Home Visiting Community Advisory Board (HVCAB) –

Meeting Summary

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| **Meeting Type: Home Visiting Community Advisory Board (HVCAB) Date: 10/25/23** | **Minutes Completed By: Jen Ettinger** |
| **Video Conference Attendees:** | |
| Sharronda Boston, Stephanie Cantres, Lydia DeLeon, Mary Dozier, Kelly Ensslin, Jen Ettinger, Debbie Finch, Jennifer Fromme, Heather Hafer, Kimberly Hardy, Amy Harter, Christine Hoeflich Olley, Tynisa Howell, Jilissa Johnson, Laurie Joseph, Joan Kelley, Chelsie Manwiller, Mary Moor, Maricarmen Morales, Tara Oliver, Kirsten Olson, Erin Rich, Amber Shelton, Crystal Sherman, Christine Stoops, Asia Summers, Emily Thompson, Kellie Turner, Janet Umble, Vik Vishnubhakta, Liset Villalobos, Stephanie Wagner. **Presenters on Bringing Infant and Early Childhood Mental Health Consultation to DE: Linda Delimata, (Illinois) and Mary Mackrain (Michigan). Community Health Worker/Health Ambassador Presentation: Breanna Thomas and Shelly Nix (ChristianaCare), Stephanie Cantres (Westside) and Cindy Beiderman (Quality Insights)** | |
| **Call to Order:** | |
| The meeting began with introductions. The minutes were approved with no corrections. | |
| **Presentation: ChristianaCare Community Health Worker/Health Ambassador Program** | |
| **Breanna Thomas, Community Health Program Coordinator and Shelly Nix, Manager, Community Benefit and Engagement**  **Community Health – Medical Group**   * The title of Health Ambassador is transitioning to Home Visiting Community Healthcare worker with all community health programs. * The shared goal is to provide services that help address the maternal and child health care needs in New Castle County (NCC). * The staff with ChristianaCare Community Health Workers includes Jamesha Brown, Breanna Thomas and Shakeena Wilson. * The ChristianaCare Health Ambassador Program has been providing services as a part of Public Health since 2012 and funding by the DPC, primarily in NCC where they provide exceptional services to those in need. * This program was born out of the recommendations made at the Wilmington Consortium to better address infant mortality in NCC, with a specific focus on the City of Wilmington. * The scope of the work includes care coordination, outreach, and education. * Care Coordination: primary role is to refer to the home visiting programs that can continue to provide the service that is needed for the family and refer resources particularly those that are within the community health program. * Refer community-based support programs, that include a vast number of agencies and organizations that provide support, a lot which is done through *Unite Delaware*. * Work with individuals and families to address unmet social needs, for example food insecurity, clothing, and baby supplies. * Meet families where they are, begin providing the services they need and build those relationships to continue to provide resources and the support that they need. * Individuals are assisted in the community with bus passes, WIC, doctors’ appointments, and hospital trips. The program uses a platform called *‘Round Trip’* for ChristianaCare patients to get to their appointments at the hospital. * Home visiting partners and their families as well home visiting clients that are ChristianaCare patients and have a MRN# within the system are able to use those services for emergency needs. * Can also assist with food, a home visitor can send in a referral that a family is in need of food, CHW will pick up food from the Food Bank of Delaware and deliver it to the family. The client will need to provide their ID so the CHW can provide that to the food bank and can drop that food off to the families. * The program does have remaining baby items to offer the HV families. If items are not available, they can refer out to *Unite Delaware* for those resources. * Much of the outreach is done with community partners which can include an invitation to a tabling event for a health fair or back to school event in NCC, where the programs can talk to families of children under the age of 5. * Participation in community groups and coalitions, outreach can include presentations at DAPI to talk about the program and how to link families with home visiting. * Also do one on one talks with partner group to talk about the importance home visiting to those in the community. * Education is a priority of this program which can include car seat safety. **\*Breanna is a certified car seat technician and can go out to referred families to show them how to install those car seats properly**. * Do have car seats available to provide to families or can refer to Safe Kids Delaware through the DMV to get a $30 voucher for a car seat. * Talk to families about developmental milestones, the importance of breastfeeding, and partner with Cribs for Kids to educate about safe sleep. **\*Breanna is certified to talk about safe sleep and to install pack and plays when referred to the program.** * A lot of families don’t know that a pack and play is meant to be packed up and taken with them, so baby always has a safe place to sleep. * When meeting with families to provide these tangible items, the CHW will discuss the benefits of home visiting and explain to how helpful it can be to have a person to support and help them. That home visitor is a person to talk and creates a safe space to come and talk and provide information. * Collaborate with other community programs, such as Child Inc., to do Lunch and Learns. There are 4 sessions talking about healthy relationships and safe sleep, as well as bringing in other organizations to give out information. * Education is a priority for CHW program to ensure the families know what’s out there, whether its resources, facts to know and making sure we can assist those families any way that we can.   ***Comments/Questions:***  ***Joan Kelly:*** *Are you working with the Medicaid Managed Care Organizations (MCO), so if a mom needs services, it’s possible to coordinate with the MCO to make sure the mom is covered?*  ***Breanna Thomas:*** *We do receive referrals from MCOs care coordinators for families that may be in need of a pack and play or who need formula.*  ***Joan Kelly:*** *So, you aren’t reaching out to them? They are reaching out to you, first?*  ***Breanna Thomas:*** *Correct, because they are more case management with those patients and our services are emergency needs. We are doing those light touches to get those resources to the families as well as presenting to them the benefits of home visiting as a part of the continuum of care.*  ***Crystal Sherman, DPH:*** *ChristianaCare Health Ambassadors have been with the program as long as MIECHV home visiting inception work since 2012 and they have done a great job. There’s been some turnover and they’ve never skipped a beat. I know all of you are aware of the baby showers that ChristianaCare puts on. The baby showers have a lot of knowledge and provide opportunity for community partners to connect. It’s a great touchpoint for families, so if there is an opportunity to partner to put those baby showers on together – please reach out to me, Breanna or Shelly.* | |
| **Presentation: Westside Family Health Community Health Worker Program** | |
| **Stephanie Cantres, Program Coordinator and Health Ambassador**   * Working with prenatal and parenting families with a goal to reduce the infant mortality. * The program is funded by DPH, to enhance health and increase access to medical, social services in the community. * Also provide services to the farm workers residing in Delaware from early spring until late Fall. These families that have children under the age 5 or that are expecting and continue to work. * Make connections for the clients to available resources in the community. Even farm workers have a need for food, if they qualify for state benefits, CHW assist in applying for those benefits. They will also go to the food bank to pick up the food. * Many of the resources provided are done as a warm handoff especially those that are referred to home visiting. CHW do encourage families to enroll in home visiting services. * Assist clients’ families with items they need, such as a crib or pack and plays through Cribs for Kids and car seats. Some are donated/funded by Westside giving them that ability to provide them with that item. * The CHW Program has good connections with all 3 of the MCOs in DE. The client is informed that it is easier if they participate in the program provided by their health insurance, because they can help with gift cards, needed items, and resources that are available in the community. * Connect families with the Safe Kids Program through DMV to provide education and an item at a reduced price. If the family does not have the $30, the CHW program will try to connect them to other programs that are free. * There are 2 certified car seat technicians at Westside who provide education and help the families understand the labels on the car seats, assist with reading the vehicle manual to ensure safety. * The program provides support groups and host virtual sessions every month called ‘lunch-n-learns’ virtual in Spanish and in English. Every 3rd Wed is in Spanish and every 3rd Thursday is in English. * The purpose of the lunch in learns is to provide families with information, promote good health during and after pregnancy. The goal is to encourage families to advocate for themselves. Topics include breastfeeding, what to expect at labor and delivery, what to expect during a prenatal visit, infant care, safe sleep and much more. * Presenters are always welcome to join us to represent their organizations and present. * There is also a session for male involvement knowing the importance of the education of the child to have the father figure. Sessions are held every other month and the next one is in Nov. It is every third Tuesday in the evening at 6 p.m. also done virtually. * Host community baby showers that are very well attended. There are games, prizes and everyone who joins gets something to take home. This year it will be in person, next one is this Saturday, Oct. 28 at the Dover Public Library from 10 am – 1 p.m. * The main topic this month is behavioral health and anxiety. Presenters will cover topics that include, perinatal anxiety during pregnancy and what does that post-partum look like. Dr. Moondago will be presenting in English and Spanish. Some families from NCC have registered for this event. * There is an online referral form located at westsidehealth.org under the support programs tab for anyone who has a referral, patients, or non-patients. If there is a family from NCC that register, they are referred to the ChristianaCare Community Health program. * There is a great deal of support from the home visiting programs and many are registered to be vendors at the baby shower.   ***Comments/Questions:***  ***Kelly Enslin:*** *The education you do for fathers, what is participation like?*  ***Stephanie Cantres:*** *We don’t get a lot of participants, but it just depends. We do try to share that we are hosting them and have other organizations that present on topics that would be interesting to that male figure. Recently, I made a connection with a gentleman that works in Child Support Outreach, so we are trying to work hand and hand to help boost attendance.*  *\*\*Stephanie sent flyer*  **Call for registration 302-678-4622 ext.1529 / Virtual Session (ZOOM)/ All registrants receive a gift card.**  **\*Flier attached to email.**  ***Joan Kelly:*** *I know the Health Ambassadors participate in the DHMIC Summit every year. It would be great if we could have families come to share their stories with us, we hear all the good things that you are doing but it would be nice to hear from families and to motivate people to continue to support these families of need. Then the public and the professionals on the team can get a better idea and how it helps and the changes that it’s made.*  ***Shelly Nix:*** *When we send our monthly reports, we do include success stories, so they are aware of what programs are doing.* | |
| **Presentation: Quality Insights Community Health Workers Presentation** | |
| **Cindy Biederman, Project Lead for Community Initiatives with Quality Insights \*contact info**  **cbiederman@qualityinsights.org**  **302-416-0562**   * The current project is the community health worker social determinants of health and home visiting initiative. * Quality Insights(QI) has been around a long time working nationwide with 50 years in DE. Historically, they have collaborated with DPH on a number projects such as preventing and managing chronic disease. * During that time, they have been on the provider and health systems side. That changed about 4 years ago when they got into this project with maternal health and have been going out into the community and engaging with the community. * For this project, funding is provided by DE Division of Public Health, but differ a bit from the two previous programs that we just heard about. They are not connected to a health system and are available to any DE woman roughly ages of 14-44, of child-bearing age. * The goal is to reduce disparities and improve health outcomes for women and babies. Having that flexibility to be open to any Delaware woman gives many options for getting referrals and for people who graduate from other programs but still need support. * The staff of 8, 5 who are bilingual, partner many community-based organizations. Each staff member has a strong connection to the community and a passion for serving women. * The connection starts with outreach by going into the community or getting intakes for the programs from other sources. They attend many community events including the ChristianaCare Baby Shower as well as other events that are put on by community-based partners. * There are many clients who self-refer because they’ve heard about the program from a friend or relative. * QI also works with the Healthy Women Healthy Baby (HWHB) Program providers. * Once we receive an intake, one of -CHW staff will reach out to the client by telephone to conduct a Social Determinants of Health (SDOH) pre-assessment, which is the foundation of their work. The SDOH assessment is based on the validated prepared tool and adapted slightly with approval from DPH. It really is the key to helping people to identify and prioritize their social determinants of health needs. * Once those are clear to the health worker and client, those referrals for resources are made, often local resources. QI has a robust social needs tool kit to address many categories and will also use *Unite Delaware* to make referrals. * Once the pre-assessment is complete, the health worker and client will know what is next to meet those community identified needs. Using a SMART goal format, the CHW will help the client set a timeline and make it actionable. * The level of need varies with each client. Some clients need more support, and some will just need resources and a goal set on a timeline. The SMART goal format is used to better familiarize the clients on how to set goals and to take the initiative to meet their own needs. * The CHW will continue to check up with the client frequently to find out how they are doing or if more help is needed. The CHW will provide support and strong engagement over a period of 3 months, but there is no set time. It’s up to that client, if they have met their goals and don’t have any additional goals, we do close out the client. * Over the last contract year, over 1800 community members were engaged which was largely through attending and tabling at events. There is a large number of intakes at events, last year there were 233 from just events. * In addition to those community events, intakes are received from DE Thrives as well as referrals from other clients. * To be strategic on the focus of the resources, QI analyzes where most of intakes came from last year. * They work throughout the state and have CHW in every county and are working to embed our CHW with partners to include regular presence at LaRed, Shepherd’s Office (Sussex-county faith-based org) Rehoboth Baby Pantry. * The CHW do outreach at Seaford Library where they have a strong ESL program. Also working with Black Mothers in Power on regular basis particularly at their resource centers and events. * Working to establish a presence at Saint Francis Center of Hope and Women’s Center. Also working with Harpers Heart, who have a diaper bank utilizing a points system, so if a family is working with QI, they earn points which they can use for other benefits. * The top 3 goals of last year were baby supplies, food, and housing. When the SDOH assessment is conducted, it goes through several categories: family and home; money and resources, which include childcare, health insurance, education, employment; and social and emotional health, including any legal needs someone has. * It does not screen for depression and anxiety, but it does ask some questions that indicate that perhaps a client might benefit from a behavioral health referral. * The collaboration with the Delaware evidence-based home visiting programs is a new partnership. Currently they are developing a smooth referral process in both directions. * The CHW establishes a trusting relationship with clients which can help them to be more receptive to home visiting. * Questions within the SDOH and intake assessments are being developed to prompt discussions centered around the home visiting program. * To get connected to the program, there is a very brief intake form. Clients can complete it themselves or have someone complete the form for them. A CHW will reach out to them within a couple of days. flyer English & Spanish with QR code. * **English Spanish \*Fliers attached to email** * The intake form is being translated into Spanish and will be available on DE Thrives soon. * The dates and times vary as to when a CHW will be in a certain location. Please email Cindy Biederman directly to inquire. [cbiederman@qualityinsights.org](mailto:cbiederman@qualityinsights.org). | |
| **Presentation: Infant Early Childhood Mental Health Consultant Project** | |
| **Introduction: Linda Delimata, Illinois**  Linda Delimata and Mary Mackrain are working on providing structure for the PAT program around infant mental health consultation. Linda was the Director of the Infant Early Childhood Mental Health Consultation in Illinois and because of the work in home visiting mental health consultation, they became a nationally known entity. From there Linda and Mary have moved have helped many states get their mental health consultation up and going.  **Mary Makrain, Michigan:** Mary was an Infant Early Childhood Mental Health Consultant in Early care and Education in Home Visiting and Early Head Start several years ago and then the project started to grow. Mary became a state coordinator and developed the model with other consultants. From that point on, she worked with EDC to run the First Center of Excellence for Infant and Early childhood Mental Health Consultation (IECMHC), which Linda was a part of that as well. Mary currently serves as a senior advisor to the MIECHV TARC, ITAC and Home Visiting COIIN project at EDC.  **Linda Delimata:** We are going to look at putting in IECMHC structures for your state so first we want to make sure that we are on the same page when it comes to mental health consultation.   * Basic definition: this is a proactive approach that helps the development of the social and emotional skills in children and when you pair a Mental Health Consultant (MHC) with the HV to provide support. * Home visitors experience many things with families and build relationships which encourages families open up. They may start to see something that needs to be addressed and many times they are mental health issues. * The MHC can help think through those things and help to strategize and help people understand what might be happening. * Strategies include reflecting with the supervisor, the consultants/home visitors of the program; case consultation; specialized training on mental health topics or things they may bring up. * There may be a need for training in self-care, but more of time it is maternal depression or intimate partner violence – things that impact the family’s mental health. * At times, the MHC may need to join on a home visit, which is rare, but there are some situations that a HV may want the MHC to put an eye on and reflect with them about what they saw. * For DE, they will be working with a team of thought partners who are experts in the field, and each has their own specialty. * Focus groups will be put together with home visitors and assessment of individual interviews. They will review data that is already available and organizing it in a needs assessment. * We will work together to create a model for Infant Mental Health Consultation in the PAT programs which has been done for other states and is a very important piece that takes a look at how this will happen for DE. * We will design an orientation for the DE programs, which will be for the people that will be the mental health consultants and for the programs as well. * Additionally, a training will be designed so the mental health consultants have many of the pieces that they need in order to the work. Many times, as counselors with early childhood infant mental health, you don’t get the specialized trainings with programs that prepare you. * This will be done by the end of this calendar year or a little after. We’ll see what that looks like and then if possible, we would then pilot this model within your PAT program. During the pilot, we will put everything we designed into place and then we will be evaluating that to see what we find from this and what shows up. * We take that evaluation and make adaptations to the model. We will then pull together our workforce of mental health consultants and then train them, so they are ready to provide increased support. If that happens, then we might consider moving it to the whole PAT programs and potentially to all the home visiting programs who may want that support. * Then do an evaluation to determine if they would be helpful to other childcare systems in your state and consider if it would be beneficial to use this in all child serving systems. * One of the things that we see, if all of things are in place, are improved child outcomes, family outcomes and as well as provider outcomes. * In Illinois, we started at the children’s mental health partnership with the home visiting programs and then eventually we wrote a model for all programs in the state (universal model). We did an 18 month-2 year evaluation on all the programs and then got our data, rewrote the data, which included all the new changes and now that is what serves our entire state. * We start with a vision!   **Mary Mackrain: Creating a Vision:** Let’s take a moment and think about ‘what if’ or ‘what we hope’.  Creating your vision for Infant Mental Health Consultation. What we know if that when development is participatory and home visitors and parents have a voice, everybody owns it and it really is part of your community and your state vs. being owned by one agency.   * We have found in Michigan and some other states that having that approach, really helps everyone understand that we all own mental health, and it is a part of all of us the work we do with families. * 5 years down the line, what would we envision for IECMHC in DE? What does success look like and make sure we have a long-term impact. * When there is a clear vision it sets the stage, everyone has an understanding as to where we are trying to go and research suggests that if you have a vision, you are more likely to have more positive outcomes.   **Vision:** *All infants, young children, and their families and those who support them, have access to high quality, equitable and culturally sensitive infant and early childhood mental health consultation creating environments where child and adults’ social, emotional, and mental wellness and capacity for mutually beneficial nurturing relationships thrive.*  ***Comments/Questions:***  ***Joan Kelly:*** *DE Medicaid has agreed to start reimbursing doulas and there is a big push in DE. They expect that by Jan 2024 that reimbursement will happen. I would like to see some collaboration with home visiting and doulas. If the doula is in the home, then they could make a referral to home visiting.*  ***Mary Mackrain:*** *I know in Michigan we have gotten Medicaid to cover case consultation in home visiting and early care and education, so that may be something happening down the line too.*  ***Joan Kelly:*** *Once everyone knows who everyone is, when doulas come in it’s just an enhancement and they could refer – make a referral right there.*  ***Mary Mackrain:*** *Sometimes it’s helpful to have a process map – when a family comes in and they have a doula, what’s next?*    ***Group ideas on the Jamboard: To have clear messaging, relationships, culturally sensitive, affordable, open communication, clear responsibilities, seeing beyond home visiting, cross system funding, detailed referral process, success stories!***  ***Vik Vishnubhakta:*** *Is it possible to add a term like ‘measurable’? Data matters and to see where we started and to be able to see the improvement over time – just to keep in mind going forward.*  ***Amber Shelton:*** *Right now, we are trying to gather information so the DE perspective and feedback can be incorporated, but there is no implementation happening at this time. We do hope this model will support implementation moving forward, potentially a pilot. This is all dependent on the PDG money as well as collaboration with MIECHV and DPH. This is about supporting the workforce that is working with the families. To look at how we support the professionals who are working in the field, day in day out, on the ground with the families that have the stressors and the vicarious trauma. What can we do as a state to help support them, so we are in turn supporting children and families in the long term to improve outcomes.*  *\*Linda and Mary will take the information collected on Jam Board and refine the vision and begin gathering data.* | |
| **Sub-Committee Update: Focus Groups and Key Informant Interviews** | |
| **Vik Vishnubhakta, Forward Consultants:**  Review of the focus report and the key informant interviews. Purpose is to discuss how we can better improve client engagement and retention in home visiting and then discuss next steps.  \*\*presentation slides  **\*SUMMARY OF HOME VISITING OUTREACH PROJECT REFUSAL GROUP INTERVIEWS attached. I don’t seem to have the presentation slides.**   * 2 Outreach groups were developed – a refusal group and an enrolled group. * Rather than looking at how to retain staff, we want to understand holistically what is going on with the clients. * The refusal group were people eligible for home visiting but that denied services. This group was contacted by 211, qualified for hv but chose not to enroll. We wanted to understand why. * The enrolled group were clients currently participating in home visiting. We wanted to understand why they chose home visiting, what they like and what they don’t like and what could be improved. * 5 individuals were contacted and interviewed in July. As an incentive, the participants were given an $100 gift card. * Questions included: *when asked about home visiting, what made you say no?* There were different responses – it wasn’t needed, issues with access to the DAFB making access difficult. * *If you were enrolled in home visiting, what would be your ideal interaction?* Participants responds included, resources, education material, breastfeeding support, assistance with childcare, and routine interactions whether it was weekly, bi-weekly or by text message. * *When asked about their ideal design?* Responses included having those resources and wanting to have more resource groups. Stating that the interaction with home visitors was singular, just the home visitor and the client. They wanted more groups where they could interact with people like themselves, individuals that were also pregnant to help with the feeling of isolation and having more parent groups. * *What about the friend or family members, would they be interested in home visiting?* *Why or why not?* Some said yes, they would but some said, they weren’t sure because of the ages of family members or not needing services. * For the enrolled group, AB&C contracted GWA and conducted 3 focus groups. Differing from the refusal group which were 5 individual phone calls, this was focus groups that consisted of 5-10 individuals. * 3 focus groups were conducted, 1 per county, New Castle was in person, Kent and Sussex were via zoom. * When asked about their motivation for enrolling, the participants stated it was because they had a child with developmental needs, or they were first time mothers with premature children interested in ensuring developmental milestones were on track. * When asked about their interest in home visiting, they mentioned activities, advice, and a wealth of different interests that brought them into home visiting. * When asked which programs and services they liked best, they stated that they like everything about home visiting overall nothing specific. It was mentioned that they do really like the flexibility of home visiting and thought the home visitors were professional and friendly. * Stating three words to describe home visiting included: helpful, supportive, encouraging – more positive statements. * What are some opportunities for improvement? What can we do better? Statements included more group meetings with other mothers, more information about premature babies, more home visits, more activities their children can do personally and virtually and expanding the home visiting program to include children to age 7. * As far as overall themes, it’s hard to overgeneralize what we saw in the focus groups and interviews because the families are all so different. * The two major overall themes independently from one another, was the isolation from one another. They love working with the hv if they are currently enrolled or they would want to work with a home visitor if they weren’t enrolled, but they’d just like to have more resources – particularly groups. * Would like to meet individuals that are like themselves that they could chat with, network or at least learn from, if they are pregnant to link to other pregnant moms, if they have children with special health care needs interacting with those other families. * More resources is what came up for both groups. We could look at increase of additional resources to those families. \*\*Reports generated by GWA and Vik’s firm and are available upon request.   ***Comments/Questions:***  ***Kirsten Olsen:*** *For the key informant interviews, since we are talking about 5 folks, and you described them as very different. Is there any thinking about a larger group, trying to get more interviews?*  ***Vik*** ***Vishnubhakta:*** *The proxy for this is if they had reached to 211, therefore we knew they were trying to find help, but again in 211 when they were asked about the opportunity for home visiting and they said no, we can easily come up with that list. We had roughly 80 individuals that had called in that were eligible for home visiting but chose not to do it. Only 5 of them could be contacted and were willing to participate in the key informant interviews. In doing this again, when it comes to the refusal group, I would try to find another way other than from 211. They could be eligible for home visiting but chose not to elect so that may be looking through Medicaid records. To work with those who were eligible through Medicaid but did not elect for home visiting.*  ***Kirsten Olsen:*** *Is there anyone, anywhere doing any social media groups, Facebook support groups, so these people can find each other?*  ***Vik Viknubahshka:*** *I did want to mention Books, Balls and Blocks.*  ***Crystal Sherman:*** *It is difficult as a state agency to be affiliated with certain groups* *or promote them without officially* *reviewing them. Now, if there are community support groups that are out there that you guys know about that we can contact parents to, let us know. This is something we can explore further with the outreach group for next steps. When reviewing these reports, we will also include the Community Health Worker programs and HMG so we can really think about outreach. Where we are conducting outreach and then tackle some of the improvements that Vik just highlighted. How we can make families feel less isolated, with programs and group work? I agree it’s hard unless offering a pretty big incentive to make families feel ok about coming to something that takes time away from their family. It’s tricky, as much as they want to be connected to peers, getting involved with a group just takes time and resources away from their families. I think that is something that our outreach committee can think through and talk about how to do that. As Vik stated, there are groups out there like Balls, Books & Blocks and other opportunities so how do we highlight that for families or how do we reduce the barriers for families to access these resources. PAT are doing the stay and play groups, HFD and NFP are working on this as well. There are opportunities out there that can maximize and figure out what works.*  ***Vik Viknubahshka:*** *I do want to share that families that participated in the study, they are representative of the families that are enrolled overall in our home visiting programs. We wanted to make sure they were families that lived in those high risk zones, had the same educational attainment, were representative of the race and ethnicity of what we are seeing in home visiting enrollment. We tried to ensure that the families that were involved in the project were overall representative or at least as much as possible as our home visiting families.*  ***Amber Shelton: Although we are hearing about families wanted more resources and connections,*** *I do feel that many of the programs offer opportunities for connections, especially with the baby showers. Posting more events may not be the way to help support the families, especially when turn out is not good. Is there another way we could think about this as opposed to hosting another group? Is it a guide by your side or a mentor?*  ***Kirsten Olsen:*** *Life happens, and I think with these families that we are working with there is a real desire for connection, but there are many barriers in real time.*  ***Crystal Sherman:*** *I think that is something we can talk about at the outreach group meeting. Just tackle you guys with all the things and all the program supervisors are a part of that and our Health Ambassadors and Community Health Workers, as well as Help Me Grow. That’s a good group to start tackling these improvements and thought-provoking ideas that we just talked through to determine how we can better support families as well as how we can find families that could benefit from home visiting as we think through retention and engagement in our programs. Just look out for an email! We’d like to schedule that before the end of the year to talk through these reports and discuss ideas. Also, with some of our programs shifting gears with the CQI work and looking at retention and engagement, that will be another topic of conversation at this meeting as well.* | |
| **Innovation Project** | |
| **Crystal Sherman:** This project addresses Social Determinants of Health (SDOH) and is about the integration of Community Health Workers (CHW) and our home visiting programs. We’ve heard great presentations from the CHW group and the QID who is new on the scene and a new partner. We had a networking meeting with our home visiting programs and the CHW programs to help get to know each other and build relationships. We did a world café style, did some questions to think through how we can better support families by working together and how we can better support our workforce. We know that is takes a village to raise a family. The next step for that work is thinking small scale – having some of the CHWs come to the HV Program sites and have more intentional meetings to talk through and think through how those relationships can work in terms of implementation. Working together with referrals and those bidirectional referrals as well as expanding these services. Look for a date for those meetings. | |
| **Presentation: Home Visiting Media Campaign** | |
| **Chelsea Manwiller, Social Media Marketing Manager:** We will be running 2 campaigns, hopefully by the end of this year or early next year. It will be running the same time, both campaigns will be with DPH.   * First campaign will be about the purpose of the campaigns and when they will be available. The second one will focus on the Nurse Family Partnership (NFP) program through CFF which will focus more on the NCC region. Both campaigns will be happening at the same time. Both audiences will be pregnant women, new parents, parents of children ages 0-5 and targeting families in the high-risk zip zones. * The goal is to increase the awareness that these services exist in DE but also to improve the click-through rate of the ads. Working to improve the ratio of the users that clicked on the ad, to the total users who saw the ad. We are trying to record the interaction of each ad and how many people are going back to the ad to learn more about the program. With the goal of increasing the number of referrals to home visiting services. * Optimization will happen about every 6 weeks, which means any videos, pictures, messaging will be swapped out to ensure we are gaining as many viewers and clicks as possible, depending on what the people are responding to. * We will also be running a 6-, 15-, and 30-second-long video ads that will feature a real DE based FSS. The 30 second video will be available in both Spanish and English. * The photos for the campaign will be stock photos and will range from a family playing with a young child while a specialist is present; a pregnant mom speaking with the specialist; and then a specialist interacting with the young child. * Some of the campaign tactics include some traditional and digital media. Traditional includes radio stations running ads in both English and Spanish, lasting about 30 seconds. The HV messaging will also be inside DART buses and bus shelters. * There will also be window clings, posters, and ceiling posters in nail salons. We will distribute flyers, rack cards and magnetic note pads to partner and providers’ offices. * Digital tactics will include ads on Reddit as well as pop up on ads that will give the user an extra life while playing a game, for example, if you view the ad all the way through. The user also has the opportunity to click on the ad and to go to the DEthrives website to learn more information. * We will be posting on social media platforms including Facebook, Instagram, TikTok and Youtube. The social media outlet ads will show up as pictures and videos and stories placed on newsfeeds. * The rack card is 4”x9” and is also present as a flyer with the QR code linking back to DEthrives landing page. There will also be downloadable files. * There is a magnetic note pad which is a new item, which will have the HV logo on it. Part of the pad will contain a milestone check list on each pad and there is room on the back of each page for notetaking. * The hard copy materials will be distributed to community partners such as the Boys and Girls Club, daycares, faith-based organizations, WIC, libraries, and state service centers. * We will be distributing materials a the community baby diaper closets and community baby showers. * Please visit our DE Thrives website. These campaign materials are available on the order materials web page. The professional page, which is called the Providers and Community page * To help us get the word out, please follow DEThrives online, which is on Facebook, Instagram, and X formerly Twitter. * When you see a post, please remember to like, comment, share, make any type of interaction with it. The more you interact with that post, the more it is going to show on your feed and is more likely to show on friends feed. Our hope is that it will snowball out and increase awareness and have more people see what the messaging is all about. | |
| **Delaware 211, Help Me Grow Update** | |
| **Debbie Finch:** Presented the snapshot for the first 9 months of the year, which really picked up this summer. HV referrals picked up, developmental screenings picked up with all the centers now in the Birth to 3 portals.   * My team did over 800 screenings, last month, that was processed. * I appreciate everyone keeping me in the loop about the language availability, any changes to their programs because that helps me get the families to the right program.   ***Comments/Questions:***  ***Joan Kelly:*** *I know we have Spanish populations and I know those populations information is in Spanish, but I think we should start looking at other languages for the large number of immigrants coming in. We need to think about having materials printed in those other languages.*  ***Deb Finch:*** *We recently got our brochures in Creole. We do have the language line and when I send them to home visiting, they are using interpreters as well.*  ***Crystal Sherman:*** *Our DE Thrives site has just been made available in Spanish. Chelsea has been going to meetings and just popping in just to see what kind of resources we can translate in other languages, what that language would be and then bringing it back to our team so we can consider based on the cost. We appreciate the feedback!* | |
| **Suggestions for Next Steps** | |
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| **Next Meeting:** | |
| Monday, January 22, 2024 at 9-11am. | |
| **Adjournment:** | |
| Meeting adjourned at 11:00 a.m. | |