Home Visiting

OUTREACH AND ENGAGEMENT TOOLKIT

MPHI®
Office of Learning & Improvement Methods

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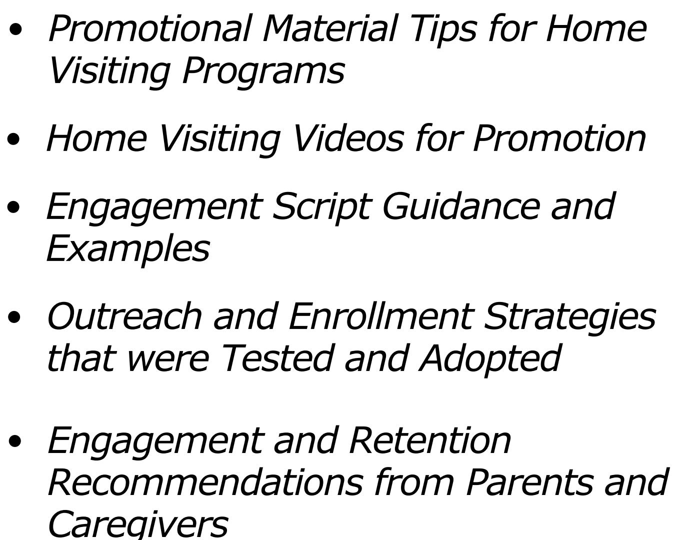

- *Promotional Material Tips for Home Visiting Programs*
- *Home Visiting Videos for Promotion*
- *Engagement Script Guidance and Examples*
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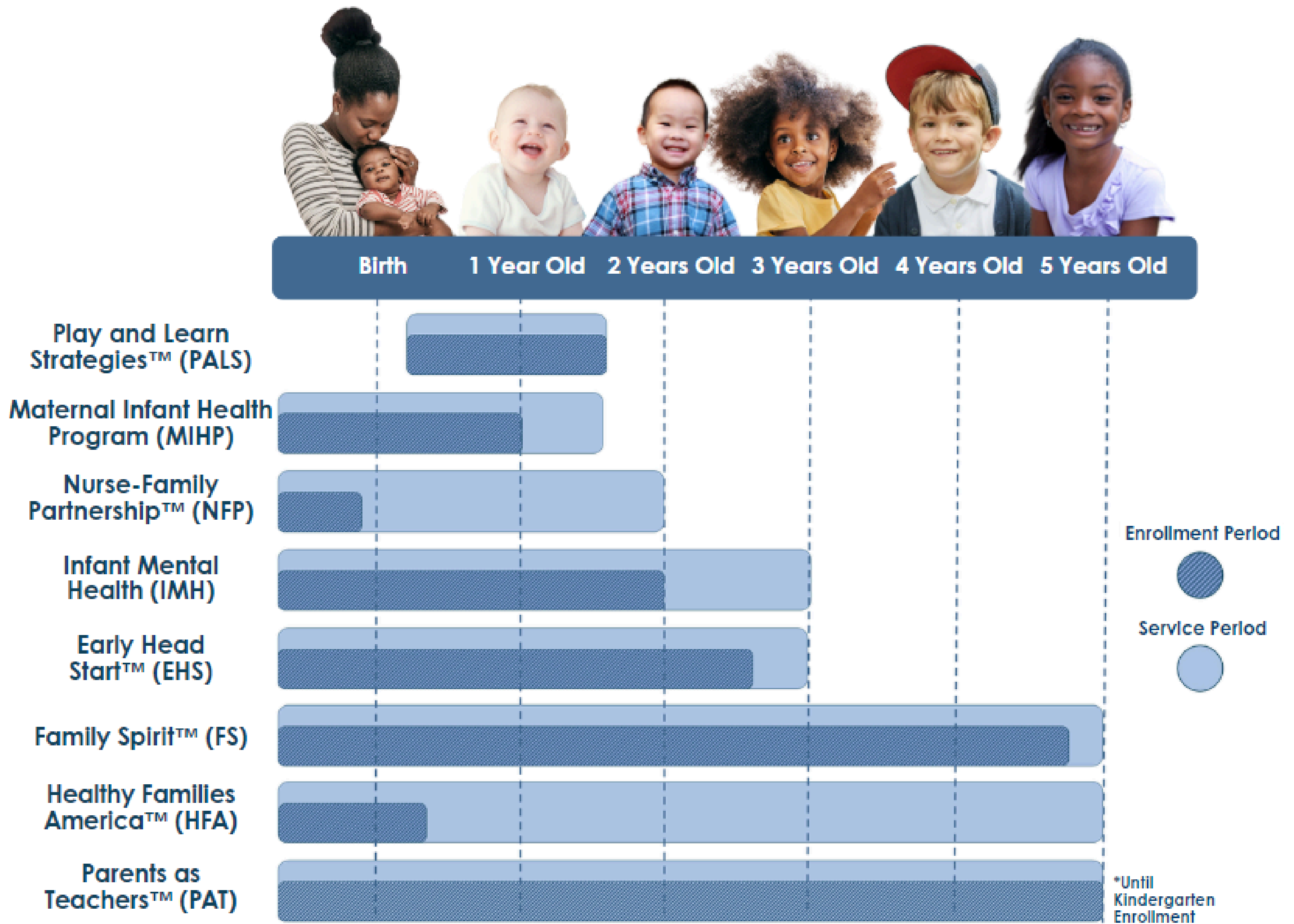
HOME VISITING IN MICHIGAN

Home Visiting programs partner with pregnant and parenting families to support them while they work to obtain their goals. In partnership with families, home visitors build trusting relationships and offer information and support as requested by families served. Using a two-generation approach, home visiting programs support parents as they foster their children's healthy growth and development. Through voluntary engagement in home visiting, parents nurture strong relationships with their children by enhancing parenting skills and working toward goals that benefit the whole family. Home Visiting programs adapt to the needs of families and are guided by the dreams and ambitions of the families they serve. Home Visiting in Michigan includes an array of options for families, which creates the potential to connect families with the type of home visiting program that best fits their needs. Home Visiting models have undergone rigorous evaluation and demonstrated many positive benefits for children and families, which ultimately benefit our communities and state as a whole. Home Visiting improves maternal and child health outcomes, prevents childhood injury and abuse, improves developmental outcomes and school readiness, and connects families with the supports they need to thrive.

The Home Visiting system in Michigan includes multiple models, each of which is unique in its design and adds to the array of options available for families. The image below outlines each evidence based Home Visiting model and describes the time frame of model enrollment and duration of service. Michigan's array of models supports families so they can be connected to a model that best fits their needs.



QUALITY IMPROVEMENT

QI is the use of a **deliberate and defined improvement process**, such as **Plan-Do-Study-Act**, which is focused on activities that are responsive to community needs and improving population health. It refers to a **continuous and ongoing effort to achieve measurable improvements** in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which **achieve equity and improve the health of the community**.

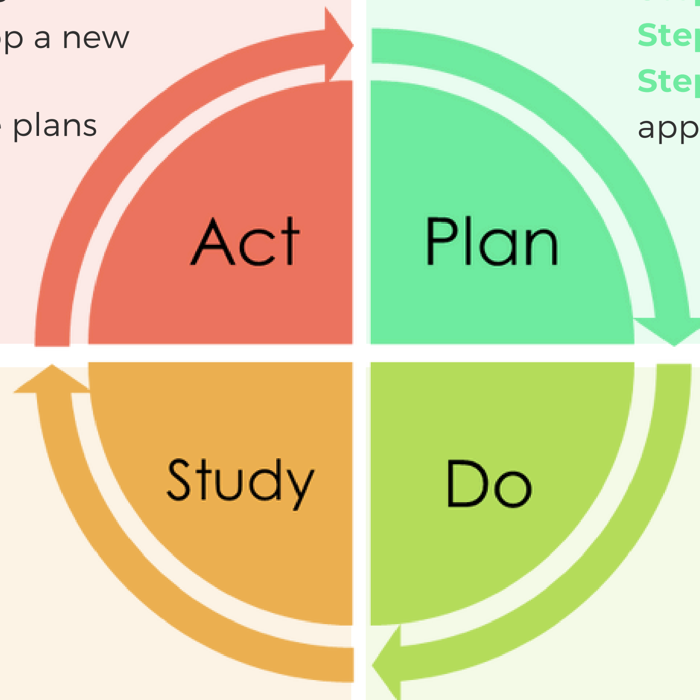
Step 1: Getting Started
Step 2: Assemble the team
Step 3: Examine the current approach

Step 4: Identify potential solutions
Step 5: Develop an improvement theory

Step 6: Test the theory for improvement

Step 7: Use data to study the results

Step 8: Standardize the improvement or develop a new theory
Step 9: Establish future plans

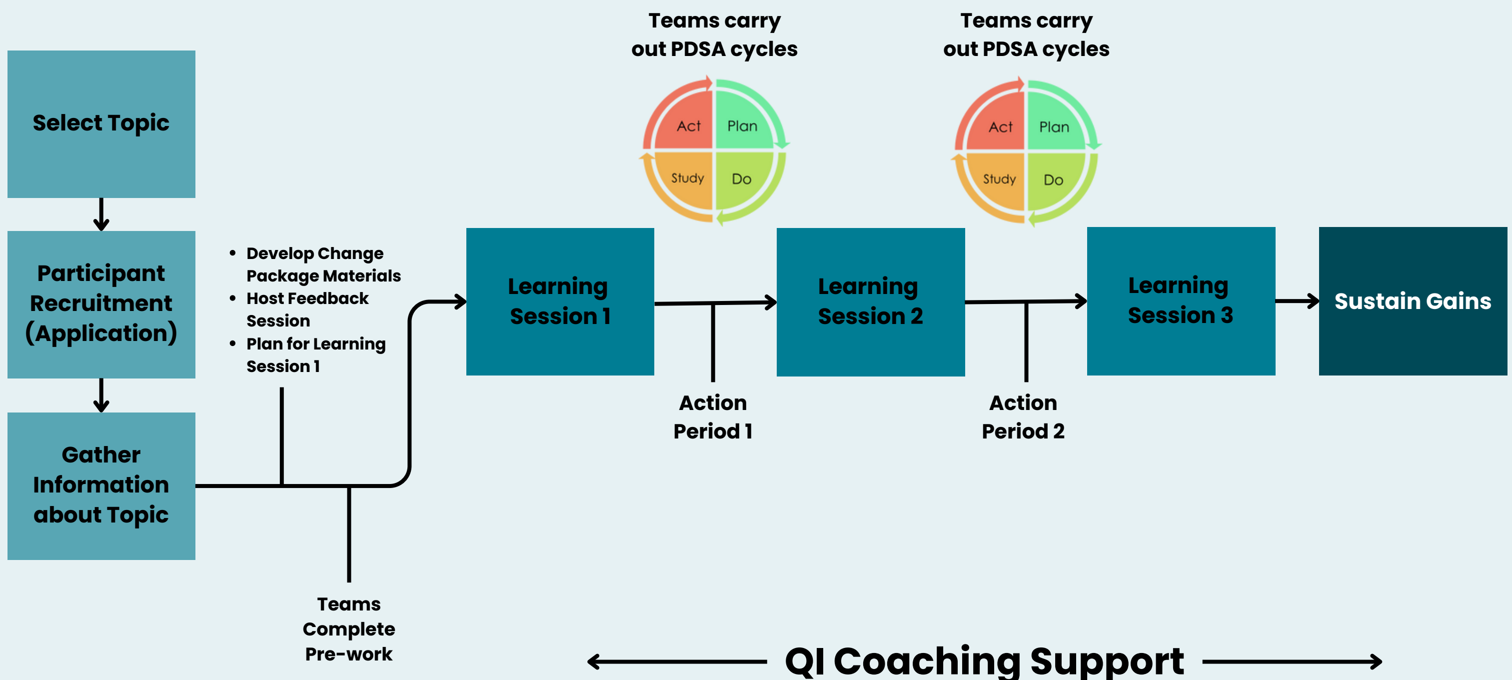


LEARNING COLLABORATIVES

What is a Quality Improvement Learning Collaborative?

Quality Improvement Learning Collaboratives are an improvement method that bring together teams who are facing similar challenges and desire to move towards a shared goal in one topic area.

QI Learning Collaboratives usually involve bringing together teams from different organizations and using experts to educate and coach the teams through their quality improvement efforts, implementing evidence-based practices, and measuring the effects. Learning Collaboratives tend to last between 12-18 months. During this timeframe, coaches and the planning team develop Change Package materials, orient the teams to the learning collaborative, teams conduct PDSA cycles, and data is tracked and reviewed on a regular basis.



2024 THRIVING FUTURES

QUALITY IMPROVEMENT LEARNING COLLABORATIVE

Overview

The Michigan Department of Health and Human Services monitored the early implementation of Thriving Futures to determine where supports may be needed. Thriving Futures is a combination of state and federal funding to increase access to home visiting services for families impacted by substance use and/or with child welfare involvement. Early implementation of Thriving Futures encountered challenges, particularly in engaging referral partners and families.

Based on these challenges, it was decided to convene a Quality Improvement (QI) Learning Collaborative (LC) in fiscal year (FY) 24 to support outreach and enrollment of families impacted by substance use or with child welfare involvement. A total of 23 home visiting programs implemented strategies to improve outreach to referral partners (like local MDHHS offices and staff) and increase family enrollment. Teams tested various strategies using PDSA (plan, do, study, act) cycles to improve and refine processes related to outreach and enrollment as well as strengthen partnerships with substance use treatment providers and local child welfare offices or agencies as referral sources.

Learning Collaborative Planning Process

During the early stages of planning for the Thriving Futures QI Learning Collaborative, the Michigan Public Health Institute (MPHI) developed a survey for local implementation agencies (LIAs) to determine what area they would like to focus on. Since the majority of teams were in the early implementation stages of their funding streams, they selected to focus on Outreach and Enrollment.

Following topic selection, MPHI QI staff gathered information on the topic area and began developing a Change Package. This included a:

- **Key Driver Diagram:** The Key Driver Diagram displays a shared theory of how outcomes might improve based on information gathered from research, observation, and experience, and sets forth the collaborative's goal. The primary drivers represent key components of the system that need to be in place to achieve the goal.
- **Driver Assessment:** The Driver Assessment supports teams participating in the Quality Improvement Learning Collaborative in understanding what they have in place with each primary driver and where they have opportunity to strengthen components of their processes that pertain to the topic for improvement.
- **SMART Aim Statement:** The SMART Aim Statement is a specific, measurable, achievable, relevant, and timebound goal the Quality Improvement Learning Collaborative is working toward with their improvement efforts.
- **Family of Measures:** The Family of Measures is a common set of measures that teams participating in the Quality Improvement Learning Collaborative share data on regularly to support an understanding of progress over time.
- **PDSA Planning Tool:** The PDSA Planning Tool is used to support teams in carrying out Plan-Do-Study-Act cycles. The tool helps teams maintain simple documentation of their improvement efforts.

Learning Collaborative participants were convened to provide and overview of the learning collaborative process, timeline, and next steps. Following the overview, QI coaches met one on one with individual teams to conduct some pre-work, which consisted of developing a process map of their outreach and enrollment processes, as well as completing an initial driver assessment. Initial baseline data for the family of measures was also collected during this time.

Overarching Aim Statement

By September 30, 2024, the FY24 Thriving Futures Outreach and Enrollment Quality Improvement (QI) Learning Collaborative (LC) will increase the percent of referrals converted into enrolled families by 12%

KEY DRIVER DIAGRAM

Primary Driver	Secondary Driver	Specific Strategies to Test	Resources
1. Outreach and Support	1. All HV program staff are well-versed in outreach approaches	(SD1) HV program, in collaboration with MDHHS and CWCS Analyst, develops outreach plan with other agencies/groups in local child welfare systems (can include: Team Decision Meeting facilitators, Private foster care agencies, Court Appointed Special Advocates, Hospitals/NICU, Early On, Residential/independent living facilities, Tertiary prevention programs – homebuilders/FTBS/FFM, Foster parents)	• FFPSA Outreach Powerpoint • HMHB Outreach Powerpoint • FLASH Outreach and Recruitment Study Report • HMHB Referral Sources
		(SD1) **Develop/revise and utilize a HV program outreach script or an 'elevator speech' that clearly and succulently communicates what the program is about and does for families**	• Outreach Scripts Examples • Outreach Toolkit – Engagement Script Guidance and Examples • DHHS Staff Interview Video • Combined Family Interview Video • Wayne HFA Team's PDSA Planning Tool Example • Individual family stories ◦ Jacquelyn's ◦ Emily's ◦ Ivana's
		(SD1) Connect with Child Welfare Community Service (CWCS) Analyst so they can help to facilitate contact with welfare worker in the local community	
		(SD1) Include parents receiving home visiting services in outreach activities (i.e., development/ revision of materials, conversations with referral partners, as referral sources, etc.)	

Primary Driver	Secondary Driver	Specific Strategies to Test	Resources
1. Outreach and Support	2. HV program and staff are well-known in the community	(SD2) Attend community meetings, groups, and events, relevant to target population, to increase visibility and build rapport	• MIECHV Press Release for Local Communities
	3. Referral partners are provided with the training and information they need about the HV program to understand the program	**(SD3) Develop/revise and utilize HV program marketing tools/communication materials that are strength-based that referral partners can use (note: these must be approved by MDHHS prior to use)**	• Promotional Material Tips for Home Visiting Programs • LA Outreach Flyer for Providers Example • Louisiana Outreach Infographic Example • Louisiana Outreach Radio PSA Example • HV Videos for Promotion • LA Outreach Flyer for Parents Example • Louisiana Outreach Story Gathering Sheet Example • Home Visiting FY22 Creative "Baby Steps" • Outreach Toolkit – Promotional Material Tips for Home Visiting Programs • Outreach Toolkit – Home Visiting Videos for Promotion • Wayne PAT ACCESS Team's PDSA Planning Tool Example • Bay Arenac PAT Team's PDSA Planning Tool Example
	4. HV program staff are supported and celebrated in their outreach efforts	(SD4) Ensure HV program staff job descriptions and responsibilities include outreach activities	• See Appendix A
		(SD4) Supervisors, as a part of supervision, check in with home visitors regularly on their outreach activities	• See Appendix A

Primary Driver	Secondary Driver	Specific Strategies to Test	Resources
1. Outreach and Support	4. HV program staff are supported and celebrated in their outreach efforts	(SD4) Professional development opportunities are provided to HV program staff to support their comfort level with conducting outreach activities (training on use of appropriate/non-stigmatizing language, FFPSA/HMHB eligible funding, Implicit Bias training, Health Equity training, trauma informed care, etc.)	• See Appendix A
		(SD4) HV program staff are recognized and celebrated for their outreach efforts	
2. Develop a Comprehensive Approach to FFPSA/HMHB Referrals and Enrollment	1. Maintain a robust network of referral partners	(SD1) Develop and implement a process for updating referral partner contacts regularly	
		(SD1) Share referral outcome with referral partners, as well as appreciation/thanks (send email, call the referral partner, send a thank you, etc.)	• Supervisor Referral Confirmation Email Example
		(SD1) Establish regular emails/communications with referral partners to create awareness of open caseload	• FSS Intro Email to MDHHS Example
	2. Maintain and implement process for receiving and processing FFPSA/HMHB referrals in a timely manner	(SD2) Streamline process for receiving and handling referrals from referral partners (i.e. common referral form, clear process for referring, etc.)	• ·Saginaw County FFPSA Procedure Example
		(SD2) Provide training to referral partners on how to make referrals	

Primary Driver	Secondary Driver	Specific Strategies to Test	Resources
2. Develop a Comprehensive Approach to Child Welfare and SUD Referrals and Enrollment	3. HV program staff are confident and skilled in supporting FFPSA/HMHB families through the enrollment process	(SD3) Try using the FFPSA Information sharing handout with families	
		(SD3) Follow up with unenrolled referrals by writing handwritten personal letters, phone calls, or connecting with case workers	
		(SD3) Utilize trauma informed practices when interacting with families during the enrollment process (inclusive language, transparency, and non-judgement, etc.)	
	4. Create and implement a 'warm handoff' process for families transitioning to/from child welfare services/SUD treatment services	(SD4) Initiate 'joint visits' between home visitor and MDHHS worker, with family consent	
		(SD4) Offer a 'meet and greet' visit before enrolling at a neutral location if desired/preferred by family	• ·Kent PAT Team's PDSA Planning Tool Example
		(SD4) Attend Child and Family meetings with MDHHS worker, with family consent	
	5. Referral and enrollment data are tracked and reviewed regularly by all HV program staff	(SD5) Establish/revise process for regularly collecting and compiling specific outreach and enrollment data elements	
		(SD5) Build outreach and enrollment data review into individual supervision and team meetings	
		(SD5) Create and utilize referral tracking tools that includes referrals received, referrals followed up on, and the outcome	• ·HMHB Client Data Entry Tracker Example

Primary Driver	Secondary Driver	Specific Strategies to Test	Resources
3. Build Trusting Relationships with Referral Partners	1. Consistent communication with MDHHS case workers/peer navigators occurs	(SD1) HV program meets monthly with their referral partners to maintain connection and discuss processes related to providing referrals	
		(SD1) HV program attends referral partner staff meeting at least quarterly to present and provide updates and foster partnership	
	2. Knowledge and information about family support services are shared between HV programs and child welfare/SUD treatment programs	(SD2) Exchange and discuss family progress updates between HV program staff and child welfare/SUD treatment services	
		(SD2) Home visitors use the FFPSA monthly update form to communicate family engagement with services to MDHHS welfare worker	
		(SD2) Invite local MDHHS workers to Local Leadership Group (LLG) or other HV coordination meetings to become familiar with home visiting services available in the community	
		(SD2) Plan and participate in 'cross-trainings' to share knowledge and resources across service systems (includes basic overview of how each system involved works, opportunities for cross system problem solving and networking, and identifying community-level planning needs for ensuring families receive services, etc.)	
	3. Time and effort is dedicated to connecting with referral partners to foster effective collaboration	**(SD3) Find ways to show appreciation/thanks to referral sources to reinforce relationships** (ex: celebration/recognition of staff by sending email to supervisor/acknowledging them at a staff meeting, thank you letters when they send referrals, etc.)	• ·Wayne HFA Team's PDSA Planning Tool Example
		(SD3) Incorporate team building activities into group meetings with referral partners to build relationships and foster trust	
		(SD3) Develop and implement partnership agreements to support productive collaboration	

OUTREACH TOOLS

PROMOTIONAL MATERIAL TIPS FOR HOME VISITING PROGRAMS

01. Use bulleted lists instead of paragraphs

02. Use photos to create interest

03. Use consistent fonts and type size throughout the document

04. Share family quotes

05. Use sans serif fonts for readability

06. Use graphics or icons, less text

07. Consider using a grade level check website to try to keep the language close to an 8th grade reading level

08. Use QR codes and links

What to include:

- Lead with the benefits for the families (some programs can help with diapers, formula, transportation, etc.)
- Focus on what the program does (long-term support, resources/connections offered, focusing on family goals, etc.).
- Ensure language is strength-based and inclusive
  - Don't use language like "help" or "at risk"
  - Use substance use instead of misuse
- Add language about voluntary nature, family led goals, and information sharing with MDHHS or other referral partners. Examples:
  - The family and Home Visitor work together to set family led goals and focus on attachment, child development, and the importance of play.
  - Services are voluntary- you are able to leave the program at any time.
  - With your consent, information about participation and progress will be shared with MDHHS

TIP SHEET IN ACTION

HOME VISITING IN MICHIGAN

Use bulleted lists instead of paragraphs

What is Home Visiting?

- Free, voluntary, in-home (virtual/neutral location available), family support services.
- For pregnant people and families with children ages 0-6.
- Connects you with caring professionals for support, coaching, encouragement, and referrals to services.
- Services are voluntary - you are able to leave the program at any time.
- Focused on your family goals and concerns.
- Some programs are able to offer you diapers, formula, help with transportation, etc.
- With your consent, information about participation and progress will be shared with DHHS caseworkers on a monthly basis.

Use photos to create interest; where possible, use photos of families from your own program that represent a variety of families and caregiver types

Use consistent fonts and type size throughout the document

What Families Have to Say About Home Visiting:

"How good it is to have the extra support. It was nice to have someone to talk to."

"Home visitors become like family members."

"Home visiting helped the entire family. It was great having a cheerleader throughout my parenting experience."

Share family quotes

Use sans serif fonts for readability

Home Visiting Focuses On:

Use graphics or icons, less text

Family-centered goals (returning to school, job training, housing, etc.)

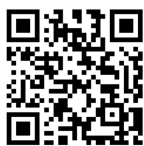
Coaching to support a healthy pregnancy

Family connection and parent-child relationships

Promoting healthy childhood development (screening for milestones, autism, etc.)

Connect with community resources and services

Use QR codes and links



For more information on evidence-based home visiting in Michigan visit:
https://www.michigan.gov/homevisiting/

Consider using a grade level check website to try to keep the language close to an 8th grade reading level

Things to Consider:

- ADA compliance strengthens document readability for everyone. Consider accessibility best practices when designing documents: https://brand.umich.edu/design-resources/accessibility/
- Try to only have one QR code or link. If there is a live person that folks can talk to for a referral, include the contact information as well.

HOME VISITING IN MICHIGAN

Home Visiting Videos for Promotion

Videos from Michigan:

- Overall Benefit of Home Visiting: Home Visiting Video
- Michigan Home Visiting Parent Stories
- Michigan Home Visiting Social Media Video
- Stories from Michigan Home Visiting Families

Model Specific Videos from Michigan:

- Nurse Family Partnership: https://youtu.be/O56clomqMwE
- Early Head Start – Home Based: https://youtu.be/sVNc8zBwlyY
- Healthy Families America: https://youtu.be/ntjol07tcX4
- Play And Learn Strategies – Infant: https://youtu.be/m_IckoClKqo
- Parents As Teachers: https://youtu.be/IV6fpbsjGOs
- Maternal Infant Health Program: https://youtu.be/xtGRArvZVUI
- Family Spirit: https://youtu.be/ROBLDv7_LU4
- Infant Mental Health: https://youtu.be/PYRwBJFw_bQ

Additional Videos For Reference:

- N-MIECHV: What a Home Visit Looks Like - YouTube
- N-MIECHV: Bilingual and Bicultural Home Visitors Meet Families Where They Are - YouTube
- N-MIECHV: Home Visitors Are Partners in Family Resilience - YouTube
- N-MIECHV: What Is Home Visiting? - YouTube
- Home Visiting - A Closer Look | Pew - YouTube
- Be Brave: A Story of Early Childhood Home Visiting - YouTube
- My Future Could Have Looked Another Way - YouTube
- Ohio Help Me Grow Home Visiting - YouTube
- Maternal Infant Early Childhood Home Visiting - YouTube
- “Emily's story": features a single mother referred to Family Home Visiting by her doctor
- "Ashley's story": features a 2 parent household having a second-child
- "Joseph's story": features a single dad
- "Diane and Louie's story": features grandparents caring for a newborn

HOME VISITING IN MICHIGAN

Engagement Script Guidance and Examples

When a provider is identified and receives the referral, the expectation is that the provider will start outreach and, if all goes as planned, enrolls the family into home visiting services. The provider will be expected to reach out and sell their own program to the family. The family may not know specifics about the program they are being referred to so it will be important for each program to convey what they are able to offer and expectations.

Things to Keep in Mind:

- An important thing to keep in mind is that Michigan has a wide range of home visiting programs and models and therefore it will be important to communicate what your program is able and unable to provide. Most referral sources are accustomed to working with a wide range of community resources and should not be expected to know the nuances of the services offered by each home visiting program.
- Regardless of how a family was referred to the home visiting program the first step would be to talk with the family about the importance of this being a voluntary service for them and to explain the benefits and expectations of your particular program to ensure they have a true understanding of what they are enrolling into.

HOME VISITING IN MICHIGAN

Engagement Script Guidance and Examples

Example Scripts:

Make sure to edit scripts to be specific for your program and home visiting model.

- **Focusing on Parent/Caregiver:** Being a parent/caregiver can be stressful. But, it can also bring you joy and be your most rewarding job. Working with a ________ can help. It's free, voluntary and takes place in the comfort of your own home , virtually, or somewhere in the community like a park or library. A _______ understands the challenges of being a parent/caregiver and is someone you can talk to about the stresses and joys of being a new parent/caregiver. A ________ is a resource you can rely on for support and advice. What happens during a visit is organized around your goals and priorities. They will also talk with you about how your baby/child is growing and what you can do to get your baby/child off to a healthy, strong start, ready for school and ready for life. Can I introduce you to a __________ to learn more/Can we set up a time to meet to get to know one another?

- **Focusing on Child Development:** Babies/children don't come with instruction manuals, but being a parent/caregiver can be one of the most rewarding jobs you have. Family Home visiting is free and voluntary. A ________ can meet you where you are—in your home, virtually, or in the community at a park or library and is based on your goals. __________ can help you tap into your strengths and love for your baby/child so you can be the best parent/caregiver for your baby/child. _____ can provide information and support during pregnancy and throughout a child's earliest years—a critical development period. They will talk with you about how your baby/child grows, how to bond with your baby/child and how to help your baby/child stay healthy and get off to a strong start. Can I introduce you to a_______ to learn more/Can we set up a time to meet to get to know one another?

MICHIGAN HOME VISITING INITIATIVE (MHVI) QUALITY IMPROVEMENT (QI) EFFORTS

Outreach and Enrollment Strategies that were Tested and Adopted

This document outlines strategies QI teams tested in the space of outreach and enrollment through Plan-Do-Study-Act (PDSA) cycles that were adopted into regular practices. If your team is faced with opportunities for improvement in family outreach and enrollment, remember you do not need to necessarily develop a unique strategy to test. Look at those detailed below and see if there is one your team can try out in your program to overcome a similar challenge.

Previous QI Learning Collaboratives

Additionally, here are links to past QI Learning Collaborative materials that may be helpful in this space, too.

- **FY 21-22 Engagement and Retention in the Virtual Environment and Beyond Learning Collaborative**
  - Key Driver Diagram
- **FY 19 Family Retention and Engagement Learning Collaborative**
  - Key Driver Diagram
  - Measurement Strategy
- **FY 16 Enrollment Learning Collaborative**
  - Key Driver Diagram
  - Measurement Strategy
- **FY 16 Retention Learning Collaborative**
  - Key Driver Diagram
  - Measurement Strategy

MICHIGAN HOME VISITING INITIATIVE (MHVI) QUALITY IMPROVEMENT (QI) EFFORTS

Outreach and Enrollment Strategies that were Tested and Adopted

Strategies Related to Outreach	
Change Tested	***Local Implementing Agency (LIA) who Tested Change***
Support a Refer-a-Friend process where current participants receive incentives to tell family/friends about the program.	Family Futures HFA
Program sends a personal email or letter to potential referral sources with an informational flyer about the program.	Ingham Intermediate School District (ISD) HFA
Track the distribution of updated program posters to expand exposure to the program; after a completed enrollment, send referral source a written 'thank you' with a small gift (HFA white board).	Ingham ISD HFA
Focus on face-to-face connections with potential referral sources to explain programming.	Kalamazoo County Health and Community Services HFA
Conduct regular recruitment to local agencies who do/can provide referrals to establish relationships with staff at locations.	Capital Area Community Services EHS
Home Visitor from program goes to women's health clinic every other week to provide education and recruit potential families.	Oakland County Health Division NFP
Use an intentional process of regularly checking in with potential referral sources to continue to build referral network.	Hurley Medical Center NFP

MICHIGAN HOME VISITING INITIATIVE (MHVI) QUALITY IMPROVEMENT (QI) EFFORTS

Outreach and Enrollment Strategies that were Tested and Adopted

Strategies Related to Enrollment	
Change Tested	***Local Implementing Agency (LIA) who Tested Change***
Send out an initial contact letter to potential families (with magnet as a small gift) within 2 days of receiving a referral.	Kalamazoo County Health and Community Services NFP
Within 24 hours of referral receipt, contact referral via phone. If referral is not reached via phone, send a letter to address on file within 24 hours.	Saginaw County Health Department NFP
Use the Family Expectations Checklist in order to assess the needs of families during the enrollment process.	Saginaw ISD HFA
Use scripted texts to connect with potential families who have been referred.	Calhoun County Health Department NFP
Send initial contact letter to families being referred on colored paper and bright envelope before home visitor reaches out via phone to make initial contact and schedule first visit.	Calhoun County Health Department NFP
Home Visitor is present in partnering WIC clinic at least 2 times/month, utilizing face-to-face contact and a personalized flyer during the referral/screening process.	Health Department of Northwest Michigan HFA
Use a participation charter or agreement to explain the program and expectations of participating at enrollment (and use it as a 'check in' if engagement declines).	Oakland Livingston Human Services Agency EHS

STRATEGIES TO ENGAGE AND RETAIN FAMILIES IN HOME VISITING

Recommendations from Parents and Caregivers

What strategies could home visitors use to help families feel more receptive to trying home visiting?

Program Promotion

- Lead with the benefits that home visiting can provide for the family (long term support, transportation, resources, family goals, etc).
- Ensure promotional materials are strength based and don't use terms such as 'at risk, help,' etc. Instead use messaging around why home visiting can benefit everyone (children don't come with instruction manuals, etc).
- Share videos about services with families - especially if they include voices of other parents.

Program Flexibility

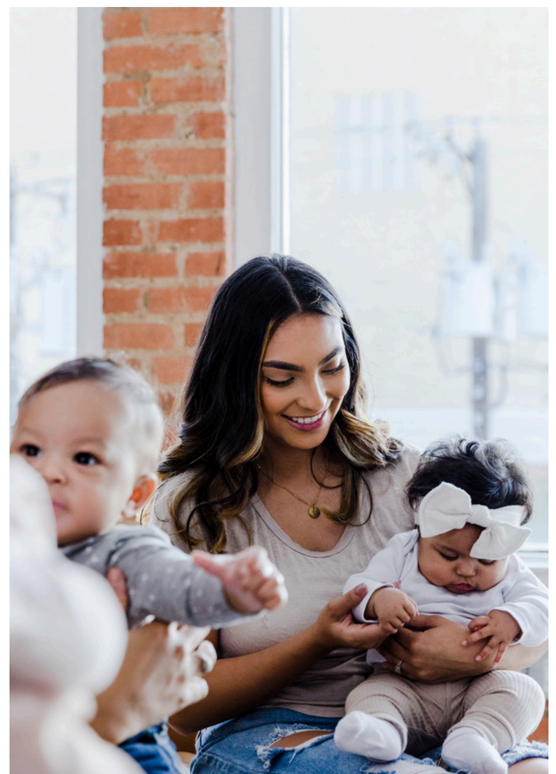
- Where applicable, continue to offer and share about any program flexibility (frequency of visits, length of visits, where to meet, etc.)
- Highlight that families have the freedom to leave services at any time - services are voluntary and there is no penalty for leaving early.
- Offer zoom, phone, or other connections outside of the home - especially at first when getting to know the family.
- Keep visits shorter, especially if the family is overwhelmed, and be flexible. Overlap visits and services when possible, to make it easier on the family.
- Attempt to meet the most important needs of the family before diving into the curriculum.

Communication and Transparency

- Let families know up front when you are available and when you aren't (evenings, weekends, etc).
- Provide contact information for supervisor with offer that, if not feeling like a good fit, family can try a different home visitor.
- Be up front about being a mandated reporter but emphasize that provider wants family to succeed with ultimate goal of family staying together- be clear that home visiting is not child welfare/CPS.
- Ask family about cultural preferences/practices before first visit.
- Be careful what you say you can do or the promises you make to a family - don't leave assessed needs unaddressed and if you promise to bring something the next visit, make sure to follow through.
- Be respectful of the parent/caregiver's time - if you are running late, text to let them know and see if they need to reschedule.
- Explain screening or assessment results with parents/caregivers.
- Appreciate being up front: "these forms have to be done as a part of the program".
- Check-in early with families, asking "How is home visiting going for you? Is there anything you need?"
- Ensure you are not communicating in a way to make families feel guilty if needing to cancel/reschedule.
- Try to share advice as 'this has worked for me/other families' instead of as something a family has to do.
- Ask each family how they prefer to be reminded of upcoming appointments and follow through with appointment reminders in preferred format
- Set up a notebook for the family to use to collect information on visits, contacts, appointments, etc.
- Provide refrigerator magnet with provider contact information for easy reference in case of lost or broken phones.
- Provide contact information for supervisor so that family can reach out themselves with concerns or to request a different provider if not a good fit.

Collaboration, Connection, and Referrals

- Use parent partners or peer navigators, where possible, to introduce services. Can also do warm-handoff meeting with any existing providers (Early On, etc.).
- Ensure you are providing effective referrals - know the details of accessing resources.
- Highlight any opportunities for families to build their village/community (playgroups, peer connections, etc.)
- Want providers to make distinction between what is a true safety concern and what is just different than what is 'normal' to you before making any CPS report.
- Do assessments casually or conversationally, don't go off a script or ask a string of questions.
- Be the intermediary/advocate for families with other services/providers if families are not getting a response or their needs met.
- Make sure parents are offered supports for their own trauma and mental health needs.



Engagement and Rapport Building

- Consider offering a meet and greet visit before enrollment, if agency allows.
- Families can feel when they are being judged. Have compassion and kindness in your interactions.
- Sit on the floor with the parent and help fold laundry.
- When you walk into a home and see a child struggling - try to be mindful that having a visitor in the home can be dysregulating for children and may not be a true reflection of child's 'normal' behavior.
- Important to parents/caregivers that their home visitors care about them and asking about their personal life, not just them as a parent/caregiver.
- Verbalize that you want to collaborate and not push an agenda. Really listen and respect that families know what they need and that they can set their own goals that you can support by breaking down into small steps.
- Be mindful of the stress that families are undergoing, there are a lot of asks of families.
- See the experience behind the emotions. Sometimes anger, frantic energy, seeming shut down, etc. masks deep care, concern, and worry about their children.
- Tell parents/caregivers what they are doing well. Provide praise and positive feedback as often as you can.
- Use strategies to engage fathers and all family members present.
- Provide opportunities for families to provide feedback, support parent leadership opportunities, and incorporate parent voice whenever possible.

STRATEGIES FOR CONNECTING WITH REFERRAL PARTNERS

The importance of collaboration, coordination, and communication between home visiting programs and potential referral partners is vital. The scope of potential referrals partners for home visiting is broad, including WIC, child welfare, health care providers, Early On, and many others. In Michigan, the hope is to have coordinated outreach on behalf of the local home visiting system instead of individual programs. Referral partners can be easily become overwhelmed and confused if they have multiple home visiting programs/models conducting outreach. Creating collaborative relationships between home visiting programs at the local level is key to a coordinated outreach approach that will benefit all local home visiting programs and center family choice in the program that will best fit their needs.

Suggested strategies for local home visiting programs to build a collaborative relationship with referral partner agencies:

Getting in the Door

- Send introductory email with information about program and any promotional materials.
- In-person outreach tends to be more successful than phone or email only. It is courteous to call or email to set up a time to go in-person to talk with the agency about home visiting.
- See if there are staff or team meetings that you could join to present about home visiting.
- If allowable, provide treats such as doughnuts, candy, etc. when meeting in-person with referral partner.
- Determine 'gatekeepers' (who makes most of the referrals for the agency?) and begin to build a relationship.

Providing Training and Support for Referral Partners

- Provide basic training on how to talk about program with families and how to make a referral
- Provide engagement script examples for referral partners to use
- Work with partners to streamline referral process and follow up expectations
- Create and share policy or procedure related to information sharing between home visiting programs and referral partners including what can/should be shared, what may not be shared, and the conditions under which information sharing can take place (e.g., whether client permission is needed).
- Consider having a family that has participated in home visiting program share with referral partner about their experience with the program and any tips they would have about how to engage families in the program.

Deepening Referral Relationship Once Initiated

- Suggest regular meetings with referring agency and HV program to review referrals and problem solve implementation challenges.
- Send a regular email to referring agency with # of openings in HV program (email should include HV program eligibility criteria, HV referral form, videos, flyer, etc.).
- Ask to attend staff meetings at least quarterly to keep services in the mind of staff and provide education to new staff about home visiting services (this is a great time to bring goodies or say thank you to staff that have been referring!).
- Invite agency representative to Local Leadership Group (LLG) or other HV coordinating meetings to become more familiar with home visiting service array.
- Share information about any new community resources that referring agency might be interested in for their families/clients.
- If home visiting system is hosting or becomes aware of a training that might be of interest to the referring agency, share the opportunity and invite them to attend.
- See if there are any boards or meetings that the referring agency has need for community partners to join.
- Consider if home visiting program staff could be present at referring agency for regularly scheduled times to connect with referral partner and recruit potential families.
- Ensure have an outreach plan to coordinate outreach activities across team including assigning one primary contact person to reduce confusion for referral partner. Also make sure to update referral partner contact information.
- Ask referral partner to include home visiting programs if hosting any community events or resource fairs. If home visiting program or agency is hosting community event or resource fair, ask referral partner if wanting to participate.

Building a Relationship With an Individual Referring Partner

- After receiving a new referral, reach out by email or phone to say thank you for the referral, introduce yourself, let them know what services your program can provide the family, and how they can contact you.
- If you receive a new referral from someone that hasn't previously referred, make sure to thank them and provide an opportunity to ask questions about the service, communication expectations, etc.
- Ask the referring partner what their preferred contact method is.
- Be clear about communication expectations (timeframe to let them know if family enrolls, do they need any other updates in the future, etc).
- If struggling to connect with a family, see if the referral partner has any new contact information for the family or if there would be an opportunity to do a joint visit in-person or virtually (warm handoff) to introduce you to family.
- Share shout outs for frequent referring agency partner staff or staff that you see going above and beyond to support their families/clients/community with their supervisor.