Maternal Infant Early Childhood Home Visiting (MIECHV)

Improving Home Visiting Systems:
Three System-Building Efforts in Oregon

KEY LESSONS LEARNED

Contributors: **Beth Green, PhD, Peggy Nygren, PhD, and Amy Gordon, MS**

December 1, 2017

Portland State University
School of Social Work
Market Center Building
1600 SW 4th Avenue
Portland, OR 97201

This Brief contains an overview of key lessons learned from a larger inquiry. Please see the full Case Study Report for more details and additional findings. For additional information, contact: beth.green@pdx.edu or nygren@pdx.edu.

Overview

As part of Oregon's MIECHV evaluation, Portland State University conducted three case studies to learn more about how MIECHV-funded home visiting programs in Oregon were working to improve the home visiting system. These case studies purposefully focused on three different approaches to systems building:

1. Developing and piloting a shared system for referrals between agency partners in Marion County;
2. Developing a community-based "No Wrong Door" referral system in Blue Mountain Early Learning Hub; and
3. Supporting shared professional development through Communities of Practice in Multnomah County.

To learn more about each of these efforts, we reviewed key historical documents (memos, agreements, and meeting notes); and conducted qualitative interviews and/or focus groups with key stakeholders including agency staff, home visitors, and parents. In Marion County, we interviewed 4 agency representatives and 3 parents who had been referred; in Umatilla County, we interviewed 6 participating agency representative; and in Multnomah County we interviewed 2 staff and conducted 2 focus groups, one with participating home visitors and one with participating supervisors. Below we provide a brief overview of each of the three approaches to systems improvement, including factors that supported the process and challenges met along the way. This is followed by a summary of lessons learned across the three communities.

Marion County: "Family Link" – A Shared Home Visiting Referral System

Family Link is a shared referral system developed in 2015 by a network of agencies in Marion County. The system was developed in Marion County, and expanded in 2017 to Polk County as well.

The goal of Family Link is to streamline the referral process by having a central Referral Coordinator who works to connect families with the "best fitting" program. Ideally, the Referral Coordinator, who has strong knowledge of the available home visiting services, helps to improve the likelihood of successful referral to appropriate services in a shorter timeframe by eliminating referrals to programs for which families are ineligible or which do not meet families' needs. The Family Link system utilizes a user-friendly referral form, designed to be short and include only basic information about the family. The system is moving towards an online form, which is in place in Polk County but not yet in Marion County. Currently, the Referral Coordinator and referral database are housed at Family Building Blocks which has 1.5 positions devoted to Family Link.

Family Link success was predicated on building trusting, effective partnerships among the early childhood, home visiting, and medical communities. The Family Link work group invested significant time and energy before piloting the referral system to elicit buy-in from the key stakeholders. As a

result, Family Link increased trust and collaboration among its partners. It also included parents as key stakeholders to help create a context in which "*parents were **hoping** to receive services, not that they were being **convinced** to receive services*." Implementation of Family Link, however, was not without challenges, requiring ongoing efforts to problem-solve, modify plans, and adapt their approaches. Key challenges included maintaining funding for the Referral Coordinator position, fluctuations in the number of referrals and the need for ongoing efforts to build community awareness of the Family Link process, waitlist management, efficient data tracking, and maintaining stakeholder engagement.

> *"I think [shared referral systems] are a real opportunity for impacting outcomes in a community by starting at the beginning. If you can work collaboratively over time, integrating these systems so that you're following families over a lifetime, not just seeing them 0-5, then you're going to really impact the quality of their lives in the long haul." - Program referral staff*

Blue Mountain Building Blocks: Building a Community-Based "No Wrong Door" Referral System for Home Visiting

Blue Mountain Building Blocks' (BMBB) "No Wrong Door" is a community-based centralized referral system developed by the Blue Mountain Early Learning Hub in Eastern Oregon. The BMBB systems relies on a web-based application for services that can be completed online or in paper/pencil by a family member or by a "systems navigator". A systems navigator can be any service provider or other professional who has been trained to assist families in completing the online application. Families learn about the BMBB system through a variety of community marketing strategies (flyers and information posted in doctor's offices, libraries, etc.) as well as through information provided by agency representatives and other community members.

BMBB is housed at Umatilla Morrow County Head Start (UMCHS) which provides the primary support for the systems work. Online applications are located on the UMCHS website, and ask a few simple questions about the family and their needs/interests. When a family completes the online application, they provide their consent for their information to be shared with participating agencies so confidentiality is not a barrier to linking families with needed services.

Key stakeholders suggested a number of factors that contributed to the initial success of BMBB. First, because families can self-refer for services, they are often ready to engage in services. Second, the online application is not intrusive, which may be important for families who may feel uncomfortable sharing detailed private information at this initial contact. The system was intentionally designed to be non-stigmatizing. The name "No Wrong Door" aims to communicate to families that the door is open for a variety of needs, and by using the system they will be connected seamlessly to services.

Another key strength of the BMBB model is, like the Family Link system in Marion County, the key role of county liaisons who reach out early in the referral process to have a one-on-one conversation with the family to discuss their needs and describe program options. This person continues to follow-up with the family and receiving agency to ensure that the family receives services. It was noted that

these county contacts do not receive additional funding support for this role, which may need to be adjusted if referrals increase in the future.

The biggest challenge for the system is under-utilization by both families and community partners; this is recognized by the key stakeholders who are actively working on increased marketing and community outreach to "get the word out" and increase use of the system. Other challenges that the BMBB system has faced to date include: (1) staff turnover among receiving agencies; (2) changes in program eligibility requirements and waiting lists; and (3) difficulty in staying up to date on changes in service and program availability.

Multnomah County: Integrating Professional Development with Communities of Practice

Home Visiting programs in Multnomah County have been working towards a more integrated home visiting system since 2013. Multnomah County used a Community of Practice (CoP) model to bring together home visitors and supervisors from 35 different home visiting programs housed within 16 different agencies. CoP meetings focused on relationship-building and developing shared understanding of the diverse home visiting programs (e.g., target populations, eligibility criteria, staff training needs/requirements, etc.), as well as sharing information about training and other resources, and identifying and prioritizing ideas for systems improvement. The CoP developed a strategic plan that identified priorities for the home visiting system, including:

1. Family Engagement (identifying referral and outreach pathways and strengthening family voice and participation in informing systems work);
2. Cultural Responsiveness and Issues of Equity/Access, including improving the cultural responsiveness of the system and the ability of home visiting programs to successfully engage and support culturally and linguistically diverse families;
3. Home Visiting System coordination, including exploring coordinated referral processes; and
4. Early Childhood System Advocacy and Resource Support.

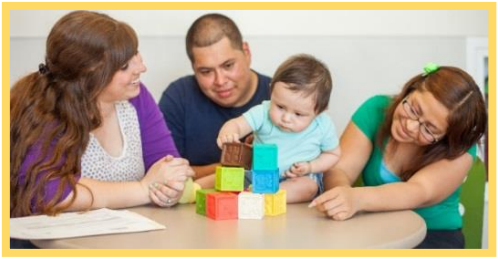
> *"Talking with other home visitors helps me to stay motivated….when you're going into work, things are really hard sometimes doing this work." – Home Visitor*

The CoP resulted in several accomplishments related to the professional development of home visiting staff. First, a shared set of Home Visitor Core Competencies were developed and implemented. Supervisors indicated that this document had become an integral part of their practice. Shared training opportunities were also identified as a success of the CoP, especially a training event focused on *Trauma Informed Care.* Most importantly, the CoP's inclusive process led to increased trust and peer support. Participants all described the importance of the initial time spent in developing relationships and shared understanding of each other's programs and identified peer sharing and support as a reason for their continued participation in the CoP.

> *"The group [CoP] takes you outside your own agency – you get to build relationships with others in other agencies, and can learn and share information about resources." – Home Visitor*

Barriers faced by the CoP in making progress on the systems priorities were most directly linked to the challenge of in sustaining the resources and support for the systems development work. Having dedicated staff to coordinate and support a plan for shared professional development (and other systems goals) was identified as a critical need. A number of participants mentioned that as the staff resources for coordination were reduced over time, it had become more and more difficult to sustain momentum. *"We've talked about other trainings, but it feels like that energy has gone done a little bit…you have to have the money, the capacity to do it. When you join a team like this you don't plan to make it a part-time job. You need people to organize it."* Key mechanisms being used to facilitate cross-agency communication, such as an e-blast, shared program descriptions and information, and facilitated, staffed regular CoP meetings have fluctuated at various points due to changes in staff availability and resources. While stakeholders were quite positive about their support for continuing the CoPs, the groups it was clear that progress was made difficult by staff and leadership turnover coupled with the time and resources needed to fully engage in the CoP work.

Lessons Learned from Home Visiting Systems Efforts



While the work took different forms in the 3 communities, several key "lessons learned" highlighted the shared successes and challenges faced in improving the home visiting system. These lessons learned include:

1. ***The importance of engaging diverse community partners, and the ongoing work needed to sustain this engagement.*** Stakeholders emphasized the importance of having multiple cross-agency partners at the table from the beginning, and making ongoing efforts to sustain engagement and buy-in from these key community partners. The fact that successful cross-program work was not something "done once" was evident, and all the groups reported that time and energy was needed to keep partners coming to the table. Central to sustained engagement was both persistent outreach and communication, as well as collaborative work to ensure that partners saw the value of time spent during collaborative meetings. Related to this was the importance of being ***responsive to the input from stakeholders***. For the CoP this meant providing ongoing ways for CoP members to have input into the CoP strategic plan as well as significant voice in CoP led activities such as shared trainings and conferences. For shared referral work, this often translated into making sure that stakeholders saw the value for their staff and clients in using the shared referral system. Another key aspect of securing engagement in the collaborative work was having specific work products, such as developing the Family Link and BMBB forms, creating home visiting competencies, and working to develop the jointly-sponsored, cross-program Trauma-Informed Care training.

   "A lot of supervisors are working cross culturally, so there's a need for [training in culturally responsive reflective practice/supervision]... We talked about what guidelines should go into the creation of the RFP that people would bid on. It was nice to have that input – what we, as consumers of that product, would want people to provide."
   – Supervisor

2. *Start small, and commit to learning along the way.* Both Family Link and BMBB started with relatively small scale roll-out and have intentionally reviewed data and engaged in shared problem-solving to adapt and modify their approaches to increase success. These modifications and adaptations required a commitment to using information as well as to creating ongoing mechanisms for communication and decision making about the project roll-out phase. Both Family Link and BMBB made sometimes significant modifications to their systems as they tried different strategies and applied their collective experiences to improving the work. Similarly, the CoP conducted surveys and held an all-day retreat about two years after the project started to collect input about how to restructure the CoP to maximize benefits to partners, and to refine their strategic work plan.

3. ***Streamline data collection.*** At the same time groups talked about the importance of collecting, sharing, and using data, all were somewhat under-resourced in their capacity to engage in data collection and utilization. Stakeholders cautioned about the need to streamline the amount of data being collected to avoid duplication of effort or unnecessary data collection. Keeping referral forms simple and non-intrusive is important for both the BMBB and the Family Link systems. Developing efficient data tracking systems and databases with ongoing technical support resources is also essential.

4. ***Be patient, allow time for relationship building, and give it time.*** All efforts emerged from several years' worth of work, and ongoing, sustained partnerships over extended time periods. A common theme for all three efforts was for partners to be patient and realize that this kind of collaborative, systems improvement work takes time to implement.

5. ***Learn from others, but recognize that there's no one-size fits all model.*** Stakeholders emphasized that there is no "one size fits all" model for a shared referral system. Each community is unique and what works in one county might not work another. That said, stakeholders indicated that having opportunities to share ideas and learn from how other communities had approached systems work, in particular in regards to developing shared intake/referral systems, had been valuable as a starting place for developing their systems.

6. ***Secure dedicated resources and support to improve professional development systems.*** Finally, all groups were challenged to bring sufficient resources to the table to fully realize their vision for sustainable systems improvement. The funding provided by MIECHV was in all cases "seed money" that provided a jump-start for the work, but was ultimately not sufficient to sustain the level of effort required for projects. It was clear that resources to support additional work required for systems-level changes/improvements was challenging to find, but critical to making progress. Funders and policy makers would do well to recognize that if such systems level improvements are desired, that resources must be invested to support the time needed for the collaborative process and staff time to sustain partner engagement and implement changes in the system.

Acknowledgements: We thank the Oregon Health Authority, Public Health Division, Maternal Infant Early Childhood Home Visiting (MIECHV) staff for their guidance and overall support on study logistics. We are grateful to the MIECHV key stakeholders including the Systems Engagement Coordinators, Referral Coordinators, program staff, and parents who gave their time and insights to make this report possible.