

**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

"Implementing Multiple Models"

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

Panelists:

Lee Ann Huang
Bradley Planey
Scott Gordon
Sunday Gustin
Lenore Scott

Facilitator:

Holly Wilcher, MS

Operator: Please stand by. We're about to begin. Good day and welcome to the ZERO TO THREE
Implementing Multiple Models conference call. Today's conference is being recorded.

At this time I would like to turn the conference over to Holly Higgins Wilcher. You may begin.

Holly Higgins Wilcher: Great. Thank you, Chris. Good morning and good afternoon everyone, depending
on where you are. My name is Holly Higgins Wilcher. And on behalf of the Maternal, Infant and
Early Childhood Home Visiting Technical Assistance Center I'd like to welcome you to today's
Webinar on Implementing Multiple Models.

Presenting today are Miss Lee Ann Huang, a Researcher with Chapin Hall at the University of
Chicago; Bradley Planey, an Associate Branch Chief at Family Health Branch with Arkansas

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Department of Health; Scott Gordon, Executive Vice President at the Arkansas Children's Hospital; Sunday Gustin, Administrator at the Office of Early Childhood Services, New Jersey Department of Children and Families, Division of Prevention and Community Partnership; and Miss Lenore Scott, Home Visitation Specialist at the New Jersey Department of Children and Families Division of Prevention and Community Partnership.

This Webinar is hosted by the Maternal, Infant and Early Childhood Home Visiting Technical Assistance Coordinating Center - or the TACC. The TACC is funded by Health Resources and Services Administration and operates from ZERO TO THREE and in partnership with Chapin Hall, the Association of Maternal Child Health Programs and Walter Reed McDonald and Associates.

The TACC is funded to provide many levels of technical assistance to support MIECHV grantees including Webinars like the one today. Support from the TACC can be accessed through your HRSA regional project officer. And we'd just like to officially thank you for joining today's Webinar on Implementing Multiple Models.

And at this time before we begin I'd like to turn the floor over to Miss Jackie Counts, a HRSA Regional Project Officer with Region 7 who'd like to provide today's welcome to the Webinar. Jackie.

Jackie Counts: Great, thank you, Holly. I am thrilled to be able to introduce the Webinar today on Implementing multiple models. While this may not be the easiest feat to accomplish it may be one of the most significant accomplishments of state home visiting systems.

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As I was preparing my remarks for today I was searching for a framework and was stuck. Then it came to me: kick ball. On Friday nights I play in a kick ball league. The first season we lost every game and got run rules and notes by the third inning.

A couple of us decided to retool the team and get athletic players. We were looking for ex-soccer players, gym rats, triathletes, et cetera. But as Casey Stengel, a famous baseball player from Kansas City used to say, getting good players is easy; getting them to play together is the hard part.

Such has been my experience with our new and improved kick ball team, the Pirates. Although we are better than last season we still aren't winning. It's not for lack of trying and desire; however. Even with this collection of talent, and I'm not counting myself amongst them, we still don't have the gaps in the field covered when someone places a kick between the two of us. We don't always call the balls that are in our catchmen area.

Then there's the matter of personal performance. Sometimes we just aren't on our game and aren't playing at our optimal level. And then there are the injuries. It seems that every week one of us is popping a hamstring or pulling a muscle. And while it's the Rec Ball League, our team is comprised of very competitive players who will go to great lengths and heroic dives for the win.

However it's the collaboration and not the competition of our individual players that led us to our first win. The team spirit, support of each other, base coaching, strategic batting order and improved catching of the balls have led to our best results.

Getting to know each other in the dugout before and after the games have been critical. And the more we play together and learn each other's style the more fun it gets and the better we function as a team.

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While home visiting is in another league of importance to my Friday night kick ball league many of the same elements apply. In the MIECHV Program we have a team of very talented individuals on the state and the community level. Then we have a roster of nine evidence-based programs all with winning records. Alone each model has had tremendous success.

Now many grantees and communities have undertaken the challenge of fielding a team of all-stars as they attempt to build a continuum of home visiting models to best meet the needs of the families in the targeted communities. All are committed to playing their best and playing as a team.

We are fortunate that we have stellar coaching staff available in our TA providers and the experience of many of you who have been practicing and playing for a long time. During today's presentation we will first hear from Chapin Hall about some of the challenges for multi-model plans. We will learn about some infrastructure considerations that can lead to more efficient fielding and batting.

Next Arkansas will share their experiences implementing five models and how they addressed fielding gaps, promoted team spirit and improved their sense of game through a training institute. I meant offensive, not offensive.

New Jersey will talk about their coaching staff and how they developed a process to recruit talent such as the home visiting models based on the priorities of the team which are the outcomes they wanted for the children and families.

New Jersey will underscore collaboration as a powerful strategy to support their team of all stars which is the continuum of models. There is no doubt that implementing multiple models and

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integrating home visiting into an early childhood system will be a long hard season. But with commitment, practice, coaching, strategizin and supportive fans the biggest winners will be the children and families we serve. And that's a team that I want to be a part of so let's play ball.

Thank you, Holly.

Holly Higgins Wilcher: Thank you so much, Jackie. And thank you for that warm welcome on behalf of HRSA. And we look forward to letting everybody get a little bit of a taste of two kick ball teams today.

So as a result of our time together today we hope that you learn about the benefits to families of implementing multiple models. We hope that you learn about the opportunities and challenges that MIECHV brings to states, territories as they attempt to build an early - as you attempt to build an early childhood system via multiple home visiting models.

And finally we hope you learn about some practical advice, lessons learned and maybe even some unsolved challenges associated with employing multiple models.

Just a couple housekeeping things before we get started today. For optimal sound quality we encourage you to call in via the phone line versus listening in to your computer speakers if that's an option. We promise you'll have a much better experience in using the dial-in number and access code provided under your audio tab of the meeting management system portal.

We will also have a question and answer period at the end of our Webinar and so we encourage you to post your questions in the questions feature of the online meeting management system throughout the Webinar as you're listening to presenters present their information and you have questions just go ahead and type in your question and we'll be collecting those to field to your presenters during the last 30 minutes of our call.

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You should have received today's handouts for the Webinar via email if you registered before 1:00 pm Eastern today. However we will also send out today's Webinar PowerPoint after the Webinar is complete to all of the registrants. We will also post them to our Website as soon as our Webinar materials have been processed to meet 508 compliance quality assurance standards.

And at this time I'm done with housekeeping and I'd like to turn the floor over to Miss Lee Ann Huang with Chapin Hall who will set the stage for implementing multiple models discussion. Lee Ann, the floor is yours.

Lee Ann Huang: Thank you, Holly. And I wanted to also thank Jackie. What a wonderful way to think about the work we are all involved in although I must admit that I'm thankful it's not actually kick ball because I - my little kids could beat me at kick ball. So thanks for that introduction.

Well what I want to do first is just start off by explaining what I will cover today. My part of the Webinar is to help provide some context for the real substance of the discussion which is when we will hear from the folks in Arkansas and New Jersey.

I'm gona to try to identify some overall themes to help you as you listen to the information they will share about actually implementing an early childhood system that uses multiple home visiting models.

So I will cover a bit of history about home visiting models working together then identify some of the opportunities and the challenges that have come about with the MIECHV initiative. I'm sure you all could have created that list yourself.

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Then we'll cover some of the benefits to families and communities and end with thoughts on infrastructure needs that should be considered when moving forward with multiple home visiting models.

So first let's talk a little bit about the history of the models working together. Let's see, as many of you might know - and some of you were probably directly involved with nationally the home visiting models that are part of MIECHV have been talking to one another since at least the late 1990s through the home visit forum, which was funded by the Packard and the Kaufman Foundations.

That started in early 2000 and included four of the nine national models that are now involved in MIECHV. There is an also even longer history of models working collaboratively at the local community level.

Chapin Hall, as have many organizations and many individuals, has been involved in a lot of those conversations, for example, the home visiting forum and with the research about home visiting for many years. We are really excited that now through the TACC, through the Technical Assistance Coordinating Center we can continue that work by providing assistance to states and models.

The last point is that there is also a long history of states working with multiple models directly. We will obviously hear from New Jersey and Arkansas during this Webinar with excellent examples of how they have created a structure for offering various home visiting models to families.

Another example is here in Illinois, where I am, there's a history, over 20 years, of HFA and PAT working together with NSP more recently becoming involved to serve families. So MIECHV is not

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the first time many states have tried working with more than one model. And it is important that as we move forward we all recognize this history and the learning that has come out of it.

Okay next I want to talk about some of the opportunities for working with multiple models at the state level. The MIECHV initiative brings many opportunities for states and communities to refine their early childhood systems by utilizing multiple models thereby offering home visiting services to a greater number and diverse array of families.

It recognizes that different models can be valuable for reaching different families or show strength in achieving different goals. MIECHV acknowledges that no one model is a silver bullet. It requires states to assess community needs at the community level and then justify why a certain model or multiple models would meet those community needs.

I'll go through several of the opportunities presented by MIECHV for implementing multiple models. But I'm not going to spend too much time on this. I think most of us really recognize these opportunities already.

One is that it may bring new stakeholders to the home visiting world in some states. It could be that the Title 5 agency it might not have previously been intricately involved in the home visiting - excuse me - network in a state or it could be new models and their representatives or it could be new implementing agencies. New actors bring new ideas, new processes, new areas of expertise and new ways of looking at old questions.

Another opportunity that many states already have some systems in place but may not have previously put those together specifically around early childhood or home visiting and MIECHV brings that opportunity.

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Collaboration must take place across agencies; education, social services, health, et cetera. Because MIECHV require different agencies to sign a memorandum of concurrence at each stage of the grant process it required a conversation about how multiple models could be used to meet a community's needs.

With the new funding under MIECHV it creates expanded opportunities for public and private partnerships. This has been happening in those states who are participating in large scale home visiting initiatives. But for many states this really is fairly new. It also moves the focus from just one partnership or one intervention to a systemic collaboration to support healthy development for young children and their families.

Another opportunity that comes up with the MIECHV initiative is it really does encourage a high standard of implementation fidelity. It increases accountability across models through its system of benchmarks. MIECHV also has legislative mandates to implement evidenced-based home visiting programs with fidelity.

And then the last opportunity that I wanted to mention is the conservation of resources. When agencies and organizations and models all collaborate there is an opportunity to save resources. For example if stakeholders can agree to use a central intake process and collect the data necessary to meet the needs of all involved parties then time can be saved. Another example if there's a specific training need identified across models then training for that could be consolidated.

Okay as usual when new and exciting opportunities arise there are always some challenges lurking in the shadows. Using multiple models through MIECHV does present some difficulties and I'll highlight a few of those now.

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So the first one, which was mentioned on the previous slide as an opportunity can also be a challenge. New actors bring opportunities for new ideas but also might be a challenge for many trying to implement home visiting services through MIECHV.

For those states who have already been implementing multiple home visiting models and have a state network or coalition around home visiting MIECHV potentially brings in new actors, new requirements, changes in the way things have been done.

For those states not yet implementing multiple models it requires starting from scratch to build a system which is very hard to do in the timeframe allowed and with the resources given.

Also sometimes people have different world views based on the field they work in. For example educators may see things with one lens and public health nurses may see things with an entirely different lens. Even within a given field professionals may see things differently or use a different language. For example like public health nurses and public health social workers, you know, may talk really differently about the same issues.

This carries over to the model. Ones that are more medically-focused may see things differently from those that are more parenting-focused or more education-focused.

Another challenge - excuse me - although the MIECHV requirements for collaboration and infrastructure building create an opportunity for stakeholders the regulations as well as state - I can't say this word - procurement processes can make building that infrastructure difficult.

When multiple models are added into the mix it can get pretty complicated. And then when decisions must be made balancing those regulations and processes and opinions can actually make making a final decision fairly difficult.

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Another challenge that I'm sure people are very aware of is the data demands. MIECHV itself has significant demands for data. And when a state is using multiple models to serve families those data demands can greatly increase. Each model collects different data and trying to figure out how to manage those various demands and meet MIECHV requirements is a difficult challenge.

Okay the last thing is the timeframe. MIECHV has requirements that states meet particular deadlines and those can be difficult under any circumstances. But when a state has multiple agencies involved and multiple models involved it might add another layer of complexity to making decisions and meeting deadline.

Okay now let's move to a happier thought which is the potential benefits for families and communities with cross model plans. I think that we all can agree that using more than one model to serve a community can foster benefits to families and communities.

Families may receive services longer. One example is serving families say first with NFP then moving them into a HIPPIY program after NFP involvement ends. Multiple models could also help a community serve a higher proportion of at-risk families by using different models to serve different types of families.

Another way multiple programs can benefit families is by offering complementary services. For example if a family is engaged with PAT but has deeper mental health needs Child First could partner with the PAT program to serve that family and others like it. Lastly for communities having multiple models may create efficiencies when curriculum and information are shared.

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Okay and the last thing I want to go over are just some infrastructure considerations. I keep thinking that's not really the right word but these are some things to think about as states are considering using multiple models or are moving in that direction.

As we will hear from Arkansas and New Jersey states with multiple models need to design structures and systems that facilitate the ability to fully implement and sustain evidenced-based programs with fidelity.

When implementing more than one model in a state through MIECHV there are many factors to consider especially concerning how the system will be structured. I'll just go over a couple of these and then we will hear much more about this from the two states.

States need to consider if they will have a universal assessment component to their home visiting services? Will all families be assessed or only those considered at risk? If families are going to be served by multiple programs how will families get into those programs? How will referrals work?

Another is centralized intake. Many local communities have set up centralized intake systems for those families identified as in need of services or who have expressed interest in home visiting. When there's only one model working with families obviously it's a simple process to bring that family into services. But communities need to consider how they will handle this when more than one model is involved.

Training is another consideration. Some states have set up state training centers to support home visiting staff, some have become official trainers for the models and can provide the initial training for staff. Others offer supplemental training to all home visitors that is not covered in model specific training. All those are viable choices but states just need to consider what will work best for them.

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Again on everyone's favorite topic, database systems, many communities wish for an integrated data management system; in practice it is difficult to implement that fully. However a community needs to consider how to reduce data burden on staff when multiple models are involved so that's a consideration.

And the last one I'll bring up is the use of a statewide home visiting meeting or some sort of way to gather people together around this - around the system. Some states see this as a critical capacity building component of the home visiting system and have implemented annual meetings for all home visiting providers in a community or a state for cross learning, information sharing and MIECHV requirements and regulations discussed.

All of these infrastructure questions must be considered as communities implement multiple models. We at Chapin Hall look forward to working with the states and the models as we all move forward together in this new MIECHV world.

So that's all I have. Holly, I'll turn it back over to you.

Holly Higgins Wilcher: Thank you Lee Ann and Chapin Hall for setting the stage for today's Webinar and providing such an excellent lead-in for thoughts to consider as we begin to hear from two states who are going to share their experiences on implementing multiple models with everyone.

At this time I would love to turn over the floor to Bradley and Scott in Arkansas who are going to talk about their journey in implementing multiple models. Gentlemen the floor is yours.

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Bradley Planey: Thank you, Holly. Under the Natural Wonders Partnership Initiative Arkansas Children's Hospital and the Arkansas Children's Trust Fund were engaging home visiting providers to map home visiting resources in the State of Arkansas.

In 2010 when the Maternal and Child Health Bureau required the Block grantees to develop a statewide home visiting needs assessment the Arkansas Department of Health approached the Natural Wonders Partnership to contribute to this needs assessment.

The Department of Health completed the needs assessment and applied for the MIECHV formula grant and reintroduced the Nurse Family Partnership model into the State of Arkansas. The program targeted six counties in Arkansas and is expanding in 2012 to a seventh county.

When the competitive grant was announced in 2011 the Department of Health saw an opportunity to use the Arkansas Home Visiting Network under the Natural Wonders partnership as a natural collaboration for developing the Arkansas application.

Through the efforts of various staff from the Arkansas Department of Health, Arkansas Children's Hospital and the coordinators of the various evidenced-based home visiting models the group was able to assemble the information that would become the MIECHV formula application.

Scott Gordon: The MIECHV expansion grant will expand three evidenced-based programs, Healthy Families America, Parents as Teachers and HIPPIY and one promising program, Following Babies Back Home, which is a nurse social worker team working with low birth weight and premature infants graduating from neonatal intensive care units in year one.

Our plan is to add Nurse Family Partnership as an expansion program in year two as the capacity of the Department of Health to continue that expansion ramps up.

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We will be piloting community-based intake in up to three communities, urban, smaller town and rural. We have a very rigorous evaluation program that is based out of the University of Arkansas for Medical Sciences. And we've created the Arkansas Home Visiting Training Institute which will work to bring the quality of home visiting skills and talents up in the entire state with the MIECHV and all home visiting programs being able to benefit from this.

Bradley Planey: In our work so far we have a few lessons learned which includes some challenges and some advantages. Some of the challenges include getting the state model leadership to have common vision of what can be accomplished through a network and providers. This was facilitated by including these same leaders in the writing of the grant application.

Then through follow up meetings that helped develop the details of the management information system and the role of the evaluation in their work. A compounding challenge in this effort is that most of the evidenced-based home visiting models work through a network of subcontracts with a variety of providers throughout the state. The need to have goals and vision of the MIECHV program understood and adopted by each of these providers is a complex and ongoing challenge.

Another challenge was the development of benchmarks that would be across all models. I won't dwell on this but it was particularly difficult challenge requiring compromise on the part of all parties. Moving from benchmarks developed for a single program within a formula grant to an environment involving a number of evidence-based home visiting models in the formula and competitive combined environment required quick and intensive collaborative work among all parties.

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It needs to be mentioned that the use of common tools and a method for data collection across multiple models again requires accommodation while presenting an opportunity for system maturation not previously available. This is especially important to evaluation of different models with different target populations. We hope that we will move from comparing apples to oranges to comparing apples to apples.

Among the advantages that we've identified so far we have learned that an inclusive approach to project implementation has resulted in high levels of buy-in by all models.

Another advantage is that involving a leadership of goal-oriented professionals has also resulted in high expectations of performance levels within the group. This is especially important as we develop the pilot for community-based intake for multiple programs in targeted communities. The obvious benefit being that we are fitting the program to the family rather than the family to the program.

Scott Gordon: The maps that you see identify home visiting in Arkansas before our expansion and home visiting after our expansion. You'll note that the state had some gaps in counties that had little or no coverage by programs and that following the implementation of MIECHV we anticipate that we will have every county in the state covered. And remembering that there were very few large cities in the state we're dealing primarily with a small town, rural population.

The next map shows the actual counties and parts of the state that MIECHV expansion will be targeting over the next two years as we move forward to expand into parts of the state that have not seen multiple programming available or have not had any home visiting program available.

One of the key project goals for expansion of services includes reducing the gaps in service accessibility at a state that is dominated by small towns and rural communities, as I've

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mentioned. As you can see in the bullet points 2 and 3 on this slide the evidence-based home visiting programs and our promising program are expanding in different ways.

Some are expanding into different sites while others are adding staff to their existing sites to expand the population they serve. Because of the MIECHV expansion Arkansas will have evidence-based home visiting programming in all 75 of our counties.

Other ways that the Arkansas Home Visiting Network is reducing the gap in service accessibility is through the coordination of information, evaluation and non-model specific training. In today's world it's important also to note that the public understands the need for home visiting services and the services that families can obtain from them.

We'll be working on a coordinated communication effort to ensure proper education of the public about the benefits of home visiting services and ways to access evidence-based home visiting models.

Bradley Planey: One of the hidden strengths of the Arkansas Home Visiting Network is the relationship between the Arkansas Department of Health and Arkansas Children's Hospital. The strength has provided the opportunity to build synergy around each organization's strengths. I would recommend to other states to consider looking at a similar relationships between their state agencies and children's hospitals. It's offered a flexibility and a strength that neither entity have by themselves.

Examples of how this relationship have been important in the early stages of our implementation are that we have a program leadership through partnership as evidenced by Department of Health staff being embedded in the structure and processes of the network.

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That we have moved from the excitement of grant development and competition to creating a stabilized environment for our home visiting program. We have been able to blend the federal expectations of creating a single set of benchmarks for formula and competitive MIECHV efforts. And the relationship allows the network to evolve and be open to input from the state model participants.

Scott Gordon: The Arkansas Home Visiting Training Institute does not train on model-specific content but rather as a complement to and expansion of basic competencies and knowledge from which all home visiting staff and families receiving services would benefit.

Its goals are to raise the level of home visiting competencies from MIECHV and other home visiting staff; to use the experience of our existing Center for Effective Parenting to jump start our training efforts and to build on the credibility of that center to expand into the home visiting arena.

And then also to serve as the host for our statewide meeting of all home visiting programs from September 24-26 of this year with the unique MIECHV track for those programs that are being funded through the MIECHV expansion and formula grant funding.

We ask that you stay tuned for further progress. While Brad and I are the agency leads for this Rhonda Sanders is our actual Arkansas Home Visiting Network Director and is the person who is responsible for herding the cats that create the comprehensive models that we're trying to put into place.

Bradley Planey: Holly.

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Holly Higgins Wilcher: Thank you so much Bradley and Scott for sharing your experiences implementing multiple models in Arkansas. We've been receiving some questions throughout your presentation and we'll present them to you later on in the Webinar for your reply.

And just to let everybody know the contact information on these slides will also be provided on the final slide at the end so you can be sure to follow up with Bradley and Scott and Rhonda about the Training Institute if that's of interest to you through their contact information provided at the end of the Webinar as well.

And so at this time I'd like to turn the Webinar over to Sunday and Lenore in New Jersey. Sunday and Lenore.

Sunday Gustin: Thank you. Hi everyone. I'm going to start with just a few words about the structure for advocacy and support of home visiting services in New Jersey. We have a statewide home visiting workgroup that has been around since about 2006. And this group of leaders actually evolved from our prevention subcommittee for our state task force on child abuse and neglect.

And they've been vocal advocates for multiple home visiting models really from almost from the point of the formation of that group. And in fact in 2006 they got together and issued a white paper that studied the issue and made program recommendations for our state.

Prior to this time, from about the mid 90s, New Jersey had one model, the Healthy Families America model. And it was funded by and located in the Child Welfare Agency.

In 2007 we had some new state funds that were earmarked - allocated for home visiting. And that's when we began to work in earnest on developing a continuum of care that includes multiple home visiting models.

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So New Jersey's Healthy Families Program had been marketed as providing services to families from pregnancy to Age 5. But when we undertook our initial analysis we discovered that what was really happening - and it was very difficult for our Healthy Family sites to keep families engaged for that length of time, up and to Age 5.

And as we discussed that finding further we acknowledged that funds really might be better utilized by narrowing the focus of home visiting services from pregnancy to Age 3 with - and actually with a greater emphasis on enrollment during pregnancy.

And one reason we could feel comfortable making that recommendation is because in New Jersey we really do have a strong network of publicly funded preschools, of head start and other early child care programs.

So that kind of, you know, again part of this discussion was also about our state and community priorities. And those in New Jersey were through this group of leaders was to ensure that we did keep a focus on the prevention of child neglect and abuse.

And you saw the diversity of that home visiting workgroup that from a health perspective that we kept a focus on prenatal health and infant and child health outcomes; that we were keeping a focus to ensure strategies to reduce racial and ethnic disparities within maternal child health, within child welfare and in education. And that we kept a focus on promoting family self sustainability and school readiness for children entering Pre K and kindergarten.

And then finally as a piece of this process we did of course undertake a needs assessment and, you know, just a few of the data elements that we looked at as part of that process. Next.

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So other important considerations as we undertook this plan to expand to multiple models it's really important to make sure that the models really do fit within your state but certainly within the target communities within your state.

And so that certainly included looking at the socio-demographic profile of the communities with all of the variability from one community to the other, of ensuring that the network included existing home visiting programs and service but also other home visiting models and services that are available in that community.

For example in New Jersey we have patient navigator services, we have some programs funded through the Department of Health that are access to prenatal care grants. And there are other resources.

And then back again to that point of making sure that at that community level, as you're integrating home visiting models, that you are looking at the transition of - to other services for families that are graduating from home visiting programs.

And then it's important to look at those key features within each of the models. For New Jersey it was important, right, as I stated that we were trying to keep that focus on pregnancy and and infancy in early childhood and so of course we've gravitated to models that embrace that, that we've looked at that entry point being pregnancy and being early to promote primary and secondary prevention.

Looking at the eligibility requirements specific to each of those models and making sure that if their models are going to implement that you're already thinking about how will you get referrals for those particular programs.

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One of our priorities in New Jersey was to look at the intensity and the duration of models. We definitely wanted longer term models that worked more long term with families. And of course within each of those target communities looking at are there special populations that we need to be addressing and are those models responsive to those particular populations and needs.

On the next slide so setting the stage for collaboration, you know, really at the heart of all of this right from the beginning was an emphasis on collaboration and not competition. And, you know, that message - it's been necessary to repeat that message kind of over and over as we've, you know, kind of evolved over the years.

And building that trust and being able to say to our partners that - in a genuine way that this work really is not about which model is better. I mean, clearly if what we have said is our states made a commitment to fund these multiple models. And we've done that because we believe they each have an important role to help us in reaching families across that broad array.

And so repeating that message from time to time both with model developers and with our grantees and with other partners has been, you know, has been an important message.

And the other piece of that is we do remind folks to go back to that needs assessment and to understand that there really is no reason that programs should be competing with each other; that there really are plenty of families to go around that need services.

Another way that we reinforce that message is when we issued our request for proposals to fund local grantees we included in that RFP process a template - really we told them what we wanted, right, sort of in terms of the needs assessment but also in terms of identifying a requirement for them to identify at their local community level who are all of those prenatal, the early childhood

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service providers and to be sure to include a description of how this model would integrate and collaborate with those other services within the system of care.

Another important activity that we undertook was we held a statewide conference, as you heard Lee Ann reference earlier in her presentation. This was actually in April of 2008. And this is when we had our three core models, Healthy Families, Nurse Family Partnership and Parents as Teachers.

And we invited representatives from all three of the national offices to come to New Jersey. And we asked them - those individuals to talk about how they see their model programs collaborating.

And another important activity that we undertook at that conference was in the afternoon we actually had our participants break out into workgroups to begin talking about and planning about collaboration at the local level. And we had, you know, a really wonderful response and it generated a lot of excitement and enthusiasm for helping us to move forward.

And in fact when the guidance came out from the Administration for Children and Families for the evidence-based home visiting initiative it's, you know, we were really ready to go. And one of the - we did include some of - because infrastructure was a piece of that we included the systems building work in our application as well as being able to expand our models as part of that initiative.

And then, I mean, all of this work prepared us last year - or when was that? Whenever - wow time is just going by. For the Maternal, Infant and Early Childhood Home Visiting application process that really positioned us well to be able to build on this concept of expanding multiple models in all of the counties across our state.

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And then finally I just wanted to make that point that it really is important to keep that bigger continuum in view and that, you know, not all families - some families will decline home visiting, some are not going to be eligible. You know, in some cases we hope those home visiting programs will be at capacity and there will be no slots available.

But we do want to make sure that our system of care that we really do have resources to be able to continue to connect families to whether that's in health or child welfare or social services or in early childhood education. And I'm going to stop here and Lenore will take over.

Lenore Scott: So based on the home visitation workgroup recommendations these are the program elements that impact the selection of multiple models within New Jersey's continuum of care.

All of our models are research-driven or evidence-based. They have visits that begin very, very early in care preferably prenatally; we're looking at the first trimester of pregnancy or by the birth of the child.

Again all of the models share the common element that they're voluntary for all of our families. And we're looking for frequent, long-term home visits so we want them to begin weekly and then decrease over time.

In New Jersey our core design includes a focus on prenatal and parent health. Again, I mean, as you heard Sunday state, we're looking to get our families into care very, very early in their pregnancy. And after their pregnancy we're looking at, you know, their interconceptual care as well.

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With our infant child health and development we have a focus on immunizations, well baby visits, our parent child interaction, family social support as well as early literacy and school readiness and family self sufficiency.

So here are the five models that are now included in New Jersey's continuum of evidence-based home visitation services. We have Healthy Families America, Nurse Family Partnership, Parents as Teachers, Home Instruction for Parents or Preschool Youngsters or our HIPPY Program, Early Head Start Home-Based Options.

We also have two other national models that are in operation in selected counties. We have Family Connections, which is a home visitation program that serves special need families from pregnancy to Age 8 as well as our Parent Child Home Program which begins working with families at Age 2-1/2 to kindergarten with the focus on early literacy, parenting and school readiness.

Next slide. Looking at this chart I think it really clearly gives you an idea of our continuum of care as well as the basic features and criteria for each of the five models. As you can see with four of the five models, Healthy Families, Nurse Family Partnership, Parents as Teachers and Early Head Start Home-Based Option we are trying to ensure our ability in New Jersey to have a wider reach within the target population of pregnancy to Age 3 helping us get closer to scale and reaching at-risk families.

Next slide. As I just mentioned the reason for including multiple models in the continuum is to broaden eligibility and enable New Jersey to reach more families across the state. But what we know about this work is that recruiting and enrolling families in home visitation services can be a challenge.

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Our systems building work in New Jersey helps to ensure that appropriate referrals flow to local programs. So basically what we're looking to do is eliminate duplication of services, improve our coordination between home visitation models as well as linking them to other needed services and reducing our recruitment time.

So by having our system building in place it's allowing the actual home visitation programs to reach capacity at a much quicker pace as well as being able to focus on the families and the needs that they have.

So some of the key features are that it enables, again as I just stated, our programs to focus on home visits. It provides the feedback and tracking system for ingoing and outgoing referrals.

It allows us to have a core center of partners in our local communities. And they include prenatal behavioral healthcare providers, social service agencies or early childhood programs and to even though we have a very trusting long-term relationship with a lot of our partners we've also tried to put in place inter-agency agreements just to really kind of cement that relationship.

Next slide. So in looking at our system I want you really to focus on Box Number 3. Referrals for service have a single point of entry here in New Jersey so what we try to do in each of our communities is have a local lead agency that is responsible for streamlining the process, connecting with all of our partners and then kind of flowing - be responsible for the flow that you're seeing on this particular chart.

They have relationships with all of the community-based services that you see in Box 5. They know what home visitation programs are in their actual community.

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And they are involved with, you know, they have a relationship with, you know, the local hospitals and clinics so whether their screens are coming through the actual clinic, going through our central intake or coming from our central intake and going to the actual clinics for screening basically everything comes through Box Number 3 and then kind of flows outward as well as inward.

So we also have - looking at Box Number 1 - relationships with our local community agencies - our - some of our grassroots agencies because a lot of them have pregnancy testing points. So because of our relationship with our Department of Health and Senior Services we have patient navigators that are integrated into a lot of our local systems of care so that they can outreach to families that are hard to reach, that are lost to care so that we can sort of maintain the streamlined process.

And I also wanted to mention two other items. Even though New Jersey was not selected for a Race to the Top Early Learning Challenge grant the discussion and planning process for this application has strengthened home visitation linkages with early childhood education.

And in April 2012 New Jersey was selected as a Help Me Grow grantee so this systems building work will now include the bolstering of partnerships for developmental screening and early intervention.

Next slide. With our MIECHV formula and competitive grants will help us expand to three core models, Healthy Families, Nurse Family Partnership and PAT to all 21 counties and bring early head start home-based option and HIPPO into our home visitation continuum. It would also help us expand central intakes statewide. As you can see right now we're currently - have our central intake system in nine counties throughout the state but stay tuned and we'll keep you informed.

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Thank you.

Holly Higgins Wilcher: Thank you so much for - Sunday and Lenore - for sharing New Jersey's journey, current practices and next steps that you're thinking about in implementing multiple models.

I see we've been getting lots of questions in for you, Scott, Bradley, Lenore and Sunday so at this time we're going to go ahead and start sharing some of those questions with you that your audience has been posing online using the online question feature.

And if you have a question for our presenters and you want to go ahead and type that in the question box we will attend to as many as we can in the next 30 minutes.

And so the first question is for Bradley and Scott. And that question is - let me see if I can find it again - who funds the Center for Effective Parenting in Arkansas? Bradley or Scott? I think you might be on mute.

Operator: Pardon the interruption. It appears that that line has just disconnected.

Holly Higgins Wilcher: Okay we'll go to the next question then until Bradley and Scott can join us again.

Here's a question for Sunday. What are the conditions, for example, funding support from leadership's dedicated staff needed to create and perhaps more importantly sustain the home visiting workgroup? Could Sunday or Lenore speak to that?

Sunday Gustin: Well, you know, I wish I had the real answer to sustainability...

(Crosstalk)

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Sunday Gustin: Oh, hello?

Bradley Planey: Hey, this is Brad and Scott. We just got back on.

Holly Higgins Wilcher: Okay great. We've got a question just on hold for you and we're going to let Lenore and Sunday answer the second one.

Sunday Gustin: So, you know, with regard to sustainability it certainly helps to have all of those partners at the table. And in fact when we look at how home visiting services across models are funded in New Jersey it really is braided funding. I think it might braid and blend - strike that. But it is funding, I mean, there's - so our federal grant comes through Title 5, through Health, right.

But I'm in the Department of Children and Families. There is committed funding from DCF. There is committed funding from our Department of Human Services through TANF. And so until we - I mean, and this is funding that's going to maintain the services that we have right now.

But of course, you know, sustainability is just - I wish I had the real answer to that. We do not have Medicaid as a reimbursement mechanism yet in New Jersey. That's certainly on our radar. And, you know, also being able to look kind of within our existing partner departments and state agencies.

Holly Higgins Wilcher: Great. Thank you so much, Sunday. And welcome back, Scott and Bradley. Just in time for your question. We have a question about who funds the Center for Effective Parenting in Arkansas.

Scott Gordon: Well actually the Center has been around for well over a decade. And it's the Arkansas State Parental Information and Resource Center and has been supported until this year through

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grants - primarily through the US Department of Education. Funding now is based in part from the hospital, Children's Hospital, and other private philanthropic kinds of support as they continue to move forward in today's world.

We have a fairly robust state funding of early childhood activities in the state with over \$115 million in state funding available for early childhood programs including center-based and home visiting programs. And some of the parental education support comes through that funding as well.

Bradley Planey: The MIECHV funding.

Scott Gordon: The MIECHV funding will actually help expand that activity so that we are able to really take the experience of the Center for Effective Parenting and refocus that into the home visiting world in a new and renewed kind of way to bring skill set development and experiential training to that set of professionals.

Holly Higgins Wilcher: Wonderful. Thank you so much for sharing your response to that question. The next question that we have is where can I find more info - information about your Following Baby Back Home program?

Scott Gordon: I would contact Rhonda Sanders, the Director of the Home Visiting Network in Arkansas. She's got that information. It is a program that's run through the Department of Pediatrics at the University of Arkansas for Medical Sciences and is based here at Children's. It is a Medicaid demonstration project which really has demonstrated a significant cost avoidance for this very, very intensely service needing population. So I would start with Rhonda.

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Holly Higgins Wilcher: Great. And we'll - Rhonda's contact information will be provided on the last slide so the participant with that great question stay tuned for the last slide of the Webinar and you can be sure to have that - as well as included in your PowerPoint.

And we have another question that I'm going to field to both of you. The question is can either of the states talk a little bit about data integration process involved with trying to combine data for multiple models for federal reporting? And this could be a whole Webinar; this is a great question. We'll start with Sunday and Lenore and then Bradley and Scott.

Sunday Gustin: In New Jersey we've actually - we've not tried to actually have an integrated data system. What we are doing is the models that we use have their own data systems. They have all been part of the discussion on setting - selecting and finalizing the selection for the federal benchmarks. So they've all had input into that.

And I should have said - and preceding the federal benchmarks what we had done in New Jersey was establish a common set of measures but we did not establish a common data system. I don't know; I hope that makes sense to you.

What we said is this is the set of measures that we looked at each of those three core models that were all, you know, in our state that we were trying to emphasize prenatal enrollment and said these are core measures, common measures that we'd like to be able to collect data on.

And it's taken a couple of years - a few years even. But they are, you know, all of the grants that we fund for evidence-based home visiting regardless of the model do collect this common set of data for us. And that's actually kind of led into - for the federal benchmarks, for the Maternal, Infant and Early Childhood benchmarks it's positioned us pretty well to be, you know, to have

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some confidence that we can do that. And that obviously is going to be a great challenge for all of us.

Bradley Planey: This is Brad in Arkansas. And the, you know, coming up with the benchmarks in itself I've already alluded to was a challenge especially since they were initially generated for a particular model. And then we discovered that we needed to try apply the same set across models.

But getting to the point of data collection and integrating that we're working with ETO to develop a program where we are using the same data collection instruments across models. And ETO was already working with the Nurse Family Partnership and HIPPI USA.

So what we've tried to do is to build on what they had earlier accomplished with those two models and build one that would accommodate the models working with the state leaders for the other models. And it's in process. But we've got a program and we're going to keep refining it as we go along. It's going to go live in July sometime.

Holly Higgins Wilcher: Wonderful. Thank you both for responding to that participant's question. And of course if you want to have follow up conversations on that very complex topic you can contact Scott and Sunday through their email.

This question is for New Jersey. Sunday and Lenore, can you elaborate on how your EBHV program work with federal Healthy Start at the state community level?

Sunday Gustin: Oh I like that question.

Holly Higgins Wilcher: Good.

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Sunday Gustin: In New Jersey we actually have three federal Healthy Start grants. And a lot of the systems work, the central intake system that Lenore described that we're doing really - we love Healthy Start because that work evolved from our federal Healthy Start grants. And even the concept of having multiple models I would say - I was actually working with Healthy Start in Trenton at one of the three sites.

And that's, you know, when we started to have that discussion about how are we going to meet the needs of our community not just with home visiting, right, so Healthy Start is looking at that bigger picture of - and looking at families from pregnancy, you know, through early childhood. So I think, you know, I think it's a great fit with our work in expanding evidence-based home visiting services.

Holly Higgins Wilcher: Great. And thank you for that response and that question was from (Kathleen Kilbane). I'll try to identify the asker as long as that's okay and I can identify the participant that's asking.

The next question is in the New Jersey slide that shows the central intake is it true to say that all parties, i.e. hospitals, community organizations, grass roots organizations, are completing the initial screen and forwarding to coordinated intake who then make the determination of what model and what partnering provider will provide home visiting services? Can you tell me about timelines from initial contact in the community and when the home visiting agency contacts the potential participant?

Lenore Scott: Well I'll start with the timeline. It actually varies by community and by the number of models that we actually have in place and also by the number of slots that are available in those actual

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communities. So it can be - if there's no, you know, if some of the programs have available slots then the turnaround is very, very quick.

Part of the other question that some of our - the local agencies they - one of the things that I didn't allude to is that in New Jersey what we're looking to do is go to a universal screening form. So with that universal screening form that's usually at our hospitals and federally qualified health centers.

So basically they would use that universal screening tool, which is called our P.R.A, and that would go to our central intake. Some of our local communities may have a variation of that actual form.

And based on the relationships that they have in the individual communities sometimes it's a screening tool, sometimes it's a phone call, sometimes, you know, it may be that, you know, they're faxing their agency referral form to the actual single point of entry which is the, you know, our lead agency in that particular community stating that they have a referral that they wanted to get into the process.

So who determines where the actual referral goes to the actual home visiting that happens at the single point of entry. So basically what the referral does is just say we have someone who needs a variety of services. They may be interested in home visitation. So then it goes to intake and then they will, you know, look at the form, make that determination and do an appropriate referral.

Sometimes a screening form may come in and they may not be interested in home visitation but they have other community-based services that they are interested in. But it will still come through central intake and get disseminated to the various community organizations.

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Sunday Gustin: And if I can just add one thing? And there usually is an established timeframe. So once it gets to central intake it's about a 72-hour turnaround for that initial whether it's a home visiting assessment or a referral to a community agency.

Holly Higgins Wilcher: Great. You all are tag-teaming on your kick ball team to cover lots of different topics today but of course all related to implementing multiple models of course. It's - all of these topics are very interconnected.

Let's see I'm just scrolling down to find the next question. And the next question is - thank you for your pause. And this could be for both of you and I'll let New Jersey, since you're still on, answer first and then Scott and Brad, if this question pertains to you please go for it too. Do you collect individual child and family-level data or program level data?

Sunday Gustin: Both. Both. We collect individual - our grantees are collecting individual - or I guess maybe I don't understand the question. At our level, at the state level, we're primarily looking at aggregate data; we're not looking at individual data. I hope that answers it. I don't know. If I...

Holly Higgins Wilcher: Great.

Scott Gordon: In Arkansas we're collecting individual level data but it'll all aggregate through the social solutions ETO platform. We use the family map and we use the ages and stages questionnaire and a number of other devices to gather information. And that's put in at preset times during the course of a family's involvement with the program. And then all that information is aggregated and reviewed through the evaluation process.

Holly Higgins Wilcher: Great. I just heard from Nancy, the asker, that that answers the question. So thank you for answering that question about data.

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Let's see, just making sure I'm not missing any other questions here that have come in remotely. If you have a couple seconds and you feel brave enough to type in a question, let me know if you don't want to be identified and I won't identify you. Just type in your comments into the questions box right there and we'll continue to spend the next couple minutes to field questions to our presenters.

Okay it looks like people may have some more follow up questions as a result of thinking about and pondering what you shared today. I'm not seeing any other questions coming in at this time in the questions feature. And actually I have a little bit about - talking about centralized intake and if New Jersey can talk a little bit about the centralized intake process and how that works.

And of course this is related to multiple models so if you wanted to speak to that briefly feel free.

Sunday Gustin: I'm not sure what else to add to...

Holly Higgins Wilcher: Okay.

Sunday Gustin: ...the central intake process. You know, as Lenore said in her presentation, I mean, this - it really - from our perspective it has a direct connection on multiple models. It provides the framework for making, you know, that one slide for making sure that, number one, that families, pregnant women and families with infants and young children, have a systematized way to be connected to services that are appropriate for their needs.

And I, you know, I think it really - it is important. When you're trying to expand and scale up home visiting services at the community and at the state level that you really do have that kind of mechanism in place because one of the things that we all want is that as we, you know, as we're

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fortunate to have this expanded funding is that we really are making sure that those slots that we now have available are filled, you know, with families and that families and children get the services that they need.

I guess I would just say if anyone - certainly if anyone has any specific questions and wants information to please feel free to contact Lenore and I. We've, you know, some of the sites that are actually using this at the local level have been very good about being willing to share their process.

And even like the question that was raised earlier about what's the timeline in terms of turnaround, you know, if anyone's looking for some specific feedback on how this works and how it can work in your community feel free to contact us.

Holly Higgins Wilcher: Great, thanks Sunday. And thanks for sharing that through the lens of the implementing multiple models topic today. So this one is - can be for both of you if you want to speak to it. One of - or for all four of your rather. One of our biggest challenges is trying to get all the staff in different models trained according to each model's requirement.

While we appreciate that there are individual model training needs is there any movement at the national - oops - not sure if you can speak to the national level - is there any movement at the national level to integrate - I'm sorry, to integrate some training on topics that might be applicable across all models?

And maybe Lee Ann, if you're still on, this - we could start with you in answering this question. And then have either of you, Bradley, Scott, Sunday and Lenore, have either of you - let me scroll down - developed this type of training in your state? So maybe we'll start with Lee Ann

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addressing that broad question and then Bradley, Scott, Sunday and Lenore, you can speak to your state level work.

Lee Ann Huang: Sure. This is Lee Ann. I don't actually feel like I really can answer it other than to say...

Holly Higgins Wilcher: Sure.

Lee Ann Huang: ...I know it is very much a topic of conversation. I know that the - and Chapin Hall's work working directly with the models it's definitely something that is a - at the top of the list of discussion for every meeting and every call or most of them anyway. So it's definitely something that the models are really talking about amongst themselves.

And then I know that it's something that HRSA and their folks and the - that everybody is talking about. So I don't think that anything is gonna concrete may happen, you know, in the next two weeks or months but it is definitely something being discussed. Everyone, I think, is very aware of the need to really look at that and think about that. So.

Scott Gordon: This is Scott...

Holly Higgins Wilcher: Thank you, Lee Ann. Thanks, Scott. Go ahead.

Scott Gordon: Just reinforcing what Lee Ann said. I think that the models - the national models do recognize that they have to come up with some way of clarifying the training issues and the unique training aspects versus the commonality of training for home visitation. And I think the more we can do that the better off we will all be.

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As we've begun to put the training - the Home Visiting Training Institute up and as we look at our approach to centralized intake we're actually looking at some sort of a decision tree that we can work with the national - the evidence-based models to help us identify what families are going to be most successful in their programs and what families are going to be most challenged in their programs so that we can begin to take the families needs and identify the program that has the best set of opportunities and strengths to match that family's particular need set and then be able to somehow improve the outcomes the families get through that involvement.

And that's going to require that the models help us understand what they do best and what they're not as strong at. And so until we can get to that point and have people working that through we're just going to have start at the local level doing it and then hopefully the national level will be able to follow through or provide some leadership over the next few months.

Holly Higgins Wilcher: Thank you so much, Scott.

Sunday Gustin: And I would just say, from New Jersey, that we've done - I don't know about nationally - but we certainly, you know, within the state I think it needs to be part of that message, right. If we're saying that we all have some core set of common measures then there's no reason why we can't have some core set of training.

And I will say as we go forward we expect to do more of that. You know, to this point where we've done common trainings have been around like all of the models we use use the ages and stages questionnaire, the ASQ-SE screening tool so the trainings have been around those kinds of elements of the work of home visiting.

But another - a couple of other things that we've done in New Jersey is that we've had a supervisor meeting bringing all of the supervisors from all of the models together talking about

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what are those common measures, right, what are the things we have in common. And that, you know, the feedback that we've gotten has been really positive. It's helped folks to see that even though it's a different model that we're all kind of there - we're all faced with the same challenges and same issues.

And I think there's a lot more we can do around that. We plan to do more in terms of CQI, you know, really addressing quality improvement across models. So I think there's a lot more that we can be doing within our state and certainly nationally. But that really will be a focus within New Jersey as we expand, you know, through the expansion, through the MIECHV expansion.

Holly Higgins Wilcher: Well thank you for that true kick ball team effort from all three of you for addressing that question. And it looks like we just have time for one more question. And we'll start with Bradley and Scott and then Sunday and Lenore. A more specific question regarding multiple models and central intake, very hot topic, how are the lead agencies in the local communities identified for the central intake?

Scott Gordon: Well we're starting with rolling this out in one of our Promise Neighborhood areas. And so we're going to put an independent intake resource into the Promise Neighborhood that is not employed by or embedded within any one of the four models.

And so that person will work with the community to identify resources, identify families, we'll do the initial screening and then we'll staff that as a group of the models and that person to then identify the best program fit for that family.

Bradley Planey: And the models that are going to be involved are the models that we have already decided to provide funding to through the MIECHV funds that we're receiving. So we're using that as part of our expansion.

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Sunday Gustin: And in New Jersey - just kind of picking up where I left off before. So with our - there are two Healthy Start sites in New Jersey, in Trenton and Camden, that already had kind of the framework for this central intake. So obviously there wasn't any, you know, that developed over time really with community providers and community input.

When we had some funding to add to expand central intake we actually did do an RFP so we went through an RFP process because one of the things we - if you remember when I was talking about we had that April conference, that statewide home visiting conference, when we did those breakout groups in the afternoon we actually - we had prenatal care providers, home visiting programs, other social service agencies that were represented and we asked them to start to have that conversation.

And I think, you know, clearly it's important if you can get consensus of who that central intake lead agency should be. And that was kind of the process that we started. But we did do an RFP and we did ask, you know, for the applicants to have letters of commitment from that, you know, partners would be part of that process.

And again - so if anyone has any particular questions or, you know, wants some follow up feel free to contact us.

Holly Higgins Wilcher: Wonderful, thank you. And we do have a - just a couple more questions on centralized intake that I will encourage folks to - just to know that we'll pass on those - your contact information to our presenters so they can respond directly to those centralized intake questions.

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And just want to thank all the participants for your great questions and our presenters for this question and answer - for participating in the Q&A portion of the Webinar today. We will really appreciate it.

It looks like at this time that's all the time we'll have for today's questions. But before we leave we'd like to gauge your interest in participating in a follow up call on this topic in the future. In just a moment you're going to see your screen change. And you're going to have a chance to tell us if you'll be interested in participating in this potential follow up call.

Bradley Planey: No, we don't vote.

Holly Higgins Wilcher: All right. It looks like 80 - we're getting - just going to give you a couple more seconds to respond. And 85% of you would like a call; 14% wouldn't. And don't worry, we won't bombard you with emails about a follow up call.

But we just wanted to gauge your willingness or your interest, rather, to participate in such a call. It looks like we have enough interest to set up a call in the future. And we'll certainly send out an invite to everyone but don't feel the need to respond if you don't have an interest. Thank you so much for voting. And we'll share this information with the TACC and let you know in the future about plans for a call.

So at this time I'd just like to thank all of the presenters today. Lee Ann, Sunday, Lenore. I first wanted to share your contact information and that contact information slides will come up momentarily.

But I just wanted to share just a warm thank you to all of our presenters today, Sunday, Lenore, Scott, Bradley, Lee Ann, we just so appreciate your time on the call and your presence and your

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sharing of lessons learned, your sharing of benefits of implementing multiple models and to families and children and the work that you're pioneering in your state and your next steps. We certainly appreciate your time and commitment to sharing with your colleagues today. And hope that this has launched future relationships and conversations between MIECHV grantees in doing this work collaboratively.

We just wanted to let you know about a Webinar coming up July 24 on fiscal leveraging. Registration information for that Webinar is forthcoming. And just wanted to show you this screen and I'll keep it on this screen for a little while so you can jot down any contact information to follow up with our presenters if you'd like.

And then just one little housekeeping thing before we let you all go. You'll also receive an opportunity via email from Africa Queen to respond to a very brief feedback form regarding your experience during today's Webinar. This - couldn't leave without thanking also Jackie Counts and HRSA for your warm kick ball welcome to us and your - HRSA's presence on the Webinar today.

We do look forward to receiving your feedback and hearing your thoughts on how this experience was for you today and how we can best meet your technical assistance needs in the future. Thank you again to all of our presenters and to participants for spending time with us today. We look forward to seeing you on the next Webinar. And thank you and have a great day everyone.

Operator: This concludes today's presentation. Thank you for your participation.

END