Alumni Peer Navigator Services Playbook

HRSA
Health Resources & Services Administration

HEALTHY start
TA & SUPPORT CENTER

NICHQ
National Institute for Children's Health Quality

U.S. DIGITAL SERVICE

Contents

Introduction

EXECUTIVE ORDER 14058 & THE BIRTH OF A CHILD TEAM

In 2021, President Biden signed **Executive Order (E.O.) 14058** on Transforming Federal Customer Experience (CX) and Service Delivery to Rebuild Trust in Government. This E.O. directed federal agencies to put people at the center of everything the government does. In the E.O., the Biden Administration committed to improving five "life experiences," or critical moments in the lives of Americans when they often interact with multiple federal agencies and levels of government. Our team, **the Federal CX Birth of a Child Team** led by the **United States Digital Service (USDS)**, was created to focus on improving the experiences of new families — especially new moms in vulnerable communities — as they begin the journey of having a baby. Our work is guided both by the directive of the E.O. and the Administration's **Maternal Health Blueprint**, which outlines steps to strengthen economic and social support for families before, during, and after pregnancy.

THE ALUMNI PEER NAVIGATOR (APN) SERVICES PILOT

Mental health conditions are **the leading cause of maternal mortality in the United States**. Given this, interventions that increase social connection and support for families are more crucial than ever. In the summer of 2023, our team worked with six grantees of the Health Resources and Services Administration's (HRSA) **Healthy Start (HS) Program** to bring the **evidence-based model of peer support** to families having a baby. This pilot program, the Alumni Peer Navigator services, was designed to help HS participants access social-emotional support, programs, and community resources in a culturally responsive way. The six pilot sites included:

1. Center for Black Women's Wellness' Atlanta Healthy Start Initiative (AHSI)
2. Family Road Healthy Start
3. Great Plains Tribal Leader's Health Board Healthy Start, Turtle Mountain Reservation
4. Greater Harlem Healthy Start at Northern Manhattan Perinatal Partnership
5. Pee Dee Healthy Start, Inc.
6. SHIELDS for Families Healthy Start

Since the APN services pilot's launch, 15 navigators have served over 200 families across the six HS sites in tribal, urban, and rural communities across the United States.

45 out of 46 (97%) moms interviewed said "yes" to continuing to work with an Alumni Peer Navigator.

The APN services pilot takes into consideration the context of each pilot site, ensuring that APN services are feasible and add value for each community. Grounded in a participatory design approach, our team conducted in-person and virtual learning visits with 10 HS sites, followed by a round of in-person design visits with HS staff and families. Their voices make up the content of this playbook.

Vision: Collective Motherhood

Our work is centered around the power of "collective motherhood," an approach inspired by the principles of collective impact and the practices and experiences of our six pilot sites. Collective motherhood is a community-based approach to supporting women through the experience of having a new baby. It creates a network of support that is aligned around the shared goal of providing resources, assistance, and emotional support to mothers, so that all families have an opportunity to thrive.

Alumni Peer Navigators (APNs) are one strategy to achieving the collective motherhood vision. APNs prioritize access, efficiency, and a human-centric approach to enrolling HS participants in federal benefits (e.g., WIC, SNAP). This playbook is designed to guide HS sites in implementing APN services within their existing HS project or inspire the creation of more accessible and impactful support systems for families. Ultimately, the goal is to scale collective motherhood through community participatory design in more communities across the country.

Key Concepts

Throughout this playbook, we will refer to the following key concepts:

Alumni Peer Navigator (APN): An APN is an individual, who was a former participant of a program or service, who provides compassionate guidance and support to individuals and families navigating complex systems, with a particular focus on maternal and child health (MCH). APNs serve as connectors, drawing on their lived experiences and training to bridge the gap between families and essential services.

Alumni Peer Navigator (APN) Services: APN services are a programmatic approach to engaging APNs to offer personalized support and guidance to individuals and families navigating various challenges, particularly related to MCH. These services aim to enhance accessibility, reduce barriers, and foster social connections. The overarching goal of APN services is to improve the overall well-being of individuals and communities by addressing specific needs through empathetic and relatable assistance.

Care Coordination Team: The Care Coordination Team may include case managers, Community Health Works (CHWs), outreach staff, mental health staff, supervisory staff, and leadership. Through care coordination, the team assesses, plans, facilitates, and advocates for services to address an individual's needs. This process utilizes communication and available resources to promote quality, cost-effective services that generate good outcomes.

Community-Based Participatory Design (CBPD): CBPD is an inclusive and collaborative approach to developing and implementing programs, services, or initiatives, which directly involves community members in the decision-making and design processes. In CBPD, community members, stakeholders, and designers work together as equal partners, valuing the unique knowledge, experiences, and insights each participant brings to the table.

Culturally Responsive Equitable Evaluation (CREE): CREE requires that diversity, inclusion, and equity be integrated into all phases of evaluation. CREE uses a participatory process that shifts power to individuals most impacted. It incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic). CREE is not just one method of evaluation; it is an approach that should be infused into all evaluation methodologies. CREE advances equity by informing strategy, program improvement, decision-making, policy formation, and change.

Customer Experience (CX): CX refers to the public's perceptions of and overall satisfaction with interactions with an agency, product, or service.

Peer Support: Peer support refers to the invaluable assistance and guidance provided by individuals who have themselves experienced similar challenges or situations related to MCH.

Service: Service refers to the sum of the help that a customer receives from an agency and its partners throughout their journey to obtain, receive, or make use of a public program (e.g., WIC, SNAP) or comply with a policy. This definition is inspired by customer perception; customers perceive the series of interactions throughout their journey as a whole when they combine to solve a need or provide assistance during a life event. The degree to which those interactions are effectively coordinated, easy to navigate, and mitigate uncertainty, determines the customer's satisfaction and trust with the service. Services, as experienced by the customer, can cut across federal budgets, programs, organizational charts, or even agencies. They do, however, require management and collaboration to be delivered effectively.

Service Blueprint: A service blueprint is a visual representation of the steps that employees or an agency takes to complete a service process.

Service Delivery: Service delivery is the actions taken by an organization, like the federal government, to provide a benefit or service to a customer of a federal government entity. This refers to the multitude of diverse interactions between a customer and federal agency.

The How-to Guide: Alumni Peer Navigator Service Plays

1 BUILDING THE TEAM

A strong team is the foundation for a successful implementation of APN services. From identifying key roles to fostering a collaborative culture, this play provides actionable steps to ensure your team is ready to make a meaningful difference in the lives of mothers and families.

Checklist

☑ Identify Key Roles:

- ✓ Determine the roles essential for APN service implementation within an integrated team.
- ✓ Clearly define these roles with your HS project's care coordination team (e.g., Community Health Workers [CHWs], Case Managers).
  - → Identify differences, where there are shared interests, and clarify how all roles support families.

☑ Recruitment Strategy:

- ✓ Develop a strategy for recruiting APNs.
- ✓ Identify mothers and caregivers who have participated in your HS project and/or those with lived experience and a passion for community support.
- ✓ Develop strategies for recruiting APNs from diverse backgrounds and with relevant lived experience to enhance team dynamics.

☑ Training and Development:

- ✓ Design a comprehensive training program for APNs.
- ✓ Include training on empathetic communication, cultural competency, professional boundaries, and program objectives.

☑ Team Collaboration:

- ✓ Foster a collaborative culture within the team among your CHWs, site leadership, and other members of your care coordination team.
- ✓ Establish regular communication channels and team-building activities.
- ✓ Work with Human Resources to identify any anticipated challenges ahead of the hiring process.

☑ Stakeholder Engagement:

- ✓ Identify key stakeholders and partners who the APN will regularly collaborate and communicate with. Include this information as part of APN onboarding.

☑ Support Systems:

- ✓ Implement support mechanisms for the team, including mentorship and ongoing training.
- ✓ Address potential challenges, both proactively and responsively, to maintain team morale and build trust.

Key Questions

1. What roles are essential for the success of APN services within your HS project? How will they complement each other?
2. How can other team members on your care coordination team support the APN role?
3. How can APNs help support the workforce capacity of your organization?
4. How can the recruitment strategy ensure diversity and inclusion within the team?
5. What training components are crucial for APNs to effectively support mothers and families?
6. How can team collaboration be fostered to enhance synergy and communication?
7. Who are the key stakeholders? How can their engagement contribute to the success of the APN services?
8. What support systems are in place to address challenges and maintain team well-being?

Case Study

Once the team at **Pee Dee Healthy Start, Inc.** decided they wanted to provide APN services, they needed to start recruiting the right people. The Case Managers thought about their past HS participants (within the last five years) and identified those who were active while in the program and in their community. In addition to good communication and interpersonal skills, the team looked for past participants with lived experience, passion, and a strong drive to support mothers in their own community. Candidates also needed have experience and knowledge around navigating federal benefits systems and community resources. The team reached out to see if these past participants would be interested in the role. For those who were interested, the team was able to offer part-time, hybrid roles, which allowed moms to participate despite time constraints.

2 TRAINING AND DEVELOPMENT

This play will help your HS project build your APNs' skills, knowledge, and empathy in order to make a lasting impact. From comprehensive training programs to ongoing professional development, this play provides a roadmap for preparing and empowering your team's APNs to navigate the complexities of supporting mothers and families.

Checklist

☑ **Training Around Core Competencies:**

✓ Provide training around the APN role, effective communication, community engagement, and cultural competency.

☑ **Hands-On Simulations:**

✓ Prepare APNs for real-life scenarios through hands-on simulations.

→ These should cover key touchpoints (e.g., initial meetings, periodic check-ins) and potential scenarios (e.g., assisting participants with grocery shopping, accompanying participants to appointments).

✓ Provide opportunities for APNs to practice empathetic and supportive interactions.

☑ **Familiarize APNs with Resources:**

✓ Ensure APNs are familiar with available resources and support services in your community.

→ This includes identifying available resources and navigating relevant systems and programs.

☑ **Continuous Learning Plan:**

✓ Establish a plan for ongoing professional development, including new topics that APNs identify as areas where they need additional support.

✓ Regularly connect APNs to learning opportunities (e.g., workshops, webinars, new resources).

☑ **Feedback Mechanism:**

✓ Implement a feedback system (from families, HS staff, and APNs) to evaluate the effectiveness of the training and continuously improve it.

✓ Foster open communication between APNs and HS staff and encourage APNs to share insights and challenges.

Key Questions

1. What specific topics should the APN training cover to best prepare APNs for their roles?
2. What types of role-playing can enhance the practical skills of APNs and prepare them to support mothers and families?
3. What resources and support services are crucial for APNs to be familiar with? What is the best way to train APNs about these resources?
4. How can the continuous learning plan be structured to ensure ongoing development for APNs?
5. How will feedback from APNs be collected and utilized to improve and refine trainings?

Case Study

Once **Family Road Healthy Start** had hired their APNs, they knew they had to provide training. In addition to the APN training provided by the Healthy Start TA & Support Center (TASC), Family Road provided additional training around topics like human resources. To design this training, the team built upon their experience employing past HS participants for other projects (e.g., local advocacy). In addition to this training, APNs engaged in role play to practice interacting with participants in real-world scenarios. For HS sites that do not have multiple APNs, supervisors or other staff can practice with the APN. Role play helps ensure the APN feels comfortable in their role before meeting with real participants.

3 STARTING THE SERVICES

This play guides you through the essential steps of launching your APN services, from establishing clear communication channels with families to coordinating with community partners. By focusing on a smooth and impactful launch, this play helps you build community trust from the start, and allows the team to effectively reach and assist families throughout the maternal health continuum of care (from preconception through pregnancy, postpartum, and beyond).

Checklist

☑ Integrating APNs into the Care Coordination Team:

- ✓ Assess the time commitment for other team members helping to integrate APNs into your project.
  - → Budget for appropriate compensation for this additional time.
- ✓ Determine who the APNs will report to and ensure this is clear to all team members.
  - → Establish a mechanism for resolving issues or conflicts.
- ✓ Develop a communication plan outlining how APNs will interact with the broader team.
  - → Establish norms around communication style and cadence.
- ✓ Pair APNs with other staff within the care coordination team who can provide support as needed.
- ✓ Collaborate with the team to create a process for documenting APNs' activities, including family touchpoints.
- ✓ Ensure that APNs have the necessary tools and resources to effectively communicate with and support the broader team.

☑ Communication and Engagement:

- ✓ Develop a comprehensive communication plan to introduce APN services to your HS women and families.
  - → Use several communication channels to maximize your team's reach and meet families where they are. Effective channels might include social media, local partnerships, and community events.
- ✓ Implement strategies to identify to participants who could benefit from APN services.
  - → Develop initiatives to conduct outreach and engage these participants.

☑ Coordinating with Community Partners:

- ✓ If you have not already, establish partnerships with local resources and service providers (e.g., food banks, WIC, health clinics).
- ✓ Leverage your HS project's referral system to ensure families have seamless access to additional support.

☑ Launch Event:

- ✓ Plan a launch event to introduce the APN services to the community and your partners.
  - → Build excitement and momentum around the services.
  - → Share the goal and intended benefit of the services for families.
  - → Invite community partners to get their buy-in, support for the services' success, and commitment to providing referrals.

☑ Monitoring and Adjusting:

- ✓ Implement a monitoring system to track the effectiveness of the services.

  This could include distributing surveys, holding one-on-one meetings with families, or hosting group feedback sessions.
- ✓ Be prepared to make adjustments based on the feedback and evolving community needs.

Key Questions

1. How will your HS project assess, communicate, and budget for the additional costs and time commitment associated with integrating APNs into your project? Will you be able to provide additional compensation for those involved in the day-to-day implementation of APN services?
2. How will you ensure APNs receive timely payment and communication about payment?
3. How will APNs communicate with and work closely with the rest of the HS team?
4. How will your project introduce APNs to the families you serve?
5. What strategies will you use to identify and engage families who can benefit from APN services?
6. How can you establish and/or leverage partnerships with local resources and service providers to enhance the support available to families?
7. What elements should be included in the launch event to generate community interest and support?
8. How will you evaluate the effectiveness of the APN services? How will adjustments be made based on feedback and evolving needs?

Case Study

After hiring their APNs, the **Center for Black Women's Wellness' Atlanta Healthy Start Initiative (AHSI)** was prepared to begin serving clients. To improve customer experience, the Family Support Specialists (FSSs) responsible for case management partnered closely with APNs. They wanted their HS participants to feel like they were interacting with one cohesive team providing a seamless, holistic experience. AHSI knew that trust, good communication, and shared collaboration across all team members would be vital to achieve that goal. Participants would have to trust their APN and understand what to expect from different members of the team. APNs were not only supervised and mentored by FSSs, but were paired with an FSS who facilitated a warm, coordinated introduction of the APNs to participants. APNs shared a caseload with the FSSs, knew who to contact with questions about a participant, and could work collaboratively with their FSS to meet the participants' needs.

4 DESIGNING WITH COMMUNITIES

This play puts the power of design directly into the hands of the community through "Community-Based Participatory Design." Through this collaborative approach, community members are engaged in the creation and refinement of APN services. This play will help your team develop solutions that resonate deeply with the unique needs and aspirations of the community, promoting a sense of ownership and inclusivity.

Checklist

☑ Build Trusted Relationships:

- ✓ Build meaningful connections within the community centered on trust.
  - → This includes deeply understanding the community's challenges, inequities, and barriers; working with communities to co-create solutions; and following through with implementation.
- ✓ Conduct listening and learning sessions to uncover community needs and aspirations.

☑ Cultivate Community-Led Solutions:

- ✓ Invite the families you serve to actively participate in the design process.
  - → Compensate them for their time and expertise.
- ✓ Facilitate collaborative sessions where families lead in generating solutions.
- ✓ Ensure that families facing multiple and complex issues are engaged in co-designing solutions.
  - → This could include participants with language barriers, participants of color, participants with disabilities, and other groups that have been historically underrepresented in creating community interventions.

☑ Establish a Continuous Feedback Loop:

- ✓ Establish a feedback mechanism to gather ongoing input from families.
  - → Use these reflections to refine and reiterate APN services on an ongoing basis. Make "agile" improvement the norm.

☑ Remain Adaptable and Flexible:

- ✓ Be open to change.
- ✓ Be willing to adapt solutions based on the feedback and evolving needs of families.

☑ **Empathy as a Driving Force:**

- ✓ Embed empathy in the design process, centering a deep respect for the experiences of families.
- ✓ Prioritize solutions that resonate with and deliver impact for community members.

Key Questions

1. How can you build relationships with families to foster trust and meaningful collaboration?
2. How can you engage families and community members in the design process? In what ways can they lead the process and shape solutions?
3. What mechanisms will be in place for continuous feedback, ensuring ongoing input from families throughout APN service implementation?
4. How can you remain adaptable and flexible throughout the design process? How can you continually incorporate changes based on the feedback and evolving needs of families?
5. How will you ensure that solutions resonate with community members?

Case Study

At **SHIELDS for Families Healthy Start**, an APN noticed that HS participants needed social connection, in addition to the other APN services they were receiving. To meet this need, the APN started hosting monthly self-care sessions on Zoom focused on different topics (e.g., home gardening). Holding the sessions virtually allowed participants to join who did not have access to transportation or were only available during certain hours. This allowed the APN to meet people where they were and tailor the solution to the participants' lifestyles. The method of service delivery can transform the experience and help build a trusting relationship between the APN and participant. Each community's needs are unique and it is important to be responsive to the needs that arise. USDS created a **blog series** highlighting how APN services were designed with communities, including insights on conducting community-centered design.

5 DEFINING AND MEASURING SUCCESS

This play provides a roadmap for assessing the impact of the APN services in a way that respects and values diverse cultural contexts. By emphasizing early engagement, this play focuses on working with your care coordination team and HS families to define success for the services from the beginning. This will ensure that all involved understand what success looks like, including the desired goals and outcomes. This play will also help guide how your HS project evaluates your APN services, while prioritizing cultural responsiveness and equity, through a **Culturally Responsive Equitable Evaluation (CREE) Approach**.

Checklist

☑ Engage the Community Early:

- ✓ Engage community members in the initial stages of evaluation design.
  - → Conduct collaborative evaluation planning with community partners and your care coordination team.
  - → Collaboratively define success metrics (i.e., what does success look like?).
  - → Incorporate community input and secure community buy-in.
- ✓ Brainstorm possible barriers to achieving success.

☑ Align Your Goals:

- ✓ Ensure success metrics align with your HS project's goals and the goals of your HS families.
- ✓ Establish a shared understanding of desired outcomes.
- ✓ Assess your existing data resources to identify what data is already being collected.
  - → Determine if this data can be used to support your shared desired outcomes and reduce burden.

☑ Provide Cultural Competency Training:

- ✓ Ensure evaluation teams undergo cultural competency training, which should include key concepts (e.g., valuing cultural beliefs, linguistically appropriate interventions).
- ✓ Familiarize evaluators with the cultural nuances, values, and history of the communities served by your site.

☑ Ensure Data Collection is Inclusive:

✓ Design data collection methods that respect diverse cultural perspectives.

Guidelines for Culturally Inclusive Data Collection:

Best Practices	Pitfalls to Avoid
• Collaborate with community leaders and members to co-create data collection tools. • Tailor interview scripts to be culturally sensitive and relevant, incorporating community-specific terminology. • Offer surveys in multiple languages commonly spoken in the community. • Implement methods like community-based participatory research to ensure active community involvement in shaping the data collection process.	• Develop surveys with questions that assume a universal understanding of certain concepts or experiences. • Use language that may be unfamiliar or culturally insensitive. • Rely solely on quantitative data without considering the qualitative aspects of cultural context. • Exclude diverse voices or perspectives by using standardized methods that may not be inclusive of the community's unique cultural nuances.

✓ Utilize diverse data sources to capture a comprehensive view of impact, including qualitative data.

✓ Understand what data collection is already being conducted in this community and exploring sharing data with other institutions in the community, to avoid asking clients the same questions multiple times.

☑ Involve Community in Evaluation:

✓ Actively involve community members in the evaluation process to understand their definition of impact and value and incorporate those perspectives into the development of your team's metrics of success.

✓ Encourage community-led assessments and feedback sessions.

✓ Brainstorm alternative ways to collect data from families besides paper surveys (e.g., participatory design sessions, group sessions, focus groups, phone calls, listening sessions).

☑ Adopt a CREE Framework:

- ✓ Integrate Culturally Responsive Equitable Evaluation (CREE) principles into evaluation criteria and methodologies.

CREE Framework:*

☑ Use Equitable Reporting Practices:

- ✓ Ensure evaluation reports are accessible, written in plain language, and culturally relevant.
- ✓ Use storytelling techniques that resonate with diverse audiences.

*Source: Culturally Responsive and Equitable Evaluation (emory.edu)

Key Questions

1. How can you actively involve the care coordination team in defining success metrics for APN services at the beginning?
2. How can you actively involve the community in defining success metrics for APN services at the beginning?
3. How can you align success metrics with both your HS project's goals and the community's goals to ensure a shared understanding of the desired outcomes?
4. How can you foster partnerships with community members to support the ongoing evaluation of the APN services' impact?
5. What data needs to be collected to learn about the impact of the APN services?
6. What data are you already collecting that will help you learn about the impact of the APN services?
7. What training will you provide the evaluation team around cultural competency?
8. What steps will you take to ensure that data collection methods are inclusive and culturally sensitive?
9. How can community members actively participate in the creation of the evaluation, providing insights that reflect their unique perspectives?
10. How will you integrate a CREE (or similar) framework into the evaluation process, guiding criteria and methodologies?
11. How will you ensure that evaluation that findings are reported in an accessible way, are culturally relevant, and resonate with diverse audiences?

Case Study

At Greater Harlem Healthy Start at Northern Manhattan Perinatal Partnership (NMPP), the site supervisor developed a process to document and track the impact of their APNs. NMPP tailored the APNS data collection templates to their site, making them easier to fill out. These modifications were informed by NMPP's deep experience working with participants to evaluate various interventions. Every HS project will develop its own way of evaluating the impact of the APN services, ensuring that the evaluation reflects the priorities and values of their community. Work with your evaluator and case managers to determine what metrics you currently track and identify additional measures that would be helpful. Consider how APNs can support data collection, including distributing surveys or collecting qualitative feedback through in-person meetings or phone calls.

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Learning Visit Sites & Project Directors:

1. Baltimore Healthy Start, Lashelle Stewart
2. Ben Archer Health Center, Inc., Mary Alice Garay
3. Center for Black Women's Wellness, Atlanta Healthy Start Initiative*, Jemea Dorsey
4. Mary's Center, Maria Gomez
5. My Baby and Me – City of Columbus, Valerie Eldridge-Bratsch
6. Pee Dee Healthy Start, Inc*, Madie Robinson
7. Strong Beginnings, Peggy Vander Meulen
8. University of Houston Healthy Start, Niccole McKinley

APN Services Pilot Sites & Project Directors:

1. Center for Black Women's Wellness, Atlanta Healthy Start Initiative*, Jemea Dorsey
2. Family Road Healthy Start, Rochelle Littleton
3. Greater Harlem Healthy Start at Northern Manhattan Perinatal Partnership, Jet Stewart
4. Great Plains Tribal Leader's Health Board Healthy Start, Turtle Mountain Reservation, Chelsea Randall
5. Pee Dee Healthy Start, Inc*, Madie Robinson
6. SHIELDS for Families Healthy Start, Vynette Brown

***Sites that participated in both the learning visits and pilot**

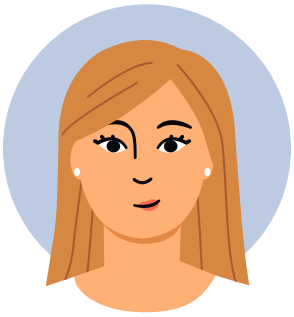
The dedication and openness of these sites have not only allowed us to develop meaningful resources, but have also contributed significantly to the advancement of the APN services. This program has the potential to lay the foundation for improving the life experience of many mothers and families to come. The team is sincerely thankful for the sites' partnership, trust, and shared commitment to improving maternal and child health outcomes.

To the 200+ Healthy Start Families who shared their vulnerable moments with us in hopes of supporting those they may never meet...

Thank you for your voice, we carry it with us.

To the HS Project Director eating a late lunch at 5pm in their office, waiting on a 6-hour hold with a benefits agency in order to seek approval of benefits for a pregnant mother...

Thank you for your wisdom and guidance.



To the Case Manager juggling large caseloads, pausing to comfort a crying baby while her mom completes a housing application...

Thank you for trusting us to be a resource to your families.

To the Alumni Peer Navigator who is driving a new mom to her daughter's three-month checkup, offering a reassuring reminder that she is not alone...

Thank you for creating a safe space for moms to be seen and heard.

Contributors

The following individuals authored and/or contributed to this Playbook. The organizational affiliations are included for informational purposes only. The views expressed in this document do not necessarily represent the official views of the individuals and organizations that participated.

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BUILDING THE TEAM

- Role/Job Description
- Role Template

TRAINING AND DEVELOPMENT

- Getting Started Here Guide
- Offering Description
- Menu of Services
- Service Blueprint
- Onboarding Checklist

STARTING THE SERVICES

N/A

DESIGNING WITH COMMUNITIES

- Solutions for Families, by Families. United States Digital Service (2023)

DEFINING AND MEASURING SUCCESS

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- **Image Source:** Culturally Responsive and Equitable Evaluation (emory.edu)

Getting Started Guide: Alumni Peer Navigators — Moms Connecting Moms to Resources & Community

Welcome! You are here for a reason. And it is life-saving, stress relieving, joy-creating and... urgently needed. It won't be easy. You may find yourself in some of the hardest and most heartfelt conversations.

The good news: You're not alone. And together, we're strengthening the Healthy Start family where babies are sacred, mamas feel connected, families grow, and community thrives. Ready to get started?

Below is some context and resources to help you onboard.

WHY ARE WE HERE?

Let's do life, together. Healthy Start currently works with 101 communities to enroll women, babies up to 18 months, and their partners to **connect families** to comprehensive health services.

You and your fellow Healthy Start alumni are rays of light in your community. Healthy Start sites report that alumni often refer new families, volunteer at outreach events, get involved in their Community Action Networks/Consortium, and are interested in finding new ways to get involved.

Over the past several months, several Healthy Start sites explored how alumni can help improve a family's experience before, during and after having a child. This led to the Alumni Peer Navigator Services (APNS) Pilot and the creation of the Alumni Peer Navigator (APN) role.

You are uniquely qualified to succeed in this role because:

- You've been a participant in Healthy Start.
- You know this community.
- You have a story to share.
- You are savvy and believe in the power of community.
- You want to help others.

Your skills are needed now more than ever. Stress is high and impacts both mom and baby. The data tells us the country should take better care of our moms. We know the Healthy Start moms deserve to feel supported and could thrive with a person like you on her team.

Thank you for coming along her side.

HOW CAN I HELP?

Customer service is a superpower. APNs come alongside the Healthy Start team to help improve a family's experience before, during and after having a child. This starts with listening.

Each Healthy Start has its own kind of magic. Over the past several months, we've worked to better understand the magic by visiting several Healthy Start sites, talking with staff, and meeting with some of the families.

We learned each Healthy Start follows the same **customer experience model**:

- **Acquire:** Attract new families to the program
- **Activate:** Enroll new families to the program
- **Retain:** Engage families before, during and after the birth of a child, up to 18 months

We also heard moms talk about the loneliness and isolation they feel when pregnant. We listened to how much mental health matters during this important time and witnessed first-hand the sighs of relief exchanged when moms share space together.

Through tears, laughter, and hugs, moms showed up for one another. They shared tips on how to use WIC, talked about how much healthy food means to them, and described how they are breaking cycles for the hope of future generations.

Over and over, moms told us how they need someone to talk to who isn't their case manager. Someone who is more like a "sister friend," who can help meet their immediate needs, and can connect them with resources and a "circle of friends".

This is where you come in.

WHAT WILL I DO?

Help moms save time and sanity.

There is power in your story and in your presence. You'll talk with families at multiple points in their Healthy Start journey. This includes encouraging new families to enroll in Healthy Start and working with families who are already enrolled in Healthy Start.

Alumni peer navigation services are a new Healthy Start offering. Every family who enrolls in Healthy Start will have the opportunity to use these services.[1]

[1]See *Menu of Peer Navigation Services*

As you work with families in this role, you can help shape how alumni peer navigation services will roll out across Healthy Start sites in the future. Over the next several months, you can help us uncover learnings and areas for opportunity. In the meantime, we have developed a few tools to help get you started. Your site will be training you on how to use these tools and onboarding you more fully into the role.

Thank you for coming alongside us.

Training to Get Started

Estimated Time to Complete: about 8 hours
Follow these steps to complete this training:

Click here and follow the instructions to join the Healthy Start Hub and access the Community Health Worker (CHW) Course. Once in the course, complete the modules outlined below. This self-paced online course will provide an introduction to the competencies needed to fulfill the roles and responsibilities of an APN in a Healthy Start program.

REQUIRED TRAINING MODULES

You will be required to take the Alumni Peer Navigator Training. This self-paced, online course will provide an introduction to the full competencies needed to fulfill the roles and responsibilities of a peer navigator in the Healthy Start program.

Training Modules:

1. Scope of Practice and Core Values (Module 1) (about 2 hours)
2. Outreach (Module 2) (about 2 hours)
3. Care Coordination (Module 5) (about 2 hours)
4. Participant Empowerment & Community Engagement (Module 6) (about 2 hours)

TOOLS AND MATERIALS

In addition to the training modules, the below materials will be useful to you in your role. These tools can also be accessed **here**.

Tool 1: Journey to Collective Motherhood: APN Service Model

- This one-pager provides an overview of the APN service delivery, from the point when a Healthy Start participant is introduced to APN services to the point when services conclude.

Tool 2: APN Services Offering Description

- This template serves as a promotional description of APN services to invite families to consider working with APN. This flexible template can be customized to your site.

Tool 3: APN Menu of Services

- This one-pager provides an overview of the scope of services provided by an APN. You can share this with your Healthy Start families to educate them about the services.

Tool 4: APN Role & Competencies

- This one-pager provides an overview of the core responsibilities and key competencies of a successful APN.

Tool 5: APN Role Description

- This template can be used to create a job description for your APN, which can be used during the recruitment and hiring process. This flexible template can be customized to your site.

Tool 6: APN Onboarding Checklist

- This fillable template serves as a tool for APNs and their supervisors to ensure they have completed all necessary training and are prepared to begin providing APN services.

Journey to Collective Motherhood:
Alumni Peer Navigator Service Model

01

AWARENESS

Healthy Start participants are introduced to APN services:

- ***Offering Description***
- Event Invites/ Promotional Flyers
- Storytelling Pitches/ Word of Mouth
- "How can I help?"

02

DECISION POINT

Participants have a consultation with their case team to determine if APN services can help them reach their goals. If it is the right fit, a warm introduction with an APN is made.

- Roles are clarified (***What is an APN?*** One-pager)
- The ***Menu of Services*** is shared

03

SERVICE DELIVERY

APN services begin. Within the first 30 days:

- In-person or virtual face-to-face introductory meeting
- Informal APN check-ins

04

CONTINUED ENGAGEMENT

Frequent interaction and engagement activities are offered to maintain connection. This can include:

- Group education classes
- Social activities with families
- Postpartum check-ins
- Joining Healthy Start Consortium

05

COMMUNITY BUILDING

APN services conclude when participant goals are met or upon graduating from Healthy Start. Invitations to become a part of the Healthy Start ***Alumni Network*** are shared. Some moms may also choose to support APN services at their Healthy Start or find other ways to stay involved.

REFERRAL

Alumni Peer Navigator Services
Offering Description

Alumni Peer Navigator Services

WHAT ARE ALUMNI PEER NAVIGATOR (APN) SERVICES?

Connect with another mom who participated in Healthy Start and understands your journey. Our Alumni Peer Navigators can assist you through pregnancy and postpartum, providing guidance on local resources and benefits, and offering compassionate support every step of the way.

If you've ever needed a person who could relate, this is for you.

WHAT'S IN IT FOR ME?

Alumni Peer Navigators can help you with:

- **Easy Enrollment:** Explore benefits and get hands-on assistance with applications, paperwork, websites, and calls.
- **Essential Supplies:** Access baby care supplies like diapers, strollers, and more, as needed.
- **Community Connection:** Join family-friendly local events and gatherings with other moms.
- **Resource Assistance:** Discover community resources for mental health, childcare, housing, recovery, employment, transportation, and financial guidance.
- **Regular Check-ins:** Receive compassionate support and gentle guidance throughout your pregnancy journey.

WHAT DO HEALTHY START FAMILIES HAVE TO SAY?

Alumni Peer Navigators play a key role in improving Healthy Start families' experiences. What some families have shared:

> **It feels like a community:** It's not just 'let me help you,' but 'how can we help each other? We will get through it together.'

> Now there are more open doors to what I can achieve and accomplish. **I am getting more resources that can help me.**

HOW DO I SIGN UP?

Reach out to your Healthy Start case manager to get started. We'll schedule an in-person or virtual meeting with an Alumni Peer Navigator to learn ways to best support your goals. Anytime is the right time to get started!

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APN Menu of Services

What can your Alumni Peer Navigator (APN) help with?

Don't be afraid to reach out. APNs are here to help you with all of these services.

BENEFIT APPLICATION ASSISTANCE:

- Provide you with applications
- Identify and prepare your documents
- Help you enroll
- Help you re-enroll

COMMUNICATIONS:

- Provide appointment reminders
- Provide event invitations
- Connect you to resources

WORK SUPPORT:

- Connect you to adult education classes or English classes
- Support finding jobs
- Support with career development

LANGUAGE ASSISTANCE:

- Provide translation support
- Help you understand documents
- Help with phone calls, emails, and tech support

COMMUNITY RESOURCES:

- Help you find housing, child care, cash assistance, food and nutrition resources, and transportation vouchers and support
- Connect you to:
  - Mental health support
  - Substance use and recovery support
  - Domestic and family violence support
  - Support groups

APPOINTMENT BUDDY:

- APNs can bring you to:
  - WIC Office Visit
  - WIC Shopping Visit
  - Medicaid Office Visits
  - Prenatal Appointments
  - Postpartum Appointments
  - Labor and delivery

Looking for other support?
Reach out to your APN to see if they can help!

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Alumni Peer Navigator Roles & Competencies

THE ROLE OF ALUMNI PEER NAVIGATORS

Alumni Peer Navigator (APN): An Alumni Peer Navigator is an individual, who was a former participant of a program or service who provides compassionate guidance and support to individuals and families navigating complex systems, with a focus on maternal and child health. APNs serve as connectors, drawing on their lived experience and training to bridge the gap between families and essential services.

APN Services: APN services are a programmatic approach to engaging APNs to offer personalized support and guidance to individuals and families navigating various challenges, particularly related to maternal and child health. These services aim to enhance accessibility, reduce barriers, and foster social connections. The overarching goal of APN services is to improve the overall well-being of individuals and communities by addressing specific needs through empathetic and relatable assistance.

APN COMPETENCIES

01

Demonstrate Equality

APNs treat those they support with respect and equality.

02

Share Hope

APNs tell stories of their personal experiences that are relevant to the current struggles faced by those they support.

03

Withhold Judgment About Others

APNs respect an individual's right to choose and do not evaluate or assess others.

04

Show Nonjudgement When Listening

APNs have good listening skills and understand that families may have different reactions to shared experiences.

05

Are Curious & Embrace Diversity

APNs treat each person they encounter with dignity and see them as worthy of all basic human rights.

06

Address Difficult Issues with Caring & Compassion

When desired by those they support, APNs engage in candid, honest discussions about stigma, abuse, oppression, crisis, or safety.

07

Encourage Peers to Give & Receive

APNs learn from those they support and respect and honor a mutual relationship of shared power, wherever possible.

08

See What's Strong, Not What's Wrong

APNs operate from a strength-based perspective and acknowledge the strengths, informed choices, and decisions of peers.

09

Set Clear Expectations & Communicate in Simple Terms

APNs clearly spell out what is expected in a peer support relationship.

Alumni Peer Navigator Role Description

Role Title:

(e.g., Alumni Peer Navigator, Peer Coach, Peer Support Specialist)

DESCRIPTION

Site Name is seeking # dedicated Healthy Start (HS) alumni to join as role title. Working as a team, role title will collaborate closely with HS staff to enhance families' experiences connecting to a broader range of community resources and social supports, including federal, state, and local benefits. The role involves establishing strong relationships with new parents and linking them to any necessary external resources to address their specific needs. Reporting directly to HS staff, role title members play a pivotal role in improving families' overall experience in the HS program and in reaching their goals to improve health outcomes before, during, and after pregnancy.

ESSENTIAL TASKS

- Help HS participants navigate community resources and benefits, including providing education about and referrals to programs that participants may be eligible for, and helping participants complete applications.
- Provide support to parents before, during, and after having a child, in coordination and collaboration with HS staff, including the participant's case manager.
- Support group-based programming and family engagement activities, either in person or virtually.
- Establish and maintain connections with local benefits offices, service providers, and other partners, consistently updating a community resource directory.
- Support HS staff in tracking, documenting, and monitoring participants' access to and use of services.
- Add: Are there any other tasks the Alumni Peer Navigator can assist with? Participate in field visits with select HS families? Participate in recruitment/outreach events?

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MINIMUM QUALIFICATIONS

- Must be a past HS participant (within the past five years)
- Must have been enrolled in at least two Federal benefits programs (at some point in the past five years)
- Must have strong knowledge of community resources, support services, and benefits programs for families
- Must live in the HS service area
- Must be willing to send and receive text messages, make and receive phone calls, and participate in video-based conferencing
- Add: Is transportation a must have or a nice to have? Would you like the person to co-locate or work from an office space one day/week?

LOCATION & TIME COMMITMENT

The role title will be based at the HS site/home office . This is a remote/in-pel position with an expected time commitment of Date Range, # of hours per week.

COMPENSATION & BENEFITS

This role is a contract position with an anticipated stipend of [Add...] paid [weekly, bi-weekly].

The role title will receive:

Add: Specific benefits... company vehicle, phone, laptop, office, WiFi, professional development fund, flexible schedule, child care assistance, etc.

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APN Onboarding Checklist

Work your supervisor to ensure that you've completed the required training.

When done, turn this into your supervisor. You're ready to go!

Alumni Peer Navigator Name:
Supervisor Name:
Healthy Start Site:
Date:

Before I start working with Healthy Start families, I confirm:

TRAINING TO GET STARTED	STATUS	DATE COMPLETED
1. I met with my supervisor.		
2. I have access to a Healthy Start email address and phone and have set up my voicemail.		
3. I completed the Alumni Peer Navigator Training.		
4. I completed any additional training that my Health Start site requires.		
5. I can access WIC and Medicaid forms and know what is required to help families apply and use these resources.		
6. I can explain what the Healthy Start program is, who qualifies, and how to enroll.		
7. I practiced and feel confident sharing my Healthy Start story.		
8. I understand the purpose my role, how these new services may benefit families, and the menu of Alumni Peer Navigator Services that I will help my site provide.		
9. I reviewed and understand my site's *confidentiality* procedures.		
10. I reviewed and understand my site's *safety* procedures and escalation protocols.		
11. I discussed and understand my site's *documentation* procedures with my Supervisor.		
12. I understand and agree to adhere to my site's *transportation* policy and liability procedures.		

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YOUR PLEDGE

Congratulations on joining the Healthy Start team! The most important part of the Alumni Peer Navigation Services (APNS) Program is actively listening to and connecting with families. Review the below expectations and sign to get started.

As an Alumni Peer Navigator, I agree to:

- Support my families: listen, share, encourage and celebrate.
- Support Healthy Start staff: communicate, document, develop relationships in the community, and maintain confidentiality as required and necessary.
- Treat families and staff with respect.
- Not gossip or share family information outside of Healthy Start.
- Serve as an ambassador of Healthy Start and its work for and in the community.
- Let my supervisor know if I am unable to continue to be an Alumni Peer Navigator.
- Reach out to Healthy Start staff if I have questions and encourage families to do the same.

Alumni Peer Navigator Signature **Date**

Supervisor Signature **Date**

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