Increase or maintain the percentage of mothers referred for services for a positive EPDS screen who receive one or more service contacts, compared to baseline.	While depression screening will be conducted for all postpartum mothers served by the program, this measure will capture outcomes for mothers with a positive EPDS. This measure will use all EPDS screenings during the reporting period and will assess for service contacts within 60 days of a referral.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
19. Percentage of children with positive screens for developmental delays using the ASQ-3 who receive services within 60 days of the screening: (100 x # of children with positive screens for developmental delays who receive services within 60 days of the screening) /total # of children with positive screens for developmental delays	Database	Increase or maintain the percentage of children receiving services within 60 days following a positive ASQ-3 screening.	This measure will be collected only for children who had a positive ASQ-3 screening and service utilization will be measured within 60 days of the positive screen.
20. Percentage of mothers with positive screens for intimate partner violence (IPV) who receive a referral for IPV resources: (100 x # of mothers with a positive screen for IPV who receive a referral for IPV resources) / total # mothers with a positive screen for IPV	Database	Increase or maintain the percentage of women receiving a referral for IPV resources following a positive IPV screen.	While IPV screening will be conducted for all mothers enrolled in the program, this measure capture outcomes for mothers with a positive IPV screening (Abuse Assessment Screen). This measure will use all positive AAS screenings during the reporting period and the referral outcome recorded within 60 days of the positive screen.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
21. Percentage of home visits where primary care givers were asked if they have any concerns regarding their child's development, behavior, or learning: (100 x # of home visits where primary care givers were asked if they have any concerns regarding their child's development, behavior, or learning) / total # of home visits	Database	Increase or maintain the percentage of home visits where primary care givers were asked if they have any concerns regarding their child's development, behavior, or learning, compared to baseline.	This measure will be collected on all home visits. Home visits conducted during the prenatal period will be excluded from this measure.
22. Percent of mothers without a high school degree or equivalent who subsequently enrolled in, maintained continuous enrollment in, or completed high school or equivalent: (100 x # mothers without a high school degree or equivalent who subsequently enroll in, maintain continuous enrollment in, or completed high school or equivalent) / total # of mothers without a high school degree or equivalent upon enrollment	Database	Increase or maintain the percentage of mothers who enroll in, maintain enrollment in, or complete high school or equivalent.	This measure will be collected for all mothers enrolled in the program and will be restricted to those mothers who did not have a high school degree or equivalent upon enrollment in the program. The Caregiver Demographic Form is completed at the time of enrollment, 6 months post-enrollment, and annually at anniversary of enrollment

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
23. Rate of injury-related visits to the Emergency Department since enrollment among children enrolled in the program: (# of children with an injury-related Emergency Department visit / total # of children enrolled in the program) x 1000	Database	Decrease in the rate of injury-related Emergency Department visits for children, compared to baseline.	This measure will be collected for all children enrolled in the program. Child Health & Wellness Form should be completed at 1 month and 3, 6, 9, 12, 18, 24, 30, 36, 48 and 60 months. The Child Health & Wellness Form may be conducted more often.
24. Percentage of infants who are always put to bed on their backs, without bedsharing: (100 x # infants always put to bed on their backs, without bedsharing) / total number of infants enrolled in the program	Database	Increase in the percentage of infants always put to bed on their backs without bedsharing, compared to baseline.	This measure will be collected for all infants enrolled in the program. Child Health & Wellness Form should be completed at 1 month and 3, 6, 9, 12, 18, 24, 30, 36, 48 and 60 months. The Child Health & Wellness Form may be conducted more often. This measure will utilize data from the most recent assessment.
25. Percentage of infants enrolled with a primary care provider: (100 x # of infants with a primary care provider) / total number of infants enrolled in the program	Database	Increase or maintain the percentage of infants with a primary care provider, compared to baseline.	This measure will be collected for all infants enrolled in the program at time of enrollment and annually at anniversary of child's enrollment.

Indicator	Source of Measure	Proposed Definition of Improvement	Data Collection Plan (timing, population)
26. Percentage of children with a family member who reported that during a typical week he/she read, told stories, and/or sang songs with their child every day: (100 x # of children read to on a daily basis) / total number of children enrolled in the program	Database	Increase in the percentage of children with a family member who reported that during a typical week he/she read, told stories, and/or sang songs with their child every day, compared to baseline.	This measure will be collected for all children enrolled in the program. Child Health & Wellness Form should be completed at 1 month and 3, 6, 9, 12, 18, 24, 30, 36, 48 and 60 months. The Child Health & Wellness Form may be conducted more often.
27. Percentage of mothers served by the program administered the Childhood Experiences Survey within 90 days of enrollment. (100 x # of mothers administered the Childhood Experiences Survey within 90 days of enrollment) / total # of women served by the program	Database	Increase or maintain the percentage of mothers administered the Childhood Experiences Survey within the first 90 days of enrollment, compared to baseline.	This measure will be collected only for women within 90 days of enrollment.