

**U.S. Department of Health and Human Services
Health Resources and Services Administration**

**Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program
Technical Assistance Coordinating Center's
Webinar**

“Centralized Intake: The Next Steps Along the Journey”

April 23, 2013

3:00pm Eastern, 2:00pm Central, 1:00pm Mountain, 12:00pm Pacific

Presentations by:

***Tod Robertson, Hawaii State Department of Health
Deborah Chosewood, Maternal Child Health and Central Intake, Great Start Georgia
Debbie Richardson, Kansas MIECHV Program & Maternal and Child Health Unit
Leah Woodall, Delaware Maternal and Child Health Bureau
Carol Wilson, Great Start Georgia***

Kim Bradley: Welcome everyone to the Centralized Intake: The Next Steps Along the Journey webinar.

We will be making several stops across the country during our journey today. We are glad to have you aboard. Your tickets have been stamped so let's get started.

Today's webinar is brought to you by the Maternal Infant and Early Childhood Home Visiting Technical Assistance Coordinating Center otherwise known as the MIECHV TACC.

The Technical Assistance Coordinating Center is funded by HRSA and staffed through ZERO TO THREE and subcontracted partners Chapin Hall, Association of Maternal and Child Health Program, and Walter R. McDonald & Associates. TACC provides different levels of support to grantees using ZERO TO THREE and partner staff along with numerous expert consultants and in coordination with other TA providers.

My name is Kim Bradley. I am a TACC TA Specialist with ZERO TO THREE. I will be moderating the webinar today. Christy Stanton who is also a TACC TA Specialist will be manning the chat box and assisting during the Q&A portion of today's webinar.

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Before we jump into our agenda I do have a few housekeeping items to share with you.

First, your phone lines will stay muted throughout the duration of the webinar. For optimal sound quality we encourage you to call in via the phone line versus listening in on your computer speakers. The teleconference line information is located in the top left corner of your screen.

You should have received the PowerPoint slides for today's webinar via email if you registered for the webinar by this morning. They will be sent out to all attendees after the webinar as well.

We have designed this webinar to be interactive. At different points you will have the opportunity to participate in some polls. In addition, we invite you to share your thoughts and questions via chat throughout the webinar and not just wait specifically ask to participate. The chat box is located in the lower left corner of the webinar window just to the left of the PowerPoint slides.

To post your comments in the chat box you will type your post into the text field at the bottom of the chat area. See number 1 on your screen. Be sure to click the arrow in the chat box or hit the return Enter button on your keyboard to ensure that everyone can see your post. Only public chat is available for this webinar.

Our map for today includes a welcome from HRSA; a presentation from Hawaii about their journey with centralized intake; updates from Georgia, Kansas, and Delaware as to the progress and lessons learned they have experienced since they first reported on their centralized intake systems last June; and finally we will then move into a Q&A session. Again, please share any questions that may come up during the presentation in the chat box. We will get to as many as we can during the Q&A session.

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Today's objectives are to increase knowledge and awareness of four approaches states are using as their centralized intake system; to explore lessons learned by states over the past ten months as they have progressed with implementing their centralized intake approach; and to increase awareness of potential challenges and barriers that may arise in developing and implementing centralized intake systems.

I would like to introduce Judith Thierry today. She will be providing our welcome from HRSA. Judith is the Branch Chief for the Eastern Implementation Program in the Division of Home Visiting and Early Childhood Systems Maternal and Child Health Bureau at HRSA. She provides oversight to 24 states and territories that comprise the eastern branch working closely with team leads and regional project officers and western branch counterparts.

She is a board certified pediatrician and received her MPH from Johns Hopkins in Health Policy and Maternal Child Health. She is a captain in the U.S. Public Health Service. Dr. Thierry served as the MCH coordinator for the Indian Health Service from 2002 to 2011. In addition she served as an Army nurse during the Vietnam era. Thank you Judy for joining us today.

Judy Thierry: It's my pleasure to be on the call and just welcome everybody, look forward to this discussion and presentations and the polls that are built in here. Just on behalf of Dr. David Willis, our division director and Michael Lu the Bureau Administrator and HRSA as a whole, we are solely engaged in the technical assistance and support that TACC brings to the grantees as well so looking forward to this session today. Thank you everybody.

Kim Bradley: Thank you Judy. Before we hear from our presenters we would first like to hear a little bit from you about the status of centralized intake in your state. You can share this information with us by selecting the letter that best represents your answer in the feedback window to the left of

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the PowerPoint slide. If you are not seeing the letter option click the little arrow to the left of the word Feedback to open that window.

As soon as the circle in front of your selected letter has turned blue with a little black dot inside, you have submitted your answer. If your answer does not fit into the options listed please post it in the chat area.

Our first question asks which stage best describes the current state of your centralized intake system. Will that be A, have not begun to work on centralized intake yet; B, formally exploring or planning; C, piloting or getting ready to pilot the system; or D, implementing the system? Please make your selection now. It looks like we have a few more folks to submit. I'm going to give another ten seconds. Great, thank you very much.

It looks like quite a number of folks are already implementing the system or B, they're formally exploring and planning. And we will be getting into more of this as we move into the Q&A session just a little bit later. Thank you.

The next poll question asks which centralized intake approach does your state or community use or are considering using. A, Statewide; B, community level; C, Help Me Grow; or D, other. And if you could please put in the chat box what other would be. Please make your selections now. I'm going to give another ten seconds so please make your selection.

Great, thank you so much. It looks like almost by far the majority of folks are looking at a community level approach. We will also explore this a little further during the Q&A session.

Now to our presentation. Our first stop today takes us to the beautiful state of Hawaii. Tod Robertson, our first speaker, is with the Hawaii State Department of Health. Tod has spent the

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past 22 years actively involved in home visiting as a home visitor, home visiting program director, and the executive director of a home visiting provider organization.

Currently Tod is the Hawaii statewide home visiting network coordinator and evidence based home visiting project director. Aloha Tod, thank you for joining us today.

Tod Robertson: Thank you Kim. Aloha Kakou, greetings from the Aloha State. I want to thank HRSA and the MIECHV TACC for the invitation to participate in this centralized intake webinar. It's a privilege to have this opportunity to describe the centralized intake system we use in Hawaii.

I would like to acknowledge the intake provider agencies who actually do this work and who collaborated on this presentation. The WYCA of Hawaii Island, Family Support Hawaii, Maui Family Support Services, Catholic Charities Hawaii, and Child and Family Service.

We call our program Early Identification. Throughout this presentation I'll use Early Identification or EID to describe our intake program. Here you can see where the Early Identification Program operates in hospitals with the highest birth rate in Hawaii.

In the lower right corner you see the island of Hawaii or the big island where we have two hospitals, one on each side of the island. As you go up the island chain to Maui there's one hospital. In the middle of the map you see Oahu. And currently we're servicing two hospitals but by June 30 of this year we'll be expanding to include two more. And in the upper left corner you see the island of Kawai where we're doing prenatal Early Identification.

The Department of Health has chosen hospital EID because the Department of Health has had long term connections with the medical community through area hospitals. Hawaii is a small state

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and as you can see has few hospital facilities so working within the hospitals seem to be a good match for the department of Health.

We estimate we're currently screening 19% of babies born in Hawaii hospitals with the addition of two Oahu birthing hospitals we estimate 25% of babies born in Hawaii hospitals will be screened by June 30 of this year.

The EID program operates in civilian birthing hospitals. We do not service the military hospital. If an active military member or military dependent gives birth in a civilian hospital they would be screened by the EID program.

All hospital and prenatal are hāpai the Hawaiian word for prenatal. Early Identification includes geographic eligibility. We have used the MIECHV needs assessment to identify geographic areas with the highest risk factors. MIECHV eligibility, a 15 point screen is a validated screening tool for child abuse and neglect risk factors. For those who are screened positive a Kempe Family Stress Checklist Assessment is completed. For those who are assessed positive on the Kempe Family Stress Checklist Assessment, home visiting services are offered.

All families whether eligible or ineligible are offered referral resources and with a signed consent the family is voluntary referred to a home visiting program.

In Hawaii we use two types of Early Identification. The first type is hospital Early Identification at birth. This occurs in civilian hospitals with the highest birth rate. Before visiting hours the EID intake worker goes to the room of all women who have given birth who live in the geographic eligibility region. They screen for MIECHV eligibility, complete the 15-point screen, administer the Kempe Family Stress Checklist, and then provide a consent for voluntary services and a resource packet.

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Hawaii has a long history with the Healthy Families America model and we have been using EID with the HFA model program for many years. As part of the MIECHV Development Grant Hawaii received, we began to try to address developing the capacity of the Early Identification program. We conducted a pilot from April of 2012 to March of 2013 with the Early Head Start model and Parents as Teachers model. We feel that pilot has been successful so effective July 1 all models will receive Early Identification referrals.

The other type of Early Identification we're doing as prenatal or hāpai Early Identification, we have created a zone of innovation on the Island of Kauai. It is a small island and therefore easily manageable for a pilot. There we have spent the last year working with local community organizations to identify referrals and there all intakes are done prenatally.

We have two types of working relationships with civilian hospitals. The first type of working relationship is a memorandum of understanding or MOU. You may be familiar with this. There are currently three hospitals using MOUs. The confidentiality assurance contained in the MOU doesn't allow for review of medical records.

Because confidentiality assurance doesn't allow for review of the medical records the intake worker must knock on each door of all women who have given birth in the hospital to inquire where the family lives and then determine their geographic eligibility.

The EID screening programs works very closely with the hospital discharge department. The Early Identification voluntary referral to a home visiting program is part of the discharge plan that the social work or discharge department develops.

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An MOU creates a vendor relationship with the hospital. The screening program is considered a vendor or a supplier of a service. The EID program is a provider of screening assessment resource and referral services.

An MOU defines the purpose of the understanding. In this case our purpose is to screen families of newly delivered children for risk factors. The MOU describes the services to be provided, screening, assessment, resources and referral; it outlines the roles and responsibilities of the EID program and the roles and responsibilities of the hospital, and provides a timeline or a term of the understanding that can be either one year or multiple years. And it can describe other terms and conditions such as how to terminate the agreement.

In working with MOUs it requires that the Early Identification program administration, their program executive officers and board of directors and attorneys review the document as well as the hospital executives, chief operating officers, and the hospital attorneys. So this can take a long time for each level of review and the document can get stalled along the way. Therefore it's a good idea to have a point person in the intake program and in the hospital to guide the MOU through the ranks.

Relationships are critical. Relationships between the EID program and the hospital staff whether that's the hospital administration or admitting or maternity floor nursing staff as well as relationships between hospital departments, between admissions and records and maternity and social work that you might have to foster the relationships between those hospital's departments.

The second type of working relationship with hospitals is the subcontractor. We have two programs that have subcontractor relationships with hospitals. As a subcontractor each individual Early Identification program staff member is processed as a contract employee of the hospital. Each individual EID staff member is a member of the post-discharge planning team.

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Each EID staff member must complete hospital new hire orientation, in-service training, confidentiality training, health percussions training, blood borne pathogens training, complete all immunizations and a TB clearance, and must comply with all hospital employee practices. Each EID staff member is issued a hospital identification badge and must comply with all hospital policies.

As a subcontractor the hospital consents to view information is built into employment. As a hospital employee with access to the electronic medical record, the 15-point screen can be completed by record review. So access to the medical record provides the family's home zip code, therefore the EID worker doesn't have to knock on each door to determine geographic eligibility.

We've had really successful subcontractor relationships. One of our hospital EID programs worked with the Hilo Medical Center admissions and records department for approximately five years and as a result of their work with the quality improvement officer of the admissions and records department the hospital OB admittance has incorporated the same 15-point screen in their admittance procedures. So because the OB admittance now administers the screen, the intake program achieves 100% screening of all OB admittance.

So the subcontractor arrangement has benefits for the intake program as well as for the hospital. It helps the hospital with their community outreach for the joint commissions formerly known as JCO accreditation.

I mentioned earlier that we have used the island of Kauai as a zone of innovation providing prenatal screening only. The EID program works with community resources such as pediatricians, perinatal support services, family centers, state and federal housing programs, Women, Infant,

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and Children or WIC program, public health nurses, homeless shelter housing, transitional housing, and bulletin boards are still popular in Hawaii so posting flyers on the Salvation Army Thrift Store and Habitat for Humanity Thrift Store bulletin board work very well.

We do community outreach at events like Prince Kuhio Day Parade, Family Summit, and resource or health fairs where hand massages or prenatal recipes are offered to women to pregnant women and they are provided information on voluntary services available to them with that hand massage or recipe exchange.

We also work with prenatal clinics. With prenatal clinics we found it is important to make the referral process as simple as possible. An easy and responsive referral process is necessary and we found that you must respond with resources and referral as soon as the clinic makes a request.

It is important to be a part of the clinic team which means showing up at each clinic and then checking in - frequently with the clinic staff in between the clinics to see if they have any more referrals.

So some of our lessons learned. It's about relationships. Relationships are so important be they the administrative relationship or relationships with the maternity floor nurses, the discharge team, or the social work department or admitting and record department.

When the administration or nursing or admitting staff changes you must establish new relationships. So it's a continual process of maintaining and establishing new relationships.

We consider one of our marks of success is when an EID worker is in the room doing their intake with families. There are medical procedures and examinations that must take place. When nurses

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enter the room and say I'll be back later it's an indication of the professional respect and their belief in and support of the intake program.

It is important to find a point person who shares your vision of how your centralized intake services will work. Be patient with that person while getting the centralized intake services set up but be persistent with that point person to get the job done.

In order to get the respect I spoke of earlier the floor nurses have to be aware of the benefits of the program. Awareness equals success so train the maternity floor staff, have regular meetings with the maternity floor staff, and find multiple in-service trainings at many levels works best whether that's at the administration level, the OB admissions and records, the head nurses, floor nurses, phlebotomists, janitorial staff, anyone who is in and out of the room while you're there doing the intake.

Another mark of our success we believe is when floor nurses are aware and believe in the program. They support the program by providing the consent and resource packets when the EID staff aren't available such as on weekends.

And when the nursing staff believe in your program they will bring your concerns about new birth families to the EID staff's attention. We have also found opportunities to cross train EID staff to provide breast feeding support in addition to intake.

So in conclusion, our next steps are going to be to move from the pilot to full scale implementation for Early Head Start and Parents as Teachers effective July 1.

We're developing a decision tree for communities that have multiple home visiting models to determine how referrals will be made, what's in the best program fit for families. And through our

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continuous improvement we're going to be refining our data collection. Thank you for allowing me to speak about our centralized intake program.

Kim Bradley: Thank you so much Tod for sharing all the great work that you all are doing in Hawaii. And your point about relationships, relationships, relationships is well taken. To that end I do have a question for you. When you were approaching hospitals about this potential partnership with them, how did you all determine if that relationship would be that of an MOU or a subcontract?

Tod Robertson: Thank you Kim for that question. We generally let the hospital take the lead with that decision. Many of our hospitals in Hawaii are owned by the same corporation so that corporation may have a preference. If not, we make a suggestion and try to support our suggestion by connecting that hospital with other hospitals we are working with so that they can discuss their experience and the pros and cons of the relationship choice.

Kim Bradley: Great thank you, very interesting. And we look forward - I look forward to hearing from you further during the Q&A session. Thanks for that information.

We're going to move on to a polling question real quick. The next polling question asks do you feel the partnerships you have are adequate for planning and/or implementing your centralized intake system. If you could please select A, for yes and B, for no. Just a few more seconds to make your selection.

It looks like most everyone feels that you do have strong relationships in place. That is great. And for those of you that are hoping to garner additional support, this can be certainly an area that the TACC provides future TA on. Thank you for participating in that poll.

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Our next stop is taking us to the great state of Georgia. Deborah Chosewood is our next speaker. She has worked in Early Intervention in birth to 5 programs in Georgia for over 10 years. She is the program manager for the Children 1st Program for the Georgia Department of Health, Public Health, Maternal Child Health section.

She also became the program manager for the central intake for Great Start Georgia when the Department of Public Health partnered with the Governor's Office for Children and Families to provide central intake.

She is a member of the Great Start Georgia collaboration team working closely with the Governor's office for children and families and other members of the state leadership team to coordinate the Great Start Georgia system of care. Thank you for joining us today Deborah.

Deborah Chosewood: Thank you for inviting us and good afternoon. I will be giving an update on the central intake system in Georgia. Last summer Dr. Debbie Cheatham had provided an introduction in a webinar that occurred last June while we were still in the planning phase. If you were not able to participate in that webinar and would like more information, our contact information will be listed at the end of this webinar.

Since Debbie's presentation last summer we have renamed our system of care Great Start Georgia. Leadership for MIECHV and Great Start Georgia is provided by the Governor's Office for Children and Families in collaboration with the Georgia Department of Public Health, the University of Georgia Center for Family Research, and the Great Start Georgia leadership team which is made up of all of the public and private child and family serving agencies in the state.

Carol Wilson who is the Great Start Georgia project manager is here with me and she will be available for questions later on during this presentation.

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This diagram represents the Great Start Georgia framework and this was discussed by Dr. Cheatham in last June's webinar in great detail. Central intake is box number 2 in this diagram. The Department of Public Health has partnered with the Governor's Office for Children and Families to coordinate central intake to support Great Start Georgia.

Prior to October 2012 the seven local counties providing home visiting were also providing their own intake and referral systems. Each county had a little bit of a different process and each agency had separate data systems for processing referrals.

In October of 2012 with public health taking over the oversight of central intake for Great Start Georgia, we were able to bring these processes together into a coordinated effort. Although we still allow for many paths into the Great Start Georgia system, we are now coordinating and centralizing where those referrals pass through and where the data is housed. Since the June webinar last year we've made great strides.

Last summer the Department of Public Health contracted with a call center services vendor that we are now calling the Information and Referral Center as we realized that they were doing more than just answering calls. The IRC as we call it opened on October 1 of 2012 and they provide statewide toll-free access 8:00 am to 8:00 pm seven days per week excluding state holidays.

The IRC is responsible for processing all electronic birth certificate referrals which come through public health from an electronic feed from our vital records department. They process all EBCs for the seven MIECHV funded counties and on behalf of public health Children's 1st Program also process all EBC referrals for those identified as at-risk in non-MIECHV funded counties for a public health program we call Children's 1st.

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The IRC also processes all telephone or online referrals into Great Start Georgia, helps us maintain our resource directories, and assists us in promoting Great Start Georgia.

In order to assure that we indeed had a centralized intake avoiding duplication of referrals that can be caused by each agency having its own referral data, we at public health created a central intake data system. This provides one central location for all Great Start Georgia referral data and screening data.

All of the individuals who complete or process referrals in Great Start Georgia utilize this data system and we also have built this data system on a platform where vital records feeds the electronic birth certificates into the system so that we are able to access that information.

Again in order to provide a centralized process we developed a standardized screening tool which is used by all providers across the state. This tool was developed in partnership with the lead agencies of the Governor's Office for Children and Families, Department of Public Health, University of Georgia, etc.

There have been community screeners who were doing this work for years in a hospital setting or in some community facilities. But public health is now providing a safety net to catch those children who may not have been identified prenatally or in the hospital setting. We also can use public health to help identify prenatal referrals through our WIC offices as Tod mentioned is happening in Hawaii.

The goal is for every expectant mother, newborn, or child birth to five in the MIECHV funded counties to be offered a screening. The - after the screening the provider and the family will determine what the best fit is for the services and make referrals to the appropriate program or programs. Weve done approximately 2700 screens to date.

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Finally we worked with the Governor's office to offer some public awareness of Great Start Georgia in the state. Our Governor's wife, First Lady Sandra Deal, helped to launch the Great Start Georgia program in January of 2013. Our public health commissioner, the executive director of the Governor's office, and the First Lady presented at this event. We invited most of the media outlets and had numerous television spots and radio spots.

We also did community presentations in each of the seven counties that are providing MIECHV home visiting and invited the local stakeholders from each of those counties.

Our biggest success has probably been the decrease in the duplication of work and an increase in the collaboration through Great Start Georgia. By having one centralized location for data that is linked to the electronic birth certificates, we are able to see who might have been missed prior to this centralized referral system.

Another success is that for the most part agencies are working on collaborating versus competing much more now than we did when we were in a more siloed structure. As Tod mentioned in Hawaii relationships are very important and that has been one of our greater successes.

Some - one of our greater challenges have been that although the system was launched on time on October 1 there have been many enhancements that were made following that date. We continue to make improvements and will likely be doing so for the remainder of this fiscal year.

As a brand new data system launched simultaneous with a brand new central intake process, it was difficult to anticipate exactly what was best as far as data entry, data capturing, reporting of data, etc. So it has been very much a work in progress which has led to some confusion among our users.

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One of our biggest surprises has been the length of time needed for startup. As we changed the wheels on the jet plane as it's flying cross country, we realized that it's difficult to anticipate some of the issues that have come up along the way.

The key to success in this situation is constant and open communication, clear feedback between partners, flexibility and willingness to admit when something is not working, and coming back to the drawing board.

To make sure that we're continuing to identify needed improvements to the system we're providing continued quality assurance or quality improvement through a variety of ways.

Some of those are weekly cadence calls that public health has with our central intake staff. The University of Georgia technical assistance team is providing technical assistance to the seven MIECHV counties. We have monthly state level collaboration team meetings and also bi-weekly cadence calls between public health and the Information and Referral Center.

The University of Georgia Center for Family Research is also conducting a central intake evaluation, the results of which will help to inform as we determine whether to expand beyond the seven counties and how to expand. That would be most useful.

So thank you for your interest in Georgia central intake and please let us know if you would like to contact us for additional information following the presentation.

Kim Bradley: Thank you Deborah. You know, Georgia is rather unique in the sense that your approach to centralized intake is statewide. What prompted the decision to take a statewide approach?

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Deborah Chosewood: Georgia had an existing program within the Department of Public Health Maternal Child Health section that provided screening and assessment to children birth to five who were at risk for poor health or developmental outcomes. That program is called Children 1st.

And when we were designing our centralized intake Georgia decided to include Children 1st and other child health programs such as our Part C Early Intervention in our screening and referrals available through central intake. Our hope is to eventually expand the home visiting referrals beyond the seven counties taking the entire Great Start Georgia system statewide.

Kim Bradley: Great, thank you so much. So we have another polling question. The next question asks is there consensus in your state for supporting the use of centralized intake system -- A, for yes and B, for no. If you could please make your selection now. This kind of ties into Georgia's presentation as well. I'm going to give just a few more seconds for folks to make their response. Great, thank you.

So it looks like there appears to be a lot of support to move forward with CI approaches for many of you. And then there's also quite a bit of you that are wanting to get additional support or in need of getting additional support. And again this is something that we could look towards the future in providing technical assistance on as we explore this topic further. Thank you to everybody that has participated in that question.

So now we are headed to Kansas. Our next speaker is Debbie Richardson. Debbie has been with the Kansas Department of Health and Environment since February 2011 and serves as the program manager of the Kansas MIECHV Program and the Maternal and Child Health Unit. She holds a Ph.D. specializing in human development and family science from Oklahoma State University. Welcome back Debbie, thank you for returning to give us an update on Kansas's progress.

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Debbie Richardson: Good afternoon everyone. I'm glad to be with you today to share the approaches we are taking with our Kansas targeted MIECHV communities. The two targeted geographic areas that we are working with in Kansas include Wyandotte County and Southeast Kansas. In both areas we're using multiple models and looking at it from a systems approach by involving all the various models as well as a coordinated intake system.

In Wyandotte County which includes urban Kansas City, Kansas, there are multiple home visiting programs involved with our MIECHV work. They include an Early Head Start site, two Parents as Teachers sites, and two Healthy Families America sites as well as A Promising Approach.

A centralized screening and referral system connections has been operating in that county for about 11 years. It is administered by a community agency that also manages multiple home based and center based early childhood education and comprehensive family support programs including the Early Head Start program as well as Head Start and the federal Healthy Start program.

In Southeast Kansas there are three counties included that are primarily rural. The MIECHV work started in Montgomery County which is shown and has since expanded to two adjacent counties with a MIECHV development grant award. So now you can extend the green box showing Montgomery County all the way to the right corner and there are three counties now involved.

Home visiting programs included in MIECHV include again Early Head Start, two Parents as Teachers sites, and Healthy Families America. A coordinated outreach and referral process across home visiting programs and other maternal and early childhood services was non-existent when we first began the MIECHV work. The community partners determined very quickly that a top priority for MIECHV was to develop such a system.

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The local community mental health center in Montgomery County offered to coordinate this service including hiring and employing a coordinator intake specialist. They are viewed as a neutral agency not affiliated with any of the specific evidence based home visiting models.

The partners chose the title My Family for the system and services were launched in late February 2012. With the recent Development Program award, work has now expanded to those other two counties.

And I'm pleased to report that the mental health centers in each of those counties are now involved to provide My Family. The three mental health centers across the three counties as well as the involved MIECHV home visiting sites work collaboratively.

While we do not have time and the purpose of this webinar is not to go into the specific details about a particular system and protocol, I'd like to provide a brief overview of how these systems work.

The Centralized Screening and Referral System serves as an outreach function to locate pregnant women and/or families with children ages birth to five who reside in the county. It serves as an entry point into the county's comprehensive early childhood system.

The purpose is to screen for multiple risks, provide timely referrals to address their needs, connect children and families with appropriate services in the community, and improve utilization of community resources including the home visiting programs.

As indicated on the left side of the screen, outreach is conducted and incoming referral sources come from a broad base of services, agencies, organizations, programs, as well as outreach throughout the general community. Both targeted MIECHV communities have taken an approach

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based on the belief that in person contact in addition to phone contact with families is critical for this system process.

Through communication and interviews by phone and in some cases in the home, needs, risks, and requests of the pregnant woman, family, infants and children are determined. The coordinated system in Wyandotte County conducts a more in-depth screening process using standardized tools and a combination of phone and in-home meetings with the family while My Family in Southeast Kansas uses a less structured process of collecting information.

Based on the family needs, risks, and requests outgoing referrals are made to multiple agencies, programs, and services in a variety of domains. This also includes referrals to the various home visiting programs. In fact a large percentage of families are referred for home visiting services.

It is also important to point out that the home visiting programs in these communities also still receive and accept referrals independent from the centralized referral system yet they regularly communicate and collaborate regarding openings, status of referrals, etc.

Each county and their local communities are unique. There are some similar and different issues and approaches in each one. First of all they have differing levels of relationships and working together from their past. There were a number of identified issues as we were conducting our initial assessments and planning for the MIECHV program.

This included tensions among the programs and agencies, their own histories, perceptions, senses of competition, transparency and communication issues, concern about the time and effort each of the individual programs was spending on outreach, concerns about reaching, engaging families, and maintaining case loads, and set of families to the programs.

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The approach we took in both communities was to utilize a strategic planning process. Each local MIECHV team has conducted many meetings in each community area with a contracted facilitator who was seen as neutral. This engaged the whole team of partners as a system of programs with regularly scheduled meetings and conducting a strategic planning process including collective - identifying a collective mission, vision, goals, and action steps.

This work has included building the centralized outreach screening and referral systems from scratch in Southeast Kansas as well as identifying areas for enhancing the existing system in Wyandotte County. The local teams have been collaboratively working through the many details of coordination and procedures.

By taking this approach the My Family system was launched in Montgomery County after just four months of planning and preparation. In the first year of operation 250 families were screened of which 84% were referred to the MIECHV programs. Many more were referred to other community resources. In Wyandotte County over 300 referrals were made to the MIECHV programs alone and hundreds of additional ones made to other community resources.

We have understood a variety of benefits thus far in each county including deepening trust, respect, working relationships, understanding, a sense of collective perspective as a team and system, and identifying even small changes in practice that have enhanced effective and efficient work.

I'd like to share real briefly just a few of the comments from the local partners. One said joint recruitment efforts are recurring and referrals have increased. Another comment was there is a commitment of the group to work together as a system.

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Another said it frees up time for the staff to see more families. We no longer feel we need to compete. We work together. And another example is collaboration has eased the process for the families themselves.

We have faced a number of challenges and continue to do so. As Tod in Hawaii discussed, relationships are crucial and so building trust and relationships and understanding have been a challenge that we have undertaken. Planning and team processes have made a difference and we will continue this approach as a system of services.

Multiple home visiting models functioning in the same community area are a challenge but we're trying to work through those. Identifying and making even small changes in practice as well as larger ones have been crucial. Some have been quick and beneficial while others have been more challenging.

We still have a number of things to fine tune and address and we will be looking toward how to consider to track families and data through and across the centralized system and home visiting programs. We plan to conduct a CQI process.

And we especially want to look at how families' needs are appropriately fit with the home visiting programs and the decision making process that happens along the way. And of course we want to assess the impact of this work on the participants, the program providers, and the collective system. Thank you for this opportunity to share about the work in Kansas and I hope it has been useful information.

Kim Bradley: It sure has Debbie, thank you so much for that update. You all have made some great progress over the past several months. A quick question for you, you noted that joint recruitment

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efforts have led to increased referrals. Can you provide an example or two of those efforts and how they have contributed to increased referrals?

Debbie Richardson: Yes. One such example is even with the coordinated outreach and screening systems the local home visiting programs and those systems have worked together and increased working together.

For example, say a Parents as Teachers program in one of the communities may be conducting or have a school district that's doing some outreach for their particular geographic area and population.

And so they may contact the coordinated intake program to work with them on providing information or say a table or booth and talking with families as they come through. Others may coordinate together on a general community health fair say for the early childhood population. So they're working together on some of those types of outreach efforts.

Kim Bradley: Great, thank you. Thank you again for sharing. You know, and this really leads us to our next and final poll question and that is does your - if you have a centralized intake system, does your centralized intake system generate a sufficient number of referrals; A, for yes and B, for no. Please make your selections now. I'm going to give just a few more seconds for folks to submit their responses.

This one appears to be a close one as well, nearly 50/50 here. So it sounds like many of you are having success with getting a sufficient number of referrals which is great.

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And for those of you that selected no, know that you're not alone. There's quite a number of folks that also feel that struggle. And this too can definitely be a topic that we focus future TA on. We have, you know, this isn't the first time we've heard this as an issue.

All right, moving on, our last state destination today is Delaware. Our next speaker is Leah Woodall. Leah is the Maternal and Child Health Bureau Chief with the Delaware Health and Social Services Division of Public Health within the Family Health and Systems Management section which houses most maternal and child health programs.

Leah is responsible for direct oversight of the Title V Maternal and Child Health Block Grant, the MIECHV Program, the State System Development Initiative, the Children with Special Healthcare Needs Program, Early Childhood and Comprehensive Systems, the Autism Registry and the Birth Defects Registry, and the Newborn Screening Programs. Thank you for joining us to provide an update today Leah.

Leah Woodall: Thank you and I'm looking forward to sharing you - sharing with all of you an update from the last time we had a presentation on Delaware's coordinated centralized intake system.

So something that, you know, I think we can all agree on is that families have very complex, interconnected needs. They have all of these needs at one time and unfortunately they have to navigate a fragmented system.

So in Delaware we really have been recognizing that we have to treat a new roadmap and transform the way that we provide support and care to achieve better outcomes for these families. And adopting this approach has required just similar to the things that you've been hearing today, required building strategic partnerships and across sectors, across agencies.

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So we've been really working with public health, education, family support agencies, early learning programs, special needs partners, and the medical arena to really identify multiple points of intervention. Because, you know, many of these people have, you know, multiple needs at the same time.

So in the last year we have pulled in all these partners to talk about how the system could work best for families. And so a coordinated system was really built on the foundation of existing grants that we've had and we've always talked about sustainability and it's been very important.

And as early childhood has really taken hold in our state we have leveraged new resources and based on those new investments have focused on getting into the grass roots through help ambassadors or community health workers and with evidence based home visiting that's another new investment that has helped build on early childhood.

And then our Help Me Grow system was a framework that we all decided would be a great focal point and could be the glue to keep this system connected and make it come together.

We have also been fortunate to leverage the top of the early learning challenge grants. So we have all agreed and aligned our goals that large scale systems change requires broad cross sector coordination. And while I would love to go through each of these components of Help Me Grow, it would be a webinar in itself to hit each component. But I'll focus on the centralized telephone access point to give you some depth about how we've made some progress.

So working with the United Way of Delaware 2-1-1 had an existing infrastructure and it was a natural alignment to work with United Way of Delaware 2-1-1. There's a legislator and an executive expectation that it serve as the primary first point for information referral and it's in Delaware code.

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So building on this infrastructure they already provide social health and government resources and we created a specialized unit called Help Me Grow. You can reach that unit by calling 2-1-1. We have three Help Me Grow call specialists. One of them is bilingual in English and Spanish.

And 2-1-1 is moving towards the association of information and referral certification AIRS qualification. So, over the next year that will move to 24 hour service so again it will be accessible and available to link parents, caregivers, child care providers, early educators, and health providers to existing resources in the community.

These Help Me Grow specialists will assess concerns and needs and they also provide referrals to services. And they do advocacy and they do family check-in or follow-up so that five business days later they'll check in and say we gave you a couple of resources, did you get connected. If not, what were the resources or the concerns that you had that prevented you from getting connected. So this contractual relationship between public health and United Way of Delaware has really been very helpful to us in our state.

So here's the flow of phone calls as they come through. You can see the existing resources that they provide through 2-1-1 and here is our Help Me Grow call specialist unit and the referrals that they provide in this unit.

And we do have a warm transfer so getting to our home visiting program connection we have established a warm transfer to these partners and we help monitor, you know, wait lists or programs if they're at capacity and we kind of share that information back and forth so that the referrals are connected and are met.

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Here is a breakdown of our calls. We only have three counties in our state, we're a small state. But it will just show you that a majority of our calls are coming into the northern part of our state, from the northern part of our state which is New Castle County followed by Sussex County which is the southern part of our state and Kent County which is the middle part of our state.

Here the top ten Help Me Grow needs based on the data that we've been collecting as calls have come in. You can see just a depth of needs that are listed here. And I think just to give you a sense of what the most - the highest need has been has been around behavioral challenges. A lot of parents calling with for example a child that may have been asked to leave child care because of behavioral concerns.

And so that's something that we've been working with our mental health and behavioral health partners to identify what those gaps are and what the concerns are and how we can support those families.

Here is a nice snapshot of our calls. Now tying together with the other themes of the other presenters, it has been slow uptake as you can see when we started a year ago, that's steady. And then in the last quarter of 2012 we saw a huge jump in the number of calls that have come in. And this is even just before we have done some social marketing efforts which is on our radar which we're about to develop.

Home visiting referrals just to give you a sense, these are the evidence based programs in our state. We also capture child development watch. While that's not a home visiting program per se, it's important for us because they're a strong partner at the table to just see what kind of referrals are being provided as the calls come in to Help Me Grow 2-1-1.

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And lastly here is the slide that just kind of ties it all together, some of the themes that we have found very successful in our state. Lending resources, as you can see we really didn't rely on one source of funding. We've been really building upon and braiding those funds because sustainability is so important to our partners. They really want to see this work well and sustainability is very important to all of us to keep it going.

And we're always focused at reaching these children as early as possible, those that may not be eligible for other services and getting them connected to existing services in the community. And it may just be that families don't know what's available or providers so this easy phone number may help as the 2-1-1 phone number is more readily recognized in our states.

And then it's low cost because we are linking to existing programs and services. And cross sector collaboration, I can't say enough about our relationships with our partners and having that ongoing dialog just, you know, identifying that elephant in the room with our partners and talking it through and keeping that communication open. And you can see that we do have a social marketing campaign on the radar as next steps and I think that will be helpful to us to increase our phone call volume.

And our champion Lieutenant Governor Matt Denn in Delaware has been at the cornerstone of our work. He is very dynamic and very engaging, has a great sense of humor but has always been a really, really good champion for children and children with special needs as well. And so it has been really important to have him as a partner and a leader in leading our effort here in Delaware. So thank you, that's a short overview of the progress that we've made over the last year.

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Kim Bradley: Thank you Leah, a lot of great information you just shared. And you guys certainly have made a ton of progress especially with those dramatic increases over the last quarter in the number of calls coming in. That's great, congratulations.

You know, you noted that you all have, you know, had to work through some issues and I think one of those issues that you shared were some turf issues. What specific actions or processes and activities have helped you address those issues over the last several months?

Leah Woodall: Sure. I think I did - I'm sorry, I did forget to talk about it. You know, I didn't mean to sugarcoat. There has been some turf issues between our home visiting providers.

And I affectionately giggle because it has been a challenge and we've been talking it through established we call them work sessions. We got Help Me Grow call specialists in the same room with representatives from each of our evidence based home visiting programs. We had a structured facilitator talk through some of the challenges.

A lot of the programs were fearful of having a centralized intake system thinking that they would lose their referral base. And so we had to talk through that through a home visiting referral decision tree matrix, essentially an algorithm and talk through if yes, you know, they're less than 28 weeks gestational age then, you know, and low income then they'll go to Nurse Family Partnership.

We talked through scenarios of different cases that may come through and what would be the best fit. And having all those individuals in the same room has really helped us kind of get on the same page, align our goals. We even established guiding principles that they came up with on their own that is set in stone in writing and we talk them through every time we meet.

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And now we're a formalized group that we report to a statewide home visiting community advisory board to make sure that their voice is heard on a statewide level.

Kim Bradley: Great, thank you. Thank you again for sharing all the information related to your progress so far. You know, I mean, we have just heard a ton of great information from everyone and I just want to thank - say thanks to all the presenters. We're now going to move into our open chat Q&A portion of our journey today.

But before we do that I do want to introduce Carol Wilson from Georgia's MIECHV or as they refer to it MIECHV program. Carol will be joining the panel for the Q&A session today. Carol is currently serving as the project manager for the Great Start Georgia initiative which focuses on expectant parents, children birth to five and their families.

Carol's experience includes the provision of direct services to expectant parents, young children, and their families as a public health nurse, management of state level public health programs and services, and coordination of several maternal, infant and early childhood community based systems.

Thank you for joining us today Carol and I have to say in true Georgia collaboration style, Deborah and Carol are in the same room right now. So thank you Carol.

Carol Wilson: Thank you. I'm happy to be here.

Kim Bradley: Great, we're happy to have you. I know that questions have been coming in throughout the webinar and we also collected questions during the registration process. Just a reminder, if you have a question or for one of the panelists if you could please type it in the chat box.

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And before I check in with Christy Stanton who has been managing or manning the chat box, I'm going to start with a few - a couple of the questions that were submitted during registration. These questions also tie into the poll questions we asked earlier.

So Carol and Leah I'm going to start with you. For those states and/or communities that are currently in the exploration or planning stage, what advice do you have for them as they start to look at or consider the various centralized intake approaches? Carol?

Carol Wilson: Yes I'll start first. I would say that as a state such as Georgia looking at the development of a statewide approach for centralized intake, one of the things that's very important is to be respectful of the communities that have referral systems in place, that have had referral systems in place for many, many years. And the communities, the community representatives and stakeholders have spent much time in the development of relationships with their local service providers.

So I think it's very important that we recognize the work that has been done and because communities like to be in control of their local systems we need to build on what they have developed over many years and appreciate their efforts while gently showing them how centralized intake could be improved by having things such as the information and referral center that we're developing in Georgia with a toll free number and also our website for Great Start Georgia which is also available statewide.

Also I think it's important to bring in the perspective of the service providers themselves who really like being able to refer to one place where they don't have to worry about the eligibility for all the different programs and don't have to be knowledgeable about every single program that might be available to families.

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And they have told us that they really like having a toll free number available to them if they don't have somebody locally that they can make their referrals to.

Kim Bradley: Thank you Carol so it sounds like that theme that Tod brought up at the beginning about the relationships, you know, with the others within the community as well as that collaboration and just being mindful of the great work that, you know, had already been started in communities is really important. Leah do you have anything to add for this question?

Leah Woodall: Well I echo Carol's comments especially the one about recognizing that the work that's been done and building on it so just recognizing those folks that are coming to the table. We use in Delaware the Collective Impact Approach just referencing Stanford and social innovation review. That gave us a structure of how we wanted to - and a framework of how we wanted to approach getting this established.

So we established a committee that was appointed by the Lieutenant Governor so our champion. That would be two areas where I think have been really helpful to us in our planning and development. And it helped us align our goals and talk about what we all wanted to achieve.

And then also talking about the sustainability of our vision of what it would look like and what would it take to keep it moving on and going. And then a backbone agency, the idea of having a convener or someone that is widely respected and embraced to lead the efforts and talk through all the challenges.

And I think we're fortunate in Delaware that public health has been seen as a convener and our MCH bureau has really just helped bridge those connections across agencies. And I think it's due to some of the funding resources that we were provided and leveraged in Delaware. So it has been helpful to us to start those conversations.

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Kim Bradley: Great thanks Leah so that braiding of funding that you mentioned in the beginning but also just the structure that you kind of put in place from the outset seems to have really helped you all move forward.

Another question that was submitted during the registration process and I'm actually going to ask Tod and Debbie to comment and we'll start with Tod. How did you get community partners to participate, collaborate, and believe in centralized intake? Tod?

Tod Robertson: Thank you Kim. You know, I think that you must develop relationships and find that point person that you can work with. And sometimes when we work with physicians it's the front desk person that we develop the relationship with.

Whoever that is, you really have to provide them with information, help them become better aware of what you intend to do. You know, find that point person who shares the values of the service that you're going to bring to their clientele, who shares your vision of providing those services in your community and be patient. In my experience it may take longer than you anticipated to get everyone in the system to see your vision and support your vision. But be persistent, keep working at it until you realize your vision.

Kim Bradley: Great thank you, wonderful advice. Debbie what are your thoughts on this?

Debbie Richardson: Well - excuse me. In our instance in Kansas with the one community that already had an existing central outreach and screening system, it was a matter of bringing all of the partners together that already knew each other and worked together but still were very quite siloed. And so it was a matter of bringing them together as the team, the MIECHV team, and to really start focusing more on the system, their collective system.

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And so that's the approach we took that I described in terms of having regular team meetings and having everyone at the table to - and having a facilitator to help them discuss and work through some of those issues collectively.

In Southeast Kansas where there hadn't been a system, again they had decided early on that was one of their priorities. They already understood the potential value of that.

So they were there already but again it was trying to pull them together and helping them to organize and construct what that system was going to be and getting it launched and off the ground. So again it goes back to relationships of bringing all of the parties together and helping to facilitate that communication to assist them in moving forward.

Kim Bradley: It does appear we have quite a few themes going through all of this with relationships leading the way there. Thank you for that response. Christy I'm going to turn it over to you to hear what has been going on in the chat box.

Christy Stanton: It has been a busy chat box, lots of questions and a lot of people helping out with answers so I appreciate everybody's participation in that. One question came in that Georgia, someone from Georgia and then Debbie Richardson from Kansas already answered in the chat box but it will be interesting to hear from Tod and Leah. And the question is do the centralized or that is how does your centralized intake staff stay abreast of openings in various home visiting programs.

Kim Bradley: Tod can you take that one first?

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Tod Robertson: Sure I'd be happy to. In many of our programs the centralized intake organization also has home visiting - is also a home visiting provider. So in those cases it's generally very easy for them to have almost a daily update from the home visiting programs as to what their availability is or when they'll have openings in the very near future.

For some of our others that do not have direct referral to their own organization's home visiting program, we have a system set up where they make referrals by fax and so they can get those on a continuous basis and they can also do a weekly update usually on Monday morning about what their availability is for the week.

Kim Bradley: Great thank you Tod. Leah?

Leah Woodall: For home visiting we have just opened the lines of communication on this very issue. And we're still perfecting the process but we're similar to Tod where we're thinking through a weekly update.

And we're fairly small in Delaware so I think we should, you know, be fairly - it should be fairly simple to do and just make sure that we do know about what the waiting lists and the openings are. So I think right now we're still seeing some programs hold on to referrals and so I think we're breaking through that conversation and we'll get there.

Kim Bradley: Great, thank you. Christy did we have any more questions submitted via the chat?

Christy Stanton: Yes there are several. One for question for Deborah was how did you work through the HIPAA and privacy issues to release the family contact information and risk factors to the appropriate service?

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Deborah Chosewood: Thank you for the question. This was actually a critical point for us in our planning phase because we were utilizing some of public health electronic birth certificate information as a way of identifying children who might have been missed prenatally. It was very important for us to come up with a plan for how to proceed without violating HIPAA.

So we share certain pieces of information without consent so that we're not violating HIPAA policies. And then additional information is shared only after a verbal consent is received from the parent. So with verbal consent we are able to make a referral and share a simple demographic information, name, address, date of birth, etc.

The only time that we share the totality of the comprehensive screening results is if we have informed written consent from the family. So as part of our screening tool when the public health or the community screeners go out to complete the screening on a family, they will have the family sign a written consent saying that their information can be shared with the other agencies to which we refer. And it's only after that written consent is formed or signed that we're able to share all of the information with the other agencies.

Kim Bradley: Thank you Deborah. You know, this question is kind of one of those hot topic questions. It was actually submitted a couple of times via the registration process as well. So we'll see if we have a chance towards the end if more folks can comment on it. But Christy I'm going to turn it over to you to see what another question from the chat is.

Christy Stanton: Okay. This was a general question for all of the presenters so we can start with let's see, perhaps with Leah. This is about immigrant populations. And there was an observation made that some immigrant individuals may be hesitant about participating in any kind of intake or information collection that we might be doing. Has anybody encountered that kind of hesitation and developed any kind of strategy to address it?

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Leah Woodall: So this is Leah. In Delaware we've - over the last few months have started a new model called Health Ambassadors. It might not be new to some folks but the idea of using community health workers or promotoras in communities of high risk to reach underserved populations.

And while we may not see specific issues with immigrants but I think this would definitely address our culturally sensitive concerns with, you know, getting folks connected to services.

We have really - we think this is going to be a great, great connector that, you know, they will have bilingual health ambassadors in these high risk communities to connect them to existing services. And they live, breathe, work, play in these communities and they connect these folks to MCH, other health services. I think it's going to be important going forward and I'd love to share that once we find more information and see the model take off.

Kim Bradley: Great thanks Leah. What about Debbie Richardson, why don't we ask - go to her next.
Debbie?

Debbie Richardson: Could you repeat the question please? I'm sorry.

Christy Stanton: Sure. One state on the chat box mentioned that immigrant populations in their state are often hesitant about providing information as part of an intake process and wondered if anyone has encountered that and developed any kind of strategy to address that hesitation.

Debbie Richardson: That is - thank you for repeating that for me. That has been a question and issue that I don't know has been totally resolved in our Kansas locations. And that is even a larger issue in the urban Kansas City, Kansas area where there's quite a diverse international population as well as language diversity.

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And so I know that the system there, and in fact it's part of our MIECHV objectives, is to try to improve some of our strategies for that specific to the coordinated outreach and intake program.

They have tried to hire some additional intake specialists that are bilingual or even have broader experience and ability to work with various cultures. But I have to say that there has been no great solution to that yet but it is something that they're working on.

Kim Bradley: Great thanks Debbie. And I think Christy we may have time for just one more response so let's go with Tod.

Tod Robertson: Thank you. In Hawaii we have a very diverse population and particularly in the big island we have a lot of immigrant population that are coffee pickers. So I would just reiterate some of the things that have already been said. It's really important that the intake workers if they can be bilingual that's really helpful to help establish the relationship.

I think we're at an advantage sometimes in using the hospitals because they receive really good care there and it does seem like in many instances a very safe place for them.

So we also try to, you know, emphasize that this is voluntary for them, that we're, you know, not pushing services on them if they're not interested but also that it's available to them to take advantage of if they feel like the services would be beneficial to their families.

Once you get a reputation in the community, particularly that immigrant community, I think that helps you get a good reputation, then people are not as fearful of your program. They have heard good things about it in the community and they have a positive outlook on what you're - the services that you're providing to them.

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Kim Bradley: Great thank you, that is definitely true and I know many programs have experienced that as well. Christy we're getting ready to wrap up here with the questions. Do you have one last one from the chat box?

Christy Stanton: I think this one is pretty brief. It is true we had many questions in the chat box and just wanted to reassure people that answers to those questions will be provided after the webinar in a written form. And I think Kim you're going to talk a little bit more about that in the next part of the webinar.

But the last question is for Leah and the question was is your model based on the family initiating their request for service by means of your 2-1-1 number?

Leah Woodall: It is but we also are promoting it to providers. So we're - we are hoping that both health providers will use the 2-1-1 number and call on behalf of their clients or patients. And it's an easy phone number for them to remember because some offices don't even have care coordinators so this is essentially a benefit to health providers to use Help Me Grow 2-1-1.

So it's - we are reaching out to families and make that phone call and we have a number of community outreach events that we have in the community to generate and promote interest and awareness in the number. And then I mentioned social marketing so our campaign will be a two-pronged approach to both health providers and consumers.

Kim Bradley: Thank you Leah. You know, another hot topic that has been discussed even on the last webinar and certainly presented through the questions submitted during registration and perhaps Christy you have even seen these in the chat has to do with that program fit and how that

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decision tree is, you know, produced and then made when areas offer multiple models. And Debbie I'd like to ask you briefly as we wrap up here to speak on that if you may.

Debbie Richardson: Yes that's an important question and again one that I don't know that we have come to a conclusion on yet but we have been talking about it a lot in our Kansas teams and systems work.

Basically right now in both of our communities I would say that there are kind of basic features or factors that are used in terms of determining program fit. And I know there are some communities in the country that have been able to drill down further on these and that's where we're headed as well.

But first of all they look at the various models, home visiting models, enrollment criteria, and particular eligibility and how maybe some of the families' features help fit best with some of those particular models. But there's not a real clear decision making process on that yet.

I know that some other areas that have these kinds of systems do have very detailed decision making trees and I think Leah in Delaware mentioned one of those.

Sometimes it's about geography, say a certain Parents as Teachers program only serves a particular school district so that may come into play. There's also the issue that we just talked about in terms of maybe families have certain languages and need a bilingual home visitor and that may come into play if those are available in some programs.

It also gets down to just who has open slots. And the programs in Kansas are still very adamant about allowing that family choice which has kind of been alluded to and discussed a little earlier

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as well. Families may have certain preferences of certain programs based on their knowledge of that program or maybe they have a family or friend that is already involved.

But these are factors and more specific factors in decision making trees are where we're headed with trying to better understand that process and develop that process.

Kim Bradley: Well thank you for that. Like I said, I do know that this is - that's a hot topic with many folks that are exploring centralized intake and that are implementing centralized intake. And we'll definitely get a chance to hear from other presenters as well. But right now unfortunately we are running out of time for this webinar.

For some of the questions that we were unable to get to today, we will be including them in the panelists' responses in the May edition of the MIECHV TACC newsletter. Speaking of which, the April newsletter will be coming out shortly. It includes several articles related to how other states are developing centralized intake systems from Arizona, Massachusetts, New Mexico, New Jersey, Ohio, to Oklahoma while Arkansas is featured in the grantee spotlight.

In addition, I'm excited to announce that the TACC will be starting its next community of practice and that will focus on centralized intake. If you are interested in participating in this community of practice please post in the chat your name, state, and email address. We plan to hold a kickoff call towards the end of May and we will send out additional details there shortly.

Again a big thanks to our speakers today Leah Woodall, Debbie Richardson, Tod Robertson, and Deborah Chosewood and a huge thank you to Carol Wilson for participating during the Q&A session and a thank you to Judy Thierry for doing the HRSA welcome as well. Please feel free to contact any of today's speakers for additional information.

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And as we pull into the station we'd like to take a moment to remind you of the learning objectives for today's webinar. Tomorrow you will receive an email from Trena Valado of WRMA that will contain a Survey Monkey link.

Please click on that link and let us know how well the learning objectives were met. Your input helps us to design future webinars and to be responsive to your needs and interest. Thank you in advance for taking the time to complete the feedback form.

You will also receive a PDF copy of the PowerPoint slides from today's presentation. An archived copy of the webinar will be posted on the TACC website once it has been processed. Thank you again for your participation and enjoy the rest of your day.

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