Home Visiting Community Advisory Board (HVCAB) –

Meeting Summary

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| **Meeting Type: Home Visiting Community Advisory Board (HVCAB) Date: 04/24/23** | **Minutes Completed By: Jen Ettinger** |
| **Video Conference Attendees: 28 participants** |
| Ama Amponsah (DCADV), Zakiya Bakari-Griffin, Noelle Bartkowski, Sharronda Boston, Stephanie Cantres, Kelly Ensslin, Jen Ettinger, Debbie Finch, Heather Hafer, Amy Harter, Christine Hoeflich Olley, Joan Kelley, Kim Liprie, Stephanie Martinez, Yolanda McCoy, Mary Moore, Kirsten Olsen, Melissa Pitts (Presenter),Trinette Redinger Ramsey, Amber Shelton, Crystal Sherman, Christine Stoops, Asia Summers, Janet Umble, Liset Villalobos, Vik Vishnubhakta, Adriana Vivero Sosa, and Stephanie Wagner.  |
| **Call to Order:**  |
| The meeting began with introductions. The minutes were approved with no corrections. |
| **Announcements:** |
| **Big thanks** to all the home visiting fields supervisors for participating and providing the data for the key informant interviews and focus groups so we can reach out to those families! |
| **Outreach Group Follow-up Discussion on Mission and Vision** |
| * **Mission Statement**: *Ensuring a collaborative approach to home visiting, advancing a continuum of equitable and diverse research-informed programs supporting prenatal through age 5.* – **Overall approval of the HVCAB group**.
* **Vision Statement (revised):** *Pregnant and parenting families in DE have access to* ***voluntary,*** *high-quality, early childhood hv as a part of a comprehensive early childhood education system* ***that provides support, encouragement******and needed resources so children and families can thrive*** *(updated as of 4/24/23).* Suggestions include wording to include: *social determinants of health*; ‘*early childhood education system’* in an efforttoblend DOE and 0-3. Other word suggestions: *prepare, support or supportive language, encouragement, resource providing*?

**Further discussion/thoughts about the vision statement and the why:** * Overall, the group liked the idea of adding supporting language and trying to blend the idea of early childhood, 0-3 and DOE3+ population. ‘S*o that’ supportive resources are provided to prepare children to* *achieve a wellbeing and parents to be successful?’* Are missing the “why”?
* Can we use the ‘o*pportunity* *to get access’* becausenot all want it. Some are apprehensive about the help, especially those in MAT treatment.
* Some reasons of hesitation: struggle with being judged; lack of autonomy and the feeling they do not have a choice and will be in trouble if they don’t make a certain choice or utilize the access and tools.
* Sometimes new moms have so much going on and they just don’t want to engage or can’t squeeze it in.
* Difficult to motivate them, they don’t see it as beneficial.
* Busy looking for a job to pay for daycare and the need for housing. Lack of affordable housing in DE.
* Want clients to look at the vision and mission statements and see that this is for them, and it’s not being forced.
* Consider using the wording ‘*voluntary participation’* it is up to client and that we are not pushing this program on someone who may not want it.
* Consider adding ‘*social determinants of health’* and ‘*helping to educate families and navigate through systems’*
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| **Update on Outreach Workgroup - Crystal Sherman and group** |
| * The task of that group is to discuss outreach and different strategies to get programs at capacity. Before delving into any recommendations that came out the retreat, it should be the priority to focus on how to get programs at the capacity especially when we are talking about expansion.
* The meeting began with programs discussing where outreach is being conducted and the resources that have to do outreach. Many programs are doing grassroot outreach, but don’t have the capacity to continue to maintain those relationships within the community.
* Programs are doing things at the statewide clinics and doctors’ offices but again with the turnover in those offices, those relationships cannot be maintained. Other places included the libraries and laundry mats.
* WIC came up as an agency where there is a lack of communication and collaboration. HMG or community health workers could help with those relationships and do outreach, engagement and education around what home visiting is and how to refer.
* Utilization of resource materials using a QR code on posters and rack cards in doctors’ offices can provide easy access for direct referral. Code can go directly to the referral for clients to self-refer or a provider could refer.
* After providing a broad-based referral source and education to the community about what HV is, is there a need to have language and information around each individual program and the differences so families can have a better idea. What the distinction is of each program so they can self-refer to the program that best fits their needs, instead of someone making that decision for them.
* Discussed turnover and exit interviews – main theme was increase in staff turnover and/or parents going back to work. Not every program does an exit interview and not every family provides information at the exit interview.
* Discussed questions that Vik had wrote for the key informant interviews and focus groups to determine if they were the right questions or are we missing something? We did get some feedback and Vik has added a few questions to the lineup. We are looking at data right now to identify families to participate and those will be scheduled soon.

**NEXT STEPS FOR OUTREACH GROUP:** Will reconvene after the key informant interviews and the focus groups are complete. Will use that information to inform our next steps, such as: using QR Codes and exploring the possibility of having folks sitting in certain offices, especially the WIC office to build those relationships.***Comments/Questions:**** *The WIC offices are closed until the end of the summer because of COVID. Is there anything we need to do with the WIC leadership? Crystal to check with leadership to see what I can find out on WIC.*
* *WIC staff working remotely since COVID, they do have contact numbers and can leave voice mails, but mailbox only hold 20 messages. For those families in need, provider can try to make a contact and get a case worker assigned to them to see what is going on with the case and help to enroll client to WIC.*
* *Hudson Center in New Castle County do take some appointments, depends on the office. They are experiencing staff shortage.*
* *Jen Fromme had reached out to Maria at WIC and she said it will be the end of the summer. HMG do have direct cell numbers for clients to use, 3 for each county, but it’s limited hours and many parents are having a hard time getting through. \*\*Deb to share contact info.*
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| **HV App Summary Presentation: Melissa Pitts, Account Executive with Tapp Network** |
| * Visual presentation by Tapp who is partnering with DPH to develop the app: *Delaware Family Support Hub.* This will be a mobile app that can be downloaded from the app store and also accessible on desktop using a web browser. Based on the survey results, many home visitors use different devices in their work with families.
* Mock-ups provided. Most of the features designed with the family support specialists (FSS) as the primary users in mind. Supervisors will also have a separate user role with a different ability within the app. We will have a small group of administrators for the app that will have control over the users and content of the app.
* Features of the app: resources, between FSS and with families with a searchable index within the database. They can be videos, pdfs, fliers, word docs, etc. that can be pulled up while with family or can be sent out. Users can recommend new resources to be added to the app. Currently, we are collecting and pulling things, but it is designed to add resources over time. Designed to be on the go or research prior.
* Resource sharing on the app will allow FSS to click a link and email the resource to the family.
* Networking – all users will be located in a directory and can create a profile, listing skills, certifications and languages spoken and will allow other staff to search. Will also provide the ability to chat with other FSS, ask questions and connect. This feature can be started from several areas within the app.
* Some operational features include a list of forms and pdfs. The profiles for each of the operating agencies can be built out over time.
* On the dashboard of the app, there is a place for announcements which will be controlled by the administrators and can include meetings and trainings.
* The app is built, and features are there. Currently in the process of getting all content uploaded into the application. In coming weeks, we will be finalizing the design and making sure all the content is there.
* Testing of app – we will be asking for a small group of users to test before it is launched to everyone.
* Aiming for the launch within the next couple months!
* Once the app is ready to launch, look for information in the upcoming newsletters and email distros.
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| **Infant Mental Health Project Highlights: Amber Shelton, DOE** |
| * DOE was awarded PDG money in the amount of $8M over the next 3 years and will run on the calendar year. DOE will be working to utilize those funds over the next 3 years and are currently in the middle of year 1.
* A part of this was an approval of 2 home visiting projects, one of those projects is the ‘*Infant and Early Childhood* *Mental Health Consultant Pilot*’. To help support the work force in a different way, DOE is looking for a coordinator to help the with statewide implementation of infant and early mental health consultants to work with the providers.
* The Home visitor/parent educator would have a reflective partner outside of their supervisor to work through situations with families that may bring about personal biases that may impact their work. These biases can also affect job satisfaction and the ability to connect with families.
* Infant and Early Childhood Mental Health Consultant (IECMHC) will work with home visitor to determine their role and responsibilities with the families. To discuss what types of strategies they could use to try and separate themselves from the success or failure of the family.
* We’ve seen nationwide that this helps with the retention of staff members because they aren’t taken on this unnecessary responsibility from the families.
* We are hoping to find someone that will help us to think this through in Delaware. What type of qualifications would this consultant need; how often would it be helpful to be working with staff? All things that haven’t been discussed because Delaware doesn’t have an Infant Mental Health Association.
* DE is unique because many other states have an association that they lean on as an advocacy group for information and support. That is the goal of the pilot, is to identify a coordinator to help the state. DE is working with MIECHV partners in TA and partnering with DPH. More information to come on this!

***Comments/Questions:**** ***Are you looking for a nurse with expertise in infant mental health or a licensed social worker with experience in mental health and/or a psychologist?*** *We are hoping to find someone that is experienced with the implementation and assist with making some of these decision points amplified for us to make the decision as a state. The coordinator would be the person to support the implementation, but as part of that we would be looking at qualifications of the actual consultant who would be working with the program. In most states, they are licensed social workers or have some sort of clinical license. We would decide if it had to be someone who has experience in home visiting, or can it be someone who has the clinical license and maybe is inclined towards home visiting? We would have to work that out but would be leaning toward someone who has a clinical license.*
* ***Do you have a sense as to how big the team might be? Is it a statewide pilot or is it a geographically targeted pilot?***  *We will start with PAT. Based on what we learn, it is my hope then we could support our other programs with that resource. We would like to talk to our MIECHV partners about using braided funding. Other states are using MIECHV funds, state funds, various funding mechanisms to support across all home visiting programs. Some states give each home visiting program an allotment of money and tell them to find who you want to work with. Some states identify the team and a point person. The hope is to parallel this with Mary Moor’s work, the early childhood consultants within the childcares. They were predominately there to support the professionals* *who* *are supporting the children, so it is similar. What we are doing is unique, supporting home visitors and the parent educators. We aren’t supporting the parents, or extended family or the children. We are doing it as a parallel process and supporting the home visitors/parent educators, so they have job satisfaction in the field and in turn have better retention rates. We are seeing a rapidly changing work force and a lot of states have used this to help retain staff. What I’m hoping is there at least one identified for each home visiting program, but if this is successful, we may see very different recommendations.*
* Once we identify a coordinator, we will have discussions with stakeholder groups about various decision points that the state needs to make. This isn’t something we aren’t just going to roll out, we are going to involve as many folks as we can.
* We do have an aggressive timeline to ensure the money gets spent and we want to ensure we are doing something to move the needle forward and not getting stuck in having conversations about it. We will get information out as soon as we can but for right now, we are just trying to identify the point person who can guide this implementation process.

***Comments/Questions:**** ***Data collection for this project - what you collect? Is it employment satisfaction or is it retention?*** *There is interest in this topic and what data points will be collected. The idea of doing this in home visiting is not as widespread as in other fields. Early Head Start has been doing this and a lot of it is tied to their grants. We really want to be looking at retention rates of staff members who are receiving this support as opposed those who are not.*
* *We also want to look to see if this is impacting the retention rates of the families because we are seeing a big turnover in families as well. Are my biases overflowing into my work and then impacting the number of families that are staying? I think retention is the number 1 data point we are looking at, retention of staff and then ultimately retention of families. If there are other things that you think need to be highlighted, I would like to hear them and see if we can incorporate them. Possibly adding job satisfaction before the retention, or as part of the retention.*
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| **Healthy Families Delaware, 2022 Data Presentation: Asia Summers, Compliance Manager (slides presented)** |
| * As an affiliate of Healthy Families America, we are to work closely with our Community Advisory Board to share our data and get feedback from the board. There are various data sets and components that we need to share, but in the factor of time we are sharing one critical element that aligns with the central focus that CAB is looking at now which is client engagement and retention.
* Staff, county designations. 4 different areas of focus: supervision, tools, entrance and exit data. We had 281 referrals, we were able to establish contact with 88% which was 247 families, contact averaged within 3 days.

\*See attached slides***Comments/Questions:**** ***It looked like our uptake of eligible families was about 50% or a little less. Do we know if that is standard over time?*** *We have intensively collected data using our HFA spreadsheets before 2022 and 2021. It seems like it trends right around that 50% mark, but we are also delving in with staff to look at specific referrals and enrollment rate. We will be discussing that with them quarterly and setting goals with them monthly and quarterly about overall statewide where we want to be. It does tend to trend overall just under the 50% mark.*
* ***So 2 referrals for 1 enrollment basically?*** *Yes*, some staff can sometimes be at 90-100% of their referrals and some staff are a little lower. Supervisors are using reflective strategies and talking through the obstacles. Sometimes we know it is out of our hands and sometimes the families are just unable to commit to the program.
* ***Zayika added:***  *One thing I want to add is that our highest engagement rate with referrals, are the referrals we receive from 211. They are explaining the services in detail and sharing who will be contacting them from our organization. We also changed our practice internally and first visit appointments are scheduled by our central intake person to decrease touch points to get a person entered into service. Kudos to Deb and her team*!
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| **Help Me Grow Data Summary: Debbie Finch, 211:** |
| * For 2022, call volume was up. We make several attempts to contact families. I give at least 3 calls, as well as email and some text. Many don’t answer the phone, call back or respond to emails. If we have an email address, we start there stating who we are and explain the Help Me Grow program. We talk about DE Thrives and what home visiting will look and that I’m going to call in the next several days (1st attempt) then we start the calling and texting or both.
* We also text previous callers. Friday, we sent a text blast to anyone in New Castle that has called 211 in the past 2 months for diapers, formula or food about a big giveaway on Saturday.
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| **Program Capacity and Enrollment Overview:** |
| **Marneda Bailey, NFP:*** Declining number of referrals and enrollees, which is reflected in the 211 data, not receiving the referrals needed to maintain a full caseload. There are several nurses who have graduates, which effects the number of available referrals for the new nurses who are ramping up their caseloads. Currently have openings statewide.
* We continue to do the outreach and looking around to find viable referrals. Getting some from Highmark and from Amerihealth, but MCOs referral aren’t always viable. Receiving some self-referrals, referrals due to past clients and some of the nurses are able to get referrals from their current clients.
* If the referral has Medicaid, they are automatically eligible, but they can in rare instances can have private insurance and be below poverty level and quality for NFP. Don’t let them not having Medicaid discourage referrals being made to NFP. We can go further into seeing if they qualify or not according to our model.
* If the referral is a minor who falls under parents’ insurance, we also look at the income of the minor at the time of enrollment. If income meets our requirements even though her parents have private insurance, she would still be eligible.
* There is a need to get messages out to licensed clinical social workers that work at ALL hospitals or the nurse navigator.
* Some of the social workers and nurse navigators attend the MSHAC meetings and can learn more about home visiting. PAT does get referrals directly from the hospitals.
* If the client is found not eligible for NFP, PAT can usually find a risk factor and enroll them.
* Debbie Finch with 211 has upcoming meetings with Amerihealth and Highmark. Met with CORAS (fka Connections) the beginning of the year in an effort to keep everyone familiar with 211 and what they do. There has been a lot of turnovers with these agencies.
* No meetings with St. Francis, supervisor does not think it’s necessary.

***Comments/Questions:**** *Would that be helpful for the outreach task force to do some relationship mapping? See who has good relationships with which practices to help find gaps?*
* *Have we thought about including the home visitors in the community health workers association in order to receive more resources and education?*

**PAT Polytech:*** Currently have capacity, getting referrals but have slowed down a bit since the height of COVID. We do have space in all three counties.
* Wasn’t seeing much staff turnover, but now since COVID, we are seeing more turnover which really hurts the program.
* The training process for new staff can take up to 2 months in order to be trained enough to see families. It’s hard when everyone is at the top capacity to find someone to serve those families.

**PAT DECC:*** The longevity of the families staying in the program has changed. Many families leaving the state to live with other family members due to the housing shortage in DE.
* We’ve had a lot of turnovers because of that. Some are just disappearing and it’s hard to get a reason why they are leaving because you can’t find them. Many families in recovery or families that have DFS involvement. That also goes for the families in Early Head Start, which currently has openings.

**PAT Christina:*** We always have room for families but are having some issues with staffing. We hired 4 new educators and have already lost 2 of them.
* Our biggest concern right now is hiring new educators and get new blood to lead the program into the future. The job is never what you can fully explain or have a perspective until you get into the work. You don’t realize all it entails and that is a challenge. We know that National PAT does recognize this, and I believe are working on a video.
* As we continue to hire and train new educators, we can kind of give them that little window. We are doing more in person visits than virtual, but virtual is still available.

***Comment/Questions:**** *Do you think the staff turnover is because they didn’t know what to expect? We get different reasons, some personal reasons, but I think it is also not realizing all the job entails. (PAT, CSD)*
* *The last couple staff that we had leave, did so for full-time positions with benefits. Their hourly rate might not be higher, but they are getting benefits and a full-time position. Some of them have children and want to work a school year. I’ve lost bilingual staff to school districts. I can’t compete with that, it’s a challenging time*. *(PAT, DECC)*
* *It’s the consistency of pay too because if you have a lot of rescheduling and no shows, your paycheck is not consistent and that’s an issue with paying your bills. (PAT, CSD)*
* *The Parent Information Center (PIC) have a training program for doulas to support the mother. Home visiting programs could partner with the doulas. Doulas could refer the mother if there are things they cannot help with.*
* *Building relationships with the doulas and the home visiting programs could create community partnership and make helpful connections.*

**Early Head Start, CFF:*** We do have openings but unfortunately those openings are due to a staff vacancy. The other 2 home visitors are at capacity, and we are trying to fill those positions. We do have a waiting list for children waiting for services.
* In-person services 100% except only when virtual is necessary because of sickness. For both home visits and in person groups.

**New Directions Early Head Start, Kent:*** We do have openings and are working to get full. Still offering virtual as needed, but mostly everything is in person. Groups are fully in person, and they have been some of the greatest things I’ve seen. Last week’s play group was at the new Camden Park area which is a beautiful location.
* We do have the ability to take for families that speak French or Creole.

**New Directions Early Head Start, New Castle County:** * Currently full right now, but families are transitioning out all the time so we are still recruiting in New Castle County. We have a lot of children getting ready to age out.
* Our center-based programs are not full because we have a classroom that is not open because of staffing issues. Hoping to get that up and running so we’ve been taking on a few more home visiting families to make up for those slots.
* For staffing, we do have new staff in Kent County, and we are fully staffed in New Castle County.
* We also have capacity for Spanish speaking families in New Castle County.
* Families are eligible if they are homeless, receive TANF, SNAP, and foster care and income. We do have ability to enroll families even if they are over income if they have other factors, but especially if they have a child with a diagnosed disability.

**Healthy Families Delaware, CFF:** * We are fully staffed, with 2 new team members one of which is a trained doula. In NCC, we are at 86% capacity and 92% in Sussex for our MIECHV funding. Our new staff is currently in case load ramp up phase. We have vacancies statewide, but we aren’t seeing a decrease in referrals.
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| **Next Meeting:** |
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| Virtual meeting date of July 24th, 9 – 11 a.m. Zoom meeting instructions will be sent prior to meeting. |
| **Adjournment:** |
| Meeting adjourned at 10:38 a.m. |