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## Testimony in Support of Senate Bill 332

*Brandi Slaughter, Voices for Ohio's Children*

Senate Health and Human Services Committee  
September 27, 2016

Chairwoman Jones, Vice Chair Lehner, Ranking Member Tavares and members of the Senate Health and Human Services Committee, thank you for this opportunity to testify before you today in support of Senate Bill 332. My name is Brandi Slaughter, and I am the CEO of Voices for Ohio's Children.

Voices for Ohio's Children advocates for policies that maximize a child's life chances by ensuring children are safe, healthy, educated, connected and employable. Voices helps ensure that the needs of Ohio's 2.6 million children are prioritized at the local, state and federal levels. In order to accomplish this goal, our organization advocates for sound public policies that help guarantee children are poised for success.

Voices has been a strong and long-standing supporter of legislative efforts to address Ohio's infant mortality crisis. We support Senate Bill 332 and applaud the efforts of Senators Jones and Tavares to make further progress on this issue. As you know, Ohio ranks 45<sup>th</sup> nationally in overall infant mortality, and it's even worse among African American infants. Our state must continue to find creative and common sense ways to guarantee that more children in Ohio see their first birthdays.

This year Voices for Ohio's Children has been convening workgroups to discuss ways that home visiting services for Ohio's families can be improved. Participants included policy staff from the state agencies that have responsibilities that impact Help Me Grow, as well as home visiting providers, community HUB providers and agencies who work directly with home visiting programs. With that said, today I would like to focus my comments on the importance of Senate Bill 332's home visiting components.

During these workgroup discussions we were able to identify areas of agreement on recommendations that were a high priority to be addressed in home visiting. These recommendations can be found in the *Home Visiting Stakeholder and Provider Workgroups Summary Report and Recommendations* released on August 12, 2016 jointly by Voices for Ohio's Children and the Ohio Partnership to Build Stronger Families.

We find many of Senate Bill 332's home visiting components to align with these recommendations:

The bill seeks to provide funding for innovative pilot projects that build on the learnings of traditional home visiting programs, but target the most challenging families to serve. Our workgroup discussions defined the need for:

- *Help Me Grow home visiting to continue to address more than just broad health outcomes of the children and parent/caregiver, but with some specific priority to address infant mortality and conditions such as asthma that are major causes of hospital readmissions; and*
- *Home visiting programs to be client and family-centered. This means that home visits happen when and where families want them, and the focus of the home visits are on what families identify as their most immediate needs.*

Innovative pilot projects would provide home visiting programs with an avenue to address these specific challenges.

The bill would require the Ohio Department of Health (ODH) to specify that families in infant mortality hot spots are to receive priority for Help Me Grow home visiting services. Our workgroup discussions defined the need for:

- *HMG home visiting to be better integrated with other services and programs serving at-risk families in the community; and*
- *Home visiting programs to reach and enroll families earlier, preferably prenatally, if we want to have the most impact on reducing infant mortality.*

Evidence shows that home visiting programs serve as a tool to reducing infant mortality in our state.

The bill would require ODH, through competitive process, to select one or more persons or government entities to create and administer a central intake and referral system for all home visiting programs operating in Ohio. Voices determined during our workgroup process that all the programs and services in a community that provide some type of home visiting need to be part of the system for outreach and referral. To do this, Central Coordination needs:

- *Clear expectations on what must be achieved, how it will be measured, and how the Central Coordination provider will be held accountable to funders, home visiting service providers, and families;*
- *A built-in screening and assessment function that allows families to be linked with the most appropriate program and services for their needs;*
- *An intake process that is based upon assessing of risks, and development of a specific plan to address those risks;*
- *Access to shared data systems within their communities, so families can really be linked with the most appropriate alternatives to meet their needs; and*
- *Adequate funding to meet these additional expectations. Although it might initially increase some costs, a truly comprehensive centralized intake system is a way to successfully leverage within a community all the funding being put into home visiting.*

Central coordination needs to add value to the intake process, and not create barriers to getting families enrolled and engaged in the services.

The bill would also require ODH to transition paying for home visiting services based on outcomes rather than process. While this proposal did not make it directly into the workgroup's final recommendations, conversations reflected the concern that home visiting programs should be outcome driven rather than being rigidly focused on curriculum driven approaches.

Voices is supportive of the types of changes to home visiting programs reflected in Senate Bill 332. We know that home visiting programs increase healthy pregnancies, improve parenting confidence and competence and improve child health, development and readiness—all direct tools to ensuring more Ohio children see their first birthdays.

Thank you for this opportunity to testify on Senate Bill 332. I would be happy to answer questions from members of the committee at any time.



# HOME VISITING STAKEHOLDER AND PROVIDER WORKGROUPS

## Summary Report and Recommendations

August 12, 2016

safe

healthy

educated

connected

employable

## HOME VISITING STAKEHOLDER AND PROVIDER WORKGROUPS

### Summary Report and Recommendations

Over the past few months, two workgroups have been discussing ways that home visiting services to Ohio's families can be improved. More specifically, their discussion has focused primarily upon the state's Help Me Grow (HMG) home visiting and the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) programs. The work was initiated and supported by the Ohio Partnership to Build Stronger Families, and Voices for Ohio's Children.

The Home Visiting Stakeholder Core Workgroup consisted of policy staff from the state agencies that have responsibilities that impact on Help Me Grow or MIECHV, which included Medicaid, Health, and Developmental Disabilities. It also included representatives from other state level organizations with involvement in home visiting programs. A listing is attached of Core Workgroup members who participated in one or more of the Workgroup meetings.

The Home Visiting Provider Workgroup consisted of home visiting providers, community HUB providers, and agencies who work directly with home visiting programs. There was geographic representation from major urban areas, and from a program that includes many smaller communities. A listing is attached of Provider Workgroup members who participated in one or more of the Workgroup meetings.

The two workgroups met from January through July. Core Workgroup meetings were 2 hours long, and Provider Workgroup meetings were 2.5 hours long. The workgroups met on an alternating schedule, which allowed each workgroup to review and discuss issues being raised in the other workgroup.

January 11	Core Workgroup meeting
January 28	Provider Workgroup meeting
May 13	Core Workgroup meeting
May 24	Provider Workgroup meeting
June 27	Core Workgroup meeting
July 7	Provider Workgroup meeting
July 26	Core Workgroup meeting

## **MEDICAID AND HOME VISITING LEARNING NETWORK**

Ohio has been an active participant in the Medicaid and Home Visiting Learning Network, which is a forum for state peer-to-peer learning about how to use Medicaid to finance home visiting services for mothers and young children. The Learning Network is engaging and supporting teams of leaders from 11 states via monthly online meetings to share ideas and strategies. Each state had a Learning Network team that included senior staff from the Medicaid agency, the MIECHV agency (Dept. of Health), and an advocate agency (Ohio Partnership to Build Stronger Families, with Voices for Ohio's Children as lead). The online meetings were organized by Kay Johnson, and funded as a legacy project of the Pew Charitable Trust Home Visiting Campaign.

While participation in the Network did not require any state workgroups to convene outside of the monthly calls, state agency leadership and the Ohio Partnership to Build Stronger Families and Voices for Ohio's Children believed that a more active and informed engagement in the Learning Network would be helpful. So, the Home Visiting Stakeholder Core Workgroup, and the Home Visiting Provider Workgroup, were organized to provide input to the Ohio team that has been part of the Medicaid and Home Visiting Learning Network. The two workgroups looked at the barriers to success and opportunities for change within the HMG home visiting program, and included participants who were also part of the state team for the Learning Network.

To keep the two workgroups informed of what was being discussed and learned in the Learning Network meetings, Voices for Ohio's Children forwarded to all the workgroup participants the eNewsletters that Kay Johnson sent out to the state teams in the Learning Network. These eNewsletters summarized what had been covered in the monthly online meeting, identified upcoming topics, and provided links to source documents on the topics covered in the monthly online meeting. The eNewsletters also included links to the slides used in the Learning Network topical presentations.

## **AREAS OF AGREEMENT BETWEEN THE TWO WORKGROUPS**

The Core Workgroup and the Provider Workgroup identified seven areas where they had agreement on recommendations that were a high priority to be addressed in home visiting. Not everyone on either of the two Workgroups was in full agreement with the final wording of each recommendation, but recommendations were not included unless there was a general agreement from all the members who participated on each Workgroup.

In some cases, participants in a Workgroup might have had agreement on the importance of an issue to be addressed in home visiting, but it is not included in the Areas of Agreement because it was either not discussed or not agreed to by participants on the other Workgroup. The Summary Discussion section for each Workgroup contains a fuller explanation of what each

Workgroup felt was important and provides additional detail on what the participants in the discussion felt should be taken into consideration in any efforts to address the issue.

This list of Areas of Agreement simply reflects where there were some areas of agreement on the issues that were discussed in both of the Workgroups. (Items are not prioritized in any specific order.)

1. HMG home visiting needs to be better integrated with other services and programs serving at-risk families in the community, including with Medicaid managed care plans. Operational definitions are needed for “at-risk”.
2. Home visiting programs need to reach and enroll families earlier, preferably prenatally, if we want to have the most impact on reducing infant mortality.
3. Home visiting programs need to be client and family-centered. This means that home visits happen when and where families want them, and the focus of the home visits are on what families identify as their most immediate needs. This means that family circumstances and preferences could allow for home visits to be conducted outside the home, or in multiple locations.
4. Early Track is not working, and must be fixed or a new system needs to be purchased/built. It should be designed specifically for home visiting, with the built-in capability to link and exchange data with other state systems for the purpose of managing family engagement and progress.
5. Providers need help with getting referrals to home visiting, and creating a clear understanding in the community of the circumstances under which home visiting can be helpful.
6. The reimbursement formula has some problems that need to be corrected, and are known to ODH. It was also noted that there is a need to develop approaches to access multiple sources of funding for various components of home visiting.
7. HMG home visiting needs to continue to address more than just broad health outcomes of the child and parent/caregiver, but with some specific priority to addressing infant mortality and conditions such as asthma that are major causes of hospital readmissions.

## SUMMARY DISCUSSION FROM CORE WORKGROUP

The Home Visiting Stakeholder Core Workgroup met four times, January—July. Except for the first meeting, which was primarily presentations on home visiting and how the current HMG and MIECHV programs operate, the Core Workgroup focused its discussions in two areas: 1) feedback to the Provider Workgroup, and; 2) defining their expectations for home visiting. Meeting summaries were prepared for each Workgroup meeting, and shared with the other Workgroup to consider at their next Workgroup meeting.

In response to the broad issues identified and discussed in the Provider Workgroup, the Core Workgroup made the following observations. Some of these observations are also reflected in the Areas of Agreement between the two Workgroups.

### A. Child Find and Referral

It was agreed that providers are generally struggling with getting referrals and enrolling families in HMG home visiting and, in fact, some counties are still only at 30% of their capacity for enrollment. The Core Workgroup also agreed that prenatal and early enrollment is important to ultimate success, and plans to reflect that priority in a new logic model for home visiting programs. The logic model and any related rules will also put more focus upon an expectation that families should receive a risk assessment, and they should get the program and services they most need and that they prioritize as needed. The State also intends to address this problem through looking at ways to better use other programs as a referral source to home visiting. For example, they are considering how to require that applications for related programs such as WIC, Cribs for Kids, and the car seats program (Ohio Buckles Kids) would also trigger a referral to HMG.

It was also agreed that central intake contractors need to consider the nontraditional referral sources identified by the Provider Workgroup, as well as consider ways to engage faith-based organizations in the referral process. There was some discussion on the importance of “closing the loop” on referrals, and how important it is to let the referral sources know when the referral is resulting in an enrollment in HMG home visiting or some other program to address the person’s needs.

It was noted that state agencies have been hearing from providers that there is a need for the state to develop outreach and enrollment materials, including public service announcements for local use in Child Find. This has become increasingly important to consider due to the transition of Early Intervention to the Department of Developmental Disabilities. The transition has created confusion in the field regarding what is still part of Help Me Grow, and what is not. A communication strategy is needed, it needs to be intentional, and it needs to be developed in

partnership with local communities since some of them have invested very heavily in the HMG branding.

There was discussion on the idea of regionalization as a strategy to improve child find and enrollment, and the strong recommendation from the Provider Workgroup that any plan for regionalization be voluntary and supported by financial adjustments to reflect any incremental costs. It was noted in the discussion that the state is considering various approaches to central intake, including regionalization approaches. The state is open to various ways to do it, and recognizes that even considering regionalization causes anxiety in the field. The planning document developed by a HMG task force several years ago is being used as a source document as various approaches to deal with improved Child Find and referral are being considered, and regionalization is just one of the strategies.

## B. Outcomes and Data

In the discussions on Provider Workgroup recommendations related to outcomes and data, it was noted that the state agencies are currently working on specific strategies to more closely align HMG outcome measures with the HEDIS measures used by Medicaid managed care plans. They also agreed that strategies and approaches are needed to facilitate the timely communication and sharing of services information between home visiting providers and Medicaid managed care plans. There was agreement that the Early Track system is not working well, and that it does not support data exchanges with other providers for the family, or allow providers to get their own performance metrics out of the system. It was noted that Early Track is inadequate as a reporting system, and is also inadequate as a billing system. There is recognition that a replacement system will take time, and the state is looking at prioritizing work on short-term fixes to make the system more responsive to current needs. The intent, however, is to start work on developing a new data system from the ground up, specific to home visiting, and that shares data with Medicaid and other partners. There is work underway to align the outcome measurements and create report cards on those outcome measures.

There was discussion on the concern that the Provider Workgroup raised about the need for some clarity and stability to program goals and targeted outcomes, and to the concern that current HMG rules may have requirements that are inconsistent with requirements of the evidence-based home visiting model that a provider is implementing. It was noted in the discussion that program goals and targeted outcomes sometimes change due to changing federal requirements (unavoidable), but also may need to change if what we are doing does not work.

There was general agreement on a basic principle that if something is not working, we do not want to continue it. A basic principle of Medicaid has been to measure, define, and defend. Home visiting should take the same approach and be willing to change what they measure and what defines success.

There was discussion on program rules in general, and it was noted that the state agencies would all like to make rules simpler and less detailed. Medicaid has been doing this by removing “process” language from rules, and using the provider agreements rather than rules whenever appropriate. For HMG rules, it was noted that the current complexity and level of detail was in part due to a push from providers and advocates to include that level of detail in rule. It was also an expectation of legislators. So, rule simplification is desirable but there may be limitations on how much simplification can be accomplished when they are revised.

### C. Reimbursement and Financing

The Core Workgroup discussed reimbursement issues in general terms, and confirmed that ODH is working on adjustments to the rates and reimbursement policy to reflect concerns they have been discussing with providers. It was also noted that adjusting the reimbursement policies and rates does not necessarily mean that rates will rise to the levels that providers would all like to receive. It was also noted that identifying how a payer such as Medicaid would pay for some home visiting services will be dependent upon reaching some understanding and agreement on what is to be paid for and how it will be measured.

## **CORE WORKGROUP PERSPECTIVES ON EXPECTATIONS FOR HOME VISITING**

There was general agreement expressed that HMG home visiting is a comprehensive program that appropriately addresses a number of outcomes that go beyond health of the child and mother. Different payers will be interested in different sets of these outcomes. Medicaid may be interested in those that address prenatal and postnatal care, for example, while Education may be interested in those address school readiness for the child. Each potential payer has measures of success that are important to them, and HMG needs to align its measures to show how it can move the measures of the payers. One implication of this way to look at the program is that HMG home visiting should consider how it can bundle services into units that address the measures important to each potential payer, and that could then be billed to that payer. There could, for example, be an infant mortality bundle (Medicaid), a school readiness bundle (Education), a Mental Health bundle, etc. It was noted that payers could include private payers, and not just public payers.

There was conversation about the importance of creating a real system of connected services available to families, and not continue to see HMG home visiting as a stand-alone program that is not coordinating with other programs. The focus needs to be on the family, and what the caregiver(s) need. One size does not fit all, and moms/fathers need to be able to prioritize what services they get from home visiting. A risk assessment may say that they need help in one area, but they should be getting that help when they are ready for it and not on some schedule defined by the home visitor. Some examples given on ways that HMG home visiting could be

better integrated with other programs and services available in the community included partnering with Centering Programs, and use of birthing hospital staff to provide continuity for initial home visits. There needs to be a real continuum of services in the community so we are providing what is truly needed and desired by the family, and not simply providing the full scope of what the home visiting program offers.

There was agreement that the focus should be on how the program could work, how we could do better, and ways to be more effective—especially in coordination with other agencies and programs that are showing better outcomes.

It was noted in the discussion that home visiting is a voluntary, non-crisis program. This creates a problem because we know that those who are most in need of a service, and recognize that need, are the ones most likely to show good outcomes. There was discussion about the difficulty in getting a mother to see the value in a 3-year program when what she may really be concerned about is the pregnancy and birth. This contributes to the problem we have in keeping families actively participating for the full length of the program. The discussion pointed to a need to create perceived value for home visiting, and to target it to those who are most in need of specific services. An area suggested to explore is in reducing stress. It was also suggested that home visiting needs to help reduce pre-term births, address racial disparities, and provide a very personalized plan for each participating family. It was noted in the discussion that we have already identified 9 communities, based on outcomes data, where we have high concentrations of families who might be very motivated to participate in a home visiting program that included this value-added emphasis on health outcomes. A strategy should be to develop content and staff training and test it out in 1-2 communities that are part of the 9 communities already identified. A general timeline was discussed, which called for developing the content and training by the end of the year, pilot testing it in at least one community starting in January, 2017, and developing a plan to fund it through the Medicaid managed care plans by July, 2017.

## **SUMMARY DISCUSSION FROM PROVIDER WORKGROUP MEETINGS**

The Provider Workgroup met 3 times from January—June. At the initial meeting, they discussed the current state of affairs in home visiting, and were asked what was working or not working related to the home visiting models, eligibility, central coordination, service duration, consumer and program outcomes and data. Based on that discussion, a list was developed of barriers to successful operation of home visiting programs, and a list of changes needed. Those lists became the focus of more in-depth discussions at subsequent meetings of the Provider Workgroup, and also at the Core Workgroup.

The Provider Workgroup identified several broad issues that were most important from the Provider perspective:

- Child Find and referral, including importance of getting prenatal referrals
- Outcomes, including relationship to HEDIS measures, home visiting contributions to reducing infant mortality, and Early Track reporting
- Overall adequacy of provider reimbursement, and financing options

#### A. Child Find and Referral

The Provider Workgroup noted that there is still not a lot of community awareness that HMG home visiting even exists. This is true in some smaller counties, as well as in some larger counties. Some counties have invested in public awareness strategies and materials, but others have not. At this point, nothing tangible has come from the State for counties to use in creating better community awareness.

Getting referrals to home visiting prior to birth of the child is very important, but also infinitely complex. Community-based leadership is needed to make it work. It is not clear what would work in small, rural communities. Community partnerships are the real key to getting referrals. There was a feeling that small counties are staffed so poorly that it would be very difficult for them to do the work needed to build and sustain effective prenatal referral networks.

There was a specific discussion about Central Coordination for Help Me Grow, and what it needs to look like. The overall theme of the discussion was that Central Coordination needs to work beyond just HMG. We need to integrate all existing “entry points” that high risk families might use—not just ODH or other state-funded home visiting programs—and eliminate the silos as we integrate identification and referral across all ODH, Medicaid, and eventually Social and Behavioral Health programming. Outreach in a community also needs to be very broad, and not focused on just the HMG program.

All the programs and services in a community that provide some type of home visiting need to be part of the system for outreach and referral. To do this, Central Coordination needs:

- Clear expectations on what must be achieved, how it will be measured, and how the Central Coordination provider will be held accountable to funders, home visiting service providers, and families.
- A built-in screening and assessment function that allows families to be linked with the most appropriate program and services for their needs.

- An intake process that is based upon assessing of risks, and development of a specific plan to address those risks.
- Access to shared data systems within their communities, so families can really be linked with the most appropriate alternatives to meet their needs.
- Adequate funding to meet these additional expectations. Although it might initially increase some costs, a truly comprehensive centralized intake system is a way to successfully leverage within a community all the funding being put into home visiting.

The Workgroup noted a caution, however, in how well Central Coordination agencies understand the unique programs and services to which they refer families. Knowing which of the available home visiting programs will be the “best fit” for a particular family may be especially challenging due to the way the Central Coordination agencies are currently operating and staffed.

Central coordination needs to add value to the intake process, and not create barriers to getting families enrolled and engaged in the services, and the Provider Workgroup had some discussion on ways that the current process creates barriers. If families are identified by a provider, it still requires additional in-person contacts from Central Coordination to get them enrolled. Especially for families in the child welfare system, any delay in enrollment creates a large probability that the mother/caregiver will change her mind and not follow-through on the enrollment. There should be no wrong door for applying and getting directly enrolled in HMG home visiting or in any other home visiting type of program in the community.

It was also discussed that there needs to be some consistency in how we define the roles for community health workers (CHW) and home visitors. Home visiting programs are using CHWs, nurses, and social workers in a variety of ways that make overall clarification a challenge. In some communities, certified CHWs are also meeting the HMG home visitor requirements but that is not how it works in most communities. Medicaid funding for CHWs appears to focus on reducing infant mortality, which suggests a very limited role for HMG home visiting since infant mortality reduction programming extends only through the first year of life. For example, if the child is enrolled in OIMRI, services can be provided only until age 1 and at that point the child is past the age for enrollment in HMG home visiting.

It was also noted that if you base HMG home visiting upon a logic model that requires an upfront assessment of risk factors, you will find that 2<sup>nd</sup> or 3<sup>rd</sup> time mothers, who may have greater challenges and complexities in their daily lives than 1<sup>st</sup> time mothers, also have high risk factors and are currently not often eligible under current eligibility rules. Providers need a broader set of risk factors for getting families into home visiting services; poverty is a good risk factor, but

not sufficient. The Provider Workgroup would like to see changes to HMG home visiting that reflect a clear and consistent logic model (goals—risk factors—outcomes).

The silos of identification and referral follow the funding streams. There are examples in places like Cleveland, Toledo, Richland County, etc. where existing identification and referral systems are being linked together to improve the appropriate connection of the mother or child to the necessary services. Assuring this component not only improves care for the mother, child and family, it also eliminates wasteful and unnecessary duplication of service. When mothers and children receive community based care coordination they should land in programming that has the following characteristics:

- Evidence based with fidelity to the evidence based model supported by HMG and other care coordination funders.
- As a central function, includes - The comprehensive identification of risk factors (health, social and behavioral health).
- As a central function, includes - The confirmation, documentation and accountability to demonstrate that risk factors identified are addressed.
- The programming is accountable for documenting outcomes and has strategies to document cost savings. Cost savings documentation can occur in single programs or across groups of programs.

It was noted that we have counties in Ohio where there are particularly challenging problems due to existence of a strong “silo approach” to outreach and referral. There are counties where there is a clear lack of coordination between programs. One specific example noted was the lack of coordination between OIMRI and local home visiting programs, who should be part of the transition in services to an OIMRI family. It was suggested that ODH should require cooperation between local programs, but that programs that are funded outside of ODH also need to be part of the system and the continuum. The current requirement for Central Coordination to make referrals first to the local HMG program is inconsistent with providing a continuum of services within the community and also may result in the family not getting the best fit. It was also noted that managed care plans are already paying for addressing social determinants. It is the local community health workers and home visitors who know where to start, where to find the services in the community. Despite some successes, we don’t have a comprehensive and required approach to assure that public health supported home visiting and managed care work together successfully, and that’s what is needed.

It was noted that it would be helpful if ODH provided additional clarity and detail on the expectations that contractors will be held to for central intake, which might lead to further

development of creative and flexible approaches to central intake. ODH could also support more success in prenatal enrollments by giving home visiting providers real-time feedback on how all the home visiting providers are doing in the community on prenatal admissions to HMG home visiting. There was discussion of the need to consider more actively engaging some of the nontraditional sources for community referrals, such as Metropolitan Housing Authorities, Settlement Houses, and the Medicaid managed care plans.

There was some clarifying discussion on the topic of regionalizing the central coordination function, amending the points discussed in the May meeting. The additional point to make is that any regionalization approach will work best if it is voluntary, but that expectations for Central Coordination need to apply equally to all counties whether part of a regional structure or not.

The Provider Workgroup noted that the kind of dialogue we have been having through the Workgroup is important and needs to be continued. It is a good venue for finding out what is working in other programs, and how to make your own program work better. It could serve as a sounding board for state agency plans on new ways to further improve the program. The Workgroup felt it important to note, however, that it should be organized around focused discussion topics—perhaps just one or two for a meeting, and perhaps even including a draft proposal related to the topic under discussion.

## B. Outcomes and Data

The Workgroup identified a need for consistency in measures for home visiting. There is a need for standardized measures that are clearly defined, and an acknowledgement that they can change over time. What is important is that they be clearly defined and standardized. The Workgroup also noted that it's important to be clear about the *type* of assessment being discussed, and the purpose of the measurement. We might be assessing for eligibility, assessing to determine the most appropriate services and service setting for the individual, or assessing as a performance measurement. The second type of assessment, should be focused upon identification of risk factors and lead to development of a specific plan to address and reduce the impact of those risk factors. Home visiting needs to continue to be addressing risk factors that go beyond typical health risk factors, and include such things as housing, food, and clothing.

Tying outcomes to HEDIS measures makes sense, as an example of an approach to align home visiting outcomes with what payers are using as outcome measures. But, we need to recognize that reducing a significant risk factor for the individual may not necessarily align with a specific HEDIS outcome. HEDIS measures focus on medical risk factors that include only a small percentage of the risk factors that may be present for an individual client.

Early Track is not working well, has not been working well for some time, and providers are not seeing any movement to address the problems in the short term or in the long term. The system is crashing frequently, and data entry is very slow and cumbersome. The basic design for Early Track is not compatible with sharing of information among team members and the medical home for the family. Providers are unable to get basic information out of the Early Track database such as unduplicated number of children currently enrolled with each provider. It is impossible for local providers to “tell the story” about the successes of home visiting when we cannot their own performance data from Early Track. Data need to be available across all home visiting programs in a community, so the full story can be told.

Because Early Track is not complete and lacks general reporting functions, local communities are wasting resources entering information into multiple systems or manually capturing data.

The general feeling was that home visiting providers are working to help identify when families need a medical home, and helping families establish one. However, the Early Track database does not really support this work, so it is mostly providers who are part of hospital-based programs who have the ability for data exchange that is an important part of having a medical home. It was also noted in the discussion that data are not accessible on social determinants.

There was discussion about the HMG home visiting rules, and that they are too complex and too process oriented. There was acknowledgement that there is counter-pressure to have the rules specific so the program cannot be changed easily or quickly. As a general principle, there was agreement that the HMG rules should start with a requirement to implement the selected evidence-based home visiting model to fidelity and avoid adding requirements that could conflict or overlap those required by the selected model.

### C. Reimbursement and Financing

Although the Provider Workgroup had some discussion on reimbursement and financing, the group did not go into much detail. This was due to the expressed acknowledgement in the Provider Workgroup discussions that providers know that ODH is working on unit rate increases. It was stated that ODH has had considerable input from providers on the current problems with the reimbursement rates, that the work needs to be completed and new rates put into effect. Providers have described to ODH areas where the current formula has a number of flaws, including an assumption of unbillable home visitor time that is unrealistically low based on actual experience. In addition, indirect expenses such as in-kind are not reflected in budgets and the true costs of operating the program are therefore not being reported to the State.

The Provider Workgroup had some general discussion on the need for risk-adjusted payment mechanisms. It was noted that this would be a good area of future discussion as part of an

overall consideration of reimbursement levels and financing options. Much of the discussion on financing was related to the need to move to a braided funding approach, and to tie funding more directly to meeting specified outcomes for the child and family. It was noted that provider networks need to be stabilized, and one way to accomplish it is to stabilize funding so that real operating budgets can be developed.

## **NEXT STEPS—OHIO PARTERSHIP AND VOICES PERSPECTIVE**

The Ohio Partnership to Build Stronger Families, and Voices for Ohio's Children, are appreciative of all the time and effort put into the discussions by participants in both of the Workgroups. The participants were insightful, and thoughtful in considering issues they believed needed to be addressed to further strengthen Ohio's home visiting programs. Some themes emerged from the discussions in both Workgroups, and many of those themes are captured in the section on Areas of Agreement.

We are supportive of the types of changes to home visiting that are reflected in the Areas of Agreement, and believe that work is underway that has the potential to address the issues raised. It is our understanding that the logic models for Ohio's home visiting programs are being revised, and expected to be ready for field review and input later in August. It will be shared extensively with home visiting providers and stakeholders during August and early September. Based on conversations at the Core Workgroup meetings, it is expected that to some extent all the Areas of Agreement between the two workgroups will be reflected in the changes proposed for the logic models and/or administrative rules. The Ohio Partnership, and Voices, plan on attending and participating in the regional meetings and providing input that is based upon the ideas developed through the discussions in these Workgroups.

There were a number of problems noted in the Workgroup discussions regarding how outreach and referral works for home visiting, and there were a number of suggestions made on ways that outreach and referral could be improved. The Ohio Partnership for Stronger Families, and Voices for Ohio's Children support the ideas raised in the Workgroups. We also believe that the Ohio Department of Health can strengthen the outreach and referral process for home visiting through changes to its contracting and funding incentives to home visiting providers and central coordination agencies. Contract deliverables and expectations, and funding incentives, should at a minimum be focused upon:

- Ensuring that other state-funded programs serving at risk families in the community are required to make referrals to home visiting when a family need is indicated.
- Referrals should be part of a community-wide system that is linked, and includes processes for determining the specific services needed and desired by the family and getting them referred to the appropriate service.

- Identification and achievement of family and child outcomes that have been based on a comprehensive set of risk assessments that span the domains addressed in the curricula for the evidence based home visiting program being implemented.

We do not anticipate that the logic model changes, or the administrative rule changes, to be proposed by the Department of Health will fully address the issues raised in the Workgroups about the need to develop ways for home visiting to expand its funding base through development and implementation of programmatic approaches to address specific outcomes desired for targeted populations. We believe that work needs to be initiated to develop the content and training, and funding for such programmatic approaches that could be implemented through home visiting. A good place to start would be in developing the content and training for using home visiting as a strategy for addressing infant mortality and conditions such as asthma that are major causes of hospital readmissions among at risk mothers. We also believe that the changes in content can be done, and must be done, within the context of continuing to support the continued implementation of evidence-based home visiting models. This will mean that our home visiting programs will continue to address the full range of family and child outcomes that are reflected in the curricula for those evidence-based programs. It will also mean that we continue to implement approaches to improve the frequency and quality of effective parent/child interactions to help ensure:

- Families are more resilient, better able to handle stress, and more self-sufficient.
- Parents are more capable and confident in raising their children.
- Children are safer, healthier, and on track to grow and learn.

We also support discussion in the Provider Workgroup that called for a possible continuation of the type of information sharing and dialogue that was part of the the Provider Workgroup meetings. It was noted in the Provider Workgroup that the kind of dialogue they had been having through the Workgroup was helpful in finding out what is working in other programs, and how to make their own program work better. It could also serve as a sounding board for state agency plans on new ways to further improve home visiting. The Ohio Partnership for Stronger Families has previously submitted to the Ohio Department of Health our recommendations on the composition for such an advisory group.

## **HOME VISITING STAKEHOLDER CORE GROUP DISCUSSION PARTICIPANTS**

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Jye Breckenridge	Department of Health
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Al Dickerson	Department of Medicaid
Icilda Dickerson	Department of Medicaid
Diane Fox	Department of Developmental Disabilities
Kim Hauck	Department of Developmental Disabilities
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Jessica Hughes	Department of Medicaid
Margaret Hulbert	United Way of Greater Cincinnati
Sandy Oxley	Department of Health
Thomas Scheid	Ohio Partnership to Build Stronger Families
Brandi Slaughter	Voices for Ohio's Children
Patrick Stephan	Department of Medicaid
Yolanda Talley	Department of Medicaid
Angela Weaver	Ohio Association of Health Plans
Jane Whyde	FCFC Association

## HOME VISITING PROVIDER GROUP DISCUSSION PARTICIPANTS

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