

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
"Fiscal Leveraging"

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

Panelists:

Katharine E. Witgert, MPH
Joan Wightkin, DrPH, MPH
Lori Connors-Tadros, Ph.D

Operator: Please stand by. We're about to begin. Good day and welcome to the ZERO TO THREE fiscal leveraging webinar. This conference is being recorded. At this time, I'd like to turn the call over to Ms. Holly Higgins-Wilcher. Please go ahead.

Holly Higgins-Wilcher: Thanks so much. Good morning and good afternoon everyone. My name is Holly Higgins-Wilcher and on behalf of Maternal, Infant, and Early Childhood Home Visiting Technical Assistance and I would like to welcome you to today's webinar on fiscal leveraging.

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

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TACC is funded to provide many levels of technical assistance support to MIECHV grantees including webinars like the one today and support from TACC can be accessed through your HRSA Regional Project Officer. Thank you for joining today's webinar.

Today we have a panel of presenters that we are delighted to share with you. We have Ms. Kathy Witgert, Program Manager for the National Academy for State Health Policy. We have Ms. Joan Wightkin, Assistant Professor of the Department of Human Being Behavioral Health of Louisiana State University School of Public Health. And finally, last but not least, Lori Connor-Tadros, Vice President with Children and Family Services at the Finance Project.

And at this time, I'd like to turn the floor over to Ms. Laurie Wolfgang, HRSA Regional Project Officer who will provide you with a welcome on behalf of HRSA. Laurie.

Laurie Wolfgang: Thank you, Holly. Hello and good afternoon to some of you and good morning for others. Thank you for joining us today for the presentation on physical leveraging. My name is Laurie Wolfgang and I'm the Regional Project Officer for the Region VI MIECHV and Early Childhood Comprehensive Systems Grant.

On behalf of HRSA, including my counterparts and the other nine HRSA Regional Offices and the Central Office staff, it's my pleasure to welcome all of you to today's discussion. When I was asked to provide the welcome today, I was a bit challenged to come up with a warm and interesting intro to such a dry and often uncomfortable topic.

As the daughter of a social worker, I was fascinated with my mother's work and the idea of helping people for a living. When I entered the field in the early nineties, I was like most new

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social work grads - full of optimism and excitement wanting to promote human and community well-being. But when I got my first job, I soon realized it wasn't about people - it was also about money.

It was 1992, and at that time managed care was rapidly becoming the predominant method of financing and delivering health and social services. The emphasis was heavily on billing codes, reimbursement rates, Medicaid eligibility and documenting and grant coding every single move we made. When I was in the homes of my clients, I felt like I was really impacting people's lives but when I got back to the office, my home visit became a widget.

I was frustrated, as was many of my colleagues with balancing our personal passion and the mission of the organization with the required business accountability of this new reimbursement climate. But the more I learned about the evolution of managed care and particularly how it can promote organizational improvement, I found that some of the very tools I was teaching my clients were the same lessons that agencies and staff needed to learn in order to survive - resourcefulness; prioritizing needs; sustainability; goal setting; short and long term financial planning, etc.

I eventually made the move to the administrative side of social services - and not for the pay or promotion but because I felt my peers needed one of their own to teach them and support them in understanding and adapting to the changing environment. I still proudly display my code of ethics and I consider myself a nurturer - even professionally.

And I know that most of you are like me and you came from one of the helping fields like medicine, nursing, social services or public health. And you may have at times felt like your

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passion for individual and public well-being are underappreciated in this financially focused industry of serving human beings. So, I hope that the information and experiences shared today by some of your own peers will provide you with some tools and ideas to help your own organization survive and evolve and eventually thrive.

Thank you again for taking the time to join us today.

Holly Higgins-Wilcher: I thank you so much Laurie for sharing your experience and thoughts and a little bit of how you came to the field and setting the stage so well for the rest of our panel presenters today.

We really appreciate it. Today we will progress through a series of activities. The first will be Kathy's participation with us to help us identify certain Medicaid financing mechanisms currently being used by States to finance home visiting services and assess the benefits and challenges each possess. To also identify additional potential financing mechanisms States may wish to consider the next steps for States wishing to pursue Medicaid financing for home visiting and in general have us explore State Title V MCH programs experience in initiating and evidence-based home visiting intervention sustainability and growth.

And last but not least, Lori will guide us through our five step approach to strategic financing including tools and worksheets that help leaders use data to drive decisions around financing and sustaining statewide home visiting program services.

Just a little housekeeping before we get started. Your phone lines will stay muted throughout the duration of the webinar and for optimum sound quality we encourage you to maintain your audio

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via the phone line versus listening in on your computer speakers. We will have a question and answer period at the end of our webinar where we will send questions that you've been posting in the question feature on your control tab to our webinar presenters.

So please chat your questions throughout. You can also post questions here of a technical nature, if you're having technical difficulties. You should have received today's handouts for the webinar via email if you registered for today's webinar at eastern – by noon eastern time today - however, we'll also send out copies of today's presentation materials to all webinar registrants at the conclusion of the webinar.

We will also post the webinar material to our new website – the MIECHV TACC website as soon as they have been processed through the 508 compliance quality assurance standards. So at this time, I would like to turn the floor over to Kathy Witgert with the National Academy for State Health Policies who will get us started with today's webinar. Kathy, the floor is yours.

Kathy Witgert: Thank you Holly and thank you to ZERO TO THREE for inviting me to participate in this webinar on home visiting. I'm very happy to be here to be part of a conversation about the sustainability of home visiting programs and the role that Medicaid can play. Next slide.

Today I'll be sharing the results of some research that NASHP conducted with support from the Pew Center on the State's home visiting campaign. Our role is two-fold - to describe how States are using Medicaid to finance home visiting and to investigate additional Medicaid financing mechanisms that could possibly be applied to home visiting services.

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So as we're getting started, we're going to put up a little poll screen that you'll see in a few seconds on your screen and we will ask you to answer the polling question that you see there. We'll say - does your State Medicaid program help finance home visiting services? And the choices that you have are - yes, Medicaid supports my MIECHV program - yes, Medicaid supports a home visiting program other than my MIECHV program - No or I Don't Know. And you can check all that apply. I'm going to give you a few seconds to respond to that while I go over a little bit of background information.

Since all of you are familiar with home visiting programs for pregnant women, new parents and young children - I'm not going to spend a lot of time describing those but I do want to run through a few ways in which these kinds of programs can vary. These issues will be familiar to you as well and it turns out that all of these factors can have important implications for using Medicaid to finance home visiting services.

First, the different home visiting programs have different goals. Some of them were designed explicitly to promote healthy pregnancy and good birth outcomes while others are focused on areas such as promoting child development, preventing child abuse and neglect or early childhood learning. The programs, as you well know, use different kinds of providers. Some use exclusively nurses, others use social workers or other community health workers to help provide home visiting services.

And there are programs of different intensities. The different duration of visits, the frequency of visits and the kinds of services that are provided at visits. And then of course the funding sources that support home visiting programs vary and they can include state, federal and private funds.

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And in many states, of course, multiple home visiting programs with varying goals are running side by side.

The examples that I will describe in this presentation are those home visiting programs financed in whole or in part by Medicaid. It's quite likely that other programs exist in these states as well. So I can see that the polling results have come up on the screen and it looks like some of you are in states where Medicaid is supporting a home visiting program but not mostly the MIECHV program that you're running, and quite a few of you are in states where either the Medicaid program isn't supporting home visiting or you're not sure.

So now I'll describe four existing Medicaid financing mechanisms we identified that states are using to support home visiting services. There may be others that our research did not uncover and I'm very interested to hear about those from you all as well.

On the next slide, I'll - I've got a few bullets about targeted case management. When NASHP did our environmental scan, we found that targeted case management is the Medicaid financing mechanism the states use most often for home visiting services. The Sanford Medicare/Medicaid services defines targeted case management as those medical assistance services that help beneficiaries gain access to medical, social, educational and other services.

Targeted case management includes four components - assessment services, development of a care plan, referrals and scheduling and monitoring and follow-up of for Medicaid enrollees. The major benefit in using targeted case management to finance home visiting is the ability to target the services to specific enrollees - women or children - and to target services in specific

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geographic areas. This allows states to target programs to high risk women or to offer services in specific parts of the state even when services cannot be offered statewide.

For example, Kentucky limits participation to high risk first time parents. There although challenges associated with using targeted case management. Each target population must be defined in a state plan amendment. So there is some administrative burden with adding a new population. But perhaps, more importantly, targeted case management does not cover a full package of services. Medical services are not part of targeted case management. It must be billed and reimbursed separately.

On the next slide, I have a bit or more in-depth example about the State of Kentucky. As part of our work, we were privileged to interview both Medicaid and home visiting staff from Kentucky's Successful Hands program. The Hands program was developed independently of Medicaid. After several years of operation, program staff determined that ninety percent of their participating mothers were eligible for Medicaid.

So the Hands Home visiting staff approached the Medicaid agency with a proposal for collaboration. They had one very special secret weapon - Hands was able to offer tobacco settlement funds that supported the program as the State's share of Medicaid funding. The State of Kentucky then crafted a State plan amendment to offer Hands in Medicaid statewide. They chose go use targeted case management as the financing mechanism.

The Kentucky Hands program uses local health departments to deliver home visiting services. Home visitors include nurses, social workers and paraprofessionals - all of them bill Medicaid for appropriate services.

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On the next slide, you'll see a description of administrative case management. We discovered that administrative case management is currently used by at least half a dozen state Medicaid agencies for reimburse for certain home visiting activities. Administrative case management activities in Medicaid can include eligibility determination, outreach, and securing authorizations needed to access medical services.

Federal government claims a fifty percent match for all administrative case management activities. There are some benefits for states to using administrative case management. First, States can offer these activities without filing a State plan amendment and the activities are available statewide to all Medicaid recipients.

And second, a major benefit to using administrative case management is that State's can limit the entities who deliver home visiting. For example, State's can require that home visiting be conducted by local health departments. The latest challenge to using administrative case management for home visiting activities - similar to using targeted case management - is that it cannot be used to reimburse for direct medical services.

Some states use administrative case management in combination with other Medicaid reimbursement mechanisms. As an example, you'll see on the next slide the State of Illinois. The Illinois Family Case Management program is run by the State's Title V agency. The program uses a hundred and fifteen local service providers to deliver case management services. These providers include health departments, federally qualified health centers and other community based organizations.

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Case managers may recommend home visiting as a service based on family's needs. The case manager knows each family's Medicaid eligibility and enrollment status at intake. Home visitors bill each encounter and report the time spent and activities conducted at each visit. For Medicaid eligible families, the State claims a fifty percent Medicaid administrative match. Illinois also bills Medicaid separately for the medical services provided.

On the next slide, I'll talk about using traditional medical assistance services to fund home visiting. The federal Medicaid statute defines the mandatory and optional medical assistance services to be provided to Medicaid enrollees. Just the way it sounds, States must offer mandatory benefits and may choose which optional benefits to offer.

Medicaid services can be offered either in a traditional office setting or as part of a home visit. The main benefit to using traditional Medicaid services as a way to provide home visiting services is that no additional administrative actions are required on the part of the State. Of course the main drawback to using only traditional Medicaid services to fund home visiting is that this category excludes many of the education and case management activities that are typically part of the home visiting program.

On the next slide, I'll show you an example from the State of Michigan. Michigan's Maternal Infant Health program is available to all Medicaid enrolled pregnant women and infants. Women receive services until sixty days post partum and infants are eligible for services until their first birthday. Home visiting services are delivered by a two-person team made up of a registered nurse and a licensed social worker.

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These providers must be affiliated with certified provider agencies - either a local health department; a federally qualified health center; or a private facility. And the providers are reimbursed for the services they render on a fee-for-service schedule.

On the next slide, I've got another State example, the State of Washington. As we've seen, no single Medicaid financing mechanism covers all the services that are typically delivered by home visiting programs. So a lot of states that are using Medicaid are using more than one Medicaid financing mechanism to support their home visiting services.

Washington's First Steps program is one example. First Steps is administered by the State Medicaid agency and Medicaid is its only source of funding. First Steps uses contracted public and private agencies in every county to deliver services. Providers can deliver services to either mothers or infants. Services to mothers are billed on a fee-for-service basis. The services to infants are provided through targeted case management. The services can be delivered in an office or in a home and the reimbursements are slightly higher for home visits.

On the next slide, I did want to give a nod to managed care. This is the last way that we found states currently providing home visiting through Medicaid. In Michigan, Medicaid managed care organizations are required to offer the same home visiting services as the State's fee-for-service program. In contrast, in Minnesota, managed care organizations choose to offer home visiting programs because they're cost effective even though the State does not require it. And in other states like Kentucky and Washington, these states (STOP) use managed care to deliver many of the Medicaid services to enrollees but they carve out and provide home visiting outside that system.

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The biggest challenge for states who rely on managed care organizations to offer home visiting is lack of access to data for monitoring service delivery and outcome. However, some of this can be overcome by specifying program and data requirements in contracts with managed care organizations.

So we just reviewed for you the Medicaid financing mechanisms that we know states are already using to finance home visiting programs. Our expert panel also identified and discussed additional Medicaid financing mechanisms that might be used to support home visiting and those are listed on the next slide.

In some ways, these mechanisms may be a better fit for home visiting than those currently in use. First, we've got section 1905A preventive services. The federal Medicaid statute defines that medical assistance services to be provided to Medicaid enrollees and the list of optional services include a broadly defined category of preventive services. A state could make the case that evidence based home visiting programs can prevent negative outcomes and should therefore be included as a preventive service.

The second possible option is EP SDT - the Early and Periodic Screening Diagnosis and Treatment program for children. And when I say children, it means up to age twenty-one. The Medicaid statute requires states to provide these eligible children with the periodic screening, vision, dental and hearing services that they need. It also requires states to provide these kids with any medically necessary health care services that are identified through the required screening even if that service is not available to adults.

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So in theory, a bundle of services could be created within EP SDT that covers home visiting services. The last potential mechanism that could be used to cover home visiting in Medicaid identified by our expert panel is the section 1915B Medicaid waiver. This waiver is most commonly used by states instituting Medicaid managed care but it could also be used more generally to allow states to selectively contract with specific providers for specific services.

So using a 1915B waiver, a state could define a home visiting service package and develop a set monthly payment for that package. On the next slide, I just wanted to underscore that the most common challenge to using Medicaid to finance home visiting is that no single Medicaid financing mechanism can pay for all of the components of a home visiting program.

As you all know home visiting programs consist of a variable but comprehensive set of services including medical care, behavioral health care, social services, and health education. In contrast, Medicaid pays for discreet services and these are often medical services. To a lesser degree, Medicaid also pays for case management and educational services. And Medicaid services can be delivered in the home, but it's important to keep in mind that Medicaid does not pay for a program.

On the next slide, I've listed a few next steps for states that might be interested in supporting home visiting services through Medicaid. The first thing to do is to choose the most appropriate financing mechanism for your circumstances. Factors to consider include the population to be served, the services to be offered, the providers who will deliver services, and the applicable federal matching rate.

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States would also want to consider the administrative burdens involved in preparing a state plan amendment or a waiver or will want to work closely with CMS throughout the process. Ultimately, state home visiting programs will need to embrace a variety of strategies to maximize their resources. I hope I've given you some ideas about how Medicaid can be a piece of that puzzle.

My contact information is on the last slide along with a link to the NASHP website where you can find a report that summarizes a lot of this information. And at this point, I'll turn it back over to Holly.

Holly Higgins-Wilcher: All right. Thank you so much, Kathy. And we just have one question for you. I'll just go ahead and pose it to you right now if you can us the full name for the acronym - what is FMAP. What does that stand for?

Kathy Witgert: SM

Holly Higgins-Wilcher: F, M as in Mary, AP

Kathy Witgert: All right - FMAP - it's the Federal Medical Assistance Percentage is the long winded way of saying the matching funds that the federal government puts forward for every dollar that the state Medicaid program expends.

Holly Higgins-Wilcher: Great. That is a great explanation. We had that question come in just a couple minutes ago. So thank you Kathy. And if you've got questions for Kathy, we just continue to encourage you to use the question feature and send it in and we'll have some question and answer time with Kathy at the end.

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And at this time, I would like to thank you Kathy, of course for sharing and just for to let our webinar participants know that I'm going to turn the webinar control panel over to our next presenter, Ms. Joan Wightkin. And so we thank you for your patience as you see the webinar screen change in front of you and Joan takes over. And the floor is yours when you're ready.

Joan Wightkin: Thank you so much. Good afternoon - good morning. I'm very pleased to join you. I consider you all a very esteemed group of dedicated men and women doing the important work out there bettering the lives of families across the states and territories.

I'm Joan Wightkin, I spent the last twenty-six years as a Title V maternal and child health director for Louisiana and have more recently worked with AMCHP - AMCHP in the technical assistance coordinating center and teach at LSU - Louisiana State University School of Public Health.

Today I'll be describing for you Louisiana's Maternal and Child Health Program's experience with initiating and growing an evidence based home visiting program over a thirteen year period. Let's see - shifting - there we go - thank you.

So where did this all start? Back in the late 1980's and primarily into the 1990's, Medicaid experienced tremendous changes in policy and those included increasing the eligibility levels up to a hundred and thirty-three percent of poverty. The reimbursement rates were increased significantly for obstetric and pediatric care. And managed care, we heard that earlier, began to come on the scene.

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And the Louisiana Maternal and Child Health Program was a safety net provider of prenatal and well baby care for women and as the private sector began to provide these services due to increasing reimbursement rates and more women eligible and children eligible - MCH had a transition from the clinic based focus to community and home based intervention. And one of the things that we did was to experiment with home visiting programs by offering funding to local entities to do and develop their own home visiting models.

At that time there wasn't a lot of strong evidence. So we were letting them experiment with what made sense to them. Around the same time moving later into the 1990's a tremendous amount of brain research publications hit the scene. And one that I remember the most is the 1997 issue of Newsweek from birth to three and you can see the picture - they are - which really jump started the larger conversation about the importance of early childhood development.

Here you see a PET scan of a three year old child's brain - a normal child and then one that experienced extreme neglect. So really, the world turned - I felt like - at that point in terms of early childhood development. And in Louisiana I began to work on addressing ourselves to infant mental health and hired some experts and began to train all of our public health nurses and social workers with a thirty hour training on infant and early childhood mental health and this really set out foundation for early childhood home visiting in Louisiana.

Sometimes it's great to be at the right place at the right time and in the late 1990's the articles began to be published in major journals on the Nurse Family Partnerships results of their fifteen year follow-up of their intervention and caught many people's attention including my own. The items like a reduction in child abuse, arrests. These are things that are - you know - grew the eye of public health.

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And continuing the funding began - to even more quickly - shift away from prenatal and well-child visits as the private sector began to learn and understand about the benefits of serving the poor population for prenatal and pediatric care. So those dollars that no longer went prenatal and well-child from the Block Grant were able to be refocused to begin Nurse Family Partnerships in two regions of the state with a one million dollar investment.

Right around the same time, our US Senator Mary Landrieu, received some funding for Louisiana from the Department of Education for early childhood development services. And she held a large kickoff of all major state policy makers to announce this new funding. And I happened to be asked by a top executive in Medicaid and he asked me if you could do one thing to improve early childhood in Louisiana what would that be.

Well, you get put on the spot and hope you get a good answer - and my answer was evidenced based home visiting by public health nurses. And he was - I was able to give him a quick explanation and he asked me to set up an appointment to explain further and as I did, he started to realize that Medicaid could be used to expand the program. And he set out to explore what that would look like.

One of the next steps was for the Medicaid director and staff and a few of us to take a trip to Oklahoma that was receiving Medicaid reimbursement for their Nurse Family Partnership program. And the Medicaid director of Louisiana know the Medicaid director in Oklahoma and they spoke the same language. And it was a very beneficial visit.

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So, over the next month, we were able to work very hard and Medicaid eventually became a reimbursement mechanism for Nurse Family Partnership in Louisiana.

Okay, so really, 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 as the backbone as the foundation, my feeling is that we would not have been as fortunate and as successful in growing our programs. And what was it that we did to build the relationship and build the trust among Medicaid and other policymakers in the child advocacy community.

I would say first and foremost, we provided the leaders with facts and trustworthy the evidence. As the publications came out, we would share articles and we explain the information to them. We built a clear agenda among the child advocates and created relationships with a lot of time and energy among the key leaders. If you build relationships and you have credible evidence, people will pay attention, they will listen.

Now, I would like to review our time line - really what went into building this trust and relationship work with the advocacy and the policymaker community. One of the foundations was the 1998 creation of our Louisiana Children's Cabinet and a cabinet advisory board which was comprised of almost all the major child advocacy organizations. This was really strengthened in 2004 with the Early Childhood Comprehensive Systems grant from MCH Bureau and gave the focus on the early childhood period in the Children's Cabinet and the Cabinet Advisory Committee.

So this group of advocates spent a lot of time lobbying legislatures - educating them about the importance of the early childhood period for intervention and annually would plead for state funding for Nurse Family Partnership expansion to all regions of the state. In 2008, they were

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successful in getting a resolution passed in the legislature to really study and see what it would take to expand Nurse Family Partnership to scale to reach fifty percent of the eligibles what was our goal after that report was submitted.

Right around that time, 2008, the Directors of the Department of Social Services and the Child Welfare Agency were invited by the child advocates to go on a home visit with the Nurse Family Partnership nurse and really that was - I would say monumental. And really changed things for us in a very positive way. I think the words of bureaucrat is nothing impaled next to seeing a mom and a baby talking about their success. So what happened as a result of these efforts, we were able to receive two million dollars in state funding and over two million dollars - a range from two to three point seven million dollars in TANF funding over the next couple of years.

So as you can see, we have a series of different funding sources in Louisiana. Ten different funding sources over eleven years - starting with the Maternal and Child Health Block grants. Local government - in our State - we call our counties parishes - and the Beauregard Parish Health Unit decided not to fund a shelter - an animal shelter that year but to fund the nurse for nurse family partnership for a year or two. Medicaid came on board and then as the word got out - private foundations started to fund locally. The (Repeads) Foundation, The Center of Our State, Baptist community ministries and the Institute of Mental Hygiene in the New Orleans region. All started out with funding from the Nurse Family Partnership team.

State general funds became permanent throughout ((inaudible)) came into the scene. Temporary Assistance for Needy Families - I just mentioned. And we also have small funding from the United Way and Entergen Corporation, our energy provider for gas and electricity. So here are the

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different funding sources and braiding - I use the word braiding. It's diverse and then it's braided and I bet many of you out there have had your hair braided at one point or other in your life.

And each sect - each of the three or four - however many sections is distinct and apart. You can see it separately as opposed to your hair combed down and when you put a braid there - it's quite strong - and yet it's each is distinct. So really braiding and the piece about distinct - it will come back in a minute and I'll talk some more about that. So small grants do build broad support for home visiting. I really believe that all government is local and with local government - local United Way - local corporations - funding one nurse home visitor will reflect their support and gains the interest of other local entities so that they may support you in the future.

Private foundations funded one to three nurse home visitors for a two to three year period. Again, you know - creating a ground swell of support. And then when that funding ran out, we were able to sustain that through Medicaid, TANF and Maternal and Child Health Block grant funding. We even had a hospital foundation grant film for outreach and marketing for their Nurse Family Partnership program.

So the grassroots support in all areas of the state really help the program grow. I can't say that enough. So here's a chart that shows you the history of the funding for Nurse Family Partnership prior to the MIECHV funding - as you can see in 1999, we started with a one million dollar investment and in 2009 we exceeded twelve million dollars.

Additionally, our advocacy grew in numbers and in strength. In 2008 to 2010, the Baptist Community Ministry Foundation funded an advocacy project. Since strains in the grassroots in State support for nurse family partnership. The National Nurse Family Partnership funded a full

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time person at that point who covered Louisiana and three other states and stationed that person full-time in Louisiana. In 2009, Louisiana was one of four states to receive Pew Center for States Advocacy Initiatives.

These activities create strong advocacy that grew where at the legislature each summer when state cuts and as you all have experienced recently - in years - we're all experiencing the strain of state cuts. And this advocacy community really protected our state funding from cuts. So after the (McVay) funding, we saw even further growth. And as you see from ninety-nine to 2013 - a fourteen year period - strong steady growth. In, again, 1999 with our one million dollar investment and in 2013 we have over twenty one million dollars for home visiting.

Now I'm going to shift gears a little bit to talk about the nuts and bolts of the careful accounting that's needed when there are multiple and braided funding sources. So braiding the funding sources really does require careful accounting and what I would like to start off with is the state dollars we had, we used that as our Title V Block Grant match. This helps somewhat during budget cuts to not want to cut the state dollars. But really the advocacy that I mentioned earlier and the ACA maintenance of efforts requirements is really what I believe protected the loss of state funds.

But those were ways we had it in separate accounting buckets - if you will. The Medicaid targeted case management which I described earlier - very -very specific use. When I did a time study which I'll tell you a little bit more about in the next slides - a typical and average home visit - the new targeted case management portion really covered only twenty-two percent of a home visit. On top of that, our Medicaid case management - targeted case management - only covered pregnant and post natal women. It did not cover funding for the child.

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TANF - Temporary Assistance for Needy Families came in 2008 and one thing that we knew we had to do very carefully because of TANF agents - the TANF, Department of Social Services and Medicaid to really tease out what was allowable in a home visit covered by TANF versus what was allowable covered by targeted case management in Medicaid. So we used time study.

We were very careful about our record keeping and billing requirements that was necessary for each of these funding sources. And while there was quite a bit of paperwork, we had to keep track of both of these two different entities. We tried to use the existing forms - the record keeping forms that the nurses used to capture the required information without adding a significant amount of paperwork burden.

So here is a slide that describes the time study by the home visiting components and population. Again, I'm looking right now at just the prenatal period of a Nurse Family Partnership home visit. And the first column is the TANF services. And TANF did allow direct services such as health education, counseling, interactive teaching. And so these were the things that nurses did in the home of the pregnant woman.

On the other hand, Medicaid targeted case management as you've heard earlier, does not allow any direct education or counseling services. Services are limited under targeted case management and Medicaid to assess the woman's need for health and social services, to develop with her a care plan, to set goals of what needs to be accomplished for her to be healthy. And then to help link her to health and social services and to overall monitor and check in on how the care plan is going.

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The third column - Maternal and Child Health - a little bit more flexible - did allow some personal health interventions that happened in the home visit - blood pressure, weighing the woman. So here we're very different and distinct activities that were listed on the nurses form that they did when they conducted a home visit.

So here we have the results of the time study. And - like I said - it's labor intensive but not impossible and very necessary to satisfy the different funding sources requirement. So here you see on the left hand column Medicaid, Maternal and Child Health and TANF. And for two quarters - I mean sorry - in one quarter in 2008 and another quarter in 2009 - a year later, we kept track of the minutes that the nurses coded on their data sheets and tallied them and you can see that twenty-three to twenty-four percent of the visits were targeted case management selling to the area that was allowable by Medicaid.

Almost twenty-nine - twenty-eight - twenty-nine percent Maternal and Child Health and forty-eight percent qualified for the TANF funding. And it was consistent over two years. So we felt good and the TANF and Medicaid policy makers were satisfied with that information. So accounting, one of the requirements for the case management was an annual cost report. And this cost report is what the standard cost report required actually by Medicare and used by Medicaid and the invoices that we used for forty some odd providers we changed to capture the information in this way.

So that's now an easy thing if you have universities, social service agencies, forty different providers of home visiting services across the state who all have their own accounting forms and invoices to ask them and provide them with a format on which to bill us. So that allowed us to meet the Medicaid cost reporting requirements and it helped us better reimbursement rates.

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Furthermore, for quality assurance, we had an annual comparison of costs per participate - participant for the entire state and by each and every of those forty providers - so was able to really get a lot out of that cost report.

And these are the categories that every penny that was charged and that we reimbursed had to fall into one of these four overall categories - direct care costs which are the services delivered by the nurse home visitors - care related costs - those salaries of their supervisors and benefits - administrative and operating and that's everything from clerical, seminars, supplies, postage, phone and property and equipment- and equipment furniture.

So, moving along to see all the different funding sources we have Medicaid, state, TANF and MCH Block Grants and then of course the addition of the MIECHV funding significantly helping expansion of the Nurse Family Partnership and initiating through a Competitive Grant - a Promising Practice. So here we have a slide that was presented - presented by Kate Johnson at the National Summit on Quality and Home Visiting Programs in this - earlier this year. And you can see the wide array that she proposes as potential funding sources.

You could see some that we've mentioned earlier today and what I think needs to be done is that each state and territory - each entity out there look at this - see what makes sense for you. Where are your relationships strongest? Where does it make sense in your state - in your community to link up with these entities where they may be some hope for funding. And in addition, in-kind, for example - WIC, a lot of our outreach was done on an in-kind basis through our WIC clinics. So again, this is some ideas for you to go back to your states and see where there is some opportunity.

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So in conclusion, I would like to let you know that Louisiana has been working and continues to work past my term there serving more and more vulnerable moms and children since 1999. And I would recommend that sustainability and growth be part of your agenda because really we want to bring this to scale to serve as many women as - and children as possible. So make that part of your agenda.

The 2012 ACA MIECHV funding increased access to NFP and a new home visiting intervention via the formula in competitive grants and really jump started a much deeper penetration. I would say probably the most important piece of all of this is relationships, relationships, relationships. To take the time to build trust with your fellow state and other entities - local entities - bring the policymakers on home visits and count your evidence. We're all here providing evidence based practices. That's something that did not always exist in federal and state funded programs. I think this is something that we can tout.

In Louisiana with our big growth from the MIECHV funding - our best opportunity that we're looking at now is Medicaid targeted case management for the children. And finally, make sure that you have a numbers staff because none of this will work unless you have someone who excels at accountability and keeping track of the various funding sources and reporting. So I will now stop and turn that back over to Holly.

Holly Higgins-Wilcher: Thank you so much Joan for that exhaustive birds eye view of Louisiana and I'm going to go ahead and pose some questions to you that we've received before we turn it over to Lori that you can address right now. Joan, regarding the TANF funding could you speak briefly what federal TANF goals Louisiana's home visiting program addresses.

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Joan Wightkin: Well - I - off the top of my head - I can't remember the exact verbiage. But it is about family strength and it also - I think that was probably the primary one - family strength and I believe there may have been some teen pregnancy prevention in there with the spacing - but that is information that I would be very glad to get back to you on.

Holly Higgins-Wilcher: Okay, great. I'll have - just noted to follow up and contact you - if she wants your contact information will provided on the last slides of the presentation. So thank you for that question. We're going to continue - continue for each of you to post your questions for Joan, Lori or Kathy in the questions tab of the control panel and we'll get to those at the end of the webinar. And again thank you Joan for addressing that question immediately. And at this time, I'm going to turn the floor over to Ms. Lori Connor-Tadros. Lori, the floor is yours.

And Lori you might be on mute. So, I'll have him unmute you. Okay.

Lori Connor-Tadros: So sorry. Hi everybody. Good afternoon. I'm looking forward to spending a few minutes with you. I'm sure that you would each like Joan and Kathy to come to your state and just be your guide on the side but in lieu of that, I am going to try to present to you a approach - a five step approach to strategic financing so that you can try to take some of the information presented today and do the work and think it through around how best to sustain your evidence based home visiting program.

You can go to the next slide. I don't - okay. The finance project is a non-profit research and technical assistance firm in DC. We work with both state and community leaders across the country and really, our job is to develop simple tools and material, conduct research that will

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enable program leaders and folks in the field working with children and families to have the numbers side. Joan's point is really important in today's society and in today's economic climate.

We need to be able to think from the beginning about the financing and spend as much time as that as we do on planning good programs. Hopefully many of you have heard about our work and seen our tools and resources and so I'm going to share a few of those with you today. Go to the next slide. I can do this. Okay.

You know, I came to the Finance Project about a little over four years ago and I really wanted to understand financing. So I was really probably in many of your types of places running programs, really caring about children and families and had been in the field for many years, and I was really getting frustrated by the fact that I had a really good program and I couldn't always both fund it at the level that I felt needed to or sustain it.

And so I was really attracted to kind of this approach which really looks at it very systematically and that's what I'm going to share with you. So these are key elements of strategic financing that's very simply clarifying financing for what those two estimating fiscal needs and this really looks at your costs. The third step is to understand the current resources, the current funding you're using and to them equate a systematic and target it in knowing where your gaps are for who and when.

And then thinking broadly about in a diverse array of funding sources and a variety of kinds of funding strategies so that you can basically build as you saw with Joan a real web of different kinds of resources that allowing you different - to do different things - implement different services

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- have different flexibilities and different kinds of financing strategies and so that your program is supported by a strong base of funding. You can move to the next slide.

So the first one is what to finance and someone submitted a question earlier on as a result of the survey and they ask this question - when we're thinking of sustainability should we be thinking about programs versus systems when we're strategizing about sustainability. And there's - that is actually a fundamental question that you all will need to ask yourself in a couple of ways and that is, are we looking to at a state level to fund a system?

So a diverse delivery system. Then that would mean that you would include funding and include program services that are both evidence based and others that have been designed and you believe are needed by the children and families in your states and your communities. But you could make a different decision. But whatever decision you make about what you want to finance that then drives obviously costs and the kinds of funding.

Really - really important to start to think from the beginning about the scope and the scale and the duration so that it's best to plan kind of three years out. Funding runs in different kinds of cycles and you need enough of a lead time if you will in order to plan for funding that you don't want to be just thinking about funding in a one-year cycle because you're just kind of getting the funding and then you're having to expend it.

You have a worksheet that was in the resources that came to you and that is really, it's called Financing for What, it's in Word, you can change it in any way, it's not rocket science but it is just a way for you to help think through with your team what we want to finance in terms of direct services, what's needed in terms of infrastructure, this will be different depending on the

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infrastructure at your state level and what capital investments are transportation or other kinds of things.

And really, really helpful to have that all laid out, it's really part of the planning for any program implementation. And we can go to the next slide.

So the second piece is to really estimate your fiscal needs. Often we get you know 50,000, 100,000 a million dollars and we you know, implement the program and we don't do a good job of capturing costs. I think Joan obviously gave you a fantastic example that was driven by the requirements of the funding stream but then allowed her to use that for advocating and determining return on investment in a variety of other things.

I think these are things you already know but you know the significant cost driver's probably 80-90 percent of your budget is going to be staffing depending on the program model, training of that staffing and fidelity and then really valuing, valuing the time it takes for governance and coordination.

And with home visiting programs, especially if you're looking to develop, to implement a system this is really, really important to have a way to value that.

Thinking through the true costs, we're so happy to get in kind resources and we don't, and really it is very important to go the extra step to say if you had to pay for that what is the current market value and to put that in your budget model so that you are actually tracking the true cost, costs.

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So valuing it at some level if you're using existing infrastructure or you're using some type of shared back office or administrative partnership or if you're accessing for example with the local health clinic or other United Way other services that get wrapped around your home visiting program or they provide the transportation.

Very, very important to be as precise as possible and to update this on a regular basis so that you can clearly understand what your costs are.

All this work does take time in the beginning but once you get the processes and procedures in place they are incredibly useful and they are actually the fundamental bedrock behind financing and sustainability. You need to have this data in order to drive fund raising and to make decisions about the most effective use of resources. We can go to the next slide please.

Oh, I forgot to do the poll I think, sorry about that. We can just go ahead and Holly do the poll right now and then they'll see that we're going to work on this next.

So what I'd like to get a sense of is what funding sources you are using, how many of you are using other funding sources other than MIECHV to implement your range of home visiting services. So if you could take a couple of minutes to complete the poll, select all that apply and then we'll just show those results and then I'll go on to the next step.

Okay that's fantastic. So it looks like I'm actually kind of surprised at this, almost 80 percent have dedicated state funds, I'm really, really pleased with that. That's fantastic. Need to really have that base of funds, I'm imagining some of that may be you're counting your Medicaid, I don't know, that's a disadvantage of not being able to talk to you. And then the CDCap funds are very

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important, not too many using Title IV-B and then some using IDEA Part C and TANF. Okay that's terrific.

So many of you have a good array of funds or at least have more than MIECHV.

Now an important next step again you have a worksheet, no back to Step, actually if you could go back Holly I'm sorry I think I might, there we go, we're on Step 3 and you have the worksheet.

Again, this is just a tool for you and it's really a tool that helps put into practice what Joan mentioned, looking at all the funding sources that were on Kate Johnson's slide or others that are coming into your state.

What are the, what, you map the current funding and you map this really both by a timing, you know the life cycle of the grant and eligibility restrictions so that you can really see where your gaps are and that's really, really important.

Something to know or use as a marker once you really look at current spending states are typically spending about three, \$230 or so, \$300 per capita for children birth to age three. There are some figures from the National Center for Children and Families that recommend a level of investment of about \$700-800 per child, so that's a marker you can use.

Now obviously the model you're implementing has different costs and thus the resources will be different, but typically you do want to look at how, what percent of funding for young children is going towards home visiting. You can do this based on the case that's been made for home visiting in terms of the return on investment.

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So the degree you can just don't go forward I just want to say one more couple minute, a couple other points that were raised in questions so I do want to address that.

One is the state funds and I think we addressed that a little bit but there was a question that came in about community level financing. I'm not sure to what degree our only state folks on here are actually grantee recipients from states but for example we're working with the State of North California with their grantees and they were very smart I guess in bringing us in from the beginning to work with those local grantees to start thinking about sustainability.

And this is where you'll have the opportunity to really look at local funds, both in terms of community-based foundations, local Department of Health, any funds that are going for example like Head Start, early Head Start from federal to local, and this is where you can again access private funding sources that perhaps have either a private or corporate that have a local connection, and these are incredibly important either seed money to seed a new innovation or to fill a gap.

Really, really important to think about how these different funds, which have different kinds of requirements and restrictions can be used if you think about this as a big puzzle for your funding how can they be used all together or you can use the braiding analogy if you like, to think about how you're going to support everything.

You can go to the next slide now, thank you. And really simply you'll see then with Worksheet 3 one of the most powerful tools that I have seen in the work we've done across the country with states and communities is actually when we get to the steps and we lay out usually in a simple Excel chart what are the costs, what are the resources and what are the gaps.

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And doing this either by strategy, by locality, by certain sub-populations, it is an incredibly powerful visual tool to both use internally for decision-making and driving your financing and also for fundraising. And you really want to think about this gives you the kind of information to systematically go through to say are you maximizing, leveraging and tapping all of the funding that you possibly could.

And here we can go to the next step, next slide, which is Step 5.

Here's where you'll then in your teams or as you're working this through think through with a diverse array of financing strategies, and you want to think about the small wins if you will, what are the easier things. Either because you have a relationship you can tap certain funding sources or you can partner so that you can save some funding.

And typically what you're going to see is that around maximizing existing resources that with a little effort and collaboration there is an incredible amount of cost savings, cost leveraging that you can do by coordinating, training and professional development, by co-locating services, I think there was a mention earlier that Joan mentioned by tapping some of the non-fiscal resources, particularly at the local level for local governments they're really quite a lot that you can tap into.

And blending and braiding funds you know blending meaning you may be providing the home visiting for X amount of hours and somebody else, for example maybe the food program is also going into the home and they may be providing some nutrition training, a variety of different things that's more or less side-by-side.

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Braiding is when you really kind of pull the funding sources together to look for more comprehensive, and if you're really you can get either at the state level or the local level agreement to actually pull some funds, so I've worked with states and actually I was a state administrator when we were able to pool state funds for early childhood services with some IDEA funds so that we were able to offer a more robust and comprehensive program.

Really looking at some of the, particularly some of the federal flexible funds TANF has been mentioned, Title V, promoting safe and stable families and Title IV-B is again another that you really would want to look at and in some cases this is going to the local level so that's where an opportunity where you would really want to partner at the local level.

A maternal child health grant, you know Title V or others that can be tapped for home visiting at local discretion, Title I there are some very innovative locally-based programs that are supporting home visiting and you can use Title I services for home visiting.

Social Services Block Grant I think was mentioned earlier, the (captive) and we talked about that. Here are some others that are available that are not necessarily used, both Americar and Vista are funds that can be tapped for some of the services that you might want to provide and can give you additional staffing to perhaps do some of the coordination, some of the outreach, and the Title V.

These are, a lot of the community prevention or violence prevention grants can be tapped for home visiting, again a lot of this as Joan said and others is really is dependent on relationships,

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but a lot of it is dependent on education and really finding that common ground in a kind of a win-win.

All righty you can go to the next slide.

There's really no limit on your financing strategies, it's again I think a matter of being really purposeful about thinking this through and in part the purpose of this Webinar was really to just give you information and ideas I think Medicaid is one of the, you know funding sources that we all are looking to and relying on. It certainly requires close collaboration at the state level with, and there are some up front costs so there's really some thinking about that.

I think that you do want to when you're planning for sustainability begin with your successes, what relationships have you established, what positive results with certain stakeholders can you build on and/or use for then going after additional opportunities. What might be some of the barriers to effectively or efficiently using multiple funding sources?

At some level at the state this is sometimes things like the procurement process or the, you know, performance - the kinds of contracting. And that may be something that you begin to work with and is more or less a mid-range stretch but something that you work on over the long term.

And it's really important for your team to think about okay we've got a set of funding sources right now, we understand where we're going in the future and where our gaps are going to be; let's identify the two or three things we're going to work on cause it does take time.

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And so what we're hoping now again that this webinar has given you some information. I've shared some tools.

There's lots more work to be done. And I know that each of you has lots of experience. And so we're hoping that as you move forward -- you can go ahead and move to the next slide -- you will begin or you will build on the work that you've already done around sustainability.

The final tool I've shared with you again is really just a tool, a tool to help you think systemically and systematically with your partners about are we looking holistically at self - at sustainability. You'll notice that the elements of sustainability in that tool include vision, results, financing, your building community support, looking at your internal controls, all the things that you will probably identify as a sustainable organization or entity.

That tool is really just designed to help you identify where you're going and to be sure that everyone on your team from home visitors to administrators to clinical supervisors to advisory board members or community partners understand what it takes to sustain what you would like to sustain and so that you all can kind of think through it together. Again that's a tool that you can adapt and use in any way that you would like.

I think you can move to the next slide. And I think I'm almost done.

We're really happy to give you more information. There's quite a lot of resources on our website around sustainability planning.

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We have a federal funding database that you can search for. It's interactive. We have a home-visiting self-strategic financing tool that we did for Michigan a while ago that puts some of this in context.

So feel free to contact me. I know it was just the tip of the iceberg. And we're hoping that these tools and information were helpful to you.

We're I think ready now to go to any other questions. Holly?

Holly Higgins-Wilcher: Thank you so much, Lori, for walking us through those resources and just for your further contact information too. And thanks so much for our audience who've been posting some really great questions we'll field to Lori, Kathy and Joan at this time. And the first comment we'll start with is Joan has a full answer to the earlier question about the two for free assistance for needy family program. Joan?

Joan Wightkin: Yes I do. Thanks, Holly, and thanks for that question.

The TANF goals are numbers 1 through 4. And what that is, is to provide assistance to families so children can be cared for in their home. Number 2 is to end family dependence on government benefits by promoting job preparation, work and marriage, reducing incidents of out-of-wedlock pregnancy and encourage the formation and maintenance of two-parent families. So it's actually one - Goal 1 through 4.

Holly Higgins-Wilcher: Great. Thank you so much.

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And the first question we have is: can you explain capital investments or elaborate on this please? And I'm not sure who that...

Lori Connor-Tadros: Could you repeat that question?

Holly Higgins-Wilcher: Was to. Can you explain capital investments or elaborate on this concept.

Lori Connor-Tadros: Oh okay. Yes. That's me. So capital investments are actually really facilities, things that you - or even sometimes data systems. These are things that you actually usually invest in and, you know, can often be depreciated.

They - and it probably may or may not be relevant to you depending on what level you need. But if you need to either build a facility, renovate a facility, purchase a van, purchase a data system, something that's really a major in, you know, a major kind of but one time or, you know, large upfront investment.

Holly Higgins-Wilcher: Great. Thank you, Lori.

And just - we just did get a comment from a person in Idaho and - on the polling question that we asked. She indicated that none is not showing as an option which is the case in Idaho so just wanted to share that with you that if we ask this again we'll have none as an option.

Lori Connor-Tadros: You mean regarding the funding sources?

Holly Higgins-Wilcher: Yes, ma'am. Yes. Okay. That's so true.

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Lori Connor-Tadros: We had a limitation, right, in the number of options we could give?

Holly Higgins-Wilcher: We did. We did. So we were limited to five options. But Laura, thank you for posing that question, letting us know about Idaho's current state in terms of that question.

This question is for Joan. And Joan, do you think it's easier to gain fiscal support for one model to spread statewide versus multiple models?

Joan Wightkin: I did click down to gain financing for - what was the question again?

Holly Higgins-Wilcher: Joan, do you think it's easier to gain fiscal support for one model to spread statewide versus multiple models?

Joan Wightkin: In my experience, the one model was easier because we had the attention, the clarity, the evidence. I really believe that it would have been more challenging if we were trying to put forth two.

That's not to say now after many years that it wouldn't be a good idea to try and come back with a model that is evidence-based and good, strong evidence to show perhaps for a different pop - part of the population, nurse family partnership is first-time moms. So I would say that in the beginning I would recommend one and then maybe start to work on the second or third.

Holly Higgins-Wilcher: Okay. Thank you so much.

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And this question is for Lori. If you have knowledge of such, can you describe the benefits and drawbacks of one, funding a child versus two, funding the program?

Lori Connor-Tadros: Oh. This is a little bit - I'm not quite clear that I understand it. The benefits or drawbacks are - of funding the child versus the program, was that the question, Holly?

Holly Higgins-Wilcher: Yes. If you have knowledge of such can you describe the benefits and drawbacks of one, of funding the child versus funding the program?

Lori Connor-Tadros: Well I am not sure I fully understand the question. I will just say this, that typically when we're working we are working around funding a program, a set of services and initiatives.

Now if the questioner might want to, you know, if she wants to - or she or he wants to write in and add a little bit more, if she's - if she or he is talking about dollars - and typically dollars do not go to the child except for (Sun) so - like Medicaid and others. So I'm not really sure I get it to be quite honest with you, Holly.

Holly Higgins-Wilcher: Okay.

Lori Connor-Tadros: I might need more information.

Holly Higgins-Wilcher: Maybe that person can follow up with you independently via your contact information.

Lori Connor-Tadros: That's a great idea. Or if they want...

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Holly Higgins-Wilcher: Yeah.

Lori Connor-Tadros: To go ahead...

Holly Higgins-Wilcher: Yeah.

Lori Connor-Tadros: If we have a minute and clarify their question because others might be interested. I just am not really sure I understand it.

Holly Higgins-Wilcher: Okay. Well I will wait for that person to potentially sign in and ask that question and clarify via the chat feature.

And in the meantime I'll just go to the next question. Okay. Let's see - looks like we don't have any other specific questions at the time.

We talked about one model versus multiple models. We can have that person type in the chat and clarify that question as well.

Also, if you have, you know, further questions you can feel free to chat - to email the presenters whose contact information is available on the last slide of the webinar.

I'm not seeing any other questions coming in. So I will go ahead and move us along to the next slide.

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But what we wanted to talk about next is potential next steps for you after participating in this webinar. And one of them is to contact your regional project officer regarding technical assistance you can receive regarding this topic.

You have just a couple minutes in time of this hour and a half webinar with Lori and Kathy and Joan. But you can definitely follow up with your regional project officer to access complication technical assistance that way.

The next thing we encourage you to work with your early childhood comprehensive systems or your tax partners to develop a fiscal plan for home visiting services programs possibly with a facilitator.

We also would encourage you to discuss materials with your state's model developers to identify Medicaid categories that fit each model being provided in your state. You can also meet with your Title V director to assess the possible funding partners in your state early childhood system.

And finally, we wanted to just clarify the webinar goals one more time. We hope that you were able to, through Kathy's presentation, identify some Medicaid financing mechanisms ((inaudible)) additional potential financing mechanisms ((inaudible)) and consider in the next steps for state tuition to pursue Medicaid financing for home visiting.

We hope that you had an enjoyable experience with Joan sharing the Title V MCH program story, initiating in evidence they attended an intervention and system ability and growth plan. And finally, Lori's exploration of the five simple parts to strategic financing including tools and

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worksheets that hopefully there's use data to drive decisions around financing and sustaining statewide home visiting programs and services.

And you should have received the resources for the approach with your webinar PowerPoint today. But we'll also send those out to you after the webinar and post it on our website.

And in this next slide, you should see the presenter contact information which is also included in your webinar PowerPoint. And you can contact Joan, Lori or Kathy directly. And we encourage you to do so.

And finally, we just want to thank you for attending our webinar today and posing a question. We really appreciate your time and we encourage you to visit our website:

miechvtacc@mchb.hrsa.gov.

And you can locate the archived webinar today and a lot of additional resources on training, how to contact your regional project officers. And we encourage you to do so and find archived webinars on this topic and other topics.

We'd also like to encourage you to save the date for August 21 where we'll have a webinar on integrating home visiting systems within early childhood comprehensive systems.

And I will just check one more time to see if we have received any more questions from participants. It looks like we haven't so it looks like you're all processing the information and a survey and feeds. And we thank you for your participation today.

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And I'd just like to send out a warm thank you to Kathy and Joan and Lori for taking the time to share different perspectives on fiscal leveraging and to Laurie Wolfgang and your warm welcome from HRSA and your presence today on the webinar.

And we really appreciate the time and attention and all the work that you are doing on the ground, webinar participants and implementing home visiting systems and the fiscal leveraging work that you're doing every day. And you will receive an opportunity to complete a feedback form that'll be emailed to you within the next 24 hours from Africa Queen. And we encourage you to complete that feedback form and give us information on how we can continually improve and providing universal technical assistance.

So at this time I'd like to thank everybody for attending and wish you a good day. Thanks, everybody.

Operator: And that does conclude today's conference. Thank you for your participation.

END

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