Moving Toward a Statewide Home Visiting System—Working Document

Elements	Rationale	Options	Feasibility	Timeframe
Single site of accountability	• Allows centralized decisions based on a view of the whole picture. • Models similar collaborative community structure which state expects to prevent duplication of admin and maximize resources. • Single site of reporting; understanding/addressing needs and gaps in services. • Spearhead quality and improvements to better support families.	• Empower a single state agency (ex: NJ Department of Children and Family Services) with implementing the system and program oversight. • Empower a multi-state agency council, such as the Council on Children and Family Services with both funding authority and decision-making authority (Thrive in Washington State). • Form a distinct cross-agency body with oversight (First Five in California).	• With MOUs between State agencies in place, this could be done in NY under any State agency (OCFS, DOH, SED, OTDA) or council. • NY's Council on Children and Families was created to advise and address these types of cross system interventions; to effectuate change the council would need more explicit authority in addition to MOUs.	• Largely dependent on policy and political will; likely would take at least 18 months to two years. • Would need active State and stakeholder engagement to decide the best location for NY.
Braided or blended State funds	• Blended or braided funding from the State to centralized community collaboratives to support various programs; minimize administrative duplication leaving more money available for serving families.	• Dependent on single site of accountability.	• Would follow above. • Will take time to identify and build community agent; build community trust in the community agent; establish shared decision-making to assure the various models are supported to serve the appropriate families.	• This would take time and likely need to follow a single State site of accountability and oversight.
Uniform Community Central Intake	• Families need a single point of access or no wrong door to access. • Streamlined statewide process with State oversight but with flexibility to make it work for each community.	• Uniform way to access services will make it easier for families, and providers who serve families, to make connections to home visiting and vice versa.	• NJ is developing a central intake process based on demos in two large cities. • Takes a great deal of local collaboration as well as state support and direction. • Other states?	• Depends on whether we pursue a local demo (or more) or try and go statewide under an identified structure.

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Triage to programs	• Many evidence-based models serve different types of families. • Triage process can assess family's needs and make appropriate referral. • Track demographics of families served; demonstrate types of home visiting programs needed. • Scaling-up depends on fidelity.	• Triage can be built into the central intake process.	• Similar to above; need robust community collaboration; shared decision-making tools and strong reliance on sharing community resources.	• Depends on whether we start with isolated demos or go statewide.
Community needs assessment	• Regions submit comprehensive community needs assessments to inform the state as to which home visiting programs are needed and where to meet community need. • Consistent with other State current initiatives.	• Counties: either LDSS or county health departments but need to work together (much like the identification of prevention agenda priorities). • Leverage statewide MIECH V grantees already operating under a needs assessment plan. • State fund a new community collaborative.	• Could something that already exists work or do we need something new? • Need child welfare, early learning and family assistance in the discussion.	• Could happen in a more complete way in 12-18 months.
Waiting lists to capture need	• Waiting lists are the only way communities can demonstrate to the state their need and the types of families in need so that the appropriate programs for each community get funded. • To reduce duplication there should be one waiting list that crosses health, child welfare, and early learning community goals and needs for each community.	• Leverage the strengths of central intake through a county agency or MIECH V grantees.	• Difficult without central intake but, like central intake, could start in isolated regions and then grow.	• More feasible in regions with a history of strong community collaboration. May take time in other areas to develop modes of communication.

Other Statewide Initiatives to Explore to Expand Access to Connect Families

Focus Area	Rationale	Options	Feasibility	Timeframe
Health: *Universal touch to capture families*	• Ideally Home Visiting touches every new family. • Consider low-touch models that touch every family to minimize stigma and capture families that are slipping through. • Improve breastfeeding rates; assure families are connected to pediatricians early and that initial concerns are addressed quickly. • Identify families that need high-touch or longer-term home visiting referrals and a 'warm' hand-off and gives families a contact they can use in the future if needed.	• Model a program after Durham Connects into managed care where plans are paid as part of their capitation to implement or contract out for a low touch (1-4 visits) model that interfaces with every new family.	• Managed Care plans are dealing with many changes in the health care delivery system right now and may not have the capacity to handle this. However, they are also at risk for many costs that home visiting can improve so there may be an opportunity and this model is not very different than what they are already doing for Health Home and DSRIP.	• Need to explore with plans and providers.
Child Welfare (Broad Definition) Assure every county uses home visiting as part of: 1) Preventive services; 2) Family reunification plans; 3) Post-adoption services; and 4) Court improvement project.	• Given the evidence-based programs that support the well-being of families, embedding and teaching strong parenting and bonding, home visiting should be widely available and offered at different stages when families interface with child welfare.	• Counties should offer home visiting services at every part of intervention and child welfare system. • Counties should track the number and demographics of families served; at what point in the system (preventive; courts, etc.) and cost of serving families and cost; report to the state for the state to decide where and how to improve the use of home visiting.	• Home Visiting is already used by counties but it is difficult to know which counties or know how many families are served. • Counties should be resourced to embed home visiting more consistently which ideally would ultimately feed into a local collaborative as identified as part of state system.	• Counties are strapped for resources but families need support to not go deeper into the child welfare system. • Work is needed to decide how to leverage what already exists and build out; could likely start with regional pilots in one or more of these areas.

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Family Economic Supports	• OTDA is a missing state agency partner in home visiting. Home visiting programs need relationships with economic assistance for families and vice versa. • Agencies that help serve families in need of housing, nutrition, heating and other assistance should be able to know about home visiting.	• Identify a point person at OTDA that we can be cultivated. • In NJ home visiting can count towards work hours under TANF. NY should explore this possibility.	• As with all State agencies there is more work to be done than resources so getting this on their radar may take time. • A specific project such as linking home visiting and TANF work hours would help.	• Feasibility will depend on how meaningful we can make the connection and not just add people.
Health: *Health Homes*	• The State has implemented a robust care coordination system through health homes to serve Medicaid members with two or more chronic conditions. • Many pre-Health Home care management systems converted to health homes but home visiting programs did not because not all of the members they serve may qualify.	• Home visiting programs should consider joining health homes in the areas they serve to get referrals from the health home for people who qualify for both health homes and home visiting. Under this scenario there are two options: 1. The home visiting program becomes the health home care manager 2. When funding allows layer home visiting on top of the HH services 3. Explore a state HH pilot that includes home visiting	• Short-term home visiting programs with capacity should partner and build relationships with HHs and explore possibilities; • Also explore whether home visiting should be layered into HH services as part of the HH or in addition to HHs? • Which is better for families and connections?	• Short term: Connections and relationships, and easy referral outside Medicaid billing for home visiting; • Longer term: build more formal or funded connections; • Home Visiting programs that want could positon themselves to be the HH care coordinator.

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Education *Assure children are ready to learn*	• As NY expands access to UPK we need to leverage the ability home visiting programs have to help children enter Pre-K as ready as possible.	• Working with school districts, Pre-K programs and child care assuring early referrals and connections are made in the education community as needed. • In addition better connecting home visiting programs to education settings will also help education partners to better connect to other home visiting partners including health and child welfare.	• This may take time to build connections and relationships but quite feasible. • Education partners should be included in home visiting collaborations at the local level; relationships and connections may be better in some places.	• May be hard to engage education partners who are overwhelmed and preoccupied with other education reform initiatives; • More opportunities may exist in early care/learning settings.