State of New Hampshire
Department of Health and Human Services

DHHS SEI Referrals Pilot: Lessons for Implementing Plans of Safe Care Referrals

Spotlighting DHHS Family Home Visiting programs

May 19, 2021

Families with Substance Exposed Infants are at disproportionate risk of experiencing adverse outcomes. Despite POSC, many families don't connect to key Social Supports

Challenge

1 in 5

DCYF Critical Incidents (fatalities, near fatalities, and other serious incidents) involved a substance exposed infant (2020)*

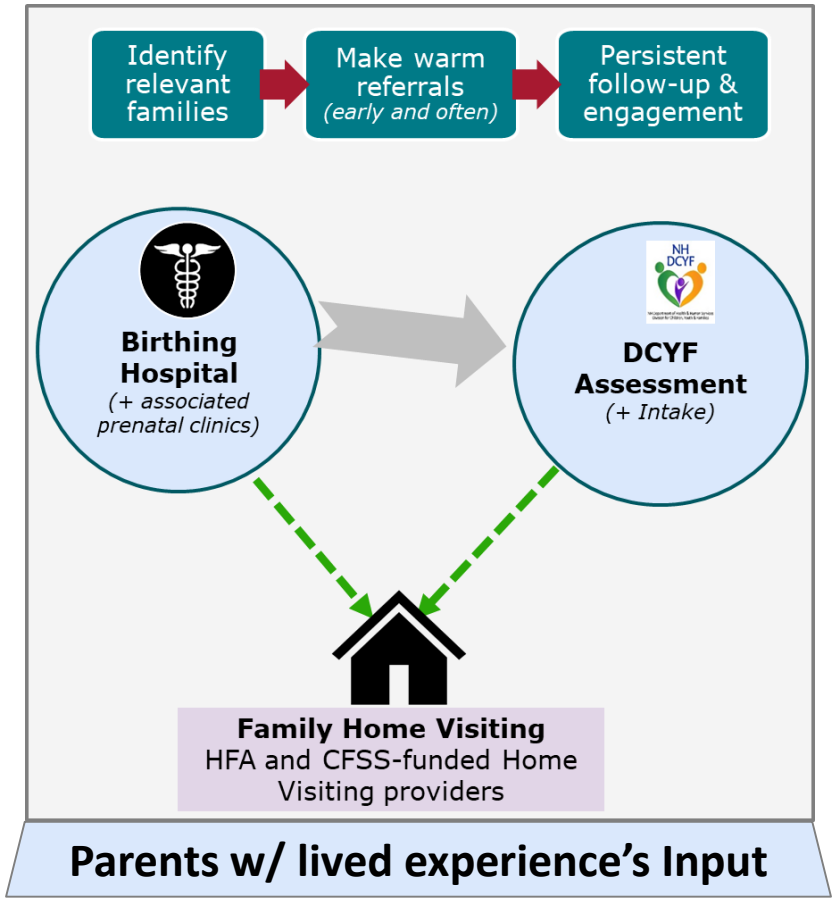
430

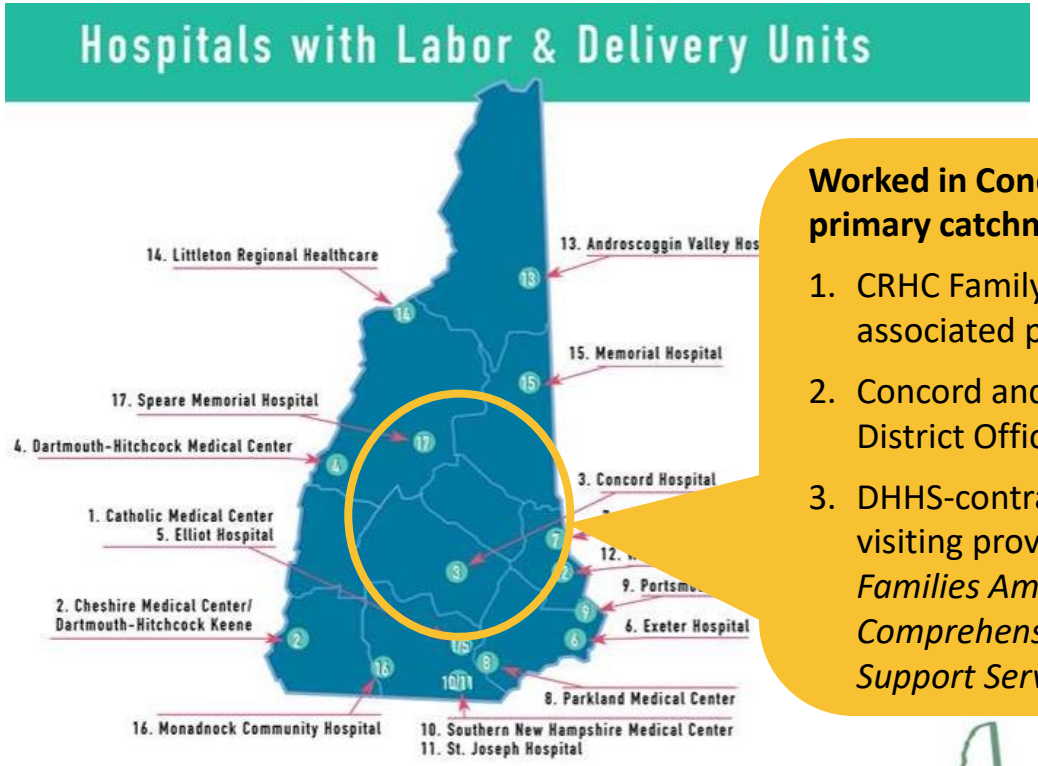
Children removed by DCYF from 2015-2019 had a history of prenatal substance exposure**

Only ~5%

Of NH families with SEI connected to key prevention service, DHHS-funded Family Home Visiting in a baseline analysis***

Approach: DHHS SEI Referrals Pilot





Worked in Concord Hospital primary catchment area with

1. CRHC Family Place & associated prenatal clinics
2. Concord and Laconia DCYF District Offices
3. DHHS-contracted home visiting providers (*Healthy Families America & Comprehensive Family Support Services programs*)

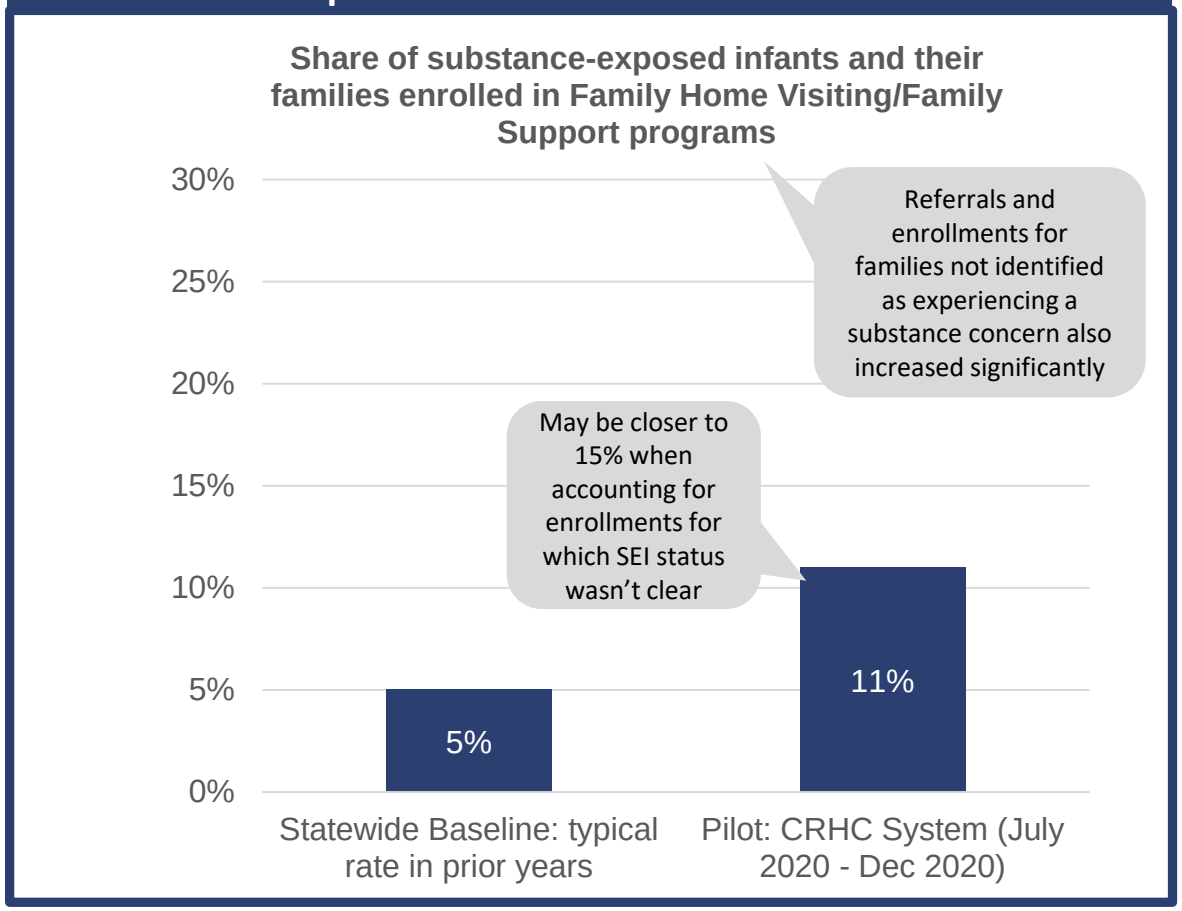
New Hampshire Hospital Association

*Sources: *Internal analysis of DCYF CY20 Critical Incidents Tracker; **NH Office of the Child Advocate System Review 2018-01 *** Internal 2019 baseline analysis of DHHS-contracted HFA & CFSS Family Home Visiting programs, often provided by Family Resource Centers*

Pilot referral results are promising and indicate importance of warm handoffs and coordination between service providers

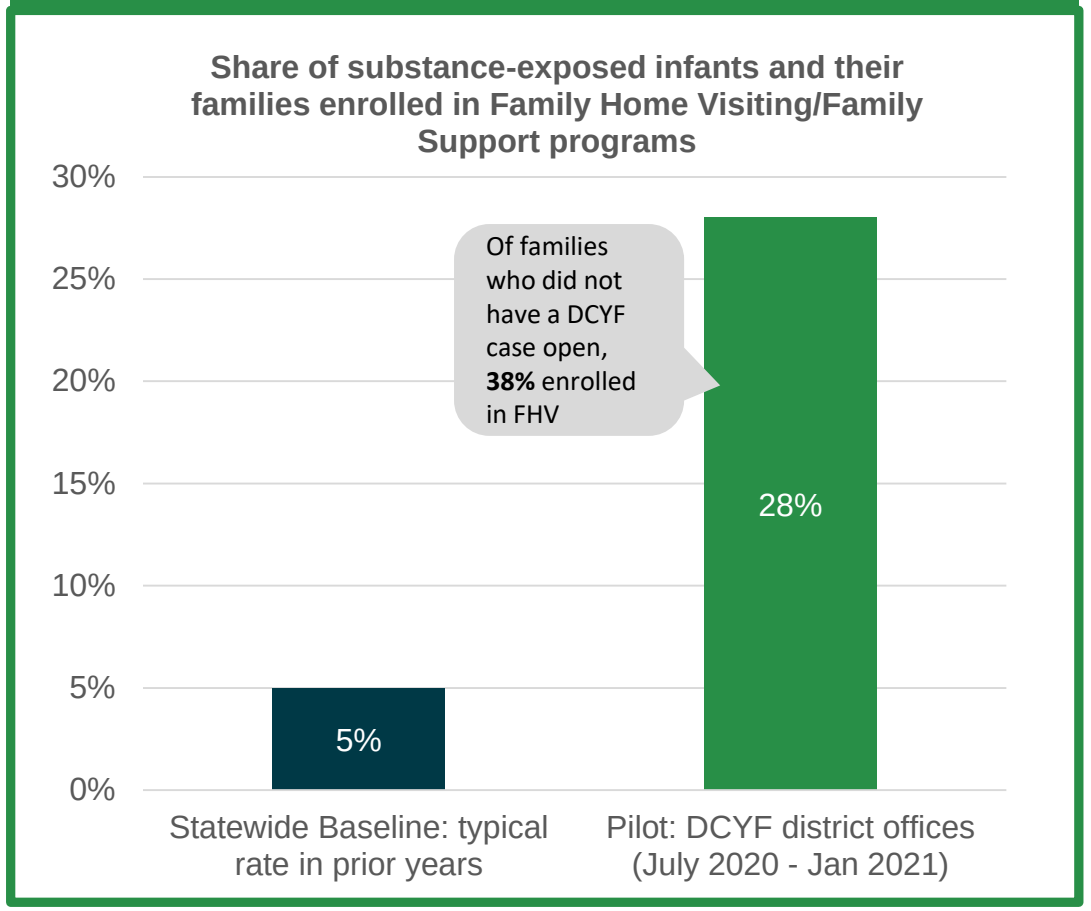
PRELIMINARY

Estimated enrollment results for families referred by Concord Hospital & associated Prenatal Clinics



Sources: 1) DHHS Vital Records Data 2) Referrals data reported from Laconia and Concord region HFA and CFSS Family Home Visiting providers for referrals received from Concord Hospital's The Family Place, Laconia Clinic, Concord OB, and the Concord Family Health Clinic from July 1-December 31, 2020. **Note**: "Families with SEI" are defined as those referrals which the FHV providers could confirm were for a pregnant or parenting person with a substance use concern/ substance exposed infant. Baseline comprises state-contracted HFA and CFSS Family Home Visiting programs. Confirmed pilot enrollments include for HFA and CFSS programs as well as DHHS-managed Early Head Start programs and Waypoint's Enhanced Care Coordination model.

Enrollment results for families assessed by Concord & Laconia DCYF District Offices



Sources: 1) DCYF Intake data and 2) Concord and Laconia DCYF DOs SEI Referrals Tracker–data extracted 02/11/21 for referrals received between 6/26/2020- 01/31/21. **Note**: This analysis looks at state-contracted HFA and CFSS Family Home Visiting programs. The baseline was estimated from internal analysis of historic CFSS and HFA enrollment data cross-walked with DHHS estimates of the full population of families with Substance Exposed Infants.

Moms with lived experience asked for early, facilitated referrals that center their input and remember to also include dads in the offers of support and accountability

"I'm an expert in me"

Moms know their own needs best. It's important for people working with prenatal families (and families with infants) to make early referrals and develop plans based on the needs I identify for me and my baby. I need you to celebrate my successes and know that I'm doing the best I can. Please listen to my goals and talk to me about why you think the referrals we're making are important. We're a team!

"Sooner is better than later"

Having a baby can be a really stressful experience. The sooner we can connect so I can learn about the services available to help me and my baby, the better. I don't want to feel overwhelmed with referrals after the baby is born. I want to feel supported in choosing different paths, such as MAT or counseling to help treat my illness. I also need time to consider all the options and think about the impacts of my choices.

"Please don't assume"

Just like I don't want you to assume my illness defines me and my ability to be a mom, I don't want you to assume I have all the tools I need. Getting into the programs I need to help me stay healthy and keep my baby safe can be difficult. Sometimes it might be hard for me to follow through with the important referrals we make together, so please check in to ask me about how they're going. I'm working hard to maintain my sobriety and have a healthy pregnancy. Having a hard time getting signed up for a program I know I need may be a trigger and could jeopardize my recovery.

"The stigma (and fear) is REAL"

When the Plan of Safe Care is offered to us late in our pregnancy or right after delivery, it can feel like a punishment. Share the plan with us early in our pregnancy so it feels more a part of normal prenatal planning, and give us time to understand how it will impact us after the baby is born. Everyone can use support after having a baby, and it helps us feel less isolated to know that. Make sure I know about general parent support opportunities AND peer recovery programs and other ways to grow my positive social connections. I may need specialized supports, but I'm also just a regular mom learning how to do a really hard job. This shouldn't all be on me. **Dads can also struggle** with substance use and may need parenting support and recovery resources to navigate challenges and keep our baby safe now and in the future. Dads are important and should be part of this planning. Help us prepare for what we might encounter, and teach me about the things I'll need to do to bring my baby home safely. Hospitals and doctors don't always have the same processes.

Insights from October 2020 focus group co-developed by DCYF Better Together and Strength to Succeed programs and DPHS Healthy Families America teams

Pilot convened POSC referral source and referral recipients to develop, test, and sustain practices for more consistent, higher quality POSC referral connections

Timing: When are the best moments in a pregnant or newly parenting family using substances' perinatal journey to offer Family Home Visiting?

Referral Offers: What are the best ways to offer Family Home Visiting? How can we effectively explain the service, answer questions, and incorporate family's input?

Handoff: How can we work together to best offer and connect families to services?

Tools: What tools can make referrals better and easier?

Follow-up/ Close-the Loop: How can we work together to ensure referred families actually start services?

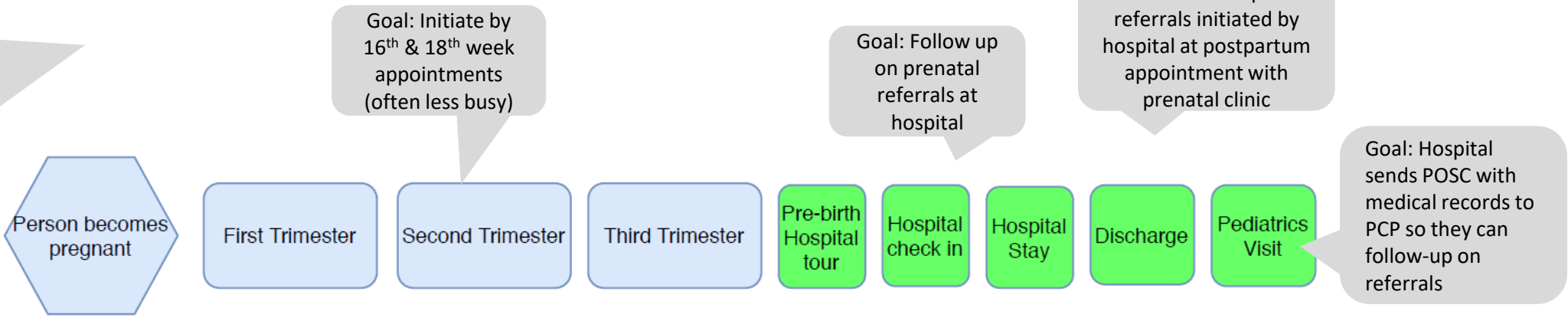
Tracking: How can we keep track of in-progress referrals and generate data to assess success?

Use data on referral process (e.g. offers, enrollments) and input from parents and service providers to learn and refine over time

Medical System Case Study: Concord Hospital and associated Prenatal Clinics

If office has a social worker, they often have most time and expertise for POSC implementation. If not, clinicians can collaborate with other staff (e.g. Patient Care Coordinator) to implement referrals

Goal: Refer early and often (treat as a conversation over time). Use later appointments to follow-up on referrals to make sure families connect.



Clinics are experimenting with different handoff strategies based on staff capacity

Clinic schedules 1st FHV apptmt

Exploring using iPads for joint video meetings

Social Workers treat referral as ongoing convo

Close-the-loop

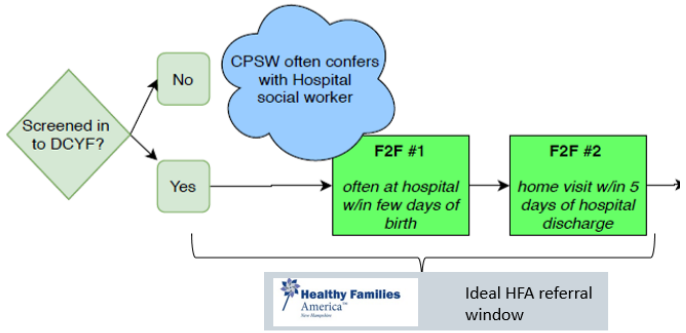
- Clinics are working to establish regular check ins with FHV providers via phone or email
- Hospital sends POSC with medical records to PCP so they can follow-up on referrals

Track Referrals

- Clinics individually tracking referrals made and completed
- Using case notes and check ins to alert hospital social worker
- Exploring methods to more systematically track social support/POSC referrals using EMR

DCYF Case Study: Concord and Laconia DO District Offices

Refer as soon as family is ready



- Referring early is ideal – allows time for follow-up and to meet Healthy Families America eligibility window (infant <2 weeks old)
- BUT if family needs more time, it's ok to wait

Offer referrals supportively

- Use referral toolkits "pitch script"
- Keep referrals strengths-based and voluntary (*worker training focused on this)*
- Connect Families with peers, e.g. DCYF Strength to Succeed program, to support POSC referrals

Make Handoff as "warm" as possible

Baseline	Goal
CPSW submits referral form	Joint FaceTime or phone call

Close the loop with families and Service providers

- Use POSC and conversations with hospital referral source + family to understand if referrals are in-progress
- If a referral is in-progress, seek family's consent to follow-up with the provider, either via a client-signed Release of Info form OR another referral form (essentially "re-referring" the family)
- Use later Face to Face to ask client if they were able to successfully enroll or re-connect them with service provider
- Work with Family Home Visiting provider to make sure referred families actually connect to services

Track Referrals

- DO Supervisors systematically track if families with SEI were offered, accepted, and connected with Family Home Visiting referral
- Regularly meeting with Provider staff to coordinate on active referrals

Insights on Implementing Plans of Safe/Supportive Care

1. POSC Referrals & Communications Infrastructure Matters

Goal is for POSC to be a plan and active process *(not just a piece of paper) that both parents and support professionals can use*

Examples of "infrastructure":

- Regular check-ins with POSC supports and service providers to help families connect to referrals
- Developing workflows for responsibly sharing POSC with other support professionals

2. There are significant challenges to making POSC referrals at Hospitals

Opportunity for hospitals to play key role coordinating referrals with prenatal clinics and PCPs (can function as "hub" to clinics' "spokes")

- Hospital stay is a busy time for family, not ideal for considering longer-term supports
- Prenatal clinics and PCPs have more time to build trust necessary for referrals and to close-the-loop on referrals families agree to
- Opportunity for hospitals to coordinate dispersed practices

3. More work is needed to enable responsible POSC referral coordination

Concerns about patient privacy currently limit extent prenatal practices, Hospital, and PCPs can follow up on in-progress POSC referrals, even within same system

- POSC in-progress referrals info often isn't shared between medical providers
- Even if POSC is shared, often community services and supports require Releases of Information to be signed for each person working with the family

Insights on how to increase the likelihood a family accepts referral and connects to a POSC service or support:

4. Effective referral offers are warm and customized

- Ask family about their needs and goals and emphasize how services can meet them
- Consider “shrinking the ask” to a small commitment from family (e.g. meet 1x time with a local resource to see what they can offer)
- Make referral “handoff” as warm as possible (ideally referral source can help intro family to service provider)

5. Effective referral offers take trust and often time

- Who offers a referral can matter: Coordinating with peers (e.g. Peer Recovery Workers) and other trusted messengers can be very beneficial
- Treat referrals like a conversation: give families time to understand and discuss service offers
- Follow-up with families to confirm they actually connect to desired services

6. Regular coordination between referral source and recipient is key

- Without support navigating complex referrals landscape, families often accept referrals but then never connect with services
- Regular referral source (e.g. medical provider) and referral recipient (e.g. community support) communication can help identify and address barriers and make sure family actually connects to services

Strategies for making the POSC work

- At minimum, pick one social support referral and develop a strong referral pathway to it
  - Many social supports (e.g. Family Home Visiting programs and similar supports at Family Resource Centers) can do additional referrals
- Identify point people on both sides of the referral handoff and develop standard ways of working together
  - Ex. setup a short recurring check in, discuss best ways to present the service, email v. fax referral forms
- Figure out way to keep track of ongoing referrals and keep coordinating with referral recipient until families connect to services they've said they want
- Build connections with local peer organizations – they're a valuable resource in of themselves and may be a better messenger when offering families additional referrals
- Engage parents with lived experience in your community throughout
- Use/adapt from menu of tools we've created – cheat sheets, talking points, etc.

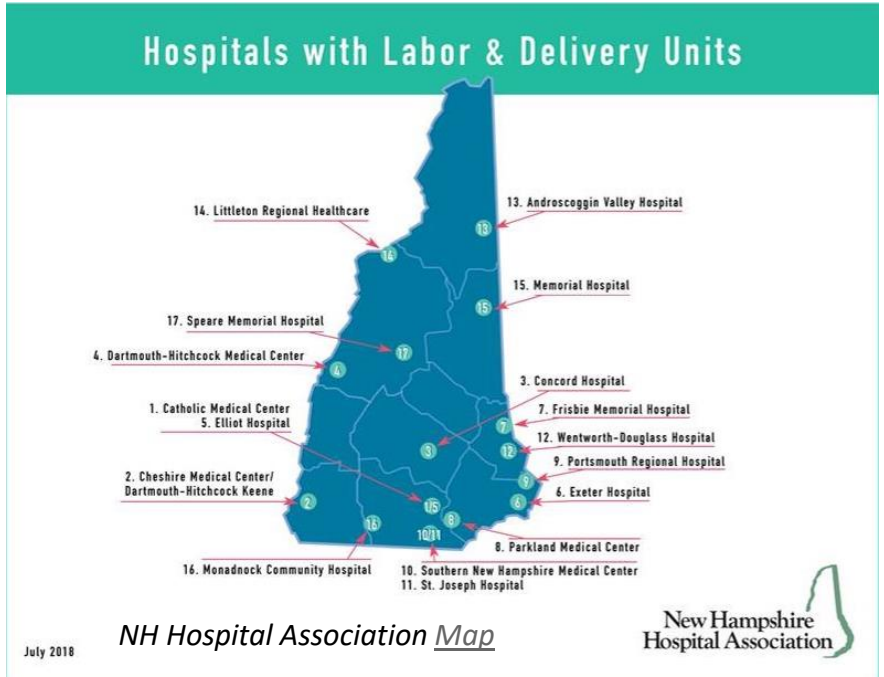
Identify and convene key community partners to support Plan of Safe Care implementation, for example:

1. Family Home Visiting/Family Support Style Programs

The NH Children's Trust hosts a town-by-town directory of most NH Family Home Visiting/Family Support programs: www.nhchildrenstrust.org/local-services

- Family Home Visiting/Family Support Style Programs can support families directly and connect them to many other resources (e.g. implement Plans of Safe Care)
- Healthy Families America (HFA) and CFSS-funded programs (which have different names regionally) are offered by NH DHHS statewide, often at Family Resource Centers
- Early Head Start provides similar services in some parts of the state as do other non-DHHS funded programs
- Additional Pregnant & Parenting Services and Supports: List & Map

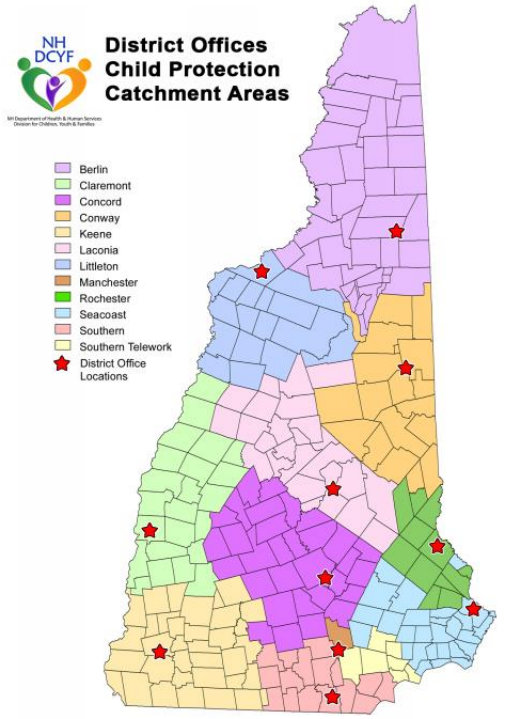
2. Medical Community



NH Hospital Association Map

- Birthing hospitals can operate as convening "hubs" for regional prenatal clinic "spokes"
- They can encourage (formally or informally) prenatal clinics to begin POSC and adopt consistent referral practices
- They can similarly coordinate with children's PCPs

3. NH DCYF District Offices



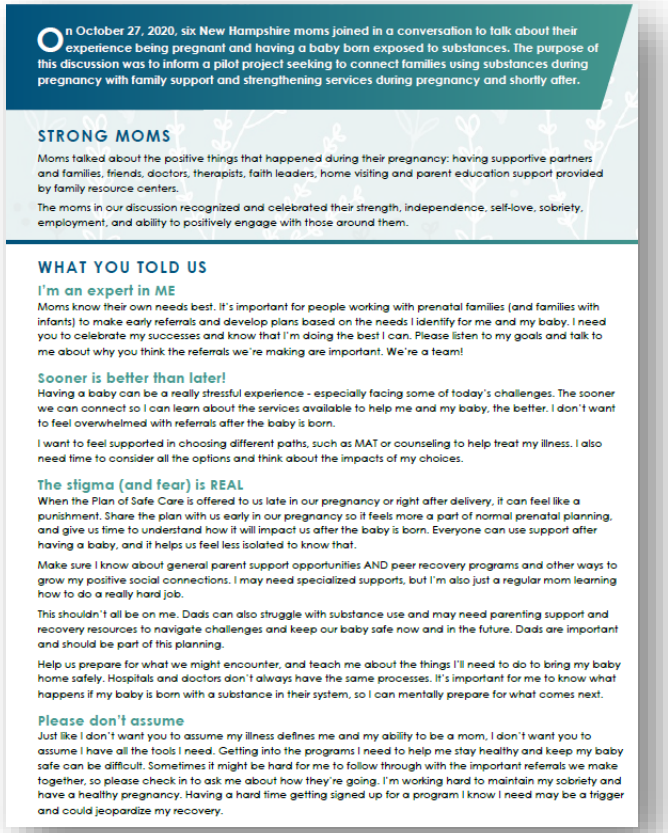
List of NH DCYF/DHHS District Offices

- DCYF can follow up on in-progress POSC referrals
- DCYF can help medical community with appropriate A/N reporting and transparent communication with pregnant parents using substances

Adopt from Menu of Tools available for adaptation to local communities

1-pager with Insights from moms with lived experience

of substance use while pregnant, generating insights on how to better support families with SEI via referrals



On October 27, 2020, six New Hampshire moms joined in a conversation to talk about their experience being pregnant and having a baby born exposed to substances. The purpose of this discussion was to inform a pilot project seeking to connect families using substances during pregnancy with family support and strengthening services during pregnancy and shortly after.

STRONG MOMS

Moms talked about the positive things that happened during their pregnancy: having supportive partners and families, friends, doctors, therapists, faith leaders, home visiting and parent education support provided by family resource centers.

The moms in our discussion recognized and celebrated their strength, independence, self-love, sobriety, employment, and ability to positively engage with those around them.

WHAT YOU TOLD US

I'm an expert in ME

Moms know their own needs best. It's important for people working with prenatal families (and families with infants) to make early referrals and develop plans based on the needs I identify for me and my baby. I need you to celebrate my successes and know that I'm doing the best I can. Please listen to my goals and talk to me about why you think the referrals we're making are important. We're a team!

Sooner is better than later!

Having a baby can be a really stressful experience - especially facing some of today's challenges. The sooner we can connect so I can learn about the services available to help me and my baby, the better. I don't want to feel overwhelmed with referrals after the baby is born.

I want to feel supported in choosing different paths, such as MAT or counseling to help treat my illness. I also need time to consider all the options and think about the impacts of my choices.

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Make sure I know about general parent support opportunities AND peer recovery programs and other ways to grow my positive social connections. I may need specialized supports, but I'm also just a regular mom learning how to do a really hard job.

This shouldn't all be on me. Dads can also struggle with substance use and may need parenting support and recovery resources to navigate challenges and keep our baby safe now and in the future. Dads are important and should be part of this planning.

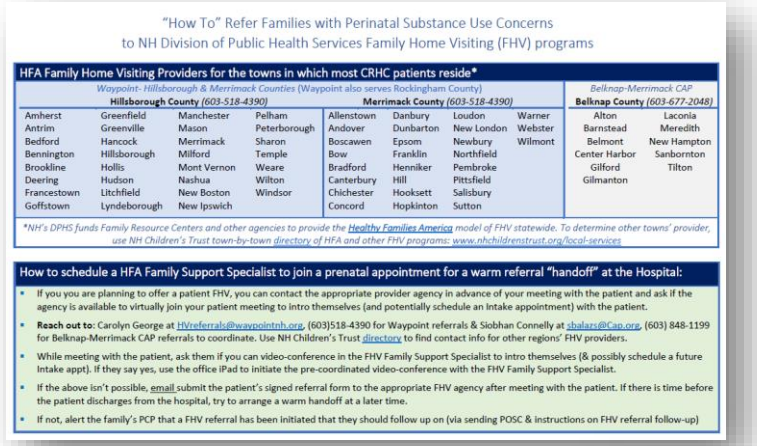
Help us prepare for what we might encounter, and teach me about the things I'll need to do to bring my baby home safely. Hospitals and doctors don't always have the same processes. It's important for me to know what happens if my baby is born with a substance in their system, so I can mentally prepare for what comes next.

Please don't assume

Just like I don't want you to assume my illness defines me and my ability to be a mom, I don't want you to assume I have all the tools I need. Getting into the programs I need to help me stay healthy and keep my baby safe can be difficult. Sometimes it might be hard for me to follow through with the important referrals we make together, so please check in to ask me about how they're going. I'm working hard to maintain my sobriety and have a healthy pregnancy. Having a hard time getting signed up for a program I know I need may be a trigger and could jeopardize my recovery.

Adaptable "How to" guide and other tools for effective referrals to Family Home Visiting

Provider catchment areas, sample talking points, handoff techniques, explainer/marketing materials and more



"How To" Refer Families with Perinatal Substance Use Concerns to NH Division of Public Health Services Family Home Visiting (FHV) programs

HFA Family Home Visiting Providers for the towns in which most CRHC patients reside*

Waypoint- Hillsborough & Merrimack Counties (Waypoint also serves Rockingham County)

Hillsborough County (603-518-4390)				Merrimack County (603-518-4390)				Belknap-Merrimack CAP: Belknap County (603-677-2048)	
Amherst	Greenfield	Manchester	Pelham	Allenstown	Danbury	Loudon	Warner	Alton	Laconia
Antrim	Greenville	Mason	Peterborough	Andover	Dunbarton	New London	Webster	Barnstead	Meredith
Bedford	Hancock	Merrimack	Sharon	Boscawen	Epsom	Newbury	Wilmont	Belmont	New Hampton
Bennington	Hillsborough	Milford	Temple	Bow	Franklin	Northfield		Center Harbor	Sanbornton
Brookline	Hollis	Mont Vernon	Weare	Bradford	Henniker	Pembroke		Gilford	Tilton
Deering	Hudson	Nashua	Wilton	Canterbury	Hill	Pittsfield		Gilmanton	
Francestown	Litchfield	New Boston	Windsor	Chichester	Hooksett	Salisbury			
Goffstown	Lyndeborough	New Ipswich		Concord	Hopkinton	Sutton			

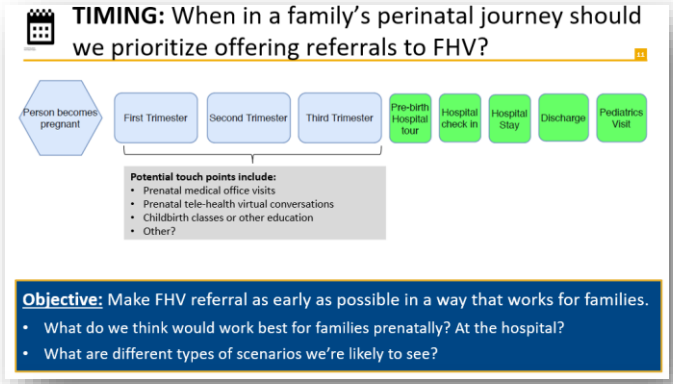
*NH's DPHS funds Family Resource Centers and other agencies to provide the Healthy Families America model of FHV statewide. To determine other towns' provider, use NH Children's Trust town-by-town directory of HFA and other FHV programs: www.nhchildrenstrust.org/local-services

How to schedule a HFA Family Support Specialist to join a prenatal appointment for a warm referral "handoff" at the Hospital:

- If you you are planning to offer a patient FHV, you can contact the appropriate provider agency in advance of your meeting with the patient and ask if the agency is available to virtually join your patient meeting to intro themselves (and potentially schedule an Intake appointment) with the patient.
- **Reach out to:** Carolyn George at HVreferrals@waypointnh.org, (603)518-4390 for Waypoint referrals & Siobhan Connelly at sbalazs@Cap.org, (603) 848-1199 for Belknap-Merrimack CAP referrals to coordinate. Use NH Children's Trust directory to find contact info for other regions' FHV providers.
- While meeting with the patient, ask them if you can video-conference in the FHV Family Support Specialist to intro themselves (& possibly schedule a future Intake appt). If they say yes, use the office iPad to initiate the pre-coordinated video-conference with the FHV Family Support Specialist.
- If the above isn't possible, email submit the patient's signed referral form to the appropriate FHV agency after meeting with the patient. If there is time before the patient discharges from the hospital, try to arrange a warm handoff at a later time.
- If not, alert the family's PCP that a FHV referral has been initiated that they should follow up on (via sending POSC & instructions on FHV referral follow-up)

Sample meeting facilitation tools

Sample agendas and slide decks to establish standard POSC implementation practices between service providers in your communities

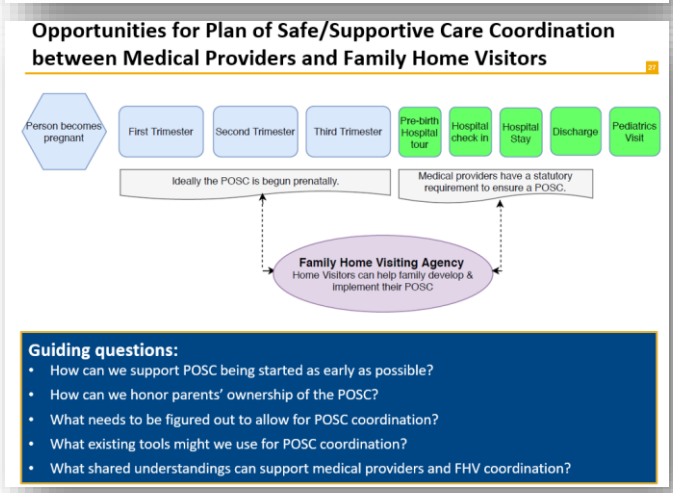


TIMING: When in a family's perinatal journey should we prioritize offering referrals to FHV?

Person becomes pregnant → First Trimester → Second Trimester → Third Trimester → Pre-birth Hospital tour → Hospital check in → Hospital Stay → Discharge → Pediatrics Visit

Potential touch points include:
- Prenatal medical office visits
- Prenatal tele-health virtual conversations
- Childbirth classes or other education
- Other?

Objective: Make FHV referral as early as possible in a way that works for families.
- What do we think would work best for families prenatally? At the hospital?
- What are different types of scenarios we're likely to see?



Opportunities for Plan of Safe/Supportive Care Coordination between Medical Providers and Family Home Visitors

Person becomes pregnant → First Trimester → Second Trimester → Third Trimester → Pre-birth Hospital tour → Hospital check in → Hospital Stay → Discharge → Pediatrics Visit

Ideally the POSC is begun prenatally.

Medical providers have a statutory requirement to ensure a POSC.

Family Home Visiting Agency
Home Visitors can help family develop & implement their POSC

Guiding questions:
- How can we support POSC being started as early as possible?
- How can we honor parents' ownership of the POSC?
- What needs to be figured out to allow for POSC coordination?
- What existing tools might we use for POSC coordination?
- What shared understandings can support medical providers and FHV coordination?

Questions and Where to go for more Information

- **Kristi Hart,** Kristi.m.hart@dhhs.nh.gov for general questions related to the DHHS SEI Referrals pilot effort or NH's Family Home Visiting and Support programs

- **Jen Ross-Ferguson**, Jennifer.j.ross-ferguson@dhhs.nh.gov for questions and collaboration ideas related to working with DCYF

- **Plan of Safe Care web-page** for this slide deck and many of the POSC referrals implementation tools developed by the pilot: https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/
  - If helpful, JSI can also share additional resources used to facilitate pilot process (e.g. slide decks, information on local resources)

Thank you!

Appendix

Presenters

- **Kristi Hart**, Kristi.m.hart@dhhs.nh.gov: Home Visiting Program Manager, Division of Public Health Services
  - Member of the NH Perinatal Substance Exposure Task Force
- **Nicole Petrin**, Nicole.Petrin@dhhs.nh.gov: DCYF Assessment Supervisor, Concord District Office
- **Jen Cross**, Jennifer.n.cross@dhhs.nh.gov: DCYF Assessment Supervisor, Laconia District Office
- **Erin Collins,** ecollins@crhc.org, Vice President, Nursing, Concord Hospital
  - Member of the NH Perinatal Substance Exposure Task Force
- **Angela Wilson,** anwilson@crhc.org, Social Worker, Concord Hospital Family Place

Example Roadmap for developing local POSC referral relationships: 2020 DHHS SEI Referrals pilot focusing on connections to local Family Home Visiting programs

	Late Spring 2020	Summer 2020	Fall 2020 – Winter 2021	Ongoing
Pre-Pilot	**Phase 1:** Setup Pilot	**Phase 2:** Design Referral Pathway	**Phase 3:** Test and refine Referral Pathway	**Phase 4:** Sustain collaboration

Strong history of Concord Hospital, DCYF, and local service providers meeting to build relationships; but still many families not connecting to supportive prevention services

Identified and convened appropriate regional service providers

- Decided to focus on Family Home Visiting (FHV) referrals given care coordination element
- Developed 3 working groups based on referral relationships (local home visiting providers met with 1. Concord Hospital/ prenatal clinics, 2. Concord DCYF DO, 3. Laconia DCYF DO)
- Setup meeting cadence
- Shared existing tools (e.g. referral forms, marketing materials)

Develop standard practices for more consistent, higher quality referral connections

Timing: When are the best moments in a SEI family's perinatal journey to offer Family Home Visiting?

Referral Offers: What are the best ways to offer FHV? How can we effectively explain the service, answer questions, & incorporate families' input?

Handoff: How can we work together to best offer and connect families to services?

Tools: What tools can make referrals better and easier?

Follow-up/ Close-the Loop: How can we work together to ensure referred family actually started services?

Tracking: How can we keep track of in-progress referrals and generate data to assess success?

Regularly close-the-loop on active referrals, learn what works best for families, rollout to staff

- Regularly check-in on in-progress referrals to prevent families from falling through the cracks
- Codify standard practices decided on in Phase 2; share with frontline staff
- Frequently review enrollment data and case practices to figure out what works
- Troubleshoot operational challenges
- Identify solutions and implement changes to improve results

Setup sustainable ongoing collaboration structures

- Maintain short ongoing meetings to focus on closing-the-loop for active referrals
- Continue using and evolving tools and practices
- Institutionalize collaboration and referrals tracking infrastructure
- Monitor if services are working well for families; consider similar work with additional services

★ Pilot Participants sought input from their communities of families

★ DHHS led a Focus Group with women with lived experience of substance use while pregnant

Involved DCYF Strength to Succeed Peer Recovery Workers as advisors and additional key service providers in this work

Example Tools:

See POSC Referrals Implementation Toolkit on POSC web-page for these and more:

https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/

Example Resource: Key Messages when offering caregivers Family Home Visiting Referrals

There are a few key messages to send to families as you offer them referrals

Family Home Visiting can help you meet your needs and goals. Lots of families work with FHV in many different ways– from help getting diapers, to connections to parenting or play groups, to support finding a job or with your child's cognitive development.

FHV is a collaborative, family driven, supportive service. You decide where and how often you meet and help set the agenda. Services do not need to take place in-person or in a family's home.

Family Home Visiting is not DCYF. It is offered by community based organizations and is intended to support families' wellbeing on their terms. They may receive some state funding but have no more requirements to report to DCYF than any other adult in NH**.**

Family Home Visiting is voluntary. You can meet with their staff only once or for as long as multiple years.

Example Resource: Tip-sheet **-** How to Effectively Approach Referrals Conversations

Tactic	Example Approach
1. **Empower the parent as the decision-maker** by asking for their permission at the beginning and throughout the conversation.	• "Can I tell you about some programs that are available to your family?" • "Do you think that this may be helpful?" • "These programs are voluntary. If you give it a try, you can decide later if it's a good fit."
2**. Focus on building a connection** by listening to the parent, and save "information" until the end of the conversation. Listen for caregivers to share their goals.	• "I have some ideas about programs that may be helpful, but before I jump into those, can you tell me a little more about what's going on with your family right now?" • "I understand that ____ has been challenging. Can you tell me more about that?" • "You don't have to decide now. Can I check in again soon to see what you're thinking?
3. **Promote belief in the client's abilities as a parent** and start from frame that the parent is the expert. Building self-esteem and confidence can be helpful drivers of change.	• "I can tell that you care a lot about your child's healthy development." • "You are the expert on your child. This resource will build on your strengths."
4. **Seek to understand family context**, validate concerns, and think of addressing the family's most urgent need first.	• "I hear you talking a lot about feeling like you don't have a lot of time, sounds like you've got a lot on your plate right now." • "Tell me what areas you're interested in working on? What would help you?"
5. **Normalize the services / need for support**.	• "These services are available to all/many families." • "Many families I've worked with, have told me they and their children have benefitted from these programs." • "We all have times when we need more support."

Example Resource: Tip-sheet – Responding to caregiver concerns about referrals

Concern	Ways you Might Respond
A. Caregiver feels overwhelmed, e.g. Time Concerns, "Too many services in place", General anxiety about a big commitment	• "Shrink the ask" – pitch Family Home Visitors as a local resource expert they can meet with 1x or as long as it takes to meet their needs • Explain Family Home Visiting will adapt to the family's schedule • Consider pausing the referral conversation until other service providers withdraw
B. Caregiver doesn't see the value of Family Home Visiting or other support programs	• Explain how programs can be customized to fit their needs and goals. • Emphasize the more concrete help Family Home Visiting can provide (e.g. accessing Baby supplies, Insurance, Job search) • Ask if you can intro them to the Provider once so they can hear more about what the program provides
C. Caregiver is hesitant to engage in service they consider associated with the state and/or DCYF surveillance	• Be honest, but clarify: These are state-funded services, but are separate from DCYF (funded by other DHHS divisions). • Clarify that they're run by community-based non-profit organizations who only share info with DCYF if parents sign a Release of Information (or if they have a A/N concern same as all NH residents)
D. Caregiver fears stigma or judgment of engaging in family support programming	• Explore if the caregiver is open to you introducing them to a home visitor to show (not tell) how they're friendly and supportive • Normalize the service: Nothing has to be "wrong". Many families find FHV helpful for facing things like how to prep for school, how to potty train, connections to play groups • Affirm caregiver's strengths – explain FHV is about building on those strengths

Example Resource: Best Practices for seamlessly connecting families to services

Only if client is not ready to engage

Connection Strategies → Warmest

Give client basic information about resource

Make a specific plan for client's next steps and provide client with referral form

Communicate directly with resource on client's behalf (e.g. send referral form)

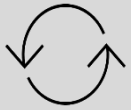
Assist client in calling resource to schedule appointment or find out when to go

In-person (or video) introduction with you, client, and resource

Complimentary tactics: can be used with any strategy

Make a specific plan for client visiting resource; include day, time, how they will travel, etc.

Work with client to complete intake papers or compile documents ahead of time

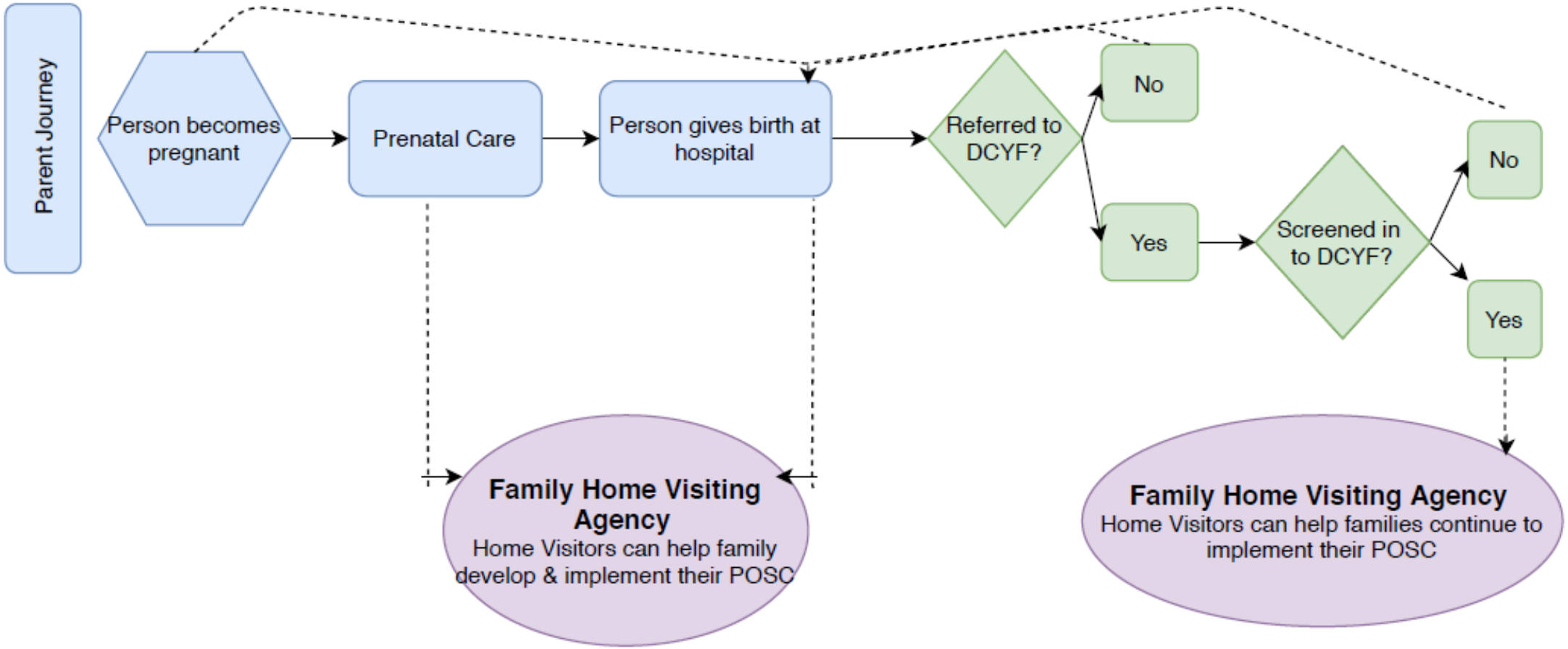


Follow up with the client and/or resource to make sure connection was successful

Key elements of a Facilitated Referral

- **Helping family** with provider's referral and/or application process (e.g. forms, scheduling Intakes, etc.)
- "**Warm handoffs**": Individualized, person-to-person connection between referral source, service provider, and family
- **Closing-the-loop**: coordinate with provider agency/resource to help them connect with family
- **Barrier busting**: Help family overcome barriers and adapt referral to their needs

Family Journey Map: Many parents never connect to supportive resources like Family Home Visiting even though there are many opportunities at which they could be referred.



Family Home Visiting/Family Support Programs

- Family Home Visiting/Family Support Style Programs can support families directly and connect them to many other resources (e.g. implement Plans of Safe Care)
- Healthy Families America (HFA) and CFSS-funded programs (which have different names regionally) are offered by NH DHHS statewide, often at Family Resource Centers
- Early Head Start provides similar services in some parts of the state as do other non-DHHS funded programs
- Additional Pregnant & Parenting Services and Supports: List & Map

Call to find a Home Visiting Program Nearest You

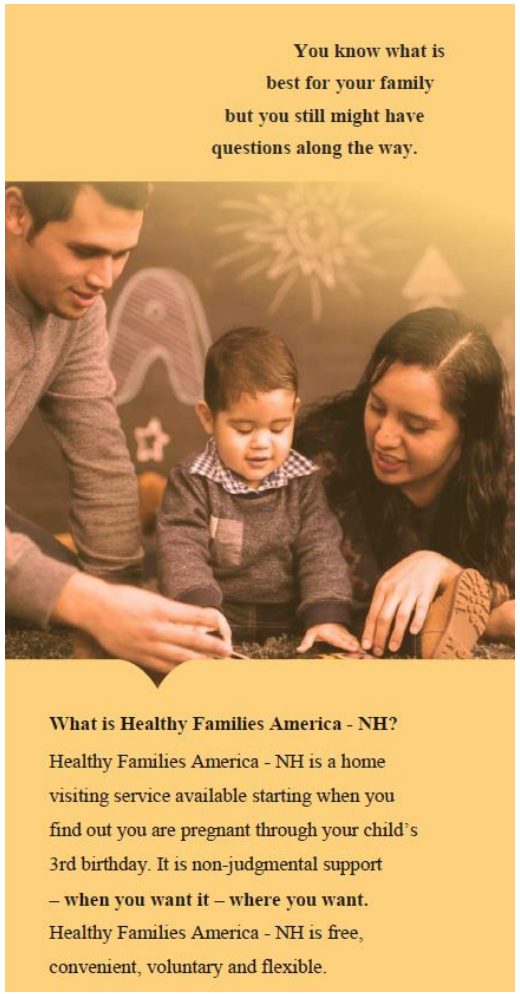
Agencies:

*Indicates Healthy Families America Only
**Indicates Comprehensive Family Support Services Only

- * Granite VNA (603) 832-8046
- **Children Unlimited (603) 447-6356 ext. 0
- Community Action Partnership of Strafford County (603) 435-2500
- *Community Action Program Belknap-Merrimack Counties, Inc. (603) 528-5334 ext. 125
- **Families First (603)422-8208
- The Family Resource Center at Gorham (603) 466-5190
- **Family Resource Center of The Lakes Region (603) 524-8811
- Home Healthcare Hospice & Community Services (603) 352-2253
- TLC Family Resource Center (603) 542-1848
- Waypoint 1(800)640-6486 or (603)518-4000
- *Waypoint provides HFA in Rockingham County

The NH Children's Trust hosts a town-by-town directory of most NH Family Home Visiting/Family Support programs: www.nhchildrenstrust.org/local-services

Existing Tools: General Family Home Visiting Marketing Supports: HFA Rack card (for clients)



You know what is best for your family but you still might have questions along the way.

What is Healthy Families America - NH?

Healthy Families America - NH is a home visiting service available starting when you find out you are pregnant through your child's 3rd birthday. It is non-judgmental support – **when you want it – where you want.** Healthy Families America - NH is free, convenient, voluntary and flexible.

Healthy Families America - NH can help your family:

- Prepare to bring your baby home from the hospital
- Have a healthy pregnancy and delivery
- Feel confident parenting
- Cope with the stress of raising a family
- Access information to keep your baby healthy and safe
- Get resources and help, like baby equipment
- Connect with other parents
- Understand your baby's emotions, needs, cues and behaviors
- And so much more!

Whether you are pregnant or already have a new baby at home, Healthy Families America - NH staff are there for you. The best part is **YOU** get to pick the:

- Type of **help**
- Type of **service**
- **Time and place to meet**

"As a new parent, when your child is born you don't know what to do. When I got involved with Healthy Families America - NH, it was so comfortable. I got answers without judgment. I felt like I wasn't alone."

To search for a service in New Hampshire, go to www.HealthyFamiliesAmericaNH.org or call 2-1-1 NH.

Talk to your local provider agency

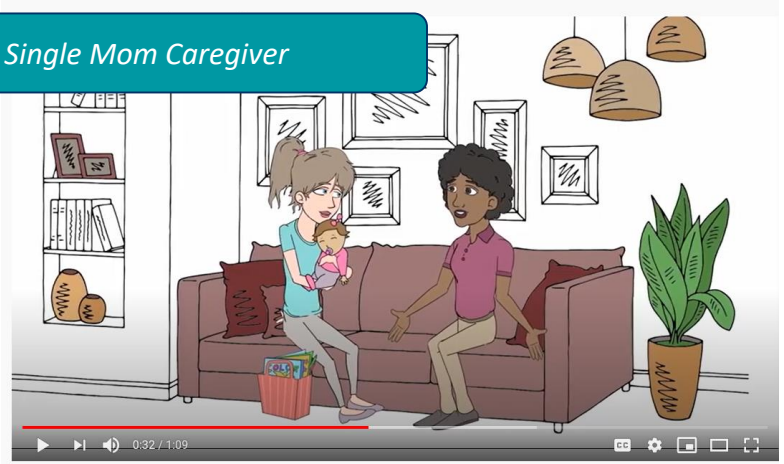
Local HFA and other Family Home Visiting providers often also have custom marketing materials that may even feature the specific staff with which a family would work.

You could also request they help you develop other referral tools (e.g., Can one of their staff record a short video introducing themselves and their program that you could show patients?)

Find digital version at:
www.dhhs.nh.gov/dphs/bchs/mch/documents/hfa-rack.pdf
Request physical copies by contacting the program coordinator at (603) 271-4566 or MIECHV@dhhs.nh.gov.

Referral Offers: General Family Home Visiting Marketing Supports - 1 minute YouTube Videos created by NH Division of Public Health Services to explain Family Home Visiting

Single Mom Caregiver



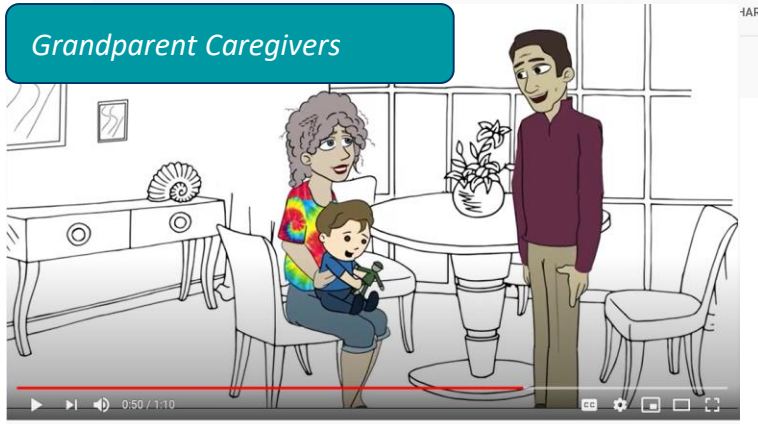
Emily's Story

Single Dad Caregiver

Joseph's Story

0 0 SHARE SA

Grandparent Caregivers

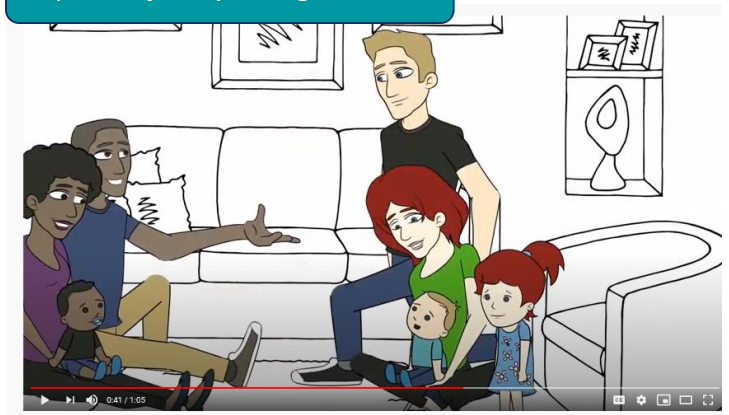


Diane and Louie's Story

25 views • Oct 4, 2018 0 0 SHARE SAVE

NH Public Health
14 subscribers

2-parent family Caregivers



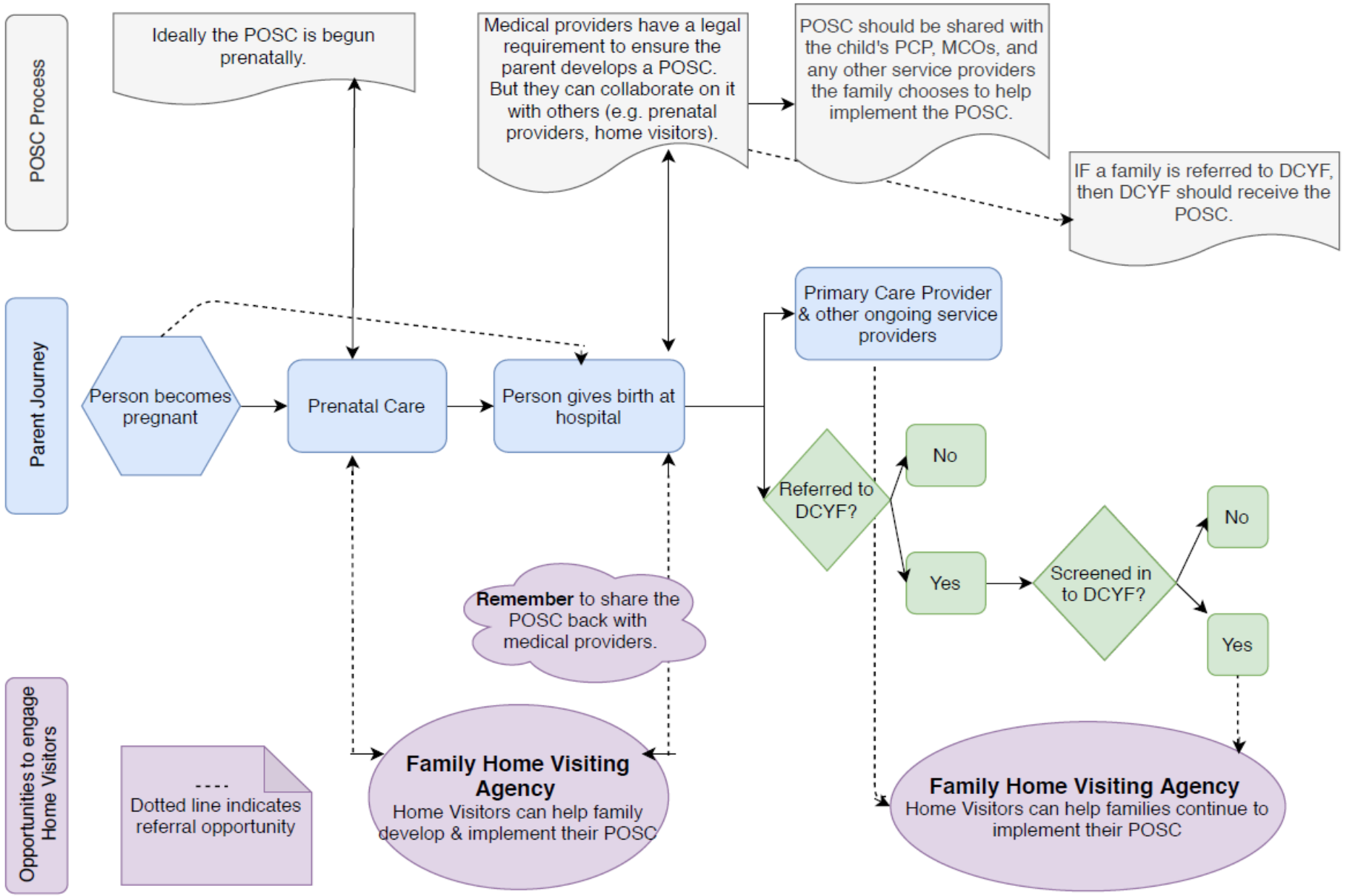
Ashley's Story

51 views • Oct 4, 2018 0 0 SHARE SAVE

- "Emily's story": features a single mother referred to HFA by her doctor - www.youtube.com/watch?v=xmN9kIm_O9U
- "Ashley's story": features a 2 parent household having a second-child - www.youtube.com/watch?v=_0jJQL9YtK4
- "Joseph's story": features a single dad - www.youtube.com/watch?v=cNdtCTAYk1E
- "Diane and Louie's story": features grandparents caring for a newborn - www.youtube.com/watch?v=CLQ-v2DXqGk

Source: https://health.usf.edu/-/media/Files/Public-Health/Chiles-Center/FPQC/MORELanguageMatters-Poster.ashx?la=en&hash=EB1FF25108F689B85347F41EBD0E7EF4213733F8&hash=EB1FF25108F689B85347F41EBD0E7EF4213733F8

How can Family Home Visitors support POSC implementation throughout a parent's journey?



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