

Request for Proposals

Michigan Home Visiting Initiative Home Visiting Rural Expansion Planning Activities

1. Introduction

The purpose of the Michigan Home Visiting Initiative (MHVI) is to build the home visiting system infrastructure, expand evidence-based home visiting services, and integrate home visiting into the larger Great Start Early Childhood system. The federal Maternal, Infant, and Early Childhood Home Visiting funding (MIECHV) is focused on the highest need communities in the state. However, there is clearly a need to address evidence-based home visitation in rural areas where high risk populations experience poor outcomes. Yet it takes time to identify the needs of a community or region and determine which services would meet the needs of those at highest risk.

In order to start the process of identifying community needs, the Michigan Home Visiting Initiative invites local agencies, working in collaboration within Prosperity Regions 1, 2, and 3, to apply for funding to carry out planning activities that could lead to expansion of evidence-based home visiting models implemented with fidelity.

2. Purpose

The purpose of this Request for Proposals (RFP) is to solicit applications from local agencies, working in collaboration within Prosperity Regions 1, 2 and 3, who are interested in the opportunity to use this planning period to identify and address the necessary infrastructure and community collaborations to prepare regions for receiving funding for evidence-based home visiting (EBHV) implemented with fidelity, in 2015, should funds be available.

Three grants are available, one each for Prosperity Regions 1, 2, and 3 (map in Appendix A).

3. Outcomes

Short-term outcomes include:

- Achieve a common vision through collaborative planning and region-wide partner engagement.
- Use the evidence-base and data to improve the quality of the home visiting system in the region.
- Prepare to expand evidence-based home visiting programs or EBHV based on Exploration results.

As a result of these activities, MHVI will expect the following longer-term outcomes:

- Home visiting resources are used effectively and efficiently at the state and local levels.
- Home visiting programs across the state are of the highest quality.
- Enrolled families experience:
 - Improvements in maternal and newborn health
 - Reduced child injuries, maltreatment and ER visits
 - Improvements in school readiness and achievement
 - Reductions in domestic violence
 - Greater economic self-sufficiency
 - Improved coordination and increased referral for other community resources

4. Grant Activities (activities to be completed by 9/30/14)

REQUIRED

The applicant must include these activities in their application:

- Establishment of a regional home visiting leadership group to guide the work.
Required home visiting leadership work group partners include:
 - At least one representative from Public Health
 - At least one representative from a Substance Abuse Coordinating Agency
 - At least one representative from Head Start/Early Head Start (EHS home based preferred)

- o At least one representative from DHS and/or CAN Council
- Recommended home visiting leadership work group partners include:
 - o Parents of children who are receiving or have received prevention-focused EBHV services
 - o One or more representatives from each county within the region
 - o At least one representative from Community Mental Health
 - o At least one representative from Education
 - o At least one representative from a Great Start Collaborative/Great Start Parent Coalitions
 - o Representatives from existing home visiting programs in the region.
- Plan to complete the MHVI Exploration and Planning Tool (see Appendix B) to explore needs and identify highest risk populations and gaps in services of the region, with a recommendation for the top priority for expanding EBHV, should funding be available.
- Development of a plan to collect and report home visiting data for the PA 291 legislative report on home visiting.

PRIORITY

The applicant must choose two or more of the following activities to include in the application, based on the priorities identified for that region:

- Use the results of the Exploration and Planning Tool to identify opportunities and activities to bring existing EBHV models into fidelity with their model; activities involving training/TA will be coordinated through MDCH with other regions choosing similar approaches, in order to achieve cost efficiencies.
- Use the results of the Exploration and Planning Tool to begin to define a continuum of coordinated prevention-focused home visiting services, which connects to a continuum of early childhood services.
- Use the results of the Exploration and Planning Tool to develop and implement a coordinated outreach plan and materials (across HV models) to reach the highest risk populations in the region as identified in the Tool.
- Support home visitors from the region to participate in the state's annual home visiting conference planned for August 12-14, 2014 in Dearborn, MI.
- Develop and implement a plan to address collaboration with the emerging perinatal system to improve home visitation follow-up upon NICU discharge (if appropriate) and improved care coordination with family centered medical homes and specialty follow-up services including Development Assessment Programs and *Early On*.

NOTE: this funding may not be used to provide direct services.

5. Funding

Grant funding will be distributed to the selected fiduciary in each region via a contract. If the selected fiduciary already has an established contract with MDCH, the funding will be amended into that contract. Funded activities must be completed by September 30, 2014.

Note: When selecting a fiduciary, there is additional information that your community will want to take into consideration:

- *If your chosen fiduciary is a Local Health Department: MDCH has a Comprehensive agreement in place with every local health department. Amendments to these agreements can be made several times each year. The funding for this project would be added to the existing agreement, as a new project, starting March 1, 2014. However, because the overall agreement was already in effect as of October 1, 2013 the new project activities may actually begin as early as January 1, 2014.*
- *If your chosen fiduciary is not a Local Health Department: MDCH is able to establish Standard contracts with non-health department entities. New contracts, or amendments to existing Standard contracts can be initiated at any time. HOWEVER, approximately six (6) weeks are required to process any new contracts or amendments. Therefore, February 1, 2014 is likely to be the earliest start date for the new project activities.*

FUNDING AVAILABLE BY REGION

Prosperity Region 1:	\$75,000
Prosperity Region 2:	\$75,000
Prosperity Region 3:	<u>\$75,000</u>
<i>Total:</i>	<i>\$225,000</i>

6. Eligibility

Applications that do not meet the eligibility criteria will not be considered.

- Applicants must be local agencies with at least part of their service area falling in the Prosperity Region for which they are applying. A map of the Prosperity Regions is attached, in Appendix A.
- Local agencies whose service area crosses into more than one Prosperity Region may participate in more than one proposal.
- Only one grant is available per Prosperity Region; therefore local agencies and partners within a given region are encouraged to collaborate to apply for this funding, and collaborate in the implementation of the activities.
- If more than one application is submitted for a given Prosperity Region, those applications will be considered in competition with each other. One only grant will be awarded per region.

7. Application Components

Given the short timeframe for the application, which is based on our timeframes for amending contracts to distribute funding, the application that is submitted must include the following components:

- One-page summary briefly describing how the region will carry out the required activities and which two or more 'priority' activities have been selected. (single-spaced, in 12pt. font).
- Identification of the fiduciary for the application, that will be responsible for assuring completion of activities, timely submission and monitoring of all funding expenditures and budget requirements during the grant period.
- Written communication agreeing to collaborate in the implementation of this grant by each collaborating partner and/or organization.
- A preliminary, estimated budget to carry out the activities, using the attached budget forms (Appendix C).

Note: a more detailed budget and a detailed work plan must be submitted via the state's eGrAMS system once the grant is awarded. The budget and work plan may be amended as the regional group convenes and engages in more extensive exploration and planning. Amendments may be made in mid-March (effective May 1) or mid-June (effective August 1).

8. Review Criteria

All proposals will be reviewed by Home Visiting Initiative staff along with other MDCH staff and/or Home Visiting Work Group partners from other agencies. Individual critiques of applications will not be provided.

Proposals will be rated based on the following criteria:

- One-page summary is attached, and includes the required and priority activities.
- Identification of the fiduciary for the project is included.
- Budget forms are included.
- Documentation that required partners will be participating.
- The greater the number of counties in the region that are included, the greater the points that will be awarded. Participation of local agencies who agree to be collaborators to this project must be documented via written communication. Such communication must be in writing (a copy of an email will suffice), and must be submitted with the proposal, and must identify the county/counties their agency serves.
- The greater the number of partners (required and recommended) that are included, the greater the points that will be awarded. Partners agreeing to be collaborators to this project must be documented via written communication. Such communication must be in writing (a copy of an email will suffice), and must be submitted with the proposal, and must identify the county/counties their agency serves.

A Scoring Matrix is included in Appendix D.

Note: It is certainly an option to invite additional partners into the project once the grant is awarded, however, we will assess the level of collaboration as a means to measure the strength of the application (# of counties that are covered, # of partners that are participating), which becomes important if there is more than one application submitted per region.

9. Timelines

A conference call will be held to review the RFP on November 26, 2013, from 10:00 – 11:00 a.m. Eastern Standard Time, and answer any questions. An audio recording of the call will be made available for those who cannot participate at the time scheduled.

1-877-336-1829
9471629#

All questions and responses will be posted to the Department's website at: <http://www.michigan.gov/homevisiting>. MDCH and MHVI staff cannot answer any specific questions related to this application through any means other than the November 26 conference call.

November 21, 2013: application released

November 26, 2013 (10:00 - 11:00 a.m.): conference call to review the RFP

December 16, 2013: applications due to MDCH (address listed below)

December 20, 2013: successful applicants notified

February 1, 2014: proposed contract start date for non-Health Department fiduciaries (*see Note in Section 5*)

March 1, 2014: proposed contract start date for local Health Departments fiduciaries (*see Note in Section 5*)

September 30, 2014: contract end date

10. Application submission

Applications are due by 3:00 p.m. Eastern Standard Time on December 16, 2013. Applications may be submitted via email or regular mail to:

Elizabeth Lounds
Unit Secretary
Michigan Department of Community Health
P.O. Box 30195
Lansing, MI 48909
loundse@michigan.gov

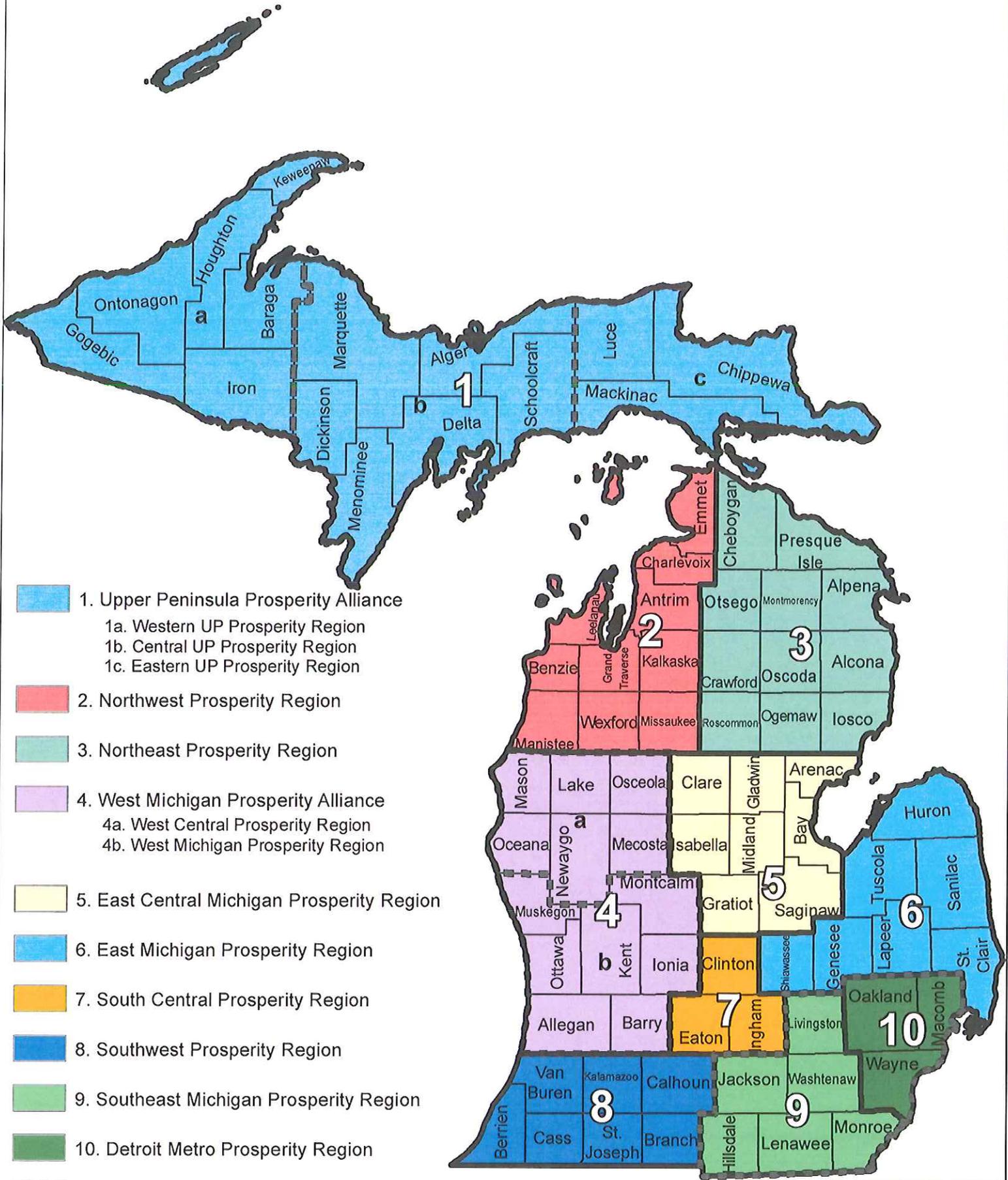
11. Program Direction and Contact Information

The Michigan Department of Community Health, Home-Visiting Initiative will be responsible for project oversight and will contract with selected grantees.

Contact person:

Cynthia Zagar, Program Coordinator
Michigan Home Visiting Initiative
Michigan Department of Community Health
(517) 335-3965
zagarc@michigan.gov.

State of Michigan Prosperity Regions



- 1. Upper Peninsula Prosperity Alliance
 - 1a. Western UP Prosperity Region
 - 1b. Central UP Prosperity Region
 - 1c. Eastern UP Prosperity Region
- 2. Northwest Prosperity Region
- 3. Northeast Prosperity Region
- 4. West Michigan Prosperity Alliance
 - 4a. West Central Prosperity Region
 - 4b. West Michigan Prosperity Region
- 5. East Central Michigan Prosperity Region
- 6. East Michigan Prosperity Region
- 7. South Central Prosperity Region
- 8. Southwest Prosperity Region
- 9. Southeast Michigan Prosperity Region
- 10. Detroit Metro Prosperity Region

Service Delivery Regions

APPENDIX B



Michigan Department of Community Health
Bureau of Family, Maternal and Child Health
Division of Family and Community Health
Child Health Unit

Michigan Home Visiting Initiative
Exploration and Planning Tool

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BACKGROUND INFORMATION

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) (P.L. 111-148). Subtitle L refers specifically to the legislation for Maternal and Child Health Services. Within Section L, Section 511 describes the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program which includes the states' mandate to complete statewide needs assessments in order to identify at-risk communities. The purposes of this section are to: (1) strengthen and improve the programs and activities carried out under Title V, (2) improve coordination of services for at-risk communities and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. From the completed needs assessment states were to use a systematic approach in order to select the most at-risk communities with high concentrations of prenatal, maternal, newborn, or child health concerns, poverty, crime, domestic violence, high school dropout rates, substance abuse, unemployment or child maltreatment. The states were also required to examine the quality and capacity of existing programs or initiatives for early childhood home visitation and the capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

In order to appropriately and most effectively accomplish this mandate the Department of Community Health was chosen as fiduciary for the MIECHV Program and was charged to move forward with this initiative. A previously established Home Visiting Work Group (HVWG) convened by the Child Health Unit within the Division of Family and Community Health undertook the federal directive to complete the required needs assessment and decide which models would most appropriately address the needs identified in the most at-risk communities (See the Great Start website for more details about the process: <http://greatstartforkids.org/node/881>.) Following an analysis conducted by Mathematica Policy Research, the Department of Health and Human Services identified nine models that met the criteria set for an evidence-based early childhood home visiting service delivery model <http://homvee.acf.hhs.gov/Default.aspx>. As noted in the legislation, only programs that would be implementing evidence based models would be considered to receive funding for this project. After gaining an understanding of all of the models being executed in Michigan, and after consideration and examination of the identified evidence based home visiting models by the HVWG, it was decided that Early Head Start, Healthy Families America, Nurse Family Partnership and Parents as Teachers would be the models Michigan would look to establish, re-establish or expand.

Based on the results, taking into consideration the outcome of the completed community risk assessments, ten counties were initially chosen by the HVWG to be recipients of the MIECHV funding for either direct service or, for Parents as Teachers, further examination of fidelity features within the model. They were: Berrien (PAT and NFP), Calhoun (PAT), Genesee (EHS and NFP), Ingham (EHS and NFP), Kalamazoo (PAT), Kent (HFA and NFP), Muskegon (HFA), Saginaw (EHS and NFP), St. Clair (PAT), and Wayne (HFA and NFP).

Currently, The Department of Community Health is pleased to offer additional opportunities for exploring funding of expansion of Nurse Family Partnership, expansion of Early Head Start and start-up or expansion of Healthy Families America models in the high risk communities identified by the community risk assessment and the Governor's initiative on focus cities. This packet is designed to support communities considering applying for these funds. It utilizes Implementation Science <http://nirn.fpg.unc.edu/> to analyze readiness for implementation. The Exploration Phase of Implementation will help communities to look at their readiness for this opportunity, examine community risk and identify the best fit home visiting model as well as help the HVWG make decisions

about awarding these funds. In thinking about the application process, keep in mind that a wide range of stakeholders (Local Leadership Group) should be involved in the process including delegates from early childhood programs and other community services, health and mental health professionals, researchers, funders, advocates, parents, elected officials, and other community leaders.

The Exploration phase of implementation should be conducted without any pre-determined outcomes, but should guide communities in establishing a target community and population as well as choosing the home visiting model that is the best fit for the unique needs of each community and population. The identified gaps and needs MUST guide decision making.

DEFINITIONS

Community: The geographical area being studied for the purpose of identifying the target community/ies with the highest concentration of risk factors. A Community may be an entire county, particular cities, zip codes or other specifically defined criteria.

Evidence Based: To meet DHHS' criteria for an "evidence-based early childhood home visiting service delivery model," program models must meet at least one of the following criteria:

- At least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains
- At least two high- or moderate-quality impact studies of the model using non-overlapping analytic study samples with one or more favorable, statistically significant impacts in the same domain

In both cases, the impacts must either (1) be found in the full sample or (2) if found for subgroups but not for the full sample, be replicated in the same domain in two or more studies using non-overlapping analytic study samples. Additionally, following the legislation, if the program model meets the above criteria based on findings from randomized controlled trial(s) only, then one or more favorable, statistically significant impacts must be sustained for at least one year after program enrollment, and one or more favorable, statistically significant impacts must be reported in a peer-reviewed journal."

Affordable Care Act

Home visiting: A voluntary, face to face service delivery strategy that is carried out in relevant settings, primarily in the homes of families with children ages 0 to 5 years and pregnant women. The visits are conducted by nurses, social workers, and other early childhood and health professionals or trained and supervised non-degreed professionals.

Home visiting curriculum: A tool or tools used to provide information, education and support as required by the home visiting model that supports the home visitor in implementing the model with fidelity. Examples of curricula include but are not limited to: Growing Great Kids, Partners in Parenting Education, Parents as Teachers, and the Florida State University Partners for a Healthy Baby.

Home visiting model: A method of carrying out home visiting for families with young children that follows unique model driven standards, expectations and/or qualitative considerations. When these standards, expectations and/or considerations are met, the model is considered being implemented with fidelity and effective in its intended outcomes. Examples of home visiting models include Early Head Start, Healthy Families America, Nurse Family Partnership and Parents as Teachers. For our purposes they are preventive in nature and do **not** include Part C programs.

Intervention: A service, voluntary or involuntary, designed to influence situations or circumstances that have been identified as concerning including poor maternal and infant health, limited positive parenting practices, infant and child developmental delays, child abuse and neglect, crime, domestic violence, learning issues and poverty.

Model fidelity: “The extent to which an intervention is implemented as intended by its designers. It refers not only to whether or not all the intervention components and activities were actually implemented, but also to whether they were implemented properly.” (Daro, 2010)

PA 291: A Michigan Act to support voluntary home visitation programs; to authorize the promulgation of rules regarding home visitation programs; and to prescribe the powers and duties of certain state departments and agencies.

[http://www.legislature.mi.gov/\(S\(oqeqm1brfg4tj1550ceits55\)\)/mileg.aspx?page=getObject&objectName=mcl-Act-291-of-2012](http://www.legislature.mi.gov/(S(oqeqm1brfg4tj1550ceits55))/mileg.aspx?page=getObject&objectName=mcl-Act-291-of-2012)

Prevention: A voluntary service delivery strategy designed to support maternal and infant health, positive parenting and appropriate infant and child development; prevent child abuse and neglect, crime or domestic violence; and promote early learning and family self sufficiency

Target Community: The area of the community where home visiting services will be offered based on analysis of data and service capacity.

Target Population: The highest risk group identified in the analysis from which enrollment to the program will take place.

Please complete packet in its entirety

Direct any questions to: Cynthia Zagar, L.M.S.W.

Program Coordinator, Michigan Department of Community Health

zagarc@michigan.gov

517-335-3965

CONTACT INFORMATION

Contact Person

Title

Agency/ Organization

Phone Number

E-Mail Address

Address

County

EXPLORATION OF READINESS

NEED

1. What criteria are being used to define the community being studied (county, city, township borders, zip codes, other)?
2. Please use [Appendix A](#) to identify the community's strengths (If you are unable to identify strengths in any of the categories listed below, leave the box blank. Do not include health and human services agencies/ programs/services here; this information will be captured in subsequent items.)
3. The federal home visiting legislation requires a data report for at risk communities. Please complete the matrix in [Appendix B](#) using the most recent data available. Where data are not available, make a narrative statement to that effect. The purpose of the colors is to support you in your decision making about your choice of home visiting model. The color of each risk factor coordinates to the identified needs of the populations and the demonstrated outcomes of each model.

FIT

4. In order to assess organizational structures and current initiatives in existence in your community, please complete [Appendix C](#) to examine the extent to which your group partners with the identified support services.
5. Please use [Appendix D](#) to examine existing home visiting initiatives in your community. Do NOT include Part C home visiting or other intervention models (Families First, Infant Mental Health, etc...).
6. The federal home visiting legislation identifies several required participants for home visiting planning. Do you have a group (Local Leadership Group/ LLG) currently in existence? (ex: Public Health, Substance Abuse, Education, etc...) Yes No
Please identify the entities and include the participants' names.
7. If there is an LLG in existence, please describe the projects that are being worked on together currently or in the recent past.
8. Please indicate the extent to which families, representing the identified service population, are authentically involved as LLG members (families are at the table and heard partners in decision-making), if one exists.
9. Does your LLG have a policy to promote authentic family involvement (including financial support and mentoring)? Yes No
If yes, please attach policy to document.

10. Please describe, and attach, a graphic illustration (i.e. logic model, theory of change, networking model, etc...), showing how you will embed the home visiting program in a high quality early childhood system that promotes maternal, infant and early childhood health, safety and development, and strong relationships (a flow chart of your Great Start Collaborative governance structure is not sufficient).
11. Does a home visiting program network (e.g. a group comprised of the Home Visiting Programs in your geographical area that meets on a regular basis for the purposes of professional development, coordination, etc...) exist in your community? If so, please describe.
12. Please describe the extent to which referrals to home visiting programs are coordinated in your community in order to reduce duplication of services.
13. Please describe the extent to which home visiting programs in your community use common forms (e.g. screening, consent to participate in services, authorization to release information, intake, assessment, etc...).
14. Please describe the extent to which home visiting programs in your county use a common database and its purpose.
15. How many of the home visiting programs in your community have program evaluations, including Quality Assurance (QA) processes in place and operating? Please describe the focus, impact, effectiveness and outcomes of them.
16. How many evaluations involve more than one local home visiting program?
17. Please describe the extent to which home visiting programs in your community have defined shared outcomes and collect data to measure these outcomes across the programs.
18. How do the stakeholders (families and community members) perceive the need for the proposed home visiting services? Include how you came to understand their perceptions.

RESOURCE AVAILABILITY

19. What is the name of the organization(s) that will receive the MIECHV program funds?
20. What human resource support is available for any hiring that would need to be done?
21. Describe the administrative and system supports currently in place at the organization(s).
22. What gaps exist (if any) with those administrative and system supports?
23. What information technology resources are available to the organization(s)?

24. Is a data collection system being used? Yes No
25. If yes, which data system is it and what is its purpose?
26. Describe any gaps that exist (if any) with the current data system being used.
27. What training resources currently exist to support the staff members for your home visiting program?
28. Describe the resources available to receive the necessary coaching and technical assistance to ensure adherence that the model (see definition) is implemented model fidelity.
29. What additional coaching and technical assistance do you anticipate needing for adherence to model fidelity and for state reporting requirements?
30. Identify resources that are needed in the community. Use [Appendix C](#) as a reference.
31. Describe the resources in place that will support the supervision necessary to the staff who will be implementing your home visiting program.

EVIDENCE

32. Based on analysis of [Appendix A](#), how can the strengths of the community be utilized in order to support your home visiting program? Are there any geographical areas of the community that seem to lack access to these strengths?
33. Based on an analysis of [Appendix B](#), are there areas of the community that appear to be the most at-risk? What are they?
34. Based on an analysis of [Appendix B](#), what are the populations most at risk in your community? Include demographic information. Be sure to tie the reviewed data to the at-risk populations identified.
35. Based on analysis of [Appendices A](#) and [B](#) which areas of the community lack the most resources?
36. What will be your identified Target Community (see definition)? Justify your decision using the information gleaned in completion of the Appendices.
37. Based on analysis of [Appendix C](#), what partnerships are priorities to be strengthened? Discuss the plan to address this priority.
38. Based on an analysis of [Appendix D](#), what are the populations and geographical areas currently being served by existing programs in your county? Which populations and geographical areas seem to be lacking services?
39. Based on an analysis of [Appendix D](#), which currently operating models are consistently (90% of the year) at full enrollment?

40. Based on an analysis of the completed appendices looking at community strengths, collaborations and community data, what will your target community be (see definition)? Explain your decision including the link to the findings in the appendices.
41. Are any Michigan approved home visiting models (Early Head Start, Healthy Families America, Nurse Family Partnership) absent from your community? Discuss how adding that model would contribute or not contribute to the establishment of a continuum of services and to the populations lacking services?
42. Based on an analysis of the questions above and the corresponding Appendices, what is the target population (see definition) that has been chosen to be served by your home visiting program? Be sure to tie the reviewed data (including community resources, strengths, gaps and risk) to the target population chosen. Explain your decision.
43. If there are already existing models in your target community that are able to serve the same target population, justify your reason for choosing that population.
44. [Appendix E](#) is for the purpose of matching the target population identified in question 42 to the most appropriate home visiting model based on proven outcomes of the models. For example, if the identified target population has a high rate of child abuse and neglect, the use of Healthy Families America or Nurse Family Partnership would be suitable choices of models.

Use the [Demonstrated Outcomes Reference Table](#) prior to Appendix E to complete the Appendix and justify your choice in models here using rationale that can be found in your work in the Appendix as well as in your answers above. For a stronger response you might also include how you ruled out the evidence based home visiting models you didn't choose.

READINESS FOR REPLICATION

45. Describe the overall operations of the organization(s) (contractor and sub-contractor) that will be receiving the MIECHV program funds including its history with similar programs and how it is qualified to oversee and manage the home visiting program. Include a description of the plan for Quality Assurance or the system currently in place; the employee evaluation policy and procedure(s); and upper management and fund development support available.
46. Identify existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g. centralized intake procedures at the community level). To what extent are you coordinating referrals and intake across home visiting programs?
47. Describe your plan to ensure implementation with fidelity to the model as well as anticipated challenges and how those challenges will be addressed.
48. Knowing that home visiting programs may only enroll 25-50% of those referred, what is the number of families you are hoping to provide service to with your home visiting program? (Do not count families being served with funds from other sources) Explain your decision.

49. How will program participants be identified and recruited?
50. Describe the plan for retaining participants enrolled in the program.
51. What is the estimated timeline to reach maximum caseload?
52. Describe how you will assure that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments while assuring fidelity to the model.
53. Describe how you will assure that services will be provided on a voluntary basis.
54. Describe how you will assure that funds will be used to service the identified at-risk target population.

CAPACITY TO IMPLEMENT

55. Describe what expert and technical assistance resources are already established within the organization(s) receiving the MIECHV funding.
56. Describe community capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level, such as a governance structure or coordinated system of planning.
57. Describe your community's current capacity (e.g. funding, staff, administration, etc...) to increase the number of families using this model.
58. Describe the operational plan for the coordination between the proposed home visiting program and other existing programs and resources in the community, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services.
59. How will the targeted population (see definition) be involved on an ongoing basis throughout the duration of this program (other than as program participants)? Include your implementation plan.
60. What opportunities exist for parents to influence program development and implementation decisions?
61. Please describe the level of community buy-in for home visiting programs.
62. How could buy-in be strengthened and how will you implement the suggestions?
63. What is the potential risk to the organization(s), community and LLG in implementing the home visiting program including the impact of change on the entities and how you will overcome these risks?
64. What sectors in your community lend the strongest support?

65. Based on local needs, gaps, and resources identified earlier, what are the key messages that community members need to hear about home visiting?
66. How can those messages be incorporated into an outreach plan and how will you implement the suggestions?
67. List the names, titles, degrees and experience of current staff whose positions will be funded in any way by these funds.
68. Describe the plan for recruiting, hiring and retaining appropriate staff for all positions. List each position to be filled. Include the plan and time frame for filling any new positions that would be posted as a result of receiving funding and how the hiring process will take into consideration hiring people reflective of the target population. If there is an existing hiring policy and procedure please attach to this document.
69. If subcontracts will be used, describe the plan for recruitment of subcontractor organizations, and the plan for how the subcontractor(s) will recruit, hire and retain staff. Include how the hiring process will take into consideration hiring people reflective of the target population. If there is an existing hiring policy and procedure, please attach to this document.
70. Describe the system for providing high quality, reflective and clinical supervision as indicated by the identified program model or organization(s). If there is an existing supervision policy and procedure please attach to the document.
71. Describe the plan to ensure all staff members are provided the training necessary in order to implement the model with fidelity. If there is an existing training policy and procedure please attach to the document.
72. Describe the system that is in place for ongoing training needs to be identified and addressed. If there is an existing training policy and procedure please attach to the document.
73. Identify which research based home visiting curriculum will be used for implementation of the MIECHV program as well as an explanation of what the rationale is for its use.
74. Is there a training required for staff in order to utilize the curriculum? Yes No
75. If yes, please describe the plan to ensure the required training for the curriculum takes place for all staff members. If there is an existing training policy and procedure please attach to the document.
76. Describe the organizations ability to support the necessary components of the implementation of the MIECHV program.

APPENDIX A

Instructions: The purpose of Appendix A is to look at the overall strengths of a community. Gaining an understanding of what those strengths are and how the project might be able to draw on those strengths can be beneficial to success in implementation. Additionally, in reviewing what the community strengths and assets are allows reflection on what might be considered gaps or needs of the community. Complete Appendix A through collaborative input from the participants in the exploration process.

	Community Strengths/ Assets	Geographical Areas Impacted
1. What is this community proud of?		
2. Faith communities		
3. Neighborhood associations		
4. Cultural/ ethnic associations		
5. Other community organizations		
6. Business investment		
7. Philanthropic investment		
8. Major community events		
9. Other assets/ resources		

Appendix B Data Source Resources

The links below may offer support in completing Appendix B. Please feel free to use other sources as needed.
It is possible that not all data are available for all the areas represented in the appendix table.

Source	Web Link
Bureau of Labor Statistics	http://www.bls.gov/
Center for Educational Performance and Information	http://www.michigan.gov/cepi/0,1607,7-113--3499--,00.html
Kids Count	http://www.milhs.org/kids-count/michigan-2
Michigan Department of Community Health, Statistics and Reports	http://michigan.gov/mdch/0,4612,7-132-2944---,00.html
Michigan Department of Education	http://www.michigan.gov/mde
Michigan State Police Incident Crime Reporting Statistics	http://www.micrstats.state.mi.us/MICR/Home.aspx
U.S. Census Bureau	http://www.census.gov/

APPENDIX B

Instructions: The purpose of Appendix B is 2-fold. First, it is important that communities are able to understand where the risk factors are greatest and the population(s) that are at greatest risk for those factors. The populations served by the MIECHV programs should be those identified through your research as having the highest risk. Additionally, **the conclusion of the work on this Appendix MUST connect to the Home Visiting Model chosen.** The outcomes linked to the risk factors are those that have been identified by the Department of Health and Human Services (<http://homvee.acf.hhs.gov/outcomes.aspx>) and are the areas being evaluated for effectiveness of the home visiting model. The colors on this chart will help you to look at the link between needs and Home Visiting Model effectiveness. **You will use this information to justify your choice in population and geographical area served, and home visiting model.**

RISK FACTORS	COMMUNITY (see definition) WIDE DATA	TOP GEOGRAPHICAL AREAS OF RISK (Include Rates and Data Source)	Concerning Risk Y/N
Premature birth (Tied to Maternal and Child Health Outcome)			
Low-birth wt. infants (Tied to Maternal and Child Health Outcome)			

Infant mortality: Rate per 1000 (Tied to Maternal and Child Health Outcomes)			
Poverty (Tied to Family Self-Sufficiency Outcome)			
Crime: Rate per 1000 [all crime types] (Tied to Crime or Domestic Violence Outcome)			
Domestic violence: Rate per 1000 (Tied to Crime or Domestic Violence Outcome)			
School drop-out rates (Tied to Family Self-Sufficiency Outcome)			
School readiness (Tied to Improvements in School Readiness Achievement Outcome)			
Substance abuse: Binge alcohol use (Potential for ties to multiple Achievement Outcomes)			
Unemployment (Tied to Family Self-Sufficiency Outcome)			
Child maltreatment: Rate per 1000 (Tied to Child Injuries, Child Abuse, Neglect, or Maltreatment & Reduction of ER visits Outcome)			

Proportion of total pop. of American Indians living in community compared to total pop. in county			
Proportion of total pop. of African Americans living in community compared to total pop. in county (Tied to Maternal and Child Health Outcome)			
Other			

APPENDIX B (part 2)

RISK FACTORS	DEMOGRAPHIC RATES- Most Current Year <i>(if available)</i>					SOURCE FOR AT-RISK COMMUNITY DATA
	Race	Age of Mother	Education	Income	Marital Status	
Premature birth: Using calculated gestational age (Tied to Maternal and Child Health Outcome)						
Low-birth weight infants (Tied to Maternal and Child Health Outcome)						
Infant mortality: Rate per 1000 (Tied to Maternal and Child Health Outcomes)						
Poverty (Tied to Family Self-Sufficiency Outcome)						
Crime: Rate per 1000 [all crime types] (Tied to Crime or Domestic Violence Outcome)						
Domestic violence: Rate per 1000 (Tied to Crime or Domestic Violence Outcome)						

School drop-out rates (Tied to Family Self-Sufficiency Outcome)						
School readiness (Tied to Improvements in School Readiness & Achievement Outcome)						
Substance abuse: Binge alcohol use (Potential for ties to multiple Achievement Outcomes)						
Unemployment (Tied to Family Self-Sufficiency Outcome)						
Child maltreatment: Rate per 1000 (Tied to Child Injuries, Child Abuse, Neglect, or Maltreatment & Reduction of ER visits Outcome)						
Proportion of total pop of American Indians living in community compared to total pop in county						
Proportion of total pop of African Americans living in community compared to total pop in county (Tied to Maternal and Child Health Outcome)						
Other						

APPENDIX C¹

Community Service	Describe Collaboration Within the Last Year (if any)	Describe Current Collaboration (if any)
Pre-K		
Child Care Providers/ Resources		
Great Start Collaborative		
Early Head Start/Head Start		
Schools/School Districts		
Early On		
Department of Human Services		
Infant Mental Health Networks		
Family Resource Centers		
Parenting Classes		
Family Literacy Programs		
Community Action Agency		
WIC		

Local Health Department		
Community Health Centers		
Pediatric Practices/Clinics		
Birthing Hospitals		
Transitional Housing		
Food Pantries		
Mental Health/Counseling Services		
Substance Abuse Treatment		
Domestic Violence Shelters/Services		
Faith-Based Services		
Funding Entities (United Way, local foundations)		
Advocacy Groups		
Other		

¹ Adapted from the Zero to Three Home Visiting Community Planning Tool; 2011

APPENDIX D²

The purpose of this appendix is to gain an understanding of the status of **prevention focused home visiting (see definition) models** in the community. It is important to examine the factors below to assess gaps that may exist in order to better identify a model that would fill those gaps. Do NOT include Part C home visiting or other intervention models (Families First, Infant Mental Health, etc...).

Program Model	Early Head Start	Healthy Families America	Healthy Start (Federal Program)	Maternal and Infant Home Visiting (MIHP)	Nurse Family Partnership	Parents As Teachers	Other Prevention Home Visiting Models
Service Population	Prenatal to age 3	Prenatal to age 5	Prenatal to age 2	Prenatal to age 1	Prenatal to age 2	Prenatal to age 5	See table D continued below
Age Admission Criteria	Prenatal to 30 months	Prenatal to 3 months	Prenatal	Prenatal to 9 months	First time moms Prenatal to 27 weeks gestation	Prenatal to 30 months	See table D continued below
Income Restriction	Yes	No	No	Medicaid Eligible	Medicaid Eligible	No	See table D continued below
Number of families or children that each model serves in the community							See table D continued below
Cumulative Program Capacity							See table D continued below
Demographics							

of Service Population							See table D continued below
Is program at full enrollment at least 90% of the year? If not, please provide an explanation.							See table D continued below
Geographical Area Served							See table D continued below

APPENDIX D continued

Program Model	Other Prevention Home Visiting Models				
Model Name					
Service Population					
Admission Criteria					
Income Restriction					
Number of Families or Children that					

Each Model Serves in the Community					
Cumulative Program Capacity					
Demographics of Service Population					
Is program at full enrollment at least 90% of the year? If not, please provide an explanation.					
Geographical Area Served					

¹ Adapted from the Zero to Three Home Visiting Community Planning Tool; 2011

DEMONSTRATED OUTCOMES REFERENCE TABLE

The chart below should be used as a **reference tool** to support the decision about home visiting model choice. It reflects the areas of strength (as identified by Department of Health and Human Services <http://homvee.acf.hhs.gov/programs.aspx>) for each Michigan approved Home Visiting Model and provides information about which populations are eligible for each model.

DO NOT MAKE CHANGES TO THIS TABLE

	Demonstrated Outcome: Improved Maternal and Child Health	Demonstrated Outcome: Child Injuries, Child Abuse, or Maltreatment and Reduction of ER visits	Demonstrated Outcome: Improvements in School Readiness	Demonstrated Outcome: Crime or Domestic Violence	Demonstrated Outcome: Family Economic Self- Sufficiency	Demonstrated Outcome * *: Coordination and Referrals for Other Community Resources and Supports	Service Population	Admission Criteria	Income Restriction
Early Head Start			X		X		Prenatal to 3	Prenatal to 30 months	Yes
Healthy Families America	X (Child Health)	X	X	X	X	X	Prenatal to 5	Prenatal to 3 months	No
Nurse Family Partnership	X	X	X	X	X		Prenatal to 2	First time moms Prenatal to 27 weeks gestation	Medicaid Eligible

****Please note that Coordination and Referrals for Other Community Resources and Supports is linked to multiple risk factors identified. The user should take that into consideration when reviewing their identified risk factors.**

APPENDIX E

Needs of Identified Population based on Analysis

Target Population Identified (Answer to Question 42) _____

Instructions: This appendix should be used in decision making about the most appropriate home visiting model for your community based on the Target Population identified and the analysis of the other Appendices particularly Appendix B. Use the reference table above and your learnings from the Evidence section of your work including the completed Appendices to identify the most appropriate model for your chosen target population. The model chosen must be able to address the needs of the target population and you must defend the rationale for your choice in question 42. The colors here tie to Appendix B and the risk factors you identified in it. The colors of the areas of risk in Appendix B will help you link most appropriately to the Identified Needs below. Please note that there is much crossover for Coordination and Referrals for Other Community Resources and Supports and the various risk factors and, as a result, that particular Identified Need should be assessed independently.

	Identified Need: Improved Maternal and Child Health	Identified Need: Child Injuries, Child Abuse, or Maltreatment and Reduction of ER visits	Identified Need: Improvements in School Readiness	Identified Need: Crime or Domestic Violence	Identified Need: Family Economic Self-Sufficiency	Identified Need: Coordination and Referrals for Other Community Resources and Supports
Needs of Identified Population (check the cells to the right that reflect the needs of your identified						

population noted in Appendix B)						
<p>Service Population What is the age range of the infants or children in the identified population? Justify your answer based on your analysis.</p>						
<p>Admission Criteria What admission criteria would be the most appropriate for the identified population? Justify your answer based on your analysis.</p>						
<p>Income Requirement Is income a factor in looking at the identified population? If so, how do the income requirements impact the target population? Justify your answer based on your analysis.</p>						
<p>Other information about the chosen population to justify your decision</p>						

Daro, D. "Replicating Evidence-Based Home Visiting Models: A Framework for Assessing Fidelity." *Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment*, December 2010, Brief 3, pp.2.

PROGRAM BUDGET SUMMARY

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

View at 100% or Larger

Use **WHOLE DOLLARS** Only

ATTACHMENT B.1

PROGRAM			DATE PREPARED	Page 1	Of 2
CONTRACTOR NAME			BUDGET PERIOD From: _____ To: _____		
MAILING ADDRESS (Number and Street)			BUDGET AGREEMENT <input checked="" type="checkbox"/> ORIGINAL <input type="checkbox"/> AMENDMENT		AMENDMENT #
CITY	STATE	ZIP CODE	FEDERAL ID NUMBER		
EXPENDITURE CATEGORY				TOTAL BUDGET (Use Whole Dollars)	
1. SALARY & WAGES					
2. FRINGE BENEFITS					
3. TRAVEL					
4. SUPPLIES & MATERIALS					
5. CONTRACTUAL (Subcontracts/Subrecipients)					
6. EQUIPMENT					
7. OTHER EXPENSES					
					-
8. TOTAL DIRECT EXPENDITURES (Sum of Lines 1-7)					-
9. INDIRECT COSTS: Rate #1 %					-
INDIRECT COSTS: Rate #2 %					-
10. TOTAL EXPENDITURES					\$ -

SOURCE OF FUNDS:

11. FEES & COLLECTIONS					
12. STATE AGREEMENT					\$ -
13. LOCAL					
14. FEDERAL					
15. OTHER(S)					
16. TOTAL FUNDING					\$ -

AUTHORITY: P.A. 368 of 1978

COMPLETION: Is Voluntary, but is required as a condition of funding.

DCH-0385(E) (Rev. 07/10) (Excel) Previous Edition Obsolete.

The Department of Community Health is an equal opportunity employer, services and programs provider.

PROGRAM BUDGET - COST DETAIL SCHEDULE

ATTACHMENT B.2

View at 100% or Larger
Use **WHOLE DOLLARS Only**

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Page

2 Of 2

PROGRAM		BUDGET PERIOD		DATE PREPARED
		From:	To:	
CONTRACTOR NAME		BUDGET AGREEMENT		AMENDMENT #
		<input checked="" type="checkbox"/> ORIGINAL <input type="checkbox"/> AMENDMENT		
1. SALARY & WAGES:				
POSITION DESCRIPTION & Name of Personnel	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY	
1. TOTAL SALARY & WAGES:			\$	-
2. FRINGE BENEFITS: (Specify)				
<input type="checkbox"/> FICA	<input type="checkbox"/> LIFE INS	<input type="checkbox"/> DENTAL INS	Composite Rate %	
<input type="checkbox"/> UNEMPLOY INS	<input type="checkbox"/> VISION	<input type="checkbox"/> WORK COMP	#DIV/0!	
<input type="checkbox"/> RETIREMENT	<input type="checkbox"/> HEARING INS			
<input type="checkbox"/> HOSPITAL INS	<input type="checkbox"/> OTHER:specify-			
2. TOTAL FRINGE BENEFITS:			\$	-
3. TRAVEL: (Specify if category exceeds 10% of Total Expenditures)				
3. TOTAL TRAVEL:			\$	-
4. SUPPLIES & MATERIALS: (Specify if category exceeds 10% of Total Expenditures)				
4. TOTAL SUPPLIES & MATERIALS:			\$	-
5. CONTRACTUAL: (Subcontracts/Subrecipients)				
<u>Name</u>	<u>Address</u>	<u>Amount</u>		
5. TOTAL CONTRACTUAL:			\$	-
6. EQUIPMENT: (Specify)				
6. TOTAL EQUIPMENT:			\$	-
7. OTHER EXPENSES: (Specify if category exceeds 10% of Total Expenditures)				
Communication:				
Space Cost:				
Others (explain):				
7. TOTAL OTHER EXPENSES:			\$	-
8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7)		8. TOTAL DIRECT EXPENDITURES		\$ -
9. INDIRECT COST CALCULATIONS:				
Rate #1	Base \$	x Rate	=	
Rate #2	Base \$	- x Rate	=	
9. TOTAL INDIRECT EXPENDITURES:			\$	-
10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9)				\$ -
AUTHORITY: P.A. 368 of 1978		The Department of Community Health is an equal opportunity employer, services and programs provider.		
COMPLETION: Is Voluntary, but is required as a condition of funding.				
DCH-0386(E) (Rev 07/10) (EXCEL) Previous Edition Obsolete		<i>Use Additional Sheets as Needed</i>		

**Michigan Home Visiting Initiative
 Scoring Matrix for applications for Rural Evidence- Based Home Visiting Expansion Planning**

Review item	0 points	1 point	2 points
One-page summary includes all of the required activities that will be completed.	No	XXX	Yes
One-page summary describes at least two priority activities that will be completed.	No	XXX	Yes
Documentation of the agency that has agreed to act as fiduciary for the project.	No	XXX	Yes
Completed budget forms are included.	No	XXX	Yes
% of counties in the Prosperity Region that will be covered by this project.	< 50%	50-99%	100%
All required partners (as outlined in the RFP) have agreed to participate in the project.	No	XXX	Yes
Total # of partners (required and recommended) agreeing to participate in the project, as documented through communications to the submission.	Actual number		