

**U.S. Department of Health and Human Services
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Webinar
“Home Visiting Financing and Sustainability”

June 30, 2015
3:00 pm ET

Presentations by:

Marilyn Stephenson, MSN, RN, Team Lead, Eastern Implementation Branch, Health Resources and Services Administration, Maternal and Child Health Bureau, Division of Home Visiting and Early Childhood Systems

Kay Johnson, President, Johnson Group Consulting, Inc. Research Associate Professor of Pediatrics, Geisel School of Medicine at Dartmouth

Operator: Good day and welcome to the Home Visiting Financing and Sustainability webinar. Today’s conference is being recorded. At this time, I’d like to turn the conference over to Katrina Coburn. Please go ahead ma’am.

Katrina Coburn: Thank you, Taylor. And good afternoon everyone. My name is Katrina Coburn. I’m the E-Learning Coordinator for the MIECHV Technical Assistance Coordinating Center. I’ll be your facilitator today. And on behalf of the TACC, I want to welcome you to today’s webinar.

During our webinar, we will invite you to all engage with us in conversation about the Home Visiting Financing and Sustainability topic. We learned a little bit about those of you that logged on early and participated in the lobby activities. Thank you for that. Uh, I hope you learned a little bit about your fellow participants during that time as well.

Here’s our agenda for the day. Um, you can see we have a lot to cover. You should’ve received an email with the link to download your pre-webinar registrant packet, and that does contain a PDF of these PowerPoint slides that we’re sharing today. So be sure and download that if you have not already done so.

It looks like we have about eighty people on with us today for the webinar. So phone lines are muted for all participants. However, because we really do want this to be an open conversation,

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if at any time you have a question or comment about the presentation we would love to hear from you. To submit your question or comment, please use the control panel that's located on the right of your screen. At the bottom of the panel is an open text field where you can type your questions.

And, we will be monitoring the question box. And, we'll share your comments and questions with the presenter during the designated Q & A time, and give her some time to respond to those then.

To kickoff today's webinar, I'm happy to introduce our HRSA representative for the day. Marilyn Stephenson is the Eastern Implemen – Implementation Team Lead for the Health Resources and Services Administration, Maternal and Child Health Bureau Division of Home Visiting and Early Childhood Systems supporting Regions I, II, III and IV. Ms. Stephenson previously served as the Project Officer for the Affordable Care Act, Maternal, Infant, and Early Childhood Home Visiting Program in Region IV. Welcome, Marilyn.

Marilyn Stephenson: Oh, thank you, Katrina. Good afternoon. On behalf of the Health Resources and Services Administration, Maternal and Child Health Bureau, Division of Home Visiting and Early Childhood Systems, welcome to the TACC June webinar, Home Visiting Financing and Sustainability.

The Patient Protection and Affordable Care Act of 2010 amended Title V of the Social Security Act Section 511 – providing an unprecedented investment in evidence-based home visiting through the appropriation of \$1.5 billion over five years that created the Maternal, Infant, and Early Childhood Home Visiting Program.

The Protecting Access to Medicare Act of 2014 extended the Home Visiting Program from September 30th 2014 through March 31st 2015, with an appropriation of \$400 million.

We celebrated the reauthorization of the Home Visiting Program with the passage of the Medicare Access and CHIP Reauthorization Act of 2015, that includes a two year extension of

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the Home Visiting Program through fiscal year 2017, with current funding levels of \$400 million per year.

State investments in home visiting services range from no previous investments to substantial investments of state general funds and other funding. In 2012, the TACC established a Community of Practice for Sustainability that allowed a cohort of grantees to share ideas and strategies for sustaining home visiting financing.

This presentation continues to build on the technical assistance provided to that cohort of grantees. We hope the presentation today will provide information that will assist you with developing strategies for financing and sustaining home visiting. Again, welcome to the webinar and thank you for participating.

Katrina.

Katrina Coburn: Thank you, Marilyn. Let me. All right. So, next I'm happy to introduce our presenter for today, Kay Johnson. Ms. Johnson's expertise encompasses a wide range of maternal and child health issues, including perinatal care, home visiting, child development, immunization, oral health and services for children with disabilities and special needs.

She has been actively involved in Medicaid policy development at the federal and state level since 1984. And has worked state home visiting policy and finance issues since 1998. Welcome, Marilyn. I'm sorry, welcome Kay.

Kay Johnson: Thanks, Katrina. Could I have the next slide, please?

I'm going to talk to you today about home visiting finance and sustainability. Um, I know that you have a lot of questions. I know that you have questions that I'm not able to answer that you all hold the answers to. Um, some things like uh continuing investment um at the federal level and assuring future funding for MIECHV, um it's going to be much up to you rather than me.

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But, I am going to talk to you about a way to think about this and a way to focus on um financing and sustainability in today's climate.

Um, next slide, please.

So, I just wanted to – to begin by saying that I really believe that we can make a difference for every disadvantaged child in our country. Um, and that our work to promote child development, health, and wellbeing begins before birth. [Inaudible] the intent of Zero to Three and continues throughout childhood and it pertains to unsustainable financing.

Um, just to give you a little more context about me. Many of you know um my professional work on home visiting or Medicaid or perinatal issues. This is a picture of me when I was 5.

Um, and before this in my early childhood, I had already experienced several adverse childhood experiences and events. Um, aces for me were maternal depression, um the death of my father when I was 3, informal foster care during his prolonged illness, a kindergarten class with 12 substitute teachers and no permanent education and baby bottle tooth decay.

So, all those things were happening in the life of this little girl. Um, but there was um support um for resilience from my family, from professionals and from my community um that enabled me to have success in a wide array of areas. And, I know that what home visiting is providing to families um like mine um is that opportunity to – to have a social support, resilience, services and other supports.

And, I uh appreciate the work that all of you do to make that happen.

Next slide, please.

So, today we're really going to work off of something I call my funding math or my fiscal math. And, uh some of you have seen this before. I think it's a way of – of thinking about um the monies that are available to support a home visiting system.

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And, clearly the MIECHV Program um up in the upper left hand corner is our big source of federal investment. But, we also have um the Title V Maternal and Childhood Block Grant Program, has had funds available, uh small amounts of funding available for home visiting since uh 1989. Um, the healthy – the Federal Healthy Start Program is doing home visiting in some communities. Um, there is mental health, injury prevention with substance abuse, tobacco settlement and of course Medicaid is a big source of funding.

Domestic violence, crime prevention, the education programs like Pre-K and Title I as well as the Individuals with Disabilities Education Act, both Part C for Zero to Three and Part B Preschool; the Child Abuse Prevention and Treatment Act, the CBCAP Program again about child abuse prevention, child welfare programs, the Temporary Assistance for Needy Families, Social Services Block Grant, Childcare and Development Fund, Early Head Start and Head Start, the State Early Childhood Advisory Councils and private sector funding.

And, what you can see here is they've got some little footnotes on these. And, based on the (SEER) at the very beginning of the MIECHV Program, when you were asked as states to submit initial application, you were asked either to get a Memorandum of Occurrence or to uh actually seek um support and commitment from these other programs.

And part of my uh pitch to you is to say, "Did you just ask them for a letter? Uh, did you ask them for a more intensive partnership? Did you look for an opportunity uh for them to bring resources to an early childhood system in your state, and to home visiting in particular?"

And most of these I've listed here are federal funding streams. And those come together with state general revenues and required state matching funds, such as in Medicaid. And then many of you have state and local special funds, children's trust fund, license plate funds, other – other mechanisms.

To me the magic then is what you do inside this circle at the bottom. Are you blending and braiding your funds as allowable to maximize the resources that you had? Are you leveraging federal dollars with state and local public and private resources? Do you have the administrative mechanisms that permits the state to use funds flexibly whenever possible and local flexibility?

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And, creating in aggregate the money that supports a – an effective and efficient local service capacity where families live, play and pray and where providers are delivering direct services, where we really get those dollars down into the community. And, making investments um that are sufficient to support and sustain quality. And, finally funds for R & D, for quality improvement, for data systems and evaluation. Some such funds are in the MIECHV Program. Some of you had those funds.

But for your whole system, and for all of the home visiting, you really want to be sure that those pieces are there.

Uh, next slide, please.

So, questions about um that model overall. We'll take – we're going to take a few questions now. Maybe let's just go put the – go back and and put the – the finance map back up in case someone has a question they want to ask about. This is the general framework I'm going to be talking to you about today, going to be talking about more specifics about funding streams.

But, um are there questions?

Katrina Coburn: So, um Kay this wasn't necessarily a question for you. We have had someone say that um what's at the bottom of this screen is a little bit challenging to read.

Um, what we can do is send out um larger – a larger version of the slides from today so people can have the full page uh version to look at. I apologize for that. Um, I do recognize that it might be a little bit challenging to see.

Kay Johnson: So, the asterisk the asterisk is for someone where you were required to send a Memorandum of Concurrence. And the diamond um is for um a Memorandum of Concurrence for two of those that have diamonds.

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So, you might have gone with Head Start or you might have gone with the State Advisory Council, or you might have gone with the Childcare and Development Fund. Um, the diamond is um those were strongly urged to – to – to engage them in collaboration. So, um Pre-K, IDEA um as – as uh as these – these diamond shapes.

And, then the last um about encouraged, um with the little uh the little trees, the little telephone poles, um the difference in strongly urged, but um those who were encouraged um to – to engage them. The point being that these – that the – the – the structure of the MIECHV Program envisioned that many of these programs would be working in partnership with you as you delivered home visiting.

And, I'm going to talk about ways I think that some of these, not just um again a letter that you send to the Fed saying sure we're our partner, but thinking about ways that these funds can be blended or braided or used to augment um a whole system um of home visiting.

Katrina Coburn: Thanks, Kay. We also have a question. Um, Linda is asking if you can talk a little bit about how CCDS funds can be used for home visiting and...

Kay Johnson: I am I am going to talk about that specifically in a few minutes. I'm going to talk about quite a number of these in a little bit more specifics.

But to generally say um childcare and development funds, uh quality funds um have been used, and sometimes thinking about enhancements that are related to early childhood mental health are two, two categories that I'm particularly familiar with where there's been an exchange. There's also cross training. For a lot of these this is about cross training in your early childhood system.

Katrina Coburn: Okay. And um we have a question from, Lorraine. How do we balance the need for systems versus services? CBCAP leadership determined that their funding is best used to support parent education classes, um as that is a huge need in our state.

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Kay Johnson: And, again I think that the more we can do, both a system analysis around the service delivery and look for those gaps.

And so, it's often easy for one agency to see from their perspective that that was – that parent education was what they thought was most important. But, if you were mapping and overlapping and even geo-mapping your services, a different perspective might emerge.

And, I think some of what MIECHV has called upon us to do in terms of documenting and assessing need and assessing need in the early childhood systems overall helps us to see whether that really is the top priority across the system.

And, I think the other thing um that that works in that is um do how – um if you're using a – a structure like nurturing parenting, well is that is that –where is that going to be provided, how is that going to be provided. Is it in free-standing Family Resource Centers? Is it uh adjacent to the WIC Clinic? Is it a part of a home visiting structure? Is it in Community Health Centers, figuring out the where.

Um, I see someone's asking about the Memorandum of Concurrence. It's – it's concurrence. Um, and I know you can't see that bottom line.

Um, and um I think um I think in general what we know is that um particularly because states were very rushed at the beginning and getting their MIECHV applications together, those – those initial letters didn't have a lot of – a lot of depth in terms of partnerships. I just think, um you know, here this many years later we have an opportunity to think a little bit more in-depth about those partnerships.

Um, you know, uh for uh for WIC to say they support home visiting in your state or Part II to say yes, we think home visiting is a good idea or the state of which has an Advisory Council to have given a letter of support for your initial MIECHV application, that was very important.

But we're well into having – thinking about a larger focus and commitment.

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Katrina Coburn: All right, great. I think that's all the questions for now Kay.

Kay Johnson: Great. Okay, we'll move along. So, I wanted to just give a little framing on context for what we're talking about today. Um, uh as many of you know I did surveys of state-based home visiting in 1998/99 and in 2008/09. And um they were done at about a decade apart. I surveyed all 50 states. Um, in 2008/09, 40 states reported to me that they had what I called state-based Home Visiting Programs. In other words, they were either financing them or they were managing the structure for them.

Um, and there were 69 programs in operation in those 40 states. This is what the financing looked like uh as sources of funds reported at that time. That there was a little over half federal; um about a third in state match, such as Medicaid match; um that there was about 30 percent that was state only; and then there were some local public dollars, some foundation dollars and some other private dollars.

Um, this this again this is before enactment of MIECHV, so it does not include that at all. We know that this picture has changed since that time.

Next slide, please.

Um, just after MIECHV was enacted, um and at the very beginning of implementation the Pew Home Visiting Campaign took a, a different look at how funds were distributed. And, they really talked about um how the funds were being allocated, and kind of what kind of funds were they?

So, as you can see over on the left, the – the blue bar, where um you had about a third of the money being categorical funding that exclusively supported home visiting.

Um, and if you look over in the red it was broad-based funding. It wasn't funding that was necessarily designated to home visiting, um but it was *available* home – but it might have been available for home visiting but it was actually allocated to other activities.

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Um, unaccounted for broad-based funding um up on – on the top there, uh sort of saying um there was there was funding that could have been generally used for home visiting, and it wasn't clear exactly how it was being used.

And I think this um encouraged a number of states to really think about um how – how they were using the available resources. What we *know* is that that because there was no primary federal funding stream before MIECHV, states were very creative about how they used their financing.

Next slide, please.

I'm going to give several state examples today. And what I want you to know is none of these are current year examples. And, all of them are only used to illustrate what's possible, um so that this does not reflect what's going on this year in Tennessee. Um, but it does reflect uh what Tennessee reported for state Fiscal Year 2014. And – and the varied sources of funding that they were using for their home visiting system overall.

So, they had a state Healthy Start, which is a home visiting um – home homegrown model there that looks something like uh Healthy Families America. And then the state Nurse Home Visitor, which is built off of a Nurse-Family Partnership model and then the state child health and development.

So you can see, over on that right hand side, a little over a third uh was state resources. And, then the other two-thirds, the MIECHV formula and the MIECHV expansion dollars uh were going into home visiting in Tennessee overall.

Next slide, please.

Again, um an example uh that doesn't include what's currently going on in Delaware, but showing a different kind of distribution, um the state general fund being a small section but a vital section here. Um, the TANF dollars, uh private money being uh as big as TANF and the state

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general fund, because it's combined and then again um this is getting uh above uh two-thirds and almost three-quarters in their MIECHV formula and competitive dollars.

Um, and so, you know, just seeing what the relative uh contribution was to what they were doing overall at that time.

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Again this is a fiscal map we did for Vermont in 2012 – building off of my uh general model. And, uh the funding has shifted a little bit. The structure has shifted a little bit. And it'll be shifting a lot, I suspect, by next year um that Vermont was using MIECHV funding, uh Project Launch funding from SAMHSA, Medicaid dollars uh and um Early Head Start resources were all coming in federal dollars. And then there was some existing state general revenue, and required matching funds, and some private funding.

And they're really working on a model with our children's integrated services as a centralized outreach intake and coordination structure, and a variety of providers at the community level, but trying to build among them um quality supports regardless of the source of funding.

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I was really struck um looking at uh what others have said about sustainability with this quote from uh Joan Wightkin, a long time Maternal and Child Health Director in Louisiana, uh, what she said in a HRSA webinar about Louisiana's approach to home visiting and – and sustainability. That I would have to say that the backbone of sustainability and growing financially is relationship and trust building among the policymakers and advocates. Without that, my feeling is that we would not have been as fortunate and as successful in growing our programs.

And I think um my 30 years of experience um thinking about financing an array of maternal and child health programs, including but certainly not exclusively home visiting, is what I would call what she said here, an inside/outside strategy; that we need uh people inside government making decisions um and – and with goodwill and transparency, and we need advocates um

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outside government um helping to push for uh – uh sustained funding and uh program changes as needed. And that the more that the two work hand-in-glove, uh the better off we all are.

Next slide, please.

So I'm just going to remind you, um thinking about this um system math and all the varied sources of funding and giving you some examples of how some states are using different combinations of these funds.

Next slide, the framework that I use to talk about this um I call spending smarter. Um, some of you know I've written reports about spending smarter on different issues, uh home visiting, early childhood, mental health, um perinatal services.

And, these are the principles that I think um are involved in spending smarter. And they're maximizing the dollars that already exist, particularly in federal funding streams, um blending and braiding your funds as allowable under federal and state law, um leveraging both smaller grant funds and entitlement dollars. Sometimes people say, "Oh it's just a little bit of money. We can't make it stretch, or that's an entitlement program. We don't know how to make a difference with that."

And, I think looking for those opportunities is important. Um, securing private sector funds that can help to fill gaps or give you a boost in implementation of something new, um using flexible funds to fill gaps in systems. And, building efficiencies um through systems approaches, like centralized intake or shared data systems. And, efficiencies by having models that are matched to family needs. I think it's a really important point, um that we know uh know one home visiting model meets the needs of all the families that we have.

And, um while um the Nurse-Family Partnership might be seen by many as the best for uh a first time pregnant women that we get early in pregnancy, there might be a family with two children who have a high risk for child maltreatment that need a different – need a different approach all together.

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And, so figuring out how we match those and using multiple models in our systems is important. And then making sure that what we're paying for is high quality and appropriate.

Next slide, please.

There are some finance strategies that I've observed over the past 20 years that missed the mark. Um, again not just in home visiting but in general. Uh, not tracking where your money is going. Um, not knowing how you're using it, both in terms of accountability and reporting but also in terms of understanding what worked. Um, that tracking is very important.

Uh, having your funds locked in silos without leveraging, particularly if there are no legal constraints, um having state general revenues that's not being used to match with Medicaid or another funding source. Um, using grants to local communities with limited guidance and low accountability. Just sending the money out there won't you get – won't get you to quality and results. I think you really need um oversight and support uh for funds we send for local communities.

Um, having model community efforts uh with no strategy for spread of that innovation and the lessons learned. I think um we've all learned a lot about this. Um, where we have models. Um, how are we going to – it's an important part of sustainability to think about the spread uh um and dissemination of lessons learned.

Um, another strategy that misses the mark is using one-time grant funds without a long range plan. Um, using it for something that requires sustainability or um, and not thinking about having a good designated one-time purpose for those funds or again a way to leverage them.

And, finally as I mentioned earlier failure to invest in data, quality improvement, R & D and evaluation, all very critical now, I think more than ever before. We know that, um in terms of – of the thinking and uh home visiting being, um you know, the number one uh legislation in terms of talking about evidence-based programming.

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Um, this is how you get your evidence, by having – having data evaluation, doing R& D that – that – that really has good research methods, um all of these things are important and we have to invest in them.

Next slide, please.

Some of the typical finance challenges, and I'm not going to read these all, but just to say that in Medicaid the biggest challenge tend to be getting approval um or fitting into your state Medicaid strategy. And, whether that means um your state has an expansion, or your state uses managed care or your state uh wants to use targeted case management, um figuring out and getting that right fit, it's going to be very important.

And, then obviously having sufficient funds to say that you can be doing matching and those can't be other federal funds, as we know.

Um, state general fund dollars, holding onto them through these tight budget times and meeting demands for accountability on those funds; I have been amazed how well uh most states have done in this area. I think many of us were concerned that with MIECHV state legislatures would see an opportunity to withdraw funds, and that hasn't been the larger trend, so you all are doing pretty well on that.

Uh, in MIECHV I think um a challenge is uh assuring your accountability and uh thinking about braiding while adhering um to the law and requirements. Um, in the Title V Block Grant many states have shifted away from direct services, and there may be a reluctance to use funds for direct services. Uh, there also have been federal and state funding cuts in Title V. Um, and uh they may feel really constrained about using dollars for home visiting when home visiting is seen as having its own resources.

The Childcare Development Fund and the Social Services Block Grant and mental health dollars are really best um used for things like cross training, quality, mental health consultation, not so much in the direct financing of uh the home – the full home visit.

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Um, and while the Individuals with Disabilities Education Act Program, particularly Part C is delivering a lot of services in home, it's not really generally considered a home visiting program. Um, thinking about how those things dovetail and again putting it as part of cross training in a system I think is very important.

And, of course for all of our funding streams, interagency turf, uh fiscal rules and siloed funding streams are continuing uh fiscal challenges.

Next slide, please.

Thinking about um collaborative finance opportunities, um I'm thinking now on the left about what are you trying to finance? So one thing you're trying to finance is well-trained staff. Um, I am a very uh big proponent of cross training for staff.

And, I know that half of the people on this call are now saying "But what about fidelity to our model?" I think there are a whole series of things that can be engaged in cross training. Not just home visiting staff, but early care and education staff, uh Part C early intervention staff, uh early childhood mental health staff who need to know uh infant and early childhood development principles, who need to understand human development, who need to uh perhaps understand how Medicaid billing works in your state.

There are a whole array of things that the full array of – of uh child development and early childhood and home visiting professionals in your state could benefit from knowing. And this – this opportunity for cross training I think is really there. Some are also thinking about cross agency credentialing.

Um, the recruitment of families um, and um I think we've sometimes had a tendency in states for uh one home visiting program or another to say "Oh that's my family. I found them first." Uh, thinking about shared resources for outreach and intake um can really help make sure families are matched to the best programs and your resources are used wisely.

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Um, common quality improvement processes and projects um I think our home visiting COLLIN is showing us how to do that and a lot of lessons to be learned there.

Uh, using private and public funds both uh as allowable for research and evaluation, um I think a lot of states have been figuring out how to do that.

And, then this referral and service network around um collaborative case assessment, shared care coordination models, how you're building into new managed care and accountable care systems, all of that's going to have to be worked on and um resources sorted through in that.

And, I think that's part of the key to our sustainability. And finally again around data and accountability. Um, as uh many of you know I've been working with the Pew uh Data Performance Project. And uh thinking with many states across the country about um cross agency data processes, uniform data systems, uh core measurements and building on uh MIECHV approaches and building on results-based accountability approaches uh for – for people thinking about how they measure across systems, and – and save resources as they do it.

Next slide, please. So, um questions about those examples?

Katrina Coburn: So, Kay you do have a lot of questions coming in. Um, I'll just start up at the top.

Um, so looking at the system map, what is the commitment at the federal level outside of MIECHV to have the other sources also contributing to braiding with home visiting? Um, are the other agencies as interested as MIECHV in an integrated system?

Kay Johnson: Well, I think it clearly varies. Um, but in thinking about the system map, there are quite a few um areas where the barriers are relatively low. Um, if I think about um CAPTA or CBCAP, if I think about um I think the injury prevention people can see themselves in this. I think clearly Medicaid can see themselves in this, although again that careful design is very critical. Clearly, the Title V uh Block Grant um and um and I think uh larger questions around um some of like the – the Pre-K or Individuals with Disabilities Education Programs, um more questions about how they fit into this.

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But, again I think when we can talk about things um like cross training in early childhood development, and centralized intake and coordination, and um other shared resources, uh programs can see themselves uh coming into this. I'm, you know, very impressed with the kind of cross agency work that's going on in New Mexico, for example – thinking about uh Part C and home visiting and other aspects of their early childhood work in close collaboration.

Um, there's just so much work going on in early childhood. And, there are relatively few resources that again the more we can think about the system supports, uh that's where I think other funders uh in those federal funding streams can see themselves.

Um, I think one of the challenges, I'd be very honest about it, um I think that while Early Head Start is um on the uh the Home V approved um evidence-based home visiting list, I think a lot of states uh have had challenges figuring out how to integrate um Early Head Start into a home visiting system, because the state doesn't have um any – a lot of levers.

Um, and so it's really about the goodwill of the programs, the Program Directors and the extent to which they can see themselves as part of the system.

So, it – it is another challenging area and I don't see Head Start giving up money. But I can see it in some states coming into, again a cross training, a centralized intake, a shared data coordination type of structure.

Katrina Coburn: Great, thank you Kay. Um, Kristin has asked if you could provide a real life example of the finance strategies that missed the mark.

Kay Johnson: Um, I don't want to pick – I don't want pick on anybody by name. But I'll just say, I'm – I'm going to use an early childhood mental health example, where there was a state that I worked with um and did a case study on uh where they were doing really impressive early childhood mental health work in two pilot sites. And they persuaded a legislature to give them a \$1 million a year for three years, which is real money in most states.

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And um and they then just decided to give a little bit of that million dollars to each county. Um, very low accountability, very low uh on guidelines or structures about what they had to do with the money. They were just sort of, you know, go forth and do something with this money.

Well, in three years the money was gone. They didn't have a strong evaluation. They didn't have much to show for what they'd invested in. And I just kept thinking about how if they'd either committed that money to um to an actual replication and spread strategy of some proven practices, or some evidence-based practices, or they had used that money to leverage Medicaid to deliver direct services to children in the area of early childhood mental health, uh they'd have had a sustainable strategy and they'd have had something to build on well into the future.

Um, but that – it was just gone and evaporated um at the end of that time. Um, I I think it's early now to use those kinds of examples with home visiting.

But I do think um without, um you know, where – where states or non-MIECHV Programs are not bringing them into a data accountability, and a fiscal accountability, and a sense of transparency, and development of quality, um we're going to we're going to look back on that as missing the mark.

Katrina Coburn: All right, that's a great example. Thanks, Kay. Um, I have one more, kind of long questions for you. It's a two-parter.

Um, could you share some examples of how states have secured private sector funding for home visiting? In those cases, are they funding direct services, infrastructure, enhancements, or something else?

Kay Johnson: Most of the examples that I know about private sector funding have been at the sub-state level. They've been for a particular model, or they've been for a particular community.

Um, there are states where they are using private sector funding. Um, I – I – I don't um encourage people to use those funds for direct services. I think building up infrastructure, think

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of an opportunity to do – um to, you know, to develop a data infrastructure; um easy to sustain, hard to get started, expensive to get started.

Think of the opportunity to bring in something like the Moving Beyond Depression evidence-based model to complement home visiting. Uh, a startup in training uh part of doing um some kind of an enhancement, um like a depression enhancement. Um, those are the things that it seems to me that private sector funding is most important for. It also can be um if you're trying to *pilot* something to move it from good idea to promising practice, so that you might want to *use* it or pose it to MIECHV. Um, that's a good use of those kinds of private funds. Um, so you, you know, maybe got it going in one side and you've got one small good evaluation. And, you want to do a randomized trial or you want to do a better evaluation or make it – see if it'll work and to replicate in two more sites. That's a really good use of funding.

And you – you can begin to move something as I said from a good idea to a – to a demonstrated promising practice. Um, if not all the way um into an evidence-based program.

Katrina Coburn: All right. And we just have one more pop up, and I don't I don't know if you're going to be able to answer this or not.

But, do you recommend any theoretical models for replication and spread approaches?

Kay Johnson: Um. I think there are uh a– no. I don't represent any particular theoretical model. But, I am – well maybe I do. Um, but there is a person, Rogers, who wrote *the* book. And I think it's in its fifth edition on Diffusion of Innovation.

Um, there are quick guides to Rogers' work um on Diffusion of Innovation. If you're deeply interested in this theoretically, um it's worth reading Rogers. I go back to my Rogers at least once a year. Um, I use it to make diagrams. I use it to clarify my thinking. I use it to find examples.

Um it's the definitive work. Um he also has case books and other people have written case books about the theory of Diffusion of Innovation.

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And, I think um it grounds *a lot* of what we do, um more than more than we really know. And he has very good uh advice and examples on when does Diffusion of Innovation not work.

So, I guess if I'm inherent to any particular theoretical model about that, it – it's Rogers and – and, you know, as they say, he wrote the book.

Um – um – um – um, I – I also think that a lot of uh spread – that spreading best practices and spreading evidence-based practices is *at* the core of most quality improvement work. It's inherent in um the PDSA cycles and the traditional quality improvement practices are *designed* to get more people to do something for which we have evidence to do a promising practice, or an evidence-based practice, um when it's not being spread.

And, so I think um all of us should be using our quality improvement strategies where we can.

Katrina Coburn: Excellent. Thank you. I'm going to go ahead and let you move on with your presentation.

Kay Johnson: Okay.

Katrina Coburn: Hm

Kay Johnson: Maybe.

Katrina Coburn: There we go.

Kay Johnson: There we go. So let's just talk about blending and braiding for a moment. Um, blending requires your more flexible funding streams.

And to me I always say, you know, I don't know. I grew up in Indiana. We had Dairy Queen. I don't have that in New England where I live now.

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But, you – you can go to another ice cream store. And they put the ice cream and the candy together. And what you have at the end is a new flavor. So, blending is like a flurry. It's a new flavor when you get to the end of it.

Um, some funding streams um notably MIECHV and Medicaid *really* are not available for blending. Um, and so uh this really does require some care um in – in selecting and – and lots of permissions and being clear about what you're doing if you want to make a new flavor.

Braiding on the other hand, um has long been used to strengthen individual trends. Those of you who were at – had seen the lobby questions, um braiding started with rope. And, sailors did it. And, they did, they wove those strands of flax because an individual strand of flax will tear and fray. And, if you weave it and braid it into rope um it does not uh tear and fray as easily.

But, um at the same time it strengthens individual strands. You can still see individual strands. I'm sure everyone here has seen braided hair. And you know that you can still see those individual strands as they came down.

Um, that permits you to make distinct reports on uses of funds as required in MIECHV, or – or look available time as required in Medicaid. Very important to make sure that you're not just mushing those ones together and we're understanding them distinctly, particularly with MIECHV's rule.

Next slide, please.

So, I'm going to again give some examples that are not from the current year. And, I'm using these examples, because I think they show us the breadth of state experience. Um, and if you have a favorite state example um that I'm not using today send it to me and I will use it.

Um, these state examples come from the National Conference of State Legislatures, as well as examples that states have sent to me directly.

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Um, and – and I did some interviews of states about these – some of these things a couple of years ago.

So, in Wisconsin um they're using MIECHV formula and competitive funds, TANF and state general purpose revenue, child abuse prevention funds again, you know, a – a – a unique kind of a balance.

In Louisiana, they're primarily funding one model, Nurse-Family Partnership. But you can see an array of funds. Um, the End Stage Block Grant, Medicaid targeted case management, TANF, state general fund and MIECHV formula and competitive funds.

Um, and so here again they're not trying to fund multiple models with different sources of fundings, but they're trying to create a whole system that's sustainable with an array of funding.

In Virginia, particularly looking at the opportunity to train home visitors, they've engaged the MCH Block Grant, Medicaid administrative funds, mental health, Part C, Child Abuse and Neglect, and Part B special education funds, an array of – of funding. Um, and Virginia has been looking at this for a long time. I did some technical assistance work with them. I think it was in 2005 at looking at their funding streams.

Next slide, please.

In Oklahoma, again thinking about this for a long time and uh in recent years using state appropriations, child abuse prevention grants, Medicaid, MIECHV formula and expansion, Local County Millage and specialty license plate dollars, again that gets into some of that unique sources of funding that may be accessible to you that you haven't thought about.

In New York, they've been exploring an array of funding, um some community-based child abuse funding, private funds, uh state general funds, the MCH Block Grant, Medicaid in two arenas, um as well as some uh general state public health and – and the Social Services Block Grant funding.

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So you can see um my map is based on reality if you put all the states together.

Next slide, please.

These examples, again from the National Conference of State Legislatures or from state uh state reports, um are examples of how the – the budget’s been dealt with in the legislative process. And, again not the current legislative year.

But, examples from recent years um where um Colorado had legislation. Um, they spent time um really changing the way that the tobacco funds would be used. They withdrew some funds and replaced them with some other tobacco funds. They’re also using the Children’s Trust Fund.

Um, in Washington State they established a Home Visiting Services Account, which requires private matching. If you don’t know much about this, really worth going to look at what – what – what Washington State is doing. Uh, it’s very unique and has a lot of strengths.

Uh, Nebraska got a re-appropriation of unexpended general funds *to* home visiting. Uh, and New Mexico made substantial new investments through state general revenue appropriations, and really uh did creative uh investment with those funds.

And, Utah and some other states are exploring pay for success and other performance-based approaches. Um, uh this is a really um – um social impact bonds and other things that different states are working at. Hot topic right now, um a little bit sophisticated uh need for understanding what this *means* before you enter into it, but certainly something that’s various states are considering.

Next slide, please.

Let’s take a quick poll. Did your state legislature address home visiting financing in the 2015 session? And the answer options are “Yes,” “No” or “I Don’t know.”

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Katrina Coburn: All right, hopefully everybody is seeing that Kay. We'll give them a couple minutes to answer.

Kay Johnson: Good.

Katrina Coburn: All right. It looks like answering has stalled so I'm going to go ahead and show those results. Looks like about 64 percent said "Yes," 21 percent said "No" and about 15 percent aren't sure at this time.

Kay Johnson: Great. Wow, more than two-thirds of you saying "Yes." That's more than I expected. Thanks for answering that poll.

Moving on...

Katrina Coburn: All right so.

Kay Johnson: ...so, um let's go to...

Katrina Coburn: I'm sorry. Kay we had a question.

Kay Johnson: Okay, good.

Katrina Coburn: Slide in there. Um, but it doesn't look like at this time we have any questions. So, actually I'm going to go ahead and – oh we got one. Sorry.

Uh, sustainability planning can be a heavy lift especially for smaller home visiting programs. Kay can you talk about, provide some feedback or strategies for smaller programs to achieve gains in sustainability?

Kay Johnson: Well, uh uh, um different – different meanings to the word smaller. Um, and uh, I think that sustainability planning ought to be going on again through a systems approach. I'm – I'm pushing systems approaches and accountability um and saying that this – these resources ought

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to be a rising tide that lifts all boats. You ought to be pushing for quality and um evidence-based and evidence informed practices across all of your home visiting programs.

If you've got a homegrown model and you see that they need to adopt some more evidence informed practices, that ought to be part of your push. If you've got um opportunities to, um you know, to replicate one of the evidence-based models in more communities, again systems thinking about what – what are our next communities, where we need these services.

And, thinking about those centralized mechanisms where there is centralized intake, data, billing functions. Um, you know there was a time, and it's all straightened out now, but ten years ago in Vermont. They had three different kinds of home visiting providers who had three different Medicaid billing protocols, and three different rates. And, it didn't make sense but each had been adopted at a different time.

So, things can get messy over time with funding. And, the more you look at what's going on and try to make sense out of it to maximize all the resources that you have now, um the more I think you're doing it.

Um, if – if you're thinking about a small state, um I've been working intensively with folks in Vermont here for the past three years. And, we're a small state. And, I – we really um are looking at those efficiencies and accountability and shared and coordinated mechanisms.

So, I think other small states can do that and sometimes it's easier to do that. I think New Mexico is small by population and resources. And, they're also able to do that.

If you're thinking about one small program, let's roll that program up into a larger structure and a larger body of thinking so that people are thinking together. Um, build an alliance, build a coalition, build a systems uh workgroup. Um, something like that I think is absolutely critical.

No one of these programs, no one of these models is going to be sustainable by itself I believe um as we go forward um into the future.

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Katrina Coburn: Great.

Kay Johnson: We go on?

Katrina Coburn: Yes, go ahead.

Kay Johnson: Okay, next slide please. So I want to talk to you a little bit about Medicaid. I know everybody has – well many people had questions about Medicaid um when you did your registration questions.

And, I just want to say um a lot of times people ask me, because they know I know a lot about Medicaid and I've worked on it over the past 30 years, "How can we finance home visiting with just Medicaid?"

And, I say "I think that's a bad idea. And I think it's the wrong question. I think our question should be, "What's the appropriate use of Medicaid in financing home visiting?"

And, I think there are um, there are two reasons why we don't want to fund all of home visiting with Medicaid. And, one is that Medicaid has not tended to pay well or tended to pay for quality. And um another is that um all of the families that we need to serve are not in the Medicaid program.

And, so I think figuring out the right size and appropriate role of Medicaid is a question that many states are asking themselves. Um, and the answers will be varied depending on the structures of your Medicaid program, your uh general revenues available to do matching, as well as the um the way that Medicaid is being implemented in your state, both from a eligibility benefit and um sort of a managed care approach.

So, um I want to reference to you the very good work that uh the National Academy of State Health – National Academy for State Health Policy, a report that they prepared at the request of the Pew Home Visiting Campaign. It's simply excellent work. I think it stands the test of time, although it came out in 2012.

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And this table is just to give you a little snapshot. I've modified it slightly. But to say the primary administrative mechanisms, approaches are on the left. Um, targeted case management also known as medical assistance case management, administrative case management, enhancing uh prenatal or maternity benefits or using medical assistance services overall.

Um, and they – um three of these really are an existing authority. Uh, targeted case management requires a state plan amendment that many states have used it effectively. Um, it does permit targeting geographically and by population, um as uh it does have kind of a – a real case management emphasis, but it's been used very effectively in a number of states. It does give the maximum uh federal matching rate.

Administrative case management, um administrative services and Medicaid are matched at 50/50 federal/state. Um, so that's sometimes smaller than your so-called Federal Medicaid Assistance Percentage or FMAP.

Um, they uh there are opportunities to limit providers but administrative services only. So, you'd be financing portions of visits and you'd be having to keep close time accountability.

Um, other states just to jump to the bottom line, have actually *added* home visiting and defined it as a benefit. And, thinking about it as a benefit that applies both to pregnant women and to – to children.

Um, and uh I think that the – the states that have done that are satisfied with the approach that they've had. I think the important thing to know is that the Centers for Medicaid and Medicare Services have approved all of these various mechanisms. There's no one way to do this.

Next slide, please.

So, here are just some examples. Again, this is adapted from that report. And, I'm going to apologize. That should say National Academy *for* State Health Policy um as the organization. In

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Illinois they've long had the Family Case Management Program and they are using administrative case management dollars.

In Kentucky and Louisiana, they've used targeted case management dollars. Um, in Medicaid they've added home – in Michigan they've added a traditional um Medicaid benefit um and and really um built it out of um, and as kind of a maternity and infant, um support model into now um a program with strong evaluation and uh large numbers served.

In Minnesota, um they've been doing the Family Home Visiting Program through managed care.

In Vermont, we have a – a Global Section 1115 Waiver to do our children's integrated services. We have um – um a uh a capitated payment um that's going out to um agencies through the children's integrated services structure.

Um, and in Washington the First Steps Program um in some ways in transition, but it had used both targeted case management and traditional Medicaid services. These are a handful of samples. There are another um six or seven states that are using Medicaid um in similar ways. I just wanted to give you a few examples and say again, there's no one right way to do this. And, it really depends on the decisions that your states are making.

Next slide, please.

Uh, finally I just want to introduce um the – to you the idea that I'm going to be convening um a Medicaid Learning Community to engage eight selected states. Um, I expect this to start in September or October.

Um, I am uh talking to the Pew Home Visiting Campaign about support and – and for this project. Um, and expect that to go forward.

Um, I'm not currently accepting applications. But, each of your states um will have an opportunity to apply for this in the future.

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So, we're not going to take questions about this project. But, I just wanted to let you know that it is coming um down the road and I'm really excited about uh being able to have a Learning Community focus on Medicaid and home visiting.

So next slide, please.

I think we just have – we have a – we have a short time. Do we want to do the poll or just go to last questions?

Katrina Coburn: Um, we're okay. We're actually scheduled till 4:30, Kay.

Kay Johnson: Okay, good.

Katrina Coburn: So we're a little early. We're...

Kay Johnson: All right, I was getting I was getting time – time warning so I'm trying to be respectful.

Katrina Coburn: You're good.

Kay Johnson: Let's go, let's go ahead and do this uh poll then. And, tell us whether or not your state is using Medicaid to fund home visiting: "Yes," "No" or "Don't know."

Katrina Coburn: We're going to give it just about 30 more seconds, Kay. People are still answering.

Kay Johnson: So, you're sort of split.

Katrina Coburn: Yeah.

Kay Johnson: Between 40 percent "Yes" and 40 percent "No" and some of you "Don't know." Those of you who don't know, go find out. You know somebody who knows the answer to that question.

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Let's just go to our last slide then. Um, so we've got some time um for additional questions, additional feedback. If you're – again if you're using a home visiting uh financing approach that I haven't talked about today, I'm sure everyone would be glad to hear about it. If you're using a source of funding I haven't mentioned today, um while we're waiting to see if some questions come in, I think the – the other big thing that I noted in your comments um and questions through the registration process, um was all of the uneasiness around what is federal funding going to continue. Um, we didn't get our continuation on our competitive money in MIECHV. Oh all this uncertainty um around – around particularly I think MIECHV continuation funding.

Um, but I think also just in, you know, the – the general sense of, you know, how is this all going to work in the future um with the with federal – the vagaries of the federal budget process.

And, I guess I just have to tell you um to – to – to go forth. Um, we're not going to get certainty. We've got a good extension here. Um, and we've got a great federal administration um really thinking about the concerns of states and respecting them. Uh, we've got a Congress that was willing to um recommit to MIECHV. And um to twice vote on continuation.

So, um I think there, you know, there are no promises. There are no permanent assurances. This program right now enjoys uh more bipartisan support than virtually any other maternal and child health program.

So, this would not be the time that I would be most wringing my hands. Um, I would be trying to figure out um how I could do blending and braiding, how I could create a system with efficiencies and um accountability, and – and coordinated systems mechanisms.

Um, I would be thinking about um how I maximize training dollars and – and how I negotiate rates, um whether it's through Medicaid or otherwise, to deliver the home visiting services that that I want to deliver um in my state.

And, um you have a lot of decisions um around all of those things. But, I know this is small comfort for me to say it. But, really um this program enjoys more bipartisan support than any

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other maternal and child health program. And, it's twice been voted on in recent time by um by a split Congress uh for continuation so um just to go do it.

Katrina Coburn: Thanks, Kay. Um, at this time we are not getting any more questions so um I do want to just really thank you for your time today. Uh, this has been fantastic. And, I can tell by the activity in the question box that people have been engaged.

Um, was there anything else that you wanted to share before we moved on to just the – the final closing out of the webinar?

Kay Johnson: Well, I guess I would just, you know, again say um think about all these sources of funding. I know the toughest part to fund is the direct service. Um, but there are a lot of other things that you're paying for.

And uh figuring out what's the best dollar to use for the direct service, and what's the best dollar to use for other administrative activities. And – and again those efficiencies is *really* critical to fiscal and other sustainability plans.

Um, thinking about it from across agency perspective – figuring out how your partners can help um and, um and you know, not feeling like you're – you're in it alone. Um, you know one thing I didn't mention today is that there are states where um their Race to the Top Early Childhood dollars had been used to help support and sustain home visiting systems and structures.

Um, so uh it does as Joan Wightkin say depend on partnerships and relationships. It does depend on having a good inside/outside strategy and having your state-based advocates know why home visiting is important. And, what – what they could be supporting in your state legislature as well um as in Congress.

And, I think um, you know, all of you I know are committed to uh good administration and stewardship of your programs. But, remembering that you're not in it alone is – is critical to sustainability.

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Katrina Coburn: That is important. Thank you. Um, really thanks for your time and for your knowledge that you shared today. I'm sure that the states will be looking eagerly for those applications for that Learning Community to come out.

Um, so I'm going to move on to uh closing out today. I want to remind everyone to watch your email for that follow-up packet um that we always send after these.

And, I also let you know that we will be having our next webinar on July 28th. Dr. Willis and Dr. Colleen Kraft will be joining us to talk about home visitor-medical home partnership. So, please join us for that.

I also want to uh encourage you to keep an eye on Groupsite as Dr. Willis has asked me to post a few questions for you to respond to in that Groupsite. Um, that will help he and Dr. Kraft prepare their presentation for you in July.

And, finally just a quick reminder to please let us know what you thought about today's webinar, by taking the time to complete the webinar evaluation that you will be receiving very soon via email from WRMA.

Uh, thanks again for joining us today. And for all that you do every day to support young children and their families. Have a great afternoon everyone.

Kay Johnson: Thank you.

Operator: And this concludes today's conference. Thank you for your participation. You may now disconnect.

END