>> All right. Welcome, everyone, to the HV-ImpACT webinar on Maximizing Caseload Capacity in MIECHV.   We will today be hearing from awardees who will share successes around this particular focus for moving our performance measures ahead.

I'd like to just start by introducing you quickly to the room. If you would like to go over to the chat on the left and introduce yourself, let us know who you are and where you are from and what your position is within MIECHV, that would be great. I would just let you know that if you need to leave our webinar early, we would ask that you take the evaluation survey link and copy it into your browser so you can complete this survey. If you leave before the final slide, then you will not get the survey to come up automatically and we really do value your feedback.

The next slide box is for audio. And hopefully you are are hearing my voice and you will be able to call back in if somehow your connection gets cut off.

And then finally, if you have any technical issues during this presentation, please do go to the technical support box and type in your questions. We will be making this presentation available in PDF and also it will be on the HRSA website along with the 508 compliant version and a transcript very shortly after this session.

So with that, I would like to get started. My name is Karen Kirone [phonetic spelling]. My picture is in the upper left-hand corner. And I'm the Universal Technical Assistance Manager for HV-Impact.

Today, we will be going through several different presenters from different awardees across the country and they will be sharing their thoughts, successes and ideas with you. During the course of the presentation, we would ask that you use the chat feature to the left to ask any questions that you may have of our presenters. We will be able to have some time for Q&A throughout the course of the session, but also at the end we save some time as well for questions that may build up. We will be recording this session, as I mentioned, and we will make sure that all of this information is

available on the HRSA website as soon as we can.

So moving ahead, I want to just again remind you, we do value your feedback. So you will be prompted immediately after the webinar to complete an evaluation. And we would ask that you take just a couple of minutes and answer those questions so that we can continually improve the resources that we put forth.

Today, during the course of the webinar, our objectives will be to learn about various MIECHV awardees' success. We'll here Alabama talk about quality being more important than quantity in building sustainable community relationships that result in and support long-term home visiting caseloads. Pennsylvania will talk about finding success through use of enrollment improvement plans, tiered supports and family support for local implementing agencies cyclical monitoring tool and the process that they use to do so.

Florida will share their experiences about learning -- using a learning collaborative approach for building a coordinated intake and referral system to increase their involvement. Georgia will share about how to maximize caseload capacity through contract monitoring. And finally, Tennessee will share their lessons learned during a multi-staged CQI project around length of retention.

So we hope that you will find this very valuable and you will ask lots of questions of our presenters as we go forth.

Our presenters for today from Alabama, we have Heather Johnson and Dianna Tullier. From Pennsylvania, we have Andrew Dietz. From Florida, we have Allison Parish. From Georgia, we have Natasha Worthy. And finally from Tennessee, we have Carla Snodgrass.

So with that, I would like to start by turning it right over to our presenters from Alabama who will present first.

>> Thank you, this is Dianna. Just kind of wanted to start out with a little history. I've been from Alabama from 2010 to 2014 with the initial receipt of MIECHV funds. I think we didn't know quite enough about home visiting in our state. So really there was more of a focus on quantity than quality. I think our program probably did not have a lot of guidance when they are setting their initial

capacities.

So as a result, from 2014 to 2016, we had some state-level staffing changes. And this really caused us to take a close look at the fact that our programs were not consistently their 85% capacity benchmark and were not leading that benchmark as a state either. So that was really kind of what led to us looking more closely at the quality and the quantity of our programs.

So reputation. When we contract with programs through more than one country, they know there is a county-specific capacity expectation. So initially a lot of our programs were holding spots open in some counties, like some of their more rural outlined counties, while maintaining waiting lists in their more primary counties. So what we did is we asked them just to stop doing that so that they can reach their overall goal of 85% enrollment. And when I felt like when that stress of the lifted off of the program, they were able to focus more on their community outreach and establishing relationships in the communities and ultimately that ended up leading to an increase in referrals.

So I'm sure most states have programs that serve multiple counties. And, you know, your larger counties fill up and you get more referrals. It's the outlying counties where you have to travel and you can't always find staff to hire in those staff that are embedded in the counties. They are just harder to serve overall. Other thing that we found is that when the programs did fill up, it kind of led to a decrease in referrals because referral sources especially physicians, we found out, get really frustrated when they make referrals to programs only to be told that their people are going to be put on a waiting list. You know, they are less likely to make referrals in the future if they think that they are just going to be placed on a waiting list.

Our state has been really fortunate in the last 12 months. We have gained additional funding from three brand-new source. Up until then, we have only had MIECHV funding and a little bit of state funding from our educational trust fund. So it began with Governor Ivey's Infant Mortality Reduction Initiative. So Alabama has one of if not the highest infant mortality rates in the country. So our Department of Public Health looked at the data and named three counties as having the highest rates in the state.

So we already had some of the -- some established home visiting in the three counties. However, the

model that the Governor was most interested in was nurse family partnership and we only had that in two of the three counties. So with the funds that we received, we added home visiting using an FT model in two of the counties and expanded in FT in the county that already had it. So adding a more medical model in two of the counties has been somewhat easier since nurses are involved. However, it's still been challenging since FT eligibility criteria [Indiscernible].

One county is extremely challenging all the way around. I don't know how many states encounter this. Probably everybody. But if a county that borders another state and pregnant women and families receive medical services in both states with their agreements with Medicaid insurance companies. So it's further complicated by a large transient military presence. So a large portion of those families go on the military post for medical services and support.

Enrollment in that county has been slow. Program has struggled to keep families engaged once they enrolled them. They have done tons and tons of public awareness. They have partnerships with Head Start, relationships with Medicaid tier coordinators. I feel -- I just think maybe, you know, kind of wonder why they got home visiting training because really they needed, you know, marketing and public awareness training instead. But things are looking up. It's very slow progress, but it's steady.

And then, I think our biggest [indiscernible] is when Alabama Medicaid became involved. And we asked them if they would consider providing matching funds for the state funds that we were getting for home visiting. And they did agree to match both the nurse -- the funds that we were standing on, both nurse and family partnerships and on Parents as Teachers. So that was really, really exciting. That has given us another pot of money to expand some services into other countries where there was no home visiting.

And then also, we are working with the Department of Human Resources on some other projects and home visiting happened to come up in conversation. So they actually decided to contract with us to fund home visits in about nine counties that did not have any funded home visiting through our program. Couple of them may have had some other home visiting, but it just wasn't funded through our program.

One of the things that we found is really successful is that we first approached existing programs

when we wanted to expand. So if we had a program that touched a new country that we wanted to go in to, we would reach out to the existing programs. I think we can all agree how expensive it is to train new home visitors. So we definitely knew that it would be more cost effective just to start with existing programs.

The other thing is to make sure to include training costs and start-up costs for new counties. And allow adequate time for model training, recruitment and enrollment. There is no golden timeline for that. You just really have to, you know, have frequent contact with the program and just make sure that you are supporting them the best way that you can. And really just accept and encourage them because, you know, they are doing the best that they can. They can't make people enroll in the program. They certainly can't make them stay in the program. Especially when you are going into more rural areas where, you know, people they don't know who are. They don't know if you are going to report them for some sort of, you know, because their house is a wreck or, you know, conditions that they live in. Just takes a while to build up that trust.

So I'm going to hand it off to Heather Johnson. Heather is part of our research and evaluation team at the University of Alabama at Birmingham. I will let her talk a little bit more about the support they provide for us and the program.

>> Thanks, Dianna. I'll just start right away with the fact that we train all home visitors and supervisors initially. It's three days of training. And so we think it's really important that everyone start off with the same knowledge base with respect to home visiting. So we talk a lot about, you know, not only what it's like to be a home visitor, not only what it's like to be in the home with a family, but we also go over all of the assessments and the benchmarks and we talk a lot about ETO. And in Alabama, we do use efforts to outcomes for our data entry. And then we discuss all the blank forms that Alabama has created to match our ETO database.

And so, in addition to that three-day training, we really try to support our supervisors and our home visitors with technical assistance and training on an ongoing, as-needed basis. So we talk a lot in the training about how this is not a one-stop, you know, training. We don't expect that they leave with an understanding of all of the data collection requirements. You know, it's just -- it's a lot. And so we

recognize that they are very overwhelmed initially. And so we try to start building that [audio cut out] with some follow-ups.

so we reach out on our part to make sure they are -- they feel supported. But we also really do hope that they will e-mail and call us. And when we do receive those e-mails and calls, we are extremely responsive. We feel like that has helped to build that trust with the programs and that they then feel comfortable moving forward that they can come to us when they don't understand something or, you know, when things get confusing which inevitably, they will become confusing. So that's sort of our overall policy.

Also, it's really important, as you all know, to monitor the program. Especially as you have new programs that are starting up. We do expect that oversights happen, missing data clearly happens and, again, it gets very confusing. So we want to make sure we have infrastructure for monitoring. And so we have a plan in place whereby sites are sent monthly reports that bring attention to their missing and/or their suspicious data. So we do for each individual site, we do monitor data on a monthly basis.

And we have a laundry list of reports that we run every single month that we look over. And then we send -- we compile all of the reports into one report that is sent to each individual site to their site managers or their lead parent educators. And they are able to see exactly what we see in terms of missing data or potentially problematic, incorrect data and they are given an opportunity to correct that in the database.

And then the following month, we will check again to see was that information, in fact, corrected or do we need to discuss it again. So that happens every single month by the 15th of the month and so sites know to look for that report between the 10th and the 15th.

We've also started to look at the DGIS report two times a year. So we compile a midyear DGIS report as well as our required end of the year DGIS report. And we break that information down for each site. And so we send a DGIS report, we call it the mock DGIS, but we send that report to sites midyear. And that allows them to see that if we were to run the DGIS report midyear, what would their data look like? How much missing data would they have?

We also started about two years ago providing Excel spreadsheets with all the missing data. So, for example, if there were sites that were missing their depression screening for certain clients, we send them a report that shows the client number, the date that the screening should have occurred, and that way they can see, you know, who the home visitor was and what happened and if it was a data entry error. It was just -- it was an oversight, they have an opportunity to correct that. And if it was missing data, they can look for trends and see if there are training needs, you know, for certain home visitors or different things that we can really specifically focus on to improve the numbers from midyear to the end of the year.

And the last couple of years that we've been doing this, it's absolutely has improved our numbers. We found that, you know, gives sites opportunity to do sort of a low impact trial run has been really, really helpful.

We also use Zoom because we are obviously spread out throughout the state. And we recognize that traveling to one centralized location can be expensive. But we use Zoom calls to really do meetings where we go over the reports and we provide them with supporting documentation and detail. And we really have a focus on in our state how do we use data to improve our, you know, our services to families. So always trying to frame it in that way. And that has helped our programs as they come alongside us.

Dianna?

>> I think we are a little over our time. So I will get through this really quickly. We grant funds to programs up front. We don't do reimbursement. The programs send us spreadsheets monthly, expenditure spreadsheets monthly. So we feel like maybe that has -- they have a little less staff turnover. We have an annual grant process that includes very specific program assurances so the programs know exactly what we expect of them. And it also allows programs to make changes easily. They decided they have had it trying to serve rural county that they cannot enroll any families that we can offer that to another program if needed.

But that's about it. Thank you.

>> All right. Andrew from Pennsylvania, would you like to start? And our presenters, you have a question in the chat. If you want to head over to the chat, you can answer it there for everyone can see. Go ahead, Andrew.

>> Sure. Absolutely. So a little bit of background about Pennsylvania. Pennsylvania our family support and home visiting programs fit within the Office of Child Development and Early Learning which is overseen by both our Human Services and Departments of Education.

So within OCDEL, which we call OCDEL. So it's Office of Child Development and Early Learning. I will be referring to it at OCDEL. Under OCDEL, we have the Bureau of Early Intervention Services and Family Supports, which is our provider state level technical supports to our family support and home visiting providers. We have a variety of staff located in OCDEL and through contracted business partners that help us provide TA through the local [Indiscernible] agencies. Staff includes data analysts within OCDEL, two fiscal specialists. One of the two at our business partners PA Key and the second one is within OCDEL. Three family support consultants which are the direct contacts for our local implementing agencies. So each LAA is assigned to a family support consultant and that's the first person they go to. And we have three across the state for all of our programs. One CQI program specialist who is also housed within OCDEL and our Needs Assessment Evaluation Team which we contracted out for our needs assessment to Children's Hospital of Philadelphia PolicyLab.

So currently our MIECHV funding supports four different evidence-based home visiting models across 30 local [Indiscernible] agencies. So we have Parents as Teachers Nurse-Family Partnership, Helping Families of America and Early Head Start. And then in addition, we fund two additional evidence-based home visiting programs, Safe Care Augmented and Family Checkup through our state funding which aren't on the slide.

So since the beginning of our MIECHV award from 2010, Pennsylvania has had the requirements that all of our McPhees local implementing agencies maintain a program enrollment of at least 95% over a three-month average. So we booked over three months instead of monthly to determine that it was -- at least at 95%. The thought was to set the expectation higher than the MIECHV requirements in order to meet minimum of 85% throughout the entire state. The expectation as stated in the

contract with our family support providers. And you can see some of the language here. We did change it. This is new language. So we did change so that if it falls below 90%, it used to say 95%. We lowered it a little bit from past years. This new language moving forward that actually included in our contract that the state has with all of the local implementing agencies.

Through close monitoring and state-provided technical assistance, MIECHV funded programs have consistently met the minimum enrollment threshold of the 85% and usually gets in 90 or 95%. Each home visiting program is designated through family support consultant as I mentioned earlier. And the consultant is responsible to provide ongoing monitoring and cyclical site visits and recommendations to help them improve enrollment.

So for enrollment or program Indiscernible] -- programs are required to report their enrollment actually monthly to their family support consultant on a designated report. The report was initially in Excel and actually has moved to our family support data system which we built over the past few years. And I will show you that in a minute.

Each year during contract renewals, or if we have a competitive application process, depending on the year, we have the local

[Indiscernible] updates their family capacity as part of renewals for the contract. That way we can talk with them and negotiate on the number of families they plan to serve as a capacity.

This is the original enrollment report here on the side. In the past, it was entered in to an Excel document. And then each agency then submitted to family support consultant via e-mail. So this enrollment included the current slots filled compared to the slots funded, any barriers to filling funded slots and any updates to the barriers or any comments they had around staffing or issues with filling their families.

Program also notes the number of children being be served and the amount of family and children served to date. So the accumulative numbers for family and children. The report was submitted by LIA, the family support consultant by the 5th of the following month. So the report for July 2019 would have been due technically August 5th, 2019. And then once they are reviewed by our family

support consultants, they were then forwarded to our family support and TQI program specialist who then put them all into one giant Excel report.

And then we at OCDEL, we had what's known as our family support steering committee. So all of those people I mentioned our data, our fiscal, our family support consultants, myself, some of the other leadership at OCDEL had monthly meetings where we meet to discuss any issues with any of our LIAs and MIECHV or our state funded LIAs which we have about 90 programs total now across the state, state and federal funding.

And then so starting actually July 1st of this year, we've actually moved away from -- well, technically starting last -- our state's fiscal year which is July 1st, 2018, we've moved away from the Excel report and built this report into our data system. And then starting in September of this year, we actually planned to have the report calculate based on the data we are collecting from all of our both MIECHV funded LIAs and state funded LIAs, we're collecting the same demographics and performance measures across all of our programs as of July 1st, 2019 now.

Additionally, what this was, was that every LIA if they fell below the threshold of the 95%, they replace that in enrollment improvement plan that will be 90% moving forward. Pending a review of any extenuating circumstances. So that we did have some where we didn't place them on a place due to circumstances outside of their control.

If an enrollment improvement plan is needed, the family support consultant will meet with the LIA and work with them to create a realistic plan to reach their 95% goal. We are also lucky enough in Pennsylvania to have state office Parents as Teachers and, two, nurse family partnership nurses from the national service office that are dedicated to MIECHV. So they are also included on these plans if it's a Parents as Teachers or NFT agency. And they are reviewed by our steering committee I mentioned earlier and then we, you know, the agencies -- the family support consultants then worked with the agencies and get monthly updates on how they are progressing to reaching to their moment above 90 and eventually towards 95%.

We haven't actually built this into our family support data system yet, but we plan to -- it's one of the forearms for the future. So we're working on that as we build an automated system for our family

support data system.

This is what the data system looks like now. If you notice the Excel was horizontal. It just changed in our data system. It's the same fields, it's just vertical. But the plan is because we have the data when caregivers and children enrolled based on what the demographic data that is collected in our data system, that eventually instead of having the agencies manually enter this, they will manually enter for July, August and September. And at the end of September, we will start giving auto calculations based on the families enrolled as of 10/1. So that should save some time and save some progress on the LIAs having to report this manually since they are entering the demographic data and performance measure data for all of the families that we're providing funding for under as the evidence-based home visiting programs.

And then one of the other things we are rolling out this year in July of 2019, is since we have over 90 agencies and 30 of them are McPhees LIAs -- we do have overlap there, but we're looking at a tiered support system for our family support consultants. So historically what had happened was that our family support consultants were mandated to do an on-site visit every -- and there were two of them. We just recently added a third one. Mandated to do an on-site visit every year for the length of our contract. And our contracts are generally five-year contracts in Pennsylvania for these programs.

So moving toward a tiered system which we are differentiating the programs based on where they are at in terms of staff vacancies and low enrollment. You know, for a Tier 1, that would be the highest tier which they would are the highest needs. And, you know, it could be because they have a new director or a new leader in the program that's responsible for their evidence-based home visiting, high staff turnover or if put on the enrollment improvement plan, they would have more touch points. So they may have on-site visit, they may have monthly calls. Tier 2, more medium level. They would be bimonthly calls for quarterly calls depending on the family support consultant and their relationship with the program.

And then it would look at, you know, if the enrollment -- if we are looking at 90% and we are at 89%, we probably wouldn't put them in Tier 2. Or if they have long-terms that they can see which has been an issue, the largest NFP site -- NFP state in the country. So we do have that concern

sometimes with the nurses and the salaries and stuff. We are working on with the agencies to look at sustainability plans and other areas to focus on there.

And then Tier 3 would be, you know, the lowest level for our agencies. So their enrollment is good. They have consistent and accurate reporting. They don't have any concerns with staffing. They are generally the agencies we have had for the last, you know, since 2010 that have been around and have never had an issue would be in Tier 3. And they would, you know, probably be quarterly calls or every six-month calls. They are the agencies that don't really need as much touch points. And if they have a question, they will reach out and ask. So we're looking at moving towards this type of system in order to, you know, assist our agencies better and help those who do have higher needs.

And then just an overview of the year. So we put out the five-year plan. Since I said all of our contracts are five years, we are looking at a five-year monitoring plan whereas the first year will really be about the, you know, an orientation to our family support programs. So we're working on a webinar series that covers stuff like introduction to the data system, introduction to CQI, introduction to program policy, fiscal policies, policies agencies should have in place. And especially if they are a brand-new agency. They are one of our contracts. And then, you know, Year 2 would start the on-site visits. So Year 2 through 4 would be the -- it would be at least one on-site visit. Not -- you know, not every agency would get an on-site visit Year 2 through 4. It would be split based on the need or the what tier they were placed in.

And then looking at community collaboration, Year 3 we are looking at, you know, self-assessments. And then Year 4 is transitions for, you know, both the families looking at that and referral plans and some of the other stuff there. So we're kind of building on, you know, helping the agencies build their local capacities too. And then Year 5, it would be on-site visits to final on-site visit year. And then we've done this with our -- we have children trust fund grants in our state. We've done this with our children's trust fund grants after the grant has finished. Historically, we have done exit interviews with them asking them, like, how we could better support them through technical assistance and stuff. So we do plan on doing active grant periods over exit interviews with those programs just to, you know, ask questions and see, you know, any feedback, you know, we can add into the next five-year cycle there.

Thank you.

>> Okay. Great, thank you, Andrew. All right, Florida?

>> Hi, everyone. This is Allison Parish. I the project director for Florida. And I'm just going to share with you a little bit about learning collaborative approach that we used for building a coordinated intake and referral system. Which was to increase enrollment for all home visiting programs in Florida and not those just funded by MIECHV. So with that, comes some ongoing challenges, successes and future plans.

So this is has been kind of a work in progress I would say. We are a non-profit. And so we do not have control over any of the state funding that goes to home visits. And we are, you know, don't have any authority over other home visiting programs. We have -- we are funding through our MIECHV dollars, both Healthy Families America, NFP and Parents as Teachers. But, again, we are actually one of the smaller funders.

So with that, we thought we would use some of our funding to try to develop a coordinated intake and referral system that would include everyone which was a pretty big ambition, but it actually has come to fruition. So I'm just briefly kind of tell you what the story was here.

And so before this CI&R learning collaborative happened, what has been happening and continues to happens, there is a prenatal risk screen that's completed by all the OBs hopefully. And then an infant risk screen that is completed in the hospitals. And historically those screens would go to the local county health departments. And with permission from the mom, then those screens could be passed on to a healthy start home visiting program here in Florida or the healthy families teams here in Florida.

And those did not go -- didn't go to any other home visiting programs and historically there was really no family choice that basically it was whichever program got to them first assuming they are eligible. And then the other home visiting programs were left to just try to find families in other ways.

And so using some of the MIECHV funding, we decided to do a learning collaborative. And as you can see, we decided to go with our healthy start coalitions because they are really a local hub for

maternal and child health. It seemed like there was one in every county. Some comparable counties and it was a good sort of base to work off of because everybody had them.

And we had them apply for funding to participate in this learning collaborative and these we were some of the key focus areas her. We are big on continuous quality improvement. This was new to some of the people participating especially if they weren't part of MIECHV. MIECHV had been doing CQI in other ways. But we were really introducing this sort of new way of thinking, of testing things, using a driver diagram before -- you know, where others had not really done that before.

So it was really up to the local teams to develop a decision tree that would work best for essentially taking, you know, the pregnant moms and women with young children and coming with a decision tree that would include all home visiting programs and decide at a local level how that algorithm was going to work. It funded staff as well as travel they needed to attend learning sessions, et cetera, and their meetings. And so they would get together. We had the model developers involved. So certainly the three major model developers as well as some of the other funders here in Florida so that we can really get some buy-in to the process. Not necessarily knowing where it was going to go, but we said, hey, we are going to try it. We are going to use it, you know, with these eight projects, try it out, see how it works.

And to our surprise, what we hoped would go statewide indeed did. It -- I will say, when I get to the challenges, went a little faster than we anticipated. But the Florida Department of Health who is the funder for the Healthy Start Programs and the Florida Association of Healthy Start Coalitions, which is where I work but is really more of a support to the Healthy Start Programs, they adopted CI&R as the cornerstones for their local systems of care.

And so at that time Florida Department of Health was also overhauling what these standards and guidelines would be for Healthy Start services in general. There were changes to the funding and the way the funding mechanisms and the way that was happening. And they just decided we'll just make all these changes at once. And so the CI&R Got rolled out at the same time that all this was happening. And I think that they -- I would say they -- it was probably a little earlier than we would have wished in terms of maybe scaling it up, maybe not doing it where there were so many changes

at once. But, you know, when the state says this is what we are going to do, then nobody was going to protest that. Because it kind of seemed like we either do it now or we don't do it at all.

And so out of that, there needed to be partner engagement, relationship building. You know, some of the community partners, unfortunately, had not really worked together. I would say for those who were part of the learning collaborative, it was going smoothly. I'm talking now about those that had not been part of that learning collaborative and all of a sudden were told, hey, you are going to do this. So they didn't have that sort of same ramp up period. Time to test their decisions trees. It was basically going live and they were testing it as they are going. And in some cases, they are still continuing to test because we are only a little every year into it.

So they had to really start working together in ways that they never had before. And for some home visiting programs, they were seeing fewer referrals and others were seeing more. So they have had to work those out.

Data was an important piece of this. And so fast developed the Well Family System CI&R tabs. So they were already using the Well Family System to collect the healthy start data for that home visiting program. And now what they have done is to create an additional tab and provider portal so that other home visiting programs regardless of funding, regardless of the type of the model are also entering those -- basically the referrals that are coming to them. You know, what's happening with those referrals. Because we don't want to just have a system where basically it's coming into this, you know, central hub. It's a person -- I should say it's a person that talks to the family. So they get the screen in or call to their number. They talk to the family. They go through kind of what their, you know, what they might be eligible for. Talk to them through what their options are. And then make a referral to the program that meets both their eligibility criteria as well as their preferences.

And so the referral then goes to the particular model. And then that program is responsible for reaching out to her and scheduling an appointment. And then entering that data back into the portal to say what happened to that referral. Did she enroll? Did she not enroll? Did they have trouble finding her? That kind of thing. They always used it -- are using it to indicate when they're at capacity. So I've heard people earlier talk about kind of the frustrations that can happen if you are at

capacity and providers are sending things to you.

Rather than a provider who is referring, say, a doctor's office or somebody else referring and having to keep track of, you know, all the different programs and whether they are at capacity or not and then the people, you know, in the programs having to [Indiscernible] all these people [Indiscernible] all they have to do is basically kind of turn off the faucet in this data system. And that way the person who is the CI&R coordinator knows, okay, I'm not sending any need to this program right now. So they would not even be offered that program.

So it actually is much more effective in terms of being able to offer the family choice and also to have, you know, a little bit more control over what's available and what's not available.

So some of the ongoing challenges -- actually, the standards and guidelines were recently finalized and the staff were just trained. So this, it seems like, okay, you launched a year ago, they are just now getting trained. They had some initial training but there has been a lot of tweaks that have been happening along the way. And, you know -- and you have staff turnover and whatnot. This has been really a lesson -- learning lesson as they go. And so these are just some of the additional tabs that have been added. There is more training.

One of the biggest challenges I think that the CQI has been an inconsistent across the state. Like I said, where we had MIECHV, MIECHV programs have been doing CQI since the beginning. They are well-versed in it. They understand it. And other places, if they didn't have MIECHV already, they may not have been using CQI and they didn't know the PDA testing and didn't necessarily have a lot of patience with testing things to see how they work out and then tweaking them. Just wasn't part of their philosophy.

And I think there is still a lot of, you know, competition remaining. If somebody has a lot of vacancies and their funder is saying they need to get their enrollment up, then, you know, they are going to get a little frustrated with the process if they are not getting more referrals.

In some cases, people have, you know, again seen a sharp decrease in their referrals. And then other cases, it's actually increased. What we are really tried to do here though is to make sure that it's

balancing out to where everybody is getting sort of the right amount of referrals. And part of that may be that we need to increase the number of referrals coming into the CI&R system. So I will get to that in just a minute.

So we continue to have joint troubleshooting at the state level, ongoing communication at local level. There is a local advisory group. There is a state advisory group. And we kept on a consultant through the end of this September to really be able to provide technical assistance to guide the group. There is also a best practices group that is, you know, trying to see, you know, what's working best and to share that with the other counties.

The home visiting advisory group includes the models, model developers, the funders, partners at other state agencies that have, you know, a vested interest. And I would say also just for Florida MIECHV that our capacity remains high. We continue to have around 89, 90%. Part of that, I'm sure, that we are also doing CQI around and have been for a long time around home visiting and retention. And that may be is a presentation for another day. But we have continued to do well, but we also want to see that this works for everybody.

So future plans and wrapping up, just that I will show you in the top right-hand corner this is our branded Connect is what we are calling it. So rather than CI&R. That's not really good for families. We're calling it Connect. Connecting families to community programs. So we want a brand to increase awareness, so the new process to really ideally have families calling us instead of us calling them so that we are not just relying on those screens. And just really making sure providers know they refer to this sort of one-stop shop that they don't have to know the different eligibility. And also that we are working with our state partners and other sponsors to try to market this in a much larger way so that everybody will know about it. And so this is a link to where we can find more information.

And I apologize for talking fast. I had a lot to go through in a very short period of time.

>> Okay. Thank you so much, Allison.

>> I'm going to turn it over to Georgia, then Natasha and then I will answer the question in the chat

box. Thank you.

>> Thank you.

>> Thank you, Allison. I'm Natasha Worthy and I'm the senior program manager through the Georgia Department of Public Health home investigating program. Maximizing caseload capacity through contract monitoring in Georgia MIECHV. Why focus on capacity?

The Georgia Department of Public Health is [Indiscernible] as the say leadership team inherited a caseload capacity for our local implementing [Indiscernible] when we began to manage the MIECHV program in 2017. As the department focused on establishing and stable transitions in the first year of implementation, the subsequent year, we focused more on developing a relationship with respective site through our recipient monitoring process. Through this process, we identify each of their concerns related to caseload capacity that affected our parent educators, the achievement of our CQI goals and objective which were around family engagement. And caseload capacity also had the had potential to [Indiscernible] our state successfully leading the capacity recommendations of our HRSA and MIECHV funding.

Georgia's contract monitoring process includes monthly reports, bimonthly calls and annual site visits. The monthly reports provide the leadership team the detail regarding staff vacancies, number of families enrolled, case closures, program financials and also the number of available slots that site had.

The bimonthly calls delivered the opportunity for the LIAs and the state leadership team to discuss information provided on the monthly report to share progress success and to discuss any challenges.

The annual site visits offered face-to-face contact to discuss the items covered during the year as well as to provide technical assistance, provide an overview of the financial documents from the site and gave us an opportunity to spend time with staff and when summer came [Indiscernible] to meet the family [Indiscernible].

Other results of the contract monitoring process, we were able to identify and address concerns and issues that were related to capacity. We learned that some sites were carrying more families per

caseload than recommended by the model. And others were not nearly reaching the recommended caseload capacity. Some of the LIAs shared that carrying the maximum number of clients when working with high risk populations was not always realistic, especially when you are factoring in that you need extended time to work with that population, in addition to the time for documentation and other work responsibilities.

This we found led to staff burnout and staff turnover. The staff and concerns revealed capacity is also been effected as a result of our LIAs having extended staff vacancies. Based on the information gathered, we are contract monitoring the state leadership team reviewed that inherited capacity goals as well as the internal policies and protocols. We found that we were giving inconsistent messages as the same team as it relates to capacity in terms of our contract we have [Indiscernible] but our expectations of them to reach the goal of 85%. And we also had no standardized way of assigning capacity to the LIAs. Therefore, we needed to develop and define capacity that aligns with the federal definition and develop policies and protocols to deploy that.

We worked with the home visiting evidence based model, the Georgia leads who provided [indiscernible] provided the feasibility of the inherited capacity goals using the early Head Start home base model, Helping Families of America, Nurse-Family Partnership and Parents as Teachers. We also received federal assistance from our project officer who supported our efforts and approved technical [Indiscernible] from the education development center home visiting [Indiscernible] improvement action team.

The HV impact representative provided our team with information on what other sites around the country would join as well as providing guidance and support throughout the process. As a result, we received approval from our project officer to implement the following protocols.

Our capacity goal for each LIA based on the number of home visitors that they have is 85%. Our Parents as Teachers model required that those part-time staff serve 20 families -- excuse me. Part-time staff would serve 10 families and full-time staff would serve 20 families. We had no changes in our Nurse Family Partnership or the Early Head Start - Home-based Option Model.

Healthy Families America for part-time staff would be responsible for seven families and the full-time

staff would be responsible for 18 families. our LIAs will have five months from the staff vacancy to hire, train and to build a caseload for the new home visitors.

The Georgia Department of Public Health will implement an incentive program to acknowledge and reward and recognize those LIAs that are meeting the 85% requirement for at least 9 years.

Next steps. We plan to develop incentive program, we are planning to update all of our contracts and monitoring teams to reflect the new policies and we want to officially inform our sites. We have informed our sites officially of the new change which is projected to start -- I am sorry, October 1st, 2019.

If you have any questions, you can please put them in the chat box. At this time, I will turn it over to my colleague, Carla, for her to proceed.

>> Good afternoon, everybody. Thanks for being on the call and hanging in with us. These great questions are come up and I appreciate that. I just wanted to catch you up a little bit about Tennessee and what we are doing here. We had evidence-based home visits programs currently in 57 of our countries. We used three models. Healthy Families America, Nurse-Family Partnership and Parents as Teachers with primarily Healthy Families America being the -- they're 95% of the programs across their state. We are looking at some potential funding that will increase us by 17 additional counties. And at that point, we will only be 20 counties out from being able to cover the state with home visiting.

So we have a lot of opportunities to see what we're doing and try to figure out how we can do things better. We used the multi-staged CQI project. You know, we can either guess it or we can try to get the data to make good decisions. So we worked on a variety of ways of gathering information. I'll kind of flip through that with you because of time. But we looked at the reasons for Program Exit as decided by the participant. And you can see there that the largest percentage there is that loss of contact, we couldn't locate, moved out of state. Though we did have a great number of families who successfully completed the program. So that gave us the beginning of data to start to look at our CQI work.

The second thing we did is really look at a cause and effect diagram for retention. So why did families exit the program then before graduation, trying to come up with all the pieces of cause and effect and how that happens. And finally, each of our agencies, we work together in a consensus workshop kind of fashion. And we are very fortunate that we have an epidemiologist here who focuses entirely on CQI. And agencies chose various projects. They looked at things like incentives. Looked at their enrollment criteria. You can see all the kinds of things that they looked at. You know, did a lot of work for a year. We did quote a lot of follow-up on that.

As a result of great work, I wished I could say that everybody was super successful and every one of those projects just rocked it. But that didn't actually happen. Some were very successful, others could not see any change in the work that was done. But on this next slide, if you look, we see that we had great improvement. We went from 9.6 months to 12.6 months today. And that happened irregardless of whether those projects were successful or failures. Some of our projects -- some of their sites bring up everybody's average. But we started to understand that everybody didn't think of CQI in the same way.

So we decided to go back to the drawing board and think about it from a different perspective. Why are we not achieving these goals performance standards and why are we not seeing improvement in their performance outcomes. And the first thing we realize is not only did our LIAs and our partners and other evidence-based home visiting programs that are not MIECHV funded in the state, we all it differently.

So we began a process in which an epidemiologist is working on kind of continuum improvement universe. She is working with us here in our central office to look at how we do business looking at sustainability and alignment. Central office and our EBHV providers are starting now to think about it and begin this process to work together to design what CQI is to understand it, to look at our processes, see how we build on them and how that we can make a system that contributes to the productivity.

The second piece that's made it difficult and you may be -- have experienced the same thing is we need it to be stabilized regardless who our players are. At our central office, I'm the third MIECHV

director in the past six years. Our office staff had some turnover. And every time a new player came on board, there wasn't a process out there that helped direct us. We are really working in consistency with how we do this work and how we play this game.

The biggest thing that's making a difference for us that is kind of a pivot piece for making a CQI plan and asking each one of our LIAs to have a champion. And that champion will then come together and work for the next -- I believe it's 12 to 14 months with us. And instead of you dividing a project for your particular LIA, they are going to work together in project teams on areas that they feel they should focus on. So we may have -- so we will have a mixture of LIAs working together. The second piece of that is that we realize as part of our CQI that we need more parent voices and have started to work on some parent focus groups. And out of that have looked at parents who have a very active voice now and have a more active voice as time goes on.

So we're bringing in parent voices and a parent advisory council for us. So those kinds of things have been the biggest pieces of what we do.

The last thing that's happening that just fits in nicely for, is we have a new process here that being the Department of Health with all 95 counties, we have a new initiative called Chant which brings together all -- we use referral sources from our birth files. So for every baby that's born, they are looked at using the parameters not only of MIECHV but some infant mortality algorithms and we look at their level of risk. So the families who are high, medium risk get a phone call from our call center offering them services through the Department of Health Chant program to meet the needs that their family identifies.

They are also -- those families with newborns who are eligible for evidence-based home visiting service based on our criteria, are then given to the corresponding EBHV program in that country and they contact this new family and offer support services. So we are already seeing justice rolled out into EBHV programs. We are already seeing an increase in the number of referrals that we're able to reach families within that second week of birth and offer them services. That gets right in with their CQI performance plan on how do we retain, how do we keep it going and what's the work we need to do.

So beginning now, we are looking to the next 18 months where we can give you a report at that point in time on how we have done with their continual improvement university and the projects that we have entertained. Any questions?

>> Okay, thank you so much.

>> Type them in the box and I will be glad to try and answer.

>> Please do enter any questions for our presenters. At the same time, we are going to bring up our CQI poll. We have just a couple short questions for you and then our final slide will be after that. So, Kate and April, could you please bring up the questions?

So we would like to ask if you will take an action step based on this webinar, yes or no? And if you will be taking an action step, if you could briefly describe what that would be. Or if you are not going to take an action step, what would have helped you in identifying a future action step? We are constantly looking to improve and make sure that our resources are most useful to MIECHV awardees. So please do take the time to fill in our poll and give us some questions of what you will take from this or what will help you to be able to take things from future webinars.

I'm just going to allow about another 30 seconds to our poll and then we will transfer to our final slide. And after our final slide, you will have an evaluation pop up into your browser. So we would ask you to take just a couple of minutes and fill in the evaluation.

Give you about 20 more seconds on the polling before we move on.

About 10 more seconds.

All right. If you could just leave the polls there, Kate, and advance the slides to the final slide and then I will be able to just kind of wrap up as everyone is still entering information. So I just want to thank you all for attending today. Thank you to our presenters. They did an excellent job of pulling together very succinct, important information and presenting it in about a ten-minute time block.

If you have follow-up questions, please don't hesitate to reach out directly to our presenters. You

can see in the file share pod, when we close this, you will see that the slides from today are already available for your download. And they will also be available on the HRSA website which you can see on this slide.

Our next webinar will be on father engagement. It will be on October 15th. And we will again feature some of our awardees and the excellent process that they are going through to advance father engagement in their own programs.

So finally, I just want to say thank you on behalf of HRSA and HV-ImpACT for attending today and I hope you have a wonderful rest of the day. Please do take a few minutes to fill in the evaluation. Thank you.