DEPARTMENT OF HEALTH

# Family Home Visiting

## Enrollment, Engagement, and Retention Toolkit

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# Summary

MDH facilitated a statewide Family Engagement Learning Collaborative that ran from February 1 – September 30, 2018. The goals were to improve family enrollment, engagement, and retention. Participants managed iterative cycles of training, testing and implementation of changes using the Plan-Do-Study-Act (PDSA) cycle, and evaluation. MDH provided tools to teams at the beginning of the Collaborative to support change. Teams also independently created tools to test and implement changes. A total of 15 local home visiting programs participated in the Family Enrollment, Engagement, and Retention Learning Collaborative including:

**MIECHV**

- Anoka County
- Cass County
- Dakota County
- Faribault-Martin Counties
- Kanabec County
- Morrison-Todd-Wadena Counties
- Mower County
- Partnership4Health + Polk-Norman-Mahnomen CHBs
- Stearns County
- Washington County

**Non-MIECHV**

- North Country + Beltrami + Quin CHBs
- Pine County

This toolkit provides a compiled list of resources utilized throughout the Family Enrollment, Engagement, and Retention Learning Collaborative. Some of these tools are evidence-based. Tools that are evidence-based will be noted and additional resources to support implementation of these tools will be linked within this toolkit. Other tools were created by Family Home Visiting Continuous Quality Improvement staff and participating programs, who we acknowledge and thank for their work creating, testing, adapting, and sharing these tools.

The Learning Collaborative focused on addressing and improving five key areas of home visiting practice that could improve enrollment, retention, and engagement of families:

- Competent and skilled workforce to support enrollment and retention
- Comprehensive data-tracking system to monitor key indicators
- Prompt and appropriate enrollment of eligible families (includes referral processes)
- Intense early engagement (i.e. during first 3 months) –establishing relationship, setting up expectations, understanding client's goals
- Active involvement of families in home visiting program – parent leadership included here

This toolkit is organized by the five practice areas and includes key takeaways learned from the Learning Collaborative. Key takeaways represent opportunities for improvement that supported positive change in one or more programming areas.

# Competent and Skilled Workforce to Support Enrollment and Retention

Home visitors provide invaluable services to families and children. Staff satisfaction and access to training can support home visitor satisfaction and education while monitoring compassion fatigue and reducing employee burnout. Key takeaways to support a competent and skilled family home visiting workforce include:

- Utilize a tool such as the ProQoL (Professional Quality of Life) to assess factors that affect home visiting staff satisfaction and retention.
- Provide access to training opportunities, both in-person and online.

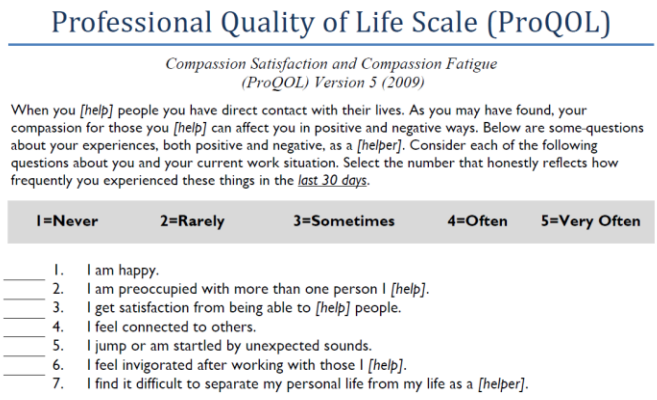
The **Professional Quality of Life (ProQoL)** tool can be utilized to assess staff satisfaction and measure compassion fatigue. Organizations could utilize the ProQoL at regular intervals to identify and support staff members struggling with compassion fatigue, burnout, or secondary traumatic stress. Regularly assessing workplace factors that affect home visiting staff satisfaction and retention can improve retention of families as well as many families disenroll during times of staff transition.

As home visitors identify and strategically address areas for improvement, providing access to training can build staff skill and confidence in targeted areas. The Institute for the Advancement of Family Support Professionals offers free online modules. There is a two-part module available on family engagement and working with parents that learning collaborative teams found to be helpful.

## Professional Quality of Life

The Professional Quality of Life (ProQoL) tool was developed by Dr. Beth Stamm and is designed to assess the positive and negative effects of helping others in a human service profession. The ProQoL is free to use. The ProQoL measure, handouts, and permission to use the tool are available online. To access the most current version of the ProQoL, visit the ProQoL website.

**Figure 1: A section of the ProQoL tool.**



Professional Quality of Life Scale (ProQOL)

*Compassion Satisfaction and Compassion Fatigue*
*(ProQOL) Version 5 (2009)*

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

| 1=Never | 2=Rarely | 3=Sometimes | 4=Often | 5=Very Often |
|---|---|---|---|---|

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.

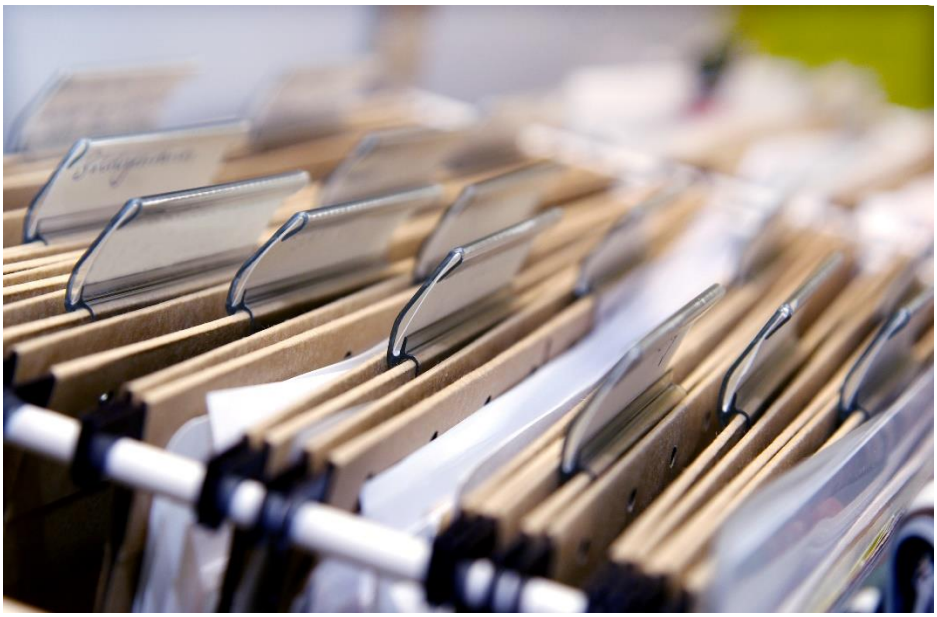
## Comprehensive Data-Tracking System

Home visitors must collect and share a lot of information about the families they are working with. Many home visitors have very large caseloads and managing data can become a big task and source of frustration. Organizational efforts to improve data-tracking systems can ease burden on home visitors to keep track of contacts made with families. Key takeaways to improve comprehensive data-tracking systems include:

- Document procedures for a streamlined referral process that includes warm hand-offs whenever possible and regular feedback to referral sources.
- Streamline data systems for data collection and entry.
- Update organizational policies to reflect changed data tracking systems.

A **referral tracking tool** can be used to record information on when a referral is received, when a home visitor contacts a family, and if the family decides to meet with the home visitor. The referral tracking tool collects the family's contact information, the date of the initial home visit is scheduled, and any follow-up needed.

A home visitor could use a **caseload tracking tool** to record how many visits they had with a family in a month. This tool could be utilized to easily identify families that could be re-engaged using creative outreach strategies.



# Referral Tracking

**Today's Date:** _____ **Referral Source:** _____

**Client Name:** _____ **Phone Number:** _____

**Address:** _____

## Accepts face-to-face

Home Visitor Assigned: _____ Visit Date: _____Visit Time: _____

Additional comments for home visitor: _____

_____

Did client speak with home visitor during initial phone call? YES NO

Case Number: _____

## Declines face-to-face

Circle reason(s) for decline.

- Doesn't need/want
- Has other services
- No time
- Doesn't want home visitor in home
- Husband/partner objection
- Other (specify): _____
- _____

Did client speak with home visitor during initial phone call? YES NO

## Follow up required

Circle and provide dates of mailing and appointments.

- Sent brochure/postcard
- Did client keep appointment? YES NO
- If NO, was it rescheduled? YES NO

## Caseload Tracking Tool Example

Record client initials, month, and number of visits. Color-coding of the clients that are keeping scheduled appointments, those that have missed appointments, and those that are not engaging in services can provide a quick visual picture of which families could benefit from creative outreach or need to be closed.

| | **January** | **February** | **March** | **April** | **May** | **June** |
|---|---|---|---|---|---|---|
| **Client A** | | | | | | |
| **Client B** | | | | | | |
| **Client C** | | | | | | |
| **Client D** | | | | | | |
| **Client E** | | | | | | |

# Prompt and Appropriate Enrollment of Eligible Families

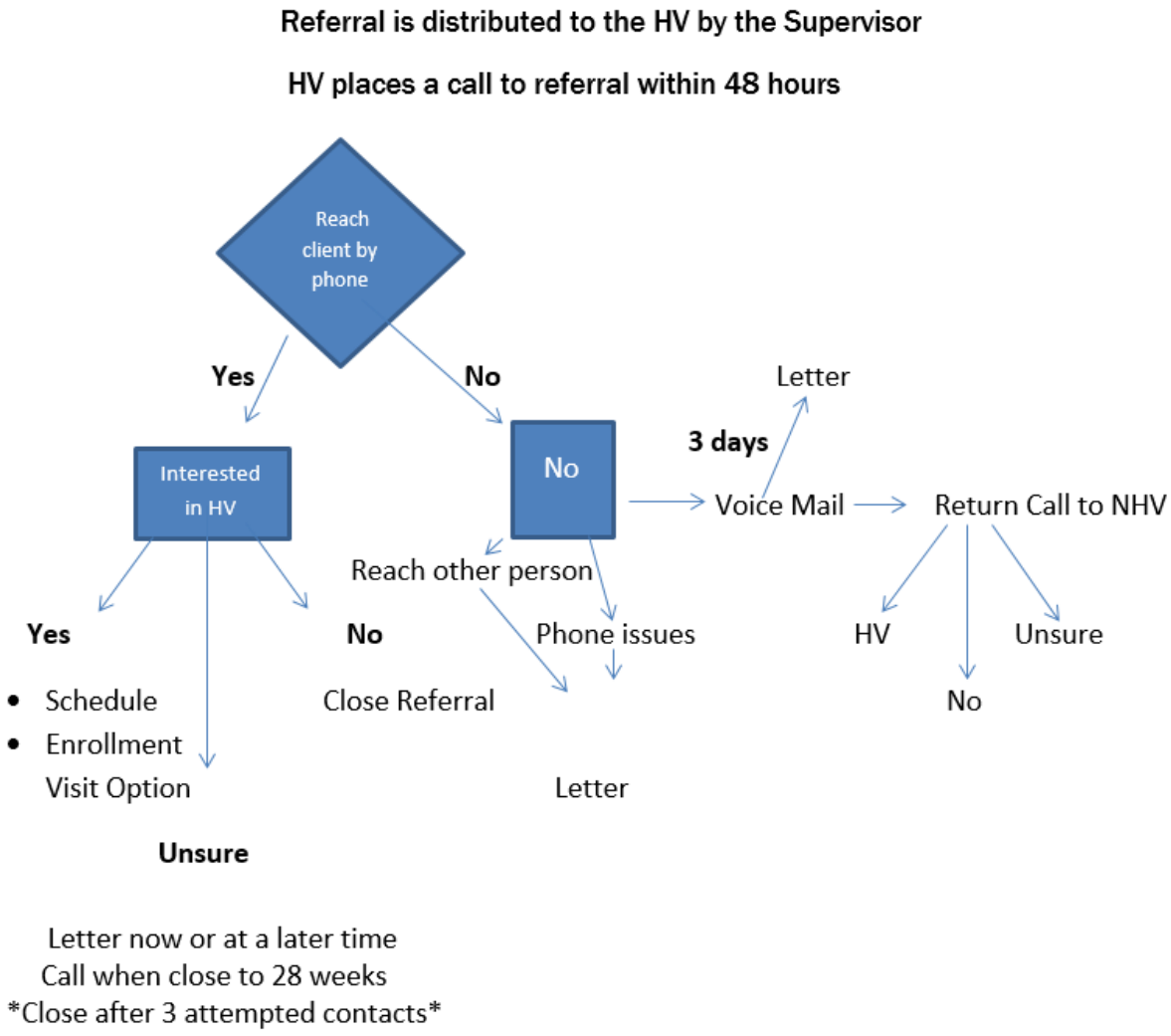
Prompt enrollment is defined as families receiving their first face-to-face contact within 14 days of referral. Two goals of the Learning Collaborative were to decrease the average number of days between referral and face-to-face contact and between referral and enrollment. Data showed that the faster families met with a home visitor face-to-face, the more likely they were to enroll in services. Key takeaways to improve prompt and appropriate enrollment of eligible families include:

- Connect with families face-to-face as soon as possible after referral.
- Document procedures for a streamlined referral process that includes warm hand-offs whenever possible.
- Regularly communicate with and seek feedback from referral sources.
- Enroll families quickly after referral.

Improving the referral and enrollment processes to be faster and more convenient for families can increase referral and enrollment numbers. Family home visiting agencies can utilize a **process map for referrals** to identify areas for improvement, especially when working with referral partners. Providing referral partners with a screening tool can support identification of families in need of home visiting services. Training referral partners on how to complete referral documents and provide the referral to the home visiting agency can decrease time between referral and enrollment. Referral partners can also display marketing materials, an **expectation handout**, and **Refer a Friend cards** to provide families with more information on home visiting services.

Home visitors can utilize a **welcome letter** and a **personalized card** introducing the home visitor to the family to support a warm hand-off between the referral partner and the home visitor. The referral partner could provide these materials to a family at the time of referral or the home visitor could send these materials to the family prior to their first visit.

## Process Map for Referrals Example



# Expectation Handout Example

Welcome to *AGENCY NAME HOME VISITING*! As the parent of a newborn you are well aware that you are about to embark on an exciting (and sometimes challenging) new adventure. *AGENCY NAME* is excited to be a part of the journey!

## How does home visiting work?

Our Home Visitors offer support and encouragement by:

- Visiting you weekly in your home (less often as time/need warrants)
- Answering your questions
- Showing you great ways to play with and enjoy your baby
- Connecting you with other new parents and community resources
- Providing links to quality childcare, medical care, and learning opportunities

You can expect:

- Having a supportive and listening ear to help with the challenges of raising an infant
- Participation in the Ages and Stages Questionnaire so that you can know exactly where your child is developmentally
- Handouts full of information on relating to your baby and fun play ideas
- Monthly playgroups/learning sessions
- Help with transportation
- Opportunities to provide feedback via parent groups/testimonials
- Small goodies throughout the year

## Contact Information:

Telephone Number Address Email

# Refer a Friend Card Example

This refer a friend card was created by Healthy Start in Michigan. A refer a friend card could look very different for your home visiting agency, but important information to include is the name of the person being referred, contact information, and preferred time to contact. It could be helpful to include information on when the person being referred could expect a home visitor to contact them and the phone number of the home visiting agency.

**Healthy Start**

Name of parent being referred: _____

Parent Contact Info:

Telephone: _____

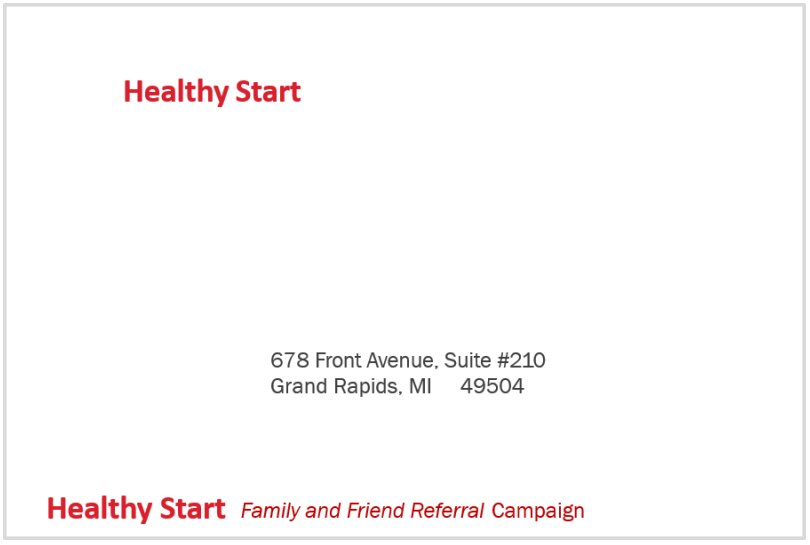
Preferred time to call:_____AM - PM

A new little one is here! *(birth date)* _____

A new little one is due soon! *(due date)* _____

My name: _____

* Eligibility requires a minimum of 3 in-home visits



**Healthy Start**

678 Front Avenue, Suite #210
Grand Rapids, MI 49504

**Healthy Start** *Family and Friend Referral* Campaign

# Welcome Letter

*Name of mom*,

You are going to have a baby! This moment can bring many feelings like: joy, excitement, surprise, or worry, among many others. You may be wondering what is next because there is much that will change, but you don't have go through it alone. My name is *name of home visitor*. I work with *home visiting agency name*, and I would love tell you how I can help you through this journey.

- As a nurse, I can support moms with the following:
- Having a healthy pregnancy and baby.
- Learning about prenatal care, child development, and becoming a parent.
- Learning ways to play with your baby that will help stimulate brain development.
- Building a strong network of support for you and your baby.
- Making your home a safe place for baby to live and play.
- Connecting to services and resources in your community.
- Setting goals for your family's future and finding ways to help reach them.
- And much more…

This is a free, confidential, non-judgmental, and voluntary service for you.

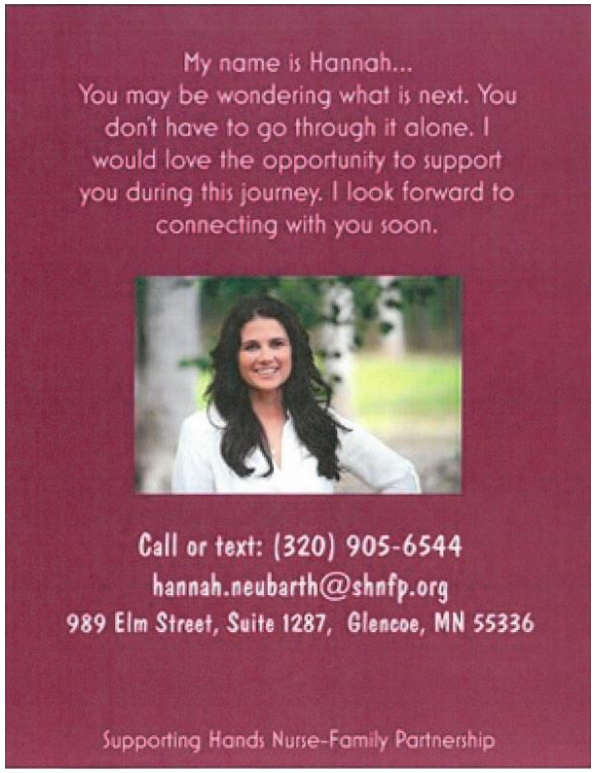
I have enclosed my personalized card with my contact info. If you have any questions or would like to know more about the program before I call you, I would be very happy to answer and provide you with additional information. You can reach me at *XXX-XXX-XXXX*.

Thank you for your time! I look forward to talking to you soon!

Sincerely,

*Name of home visitor*

## Personalized Home Visitor Card Example

# Intense Early Engagement (i.e. during first three months)

Intense early engagement was measured during the collaborative as the proportion of families that received weekly or bi-weekly visits according to the home visiting model the family was receiving. Intensive early engagement is important for establishing relationships between the home visitor and the family, setting expectations of services, and understanding client's goals. Key takeaways to improve intense early engagement include:

- Establish and review client-centered goals at each visit to ensure existing needs are being met and new opportunities are continuously identified.
- Utilize a comprehensive Family Needs Checklist at service offer, enrollment and regular intervals to continually demonstrate the value of the program.
- Develop a consistent follow-up process for missed visits.
- Ask for feedback from families on their experience receiving home visiting services.

Regular discussion of client goals and interests can support families establishing a relationship with home visitors and encourage retention if families continue to see value in working with a home visitor. Utilizing of a comprehensive **Family Needs Checklist** at service offer, enrollment, and regular intervals to continually demonstrate value of the program can promote continued family engagement with services. Using a tool to discuss client needs and goals while identifying new goals can support retention as families and home visitors work to co-create plans to work towards achieving these goals.

If a family misses a visit, re-scheduling the visit is important to keeping the family engaged in services. Quickly addressing missed visits can show the family that the home visitor is interested in supporting the family and responsive to their needs. If a family misses a visit, a home visitor should attempt to re-engage the family as soon as possible to support retention in services. A home visitor can develop **guidelines for addressing missed visits** to inform their outreach to families. The home visiting agency can create a **missed visit follow-up process** to guide next steps, which can include leaving a door hanger if the family isn't home and sending follow-up notes via phone or mail.

To actively engage families early in their enrollment in the home visiting program, evaluating the family's experience of receiving services and their satisfaction can support home visitors identifying opportunities for improvement. A **family engagement questionnaire** provided to families within the first three months of services can allow families to share what they have enjoyed, what they would change, and if their expectations are being met. A **family engagement focus group** could be held with families that are newly enrolled in the program to learn about their experiences while connecting them to other families that are also receiving services.

## Family Needs Checklist

# What can home visiting do for you?

**Name:** _____ **Date:**_____

### I need help with:

- ☐ Getting Medicaid/WIC/Food Stamps
- ☐ Scheduling pregnancy appointments
- ☐ Finding a pediatrician
- ☐ Finding transportation
- ☐ Finding affordable, nutritious food
- ☐ Finding stable housing
- ☐ Finding a counselor
- ☐ Working to quit smoking
- ☐ Finding drug or alcohol treatment
- ☐ Dealing with an abusive relationship
- ☐ Finding resources for my other children
- ☐ Setting goals for myself/my family
- ☐ Other:_____

### I wish I knew more about:

- ☐ What to expect during pregnancy
- ☐ What to eat during pregnancy
- ☐ Making a "birth plan"
- ☐ Labor and delivery
- ☐ How my baby grows and learns
- ☐ How to take care of my baby
- ☐ Birth control and family planning
- ☐ Breastfeeding
- ☐ Reducing stress
- ☐ Child support / custody
- ☐ Immunizations
- ☐ Making my home safe for baby
- ☐ Other:_____

### I want to find:

- ☐ Pregnancy support or a doula
- ☐ Childbirth or Lamaze classes
- ☐ Baby supplies
- ☐ Job-seeking support
- ☐ English As a Second Language classes
- ☐ GED classes
- ☐ Childcare
- ☐ Playgroups/support groups for moms
- ☐ Other:_____

### I would like:

- ☐ Someone to check on the progress of my pregnancy
- ☐ Someone to check on my baby's development
- ☐ Someone to talk to
- ☐ Other:_____

# Guidelines for Addressing Missed Visits

## Appointments

- Call/Text client 1 day prior to scheduled visit to confirm appointment.
- If no response, call/text client day of appointment to confirm.

## Visit cancelled by client in advance of home visit

- If client cancels their scheduled HV, reschedule HV for same week at the time of the call/text.
- Sample language you can use: “I’m holding time in my calendar to meet with you this week, what works best for you?”
- If client does not respond to call/ text, make another call/text attempt in 2 days of missed visit.
- If client does not respond, make a call attempt within 1 week of missed visit.
- If client does not respond within one week, continue to outreach with text/call according to current client level.
- If client does not respond within three weeks of the missed visit, send a mailing to the client.
- If client does not respond within four weeks of the missed visit, plan to drop by and leave a note at the home if no answer.
- If client does not respond within five weeks, do another mailing AND text message/call.
- Document all attempts.

## If client is a no-show for their scheduled visit,

- Call client from vehicle outside client home, if no answer send client a text message letting them know you are outside. Wait 10 minutes for response.
- After 10 minutes, send another text asking to reschedule their home visit for the same week.
- If client does not respond to call/ text, make another call/text attempt in 2 days of missed visit.
- If client does not respond, make a call attempt within 1 week of missed visit.
- If client does not respond within one week, continue to outreach with text/call according to current client level.
- If client does not respond within three weeks of the missed visit, send a mailing to the client.

- If client does not respond within four weeks of the missed visit, plan to drop by and leave a note at the home if no answer.
- If client does not respond within five weeks, do another mailing AND text message/call.
- Document all attempts.

## Strategies to try:

- Offer visit at alternative location than home.
- If client is receiving WIC services, work with WIC to identify when they will be in the WIC clinic next and make an attempt to see them there.
- Let them know you are concerned about them; ask them to respond to you so you know they are OK.
- Ask them if there is something you could help them with.

## Missed Visit Follow-Up Process

To guide actions when a client misses a scheduled HV and a follow up visit is not scheduled.

1. (If at client's home) Leave the NFP door hanger or leave a note for the client, stating you were there for a home visit, and sorry to have missed her.

2. Use client's primary contact method (text, phone call, email) to reach out to the client by the end of your work day (day of the missed visit).

3. If no response from the client within the next 24 hours, reach out a second time, utilizing the client's primary contact method; if the client does not respond, follow up that same day, utilizing a secondary contact method.

4. If no response by one week past the missed visit, attempt to contact the client again, utilizing their primary contact method; and if no response, their secondary contact method.

5. If no response by/within one month of missed visit (4 weeks past the date of the missed HV):

6. Send a "miss you" letter or note. You may want to send educational information with this letter as well, such as information specific to the client's gestational stage of pregnancy.

7. Check with WIC to determine when the client's next WIC appointment is scheduled, to attempt to connect with the client (in person) at WIC.

8. If no response within the next 2 weeks, (now 6 weeks past the missed visit date), send out the first disengagement letter.

9. If you receive no response from the client using these guidelines, close the file upon 90 days with no client contact.

## Family Engagement Questionnaire

The purpose of the following questions is to engage families early in the home visiting process and ensure that our program and services are customer focused. Having a customer focus encompasses the ways in which we:

- Listen to the voice of those being served.
- Build relationships.
- Determine level of satisfaction.
- Use information to identify and act on opportunities for improvement.

Please complete this form with new families on the 3rd, 4th, or 5th visit.

Is the program what you expected it to be?

If yes – what is your favorite part?

If no – what could we do differently?

# Family Engagement Focus Group

This focus group was for participants that were receiving Nurse Family Partnership, but can be modified for any home visiting model.

**We will ask you some questions that we have and are open to any input, advice or critical feedback that we can use to improve the NFP program and help more families!**

## Enrollment:

1. Think back to when you were first told about NFP home visits. What was your initial feeling about the idea of signing up?

2. What helped you make the decision to be involved?

3. How can we explain the program better to first time moms?

4. How likely is it that you would recommend home visiting to a friend or family member? Please pick a number between 0 and 10. 0= Not at all likely 10= Very likely

## Engagement:

1. Think about your involvement in home visits. How much of a positive difference has the Nurse-Family Partnership program made in your life? Please pick one of the following words.

None Little Moderate Large Extreme

2. Overall, how well has the Nurse-Family Partnership program met your needs? Pick one of the following words.

Not well at all A little bit Fairly well Very well Extremely well

3. How often do staff at the Nurse-Family Partnership treat you with respect? Pick one of the following words.

Never Rarely Sometimes Mostly Always

4. What is the Nurse-Family Partnership program good at?

5. What could the Nurse-Family Partnership program do better?

6. What supports do you need from our program to assist you with keeping your home visits so that we can help you reach your goals?

7. Think back to your first few home visits with your nurses. What about those visits made you want to keep meeting with your nurse?

# Active involvement of families in home visiting program

Continuing to demonstrate how a program can meet a family's needs can encourage retention and active involvement in home visiting programming. As a family maintains services and their needs change, it is important to utilize strategies that promote parent leadership, respond to changing schedules, and support families building their social support networks are crucial for retention. Key takeaways to improve active involvement of families in home visiting include:

- Solicit feedback from families on a regular and structured basis to ensure client expectations are matching their experience and identify improvement opportunities.
- Flexible scheduling options for home visits that include evenings and weekends to accommodate client work/school schedules.
- Strategic use of program incentives (such as diaper packs, photo albums, gift cards, etc.), particularly leading up to key milestones or loss of engagement, to motivate clients to stay engaged in the program.
- Provide opportunities for families to connect clients and staff in fun, informal ways.

Parent leadership in family home visiting programs can improve services by involving families as partners in planning, evaluation, and quality improvement initiatives. Parents can provide feedback on short **check-in cards**, longer **satisfaction surveys**, or participate in more formal parent leadership activities to share their experiences and ideas for improvement. The Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) has a **toolkit** dedicated to building parent leadership in continuous quality improvement.

Flexible scheduling options that can accommodate a family's work and school schedules can support active family engagement as life circumstances change. Offering visits outside of daytime hours can aid in maintaining enrollment and engagement. Being able to provide visits to families on evenings or weekends could ensure that they continue to receive parenting education and support. Many times, fathers are not active participants in home visiting due to conflicting work and school schedules. Flexible scheduling options could promote increased father engagement in services if fathers are able to attend visits at night or on weekends.

Families make strong connections to their home visitor. Changes to their assigned home visitor (caused by family relocation, HV reassignment, or other reasons) can lead to clients disengaging or dropping out of the program. Determining a transition process for informing families of staff transition and developing materials to **communicate transition information** to families can support both staff and families with navigating changes in home visiting staff.

During transitions, milestones, or periods of time when families frequently disenroll from services, strategic use of incentives can re-engage families and encourage retention. Incentives to remain enrolled in services for six months or a year might include gift cards, photo albums, or items for their child. If incentives and milestone awards are being provided, systems should be in place to manage protocols for providing incentives, managing inventory, and tracking

what families have received. An **incentive milestone questionnaire** can be completed by each home visitor to inform organizational policies and procedures.

Providing opportunities for families to connect with home visitors and other families in their community through casual, informal events can support relationship development and increase parent satisfaction with the program. Holiday parties, parent networking groups, milestone celebration events, new mom groups, and father groups can all help meet family needs while encouraging parent leadership in home visiting programs and building stronger social connections among clients, their community, and the home visiting program.

## Check-in Cards

Dear Parent,

Thank you for taking a few minutes to complete this short check-in card. We would like to find out how the home visiting program is working for your family.

Your feedback is appreciated!

Parent: Date: Home Visitor:

### How are you currently feeling about our home visits?

### What do you like best about your home visits? Please circle all that apply.

- Child development information
- Activities provided
- Having another adult to talk to
- Working on goals for my child and myself
- Other (please describe):

### What supports do you need from our program to assist you with keeping your weekly home visits so we can help you reach your family's goals?

- Appointment calendar
- Reminder text/call from home visitor
- Visit scheduled at same day and time each week
- Other (please describe):

### Are there other things that I can help you with?

## Satisfaction Survey

Dear Parent,

Thank you for taking a few minutes to complete this survey. We would like to find out what you like about home visiting and suggestions you have for how it can be improved. Your feedback is appreciated!

Parent: Child: Home Visitor:

1. How often do you meet with your home visitor?

2. Does your home visitor bring you information on (circle all that apply):

- Child development
- Parenting
- Relationships
- Community resources
- Goal setting
- Health information
- Other: _____

3. Of the information shared with you, what have you found to be the most useful?

4. What do you like best about your visits?

- Child development information
- Activities provided
- Having another adult to talk with
- Working on goals for my child and myself
- Referrals to community resources
- Other: _____

5. What do you like least about your visits?

6. When you enrolled in the program, what were you hoping to get out of your participation? Has the program met these needs?

7. What would you say are the benefits to your family from being in home visiting?

8. What suggestions do you have for us to improve the program?

## Communicating Transition Information

## Incentive Milestone Questionnaire

Please describe the following to help us get a better understanding of the incentive/milestone awards and how they are being used with families to help with retention.

1. How often do you use the available incentives/milestone awards with your clients?

2. How do you determine when you will use the incentives/milestone award?

3. Do you use the same protocol for providing incentives/milestones for all of your clients? If not, what criteria do you use?

4. What type of tracking system do you use to keep track of what has been provided to each client?

5. What type of tracking system do you use to keep track of your inventory of incentives/milestone awards?

6. Please list some examples of feedback that your clients have provided regarding the incentives/milestone awards:

Minnesota Department of Health
Child & Family Health/Family Home Visiting
85 7th Place East, Suite 220
PO Box 64882
St. Paul, MN 55164-0082
651-201-4090
health.fhvcqi@state.mn.us
www.health.state.mn.us

04/01/20

*To obtain this information in a different format, call: 651-201-4090.*