

Michigan Maternal, Infant and Early Childhood Home Visiting Development Grant
Michigan Department of Community Health
320 South Walnut Street
Lansing, MI 48913-1557
Voice 517/335-9230, fax 517/335-8697
peelern@michigan.gov

PROJECT ABSTRACT

There is a clear need in Michigan to strengthen state-level infrastructure as well as policy and procedures in order to support a high-quality, evidence-based home visiting system, and a need to expand evidence-based home visiting programs to address the state's high priority outcomes. Through the proposed project, Michigan will address these the needs and challenges to effective system and program implementation by testing strategies that align with the following priority elements:

- Priority Element 1: To support improvements in maternal, child, and family health, specifically, to reduce infant mortality.
- Priority Element 2: To support effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected.
- Priority Element 3: To support the development of statewide home visiting programs, by improving infrastructure components.
- Priority Element 4: To support the development of comprehensive early childhood systems, by improving infrastructure that enhances the success of the services models and the system.
- Priority Element 5: To reach high-risk and hard-to-engage populations.
- Priority Element 8: To support fiscal leveraging strategies to enhance program sustainability.

In order to address these priority elements and improve the ability of Michigan's home visiting system to achieve the federal benchmarks and drive improvement in the state's high priority early childhood outcomes, Michigan proposes a project designed to develop and test strategies for addressing the some of the most significant barriers this state faces in implementing an integrated home visiting system. These strategies build on Michigan's overall MIECHV program strategies and were selected as the focus of this Development Grant because they are central to addressing barriers to building an integrated state system and home visiting infrastructure. Michigan will:

1. Build the capacity of home visiting programs to address community needs using evidence-based models, specifically by expanding or establishing Nurse Family Partnership home visiting programs for African American first time mothers in six at-risk communities;
2. Pilot a coordinated system for outreach, intake, referral and follow-up for home visiting in three communities;
3. Prioritize, update and implement state-level policies, procedures, standards, and funding mechanisms that support high quality, evidence-based home visiting.

The result of the proposed activities will be to:

- a. Demonstrate improvements in maternal and child health for enrolled families;
- b. Operate local programs more effectively and efficiently through improved local referral systems;
- c. Achieve better alignment of and reach of home visiting programs across state and local agencies.

INTRODUCTION

Michigan's Governor has identified three priority indicators of the state's performance in the area of health and education related to early childhood. These include infant mortality, obesity in the population, and third graders reading at grade level. Additionally, the Governor has announced the formation of a new office, the Michigan Office of Great Start-Early Childhood, which will focus the state's investment in early childhood programs on a common set of outcomes:

- Children born healthy
- Children healthy, thriving, and developmentally on track from birth to third grade
- Children developmentally ready to succeed in school at the time of school entry
- Children prepared to succeed in fourth grade and beyond by reading proficiently by the end of third grade

In order to achieve the Governor's outcomes for early childhood and achieve progress on the federal home visiting benchmarks, Michigan must build an integrated and efficient home visiting system that has the capacity to align family and community needs with evidence-based home visiting services.

Michigan has a long history of providing prevention-focused home visiting services. In the Needs Assessment conducted for the state's Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) during 2010, the state identified nine state level home visiting programs supported by State or Federal funds. Two programs are available statewide, while many others are implemented on a county or community by community basis, depending on the availability of funding, local priorities, level of interest, and other factors.

The State has taken steps toward building an effective and efficient home visiting system through its MIECHV FY2010 Formula grant, and will continue to do so through the FY2011 Formula grant (see Attachment 6, MIECHV Summary Progress Report for a summary, as well as the overall MIECHV program Logic Model, Figure 1 in Attachment 1). However, the current system lacks several key features that research suggests drive successful, effective implementation.

- The system is decentralized and uncoordinated, and consequently lacks a shared vision and common goals.
- Additionally, home visiting programs are not consistently integrated or targeted at the state or local level, and meaningful commitment to sustained partnerships across agencies is limited.
- Finally, Michigan has not aligned model selection with community need. The State's more local and funding-driven approach is evidenced in the fact that that communities with the highest rates of infant mortality do not offer programs such as Nurse Family Partnership that have demonstrated success in reducing risk factors for infant mortality.

There is a clear need to strengthen the state-level infrastructure as well as policy and procedures in order to support a high-quality, evidence-based home visiting system, and a need to expand evidence-based home visiting programs to address the state's high priority outcomes.

This funding opportunity provides Michigan with the prospect to address these the needs and challenges to effective system and program implementation by testing strategies that align with several priority elements listed in the FOA, including:

- Priority Element 1: To support improvements in maternal, child, and family health, specifically, to reduce infant mortality.

- Priority Element 2: To support effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected.
- Priority Element 3: To support the development of statewide home visiting programs, by improving infrastructure components.
- Priority Element 4: To support the development of comprehensive early childhood systems, by improving infrastructure that enhances the success of the services models and the system.
- Priority Element 5: To reach high-risk and hard-to-engage populations.
- Priority Element 8: To support fiscal leveraging strategies to enhance program sustainability.

In order to address these priority elements and improve the ability of Michigan’s home visiting system to achieve the federal benchmarks and drive improvement in the Governor’s high priority early childhood outcomes, Michigan proposes a project designed to develop and test strategies for addressing the some of the most significant barriers this state faces in implementing an integrated home visiting system. These strategies build on Michigan’s overall MIECHV program strategies (see overall Program Logic Model in Attachment 1, Figure 1), and were selected as the focus of this Development Grant because they are central to addressing barriers to building an integrated state system and home visiting infrastructure. These three strategies and intended activities are described in more detail in the MIECHV Development Grant Logic Model (Attachment 1, Figure 2). If awarded, Michigan will:

1. Build the capacity of home visiting programs to address community needs using evidence-based models, specifically by expanding or establishing Nurse Family Partnership home visiting programs in several at-risk communities;
2. Pilot a coordinated system for outreach, intake, referral and follow-up for home visiting in three communities;
3. Prioritize, update and implement state-level policies, procedures, standards, and funding mechanisms that support high quality, evidence-based home visiting.

As detailed in the Development Grant Logic Model (Attachment 1, Figure 2), the result of the proposed activities will be to:

- a. Demonstrate improvements in maternal and child health for enrolled families;
- b. Operate local programs more effectively and efficiently through improved local referral systems;
- c. Achieve better alignment of and reach of home visiting programs across state and local agencies.

NEEDS ASSESSMENT

The proposed home visiting program addresses three related, but essentially different, needs:

1. The need to strengthen the state-level infrastructure in order to support a high-quality, evidence-based home visiting system.
2. The need to streamline and coordinate outreach, intake, referrals and follow-up across home-visiting programs at the community level.
3. The need to expand evidence-based home visiting programs for African American parents in counties with the highest infant mortality rates and the greatest disparities in rates across sub-populations.

Need to Strengthen the State-level Infrastructure to Support a High-quality, Evidence-based Home Visiting System

Priority Element 2: To support effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected.

Priority Element 3: To support the development of statewide home visiting programs, by improving infrastructure components.

Priority Element 4: To support the development of comprehensive early childhood systems, by improving infrastructure that enhances the success of the services models and the system.

State agencies have been engaged in child and family services systems-building efforts since the 1980's, and Michigan laid a foundation to support building a strong home visiting program system.

- In 1987, the Michigan Department of Mental Health (now part of the Department of Community Health) began to invest in Coordinated Community Planning (CCP). This initiative brought the directors of local health, education and human services agencies together to form Human Services Coordinating Bodies (HSCBs) that worked to establish services to prevent mental health problems across the life span. Their efforts focused largely on children and adolescents.
- In 1994, the directors of the Michigan State Department of Social Services (now the Department of Human Services), Public Health, Mental Health, Office of Services to the Aging (now combined to form the Department of Community Health), and the Superintendent of Public Instruction signed a document of commitment to improve systems of care for Michigan families and their children. The commitment evolved out of a growing understanding and awareness that not all families receive what they need when seeking services and support. Although each department individually had made impressive strides toward a cooperative system of educating and serving children and families, there had been only limited success in changing the way education and human service systems met the needs of their constituencies.
- The State directors commissioned a report to recommend a road map to lead Michigan toward systems reform for children and families. In February of 1995, a report, entitled "Systems Reform for Children and their Families: Strategies for Change", was delivered to the directors. It was the result of hundreds of hours of listening, conceptualizing and planning by a large task force and four workgroups. The initiative and work that grew out of the systems reform task force was known as Putting It Together (PIT) with Michigan Families. On the State level, the human service directors and the superintendent of public instruction created an ongoing interagency group to work across systems to improve services to families and children. The task force also recommended the development of Multi-Purpose Collaborative Bodies (MPCBs) throughout every county of the State. The MPCBs were designed to forge community alliances, create a shared vision and mobilize resources for services and supports to local families that were collaborative, seamless and family-centered. Family members were recruited and seen as important members of MPCBs across the State.
- In 2005, the Early Childhood Investment Corporation (ECIC) was created as a public-private partnership to be Michigan's focal point for information and investment in early childhood in Michigan so that children can arrive at the kindergarten door, safe, healthy and eager for learning and life. The ECIC was charged with implementing Michigan's Great Start early childhood comprehensive system at the local and state levels, with Great Start Collaboratives (GSCs) and their Great Start Parent Coalitions (GSPCs) working at the local/regional level, and multiple groups working at the state level. One of these groups, called the Great Start System Team (GSST), is made up of representatives of the State departments that serve young children.

In 2009, the GSST appointed a Home Visiting Workgroup (HVWG) to focus on developing a State home visiting system.

Through all of these broad-based systems-building initiatives, as well others designed for very specific populations (e.g., children and youth with serious emotional disturbances), Michigan has been working for nearly 25 years to develop collaborative health, human services and education systems that better meet the needs of children and families. This has proven to be a much more difficult undertaking than originally imagined, and has been all the more challenging in the last several years as economic conditions have pushed more families into poverty while services have contracted. Although some system-level improvements have been made, a great deal remains to be done. This has been documented in two recent reports.

Evaluation of the Great Start Initiative

In March of this year, the ECIC issued a report titled, *Evaluation of the Great Start Initiative, Report 2010/2011*. The report summarizes the results of the Great Start Survey, which was distributed to GSPCs, GSCs, and other key community stakeholders across the State. One of the guiding survey questions was: To what extent are the GSCs/GSPCs effective at building an effective early childhood system?

Survey results suggest that GSCs and GSPCs are making important headway in building the systems changes needed to ensure that all children are ready for school. About 1/2 to 2/3 of respondents noted the Great Start efforts in their community are making at least some impact on:

1. Building more responsive community contexts such as generating broad community support for early childhood issues, and promoting system improvements such as better workforce development.
2. Improving and expanding the early childhood systems around the State, such as strengthening service coordination and collaboration, and increasing access to services and supports.
3. Improving outcomes for children and families.

However, survey results also indicate that:

1. Most families reported that the local service system does not meet their needs.
2. Most local service and support organizations surveyed reported that they are not yet ready to change to more effectively meet the needs of young families.
3. While local organizations on the GSC appear to have strong referral networks, they are far less likely to actively share information and resources with each other.

The survey showed that GSCs and GSPCs appear to become more effective over time. It also indicated that more was accomplished by GSCs and GSPCs that had created effective governance structures, developed local systems change capacity, actively pursued systems change strategies, developed strong partnerships, promoted the value of the GSC/GSCB in the community, had a history of effective collaboration, and had an environment in which local organizations were actively sharing resources (e.g., blended funding, co-location of staff).

Project LAUNCH Environmental Scan Preliminary Report

In 2009, the DHHS Substance Abuse and Mental Health Services Administration (SAMHSA) funded the Michigan Department of Community Health (MDCH) to implement Project LAUNCH

(Linking Actions for Unmet Needs in Children's Health). LAUNCH is intended to promote the wellness of children from birth to 8 years of age by addressing the physical, emotional, social, cognitive and behavioral aspects of their development. Grantees use a range of evidence-based public health strategies, including home visiting programs, to achieve their goals. They also work to build infrastructure, strengthen coordination among child-serving systems, and improve methods for providing services. LAUNCH includes state and local components; Saginaw County was selected as Michigan's local site.

In 2009, LAUNCH conducted an environmental scan in order to develop a comprehensive understanding of the early-childhood system at the state and local levels. This understanding was intended to inform the development of strategic plans aimed at creating more comprehensive, integrated, effective and efficient systems at both levels. Findings were summarized in the *Project LAUNCH Environmental Scan Preliminary Report*, September 10, 2010. Data for the scan were collected through local parent focus groups, local provider focus groups, a local key informant survey, and interviews with State key informants.

The scan revealed the following systems issues, among others:

- Parents are unaware of the range of services available in the community.
- Administrators and providers are more aware of what is happening in their own service areas and less aware of how services are delivered across the early childhood system.
- There is no system-wide approach to creating links between early education programs and primary care providers.
- There is a need for greater interagency collaboration to reduce duplication of services and to smooth transitions for families from one service to another.
- There is a need to address disparities in service provision and outcomes.
- There is no statewide workforce development plan for those working with young children and their families, despite a lack of qualified and trained staff.
- State and local efforts to improve quality and build workforce competence vary from program to program.
- There is no general agreement among policy makers, funders, and providers of the importance of evaluation and the need to use data to improve practice; evaluations vary by programs and are largely driven by the requirements of the funding source.
- There is a need for a shared database on program services and outcomes to allow providers to track the services a family receives and reduce duplication, but privacy laws make this difficult.
- There's a need for more and better data on program outcomes.
- There is a need to make program fidelity assessment more routine and systematic.
- Stakeholders lack knowledge regarding the public health approach; there is no legislation or policy that supports a public health approach across multiple sectors of the system.
- There is a pervasive view that the State lacks sufficient resources to implement many of the changes that have been planned; the capacity of the system is strained and the focus on quality has been reduced in some cases.

The report indicated that State leaders have been working to address access issues, largely through joint planning activities. Committees are engaged in planning to implement cross-system referral forms and processes, blended funding, and shared data systems. However, joint enrollment for some early childhood programs was the only strategy mentioned that is actually being implemented. To date, most activities remain in the planning stages. State efforts to increase

service coordination have focused on joint planning for cross-system purposes, more integrated funding, and shared information systems; however, most of these efforts have not yet gone to implementation.

The *Evaluation of the Great Start Initiative* and the *Project LAUNCH Environmental Scan Preliminary Report* provide data on efforts to build early childhood comprehensive systems at the state and local levels. Data are also available that were collected as part of the State’s more recent efforts to build the home visiting system, an important component of the larger system. These data were collected through Community Needs Assessments that the HVWG conducted to help determine which of the 10 counties with the highest concentration of risk (as identified in the *MIECHVP Statewide Needs Assessment*) would receive FY2010 MIECHVP funds, as Michigan’s formula-based award was not sufficient to support home visiting services in all 10 counties (see Attachment 6 for a Summary Progress Report on MIECHV previous activities and next steps).

The HVWG developed a Community Readiness Assessment tool that included 32 items. Each item was scored on a scale of 0-2 points (Not ready=0, Somewhat Ready=1, Ready=2). When averages were computed across the ten counties, fifteen items had an average score of < 1, meaning that the average fell below the ‘Somewhat Ready’ category. The HVWG determined that technical assistance related to these items would be a necessary step to ensuring the ability of local communities to operate home visiting programs in the context of a broader system. The 15 items and average scores are displayed in the table below.

Table 1. Community Readiness Assessment Items with Lowest Average Scores

Item	Average Score
1. Shared use of Authorization to Share Information form	.45
2. Extent to which shared Authorization to Share Information forms comply with privacy laws	.50
3. Extent to which communities are coordinating efforts to maximize use of Medicaid	.50
4. Extent to which HV programs in community use a shared database	.50
5. # of HV programs in the county that are working toward fidelity (if not in fidelity)	.55
6. Local Leadership Group has and implements policy to promote authentic family involvement (including financial support and mentoring)	.65
7. Extent to which HV programs have defined shared outcomes and collect data to measure these outcomes across programs	.70
8. LLG is developing infrastructure needed to support HV system	.80
9. LLG grasps that infrastructure development requires major change to current system	.80
10. Extent to which families representing the service population are authentically involved in LLG	.80
11. # of evaluations involving more than one HV program	.80
12. # of programs in community implementing HV programs that meet program fidelity	.80
13. Extent to which HV programs in community use common forms	.90
14. Extent to which feedback is given to Primary Care Providers who refer to HV programs	.90
15. # of HV programs that can demonstrate program/policy changes as a result of CQI	.90

These scores demonstrate that communities need significant support from the State to be able to build viable local home visiting infrastructure and systems. The feedback gathered during the site visits conducted as part of the process suggested that state level coordination would facilitate system building at the local level.

Additionally, in the process of completing the *MIECHVP Statewide Needs Assessment* and the *FY2010 Updated State Plan*, the HVWG cataloged all existing home visiting programs, specifying target populations, models used, outcomes addressed, funding sources, service gaps, etc. This theoretically simple task was not simple at all, because different departments administered their respective home visiting programs differently, used different definitions, and collected different data on different measures. This task highlighted the need to establish clear definitions and a common language from which to analyze and discuss our existing system in order to improve communication, collaboration, coordination and ultimately service delivery.

Given the strength of the evidence that system improvements are critical to improving the quality of the implementation of home visiting programs in Michigan, this challenge was a focus in Michigan's formula grant application. In Michigan's *MIECHVP FY2010 Updated State Plan*, the State identified the following priorities for infrastructure building efforts:

1. Cross-system and model procedures, standards, and forms
2. Workforce development supporting all home visitors and supervisors to meet core competencies
3. Single/centralized point of referral or intake
4. Integrated data systems that allow an overview of services being provided
5. Development of a dashboard that helps track outcomes achieved by the overall system

The GSST has recently made a commitment to redouble its efforts to strengthen the infrastructure needed to support a high-quality State home visiting system. This is due in no small part to the momentum generated by the MIECHVP and its emphasis on implementing evidence-based home visiting models. The GSST is in the process of developing a *Home Visitation Initiative Agreement*, covering the intent, values, core assumptions and points of agreement that will undergird their work to build a State home visiting system. The Team intends to:

1. Implement activities toward shared outcomes.
2. Assess existing home visitation funding/programs and align them with the shared outcomes.
3. Develop common data elements and tracking mechanisms across departments for home visitation programs.
4. Align early childhood messaging across programming, in keeping with evidence based and best practices relative to health, development and learning.

There is no doubt that systems-building at the state and local levels is complex, challenging, and necessary work. However, framing a systems-building initiative across home visiting programs is a new and hopeful way for Michigan to proceed with this work; it is less complex than building a comprehensive system incorporating all early childhood services and supports, but more encompassing than building a system around an initiative designed for a special population. Although the GSST stands poised to embark upon strengthening the State's home visiting program infrastructure, it is critical that staffing is dedicated to this undertaking, or it will not move forward.

Need to Streamline and Coordinate Outreach, Intake, Referrals and Follow-Up Across Home Visiting Programs at the Community Level

Priority Element 2: To support effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected.

Priority Element 3: To support the development of statewide home visiting programs, by improving infrastructure components.

Priority Element 4: To support the development of comprehensive early childhood systems, by improving infrastructure that enhances the success of the services models and the system.

Priority Element 8: To support fiscal leveraging strategies to enhance program sustainability.

As stated above, establishing a coordinated/centralized point of referral or intake was one of the top five infrastructure-building priorities identified in Michigan's *MIECHVP FY2010 Updated State Plan*. This was deemed a priority based on data from multiple reports on early childhood services systems (also referenced in the section above) that indicated the following:

1. Parents are unaware of the range of services available in the community.
2. Most families reported that the local service system does not meet their needs.
3. Administrators and providers are more aware of what is happening in their own service areas and less aware of how services are delivered across the early childhood system.
4. There is a need for greater interagency collaboration to reduce duplication of services and to smooth transitions for families from one service to another.
5. Early childhood providers, including health care professionals, who make referrals to home visiting programs do not get feedback on the disposition of their referrals.
6. Ultimately, the success and effectiveness of local home visiting programs will be enhanced by better coordination of referrals/intake and better fit between family needs and programs in which they are enrolled.

On April 18, 2011, HRSA offered a webinar regarding the importance of central intake and coordination of referrals for home visiting programs. Presenters from states that have established local coordinated intake and referral systems said that results include: enhanced awareness of home visiting services; streamlined referrals connecting families with "best fit" programs; enhanced relationships; increased number of families served; and better monitoring of duplication of services.

Michigan's communities vary widely in their ability to provide coordinated outreach, intake, referral, and follow-up. A few counties have begun to experiment with coordinated intake and referral, but workers in other more populous counties are not even able to identify all of the home visiting programs operating within their boundaries.

Concurrent to the state work to improve its Home Visiting system within the context of the comprehensive early childhood system, Michigan is actively engaged in a CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) project. One of the key components of this project is that the patient centered medical homes must be linked functionally to community resources. Physicians will use Data Registries to support the access, referral and linkage components of the project, which will link to centralized access points within communities. The effective coordination between medical homes and community resources and service providers (such as home visiting programs) and the infrastructure needed to accomplish this is a key deliverable of the MAPCP project. It will be critical for efforts related to coordinated/centralized referral system to be connected with the work of the MAPCP project.

The Michigan Early Learning Advisory Council is implementing another data-related project, the Great Start P-8 Data Mapping and Planning Initiative. The purpose is to conduct a scan and analysis to assist in determining steps to establish a unified early childhood data system in Michigan. Efforts to establish a coordinated/centralized referral system will also need to be linked to this important project.

Need to Expand Evidence-Based Home Visiting Programs for African American Parents in Counties with the Highest Infant Mortality Rates and the Greatest Disparities in Rates

Priority Element 1: To support improvements in maternal, child, and family health, specifically, to reduce infant mortality.

Priority Element 2: To support effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected.

Priority Element 5: To reach high-risk and hard-to-engage populations.

Priority Element 8: To support fiscal leveraging strategies to enhance program sustainability.

As part of the *Maternal, Infant and Early Childhood Home Visiting Program Statewide Needs Assessment* that Michigan submitted to HRSA in September, 2010, Michigan identified communities with the highest concentration of risk. Michigan analyzed the data by county (i.e., community = county). When county data were not available for a particular indicator (e.g., high school drop-out data), a close approximation was used instead.

Thirteen indicators drove the identification of high risk communities; ten that were required by HRSA, plus three additional indicators identified by the HVWG. The 13 indicators include:

1. Premature birth
2. Low-birth weight infants
3. Infant mortality
4. Poverty
5. Crime
6. School drop-out rates
7. Substance abuse
8. Unemployment
9. Child maltreatment
10. Domestic violence
11. Presence of an urban center in that county
12. Proportion of the total population of American Indians living in each county compared to the total population of American Indians in the State
13. Proportion of the total population of African Americans living in each county compared to the total population of African Americans in the State.

Upon completion of the analysis, 10 of Michigan's 83 counties were identified as having the highest concentration of risk, as compared to the statewide level of risk. These counties and the major cities within them, listed from highest to lowest concentration of risk, are as follows: Genesee (Flint), Wayne (Detroit), Saginaw (Saginaw), Calhoun (Battle Creek), Ingham (Lansing), Kalamazoo (Kalamazoo), Muskegon (Muskegon), Berrien (Benton Harbor), Kent (Grand Rapids), and St. Clair (Port Huron).

Four months after our *Statewide Needs Assessment* was submitted to HRSA, Michigan's newly-elected governor, Rick Snyder, took office. Shortly thereafter, Governor Snyder released the MIDashboard,

which will be used to track progress on Michigan’s performance with respect to 21 priority indicators. Two of the priority health indicators identified by the Governor that are related to early childhood are infant mortality rates and obesity rates. MDCH staff has been asked to direct resources toward activities that will “move the needle” on these two indicators. With this charge in mind, the HVWG took a deeper look at State and county infant mortality data to plan for the expansion of the Michigan Home Visiting Program system.

In 2009, Michigan ranked 37th in the United States in infant mortality rates. The death rate for all Michigan infants is 7.6 per thousand (three-year moving average, 2007-2009). The death rate for Medicaid infants is 8.8 per thousand, while the death rate for non-Medicaid infants is 6.6 per thousand; poverty is clearly related to infant mortality. However, the racial disparity is much more glaring than the income disparity. The death rate for black Michigan infants is 15.4 per thousand (three-year moving 2007-2009), twice the State rate. This wide racial disparity is extremely troubling and highly unacceptable.

The HVWG compared the 10 counties having the highest concentration of risk scores in the *Statewide Needs Assessment* with the 10 counties having the highest overall infant mortality and black infant mortality rates. As shown in the table below, these are by and large the same counties. Only two of the counties with the highest concentration of risk scores (Kent and St. Clair) are not among the 10 counties having the highest overall infant mortality and black infant mortality rates, and only two of the counties having the highest overall infant mortality and black infant mortality rates (Jackson and Macomb) are not among the 10 counties having the highest concentration of risk scores. Furthermore, the counties that do not overlap are, for the most part, clustered near the bottom of the rankings.

Table 2. Infant Morality Data, by County/City

County	Concentration of Risk (COR) Score <i>Statewide Needs Assessment</i>	Infant Death Rate 2007-2009 All Infants 3-Yr Moving Average (rankings in parentheses)	Infant Death Rate 2007-2009 Black Infants 3-Yr Moving Average (rankings in parentheses)	Infant Death Rate 2007-2009 All Infants in City with Death Rate > 7.5 per 1000 3-Yr Moving Average (rankings in parentheses)
Genesee	13	9.0 (4)	17.9 (3)	Flint 12.9 (5)
Wayne	12	10.4 (3)	15.3 (7)	Detroit 14.8 (4)
Saginaw	11	10.5 (2)	19.1 (2)	Saginaw 21.3 (1)
Calhoun*	10	11.5 (1)	20.5 (1)	Battle Creek 8.4 (9)
Ingham	10	7.4 (6)	16.9 (4)	Lansing 8.6 (8)
Kalamazoo*	9	8.3 (5)	19.1 (2)	Portage 18.6 (2)
Muskegon	9	7.1 (7)	8.2 (8)	-
Berrien*	8	9.0 (4)	16.7 (5)	-
Kent*	8	Not in top 10 IM counties 6.9	13.4	Grand Rapids 7.8 (11) Wyoming 8.0 (10)
St. Clair	8	Not in top 10 IM counties Rate not calculated; <6 events	Rate not calculated; <6 events -	-
Jackson	Not in top 10 COR counties	7.1 (7)	15.4 (6)	-
Macomb	Not in top 10 COR counties	7.1 (7)	15.0 (7)	Warren 11.1 (7)

Oakland*	Not in top 10 COR counties	Not in top 10 IM counties 6.3	14.7	Pontiac Southfield	18.3 (3) 12.1 (6)
----------	-------------------------------	-------------------------------------	------	-----------------------	----------------------

*County has a currently operating NFP program.

The four counties funded to implement NFP in 2004 included Kent, Berrien, Oakland, and Wayne Counties, with services targeted to first-time African American mothers. These programs were operated by local health departments in order to leverage additional matching funds through Medicaid. Funding for a fifth site, in Kalamazoo, was added in 2007. As of June 2009, state funds for these five programs were eliminated from the state budget. As a result, the Wayne County program is defunct, while the others are patching together funds from a variety of source and have been struggling to survive. A new NFP program was established in 2010 in Calhoun County with funds from the W.K. Kellogg Foundation.

A more detailed profile is provided below for each of the six counties proposed to receive funds from this grant in order to establish a new NFP program or to keep an existing NFP program in operation.

GENESEE COUNTY

Genesee County is Michigan’s fifth most populous county with a population of 425,790. The county seat and population center is Flint, the seventh largest city in Michigan. Genesee County spans 640 square miles and is located in the eastern/central portion of the Lower Peninsula. There are 11 cities and five villages located within the county. For decades, Genesee County played a significant role in the automotive industry; however since the late 1960s, it has suffered from disinvestment, deindustrialization, and depopulation. Genesee County’s redevelopment will rely heavily on its institutions of higher learning.

Genesee exceed State averages on 13 indicators of risk, which is the high score across the 10 counties: preterm birth (with a State high of 14.0%); low birth weight; infant mortality; poverty; prescription drug use (State high of 6.01%), illicit drug use (State high of 7.62%); category A crimes, all crime; domestic violence; high school drop-outs; unemployment; child maltreatment; a high proportion of both American Indians and African Americans living in the county as compared to the total population of American Indians and African Americans in the State; and the presence of an urban center.

Genesee County’s infant mortality rate is 9.0% (2007-2009 moving average), ranking it fourth overall in the state. Genesee also ranks third in the state for infant mortality rates among black infants, at 17.9%. Genesee’s population center, the city of Flint, has an infant mortality rate of 12.9%, ranking it fifth among Michigan cities. The rate of live of births in Genesee County to first-time mothers is 40.4% overall, with 36.2% being to first-time black mothers.

Genesee County identified a total of ten home visiting programs. In addition to the two statewide programs (Maternal Infant Health Program and Community Mental Health Home-based Services), there are seven programs that target families with risk factors. Two of these specifically target African American families. Approximately 1,744 individuals/children/families with risk factors were served in a 12-month period by eight of these programs. Data were not available for one of the programs as it has not yet begun to serve families. There is also one program with universal entry that has served 920 families in a 12-month period.

Of the ten home visiting programs identified by Genesee County, two of them address infant mortality (Maternal Infant Health Program, Healthy Start). The community does not currently operate any federal evidence-based home visiting models that have evidence of effectiveness in addressing infant mortality or improvements in maternal and child health indicators. Per a recently completed second-cut data analysis, African American infants were identified as a target population in Genesee County that is experiencing multiple risk factors. One compelling factor in this determination was the infant mortality rate among African American babies. Genesee's second-cut analysis also revealed that there is a lack of capacity in existing home visiting programs to serve this population, as well as other at-risk populations.

WAYNE COUNTY

Wayne County boasts a population of 1,820,584, making it the 13th most-populous county in the United States. The county seat is Detroit, the largest city in Michigan. Thirty-three additional cities and nine townships make up the remainder of Wayne County. Wayne County is located in southeast Michigan and devotes 83% of its 614 square miles to urban uses. Automobile manufacturing continues to be a primary force in the Detroit economy. In recent years, however, dependence on the auto industry has decreased, while the services sector has increased. Commercial shipping continues to contribute to Detroit's status as a major international market.

Wayne exceeded State averages on twelve indicators of risk: preterm birth; low birth weight (State high of 10.6%); infant mortality (State high rate of 10.4/1,000 live births); poverty (State high of 20.5%); binge alcohol use; category A crimes (State high with a rate of 55.4/1,000 residents), all crimes and juvenile crimes; domestic violence (State high rate of 14.7/1,000); high school drop-outs (State high of 16.1%); unemployment (State high of 15.4%); a high proportion of both American Indians and African Americans living in the county as compared to the total population of American Indians and African Americans in the State (both State high rates of 13.2 and 54.9, respectively); and the presence of the State's largest urban center.

Wayne County's infant mortality rate is 10.4% (2007-2009 moving average), ranking it third overall in the state. Wayne also ranks seventh in the state for infant mortality rates among black infants, at 15.3%. Wayne's county seat, the city of Detroit, has an infant mortality rate of 14.8%, ranking it fourth among Michigan cities. The rate of live of births in Wayne County to first-time mothers is 39.7% overall, with 40.5% being to first-time black mothers.

Wayne County identified a total of eight home visiting programs. In addition to the two statewide programs (Maternal Infant Health Program and Community Mental Health Home-based Services), there are six programs that target families with risk factors. Approximately 8,431 individuals/children/families with risk factors were served in a 12-month period by five of the programs. Data were not available for three of the programs.

Of the eight home visiting programs identified by Wayne County, two of them address infant mortality (Maternal Infant Health Program, Healthy Start). The community also operates several Healthy Families American programs, although not with fidelity to the model (which is being addressed through Michigan's Updated State Plan). Per a recently completed second-cut data analysis, African Americans in several communities were identified as target populations in Wayne County that are experiencing multiple risk factors. One compelling factor in this determination was the infant mortality rate among African American babies, which accounts for a staggering 51.2% of the African American deaths in the state of Michigan. Wayne's second-cut analysis also revealed that there is a lack of

capacity in existing home visiting programs to serve this population, as well as other at-risk populations, primarily due to a lack of funding.

SAGINAW COUNTY

Saginaw County is a unique blend of urban and rural landscapes with a diverse population of 200,169. It covers 812 square miles and is located in the central portion of the Lower Peninsula of Michigan. Saginaw County encompasses the cities of Saginaw, Frankenmuth and Zilwaukee. The region remains an important manufacturing center, popular recreation and tourism area, and a leader in agricultural production. Saginaw County is now positioning itself toward an economic foundation based in the medical and education industries.

Saginaw exceeded State averages on eleven indicators of risk: preterm birth; low birth weight; infant mortality; poverty; binge alcohol use, marijuana use, and illicit drug use; category A crimes, all crime, and juvenile crimes; domestic violence; child maltreatment (with a State high rate of 22.9/1,000 children); a high proportion of both American Indians and African Americans living in the county as compared to the total population of American Indians and African Americans in the State; and presence of an urban center.

Saginaw County's infant mortality rate is 10.5% (2007-2009 moving average), ranking it second overall in the state. Saginaw also ranks second in the state for infant mortality rates among black infants, at 19.1%. Saginaw's population center, the city of Saginaw, has an infant mortality rate of 21.3%, ranking it first among Michigan cities. The rate of live of births in Saginaw County to first-time mothers is 39.9% overall, with 37.9% being to first-time black mothers.

Saginaw County identified a total of seven home visiting programs. In addition to the two statewide programs (Maternal Infant Health Program and Community Mental Health Home-based Services), there are four programs that target families with risk factors. One of these programs specifically targets families in communities with large minority populations. Approximately 1,133 individuals/children/families with risk factors were served in a 12-month period by five of the programs. Data were not available for one of the programs, as it was not operational until January 2011. There is also one program for all families with children 0-5 years old residing in all 13 public school districts in the county. It served 525 families in a 12-month period.

Of the seven home visiting programs identified by Saginaw County, two of them address infant mortality (Maternal Infant Health Program, Healthy Start). The community does not currently operate any federal evidence-based home visiting models that have evidence of effectiveness in addressing infant mortality or improvements in maternal and child health indicators. Per a recently completed second-cut data analysis, African American children were identified as a target population in Saginaw County that is experiencing multiple risk factors. One compelling factor in this determination was the infant mortality rate and the disproportionate number of African American babies in this population. Saginaw's second-cut analysis also revealed that there is a lack of capacity in existing home visiting programs to serve this population, as well as other at-risk populations.

INGHAM COUNTY

Ingham County is located in the central portion of the Lower Peninsula in Michigan and is home to the State Capital of Lansing. Lansing is the only state capital in the nation that is not also a county seat, which is currently in Mason. The population of Ingham County is 280,895 and it encompasses 559 square miles of mostly urban communities and a few outside rural communities. The economy in

Ingham County is driven by the presence of Michigan State University, Lansing Community College and Sparrow Hospital system, as well as State government.

Ingham exceeded State averages on ten indicators of risk: preterm birth; poverty; binge alcohol (State high of 28.02%) and marijuana use, prescription drug use, and illicit drug use (State high of 4.28%); category A crimes, all crime, and juvenile crime (State high at a rate of 107.74/1,000); domestic violence; high school drop-outs; child maltreatment; a high proportion of both American Indians and African Americans living in the county as compared to the total population of American Indians and African Americans in the State; and presence of an urban center.

Ingham County's infant mortality rate is 7.4% (2007-2009 moving average), ranking it sixth overall in the state. Ingham also ranks fourth in the state for infant mortality rates among black infants, at 16.9%. Michigan's capital, the city of Lansing, has an infant mortality rate of 8.6%, ranking it eighth among Michigan cities. The rate of live of births in Ingham County to first-time mothers is 41.8% overall, with 38.5% being to first-time black mothers.

Ingham County identified a total of six home visiting programs. In addition to the two statewide programs (Maternal Infant Health Program and Community Mental Health Home-based Services), there are three programs that target families with risk factors. Approximately 1,341 individuals/children/families with risk factors were served by these five programs in a 12-month period. There is also one program for "parents that can't access other services." It served 341 families in a 12-month period.

Of the six home visiting programs identified by Ingham County, one of them addresses infant mortality (Maternal Infant Health Program). The community does not currently operate any federal evidence-based home visiting models that have evidence of effectiveness in addressing infant mortality or improvements in maternal and child health indicators. Per a recently completed second-cut data analysis, the zip code area of 48911 was identified as a target population in Ingham County that is experiencing multiple risk factors. One compelling factor in this determination was the high rate of "birth-related risks," and another was the high percentage of African Americans living in the community. Ingham's second-cut analysis also revealed that there is a lack of capacity in existing home visiting programs to serve this population, as well as other at-risk populations.

BERRIEN COUNTY

Berrien County is located in the extreme southwest of Michigan and borders the State of Indiana to the South and a portion of Lake Michigan to the West. It encompasses 571 square miles of land. The county seat is St. Joseph and other major cities include Niles and Benton Harbor. The population of Berrien County is 156,813 and it contains mostly rural communities. Berrien County has a diversified economic base with its manufacturing, agriculture, tourism and service industries, which is enhanced with the unique farm markets within the area.

Berrien exceeded State averages on eight indicators of risk: infant mortality; poverty; prescription and illicit drug use; category A, all, and juvenile crimes; domestic violence; child maltreatment, and a high proportion of both American Indians and African Americans living in the county as compared to the total population of American Indians and African Americans in the State. Berrien does not have an urban center in the county.

Berrien County's infant mortality rate is 9.0% (2007-2009 moving average), tying it for fourth overall in the state. Berrien also ranks fifth in the state for infant mortality rates among black infants, at 16.7%.

There is no specific data regarding infant mortality rates available for cities within Berrien County. The rate of live of births in Berrien County to first-time mothers is 36.4% overall, with 36.0% being to first-time black mothers.

Berrien County identified a total of five existing home visiting programs. In addition to the two statewide programs (Maternal Infant Health Program and Community Mental Health Home-based Services), there are three programs that target families with risk factors. One of these programs specifically targets African American families. Another specifically targets women with a previous alcohol-exposed birth. Approximately 613 individuals/children/families with risk factors were served in a 12-month period by four of these five programs. Data is not available for one of the programs as it is in the beginning stages.

Of the five home visiting programs identified by Berrien County, two of them address infant mortality (Maternal Infant Health Program, Nurse-Family Partnership). The community currently operates one evidence-based home visiting model (NFP) that has evidence of effectiveness in addressing infant mortality or improvements in maternal and child health indicators. Per a recently completed second-cut data analysis, the City of Benton Harbor was identified as a target population in Berrien County that is experiencing multiple risk factors. One compelling factor in this determination was the infant mortality rate in the city (also in the additionally identified areas of Benton Township and the City of Niles), as well as the high percentage of African Americans in the community. Berrien's second-cut analysis also revealed that there is a lack of capacity in existing home visiting programs to serve this population, particularly in rural areas, as well as other at-risk populations.

KENT COUNTY

Kent County has a population of 602,622 and is the fourth largest population center in the State of Michigan. Kent County has an equal blend of urban and suburban communities, with a rural population of about 20%. The county seat, Grand Rapids, has a population of 192,252 and is the second largest city in the State. It is located in West Michigan and covers 864 square miles and is home to 9 cities. The area was a manufacturing center particularly known for furniture, but in the past 10 years, economic development has focused on diversification of businesses in health, research sciences and tourism.

Kent exceeded State averages on eight indicators of risk: infant mortality; poverty; category A crime and juvenile crime; high school drop-out rates; child maltreatment; a high proportion of both American Indians and African Americans living in the county as compared to the total population of American Indians and African Americans in the State; and presence of an urban center.

Kent County's infant mortality rate is 6.9% (2007-2009 moving average), ranking it outside of the top ten overall in the state. Kent also does not rank within the top ten in the state for infant mortality rates among black infants, at 13.4%. Kent's county seat, the city of Grand Rapids, has an infant mortality rate of 7.8%, ranking it eleventh among Michigan cities. The rate of live of births in Kent County to first-time mothers is 38.7% overall, with 36.3% being to first-time black mothers.

Kent County identified a total of nine existing home visiting programs. In addition to the two statewide programs (Maternal Infant Health Program and Community Mental Health Home-based Services), there are six programs that target families with risk factors. Two programs specifically target African American families. One program is operated by the Inter-tribal Council of Michigan, serving Native American communities. One program specifically targets women with a previous alcohol-exposed birth. One program combines funds from multiple sources and contracts with multiple providers to

serve at-risk families with the primary goal of preventing child abuse and neglect. There is also one program with universal entry for all families in the Kent Intermediate School District which served 553 families (859 children) in a 12-month period. Approximately 3,757 individuals/children/families with risk factors were served by these eight programs in a 12-month period.

Kent County also identified the following two systems-level initiatives:

1. *Welcome Home Baby* is a new gateway program for all first-time mothers and mothers 25 years and under with a previous birth. Services include needs assessment and referrals to home visiting programs, as well as to other resources.
2. *Home Visitor Provider Network* is a community coalition of 55 individuals from 20 local agencies that provide all of the home visiting programs serving pregnant women and children 0-5 years old in Kent County. The Network is in the process of updating an extensive grid with information on all local home visiting programs including funding sources, capacity, number of home visits, etc.

Of the nine home visiting programs identified by Kent County, four of them address infant mortality (Maternal Infant Health Program, Healthy Start, Nurse-Family Partnership, and Healthy Families America). The community currently operates two evidence-based home visiting model (NFP) that has evidence of effectiveness in addressing infant mortality or improvements in maternal and child health indicators. Per a recently completed second-cut data analysis, African Americans were identified as a target population in Kent County that is experiencing multiple risk factors. One compelling factor in this determination was rate of poor pregnancy/birth outcomes. Kent's second-cut analysis also revealed that there is a lack of capacity in existing home visiting programs to serve this population, as well as other at-risk populations.

This Needs Assessment suggests that the existing decentralized, uncoordinated approach threatens implementation quality; that families have no way to connect with the right services at the right time, which threatens implementation quality; and that programs that address risk factors for infant mortality – a huge problem in our state – are not available and/or insufficient in at risk communities.

METHODOLOGY

In order to address the selected priority elements and improve the ability of Michigan's home visiting system to achieve the federal benchmarks and drive improvement in the Governor's high priority early childhood outcomes, Michigan proposes a project designed to develop and test strategies for addressing the most significant barriers this state faces in implementing an integrated home visiting system. If awarded, Michigan will:

1. Establish state-level policies, procedures, standards, and funding mechanisms that support high quality, evidence-based home visiting.
2. Pilot coordinated intake and referral systems for home visiting in three communities.
3. Build the capacity of home visiting programs to address community needs using evidence-based models.

Strategies/Activities

Establish state-level policies, procedures, standards, and funding mechanisms that support high quality, evidence-based home visiting.

Michigan proposes to conduct a comprehensive state-level environmental scan to identify, prioritize, and ultimately update and implement state level policy/procedures that will help establish and implement high quality, evidence-based home visiting systems at the state and local levels:

- a. Establish how models currently operating or that could be added will compose a system that addresses the state's priority outcomes/benchmarks across the targeted age groups, and establish statewide funding strategy to begin to fill the gaps.
- b. Create a common set of outcomes/benchmarks and common measurement structure through which the state can assess the effectiveness of the system – both process and impact.
- c. Create common program standards (e.g. expectations for needs assessment that ensures service delivery to high need populations; to prioritize services to address state's outcomes; to require use of evidence-based models with fidelity that FIT the target population; require use of model with best FIT).
- d. Coordinate efforts with the Great Start P-8 Data Mapping and Planning Initiative and the state's CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) project to streamline efforts and establish a common data registry/system into which enrollment and benchmark data could be entered and analyzed.

The state proposes to hire a .5 FTE Policy Specialist to work with the MIECHV program, the HVWG, and the GSST to facilitate the environmental scan process, and carry out activities necessary to update and implement policy and procedures that will address needs and help achieve the defined outcomes. Details about the role of the Policy Specialist are included in the Implementation Plan, below, under Workplan.

Through the Policy Specialist, the state will also collaborate with the Pew Home Visiting Campaign efforts to identify opportunities for advancing state policies in Michigan that strengthen the quality of home visitation programs and expand the use of evidence-based research.

On June 22, Governor Snyder signed the FY 12 State budget, which included a new provision stating that MDCH shall use at least 50% of funding for home visiting for evidence-based models, or for models that conform to a promising approach that are in the process of being evaluated for effectiveness, with a goal of being evidence-based by January 1, 2013. This provision will support the MIECHV work to implement evidence-based home visiting programs throughout the state. The FY 12 MDCH budget also contains a provision requiring that the department establish an integrated benefit for Medicaid evidence-based home visiting services to be provided by Medicaid health plans for eligible beneficiaries. This provision will likely have a significant impact on fiscal strategies and sustainability strategies for home visiting programs in Michigan.

Pilot coordinated intake and referral systems for home visiting in three communities.

In order to establish solid infrastructure that will enhance the success of home visiting programs and efforts, Michigan proposes to pilot local coordinated/centralized outreach, intake, referral, and follow-up systems intended to:

1. Improve access; make it easier for families to be linked to home visiting programs and for health care and other providers to make referrals.
2. Ensure that families are matched to the programs that best meet their needs.
3. Reduce costs by conducting joint outreach activities.
4. Increase efficiencies by making sure available slots across programs are filled.
5. Reduce duplication of services.
6. Utilize a Data Registry to guide and document efforts.

The HVWG will issue an RFP to counties with existing or new Nurse-Family Partnership (NFP) programs to solicit applications to develop and pilot centralized/coordinated outreach, intake, referral, and follow-up for home visiting programs, in order to use services and funding in the most effective and efficient manner, while still taking family preference into account. Applicants would be asked to:

1. Establish central point of intake to process and forward referrals
2. Create common policy around referral and feedback to referral source
3. Create common forms for referral, feedback to referral source
4. Measure success of referral and feedback to referral source
5. Ensure integration with local medical home initiatives including the state's MACAP project.
6. Collaborate with the state in the exploration and development of an electronic Data Registry that can help to capture and display basic data needed for a coordinated outreach, intake, referral and follow-up system.

Based on the quality of their grant applications, entities in three of the communities implementing Nurse Family Partnership programs would be selected to conduct the pilots. They will be required to collaborate closely with state activities and efforts (under this grant, under the overall MIECHV program, the MACAP project, and with other related projects), and will also be required to share lessons learned with the rest of the State to support growth and sustainability of the system.

Working closely with the MACAP primary care medical home initiative sites and coordinating with the Great Start P-8 Data Mapping and Planning Initiative (along with other projects/programs identified for inclusion in the individual pilot sites) will allow the state to achieve shared outcomes, maximize use of multiple, varied funding sources, and support sustainability of the centralized/coordinated intake, referral and follow-up systems that are piloted in the three communities. This strategy also positions Michigan to take a major step forward in building infrastructure that supports the effectiveness and success of evidence-based home visiting systems and supports the achievement of priority outcomes.

In order to support these activities, Michigan proposes to hire a 1.0 FTE TA Specialist provide training and technical assistance to pilot sites. Michigan will also allocate funds to purchase external TA/consultation from other states or entities that have successfully implemented coordinated systems for outreach, intake, referral and follow-up; this could include sites visits to Michigan or to the external site, presentations, conference calls, webinars, etc. In addition, the state will also release a Request for Proposals to establish a contract with a to be determined entity or individual to research and map the specifications for a Data Registry to be used in conjunction with central/coordinated outreach, intake, referral and follow-up pilot sites.

Build the capacity of home visiting programs to address community needs using evidence-based models.

Michigan proposes to expand/sustain or establish Nurse Family Partnership (NFP) home visiting programs for African American first-time parents in communities with high infant mortality rates.

Starting in 2004, Michigan began to provide state funding for NFP programs in four counties with high infant mortality rates and high black infant mortality rates. This decision was based on data that led Michigan to conclude that NFP would be an effective strategy in the State's overall plan to reduce infant mortality. According to the Office of Minority Health and Health Disparities, promising strategies for reducing infant mortality rates include a "focus on modifying the behaviors, lifestyles,

and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness” (<http://www.cdc.gov/omhd/amh/factsheets/infant.htm>). NFP nurse home visitors utilizing the NFP Visit Guidelines address all of these areas in their work with clients, which means that NFP not only has a strong evidence-based, but it is also an excellent fit for addressing the conditions that lead to increased infant mortality.

In the FY 2012 state budget, the Michigan Legislature allocated \$1.5 million in new state funds specifically to support NFP programs. In addition, a major foundation has given a preliminary commitment to allocate funds to help support NFP in Wayne County. Funds from these two sources will be leveraged to generate additional funds for NFP through Medicaid matching strategies, then combined with funding requested in this Development Grant application. This funding strategy was chosen because it helps the state to maximize available funding and service delivery, and it supports program sustainability by using multiple, varied funding sources. The strategy also positions Michigan to take a major step forward in building its evidence-based home visiting system and addressing priority outcomes.

The table below indicates which of the 10 counties with highest concentration of risk would receive Development grant funds (in addition to funds from other sources) for NFP:

Table 3. Counties receiving NFP funding

County	Receipt of Development Grant Funds	# Families Served Annually
Genesee	Yes, to establish new program.	100
Wayne	Yes, to re-establish new program.	200
Saginaw	Yes, to establish new program.	100
Ingham	Yes, to establish new program.	100
Berrien	Yes, to sustain/expand existing program.	100
Kent	Yes, to sustain/expand existing program.	100-150

Existing NFP programs in three additional communities already have funds to continue their programs (Calhoun and Oakland Counties), or will receive state and Medicaid matching funds (Kalamazoo County), but not funding under this grant.

In order to successfully implement and support the proposed NFP programs, the state will establish a 1.0 FTE position for an NFP State Coordinator/Clinical Nurse Consultant. This position will work closely with the NFP National Service to support successful fiscal and administrative program implementation

Goals/Objectives

These above strategies and activities are directed toward achieving the following grant goal and objectives:

Grant Goal:

To develop capacity to build a home visiting system that supports the effective and efficient implementation of home visiting programs that align with community needs and target shared, high priority outcomes.

Grant Objectives:

By the end of the grant period, Michigan will have established State-level policies, procedures, standards, and funding mechanisms that support high quality, evidence-based home visiting, as evidenced by achieving the following objectives:

1. All State agencies that administer local home visiting programs will have a plan in place to implement a common set of outcomes and benchmarks.
2. All State agencies that administer local home visiting programs will have a plan in place to ensure that the programs they fund implement evidence-based home visiting models with fidelity.
3. All State agencies that administer local home visiting programs will have a plan in place to ensure that the programs they fund are coordinated with one another at the local level.
4. 80% of home visiting agencies at the State and local levels will report that the common outcomes and benchmarks, program standards and models, and framework for home visiting coordination developed through this grant will support the implementation of a high quality home visiting system.
5. Additional funding for the implementation of evidence-based home visiting models will be secured.

By the end of the grant period, Michigan will have developed a coordinated system for outreach, intake, referral, and follow-up, as evidenced by achieving the following objectives in the three pilot communities:

1. The number of referrals received by the lead coordinating agency will increase every six months.
2. The number of families who receive a referral that receive home visiting services will increase every six months.
3. 90% of spaces for families in all home visiting programs will be filled.
4. 90% of pregnant, first-time mothers seeking home visiting services will be referred to NFP.
5. 90% of home visiting programs will report that the outreach, intake, referral, and follow-up system piloted in their community is effective and efficient.

By the end of the grant period, Michigan will have built the capacity of home visiting programs to address community needs using evidence-based models by implementing or expanding NFP in six communities, as evidenced by achieving the following objectives:

1. Four new NFP programs will meet the 18 NFP fidelity standards.
2. 80% of clients served by two expanded NFP programs will be African American first time mothers facing multiple risk factors for infant mortality.
3. 80% of clients served by two expanded NFP programs will:
 - a. Receive the recommended number of prenatal visits while enrolled in the program.
 - b. Not become pregnant 0-12 months postpartum.
4. 80% of children served by two expanded NFP programs will:
 - a. Be up-to-date with well child visits.
5. 90% of clients served by the six NFP programs funded through this initiative will:

- a. Receive a screening for maternal depression and, if needed, receive a referral to appropriate services.
 - b. Be provided with information on injury prevention, safe sleep, and car seat safety.
6. The six NFP programs funded through this initiative will meet reporting requirements for all benchmarks and constructs, as required in the State Plan.

Using Michigan’s MIECHV Logic Model as a starting point, a logic model for this project was developed to reflect the relationship between this project’s strategies and anticipated outcomes. Both logic models are included in Attachment 1. Michigan’s MIECHV Program Working Logic Model (Attachment 1, Figure 1) provides the context for the logic model developed for this Development Grant application (Attachment 1, Figure 2). The strategies, outputs, and outcomes that Michigan will target through this funding opportunity, if awarded, are highlighted in bold text in the Michigan MIECHV Program Working logic model. This project will advance Michigan’s MIECHV project by (1) establishing policies, standards, and funding mechanisms that support a common vision, (2) establishing a coordinated intake and referral system (in pilot communities), and (3) building the capacity of HV programs to address community needs using evidence-based models (by establishing and expanding NFP programs in high need areas).

This project’s Development Grant Logic Model includes inputs, strategies, outputs, and outcomes. Inputs include funding for this initiative and for home visiting in the state, the evidence base supporting home visiting models and the models themselves, the institutional and programmatic infrastructure for home visiting in the state, and the many partners that will be involved in the implementation of this project. The strategies reflect some of the most difficult implementation challenges faced in this state, as well as priorities identified in Michigan’s MIECHV logic model, as noted. The logic model asserts that:

1. By implementing strategies to establish state-level policies, procedures, standards, and funding mechanisms for high quality home visiting, Michigan’s home visiting system will become more aligned in that it will move toward operating under common standards, pursue common outcomes and benchmarks, improve the sustainability of funding for home visiting, and begin to operate as an integrated system.
2. By piloting a coordinated system for outreach, intake, referral, and follow-up, the efficiency of these processes in pilot communities will improve, relationships between agencies will be strengthened, and families will receive home visiting services that align with their needs.
3. By building the capacity of home visiting programs to address community needs through expanding NFP in areas of the state where infant mortality is high, gaps in services in high need communities will be reduced and enrolled families will demonstrate improvements in maternal and newborn health.

Empirical and Theoretical Framework

Research regarding program implementation has generated a wealth of information regarding factors that facilitate and inhibit program effectiveness. Certainly this body of research suggests that effective implementation drives better outcomes and that attention to implementation is critical to ensuring effective and efficient use of programming dollars. Implementation research also suggests that model fidelity can only be achieved if it is supported by the implementation context. Multiple factors have been identified at the individual, organizational, and community levels that facilitate or inhibit effective implementation and model fidelity (Fixsen, Naom, Blasé, Friedman, & Wallace, 2005).

As noted, Michigan faces several key challenges in the effective implementation of its home visiting system. As a decentralized state, it is particularly challenging to create and operate under a shared vision, to integrate programming, or to form lasting partnerships across agencies. These are precisely the factors identified by Riley et al. (2001) as predicting effective implementation of health promotion programs.

As noted, Michigan selected three key strategies in order to begin to address these factors. In order to guide both the implementation of these strategies and the evaluation of this effort, Michigan is using the work of both Fixsen and Blase's (2008) and Durlack and DuPre (2008).

Michigan's strategies take an ecological approach to system building and, as such, align with Durlack and DuPre's (2008) Framework for Effective Implementation. This Framework was developed through a comprehensive review of the implementation literature, which identified factors at multiple levels of the ecological system that drive successful implementation. The first and second strategies are designed to address what Durlack and DuPre call **Community Level Factors**, which include prevention theory and research, politics, funding, and policy. The second and third strategies will be implemented and evaluated based on the **Provider Characteristics, Characteristics of the Innovation**, and factors relevant to the **Prevention Delivery System** identified by these authors. This framework emphasizes interaction between factors and contextualizing program implementation in the larger ecological context in which programs are disseminated, adopted, implemented, and sustained. This contextualized approach to understanding program implementation fits Michigan's experience and provides a helpful structure for understanding, addressing, and evaluating progress toward changing the implementation challenges faced by Michigan's home visiting system.

The Provider Characteristics identified by Durlack and DuPre will be understood in the context of Fixsen and Blase's (2007) Conceptual Framework for Effective Implementation. This Framework organizes what Durlack and DuPre called 'provider characteristics' that drive effective implementation along three dimensions: **Competence, Organization, and Leadership**. The implementation drivers associated with each of these dimensions will be explored as part of the evaluation and supported as part of the implementation of NFP programs in each community.

Additionally, Michigan's third strategy involves implementing new NFP programs, and Fixsen and Blase's (2008) work on the stages of implementation will be a key resource in guiding the implementation and evaluation of this strategy in particular. Fixsen and Blase emphasize that implementation is a process that evolves over time and in stages. Program implementation begins with **exploration**, which involves forming an implementation team, assessing community need and service availability, building capacity and buy-in, becoming familiar with the program and assessing feasibility. The second stage of implementation, **installation**, involves building the infrastructure for a program, selecting a provider, establishing where the program fits in the service system, hiring and training staff and volunteers. The third stage of implementation is **initial implementation**, which includes early efforts to implement the program, and the fourth stage is **full implementation**, which is characterized by a fully functioning and integrated program. Once fully implemented, programs move into the **innovation** stage, during which they begin to improve quality and evaluate impact. The final stage of implementation is **sustainability**, during which programs have demonstrated good outcomes, have stories to support their value, and established a base of support.

By drawing from both Durlack and DuPre's Framework for Effective Implementation and Fixsen and Blase's work on both implementation drivers and implementation stages, Michigan's approach will draw from, align with, and feed into the evidence base regarding effective program implementation.

WORK PLAN:

Michigan's Workplan for implementing the proposed Development Grant is included in Attachment 7. The Workplan describes project Objectives, Activities, Staffing, and a timeline for completion of the activities for the two year project.

Implementation Plan for Proposed State Home Visiting Program

The following Implementation Plan lays out the activities and steps that will be used to achieve each of the activities proposed for the project. It is divided into three sections, corresponding to the three key components of this application.

A. Establish/expand NFP

Michigan's plan to implementation new NFP programs and expand existing NFP programs is strongly grounded in implementation science. The State's commitment to this approach is based on experience with past systems-building initiatives that had to be "restarted" multiple times because the findings of implementation science had not been incorporated into the state and local level action plans. For example, in previous initiatives it became clear that often communities did not really understand the concept of fidelity to the model, were not truly ready to make the major program and systems changes required (although they thought they were), did not have experience with using data for CQI purposes, and did not have strong leaders to spearhead the challenging work of systems-building. When the State was exposed to the principles derived from implementation science, we experienced a collective ah-hah moment and felt we clearly understood what we really needed to do to help communities succeed.

Implementation is most successful when a number of factors are attended to by programs and organizations (state and local) that have the responsibility for the system building/change. The factors impacting the success of these endeavors include:

1. Practitioners receive training, coaching, and frequent performance assessments.
2. Organizations provide the infrastructure needed for training, supervision and coaching, as well as regular process and outcomes evaluation.
3. Community and consumers are involved in the selection and evaluation of programs/practice.
4. Funding streams, policies and regulations create a positive environment for implementation and program operations.

Michigan has had extensive experience working with the NFP Program Developer for the Midwest Region in the past, and has had in-depth conversations with her to develop this proposal. MDCH will contract with an NFP State Coordinator/Clinical Nurse Consultant, who will ensure that NFP is implemented with fidelity to the model in each of the six program sites.

The Director of Program Development, NFP National Service Office (NSO), has provided a letter verifying that the NSO has reviewed Michigan's proposed application and that it includes the specific elements requested in the FOA, and that the NSO is supportive of Michigan's participation in the national evaluation and any other related HHS effort to coordinate evaluation and programmatic technical assistance (Attachment 8).

1. Plan to engage community

The Health Officers of the local health departments in each of the six selected counties have indicated they will administer NFP programs as described in this application and have submitted

letters of agreement (Attachment 4). The Great Start Collaborative Directors in each county have agreed to help integrate the new NFP programs within their respective local early childhood systems (Attachment 9). The Great Start Collaborative in each community will play a key role in integrating NFP with community partners and engaging community partners with these NFP programs.

2. Plan for monitoring, program assessment and support, and technical assistance
The NFP State Coordinator/Clinical Nurse Consultant will assist new sites with start-up activities, and be responsible for the monitoring function, as well as for program assessment, support, and technical assistance. The NFP State Coordinator/Consultant will work closely with the NSO Program Developer to facilitate communications between the NSO and the program sites. The NFP State Coordinator/Consultant will also participate in monitoring, program assessment and support, and the provision of technical assistance.
3. Plan for professional development and training
All NFP program staff will participate in professional development and training activities as required by NFP. Michigan ensures that every team of nurses employed to deliver NFP will:
 - a. Receive NFP-specific education as well as expert NFP nursing practice consultation to develop basic competencies in delivering the program model successfully;
 - b. Receive adequate support and reflective supervision within their agencies;
 - c. Receive ongoing professional development on topics determined by nursing supervisors to be critical for continued growth. Professional development may be offered within a host agency or through more centralized or shared venues;
 - d. Engage in individual and collective activities designed to reflect on the team's own practice, review program performance data, and enhance the program's quality and outcomes over time; and
 - e. Utilize ongoing nurse consultation for ongoing implementation success.
4. Plan for staffing and subcontracting
The State will establish contracts with the local health departments that will responsible for administration of the NFP programs, obligating them to meet all requirements specified by the NFP NSO within designated timeframes. Specifications will require maintaining fidelity to all of the model standards, including those pertaining to hiring, training, curriculum, supplies, supervision, staffing, timeline to reach caseload size, TA participation, data collection, reporting, etc. Contracts will be written as soon as this grant application is approved.

At the State level, oversight across NFP projects will be provided by the NFP State Coordinator/Consultant with funds from this grant. The NFP State Coordinator/Consultant will report to the MDCH Perinatal Health Unit Manager, whose time will be provided on an in-kind basis.

5. Plan for recruiting and retaining participants
Plans will be developed individually by community, to reflect the needs/issues with each community. The work will be facilitated by the NFP State Coordinator/Consultant and the NSO Program Developer and build on best and promising practices for recruitment and retention.
6. CQI plan
The State has agreed to participate in all NFP quality initiatives including, but not limited to research, evaluation, and continuous quality improvement. The State will also monitor model

quality via our Continuous Quality Improvement teams at both the state and local levels, as described in our *FY 2010 MIECHVP Updated State Plan*. The GSST Home Visiting Workgroup (HVWG) will add local and state stakeholders with a variety of perspectives on the home visiting system and function as the State CQI team. The Home Visiting Program Local Leadership Group that was established in each of the six selected counties will add additional stakeholders and function as the local CQI team.

7. Plan to maintain fidelity to model
Michigan will enter into a service agreement with the NFP NSO and implement NFP in accordance with the agreement. In so doing, Michigan will implement NFP with fidelity to the model.
8. Plan to collect data on legislatively-mandated benchmarks
Data on legislatively-mandated benchmarks will be collected for all NFP participants, as described in our *FY 2010 MIECHVP Updated State Plan*. Although the *State Plan* proposes to expand existing Healthy Families America programs and Early Head Start – Home-based programs, rather than NFP programs, the data collection plan is also applicable to for NFP program participants. The State will establish a contract with the NFP NSO to share data they are collecting, to enable measurement of MIECHV benchmarks.
9. Plan to coordinate with appropriate entities/programs
The Local Leadership Group (LLG) in each of the six counties will help to coordinate the NFP with other local home visiting programs. The LLG also will ensure that the NFP is integrated within the larger local early childhood system. The LLG is in a position to do this because it is required to be a subcommittee of, or to be otherwise clearly linked to, the local Great Start Collaborative, which is responsible for the building the comprehensive early childhood system at the county level.
10. Description of how the proposed activities would fit into the state administrative structure
The Michigan Home Visiting Program is administered by the Michigan Department of Community Health, which is the State’s Title V agency. It is a component of Great Start, Michigan’s initiative to build comprehensive early childhood system at the state and local levels to ensure that every young child arrives at kindergarten healthy and ready to succeed, with parents who are committed to educational achievement. Integral to the state-level planning for ECCS is the Great Start Systems Team (GSST), a state-agency advisory group in place to operationalize the *Great Start Blueprint* (ECCS State Early Childhood Plan).
In 2009, the GSST charged a Home Visiting workgroup (HVWG) to study existing home visitation programs in the State in order to develop a set of interdepartmental recommendations to more effectively address financing, coordination, administration, common messaging and future investment in home visiting. When DHHS announced the *Maternal, Infant, and Early Childhood Home Visiting Program* in June 2010, it was determined that the HVWG would advise the GSST as it develops Michigan’s new Home Visiting Program. Programs funded under this grant would be monitored by MDCH staff who will report to the HVWG, and the HVWG will report to the GSST. An organizational chart describing the current relationships among the State-level agencies and entities, relationship to the GSST and HVWG, and relationship to local partner agencies and entities is attached (Attachment 5).
11. Plan to ensure incorporation of project goals, objectives, and activities into the ongoing work of the eligible applicant and any other partners at the end of the federal grant

Michigan is very invested in developing a high-quality home visiting system that supports evidence-based models. The GSST and the entire Great Start system will advocate for funding and policies that will allow the State to continue to support home visiting programs throughout the course of, and at the end of, this federal grant.

B. Local Centralized Outreach, Intake, Referral and Follow-Up System

1. Plan to engage community

An RFP will be issued to solicit applications from entities in NFP counties that are interested in piloting a centralized outreach, intake, referral and follow-up system. Three pilot projects will be funded.

2. Plan for monitoring, program assessment and support, and technical assistance

The RFP will be developed based on consultation from persons who have established similar systems in other states. Ongoing technical assistance on the development of a centralized system will be provided by the *Technical Assistance Specialist* (1.0 FTE) with funds from this grant. The *Specialist* will report to the MDCH Child Health Unit Manager, who is the Project Administrator for the Michigan MIECHVP, and whose time will be provided on an in-kind basis.

3. Plan for professional development and training. A plan for professional development and training will be determined by the pilot sites, working with the state TA Specialist. Michigan will also allocate funds to purchase external TA/consultation from other states or entities that have successfully implemented coordinated systems for outreach, intake, referral and follow-up; this could include site visits to Michigan or to the external site, presentations, conference calls, webinars, etc.

4. Plan for staffing and subcontracting

The State will establish contracts with the three local entities selected as pilots. A *Technical Assistance Specialist* (1.0 FTE) will be hired with funds from this grant. The *Specialist* will report to the MDCH Child Health Unit Manager, who is the Project Administrator for the Michigan MIECHVP, and whose time will be provided on an in-kind basis.

In addition, the state will also release a Request for Proposals to establish a contract with a to be determined entity or individual to research and map the specifications for a Data Registry to be used in conjunction with central/coordinated outreach, intake, referral and follow-up pilot sites.

5. Plan for recruiting and retaining participants. Not applicable.

6. CQI plan. CQI activities will build on the State's overarching SQI plan. Implementation and success will be monitored by the CQI teams (e.g. LLG) in the communities who are successful in bidding on the RFP for to pilot the centralized outreach, intake, referral and follow-up systems.

7. Plan to maintain fidelity to model. Not applicable.

8. Plan to collect data on legislatively-mandated benchmarks. Not applicable.

9. Plan to coordinate with appropriate entities/programs

The goal of funding the pilots is to determine how best to coordinate home visiting programs at the county level.

10. Description of how the proposed activities would fit into the state administrative structure. See #10 in Section A above.

11. Plan to ensure incorporation of project goals, objectives, and activities into the ongoing work of the eligible applicant and any other partners at the end of the federal grant. See #11 in Section A above.

C. Establish State-level Policies, Procedures, Standards, and Funding Mechanisms to Support a High-Quality, Evidence-Based Home Visiting System

Implementation of this component is different from implementation of the first two components, in that it involves inter-departmental policy-making, rather than the implementation of programs or coordination of multiple programs. Because it is so different, the 11 implementation plan items discussed in the first two sections do not appear to be applicable.

The implementation plan for this component consists of four key tasks:

1. MDCH will hire a *Policy Specialist* (5.0 FTE) with funds from this grant. The *Specialist* will report to the MDCH Child Health Unit Manager, who is the Project Administrator for the Michigan MIECHVP, and whose time will be provided on an in-kind basis.
2. The *Specialist* will assist the HVWG to identify policies, procedures, and standards that support high-quality, evidence-based home visiting systems.
3. The Specialist will present these policies, procedures and standards to the HVWG.
4. The HVWG will review these policies, procedures and standards and use them to develop recommended policies, procedures and standards to the GSST.
5. The Project Administrator will present the recommended policies, procedures and standards to the GSST.
6. The GSST will review, revise and ultimately adopt inter-departmental policies.

RESOLUTION OF CHALLENGES

In developing this proposal, Michigan has identified the following potential challenges, and potential approaches to address the challenges:

Challenges likely to be encountered in designing and implementing Work Plan activities	Approaches that will be used to resolve challenges
1. The project may encounter resistance to moving from a decentralized system to a more centralized system in which the State assumes more decision-making authority regarding home visiting models that will be funded.	The project will provide multiple professional development activities to allow communities to come to an understanding of the rationale for this move and engage them in planning for the transition.
2. The project may encounter resistance to moving from non-evidence-based models that serve a greater number of families to evidence-based models that	The project will provide multiple professional development activities to allow communities to come to an understanding of the rationale for this move and engage them in planning for the

serve significantly fewer families.	transition.
3. It may be difficult to find qualified individuals with cross-systems experience, as well as master’s level nurses (NFP), to fill job openings at the State level.	The project will use professional social networks to attempt to locate individuals with cross-systems experience. We will use State connections with schools of nursing at Michigan’s institutions of higher learning.
4. It may be difficult to find qualified nurses to fill NFP job openings at the local level.	The project will use State connections with schools of nursing at Michigan’s institutions of higher learning.
5. The burden of administering all of the tools required to measure progress toward benchmarks may be heavy for staff at local the level.	Great care will be taken to educate staff about the importance of administering the measures and about how do this efficiently.
6. It may be challenging to get GSST members to come to consensus on some joint policies.	Having a half-time staff person to focus solely on interdepartmental policy-making will help the GSST to make decisions based on solid information and recommendations.
7. It may be challenging to implement some grant activities concurrently with the establishment of the new Great Start Office of Early Childhood.	One of the GSST members (who is also a HVWG member) is detailed from the ECIC to the Department of Education to help establish the new office, so there will be close communication between this project and the new office.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

Staff Qualifications

The Michigan Public Health Institute (MPHI) is serving as the evaluator for Michigan’s Home Visiting Program and, if awarded, will serve as the evaluator for this initiative as well. The evaluation will be lead by Dr. Cynthia Cameron and Dr. Julia Heany, and it will be staffed by a team of research assistants who have program evaluation experience and familiarity with home visiting.

Dr. Cynthia Cameron will serve as co-principal investigator for the project. Dr. Cameron studied families and the systems that serve them at Michigan State University, where she earned her PhD in family ecology. Dr. Cameron has extensive experience working with parents of children with special needs. She is a long-time advocate of compensating parents for their expertise on how to improve service delivery and has employed numerous parents as consultants to the health, human service, and education systems. Dr. Cameron currently acts as the director of the Region 4 Genetics Collaborative which supports parent consultants from Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin to participate in developing and implementing a regional plan to ensure that children with heritable disorders have access to a medical home. She also administers the Parent Leadership Project which is designed to enhance the skills that parents need to actively and effectively participate on State level advisory boards. Dr. Cameron brings extensive knowledge of home visiting evaluation and early childhood system building to the project team.

Dr. Julia Heany will serve as co-principal investigator for the project. Dr. Heany currently serves as a Program Director at the Michigan Public Health Institute (MPHI) where she is responsible for

overseeing the major operations of the Center for Healthy Communities (CHC). Dr. Heany completed her PhD in Community Psychology from the University of Missouri-Kansas City in 2005. Dr. Heany's research interests involve identifying the ways communities facilitate or inhibit family health and wellbeing through studying the interconnections between multiple levels of the human ecological context. More specifically, Dr. Heany's research interests center on the social and legal response to violence against women, the prevention of child maltreatment, and child and family policy. Dr. Heany has over ten years of research experience, including experience with program evaluation, the use of multi-method design, and participatory models of community research. Dr. Heany currently fulfills the role of principal investigator on various research and evaluation projects within MPHI-CHC, including the statewide evaluation of Michigan's Zero to Three Program, which funds home-based child abuse prevention programming in the areas of the State with the highest rates of abuse and neglect.

Organizational Experience

MPHI has the organizational experience and expertise in both evaluating early childhood programs and studying program implementation to carry out the evaluation of this project. MPHI currently collaborates with the MDCH and the Michigan Department of Human Services (MDHS) on several State-level evaluation projects that involve measuring program implementation and outcomes at both the state and local levels. As such, MPHI has experience designing and implementing evaluation methods that accommodate local variability while capturing consistent data that can be reported at the state level.

For example, MPHI currently conducts the state level evaluation of the Zero to Three Secondary Prevention Initiative. Zero to Three is a research and evidence based, community oriented, and collaborative child abuse and neglect (CAN) prevention initiative charged with integrating a system of services for Michigan's expectant families and those with children age birth through three who have been identified as at-risk of child abuse and neglect. Zero to Three funds are allocated to grants that support community based, collaborative prevention programs designed to meet the following program goals:

- Foster positive parenting attitudes and skills
- Promote positive parent-child interactions
- Enhance child health, development, and school readiness
- Support healthy family environments
- Strengthen local capacity to serve families at-risk

In order to evaluate the Zero to Three Secondary Prevention Initiative, outcomes are measured and reported annually. Child abuse and neglect prevention outcomes are core to the Zero to Three Secondary Prevention initiative and correlate with the Zero to Three Secondary Prevention Program Indicators. Local grantees are accountable for collecting data and submitting written quarterly reports that measure expected outcomes and indicators. The primary goal of the project is to evaluate the Zero to Three Secondary Prevention program, reporting outcomes to DHS and providing local grantees with resources for local evaluation and quality improvement. MPHI monitors built-in measures of dosage exposure such as number of families and children served, number of pregnant women served, number of families with three or more risk factors for child abuse and neglect served, number of families screened, new enrollees, number of families completing services, number of services delivered (contacts), proportion of services delivered by type, and proportion of families meeting service indicators. Additionally, MPHI monitors local data collection and reporting activities for accuracy and continuous improvement. MPHI staff receive data from grantees on both a quarterly and annual basis. MPHI staff assess these data for completeness and accuracy, and follow-up with grantees regarding

any missing or inconsistent information. Moreover, MPHI provides ongoing training and technical assistance to local grantees with data collection.

In addition to having experience evaluating statewide home visiting programs, MPHI has experience studying program implementation and monitoring model fidelity. MPHI utilizes an approach to monitoring fidelity that is designed to ensure data are captured that speak to both the extent to which a program model was implemented as designed and factors driving deviation from the model. MPHI's experience with performance management and quality improvement allows for the development of monitoring strategies that can be used to drive process improvement at the program level, as well as addressing evaluation objectives.

For example, MPHI is currently the evaluator for a CDC-funded REACH US grant of the Intertribal Council of Michigan (ITCM). Through the REACH US project, ITCM coordinates tribal community-based programs that implement culturally tailored evidence-based interventions to eliminate health disparities in cardiovascular disease and diabetes, and address behaviors such as poor nutrition, lack of physical activity and tobacco use, among three federally qualified American Indian communities in Michigan. Using the principles of community-based participatory evaluation, MPHI develops and implements evaluation strategies at the local program level and coordinates these activities with the national REACH US evaluation effort. Key evaluation activities include analysis of RPMS clinic data, tribal specific analysis of REACH Risk Factor Survey data, training Tribes on the CDC CHANGE tool, and analyzing CHANGE tool data.

Purpose

The evaluation of Michigan's competitive MIECHVP grant is designed to meet the needs of multiple stakeholders. First, it is designed to inform continuous quality improvement (CQI) at the local and state levels. Data will be used to identify opportunities for improvement and will be used to track change over time. Second, it will be used to provide information that can be used by state and local partners to build on or expand the implementation of the strategies tested as part of this grant. Third, it will be used to provide information to HRSA regarding the implementation and outcomes of the strategies toward building capacity in the implementation of a statewide home visiting system. Finally, it will be used to identify lessons learned regarding system building that can be broadly disseminated to other state and local agencies that are confronted with challenges similar to Michigan's.

The evaluation reflects the logic model presented in the introductory section of this application and the grant goal and objectives presented in the methods section. It also builds on the ecological approach to program implementation reflected in Durlack & DuPre's (2008) Framework for Effective Implementation and the specific strategies selected. Using Schoenwald & Hoagwood's (2001) recommendations regarding the foci of implementation studies using an ecological approach, this evaluation will explore characteristics of the home visiting system (e.g., policies, financing), characteristics of the organizations administering and implementing home visiting programs (e.g., structure, climate), and characteristics of the home visiting services delivered by the NFP programs funded through this grant, as well as the staff and clients of these programs.

The evaluation reflects the logic model presented in the introductory section of this application and the grant goal, objectives, and strategies presented in the methods section. It also builds on the ecological approach to program implementation reflected in Durlack & DuPre's (2008) Framework for Effective Implementation and Fixsen & Blase's (2007, 2008) work on implementation drivers and stages of implementation. Using Schoenwald & Hoagwood's (2001) recommendations regarding the foci of implementation studies using an ecological approach, this evaluation will explore characteristics of the

home visiting system (e.g., policies, financing), characteristics of the organizations administering and implementing home visiting programs (e.g., structure, climate), and characteristics of the home visiting services delivered by the NFP programs funded through this grant, as well as the staff and clients of these programs.

Evaluation Questions

The evaluation will study both the process of implementing the three targeted strategies and the outcomes of this effort. The following process and outcome evaluation questions, organized by strategy, will guide data collection:

Strategy 1: Establish state-level policies, procedures, standards, and funding mechanisms that support high quality, evidence-based home visiting.

Process Questions

1. Were common standards, outcomes, and benchmarks for home visiting established?
 - a. Who was involved with this process? How were they engaged and how was their involvement sustained? Were key partners missing?
 - b. What strategies were used to identify and prioritize common standards, outcomes, and benchmarks? What barriers were confronted during this process?
 - c. What policies, procedures, and practices were identified that either drive decentralization or could promote a common vision? What policies, procedures, and practices were targeted for change and what stage of implementation was achieved at the end of the grant period?
 - d. Were strategies to ensure that common standards, outcomes, and benchmarks are incorporated into data systems that capture information regarding home visiting at the state and local levels? Were common data elements established? What stage of implementation was achieved at the end of the grant period?
 - e. What organizational, institutional, and/or political forces facilitated or inhibited the movement toward common standards, outcomes, and benchmarks for home visiting?
2. Were strategies to support fiscal leveraging identified and implemented?
 - a. Who was involved with this process? How were they engaged and how was their involvement sustained? Were key partners missing?
 - b. What strategies were used to identify and prioritize opportunities for fiscal leveraging? What barriers were confronted during this process?
 - c. What policies or other formal agreements were identified to leverage resources for home visiting? What stage of implementation was achieved at the end of the grant period?
 - d. What organizational, institutional, and/or political forces facilitated or inhibited the development and implementation of fiscal leveraging strategies?
3. Was a statewide framework established that describes how the home visiting models operating in the state could be aligned to ensure that community needs are addressed and all priority outcomes and benchmarks are targeted?
 - a. Who was involved with this process? How were they engaged and how was their involvement sustained? Were key partners missing?
 - b. What strategies were used to develop the framework? What barriers were confronted during this process?

- c. What policies or other formal agreements were identified to support the implementation of the framework at the state and local levels? What stage of implementation was achieved at the end of the grant period?
- d. What organizational, institutional, and/or political forces facilitated or inhibited the development and implementation of a statewide framework for aligning home visiting programs? What characteristics of the models themselves facilitated or inhibited this process?

Outcome Questions

1. Do all State agencies that administer local home visiting programs have a plan in place to implement a common set of outcomes and benchmarks?
2. Do all State agencies that administer local home visiting programs have a plan in place to ensure that the programs they fund implement evidence-based home visiting models with fidelity?
3. Do all State agencies that administer local home visiting programs have a plan in place to ensure that the programs they fund are coordinated with one another at the local level?
4. Do 80% of home visiting agencies at the State and local levels report that the common outcomes and benchmarks, program standards and models, and framework for home visiting coordination developed through this grant will support the implementation of a high quality home visiting system?
5. Was additional funding secured that will support home visiting and sustain the gains achieved during this grant period?

Strategy 2: Pilot a coordinated outreach, intake, referral and follow-up system in three communities.

Process Questions

1. How were the 3 pilot communities selected? How was the lead coordinating agency selected?
 - a. What existing capacity did these communities and agencies offer?
 - b. What barriers or challenges did they anticipate?
2. How were state and local coordinating agency staff selected, trained, and supported in their role?
 - a. What were their technical assistance needs?
 - b. How were their TA needs addressed?
3. Were partnerships and coordination between agencies providing home visiting services and referrals to home visiting services improved?
 - a. What partners were involved with this process in each community? How were they engaged and how was their involvement sustained? Were key partners missing?
 - b. What strategies were used to build partnerships and improve coordination between agencies? What barriers were confronted during this process?
 - e. What policies or other formal agreements were identified and implemented to support partnership and coordination between agencies?
 - c. What organizational, institutional, and/or political forces facilitated or inhibited improved coordination between agencies?
4. Were common outreach, intake, consent, referral, and follow-up materials and procedures developed and implemented?

- a. What challenges were confronted in the development and implementation of materials and procedures? To what extent were these challenges resolved? How were they resolved?
5. Did the coordinated outreach, intake, referral, and follow-up system meet the needs of agencies providing referrals and home visiting agencies?
 - a. Were materials and procedures clear to partner agencies?
 - b. Did materials and procedures accurately represent and meet the needs of partner agencies?
 - c. Did agencies providing referrals feel that their interactions with the coordinating agency were helpful, timely, respectful, and effective?
 - d. Did home visiting agencies feel that their interactions with the coordinating agency were helpful, timely, respectful, and effective? Did home visiting agencies feel that referrals were directed consistent with policy?
 6. Did the coordinated outreach, intake, referral, and follow-up system meet the needs of clients?
 - a. Were materials clear to clients?
 - b. Were clients satisfied with the procedures used by coordinating agencies to connect clients with home visiting services?
 - c. Did clients feel that their preferences were honored by the coordinating agency?
 - d. Did clients feel that their interactions with the coordinating agency were helpful, timely, supportive, respectful, and effective?

Outcome Questions

1. Did the number of referrals received by the lead coordinating agency increase every six months throughout the course of the grant?
2. Did the number of families who receive a referral that receive home visiting services increase every six months?
3. Were 90% of spaces for families in all home visiting programs in the pilot communities filled? Were home visiting programs more likely to reach capacity at the end of the grant period as compared with the start of the grant period, controlling for the number of home visiting slots available? Were NFP programs in pilot communities more likely to reach capacity than NFP programs in other communities?
4. Were 90% of pregnant, first-time mothers seeking home visiting services referred to NFP?
5. Did 90% of home visiting programs report that the outreach, intake, referral, and follow-up system piloted in their community was effective and efficient?

Strategy 3: Build the capacity of home visiting programs to address community needs using evidence-based models by implementing or expanding NFP in six communities.

Process Questions

1. How were the four new and two expansion sites selected?
 - a. What stage of implementation characterized each site at the point of selection and at the end of the funding period?
 - b. Did evidence suggest that NFP aligned with local needs and resources in each expansion site?
 - c. Did the home visiting agencies selected for funding believe NFP would meet a community need effectively?

- d. Did the home visiting agency staff believe that they would be able to effectively implement NFP and meet the objectives of this grant?
- e. Did the home visiting agency staff have the skills necessary to implement NFP effectively?
2. What characteristics of the NFP model facilitated and inhibited effective implementation?
 - a. To what extent was NFP viewed as compatible with each agency's priorities and practices?
 - b. What challenges did each site face in ensuring fidelity to the NFP model?
 - c. What strategies were used to ensure fidelity to the model elements in each area, including clients, intervention context, expectations of nurses and supervisors, application of the intervention, reflection and clinical supervision, program monitoring and use of data, and the agency?
3. To what extent did all six NFP sites have the organizational capacity to support effective implementation of NFP?
 - a. How was NFP effectively integrated with each agency's existing structures and programming?
 - b. To what extent did each site have the necessary leadership support, supervisory support, and staffing support in place to implement NFP?
 - c. To what extent did each site engage in effective communication internally and with other agencies?
 - d. What were the strengths and limitations of the programs' data systems? Were they effective tools for decision support?
 - e. In what ways did NFP sites use CQI to address changes constructively and achieve targeted outcomes?
 - f. To what extent did NFP sites receive the training, coaching, and technical assistance they needed to implement NFP effectively? What performance assessment processes were implemented and how were they viewed?
4. What strategies did NFP sites use to recruit, enroll, and retain high need African American first time mothers during pregnancy? What strategies were most and least effective?

Outcome Questions

1. Did the four new NFP programs meet the 18 model elements used to establish fidelity to the NFP model by the end of the grant period?
2. Were 80% of clients served by the two expanded NFP programs African American first time mothers facing multiple risk factors for infant mortality?
3. Did 80% of clients served by the two expanded NFP programs receive the recommended number of prenatal visits while enrolled in the program?
4. Did 80% of clients served by the two expanded NFP programs not become pregnant 0-12 months postpartum?
5. Were 80% of children served by two expanded NFP programs up-to-date with well child visits?
6. Did 90% of clients served by the six NFP programs funded through this initiative receive a screening for maternal depression and, if needed, receive a referral?
7. Were 90% of clients served by the six NFP programs funded through this initiative provided with information on injury prevention, safe sleep, and car seat safety?
8. Did the six NFP programs funded through this initiative meet reporting requirements for all benchmarks and constructs, as required in the State Plan?
 - a. Did the two expanded NFP programs achieve progress on each benchmark and construct?

- b. Did the four new NFP programs achieve progress on each benchmark and construct?

Approach & Design

The design of this evaluation is grounded in Durlack and DuPre's framework for effective implementation and Fixsen & Blase's stages of implementation and implementation drivers, as described above. Additionally, the evaluation design aligns with the theory of change articulated in the project logic model, and draws from the NFP theory of change. The evaluation also embraces a participatory approach in that the evaluation will unfold in close collaboration with project partners and it will be designed to provide partners will useful and actionable information.

Given the complexity of Michigan's home visiting program and the multiple levels of change targeted by the strategies implemented through this grant and Michigan's MIECHV grant, it is critical that the evaluation employ a mixed-methods, multi-level design. Evaluation methods will capture both quantitative and qualitative data regarding strategy implementation and outcomes. Multiple data sources will be used to answer the evaluation questions described above in order to create a comprehensive picture of how strategies are implemented and progress toward grant objectives.

Methods

Data collection methods will be designed to capture the information necessary to answer the evaluation questions listed above and to provide stakeholders with needed information. Protocol for each of the methods described below will be developed in collaboration with the MIECHV grant's Continuous Quality Improvement (CQI) team, which includes HVWG participants, local agency representatives, and program participants. Stakeholder input will be used to ensure that each data collection method is sensitive to community context, relevant, and useful.

Before data collection begins, MPHI will submit this project to MPHI's Institutional Review Board (IRB) to ensure the protection of human subjects. In order to ensure that data collection is carried out in a way that is consistent with protocol and human subjects protections, MPHI will provide an orientation for program staff at all levels to the evaluation design and using data for quality improvement. Additionally, MPHI will provide ongoing technical assistance on the evaluation and quality improvement throughout the grant period.

Meeting Participation & Participant Observation

Consistent with a participatory approach to evaluation, members of the evaluation team will engage with this project as participant observers, both to share information about the evaluation and to gather information about the process of implementing the project's three key strategies. A member of the evaluation team will attend meetings of the HVWG and State CQI team. A member of the team will also periodically attend GSST meetings and key meetings at the local level. When feasible and appropriate, a member of the evaluation team will conduct observations in direct service settings, collecting information about system operations and the implementation of new policies and procedures. Any observations will be designed to be as non-invasive as possible and will be coordinated around the needs and concerns of our partners. Observations will be carefully documented and analyzed in concert with other data to provide rich, contextual descriptions of the implementation of project strategies. Evaluation team members anticipate spending 3-4 days per month conducting observations and attending meetings in order to gather first-hand knowledge of how the project is implemented and to contextualize data gathered through other sources.

Quarterly Conversations

The evaluation team will convene calls on a quarterly basis with each funded community, as well as state staff assigned to this project including the TA specialist, policy specialist, and State liaison to NFP. These calls will be used to gather information about project activities over the last quarter. Questions will be designed based on the specific work plan of the participants and the process evaluation questions most closely related to participants' activities. Calls will be carefully documented through detailed notes. They will be used as a data source, but also to ensure that the evaluation remains relevant and aligns with project implementation as it shifts and changes over time.

Key Informant Interviews

In-depth interviews will be conducted with key partners from participating state and local agencies. These interviews will explore key implementation issues and questions in detail. The evaluation team anticipates conducting approximately 20 key informant interviews each year. These interviews will be conducted by a trained member of the evaluation team using a semi-structured instrument designed to capture information regarding key characteristics of program implementation. Interviews will be scheduled to be as convenient as possible for participants and will be designed to take less than an hour to complete. Interviews will be tape recorded and transcribed for qualitative analysis.

Project Documents

Project outputs include several documents that will be used as a data source for both the process and outcome evaluation. Other useful documents will be produced over the course of project implementation as well, such as applications from communities to develop a coordinated intake and referral system. All documents that are relevant to the process or outcome evaluation questions will be collected and reviewed.

Surveys

Structured surveys will be developed and administered in order to gather information regarding project implementation and outcomes from a broad audience. State and local stakeholders will receive a **Stakeholder Survey** designed to measure perceptions of Michigan's home visiting system. It will include questions regarding funding stability and sustainability; the degree to which home visiting programs pursue common outcomes and benchmarks or operate under common standards; the relationships between home visiting agencies in a community and with other agencies that serve families and children; the efficiency and effectiveness of referral systems; and the alignment between service availability and community needs. The survey will be administered electronically at the beginning and end of the funding period.

In communities piloting coordinated intake and referral systems, the post-test Stakeholder Survey will include an additional module designed to capture information regarding the degree to which the system met the needs and expectations of partner agencies. The **System Coordination Survey** module will be sent to both agencies providing referrals and home visiting agencies, and it will be administered electronically. Survey questions will align with the process evaluation questions described above.

Coordinated intake and referral sites will be asked to collect data from program participants regarding their satisfaction with services. The **Intake and Referral Client Survey** will be designed based on the evaluation questions listed above and it will include questions of particular importance to each site. The evaluation team will work closely with each site to develop a survey administration protocol that protects the rights and privacy of clients and is likely to achieve a reasonable response rate.

Both newly funded and expanded NFP program staff will be asked to complete an **Implementation Capacity Survey**. This survey will align with Durlack & DuPre's (2008) Framework for Effective

Implementation and Fixsen & Blase's implementation drivers and stages of implementation. It will capture information about attitudes and beliefs of agency staff regarding the implementation of NFP in their community by their agency, agency practices and processes that may facilitate or inhibit effective implementation, and training and technical assistance. The survey will be administered electronically at the beginning and end of the funding period.

Program Data

Finally, program data from both coordinated intake and referral sites and NFP program sites will be used to answer evaluation questions. Coordinated intake and referral sites will be required to collect data regarding (1) how families reach the coordinating agency (e.g., referral source, exposure to outreach efforts), (2) family demographic characteristics and eligibility for services, (3) referrals made (e.g., time from first contact to referral, referral alignment with eligibility and policy), and (4) referrals completed (e.g., families receiving services, reason for declining services). The evaluation team will develop a tracking database to maintain this information and will provide agencies with training and technical assistance in utilizing the tracking database.

NFP programs funded through this initiative will be required to submit the same data elements as is required of all direct services grantees under Michigan's MIECHV grant. This will include data they are required to collect for national NFP, as well as additional required data elements. As such, they will collect and submit data regarding progress toward meeting all federally required benchmarks and constructs. These data will be used to measure progress toward achieving outcomes under this project as described in the evaluation questions.

Analysis

Analytical methods will be designed to respond to the evaluation questions and adapted based on data quality and availability. The analytical methods that may be used are described.

Qualitative Analysis

Qualitative data will be analyzed using procedures described by Taylor and Bogdan (1998) as follows. Two evaluation team members will simultaneously become familiar with qualitative data sources through multiple readings and tracking of emerging ideas. During this process, themes, typologies, concepts, and theoretical propositions will be developed by each evaluator. The two evaluators will then work together to develop a coding scheme. The codes will be applied to the data separately by each evaluator, and problems with the coding scheme will be identified and revised. Once data are coded by each evaluator, they will work together to obtain agreement on the proper code for each data element. Coded data will then be sorted into categories and reviewed. Interpretations and conclusions will be developed through a process of reviewing and rethinking the data in each category. The final step will involve reviewing interpretations and conclusions in context. During this step, data will be discounted by considering factors such as differences between solicited and unsolicited comments and the investigator's impact on the participants. Such evidence will suggest study limitations.

Quantitative Analysis

The analytical strategy used to respond to process and outcome evaluation questions that involve quantitative data will include both presenting simple descriptive statistics and utilizing inferential statistical tools where appropriate.

Reporting & Dissemination

In addition to working in collaboration with the State to meet all federal reporting requirements, MPHI will provide quarterly reports, both written and verbal, to the State HVWG regarding the status of the evaluation. These quarterly reports will provide an opportunity to utilize emerging results to inform CQI activities, as well as ensuring that the evaluation remains in alignment with the project. MPHI will also provide a comprehensive evaluation report at one year and at the conclusion of the grant period. The structure and content of these reports will be informed by project partners, and the reports will be designed to both report findings and inform action.

ORGANIZATIONAL INFORMATION

Michigan is using an interdepartmental structure and team process to address early childhood systems and services integration and coordination. The three involved state departments are MDCH, the Michigan Department of Education (MDE) and the Department of Human Services (DHS). Each department contributes experience, resources and services to impact early childhood outcomes. Another partner in early childhood system building is the Early Childhood Investment Corporation (ECIC). ECIC was founded in 2005 to be a focal point for information and investment in early childhood, including serving as a bridge for public-private funding partnerships on behalf of early childhood systems-building. These four agencies/organizations partner in forming the Great Start System Team (GSST), which has been functioning as the means through which early childhood systems resources, strategic direction and system-building is occurring for Michigan's young children and their families. The MIECHV program is supported within this interdepartmental infrastructure, and has its own Home Visitation Workgroup (HVWG) and subcommittees under the GSST. The Project's Organizational Chart (Attachment 5) reflects this inter-organizational structure as it relates to the MIECHV. The Directors of these agencies/organizations share a commitment to participating in and supporting the goals and work of the MIECHVP, as evidenced by the Memorandum of Concurrence (Attachment 9) that was submitted as part of the MIECHV formula grant application for FY 2010.

Michigan's Governor recently created a new Office of Great Start—Early Childhood that will reside within the Michigan Department of Education. It will combine early learning and child care programs and resources, and work to coordinate funding streams related to early childhood. This will strengthen the focus and accountability on early childhood outcomes for which all of the involved departments share responsibility. Collaborative planning, combined with fiscal strategies to maximize resources across departments, and alignment of policies and priorities will be necessary. All of this speaks to the necessity and clear intent to continue and grow the support for early childhood, including home visitation, into the future. Each of the state departments involved is committed to maintaining, and whenever possible, expanding the resources directed to home visitation. The Executive Order establishing the new Office was just released, on July 30, 2011. While the new office is not reflected in the Project Organizational Chart (Attachment 5), the chart will be updated as details about the new office are released.

The Michigan Department of Community Health (MDCH) is the applicant organization for the MIECHV competitive grant. MDCH is responsible for a comprehensive range of publicly funded health services, resources, policies and outcomes across the state. These are directed to fulfill the Department's stated mission: "MDCH will **protect, preserve, and promote** the health and safety of

the people of Michigan with particular attention to providing for the needs of vulnerable and underserved populations.” The Department includes the State Medicaid Agency, Public Health, Behavioral Health and Developmental Disabilities (including Substance Abuse), Health Policy and Planning, Office of Services to the Aging. It also includes the administrative fiscal, legal, contracting and operational support necessary for managing the over fourteen-billion-dollar annual budget that supports this range of responsibility and accountability. An overall organizational chart for MDCH is provided in Attachment 5.

Each of the major administrations within the Department is responsible for a wide range of health activities and system infrastructure, specific to each health component at both the state and local levels. Each area works with a complex array of stakeholders, including providers, advocates, provider organizations, health care systems, community-based organizations, universities, private sector funders and foundations, federal officials and regulators, other state departments, citizens and service participants.

MDCH approaches its work with an understanding shared across its administrations that the health and wellness of Michigan’s citizens requires an integrated system that is seamless, supports the individual and family across the life course, and that health is holistic. “Holistic” encompasses individual health and development, including mental and relational health. However, it also includes the individual as impacted by his/her home and community environment, and recognizes the impact of social and economic determinants of health, including racism. Hence, all areas within MDCH work together to provide an integrated system of care at any given point in time, as well as over time—recognizing that health begins prior to conception and must be maintained and protected through older age. MDCH’s established vision reflects this systems approach: “Improve health, improve care, lower costs through a competitive and collaborative organized system of care.”

MDCH has the lead responsibility for Michigan’s activities related to health care reform and the Affordable Care Act (ACA). Michigan’s Governor is supportive of maximizing the opportunities for Michigan’s citizens under the ACA, and all administrations are actively seeking (and securing) funding opportunities as they are made available. Many shared activities and strategies are used across MDCH and are a constant and ongoing source of expansion and improvement. This covers joint efforts toward outcomes achievement, the use of matching and leveraging fiscal strategies, shared and complementary policy development, use of relevant data and evaluation results across related areas, common approaches to provider network management and support, and especially the prioritization of person and family-centered planning and involvement.

Of particular significance, Michigan is the largest participant state in the CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) project. Michigan’s project involves over 500 physician practices across the state and all third-party payers, public and private, are involved. Blue Cross Blue Shield is heavily involved, and the collaborative processes involved amongst all the key health players, including physician organizations and hospital systems, are extremely impressive. One of the key components of this project is that the patient centered medical homes, which are the project focus, must be linked functionally to community resources. Physicians are required after the first year of the project to have data registries as apart of their conversion to electronic medical records. These registries will necessarily be linked to the access, referral and linkage components, which will involve centralized access points within defined geographic communities. The effective coordination between medical homes and community resources and the infrastructure needed to accomplish this is a key deliverable of the project. This project involves pediatricians and family practitioners who will be

-serving as the medical home for children, and pediatric pilots in designated communities are being planned.

It is within this context that MDCH highly values the opportunity to apply for this competitive component of the MIECHVP. The MIECHVP resides in the Public Health Administration, as part of the Title V Maternal and Child Health (MCH) focus area, the Bureau of Maternal, Child and Family Health. This Bureau is also where Michigan's Early Childhood Comprehensive System (ECCS) grant resides, which is then sub-granted to ECIC as part of the collaborative support between the involved organizations. The MIECHVP is specifically managed within the Division of Family and Community Health, where all of the State's 50-plus MCH programs and initiatives are housed, excluding WIC and CSHCS. Thus it is woven into Title V, in keeping with the ACA-driven changes to the Title V language in the Social Security Act. This Division also administers the state's LAUNCH project, bridges to the Health Start and REACH projects in the state, and other related activities.

MDCH is particularly excited about using the MIECHVP grant process, and this competitive application in particular, as a complementary project to align with the CMS MAPCP work. This represents a powerful opportunity to inform and guide how MAPCP is shaped in Michigan to meet the needs of pregnant women, infants and young families. The centralized access components to be established in three communities as part of this competitive home visitation application would be aligned with the additional pediatric pilots being developed under the MAPCP project. The timing is perfect for administering these pilots in a complementary way so that both projects are strengthened because of the influence of the other.

This centers early childhood system issues and home visitation at the heart of health care reform, integrates them fully into the implementation of medical homes, and, amazingly, takes MIECHVP directly to the heart of the multi-payor system. This is exactly where home visitation must be situated--as a full part of the benefit system for health care for every mother and family, covered by every third-party payer. The administrative team structure is already in place within MDCH to make this alignment between the two projects happen, with high level management staff already planning how the resource and system development synergy between the two projects could establish a model of national significance.

The fiscal strategies and opportunities for matching and leveraging are also at the heart of this opportunity. This would support the data and care coordination infrastructure bridges needed between primary care and community support, connecting both sets of resources. If constructed thoughtfully and thoroughly, match opportunities relative to access could be maximized as local agencies, such as local health departments, could draw down administrative outreach dollars from Medicaid. Aggregated data could not only profile specific target populations and their respective outcomes, but costs could be totaled on both the medical and the community sides. Most importantly, outcomes could be related to both costs and service utilization (e.g., are there improved health outcomes for those young children who also receive appropriate community resources, and subsequently, are these children with stronger health outcomes from birth better able to achieve school readiness because of more effective use of early education and care resources?) The information gained for the purposes of directing ongoing quality improvement would be invaluable and would be built into the processes to be designed and implemented.

Home visitation is a component of many programs through the administrations within MDCH. This includes the existing Nurse Family Partnership (NFP) program, currently in five Michigan counties, as well as the Maternal and Infant Health Program (MIHP). MIHP is part of Michigan's Medicaid State

Plan, and is available to all pregnant women who are Medicaid eligible, and is available to women and their infants through their first year of life. All women covered by Medicaid are mandatorily enrolled in one of the Medicaid Health Plans, and health plans are required to refer all pregnant women to MIHP. More than half of Michigan's births currently are Medicaid covered, which involves over 50,000 births a year at this point. MIHP is currently engaging in an evaluation process with the intent to assure it meets evidence-based criteria as a component of Michigan's home visitation continuum development. State, local and private foundation funding through the local health departments used for Nurse Family Partnership over the years also draws down federal Medicaid dollars. Thus the management of NFP specifically, with its anticipated expansion through this grant application, is already leveraging federal dollars and integrated work occurs between public health and Medicaid staff in all aspects of managing and support NFP.

MDCH prioritizes addressing disparities in health outcomes across all of its activities. There is hardly a health outcome measure that does not reflect significant adverse health outcomes related to race and ethnicity. As noted earlier in the Needs Assessment, African American infants die at about three times the rate of white infants. Throughout all of its policies, practices and contracts MDCH addresses and requires all involved parties to assure cultural and linguistic competency, has standards and requirements relative to literacy and language for health related materials, and yet also recognizes the constant need to better understand and improve how competency in this area is achieved. Eliminating the impact of institutional racism is a stated goal. Understanding how racism impacts health outcomes, particularly infant mortality, and how staff can be better trained to reduce and eliminate this impact is the purpose of a multi-year grant, Practices for Reducing Infant Mortality with Equity (PRIME), from the Kellogg Foundation. Given the scope of this grant's activities over time, the MIECHVP will have the opportunity to be positively impacted.

MDCH also has a cross-administration, management-level workgroup that addresses diversity issues, and within the Public Health Administration, has a whole section devoted to Health Disparities Reduction and Minority Health. Staff working on the MIECHVP project also participate in the planning done through this area; all work is geared to improving equity in health strategies and elimination of disparities in outcomes. This is work that is taken very seriously and with great commitment. Local communities involved in MIECHVP will be included in these strategies from the inception of this work.

Ongoing needs assessments for the defined target populations occur in a wide variety of ways, through many different state and local venues. All of the involved state departments and ECIC complete assessments. MDCH requires needs assessments from its managed care plans, its community mental health agencies—virtually across all program areas. Public health is currently engaged in a planning process to strengthen its approach to geographic health assessment in preparation for meeting national accreditation requirements at both state and local levels. This is being done in collaboration with the Michigan Health and Hospital Association, recognizing the dual assessment responsibilities of each and believing that a shared combined approach will be more effective.

MDCH has a very strong epidemiological division, with experienced and skilled professional staff. Many assessments are done in collaboration with researchers at Michigan's major universities. Kids Count Data, collected annually, is particularly well done in Michigan, That information is constantly used as needs of children and families around the state are defined and updated. All this said, there is still much need for a more focused and integrated approach to compiling needs assessment data specific to the requirements of the MIECHVP, including some of the additional data Michigan has defined as being integral to this effort. Building and expanding this needs assessment infrastructure

and capacity is clearly a goal for Michigan within the parameters of this project over time. Improving the data collection process via identifying the type of registry needed for an effective, centralized access/intake component and beginning to develop it is critical to the improved ability to identify needs, and understand the extent to which needs are or are not addressed by service utilization.

While it is not possible to assure resources into the future, given Michigan's budget is decided upon annually by the legislature and resources in Michigan have been decreasing for years, Michigan's Governor has made a very clear priority of early childhood outcomes. He has also chosen improving infant mortality as one of his two "dashboard" health priority outcomes. Two very significant signs of his support, and that of the current legislature, are evidenced in the next budget year (beginning October 1, 2011) in which \$1.5 million new dollars were allocated in the budget for NFP. Given the degree to which the Michigan budget was reduced again this year, inserting these new dollars under these most difficult of times, is a very positive sign and speaks to the intention nature.

It is understood that these dollars will draw down additional federal Medicaid funding. This is more funding than was previously in place for NFP, as funding was eliminated about two and a half years ago. Additionally, there is language that requires 50% of the dollars in the MDCH budget that are used to support home visitation programs, be used to support evidence-based models beginning in 2013. Analysis is also required of MDCH next fiscal year on the feasibility of integrating evidence-based home visitation models into the managed care plans. These are very clear indications of the priority that is placed on home visitation and its importance to health and early childhood outcomes.

	Alissa Parks	Senior Director of Great Start Consultation and Technical Assistance	HVWG member/grant contributor & reviewer
MICHIGAN LEAGUE FOR HUMAN SERVICES	Jane Zehnder-Merrell	Project Director, Kids Count in Michigan	HVWG member/grant reviewer
MICHIGAN DEPT. OF COMMUNITY HEALTH	Alethia Carr	MCH Director, Bureau of Family, Maternal and Child Health	HVWG member/grant reviewer
	Deborah Hollis	Director, Bureau of Substance Abuse and Addiction Services	HVWG member
	Sheri Falvay	Director, Mental Health Services to Children and Families	HVWG member
	Violanda Grigorescu	Director, Division of Genomics, Perinatal Health and Chronic Disease Epidemiology	HVWG member/grant contributor & reviewer
	Brenda Fink	Director, Division of Family & Community Health	HVWG member/grant contributor & reviewer
	Paulette Dobyne-Dunbar	Manager, Women, Infants and Family Health Section	Grant contributor & reviewer
	Nancy Peeler	Manager, Child Health Unit; Project Director for Home Visiting Program	HVWG member/grant writer & reviewer
	Sheila Embry	Manager, Quality Improvement and Program Development Section, Medical Services Administration	HVWG member
	Jackie Prokop	Manager, Ambulatory Benefits Section, Medical Services Administration	HVWG member
	Deb Marciniak	Senior Project Coordinator	HVWG member/grant writer & reviewer

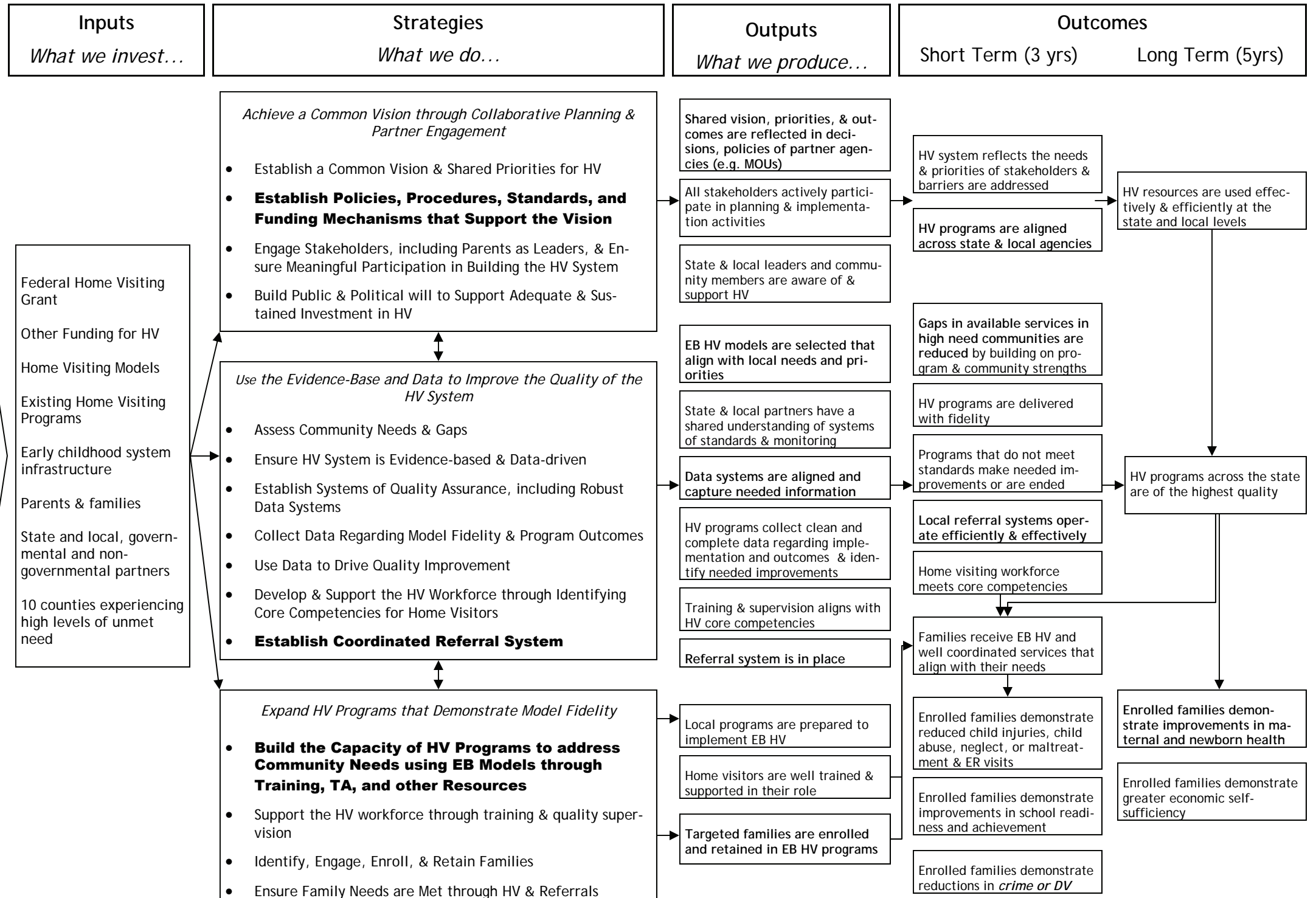
	Mary Ludtke	Early Childhood and Collaboration Consultant, Mental Health Services to Children and Families	HVWG member/grant writer & reviewer
	Carolyn Foxall	SPF-SIG Coordinator, Substance Abuse	HVWG member
	Angela Smith-Butterwick	Women's Treatment Specialist, Substance Abuse	HVWG member
	Tiffany Kostelec	Public Health Liaison to Part C	Grant contributor & reviewer
	Lin Dann	Project Director for Project LAUNCH	Grant contributor & reviewer
	Mary Kleyn	Newborn Screening Epidemiologist	HVWG member
	Penny (Verran) Eisfelder	Home Visiting Program Analyst	HVWG member/grant writer & reviewer
MICHIGAN MIECHVP EVALUATION TEAM			
MICHIGAN PUBLIC HEALTH INSTITUTE	Cynthia Cameron	Systems Reform Senior Program Director	MIECHVP Evaluator/grant contributor & reviewer
	Julia Heany	Program Director	MIECHVP Evaluator/grant writer & reviewer
NATIONAL MODEL DEVELOPER			
NURSE-FAMILY PARTNERSHIP NATIONAL SERVICE OFFICE	Kimberly Friedman	Program Developer, Midwest Region	Grant contributor
	Mary Jo O'Brien	Regional Team Leader, Midwest Region	Grant contributor
LOCAL LEVEL-SIX IDENTIFIED COUNTIES			
		Great Start Collaborative Directors	Helped gather Home Visiting Program information from partner agencies, member

		Local Public Health, Health Officer	Helped gather Home Visiting Program information in Public Health
		Head Start Directors	Provided data regarding Head Start Community Needs Assessments
		Local Leadership Group for Home Visiting	Great Start Collaborative Directors; Local Public Health, Head Start , Substance Abuse and CAPTA Grantee representatives; plus additional members, to guide local component of ACA Home Visiting Program. Will act as local CQI team.

*The ECIC is a public-private partnership which serves as the focal point for information and investment in early childhood in Michigan so that children can arrive at the kindergarten door, safe, healthy and eager for learning and life. The 15-member ECIC Executive Committee includes representatives of local government, State government, family advocacy organizations, corporations, unions, business associations, national foundations, community foundations, and health care research organizations.

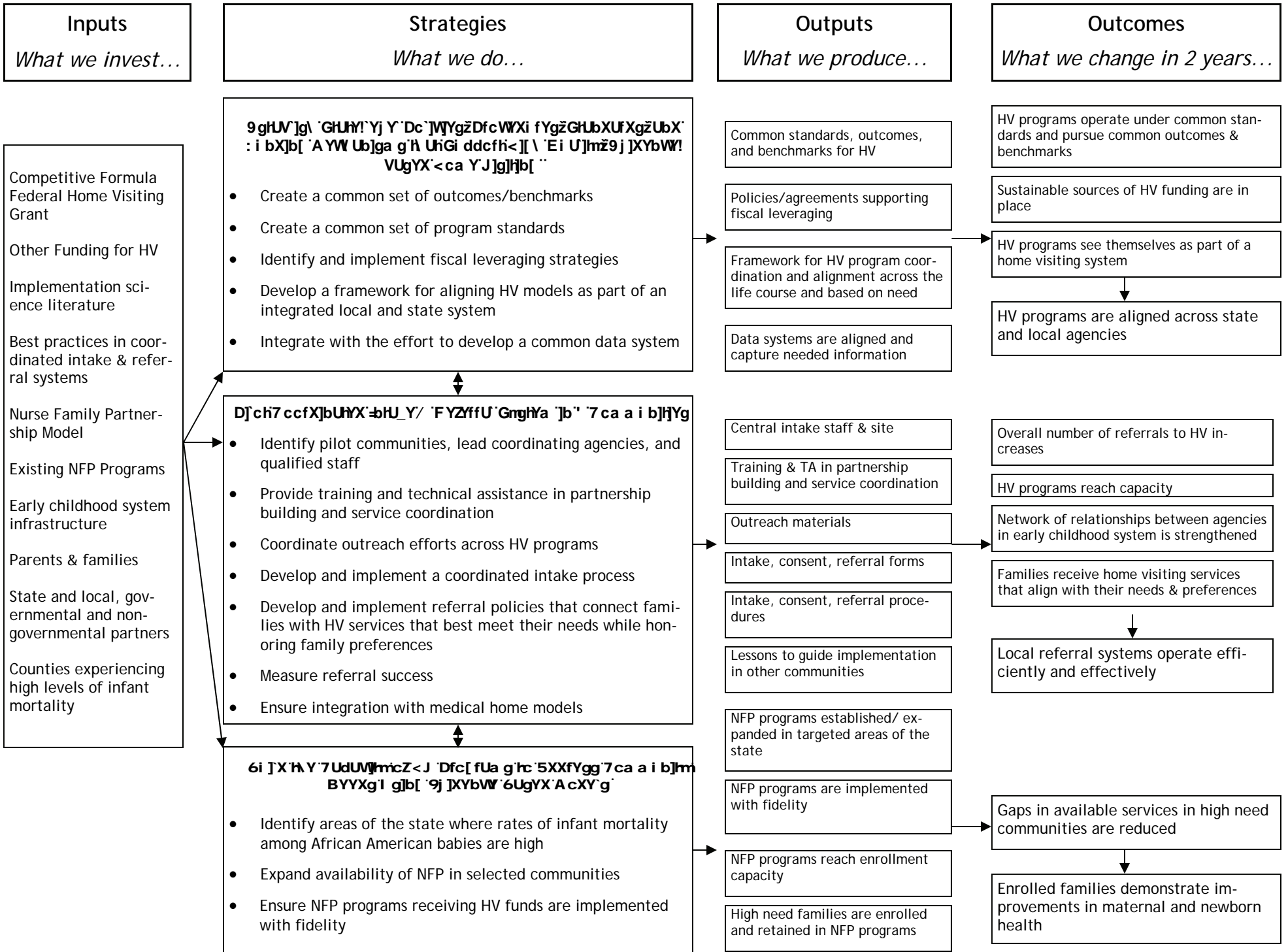
Michigan's Maternal, Infant, and Early Childhood Home Visiting Program Program Working Logic Model—June 8, 2011

Figure 1



Michigan's Maternal, Infant, and Early Childhood Home Visiting Program

June 1, 2011



Title: Project Administrator/Director

Description of duties and responsibilities: This position is responsible for the day-to-day supervision of the Home Visitation Project, as well as for supporting and managing the project across comparable levels within other state departments. The Project Director is responsible to assure the project is focused and following the required work plan and timeframes, alerting higher administrative staff if/when additional support is needed to address issues. This position will participate in the Great Start System Team and Home Visiting Workgroup (Chair and will collaborate with management peers across state departments and within the ECIC). At times this position will also support and interact with stakeholders in communities developing a Home Visiting System/Programs as needed and appropriate to facilitate the achievement of the project goals. The position is also responsible to assure coordination and alignment of this project within the larger context of the Affordable Care Act as it develops in Michigan, with Michigan's CMS Multi-payer advanced Primary Care Practice Demonstration project, and other key health and early childhood systems infrastructure activities. Position must also understand applicable fiscal matching, braiding and threading funding strategies and contribute to the development of new ways to use funding and other state and local resources more effectively.

Qualifications for position: Master's Degree in early childhood health, development, public health, social work or mental health, preferred.

Supervisory relationships: The Project Administrator reports to the Director of the Division of Family and Community Health within the Bureau of Maternal, Child and Family Health, in the Public Health Administration of the Michigan Department of Community Health. This is the division that administers all of the state's MCH services except for CSHCS and WIC.

Skills and knowledge required: Knowledge of systems level planning and planning models including conducting an environmental scan; state level policy development; system level fiscal planning and development of fiscal policy on behalf of the Great Start Systems Team and in cooperation with ECCS Coordinator. Knowledge of system level collaborative approaches to facilitate Home Visiting Project planning and implementation activities. Skills in cross system/strategic planning, facilitation of groups and cross system policy and programmatic development/analysis. Child health and behavioral health and programmatic expertise, supervisory skills, administrative management abilities for complex projects and statewide programming. Leadership capabilities on behalf of children for use in federal, state-to-state and state-local contexts. Ability to relate fiscal strategies to program and system concepts and infrastructure.

Prior experience required: Expertise in and experience with the public health model, and extensive experience in the design, implementation and evaluation of statewide collaborative initiatives including experience in cross system planning and state level policy analysis. Successful staff supervisory experience with master's plus professional staff; successful management experience with large, complex statewide programs that interface with other childhood systems and that have complex federal, state and/or legislative requirements

Personal qualities: Communication skills (verbal, written, electronic, etc.); work well with a range of professionals and parents; organizational skills, be a self-starter, and be able to assist others in "think globally" and, also, to identify barriers to operationalizing programs, policies and fiscal approaches.

Amount of travel and any other special conditions or requirements: Travel within the state as needed; potential travel for national meetings/conferences.

Salary range: \$90,000 - \$110,000 total, including fringe package

Hours per day or week: .3 FTE, approximately 12 hours a week on average.

Title: Technical Assistance (TA) Specialist

Description of duties and responsibilities: This position is responsible for working with the Home Visiting Workgroup to identify pilot communities to develop a centralized/coordinated point of outreach, intake, referral and follow up for local home visiting programs. The specialist will assist communities in determining criteria for the selection of their lead coordinating agencies as well as identification of qualifications of staff. The specialist will provide training and technical assistance in partnership building and service coordination. The specialist will assist the community in developing the system that ensures coordination of outreach efforts across home visiting programs, development and implementation of a coordinated intake process, measures referral success and is integrated with medical home models. The position will work with identified community groups to build the infrastructure of the centralized/coordinated intake system including development of local interagency agreements, policies for the operation of the centralized/coordinated entity as well as referrals to connect families with home visiting services that best meet their needs while honoring family preferences. The specialist will also need to understand how to coordinate and integrate centralized intake activities related to this grant with Michigan's CMS Multi-payer Advanced Primary Care Practice Demonstration pediatric pilots, including how data linkages are developed within the context of the larger health care reform and Michigan's early childhood system building activities.

In addition, the specialist will document the process used by the initial communities as they build the infrastructure to support a centralized/coordinated outreach, intake, referral and follow up system to inform additional communities as they develop their system (replication of system).

This position will coordinate activities with the Project Director and the Great Start System Team. The specialist will report to the Home Visiting Workgroup on a regular basis. This position will also serve as a communication and facilitation link between Home Visiting Project other relevant projects.

Qualifications for position: Master's Degree in early childhood health, development, public health, social work or mental health.

Supervisory relationships: The Specialist will report to the Project Administrator.

Skills and knowledge required: Knowledge of systems level planning and planning models including conducting an environmental scan; state level policy development. Knowledge of system level collaborative approaches to facilitate the Home Visiting centralized/coordinated outreach, referral, intake and follow up system planning and implementation activities. Skills in cross system/strategic planning, facilitation of groups and cross system policy and programmatic development/analysis. Ability to relate fiscal strategies to program and system concepts and infrastructure.

Prior experience required: Expertise in and experience with the public health model, and extensive experience in the design, implementation and evaluation of collaborative initiatives including experience in cross system planning and implementation.

Personal qualities: Communication skills (verbal, written, electronic, etc.); facilitation skills; work well with a range of professionals and parents; organizational skills, be a self-starter, and be able to assist others in "think globally" and systemically as well as to identify challenges to operationalizing system level infrastructure in addition to state/local policies and fiscal approaches.

Amount of travel and any other special conditions or requirements: Successful candidate will be required to travel on a monthly basis within the state.

Salary range: Will be determined based on educational level and skills/knowledge of the candidate.

Hours per day or week: 1.0 FTE (40 hours per week)

Title: NFP State Coordinator/Nurse Consultant

Description of duties and responsibilities: The Nurse Family Partnership (NFP) State Coordinator/Clinical Nurse Consultant will work closely with the NFP National Service to support fiscal and administrative program implementation; to ensure model implementation with fidelity; provide operational guidance to local NFP supervisors; provide ongoing support to foster professional development of nurse home visitors; ensure reflective supervision of NFP home visiting staff occurs as required; and keep MDCH aware of each local projects status. The person will participate on the Home Visiting Workgroup to ensure that state and local NFP activities are fully integrated into the state's home visiting system and early childhood comprehensive system; work with local NFP sites to ensure they are fully participating in local early childhood system building efforts; and work with Evaluation team to support successful data collection and reporting for the overall MIECHC initiative.

Qualifications for position: Master's degree is required in nursing, public health, social work, early childhood health, development or mental health. Must possess a current license as a registered nurse in the State of Michigan or another state and be eligible to acquire a license to practice in the State of Michigan before hiring and within one month of position offer.

Supervisory relationships: The NFP State Coordinator/Clinical Nurse Consultant will report to the Manager of the Perinatal Health Unit.

Skills and knowledge required: Knowledge of quality assurance/improvement; program monitoring; methods to plan, develop, implement, monitor and evaluate public health or health programs; techniques of individual and group collaboration; expert knowledge of perinatal and early child health; ability to analyze and interpret complex nursing/health care related data; ability to provide leadership to other nursing professionals; and identify training needs, plan, and conduct training workshops and meetings.

Prior experience required: At least four years of background in maternal child health with at least one year of home visiting or public health/community nursing experience. Four years of post master's experience providing leadership to other health professionals either via supervision or team leadership is desired.

Personal qualities: Ability to communicate effectively with others and maintain favorable public relations.

Amount of travel and any other special conditions or requirements. Successful candidate will be expected to travel to designated communities for training, technical assistance/consultation, as needed. Will also be required to travel to national meetings relevant to nursing/clinical implementation of the project and/or state sponsored activities supporting the project.

Salary range: Will be determined based on educational level and skills/knowledge of the candidate.

Hours per day or Week: 1.0 FTE (40 hours per week)

Title: Policy Specialist

Description of duties and responsibilities: This position is responsible for assisting state level system in the identification of policy, procedures and standards that supports high quality, evidence-based Home Visiting Programs. The Policy Specialist will scan the policies and procedures across the state departments to identify those policies and procedures that need to be aligned to support the community based, high quality, evidence-based Home Visiting Programs. The specialist will also investigate what policies, procedures; standards are implemented in other states. The specialist will work with Great Start System Team in the identification of policies to be reviewed and/or developed.

Based on the results of the state level policy scan, the Policy Specialist will develop state level policy, procedures and/or standards that support local infrastructure (centralized/coordinated outreach, intake, referral and follow up; data collection; use of evidence-based models; etc.) for the local Home Visiting Program.

This position will coordinate activities with the Project Director and the Great Start System Team. The specialist will report on a regular basis to the Home Visiting Workgroup. This position will also serve as a communication and facilitation link between Home Visiting Project other relevant projects.

Qualifications for position: Master's Degree in early childhood health, development, public health, social work, or mental health.

Supervisory relationships: The Specialist will report to the Project Administrator.

Skills and knowledge required: Knowledge of systems level policy, policy development. Knowledge of system level collaborative approaches for development and implementation of policy is required. Skills in cross system/strategic planning, policy and programmatic development/analysis.

Prior experience required: Expertise in and experience with the state level policy is human services programming and cross system initiatives including experience in cross system planning and state level policy analysis.

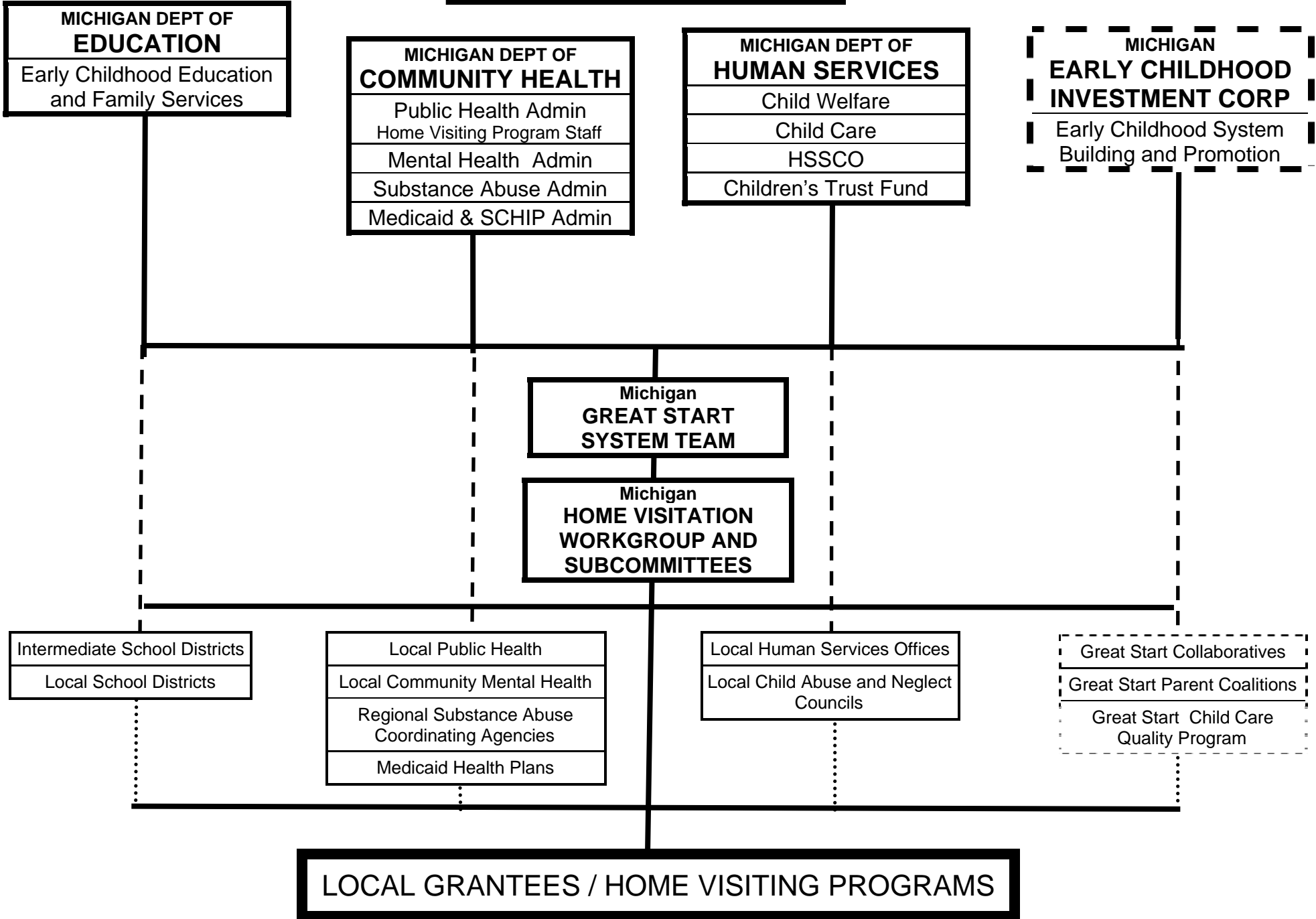
Personal qualities: Communication skills (verbal, written, electronic, etc.); work well with a range of professionals and parents; organizational skills, be a self-starter, and be able to assist others in systemic approaches as well as to identify barriers to state policies.

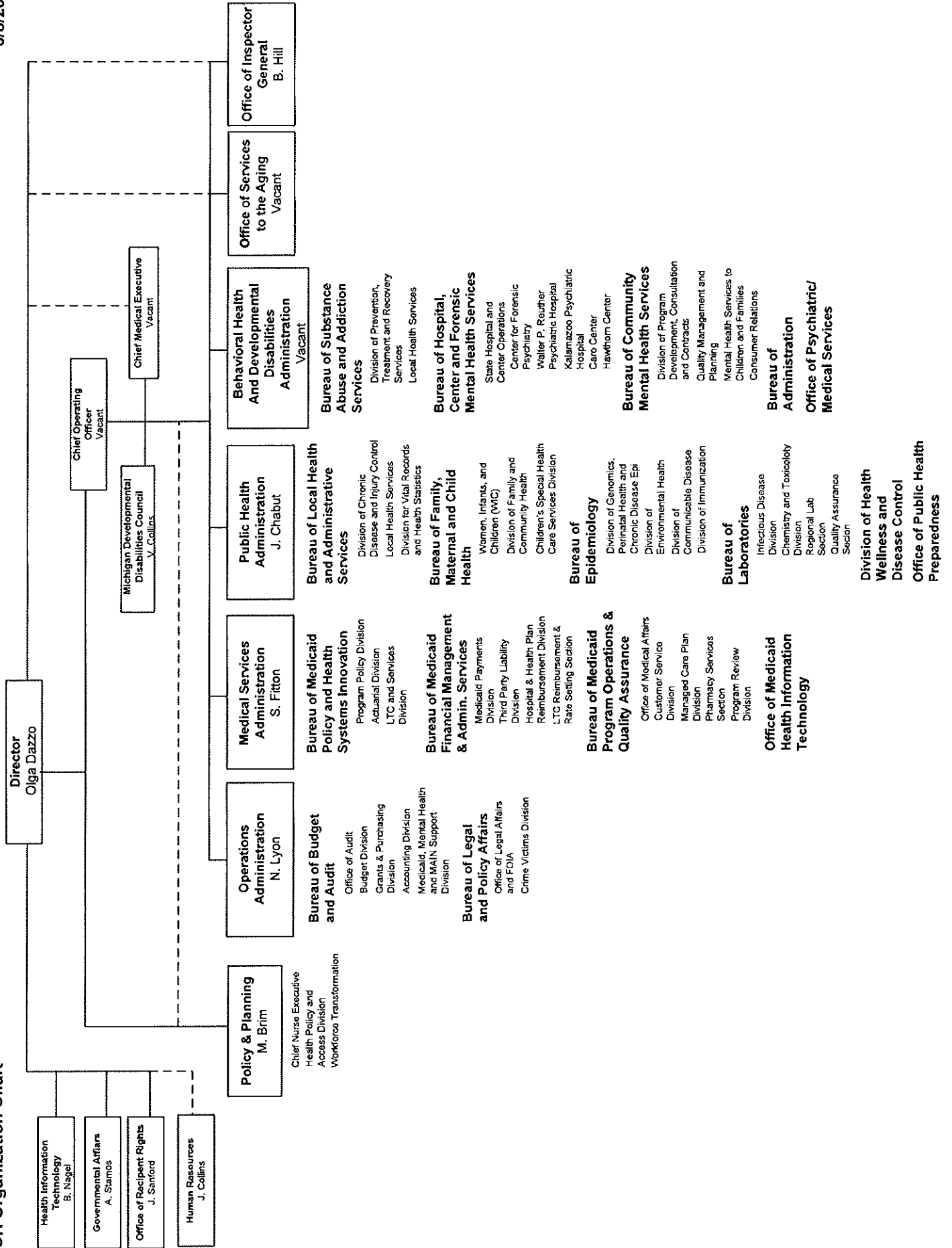
Amount of travel and any other special conditions or requirements: Successful candidate will be required to travel on a monthly basis within the state.

Salary range: Will be determined based on educational level and skills/knowledge of the candidate.

Hours per day or week: .5 FTE (20 hours per week)

STATE OF MICHIGAN





Attachment 6: Summary Progress Report

Implementing Home Visiting Programs

The Michigan Departments of Community Health, Human Services, and Education have been investing in home visiting programs in Michigan since about the mid-1980s, and are working collaboratively in the implementation of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). Michigan has identified nine state-level home visiting programs supported by State or Federal funds. “State-level” means that there is some involvement or program coordination occurring at the state level. One program is the Maternal Infant Health Program (MIHP), which is available to all pregnant women enrolled in Medicaid, and their infant through the infant’s first year of life. MIHP served about 50% of the families whose childbirth medical expenses were covered by Medicaid in 2009. MIHP has the broadest reach of all home visiting programs in Michigan. The other home visiting program available to Medicaid recipients statewide is Community Mental Health Home-Based Services. This is an infant mental health services program for children 0-47 months that have a parent that meets diagnostic criteria for mental illness, developmental disability or dual diagnosis. Home-based Services, based on parental diagnosis, were provided to 1,031 families in 2009.

An additional seven home visiting programs are available in fewer of Michigan’s 83 counties. Early Head Start is offered in 64 counties, but the other six programs are only offered in three to thirteen counties. Many programs serve only a restricted area within a county (e.g., zip code area).

Michigan is in the process of developing a Home Visiting Program database that will include an extensive list of home visiting programs with detailed information on each, based on common definitions of requested fields. It is anticipated that database will be populated with information on home visiting programs in all of Michigan’s 83 counties by the end of this fiscal year.

Michigan has had experience implementing five of the seven models that were determined to meet the evidence-based criteria established by HRSA and ACF: Nurse-Family Partnership (NFP), Healthy Families America (HFA), Early Head Start-Home Based Program (EHS), Parents as Teachers (PAT), and Home Instruction Program for Preschool Youngsters (HIPPPY). However, investment in any given model has waxed and waned, depending on the availability of funding. The economic downturn confronting Michigan over the last several years has definitely taken a toll on home visiting programming.

In the *MIECHVP Updated State Plan* submitted to HRSA on June 8, Michigan proposed to expand service slots in existing programs that were already implementing evidence-based models in six of the ten counties that had the highest concentration risk scores as identified in the *Statewide Needs Assessment* that was submitted to HRSA September 20, 2010. The counties, their respective targeted at-risk populations, models to be expanded, and numbers of families to be served are given in the chart below.

County	Targeted At-Risk Population	Model	No. Families to be Served
Genesee	Teen parents in City of Flint	EHS	24
Wayne	African-American pregnant and parenting teens in	HFA	50

	City of Highland Park		
Saginaw	African American children in City of Saginaw	EHS	24
Ingham	Families in City of Lansing, Zip Code 48911	EHS	24
Muskegon	Parents 16 to 25 years of age	HFA	50
Kent	Hispanic/Latino families in City of Grand Rapids	HFA	50

The MIECHV Updated State Plan also includes funding and provisions to begin to create a set of core competencies for home visiting staff, which would improve service delivery across all home visiting models. The proposed Development Grant builds on the work outlined in the Updated State Plan by creating additional program expansion (NFP in counties with high infant mortality), building additional infrastructure components (centralized/coordinated referral/intake), and addressing policy and procedures that underlie the success of an integrated home visiting system that operates within the context of a comprehensive early childhood system.

Fostering the Integration of Home Visiting Programs into Early Childhood Systems

In February of 2005, the Early Childhood Investment Corporation (ECIC) was created to ensure that every young child in Michigan has a Great Start and arrives at kindergarten healthy and ready to succeed, with parents who are committed to educational achievement. The ECIC is responsible for facilitating the development of Michigan’s early childhood comprehensive system at the state and local levels. Accomplishing this involves the combined efforts of parents, community leaders, business, the legislature, state and local government, faith-based organizations and philanthropic organizations. By connecting all of these sectors, the ECIC brings opportunities to the State public and private infrastructure that would not otherwise be available.

The ECIC and the Departments of Community Health, Human Services, and Education collaborate to support the work of early childhood systems development. MDCH, which is Michigan’s Early Childhood Comprehensive System (ECCS) grant recipient, details ECCS project staff and activities to the ECIC, because of the leadership role ECIC plays relative to early childhood systems development.

Integral to the state-level planning for ECCS is the Great Start Systems Team (GSST), a state-agency advisory group in place to operationalize the *Great Start Blueprint* (ECCS State Early Childhood Plan). The GSST provides oversight for Project LAUNCH, the MIECHV, and for other early childhood systems-building initiatives. The GSST is co-convened by MDCH and the ECIC.

In 2009, Michigan’s previous Governor, Jennifer Granholm, the State department heads, and the ECIC jointly concluded that a collaboratively-built statewide home visiting program system should be a key component of Michigan’s early childhood comprehensive system. The GSST was charged with overseeing the development of the home visiting system and appointed a Home Visiting Workgroup (HVWG) to operationalize this charge. The GSST asked the HVWG to study existing home visitation programs in the State in order to develop a set of interdepartmental recommendations to more effectively address financing, coordination, administration, common messaging and future investment in home visiting.

When DHHS announced the *Maternal, Infant, and Early Childhood Home Visiting Program* in June 2010, it was determined that the HVWG would serve in an advisory role for the Michigan’s new Home Visiting Program. The HVWG has developed a number of sub-committees and has actively participated

in the preparation of Michigan's applications in response to the multiple MIECHVP funding opportunity announcements.

The HVWG includes representatives of all entities required by DHHS for the MIECHVP, and several of the HVWG members also participate on the GSST. Nearly all of the members have collaborated on many other early childhood initiatives and have developed strong working relationships with each other. They are personally committed to building a sound home visiting system as a key component of a comprehensive early childhood system. The HVWG is chaired by the MDCH Director of the Division of Family & Community Health who reports directly to the Title V Director.

In May 2011, Michigan's new Governor, Rick Snyder, released a special message about Education, in which he announced the creation of the Office of Great Start, to be a focal point within State government for early childhood service delivery. The Office will be located in the Michigan Department of Education. Among its contributions will be ensuring the coordination of key programs (some of which are likely to be home visiting programs) across departments for the purpose of integration, continuity, accountability and also for maximizing direct service. An Executive Order with more details about the new Office was just released, on July 30, 2011. Details regarding operations of the new office are being developed; the MIECHV Program Organizational Chart will be updated to include the new Office as those details are released. Governor Snyder has indicated that he also plans to release a special message about Public Health/health care in the fall of 2011.

Promoting Effective Policy to Support and Strengthen Home Visiting Programs

On June 22, Governor Snyder signed the FY 12 State budget, which included a new provision stating that MDCH shall use at least 50% of funding for home visiting for evidence-based models, or for models that conform to a promising approach that are in the process of being evaluated for effectiveness, with a goal of being evidence-based by January 1, 2013. As a result, MDCH has accelerated the pace of its work with the Michigan State University Institute for Health Care Studies to conduct a rigorous, comprehensive evaluation of the Maternal Infant Health Program (MIHP). As described above, MIHP is the State's largest home visiting program, representing an investment of about \$18 million dollars annually. The FY 12 MDCH budget also contains a provision requiring that the department establish an integrated benefit for Medicaid evidence-based home visiting services to be provided by Medicaid health plans for eligible beneficiaries. This provision will likely have a significant impact on fiscal strategies and sustainability strategies for home visiting programs in Michigan.

The FY 12 State budget allocates new funding of \$1.5 million dollars for Nurse Family Partnership programs. Funding had been available for NFP prior to 2009, but was eliminated from the State budget. This new allocation represents a renewed state commitment to funding this evidence-based home visiting models.

Evaluating Programs and Using the Information Received to Improve the Quality of Home Visiting Programs and Early Childhood Systems

Generally speaking, rigorous evaluations of home visiting programs in Michigan using randomized controlled trials or quasi-experimental designs have not been conducted, largely because they are so costly. However, program evaluations have been conducted or are underway for the following home

visiting programs: Nurse Family Partnership; 0-3 Secondary Prevention Programs funded by the Michigan Department of Human Services (MDHS); Early Head Start; and the Maternal Infant Health Program. Available outcomes are reported in the section below (Improving Outcomes for Families Served by the Home Visiting Program).

Some programs have been required to submit process and outcome data on a regular basis for continuous quality improvement (CQI) purposes, but others have had very minimal data reporting requirements. The MIECHVP has provided a strong impetus to invest in evidence-based models and to require the collection of process and outcome data on an ongoing basis in order to make program improvements. In our *FY 10 Updated State Plan*, Michigan proposed to create a culture of quality using a systematic approach involving four steps: 1) establishing state and local CQI teams; 2) developing the capacity to ensure data availability and access; 3) monitoring progress toward objectives, and 4) sustaining CQI as the way of doing business. Michigan’s goal is to bring the State home visiting system as a whole, as well as individual local programs, to the point where they use CQI on a regular, ongoing basis to ensure that programs are delivered with model fidelity and are meeting legislatively mandated benchmarks over time.

The MIECHVP has also provided an impetus for us to begin to link our evaluation efforts across home visiting programs. One of the evaluators for this project also leads the evaluation of Zero to Three Secondary Prevention Programs funded by MDHS (TANF dollars). Also, evaluators from other federally-funded projects, including the Early Childhood Comprehensive System Initiative and Project LAUNCH, along with the evaluators for the Medicaid-funded Maternal Infant Health Program (MIHP) developed by MDCH, are linking via the HVWG Benchmarks Committee to share information and explore opportunities for collaboration and alignment.

Improving Outcomes for Families Served by the Home Visiting Program

Michigan can report positive outcomes for families for the following home visiting programs:

1. Nurse-Family Partnership, NFP Michigan State Profile, 2011

Demographics at intake: 19 years median age; 94% unmarried; 74% Medicaid recipients, 70% African American.

- 93% of children had all recommended immunizations by 24 months
- 41% of mothers who entered the program without a diploma/GED have since earned their diploma/GED, and another 26% are working toward obtaining one
- 89% of children were born full term and 89% were born at a healthy weight - at or above 2500 g (5.5 lbs)

	NFP	State
• % of Preterm Black or African American Births, 2006-2008	8.6%	18.4%
• % of Low Birth weight Black or African American Births, 2006-2008	8.1%	14.1%

2. 0-3 Secondary Prevention Outcomes & Return on Investment Report, FY 2009 – An Interagency Initiative to Prevent Maltreatment

This evaluation was conducted across a variety of home visiting programs.

- 99.5% of the at-risk families participating in 0-3 did not become involved in Children's Protective Services and out-of-home placement in FY 09.
- 90.2% of children were up to date with well-child visits.
- 88.8% of children were up to date with age appropriate immunizations.
- 91.5% of pregnant women had the recommended number of prenatal care visits (15 percentage points higher than the national average of 75.4%).

Providing Services to Vulnerable or High-risk Populations

Most of the funds that have been invested in home visiting programs in Michigan have been targeted toward prevention efforts for high-risk populations. Eligibility criteria used by each department are described below:

- The Michigan Department of Community Health (MDCH) is responsible for administering public health, mental health, substance abuse, and aging services, as well as the state's Medicaid program. For the most part, MDCH has funded home visiting programs targeted at families with Medicaid. The Nurse Family Partnership programs that MDCH has supported were targeted at low-income, first-time African-American mothers in communities with high infant mortality rates.
- The Department of Human Services (MDHS) is responsible for administering child welfare services, including child protection services, adoption and foster care. MDHS has funded home visiting programs targeted at families with Category III (preponderance of evidence of child abuse or neglect is not found) or Category IV (preponderance of evidence of child abuse or neglect indicates low or moderate risk) Child Protective Services cases, and at families with three or more identified child abuse and/or neglect factors.
- The Michigan Children's Trust Fund (CTF) partners with DHS in child abuse/neglect prevention efforts. CTF has funded home visiting programs targeted at families with identified child abuse and/or neglect factors.
- Early Head Start Programs are targeted at families living at or below 100% of the Federal Poverty Guidelines. Families receiving public assistance (TANF or SSI), or who are homeless, or who have a child in foster care or who is a ward of the state, are automatically eligible.
- In some local communities, a portion of Michigan Department of Education Great Parents/Great Start program funds support home visiting programs. These programs tend to have universal eligibility, but many end up serving families at the low end of the income ladder.

**MICHIGAN Maternal, Infant and Early Childhood Home Visiting Program
Competitive Grant Application
WORK PLAN—TIMELINE**

Grant Period: From October 1, 2011 to September 30, 2013

Program Element I: NURSE-FAMILY PARTNERSHIP EXPANSION									
Michigan will build the capacity of home visiting programs to address community needs using evidence-based models by implementing or expanding NFP in six communities, as evidenced by achieving the following objectives:									
PLAN	STAFF	FY1 Q1	FY1 Q2	FY1 Q3	FY1 Q4	FY2 Q1	FY2 Q2	FY2 Q3	FY2 Q4
OBJECTIVE 1: Monitor rates of infant mortality, especially among the African American population.									
1. Ongoing data analysis to monitor communities with highest infant mortality rates.	MDCH								
OBJECTIVE 2: Expand or establish NFP in selected communities with high infant mortality for African Americans.									
1. Develop contracts with six local agencies in chosen communities.	Program Analyst								
2. Manage contracts with six local agencies in chosen communities.	Program Analyst								
OBJECTIVE 3: Ensure NFP programs receiving home visiting funds are implemented with fidelity.									
1. Hire 1.0 FTE NFP Coordinator/Nurse Consultant	Project Director Perinatal Unit Mgr.								
2. Implement funding strategy for expanded and new NFP sites.	NFP Coord./NC								
3. Develop state-level plan to ensure programs implement NFP with fidelity.	NFP Coord./NC HVWG								
4. Develop implementation plans with each local community, including training and TA.	NFP Coord./NC HVWG								
5. Provide individual and group TA for NFP sites.	NFP Coord./NC								

6. Monitor progress of NFP sites.	NFP Coord./NC									
7. Report progress to HVWG/GSST.	NFP Coord/NC									
8. Share lessons learned to stakeholders across state.	NFP Coord/NC									
Program Element II: COORDINATED SYSTEM OF OUTREACH, INTAKE, REFERRAL AND FOLLOW-UP										
Michigan will develop a coordinated system for outreach, intake, referral and follow-up, as evidenced by achieving the following objectives in the three pilot communities in order to enhance the success of NFP and other home visiting programs:										
Objective 1: Identify pilot communities, lead coordinating agencies and qualified staff.										
1. Hire 1.0 FTE Technical Assistance (TA) Specialist.	Project Director									
2. Form work group of GSST	GSST									
3. Research local systems developed by other initiatives.	TA Specialist									
4. Determine how pilots will interface with new CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) project.	TA Specialist									
5. Determine how pilots will interface with 211/First Call for Help System.	TA Specialist									
6. Develop and issue RFP.	TA Specialist GSST WG									
7. Select pilot sites and determine lead coordinating agencies.	TA Specialist GSST WG									
8. Develop and manage contracts with pilot sites.	TA Specialist Program Analyst									
9. Develop and manage work plans with pilot sites.	TA Specialist Program Analyst									
Objective 2: Provide training and technical assistance in partnership building, outreach and service coordination.										
1. Research training and TA systems developed by other initiatives.	TA Specialist									
2. Develop training and TA plan to be implemented in three pilot sites.	TA Specialist GSST WG									

3. Provide initial training and additional trainings, as necessary.	TA Specialist								
4. Provide individual and group TA to three pilot sites.	TA Specialist								
Objective 3: Coordinate outreach efforts across home visiting programs.									
1. Research outreach efforts implemented within other initiatives.	TA Specialist Pilot Sites GSST WG								
2. Develop and implement outreach plan in pilot communities.	TA Specialist Pilot Sites GSST WG								
Objective 4: Develop and implement a coordinated intake process.									
1. Research intake efforts implemented within other initiatives.	TA Specialist Pilot Sites GSST WG								
2. Develop and implement intake plan in pilot communities.	TA Specialist Pilot Sites GSST WG								
Objective 5: Develop and implement referral policies that connect families with home visiting services that best meet their needs while honoring family preferences.									
1. Research referral policies implemented in other initiatives.	TA Specialist Pilot Sites GSST WG								
2. Develop and implement referral plan in pilot communities.	TA Specialist Pilot Sites GSST WG								
Objective 6: Measure referral success.									
1. Develop plan for measuring referral success.	TA Specialist Pilot Sites								

	GSST WG								
2. Develop necessary tools for measuring referral success.	TA Specialist Pilot Sites GSST WG								
3. Report progress to HVWG/GSST	TA Specialist								
4. Share lessons learned to stakeholders across State.	TA Specialist								
Objective 7: Ensure integration with CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) project.									
1. Develop plan for integrating home visiting intake system with CMS MAPCP project.	TA Specialist GSST WG								
2. Participate in CMS MAPCP system-building efforts and subcommittees.	TA Specialist								
3. Develop and issue RFP to determine entity or individual to research and map the specifications for a Data Registry.	TA Specialist GSST WG								
4. Develop and manage contract with chosen entity/individual	TA Specialist Program Analyst								
5. Develop and manage work plan with chosen entity/individual	TA Specialist GSST WG								
Program Element III: STATE-LEVEL POLICIES AND PROCEDURES									
Michigan will establish State-level policies, procedures, standards, and funding mechanisms that support high-quality, evidence-based home visiting, as evidenced by achieving the following objectives:									
Objective 1: Develop a framework for aligning home visiting models as part of an integrated local and state system.									
1. Hire a .5 FTE Policy Specialist	Project Director								
2. Conduct a state-level environmental/policy scan	Policy Specialist								
3. Develop GSST policy work plan.	Policy Specialist GSST								
Objective 2: Create a common set of outcomes/benchmarks for the home visiting system.									
1. Determine a common set of outcomes/benchmarks across home visiting programs.	Policy Specialist GSST								

2. Develop plan to integrate common outcomes/benchmarks within agencies and funding streams.	Policy Specialist GSST								
3. Develop a scheme for measuring local communities' achievement of common outcomes/benchmarks.	Policy Specialist GSST								
4. Monitor local communities' achievement of common outcomes/benchmarks.	Policy Specialist GSST Local QI teams								
Objective 3: Create a common set of program standards.									
1. Determine a common set of program standards across home visiting programs.	Policy Specialist GSST								
2. Develop plan to integrate common policies/procedures within agencies and funding streams.	Policy Specialist GSST								
3. Develop a scheme for measuring local communities' adherence to common policies/procedures (program standards).	Policy Specialist GSST								
4. Monitor local communities' adherence to common policies/procedures (program standards).	Policy Specialist GSST								
Objective 4: Identify and implement fiscal leveraging strategies.									
1. Research fiscal leveraging strategies used by other states, as well as within individual communities in Michigan.	Policy Specialist GSST								
2. Develop a plan to secure additional funding for NFP and other home visiting programs, using fiscal leveraging.	Policy Specialist GSST								
3. Collaborate with relevant stakeholders (i.e. Medicaid) to maximize fiscal leveraging strategies.	Policy Specialist GSST								
Program Element IV: Project Evaluation									

Michigan will develop an evaluation protocol for measuring program implementation and outcomes at both the state and local levels.

Objective 1: Refine existing state evaluation plan for MIECHV.

Modify data collection tools and protocol, as needed.	Evaluation Team								
Establish procedure for receiving data from NFP NSO	Evaluation Team								
Submit evaluation for IRB review.	Evaluation Team								
Develop and provide training on evaluation and using evaluation data.	Evaluation Team								
Disseminate tools and protocol	Evaluation Team								
Provide TA on evaluation and QI	Evaluation Team								
Complete quarterly conversations	Evaluation Team								
Conduct key informant interviews.	Evaluation Team								
Develop and administer stakeholder survey.	Evaluation Team								
Develop and implement system coordination survey.	Evaluation Team								
Develop and implement intake and referral client survey.	Evaluation Team								
Develop and implement implementation capacity surveys.	Evaluation Team								
Collect and analyze data from agencies.	Evaluation Team								
Develop and submit reports (quarterly/annually).	Evaluation Team								

BUDGET INFORMATION - Non- Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non- Federal (f)	Total (g)
1. ACA FY2011 Compet HV Budget Year 1	93.505	\$	\$	\$ 2,595,614	\$	\$ 2,595,614
2. ACA FY2011 Compet HV Budget Year 2		\$	\$	\$ 2,800,191	\$	\$ 2,800,191
3.		\$	\$	\$	\$	\$ 0.00
4.		\$	\$	\$	\$	\$ 0.00
5. TOTALS		\$ 0.00	\$ 0.00	\$ 5,395,805	\$ 0.00	\$ 5,395,805
SECTION B - BUDGET CATEGORIES						
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)	
	(1) Year 1	(2) Year 2	(3)	(4)		
a. Personnel	\$ 18,268	\$ 18,268	\$	\$	\$ 36,536	
b. Fringe Benefits	\$ 10,910	\$ 10,910	\$	\$	\$ 21,820	
c. Travel	\$ 3,000	\$ 3,000	\$	\$	\$ 6,000	
d. Equipment	\$ 0	\$ 0	\$	\$	\$ 0	
e. Supplies	\$ 7,500	\$ 2,400	\$	\$	\$ 9,900	
f. Contractual	\$ 2,495,913	\$ 2,709,090	\$	\$	\$ 5,205,003	
g. Construction	\$ 0	\$ 0	\$	\$	\$ 0	
h. Other	\$ 58,123	\$ 54,623	\$	\$	\$ 112,746	
i. Total Direct Charges (sum of 6a -6h)	\$ 2,593,714	\$ 2,798,291	\$	\$ 0.00	\$ 5,392,005	
j. Indirect Charges	\$ 1,900	\$ 1,900	\$ 0	\$	\$ 3,800	
k. TOTALS (sum of 6i and 6j)	\$ 2,595,614	\$ 2,800,191	\$	\$ 0.00	\$ 5,395,805	
7. Program Income		\$ 0	\$	\$	\$ 0	

SECTION C - NON- FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	\$	\$	\$	\$
9.	\$	\$	\$	\$
10.	\$	\$	\$	\$
11.	\$	\$	\$	\$
12. TOTALS <i>(sum of lines 8 and 11)</i>	\$	\$	\$	\$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$	\$	\$	\$	\$
14. Non- Federal	\$	\$	\$	\$	\$
15. TOTAL <i>(sum of lines 13 and 14)</i>	\$	\$	\$	\$	\$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.	\$	\$	\$	\$
17.	\$	\$	\$	\$
18.	\$	\$	\$	\$
19.	\$	\$	\$	\$
20. TOTALS <i>(sum of lines 16 -19)</i>	\$	\$	\$	\$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks	