How Home Visiting Supports Michigan Families

2016 Home Visiting Initiative Report

This report was prepared and submitted as required by Public Act 291 of 2012 (PA 291), Michigan's Voluntary Home Visiting Programs.

MDHHS Michigan Department of Health and Human Services

MICHIGAN Department of Education

May 2017

Dear Governor Snyder, Michigan legislators, and citizens:

On behalf of the Michigan Departments of Education and Health and Human Services, we are pleased to submit Michigan's annual report on home visiting.

Every year, nearly 35,000 families voluntarily participate in an evidence-based, prevention-focused home visiting program. These families welcome a highly trained service provider into their homes to provide support and mentoring from pregnancy through their children's first years of life.

Research demonstrates clear benefits to participating in a home visiting program for young children, their families, and our state. Participants experience improved health outcomes, improved economic self-sufficiency, fewer instances of child abuse and neglect, and more coordinated access to community resources. Children are more likely to grow up healthy and enter kindergarten ready to learn. These outcomes save money in the long term and mean fewer investments in social services and remediation.

These results are a driving force behind our efforts to expand access to home visiting in Michigan. Over the past year, our departments worked closely to improve opportunities, access, and outcomes for Michigan children and families. This report showcases our shared effort to align and coordinate services to ensure taxpayer dollars are spent efficiently and that families and children receive relevant, effective services. We also know we can do more. That's why this report identifies what home visiting programs will be doing in 2017 across both of our agencies, why MDE's Top 10 in 10 strategies include home visiting, and how with our partners we plan to serve more families effectively and efficiently to build a foundation for a healthier Michigan.

Respectfully,

Nick Lyon
Director

Michigan Department of Health and Human Services

Brian J. Whiston
State Superintendent

Michigan Department of Education

Acknowledgements

This report would not have been possible without the time and talent of many stakeholders across the state. The Michigan Departments of Education and Health and Human Services (MDE and MDHHS) would like to thank our partners for their support in gathering data, reviewing content, sharing stories, serving on workgroups, and creating and implementing a shared vision for home visiting in Michigan. Children and families across our state receive better services and support because of this collaborative effort.

MDE and MDHHS are particularly grateful to those individuals who serve on the workgroups responsible for producing this report including: Scott Addison, Debra Darling, Reneé DeMars-Johnson, Chris Fussman, Julia Heany, Tiffany Kostelec, Cristin Larder, Mary Ludtke, Patricia McKane, Chris Miller, Amber Myers, Laura Olson, Guy Thompson, Robin VanDerMoere, and Amy Zaagman.

We also acknowledge the work of Public Sector Consultants for their support in producing this report.

Table of Contents

Executive Summary

Parenthood is an exciting—and daunting—experience. A child's first days, weeks, months, and years are critical to their development, but this time can also be intimidating for parents. Home visiting programs equip families with the tools they need to overcome those challenges. These programs partner with families with multiple risk factors to support them during pregnancy and their child's early years, with some programs continuing support until a child is five years old. Trained service providers, such as nurses and social workers, help families build the knowledge and skills they need to maintain a healthy home environment for their child. In other words, home visiting programs support and empower parents to be their child's first and most important teacher.

Home Visiting Works

Home visiting programs have been rigorously and thoroughly evaluated, and decades of national research consistently shows that home visiting improves outcomes for children and families. The U.S. Department of Health and Human Services has led an extensive effort to review and catalog this research through the Home Visiting Evidence of Effectiveness project.[1] Below is a summary of their findings.

Improved Family Health

Women and children that participate in home visiting programs experience improved health outcomes. Mothers that participate have improved prenatal health and fewer instances of maternal depression.[2] Their children are less likely to have a low birth weight and are more likely to be immunized.[3] Children are also less likely to experience child abuse, neglect, or maltreatment.[4]

Improved School Readiness

Children whose families participate in home visiting programs are socially and academically more prepared for school.[5] Developmental delays are more likely to be identified early due to increased participation in developmental screenings. Nationally, children experience improved social-emotional development and they are less likely to experience behavior problems.[6]

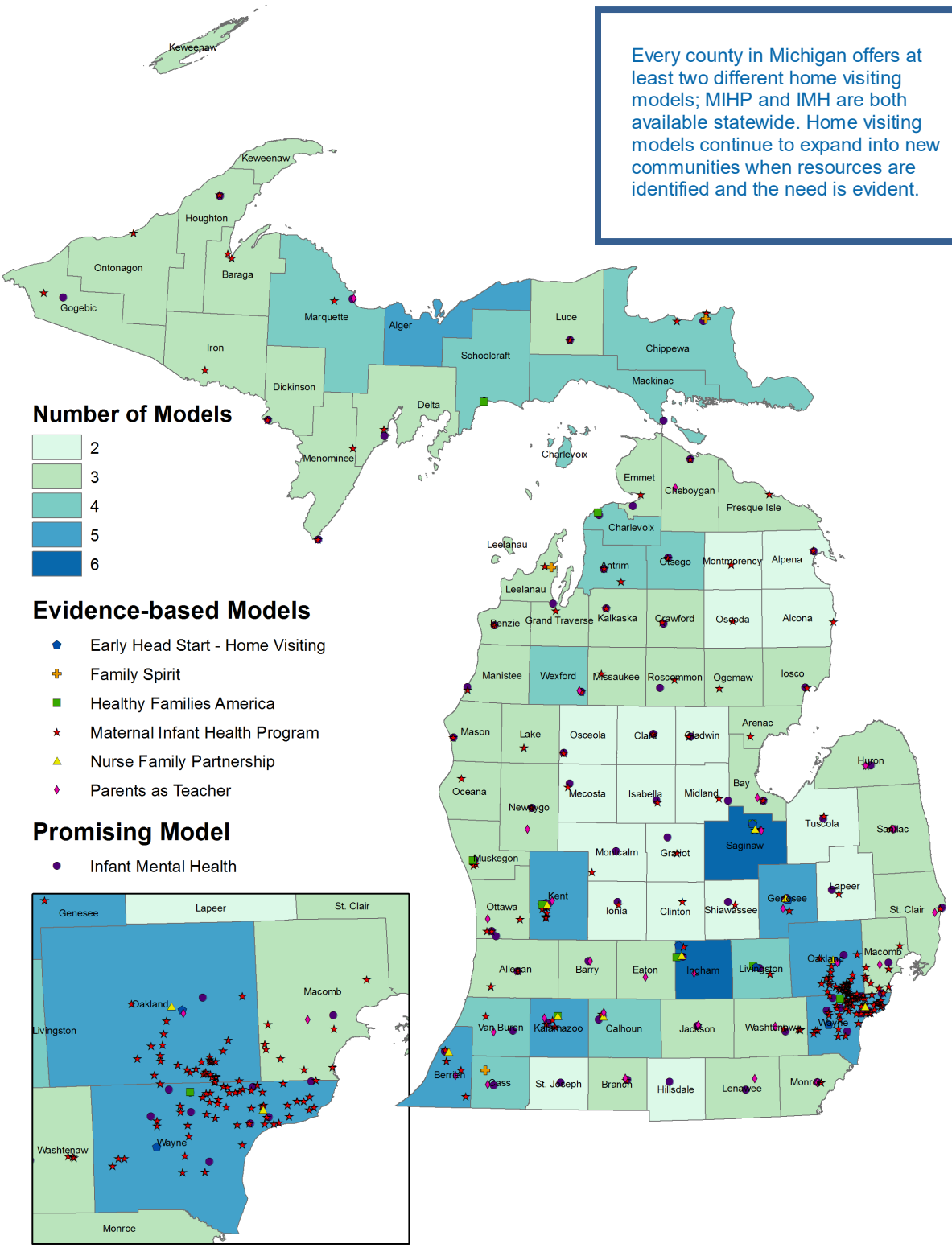
Improved Self-sufficiency for Families

When families participate in a home visiting program, women are more likely to earn their high school diploma or GED, to enroll in school or training, and to be economically self-sufficient.[7]

Different Home Visiting Models Meet the Needs of Different Families

As the name suggests, home visiting professionals provide services in a family's home. They nurture, coach, educate, offer encouragement, and refer families to services to achieve a shared goal: building a safe, healthy, and stimulating environment for their child. Not every family needs the same type of supports. That is why there are currently seven home visiting models that meet the criteria required to receive funding from the State of Michigan. Six are considered evidence based and one is considered a promising practice. Models vary based on the population they serve, the age of recipients, the intensity of services provided, the time period when services are provided, and the outcomes they are proven to achieve. The map below highlights how many models serve each county in our state.

Exhibit 1. Where are State-funded Home Visiting Programs Available? Program Offices and Number of Models per County



Michigan's Investment Shows Results

Michigan invests state, federal, and private funds to support home visiting. To ensure these funds are efficiently and effectively invested, Michigan has a coordinated system of home visiting services that leverages the expertise of local, regional, and state partners to deliver quality services for families. All home visiting partners are dedicated to program improvement and have committed to robust data collection to document outcomes and guide improvement. Since 2013, Michigan has focused on ten indicators to gauge success in state-funded home visiting services:

- **Prenatal care:** Approximately two in three pregnant women enrolled in home visiting received adequate prenatal care
- **Preterm birth:** One in eight mothers enrolled in home visiting have a preterm birth
- **Breastfeeding:** Approximately three in four mothers enrolled in home visiting initiate breastfeeding
- **Maternal tobacco use:** Over 80 percent of women enrolled in home visiting for six months were not using tobacco at six months of enrollment or program exit
- **Maternal depression:** Forty percent of women who needed a referral for depression received it
- **Maternal high school completion status:** Of women who enrolled in home visiting before completing their high school education, 28 percent stayed in school, returned to school, or completed high school
- **Postpartum visits:** Three in five women who participated in home visiting visited their doctor postpartum
- **Well-child visits:** Nearly all children participating in home visiting attended their last recommended visit
- **Child maltreatment:** Most children participating in home visiting (94 percent) do not have a case of confirmed child maltreatment
- **Child development referrals:** Approximately three in ten children received follow-up after a developmental screening indicated need

More Michigan Families Could Benefit from Home Visiting

In 2017, the Michigan Home Visiting Initiative (MHVI)—our statewide, cross-agency effort to implement home visiting—will promote and support access to evidence-based, prevention-focused home visiting services. The initiative will continue to lead a collaborative effort to bring home visiting services to communities across Michigan in an efficient, aligned manner that increases support for families, avoids duplication of service, and maximizes the impact of taxpayers' investments. MHVI will develop well-trained, high-quality service providers that focus on fidelity and commit to parent success. MHVI will also strive to align data collection systems and protocols to increase data accuracy and guide program improvement.

In Michigan, we are committed to connecting parents with well-trained providers who use an evidence-based approach to guide and assist parents through the trials of parenthood. There are many challenges facing new parents, and sometimes having a little extra support can go a long way toward helping a family succeed.

Home Visiting Provides Michigan Families with Support and Coaching

Overview

Parenthood is an exciting—and daunting—experience. A child's first days, weeks, months, and years are critical to their development, but this time can be intimidating for parents. From selecting baby essentials to ensuring their child is sleeping as safely as possible, parents make countless decisions while trying to do what is best for their child. Sorting through conflicting opinions to figure out what is best can be trying for the most well-resourced families, and it is particularly challenging for families struggling economically.

Home visiting programs work to equip parents with the tools they need to overcome challenges. Home visiting programs partner with families with multiple risk factors to support them during pregnancy and their child's early years—with some programs continuing support until their child is five years old. Nurses, social workers, and other trained professionals help families build the knowledge and skills they need to maintain a healthy home environment for their child. In other words, home visiting programs support and empower parents to be their child's first, and most important, teacher.

These voluntary, evidence-based, prevention-focused programs match their supports to specific family and community needs. Across the state, Michigan's Home Visiting Initiative includes seven different home visiting models each tailored to a specific set of needs. The goal of this continuum is to meet families where they are and offer the type and intensity of services that are most likely to improve outcomes for families and young children. The specific models available in each community vary.

Home Visiting Works

Home visiting programs have been rigorously and thoroughly evaluated, and decades of research consistently shows that home visiting improves outcomes for children and families. The U.S. Department of Health and Human Services has led an extensive effort to review and catalog this research through the Home Visiting Evidence of Effectiveness project.[8] All evidence-based home visiting models benefit families in at least one of the following areas:

- Improve child health
- Improve maternal health
- Promote child development and increase school readiness
- Promote use of positive parenting practices
- Reduce crime and domestic violence
- Reduce child maltreatment
- Improve coordination of services and referrals to appropriate agencies
- Improve family economic self-sufficiency[9]

In Michigan, home visiting programs monitor a number of outcomes to track progress and success (see the "Outcomes" section of this report). Broadly speaking, home visiting in Michigan is working to improve family health, increase school readiness, and improve family self-sufficiency, and can result in cost savings for our state.

Improved Family Health

Women and children that participate in home visiting programs experience improved health outcomes. Women that participate in home visiting have improved prenatal health and fewer instances of maternal depression.[10] Their children are less likely to have a low birth weight and are more likely to be immunized.[11] Additionally, these children are less likely to experience child abuse, neglect, or maltreatment.[12]

Increased School Readiness

Children whose families participate in home visiting programs are socially and academically more prepared for school.[13] Developmental delays are more likely to be identified early due to increased participation in developmental screenings. Children experience improved social-emotional development and are less likely to experience behavior problems.[14]

Improved Self-sufficiency for Families

When families participate in a home visiting program, women are more likely to earn their high school diploma or GED, more likely to enroll in school or training, and more likely to be economically self-sufficient.[15]

Return on Investment

Home visiting efforts improve outcomes for families which, in turn, contributes to cost savings for states. National research shows that over time, the highest-quality home visiting programs save taxpayers $5.70 per dollar invested. These savings come from reduced mental health, criminal justice, and welfare costs. Home visiting participants are also more likely to be employed. Together this research shows that these outcomes produce $41,000 in benefits to society per family served.[16]

Families Served

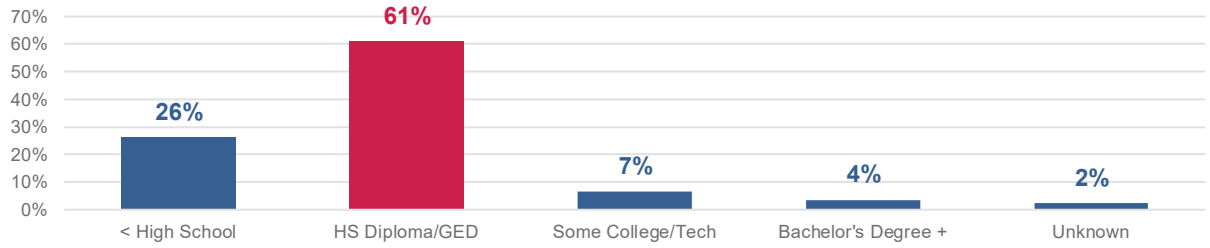
Across Michigan, nearly 35,000 families participated in a state-funded home visiting program in 2016. Each family received services tailored to their specific need and circumstances. Please see Appendix II for more detail about the demographics of home visiting participants in 2016.

Exhibit 2. Who Is Served by State-funded Home Visiting?

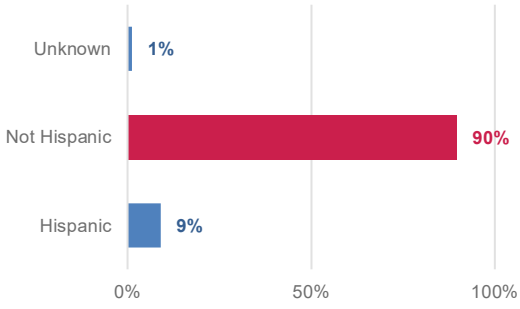
Home Visiting by the Numbers	
Total Home Visits	212,390
Total Women Served	20,881
Total Children Served	23,504

Demographics of Women Participating in Home Visiting Services

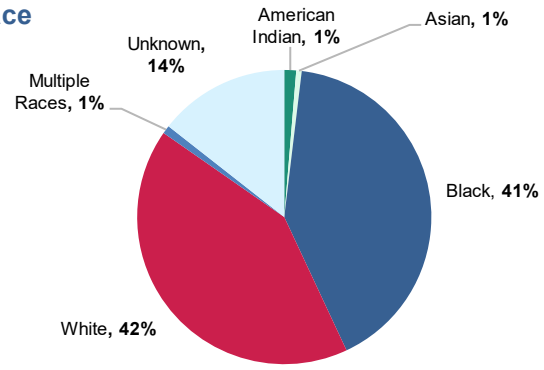
Education



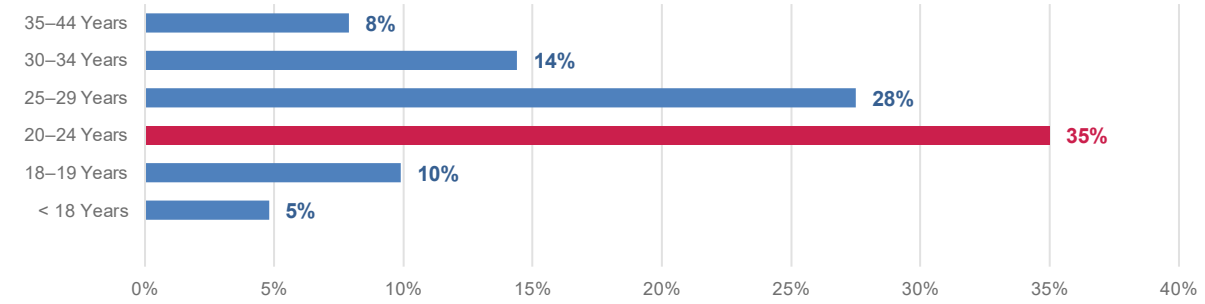
Ethnicity



Race



Age



Home Visiting Services

How Home Visitors Partner with Families

As the name suggests, home visiting professionals provide services in a family's home. They nurture, coach, educate, offer encouragement, and refer families to services to achieve a shared goal: building a safe, healthy, and stimulating environment for their child. During pregnancy, home visitors encourage mothers to receive regular prenatal care, avoid risky behaviors, and adopt healthy habits. Once the baby is born, home visitors coach parents on positive parenting practices, support breastfeeding, help parents prepare for well-child visits, teach parents about child development and nutrition, conduct developmental screenings, support older children when a new baby arrives, and encourage parents to attend to their own health care needs. Home visitors also help families connect with community-based resources and state and federal programs. This could include applying for health insurance, accessing early intervention services, finding child care, connecting with community resources for stable housing, or finding a job. Home visitors' roles extend beyond the parent-child relationship—they discuss topics such as continuing family education, managing family finances, understanding domestic violence, and dealing with trauma.

What does this look like for families? MDHHS and the Early Childhood Investment Corporation (ECIC) partnered to create an opportunity for parents to share their experiences through a series of digital stories. These stories capture, in a parent's own words, how he or she has been supported by home visiting and in some instances, how their lives are now different as a result of participating in home visiting. In these videos, many home visiting participants talk about the importance of having one person to help them with a range of problems. "If I have questions, I can get them answered. I don't have to just guess anymore," said Robin, a home visiting participant. She explained that her home visitor connected her with resources and was always available if she needed someone to talk to about her son.

Parents, however, also admit having some skepticism about welcoming a stranger into their home. Whitney, another participant, was not sure she needed home visiting because she has strong family support, but after trying the program, she said she developed a friendship with her home visitor and came to rely on her, especially for guidance regarding child development. "Having someone help me know that my daughter was on track and giving me ideas for what I can do with her to spark her interest in new things and to help her learn through playing, that was a great, great thing for us," Whitney explained.

Other parents said their home visitor helped connect them with services like early intervention. Ka'Mesha, a home visiting participant, was worried about her son's speech development, and her home visitor connected her with early intervention services—something she would not have known about without home visiting. "I think I'd be stuck in the same position if [my home visitor] was not here—clueless . . . She's really been a blessing," Ka'Mesha said.

A Service Continuum

Evidence-based, prevention-focused home visiting services are implemented with an eye toward matching the appropriate model to the identified community needs. In Michigan—for funding of models separate from the Maternal Infant Health Program (MIHP), which is Medicaid-funded—this starts with a community needs assessment and exploration and planning process to better understand the type and intensity of local needs. Local communities—typically under the leadership of a public health department, intermediate school district, or nonprofit partner—consider a range of data including: poverty rates, preterm births, infant mortality, prenatal health, school readiness, domestic violence, child maltreatment, substance abuse, community resources, and local strengths. This community exploration leads to identification of a model that, if implemented, will ideally lead to improved outcomes for families in the community.

Currently, seven home visiting models meet the required evidence base in specific outcomes to receive funding from the State of Michigan. Models vary based on the population they serve, the intensity of services they provide, and their demonstrated outcomes. For example, one model serves women from pregnancy until their child is one year old. Other models serve families from pregnancy until their child is five, and one model serves first-time mothers. Each provide support to families but do so using an approach that is specific to that particular model. Please see Appendix III for more detail about each state-funded, accredited home visiting model in Michigan.

Exhibit 3. Different Home Visiting Models Serve Different Populations and Achieve Different Outcomes

Model	Acronym	Evidence Level[17]	Population Served	Outcomes
Early Head Start—Home Visiting	EHS-HV	Evidence-based	Low-income parents and their children from prenatal through age three	Promotes child development and school readiness, reductions in child maltreatment, positive parenting practices, family self-sufficiency, and service referrals.
Family Spirit	FS	Evidence-based	Native American families and their children from prenatal through age three	Promotes maternal health, child development and school readiness, and positive parenting practices.
Healthy Families America®	HFA	Evidence-based	Families at risk for adverse childhood experiences, including child maltreatment. Services start prenatally or within three months after the baby's birth and are available until age five.	Promotes child health, maternal health, child development and school readiness, reductions in child maltreatment, reductions in juvenile delinquency, positive parenting practices, family self-sufficiency, and service referrals.
Infant Mental Health	IMH	Promising and currently engaged in a rigorous evaluation to establish the evidence base for this model.	Families in which the parents' condition and life circumstances, or the condition of the infant, threaten parent-infant attachment. Families generally begin services after birth, although services may begin during pregnancy, and continue until their child is age three.	Promotes parent-infant attachment and positive social, emotional, behavioral, and cognitive development of the infant/toddler.
Maternal Infant Health Program	MIHP	Evidence-based	Pregnant women and infants	Promotes healthy pregnancies, good birth outcomes, and healthy infants.
Nurse-Family Partnership	NFP	Evidence-based	First-time mothers (enrolled before the 28th week of pregnancy) and their children to age two	Promotes child health, maternal health, child development and school readiness, reductions in child maltreatment, reductions in juvenile delinquency, positive parenting practices, and family self-sufficiency.
Parents as Teachers™	PAT	Evidence-based	Parents and their children from prenatal through age five	Promotes child development and school readiness, reductions in child maltreatment, positive parenting practices, and family self-sufficiency.

Home Visiting Implementation

Implementing a coordinated, efficient system of home visiting services requires collaboration and support from a wide range of partners at the local and state level.

Local Leadership and Implementation

Local Home Visiting Leadership Groups

Home visiting leadership groups often include local planning bodies or governance structures in communities funded by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program whose purpose is to build local capacity to coordinate prevention-focused home visiting services as part of an early childhood system. Each is connected to a local Great Start Collaborative to ensure connection between home visiting and the comprehensive early childhood system.

Home Visiting Programs

Home visiting services are provided by programs, sometimes called local implementing agencies (LIAs), that operate a specific model, hire home visitors, and recruit and serve families.

Each LIA uses a specific service and support strategy, known as a model, for delivering home visiting. Models differ in their scope of practice, outcomes, populations served, home visitor education requirements, and terms of service for families. A local agency may implement multiple models in one area, or different models may be implemented by different agencies within the same community.

LIAs receive state and federal funding from state departments, and a variety of entities serve as LIAs, including local public health departments, community mental health service programs, intermediate school districts, and local organizations and businesses.

Over 300 home visiting programs are offered in Michigan.

State Leadership and Support

Michigan's Home Visiting Initiative

Michigan's Home Visiting Initiative (MHVI) is a cross-agency collaboration that leads Michigan's statewide effort to increase access to home visiting in a coordinated, efficient manner. The goals of the MHVI are:

- Create a vision by engaging partners in a collaborative process to plan and implement policies, procedures, standards, measures, and funding mechanisms that support common goals
- Strengthen the home visiting network by improving the quality of the system and supporting the use of evidence-based model programs
- Promote positive outcomes by measuring and reporting progress toward improving child health and safety, supporting healthy development, reducing family violence, improving maternal child health, and encouraging economic self-sufficiency

In collaboration with partners from across MDE and MDHHS as well as stakeholders from ECIC and the Michigan Public Health Institute, MHVI works to develop and implement policy, procedures, and standards; award funding; provide professional development opportunities for home visitors; collect and analyze data; focus on continuous quality improvement projects; and coordinate programs and funding streams. For example, MHVI has partnered with child welfare by sharing information about home visiting with staff and stakeholders and ensuring that there is child welfare representation for state and local collaboration. In its

partnerships with offices at MDE, MHVI, for example, ensures there is broad representation on the MHVI Learning Collaborative and coordination at the state and local level between evidence-based home visiting and early intervention services. Other examples of collaboration by the MHVI include sharing professional development opportunities with the Maternal Infant Health Program as well as conducting state level continuous quality improvement projects that will impact home visiting statewide.

MHVI is intentionally located in Michigan's early childhood system to integrate and coordinate a range of early childhood services. Michigan uses an interdepartmental structure and team process with ECIC, MDE, MDHHS, and other stakeholders to coordinate and integrate early childhood systems and services. Coordination occurs within the Great Start Operations and Great Start Steering Teams which function as the means through which early childhood system resources, strategic direction, and system building is occurring for Michigan's young children and their families. This approach ensures that efforts are efficient and unduplicated and that meaningful connections are made within agencies as well as within the local communities they serve.

To maintain a strong focus on quality, MHVI has prioritized its capacity-building function. Throughout 2016, the initiative hosted and coordinated numerous trainings, workshops, and conference calls, all focused on improving the quality of services. The capstone of this yearlong training effort was the annual home visiting conference; nearly 650 attendees gathered to learn how to improve service provision in their community.

MHVI is staffed by a unit located within the Early Childhood Health Section of the Division of Child and Adolescent Health in MDHHS.

Home Visiting Workgroup

The home visiting workgroup is one place where MHVI partners come together to coordinate efforts and improve quality across models, programs, and partners. This group meets regularly to discuss opportunities in home visiting and how to capitalize on those opportunities for all models and programs, statewide. For example, the workgroup participated in a state-level continuous quality improvement project to improve the rate of referral for services for maternal depression by developing and aligning common definitions for how to count referrals for maternal depression—a critical precursor to accurately collecting data.

Michigan's Investment in Children and Families

Michigan invests state, federal, and private funds to support home visiting. Roughly 36 percent of Michigan's total investment is made up of state resources, 64 percent is federal resources, and less than 1 percent consists of private investment. Each of these investments include specific program requirements and accountability metrics. Michigan deploys each funding stream strategically to achieve improved outcomes for children and families and to invest public resources effectively and efficiently.

For a detailed accounting of how home visiting resources are invested, please see Appendix V. This table identifies the funding sources supporting each of Michigan's seven home visiting models.

State Funding

General Fund

Michigan provides direct support to the Nurse-Family Partnership through MDHHS appropriations. In addition, in 2014, the legislature first appropriated state funds for the expansion of home visiting programs in northern Michigan and the Upper Peninsula. Following this expansion, the Michigan Home Visiting Initiative has continued to partner with LIAs to support families in those regions. Education and promotion of the programs in these regions is ongoing, as it is across the state. In addition, General Fund dollars are used to draw down matching Medicaid funds that support various home visiting models in the state, including the Maternal Infant Health Program and Infant Mental Health.

State School Aid

The legislature appropriates funds to MDE that may be used for home visiting through the State School Aid Act, Section 32p. Local programs funded through the 32p early childhood block grant include Parents as Teachers, Healthy Families America, Early Head Start—Home Visiting, and the Nurse-Family Partnership. In FY 2016, the legislature appropriated additional funding within 32p for evidence-based home visiting to improve third-grade reading levels. These funds were not distributed until mid-August 2016 and therefore are not represented in this report.

Federal Funding

Maternal, Infant, and Early Childhood Home Visiting

MIECHV is a federal grant program that is awarded on a formula grant basis. Since its inception, MIECHV has had bipartisan support in Congress. The MIECHV program funds allow Michigan to increase evidence-based home visiting services in communities with high risk. The law requires that 75 percent of state funding is used to support direct service. In addition to serving families, MIECHV program funding also allows Michigan to implement an aligned system that maximizes outcomes for families through collaborative planning and partner engagement. MIECHV also requires that Michigan use evidence-based data for planning and quality improvement throughout the system, and requires outcome reporting on numerous indicators. In Michigan, funds are administered by the MDHHS.

Child Abuse Prevention and Treatment Act

Michigan receives Child Abuse Prevention and Treatment Act funds to develop, operate, expand and enhance community-based, prevention-focused programs and activities designed to strengthen and

support families and to prevent abuse and neglect. Title II funds, called Community-based Child Abuse Prevention Grants (CBCAP), can be used for home visiting. The Children's Trust Fund (CTF) is the entity designated to apply for, receive, and use these funds in Michigan.

Medicaid

Medicaid funds can also be used to support evidence-based home visiting models. Some funding is provided through the Medicaid State Plan for the Maternal Infant Health Program and Infant Mental Health, and other funding is part of a match strategy, as is the case with several Nurse-Family Partnership programs.

Private Funding

Children's Trust Fund

Each year, the CTF raises private dollars which are granted to local communities for home visiting programs and other services.

Outcomes

Michigan is committed to understanding, evaluating, and improving our home visiting efforts. To do this, state-funded home visiting programs are expanding their data collection efforts to assess progress against ten common indicators:

- Prenatal care
- Preterm birth
- Maternal tobacco use
- Maternal depression referrals
- Maternal high school completion status
- Postpartum visits
- Well-child visits
- Child maltreatment
- Child development referrals

By tracking Michigan's progress on key outcome measures, we can identify where program improvements should be made and quantify the impact home visiting has on children and families across our state.

Progress and Limitations

Over the past three years, home visiting programs statewide have wrestled with how best to collect indicator data. Each home visiting program in Michigan participates in a robust data collection system to ensure that programs are implemented consistently, have a clear understanding of who they serve, and produce outcomes. These data collection systems, however, are aligned with each program and are not consistent statewide, which introduces some challenges when Michigan tries to aggregate data across programs. The indicator data shared below notes these limitations to ensure that data are analyzed in context and used appropriately.

Our state has made progress, and we must continue to improve data collection. For the second year, Michigan can report data for all ten indicators. We have introduced quality protocols to ensure the data are as accurate as possible, and we have provided contextual information to help readers interpret the data. Work to align data collection efforts is ongoing. This work will allow for more extensive comparisons and review in the future. For example, representatives from each state department and agency that fund evidence-based home visiting meet monthly to discuss data collection barriers, identify ways to achieve more consistent data, and deploy updated collection tools. This collaboration has already changed how models collect and report their data.

The strength of the home visiting continuum of service is the variety of models and programs that reach a wide range of citizens who can benefit from these efforts. A challenge is that data may not be easily aggregated or directly comparable. There are some data elements that we are not yet able to report and will require further refinement of our data collection and reporting tools before we are able to report them. We are also working to identify better contextual data. Each of the home visiting models serve a different population with different baseline data for each of the indicators. It is difficult to find the best comparison group to fairly judge progress. Using population data is inaccurate because home visiting participants tend to have lower incomes and more risk factors than the general population. Using data about families with economic challenges is difficult because many of these families participate in some form of home visiting,

making it difficult to understand home visiting's impact. This report has opted to provide context data where available, despite these imperfections, to make the report as useful as possible.

In addition, we are working to improve the data we have about the costs associated with home visiting—particularly the cost of serving a family with an evidence-based home visiting program. Michigan is participating in national discussions about how to accurately calculate these costs. We will continue to participate in these conversations and consider how to apply proposed methodologies to Michigan's efforts in 2017.

Monitoring and Accountability

Data are largely used to guide program improvements, and they are also a critical component of the state's accountability system. The data are used to ensure that Michigan is investing state and federal dollars in voluntary, evidence-based, prevention-focused home visiting programs that improve the health, well-being, and self-sufficiency of parents and their children. They guide conversations about how programs can improve and where collaboration would benefit families and our state. In addition to state-level accountability measures, each home visiting program follows model-specific standards to ensure fidelity and guide continuous improvement.

State Indicator Outcomes and Measures Overview

Michigan collects and reports the same elements for each of the ten state indicators. These elements are:

- An explanation of why this measure is important, including relevant contextual data
- Statewide data for home visiting participants
- Calculation
- Data source
- Models reporting

Notes

- Only state-funded home visiting programs or pass-through federally funded programs, that are formally affiliated with their model are included in this report. Michigan funds seven evidence-based and promising models, however, not every model reports data for each indicator. Some models are not yet able to report data as they are still developing their programmatic data collection methodology. In other cases, models collect data, but there are challenges when aggregating data at the state level. Please see Appendix VI for clarification regarding which home visiting participants are included in the denominator of each calculation.
- Model-specific notes:
    - Early Head Start-Home Visiting is supported largely by federal grants made directly to local organizations. Only EHS-HV programs that receive state funds in addition to federal support are included in this report.
    - The Maternal Infant Health Program is the largest home visiting model in the state (making up 60 percent of home visiting programs) and the largest proportion of the data included in this report.

Access to Prenatal Care

It is essential that women have access to quality, consistent prenatal care. Prenatal care can reduce the risk of infant health problems such as low birth weight, cognitive impairments, and heart problems. Babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight and five times more likely to die than those whose mothers receive prenatal care.[18] When women have regular prenatal care, they are also more likely to identify and treat problems early and help women make healthy choices during pregnancy. [19]

Home visitors encourage women to begin prenatal care early (ideally in the first or second month of pregnancy) and continue prenatal visits regularly until delivery. They also help women overcome barriers to access prenatal care, such as limited resources or transportation issues.

Practically, this is measured using the Kotelchuck Index, which characterizes care with an adequacy score. This score is based on when care begins and the number of times the woman receives care. Michigan considers the top two ratings in the Kotelchuck Index, "adequate" or "adequate plus," as a satisfactory prenatal experience. To meet this level of care, a woman must begin prenatal care by the fourth month of pregnancy and receive 80 percent or more of the expected visits.[20] The most recent statewide data indicate that 77.3 percent of all mothers and 67.8 percent of black mothers achieve this standard in Michigan.[21]

Exhibit 4. Approximately Two in Three Pregnant Women Enrolled in Home Visiting Received Adequate or Adequate Plus Prenatal Care

Note: Vital records data indicate that 69.6 percent of women enrolled in home visiting during pregnancy received "adequate" or "adequate plus" prenatal care.

Calculation

Percent of women enrolled in home visiting services during pregnancy who received adequate or adequate plus prenatal care = Number of women enrolled in home visiting during pregnancy who received "adequate" or "adequate plus" prenatal care / Number of women enrolled in home visiting during pregnancy

Data Source

Vital records

Models Reporting

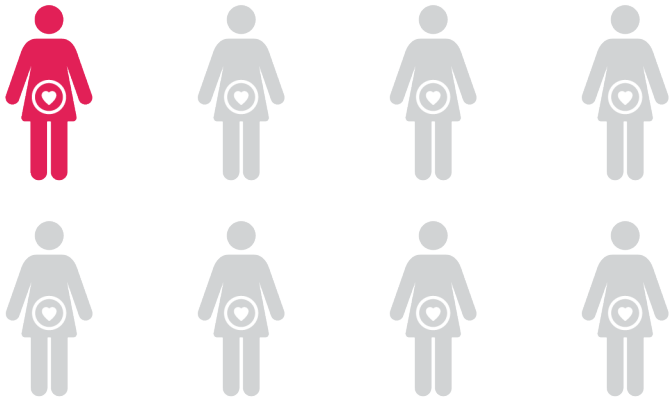
All eligible models provided data for this measure: EHS-HV, FS, HFA, MIHP, NFP, and PAT.

Preterm Birth

During a pregnancy, even in the final weeks and months, babies experience important growth. Babies that are born before 37 weeks of gestation miss out on this development which can lead to short- and long-term health challenges and an increased risk of infant death. For example, premature babies can experience breathing and feeding difficulties, and they are at greater risk for vision problems and hearing impairment.[22] Preterm birth can also be an emotionally and financially demanding experience for families.

Preterm birth has many causes, and preventing all preterm birth is challenging. However, women who are healthy before and during pregnancy are more likely to carry their pregnancies to term. Home visitors work with women on healthy eating and getting exercise, avoiding exposure to tobacco or other drugs, and reducing stress. Even if a woman delivers a preterm infant, having a home visitor increases the likelihood that the infant will survive and thrive. Nationally, nine in ten infants are considered full term, meaning they are born after 37 weeks' gestation.[23] While only 9.9 percent of all mothers deliver preterm in Michigan, 14.1 percent of black and 13.3 percent American Indian mothers deliver preterm. This highlights the disparity among races in the state in terms of preterm births and is similar to the nationwide statistics.[24]

Exhibit 5. One in Eight Mothers Enrolled in Home Visiting Have a Preterm Birth



Note: Vital records data indicate 12.3 percent of women enrolled in home visiting during pregnancy have a preterm birth.

Calculation

Percent of women enrolled in home visiting services during pregnancy who have a preterm birth (<37 weeks gestation) = Number of women enrolled in home visiting services during pregnancy who have a preterm birth (<37 weeks gestation) / Number of women enrolled in home visiting during pregnancy

Data Source

Vital records

Models Reporting

All eligible models provided data for this measure: EHS-HV, FS, HFA, MIHP, NFP, and PAT.

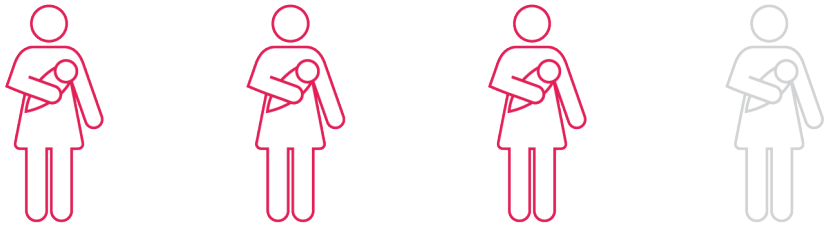
Breastfeeding

Breastfeeding is associated with numerous health benefits for infants and mothers. Breastfeeding provides strong support for healthy infant development and protects infants from common childhood illnesses. In addition, children experience long-term benefits, such as a reduced risk for obesity and type-2 diabetes. Breastfeeding also promotes positive outcomes for mothers, as women who breastfeed have a reduced risk of breast and ovarian cancers and, research suggests, a reduced risk of postpartum depression.[25]

Home visitors promote breastfeeding to women before and after delivery. Prior to delivery, home visitors encourage women to initiate breastfeeding once their child is born and to continue breastfeeding through the first 12 months of the child's life. After delivery, home visitors support mothers through regular discussions about breastfeeding and referrals for additional lactation support when needed. They also help women address barriers to breastfeeding such as having access to a pump, workplace concerns, and concerns of family members.

In Michigan, the percent of women who have breastfed their infant, is slightly below the national average (as of 2013).[26] Data from the 2015 Michigan Provisional Birth File reveal that initiation rates are lower among specific segments of the population who face additional barriers to breastfeeding, including black women (65.3 percent initiation rate) and women without a high school diploma (63.4 percent initiation rate), compared to the statewide average of 81.9 percent.[27]

Exhibit 6. Approximately Three in Four Mothers Enrolled in Home Visiting Initiate Breastfeeding



Note: Vital records data indicate that 74.0 percent of women enrolled in home visiting initiate breastfeeding.

Calculation

Percent of women enrolled in home visiting services during pregnancy who initiate breastfeeding = Number of women enrolled in home visiting services during pregnancy who initiate breastfeeding / Number of women enrolled in home visiting during pregnancy

Data Source

Vital records

Models Reporting

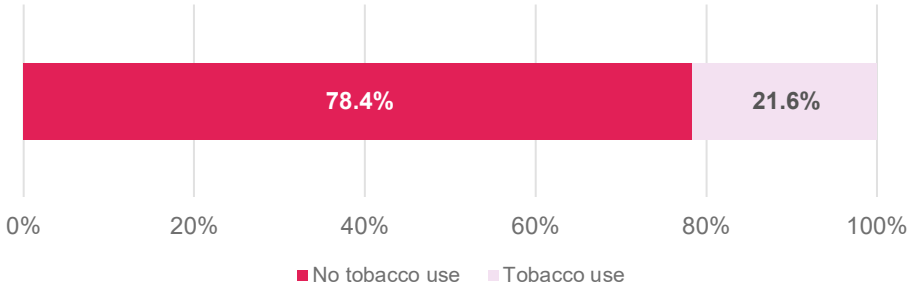
All eligible models provided data for this measure: EHS-HV, FS, HFA, MIHP, NFP, and PAT.

Maternal Tobacco Use

A woman's health is vital to her baby before and after birth. Smoking during pregnancy remains one of the most common preventable causes of infant disease, illness, injury, and death. Maternal cigarette smoking during pregnancy increases the risk for pregnancy complications, including serious bleeding and premature birth, as well as increased risk for sudden unexplained death after a baby is born.[28] Maternal smoking and exposure of the child to secondhand smoke after delivery increases an infant's risk of respiratory tract infections (such as bronchitis or pneumonia), ear infections, and unexplained infant death.[29]

Home visitors encourage women to quit and/or avoid smoking during and after pregnancy, and connect women with programs and services to help them quit smoking. In Michigan, 20.5 percent of pregnant women report smoking six months after giving birth.[30]

Exhibit 7. Nearly 80 Percent of Women Enrolled in Home Visiting for Six Months Were Not Using Tobacco at Six Months of Enrollment or Program Exit



Note: Program data indicate that 78.4 percent of women enrolled in home visiting for six months were not using tobacco or smoking at six months of enrollment (EHS-HV, HFA, NFP) or at program exit (MIHP).

Calculation

Percent of women enrolled in home visiting services for at least six months who were using tobacco or smoking at six months or upon program exit = Number of women enrolled in home visiting services for at least six months who were using tobacco or smoking at six months or upon program exit / Number of women enrolled in home visiting for six month

Data Source

Program data

Models Reporting

Four of six eligible models provided data for this measure: EHS-HV, HFA, MIHP, and NFP.

Maternal Depression

Maternal depression can have serious impacts on all family members. Fortunately, early identification, referral, and support can help mitigate its lasting effects. Maternal depression is common during and after pregnancy. Women who are depressed may feel sad or restless, withdraw from friends and family, sleep too little or too much, and, in general, may not care for themselves or their child as they would like. Untreated depression during pregnancy can lead to premature birth, low birth weight of the baby, or other issues depending on the severity of the depression. Untreated depression after the baby is born can impact a mother's ability to parent her child as she may have trouble focusing, lack energy, and not be able to meet her child's needs or provide necessary interaction.[31] Children whose mothers are depressed are at increased risk for difficulties with attachment and other long-term effects, including difficulties in school.[32]

Home visitors work with women to identify and screen for signs of depression and refer women with a positive screen to appropriate supports. Screening for maternal depression is a critical first step toward identifying women with depressive symptoms and connecting them with services within their community. Home visitors also help women overcome challenges accessing services. Oftentimes it can be difficult to locate a provider. In other cases, women must overcome resistance from family members and the stigma that can be associated with getting help.

While Michigan's data currently suggest a low rate of referrals, the state has identified through the continuous quality improvement process that one issue impacting referral rates is discrepancy between different home visitors as to what constitutes a referral. In many cases, home visitors are only reporting that they made a referral if their referral was accepted by their client. Work is ongoing to create and deploy a common definition to accurately assess current practice.

Exhibit 8. Two in Five Women Who Needed a Referral for Depression Received It

Note: Data reporting by the home visiting models indicate that 39.7 percent of women enrolled in home visiting received a referral for services when a validated maternal depression screening indicated a need.

Calculation

Percent of women enrolled in home visiting services with need for follow-up depression evaluation and intervention who received referral for these services = Number of women enrolled in home visiting services who received maternal depression screening with a validated tool whose results indicated need for referral who were referred for follow-up evaluation and intervention / Number of women participating in home visiting services who received maternal depression screening with a validated tool whose results indicated need for a referral

Data Source

Program data

Models Reporting

Five of seven eligible models provided data for this measure: EHS-HV, FS, HFA, MIHP, and NFP.

Maternal High School Completion

Young mothers face significant barriers to completing their education, including access to quality child care, unstable housing situations, having to work during school hours, social stigma, and wanting time with their children. Overcoming these barriers, however, is critical. Earning a high school diploma increases a mother's ability to be economically self-sufficient by increasing access to better paying jobs and pursuing higher education.[33]

For those participants who have not yet graduated from high school, home visitors work with women to overcome the challenges they face and help them stay in school or return to school and earn a high school diploma or GED. A goal for home visiting programs is to see an increase in the percentage of women enrolled in or completing a high school diploma or the equivalent.

Exhibit 9. Of Women Who Enrolled in Home Visiting Before Completing Their High School Education, 28 Percent Stayed in School, Returned to School, or Completed High School

Note: Program data indicate that 27.7 percent of women entering home visiting without a high school diploma/GED stayed in school or returned to school to complete a high school diploma or a GED.

Calculation

Percent of women entering home visiting without a high school diploma/GED who were still enrolled in or completed high school/GED by the end of FY 2016 = Number of women who enter the program without a high school diploma or GED certificate who are either still enrolled in school or a GED program or who have successfully completed high school or received a GED certificate / Number of women who enter a home visiting program without high school or GED completion

Data Source

Program data

Models Reporting

Three of seven eligible models provided data for this measure: EHS-HV, HFA, and NFP.

Postpartum Visits

In the weeks after delivery, mothers experience significant physical, social, and psychological changes. Postpartum visits are a powerful tool to assess a woman's physical and mental well-being after delivery, follow up on physical complications due to delivery, provide breastfeeding support, answer questions about infant health and safety, evaluate mental well-being, and discuss planning any future pregnancies. Postpartum care is shown to improve maternal and child health by being responsive to the needs of a new mother who, in turn, is healthy and receives support to care for her infant.[34] In Michigan, 66.7 percent of women attend a postpartum visit.[35]

Home visitors encourage women to follow up with their doctor and work to increase the number of women who receive postpartum care. They also help women identify and address barriers to attending a postpartum visit.

Exhibit 10. Three in Five Women Who Participated in Home Visiting Visited Their Doctor Postpartum

Note: Managed Care Encounter/Fee For Service Claim data indicate that 65.0 percent of women who were enrolled in home visiting before 30 days postpartum received a postpartum visit within 60 days of delivery.

Calculation

Percent of mothers enrolled in home visiting prenatally or within 30 days of giving birth who receive a postpartum visit with a health provider within two months (60 days) following birth

=

$$\frac{\text{Number of mothers enrolled in home visiting prenatally or within 30 days of giving birth who completed a postpartum visit with a health provider within two months (60 days) following birth}}{\text{Number of mothers enrolled in home visiting prenatally or within 30 days of giving birth who are at least two months (60 days) postpartum}}$$

Data Source

Managed Care Encounter/Fee For Service Claim data

Models Reporting

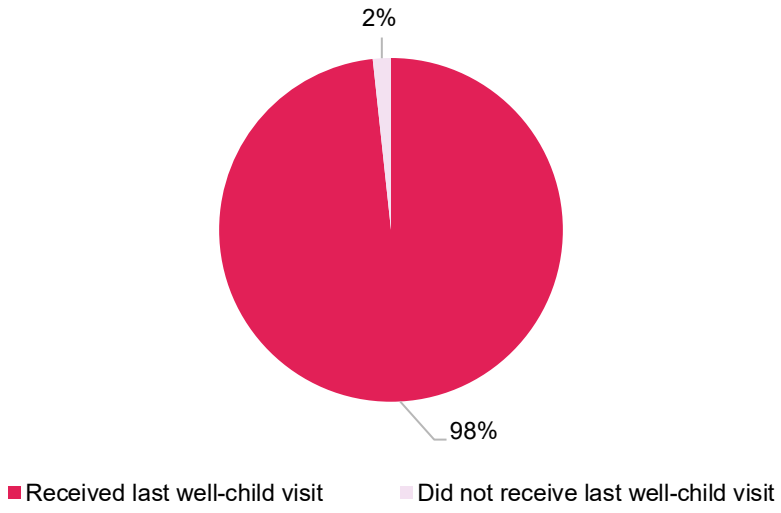
One of seven eligible models provided data for this measure: MIHP.

Well-child Visits

Well-child visits are an integral part of preventive pediatric healthcare. The American Academy of Pediatrics (AAP) recommends that a child attend ten well-child visits by their second birthday.[36] During well-child visits, doctors track a child's growth and development, give immunizations, and answer parents' questions and concerns. Children who received their last recommended visit are considered up to date on well-child visits.[37]

Home visitors encourage mothers to schedule well-child visits. They help mothers connect to a medical home, feel comfortable speaking with a medical provider about their concerns, and help them know what to expect in each appointment.

Exhibit 11. Nearly All Children Participating in Home Visiting Attended Their Last Recommended Visit



Note: Data from the reporting home visiting models indicate that 98.0 percent of children enrolled in home visiting received their last recommended well-child visit based on the AAP Bright Futures schedule.

Calculation

Percent of children participating in home visiting who received last recommended visit based on AAP Bright Futures schedule = Number of children participating in home visiting who received their last recommended well-child visit based on AAP Bright Futures schedule / Number of children participating in home visiting

Data Source

Program data, Medicaid managed care encounter/fee for service claim data

Models Reporting

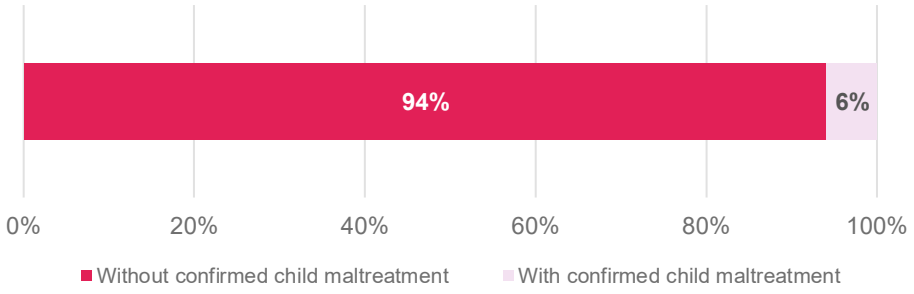
Five of seven eligible models provided data for this measure: EHS-HV, FS, HFA, MIHP, and NFP.

Child Maltreatment

Child maltreatment is the abuse and neglect of a child under the age of 18 by a parent, caregiver, or another individual in a custodial role. Child maltreatment includes physical, sexual, and emotional abuse, as well as neglect. Child maltreatment is a significant contributor to childhood disease, illness, injury, and death and has lasting effects on mental health, can lead to drug and alcohol misuse and/or risky sexual behavior, obesity, and criminal behavior which persists into adulthood.[38]

Home visitors work with families to promote positive parenting practices and prevent child maltreatment. Most child maltreatment cases involve neglect, and home visitors help families access basic resources to care for their child, such as food, adequate housing, healthcare, and more. They also work closely with mothers and caregivers to reduce maternal stress and increase social supports—both of which are strategies that impact the home environment and can prevent child abuse or neglect. Statewide, 1.47 percent of children are confirmed victims child maltreatment.[39]

Exhibit 12. 94 Percent of Children Participating in Home Visiting Do Not Have a Case of Confirmed Child Maltreatment



Note: Data from the reporting home visiting models indicate that 94.2 percent of children in families participating in home visiting for at least six months did not have confirmed case of child maltreatment.

Calculation

Percent of children in families enrolled in home visiting for at least six months with confirmed child maltreatment = Number of children in families who participated in home visiting for at least six months with confirmed child maltreatment / Number of children in families who participated in home visiting for at least six months

Data Source

Child Protective Services

Models Reporting

Six of seven eligible models provided data for this measure: EHS-HV, FS, HFA, MIHP, NFP, and PAT.

Child Development Referrals

Early intervention can dramatically improve outcomes for children with developmental delays. Developmental screening provides the best opportunity to identify children with potential delays early and connect them to intervention services.[40]

Home visitors complete the Ages and Stages Questionnaires, Third Edition® (ASQ-3™) and the Ages and Stages Questionnaires®: Social-Emotional, Second Edition (ASQ:SE-2™) for every child they serve. These nationally validated tools help to determine if a child should be referred for additional evaluation or appropriate services.

MHVI is actively working to understand how home visitors define making a referral and to uncover barriers to making a referral for early intervention services. At this time, there appear to be three likely reasons for Michigan's low referral rate. First, the ASQ allows evaluators to recommend that a child be reevaluated after a period of time. Anecdotally, home visitors report that this is common practice. Second, availability of early intervention services can vary from county to county. Based on conversations with those in the field, home visitors tend to serve a child themselves rather than refer a family for services only to have the family go through another evaluation and risk being ineligible for service. Finally, home visitors differ on when they enter a referral. If a home visitor makes a referral, but the family decides they do not want the services at this time, some home visitors do not document this interaction as a referral. MHVI continues to collect qualitative data to understand why referral rates are low in order to inform an action plan and training for home visitors.

Exhibit 13. Approximately Three in Ten Children Received Follow-up After a Developmental Screening Indicating Need

Note: Data from the reporting home visiting models indicate that 28.0 percent of children enrolled in home visiting who received developmental screening that indicated need for referral received a follow-up.

Calculation

Percent of children in home visiting referred for follow-up evaluation and intervention if needed is indicated by developmental screening with ASQ

$$= \frac{\text{Number of children participating in home visiting who received developmental screening with ASQ that indicated need for referral who were referred}}{\text{Number of children participating in home visiting who received developmental screening with ASQ whose screening results indicated need for referral for follow-up evaluation and intervention}}$$

Data Source

Program data

Models Reporting

Five of seven eligible models provided data for this measure: EHS-HV, FS, HFA, MIHP, and NFP.

Conclusion

Home visiting programs provide a range of family support and coaching services to thousands of parents across Michigan tailored to their individual and community needs. These voluntary programs improve outcomes for children and families, and save taxpayers money. In 2017, the Michigan Home Visiting Initiative will continue to promote access to evidence-based, prevention-focused home visiting services. MHVI will cultivate a cadre of well-trained, high-quality service providers that focus on fidelity and are committed to parent success. We will continue to lead a collaborative effort to bring home visiting services to communities across Michigan in an efficient, aligned manner that increases support for families, avoids duplication of service, and maximizes the impact of taxpayers' investments. MHVI will also continue to facilitate dialogue about how to align data collection systems and protocols to increase data accuracy and guide program improvement.

Through home visiting services, parents connect with well-trained providers who use an evidence-based approach to guide and assist them through the challenges of parenthood. There are many challenges facing parents and sometimes having a little extra support can go a long way toward helping a family succeed. Parenting is one of the most challenging and impactful roles a person can experience, and home visiting is one of the few services available that is focused on making sure parents have what they need to carry out this role well.

Appendices

- **Appendix I:** Acronyms
- **Appendix II:** Demographic Information and Service Statistics
- **Appendix III:** Home Visiting Models: Evidence-based and Promising Practices
- **Appendix IV:** Where are Home Visiting Services Available?
- **Appendix V:** Where are Programs Located?
- **Appendix VI:** 2016 Home Visiting Investment by Model and Source
- **Appendix VII:** Technical Notes

Appendix I: Acronyms

- **AAP** American Academy of Pediatrics
- **CBCAP** Community-based Child Abuse Prevention
- **CTF** Children's Trust Fund
- **ECIC** Early Childhood Investment Corporation
- **EHS-HV** Early Head Start—Home Visiting
- **FS** Family Spirit
- **HFA** Healthy Families America
- **IMH** Infant Mental Health
- **LIA** Local implementing agency
- **MDHHS** Michigan Department of Health and Human Services
- **MDE** Michigan Department of Education
- **MHVI** Michigan Home Visiting Initiative
- **MIECHV** Maternal, Infant, and Early Childhood Home Visiting
- **MIHP** Maternal Infant Health Program
- **MPHI** Michigan Public Health Institute
- **NFP** Nurse-Family Partnership
- **PAT** Parents as Teachers

Appendix II:
Demographic Information and Service Statistics

Service Statistics	
Total Home Visits	**212,390**
Total Families Served	**34,587**
Total Children Served	**23,504**
Total Women Served	**20,881**
Pregnant Women	14,686

Note: The number of women served is lower than the number of families served because the definition of "family" differs by program. In some cases, it is unknown if there is a mother in the family, and separate demographic data is not available.

Household Demographic Characteristics	#	%
Federal Poverty Level:	**34,587**	**100.0**
<= 50%	14,284	41.3
51–100%	3,265	9.4
101–133%	1,457	4.2
134–250%	599	1.7
251% +	70	0.2
Unknown	14,912	43.1

Child Demographic Characteristics	#	%
Insurance:	**23,504**	**100.0**
None	57	0.2
Medicaid	22,941	97.6
TRICARE	0	0.0
Private/Other	170	0.7
Unknown	336	1.4
Race:	**23,504**	**100.0**
American Indian/AN	193	0.8
Asian	110	0.5
Black	8,209	34.9
Native Hawaiian/PI	6	0.0
White	8,865	37.7
Multiple Races	262	1.1
Unknown	5,859	24.9
Age:	**23,504**	**100.0**
< 1 Year	17,876	76.1
1–2 Years	5,343	22.7
3–5 Years	267	1.1
Unknown	18	0.1
Gender:	**23,504**	**100.0**
Female	11,461	48.8
Male	12,031	51.2
Unknown	12	0.1

Maternal Demographic Characteristics	#	%
Insurance:	**20,881**	**100.0**
None	78	0.4
Medicaid	20,302	97.2
TRICARE	3	0.0
Private/Other	259	1.2
Unknown	239	1.1
Ethnicity:	**20,881**	**100.0**
Hispanic	1,898	9.1
Not Hispanic	18,664	89.4
Unknown	319	1.5
Race:	**20,881**	**100.0**
American Indian/AN	276	1.3
Asian	122	0.6
Black	8,589	41.1
Native Hawaiian/PI	12	0.1
White	8,690	41.6
Multiple Races	186	0.9
Unknown	3,006	14.4
Marital Status:	**20,881**	**100.0**
Married	4,579	21.9
Widowed	41	0.2
Separated	204	1.0
Divorced	361	1.7
Never Married	15,069	72.2
Unknown	627	3.0
Education:	**20,881**	**100.0**
< High School	5,459	26.1
HS Diploma/GED	12,751	61.1
Some College/Tech	1,408	6.7
Bachelor's Degree +	753	3.6
Other	16	0.1
Unknown	494	2.4
Age:	**20,881**	**100.0**
< 18 Years	1,012	4.8
18–19 Years	2,071	9.9
20–24 Years	7,303	35.0
25–29 Years	5,751	27.5
30–34 Years	3,007	14.4
35–44 Years	1,642	7.9
45 + Years	52	0.2
Unknown	43	0.2
Primary Language:	**20,881**	**100.0**
English	19,559	93.7
Spanish	505	2.4
Arabic	223	1.1
Other	102	0.5
Unknown	492	2.4

Appendix III: Home Visiting Models: Evidence-based and Promising Practices

Early Head Start—Home Visiting

EHS-HV is a two-generation federal initiative aimed at advancing young child development and strengthening families.[41] The program provides high-quality services, offers activities that promote healthy development, and identifies issues early. EHS-HV promotes positive, ongoing relationships and emphasizes the importance of parents as a child's first and most important relationship. EHS-HV also works to be inclusive of all children—especially those with disabilities. The model emphasizes cultural competence, offers responsive services based on family's needs, and collaborates with community partners.

Population Served

- Low-income pregnant women
- Low-income families with children from birth through age three
- Families with a child with a disability

Target Outcomes

- Promote healthy prenatal outcomes for pregnant women
- Enhance the development of very young children
- Promote healthy family functioning

Model Intensity

Families participating in EHS-HV receive weekly home visits (a minimum of 48 visits annually). Each visit lasts a minimum of 90 minutes. Families are also offered two group socialization activities per month (a minimum of 22 activities annually).

Family Spirit

Family Spirit was developed by the Johns Hopkins University Center for American Indian Health in collaboration with many tribal communities.[42] The program is designed to promote women's parenting skills and help them overcome individual and environmental stress. The model also uses traditional tribal teachings throughout the program.

Population Served

- Pregnant women and families with children younger than three
- Native American populations (though the program is also used in non-Native communities with high maternal and child behavioral health disparities)

Target Outcomes

- Increase parenting knowledge and skills
- Address maternal psychosocial risk factors (such as substance and alcohol use and depression)
- Promote child development
- Prepare children for school success

- Ensure children have healthcare and receive well-child visits
- Connect families to community services
- Promote life skills and behavioral outcomes for children and parents
- Promote healthy prenatal outcomes for pregnant women
- Enhance the development of very young children
- Promote healthy family functioning

Model Intensity

Home visits occur weekly during the child's first three months, biweekly from four to six months, monthly from seven to 22 months, and bimonthly from 23 to 36 months. If the family participates in the full program, they receive 52 home visits. Visits generally last 45–90 minutes.

Healthy Families America

HFA was designed by Prevent Child Abuse America and is built on the tenants of trauma-informed care.[43] The program is designed to promote positive parent-child relationships and healthy attachment. It is a strengths-based and family-centered approach. HFA aims to be culturally sensitive and reflective in its practice.

Population Served

- HFA targets parents facing challenges such as having a low income or a history of abuse. Local communities select their specific target population based on local needs.
- Enrollment occurs during pregnancy or within three months of birth
- Once enrolled, services continue until the child's fifth birthday

Target Outcomes

- Reduce child maltreatment
- Improve parent-child interactions
- Increase school readiness
- Promote children's physical health
- Promote positive parenting
- Promote family self-sufficiency
- Increase access to medical and community services
- Decrease child injuries and emergency room use

Model Intensity

Families receive one home visit per week for the first six months after birth. After that, visits may be less frequent, depending on the families' needs. Home visits generally last 60 minutes.

Infant Mental Health

IMH is a promising practice developed and implemented by MDHHS.[44] The program provides support to families that are at increased risk for parent-infant attachment challenges, which affect social, emotional, behavioral, and cognitive development of infants/toddlers. Services are provided locally by community mental health agencies. The model is currently participating in rigorous evaluations to achieve an evidence-based practice status.

Population Served

- IMH serves families with multiple risks such as adolescent parents, low-income parents, infants with low birth weight, parents with a mental illness, and others. Local Community Mental Health Service Programs provide Infant Mental Health services based on criteria established by MDHHS.
- Enrollment occurs during pregnancy, at birth, and up to three years of age.

Target Outcomes

- Facilitate access to community resources
- Teach problem-solving and decision-making skills
- Teach and assess child development
- Promote positive parenting
- Teach coping skills
- Prevent abuse, neglect, developmental delays, and behavioral and emotional disorders

Model Intensity

The IMH service schedule varies based on family needs. Generally, families receive weekly home visits, though visits may be more frequent if the family is in crisis.

Maternal Infant Health Program

MIHP is a population-based management model, meaning that the health of the entire population is addressed in addition to specific participants.[45] Services supplement regular prenatal and infant care, as well as assist healthcare providers in supporting the families' health and well-being. Care coordination services are provided by a registered nurse or licensed social worker.

Population Served

- Medicaid-eligible pregnant women and their infants through 12 months

Target Outcomes

- Promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development
- Improve the health and well-being of Medicaid-eligible pregnant women and infants through a standardized, system-wide process
- Decrease infant mortality

Model Intensity

Participating mothers take part in a risk identifier and up to nine visits. Once their child is born, the family receives up to nine more visits. A physician may then order nine additional home visits, and an infant exposed to substance abuse may receive up to 18 additional visits.

Nurse-Family Partnership

NFP offers families one-on-one home visits with a registered nurse.[46] The model is grounded in human attachment, human ecology, and self-efficacy theories. Home visitors use model-specific resources to build on a parent's own interests to attain the model goals.

Population Served

- First-time, low-income mothers and their children
- Enrollment occurs no later than the 28th week of pregnancy

- Services continue until the child is two years old

Target Outcomes

- Improve prenatal health and outcomes
- Improve child health and development
- Improve families' economic self-sufficiency

Model Intensity

In the first month of enrollment, a family receives weekly home visits which continue every other week until the baby is born. In the child's first six weeks, visits occur weekly and then every other week until 20 months. The final four visits are monthly until the child is 24 months old. Visits generally last 60–75 minutes. The visit schedule can be changed based on family needs.

Parents as Teachers

PAT works to improve parent-child interactions, parenting, and family well-being.[47] The model believes that improving parenting knowledge, attitudes, and behaviors as well as family well-being improves child development.

Population Served

- Pregnant women and families with children from birth through kindergarten entry. Families can enroll at any point during this time.
- Local communities select their specific target population based on local needs. These may include first-time parents, immigrant families, low-literacy families, children with special needs, and more.

Target Outcomes

- Increase knowledge of early childhood development
- Improve parenting practices
- Detect developmental delays and health issues early
- Prevent child abuse and neglect
- Increase school readiness

Model Intensity

Services vary by program, but families with one or no high-needs characteristics generally receive at least 12 home visits annually. Families with two or more high-needs characteristics receive 24 home visits annually. Home visits last approximately one hour.

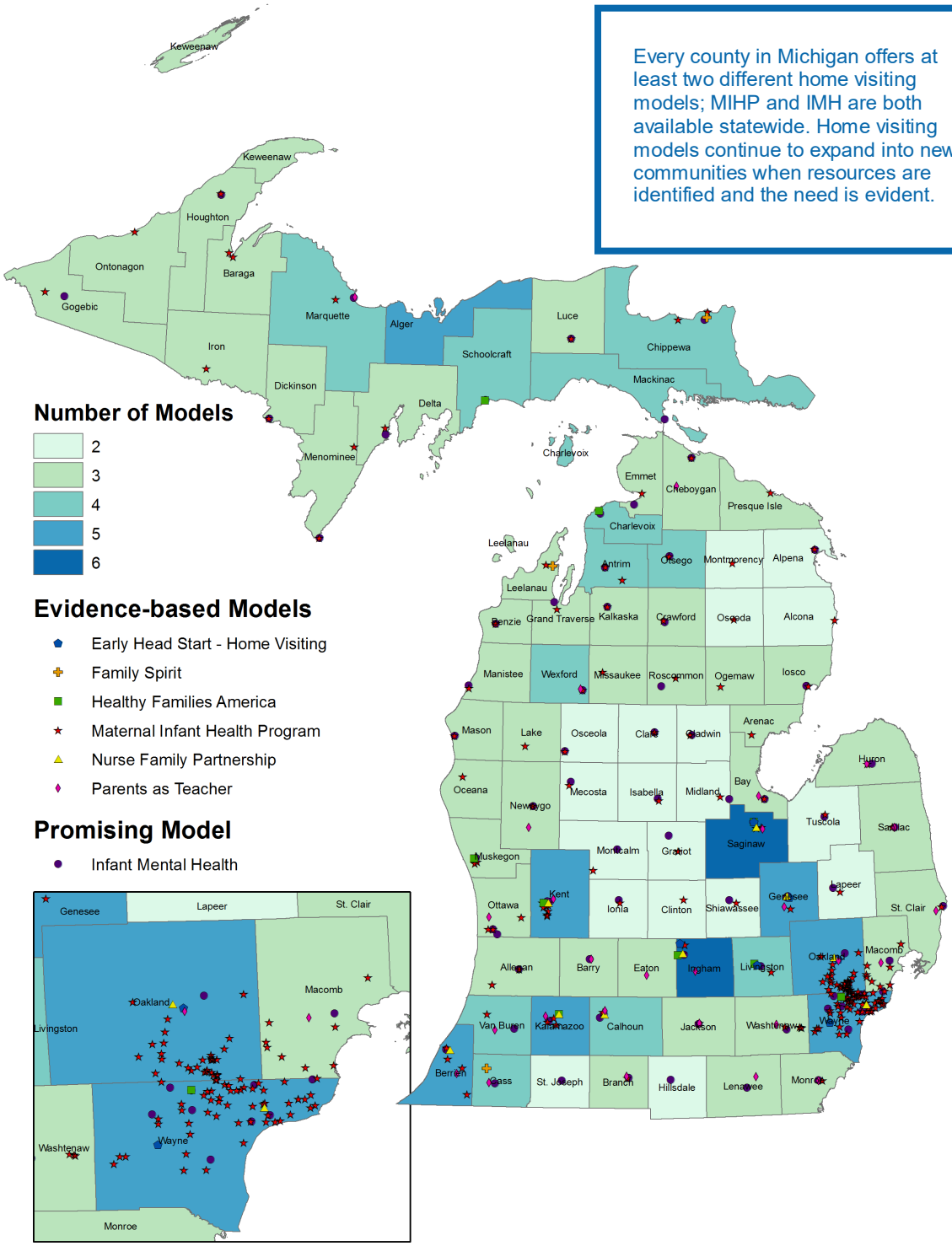
Families are also offered at least 12 group meetings a year and providers screen children for developmental, health, hearing, and vision concerns annually.

Appendix IV:
Where are Home Visiting Services Available?

Maps of State-funded, Accredited Home Visiting Programs

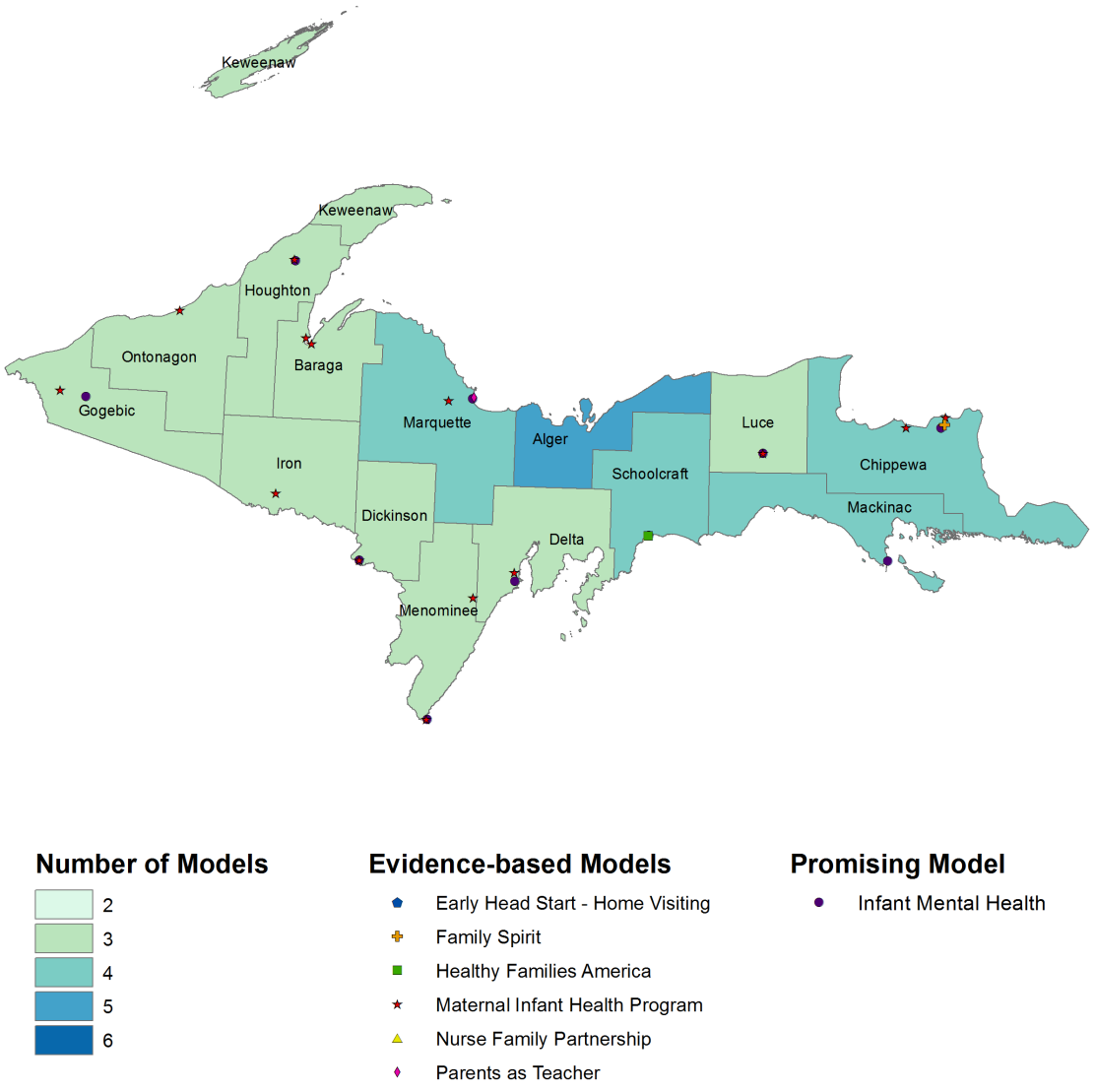
Home Visiting Services in Michigan

Exhibit 14. State-funded Home Visiting Programs: Program Offices and Number of Models per County



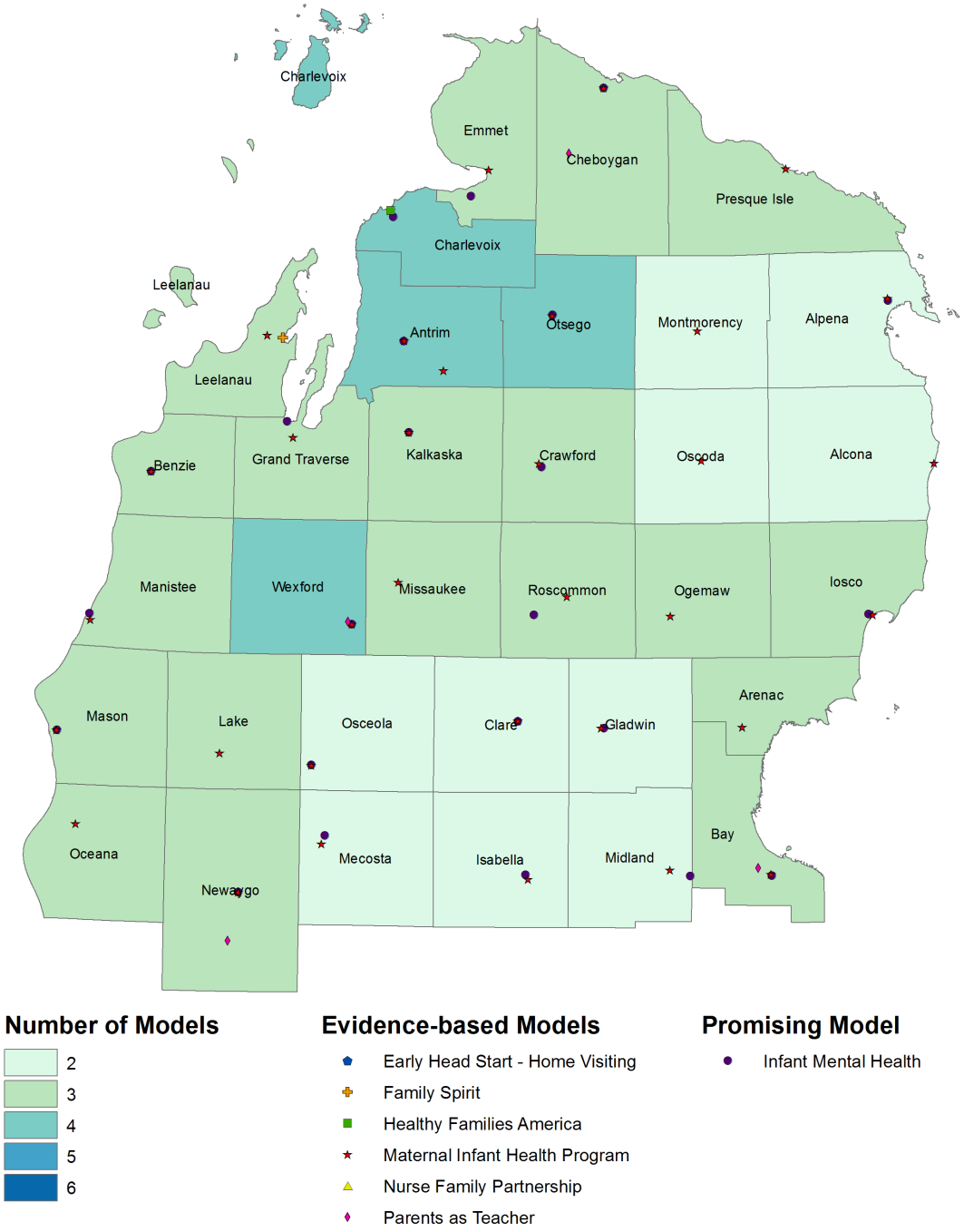
Home Visiting Services in the Upper Peninsula

Exhibit 15. State-funded Home Visiting Programs: Program Offices and Number of Models per County—Upper Peninsula



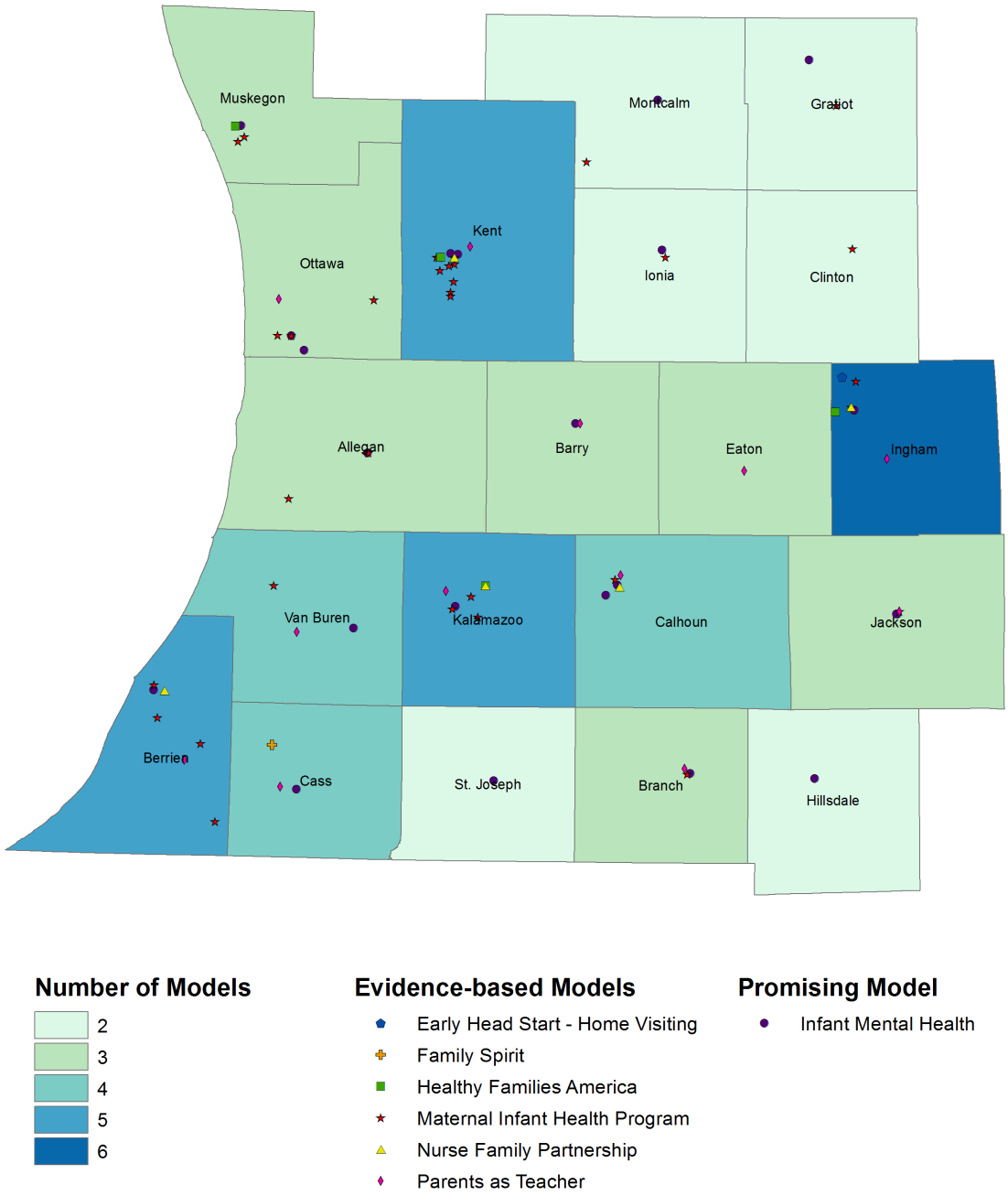
Home Visiting Services in the Northern Lower Peninsula

Exhibit 16. State-funded Home Visiting Programs: Program Offices and Number of Models per County—Northern Lower Peninsula



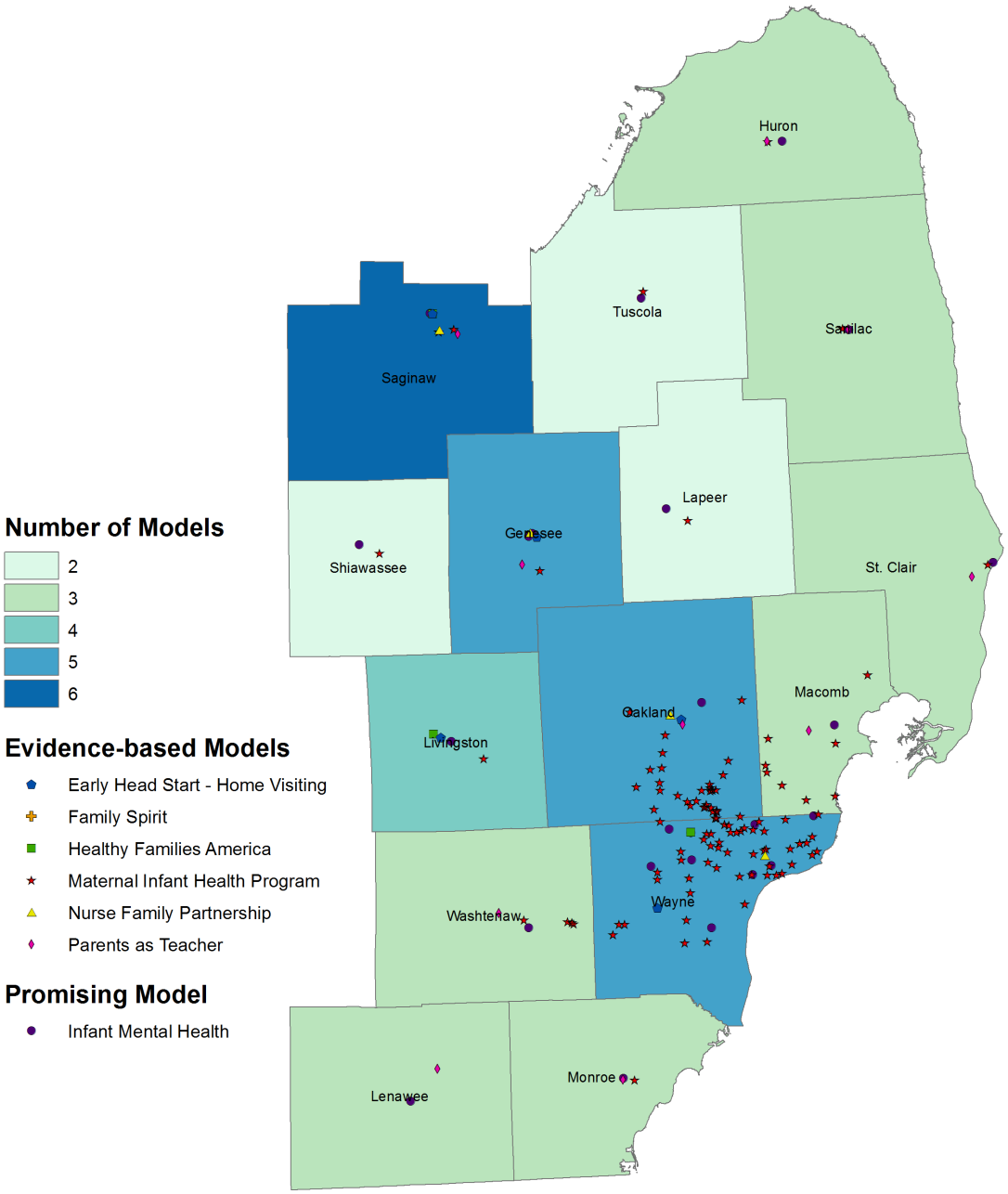
Home Visiting Services in Southwest Michigan

Exhibit 17. State-funded Home Visiting Programs: Program Offices and Number of Models per County—Southwest Michigan



Home Visiting Services in Southeast Michigan

Exhibit 18. State-funded Home Visiting Programs: Program Offices and Number of Models per County—Southeast Michigan

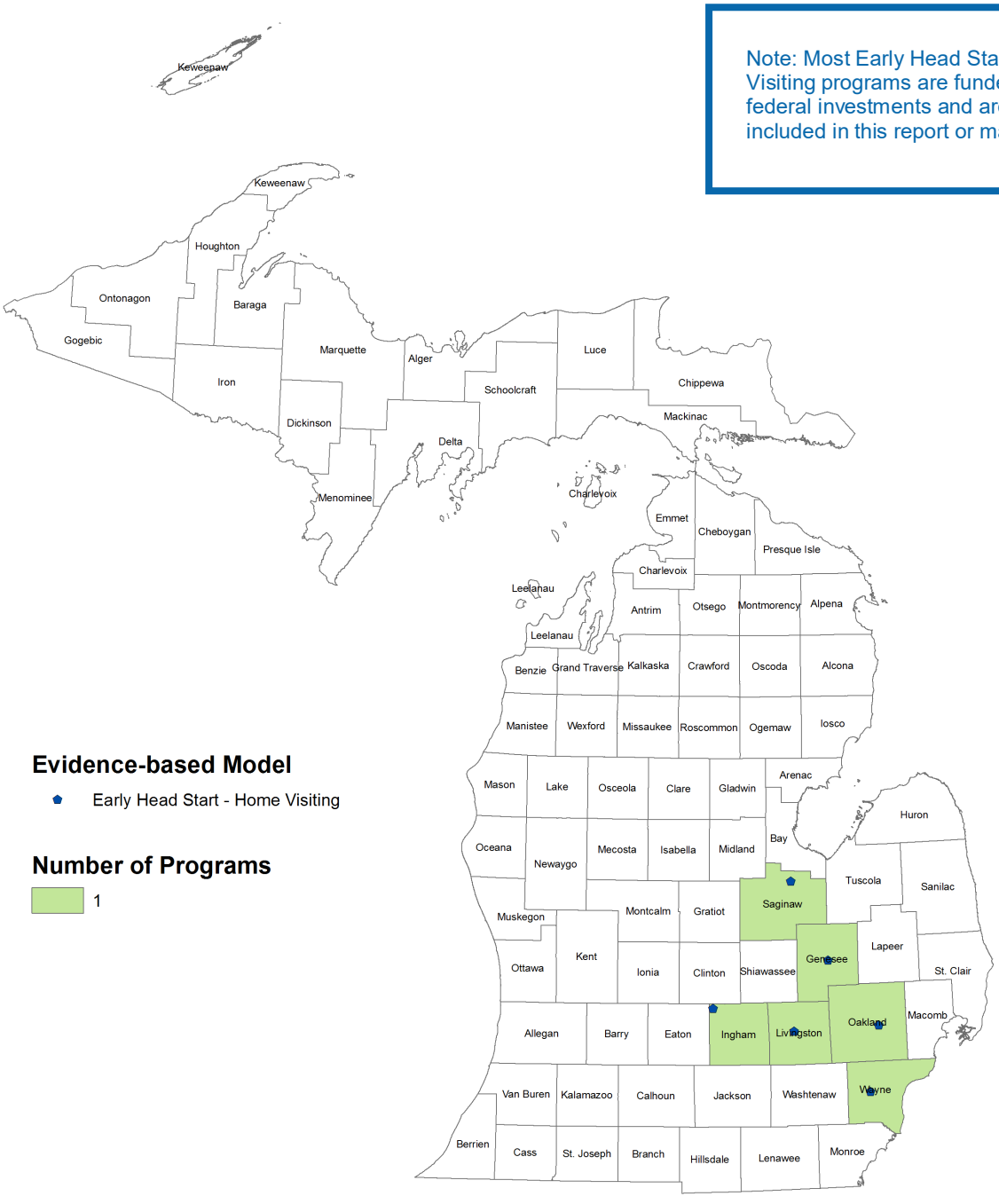


Appendix V:
Where are Programs Located?

Maps of State-funded, Accredited Home Visiting Programs and Counties Served

Early Head Start-Home Visiting

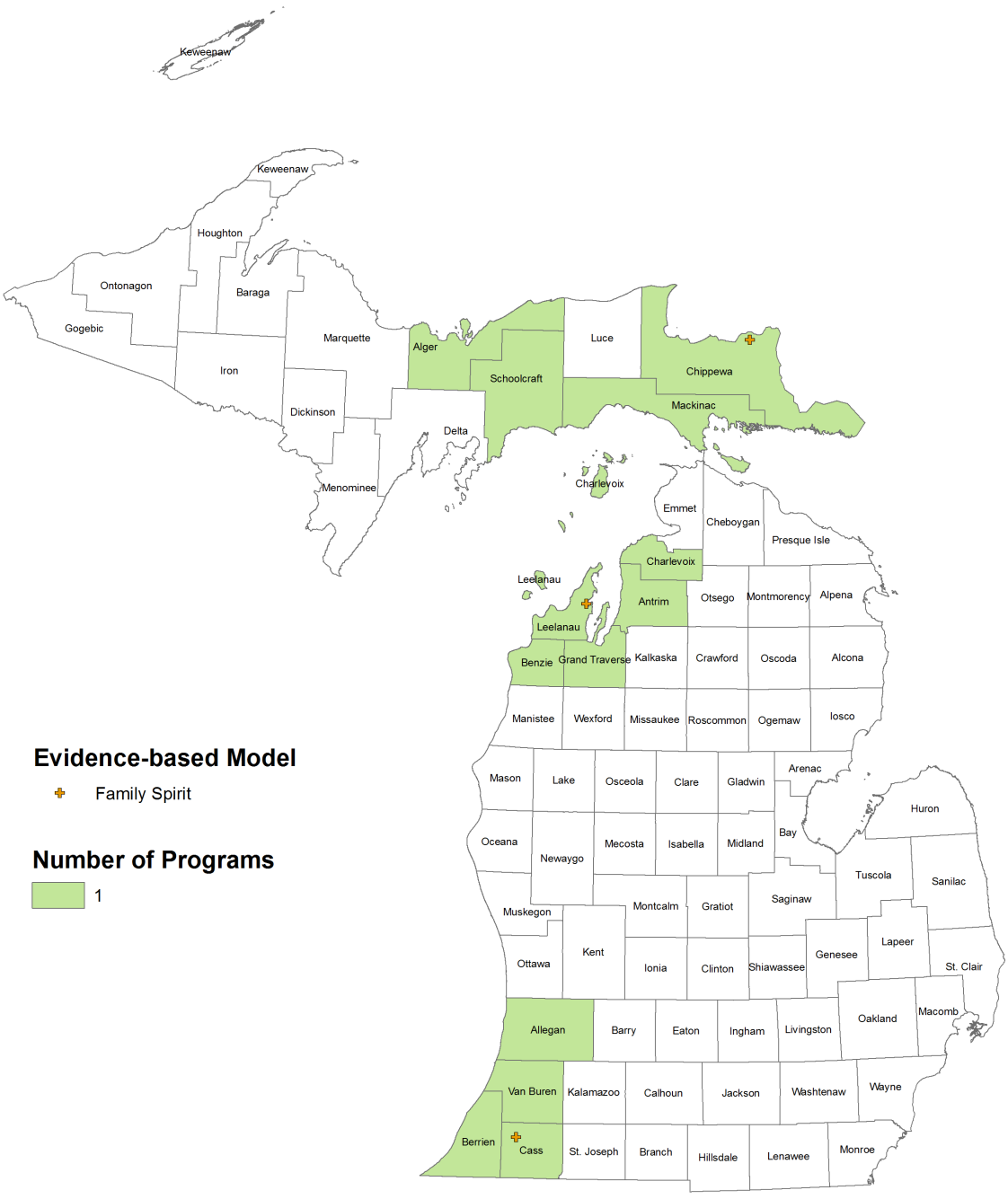
Exhibit 19. Early Head Start—State Funded: Program Offices and Counties Served



Note: Most Early Head Start-Home Visiting programs are funded by federal investments and are not included in this report or map.

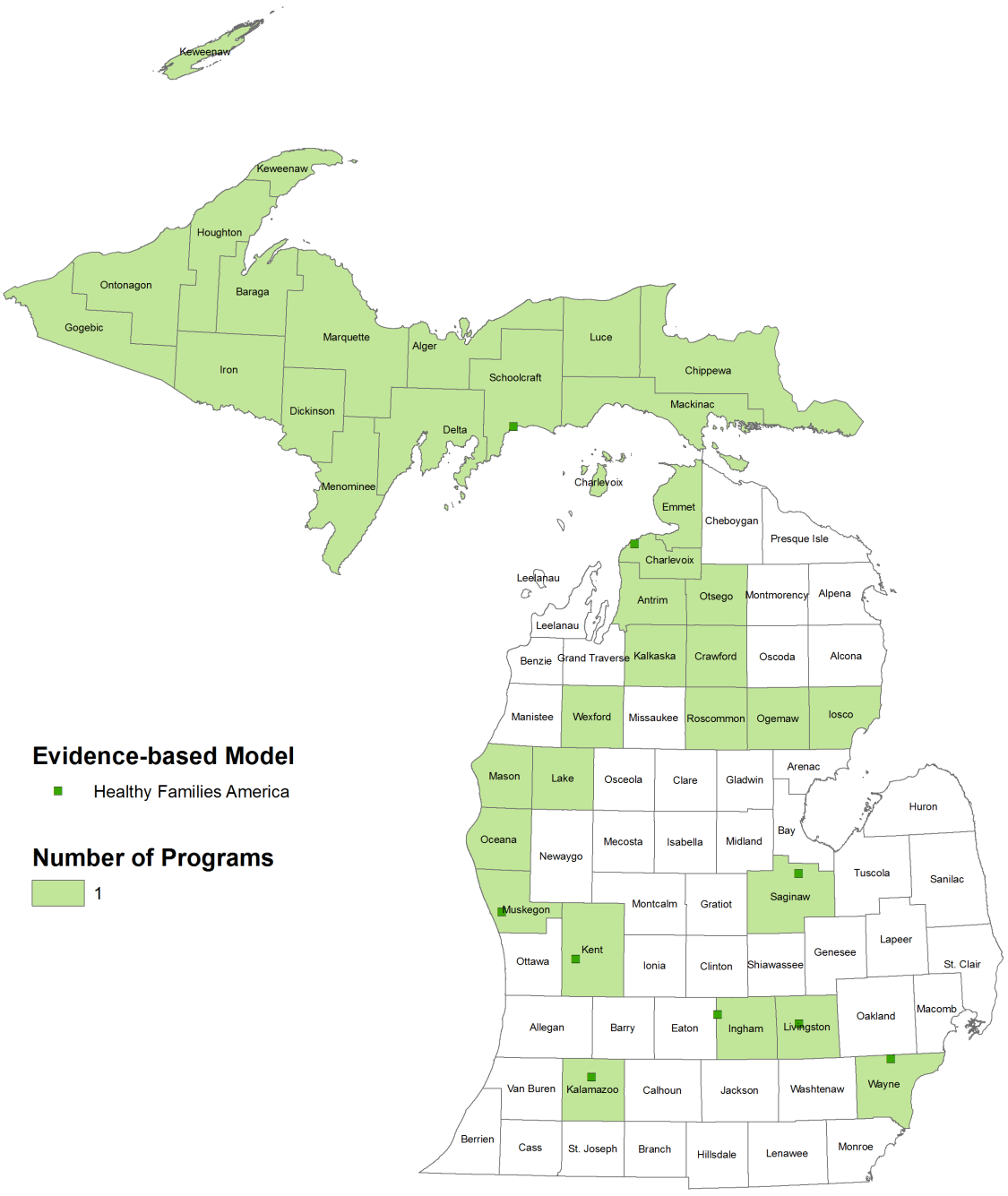
Family Spirit

Exhibit 20. Family Spirit—State Funded: Program Offices and Counties Served



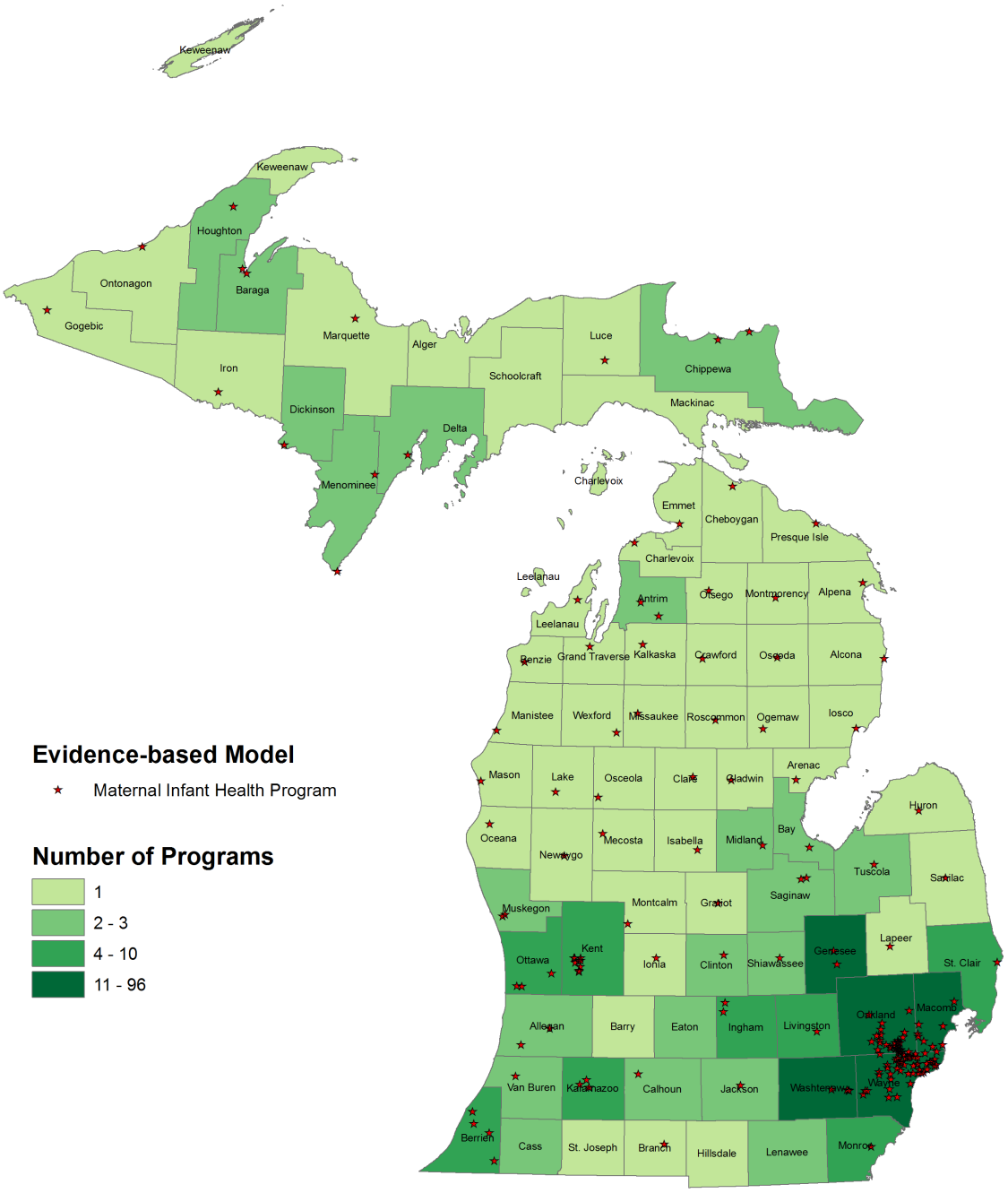
Healthy Families America

Exhibit 21. Healthy Families America—State Funded: Program Offices and Counties Served



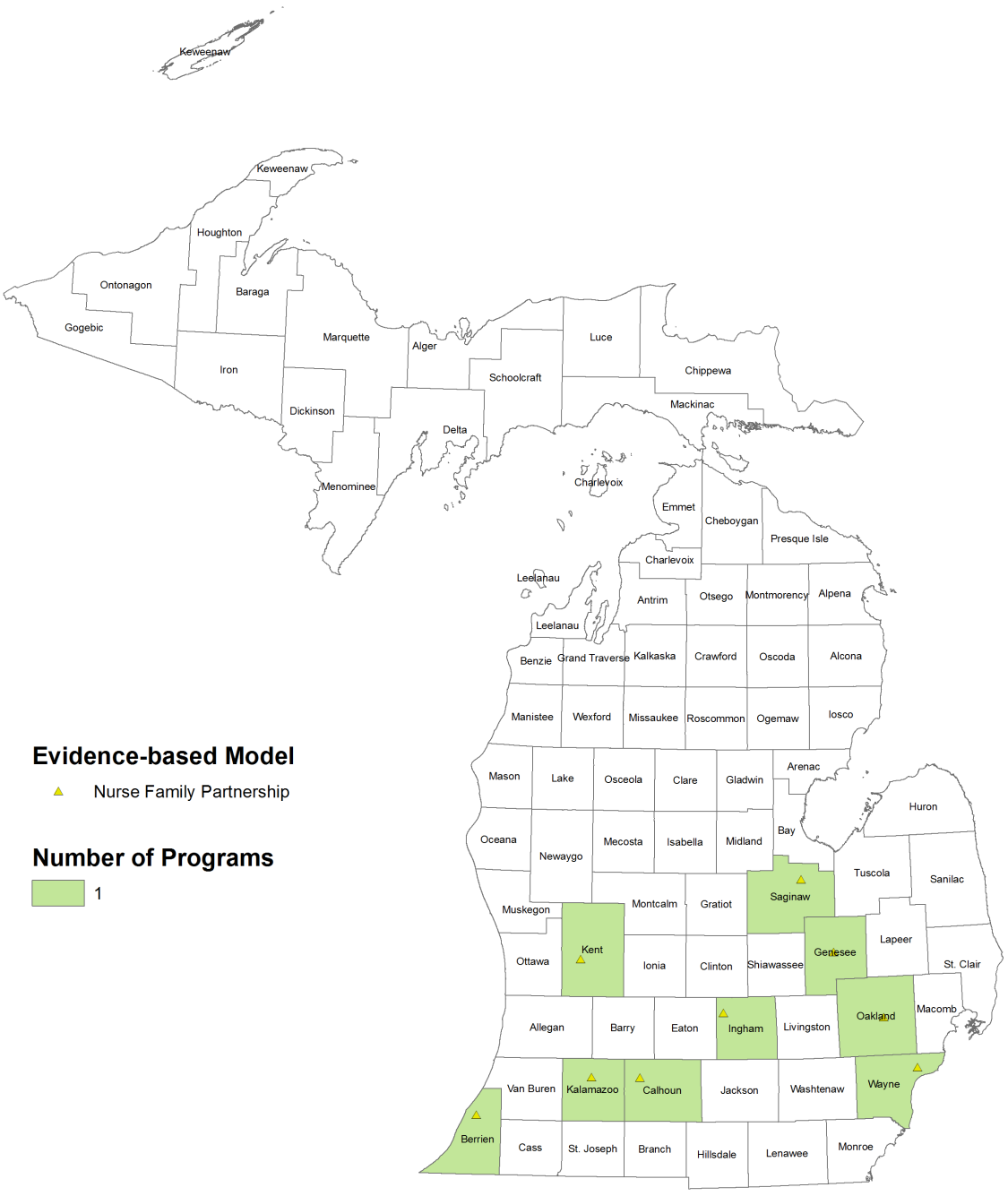
Maternal Infant Health Program

Exhibit 22. Maternal Infant Health Program—State Funded: Program Offices and Counties Served



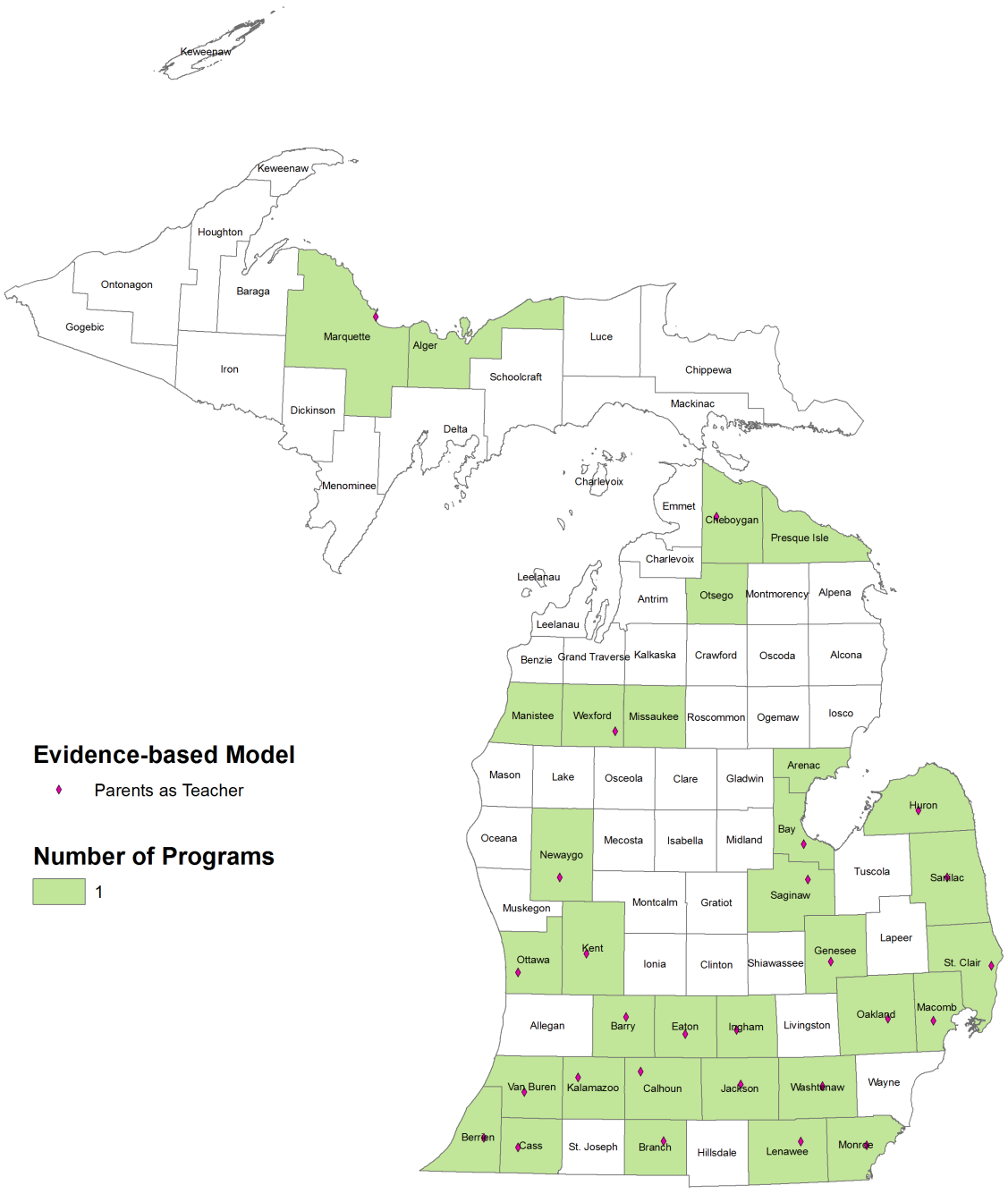
Nurse Family Partnership

Exhibit 23. Nurse Family Partnership—State Funded: Program Offices and Counties Served



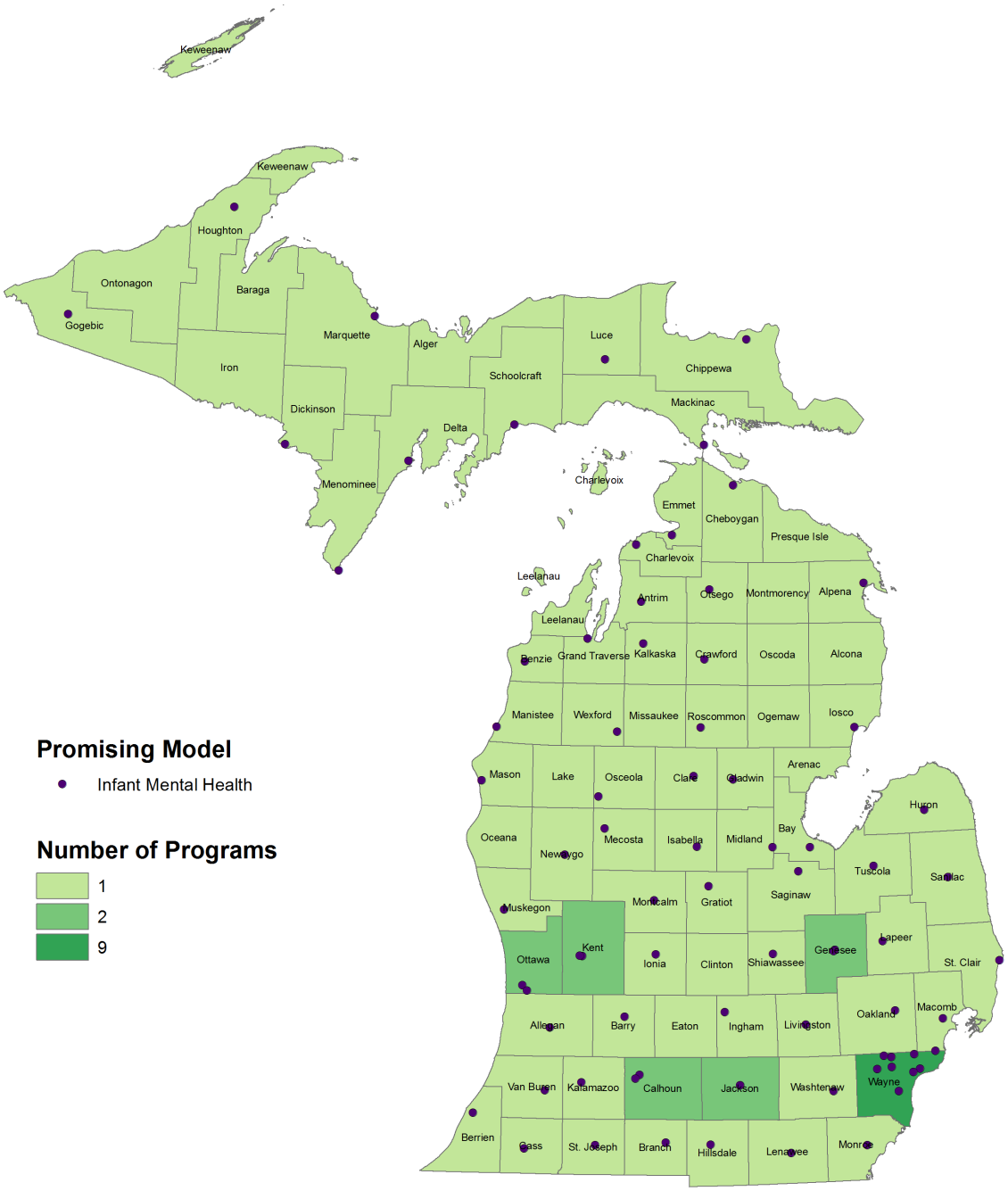
Parents as Teachers

Exhibit 24. Parents as Teachers—State Funded: Program Offices and Counties Served



Infant Mental Health

Exhibit 25. Infant Mental Health—State Funded: Program Offices and Counties Served



Appendix VI: 2016 Home Visiting Investment by Model and Source

Home Visiting Model	Funding Source	Federal Funding	State Funding	Private Funding
Early Head Start (EHS-HV) (Note: The Administration for Children and Families Federal funding that supports most EHS-HV programs are distributed directly to the grantees and do not flow through the state budget. Those funds are not included in this total).	MIECHV	$976,821		
	State School Aid Act, Section 32p Block Grant Funds		$251,691	
Healthy Families America (HFA)	MIECHV	$2,654,477		
	CBCAP	$42,984		
	CTF (License plates, donations, tax check off, etc.)			$95,675
	State General Fund		$819,731	
	State School Aid Act, Section 32p Block Grant Funds		$203,101	
Maternal Infant Health Program (MIHP)	Medicaid	$13,204,824	$6,924,481	
Nurse Family Partnership (NFP)	MIECHV	$3,464,333		
	Medicaid	$ 1,077,936		
	State General Fund		$1,036,053	
	State School Aid Act, Section 32p Block Grant Funds		$14,897	
Parents as Teachers (PAT)	State School Aid Act, Section 32p Block Grant Funds		$2,553,779	
	CBCAP	$77,807		
	CTF (License plates, donations, tax check off, etc.)			$173,184
Family Spirit (The Administration for Children and Families Federal funding that supports many tribal programs are distributed directly to the Inter-Tribal Council and do not flow through the state budget. Those funds are not included in this total).	State General Fund		$200,000	

Home Visiting Model	Funding Source	Federal Funding	State Funding	Private Funding
Infant Mental Health (IMH)	Medicaid	$4,890,140		
	State General Fund		$2,734,743	
All Models = $41,396,657		**$26,389,322**	**$14,738,476**	**$268,859**

Appendix VII: Technical Notes

This appendix provides technical notes for each of the indicators reported in the report.

- **Access to prenatal care:** Of the 14,686 women enrolled in a home visiting program during pregnancy in FY 2016, the denominator of the access to prenatal care indicator includes the 10,160 whose records were matched to Vital Records and had complete data on prenatal care visits.
- **Preterm birth:** Of the 14,686 women enrolled in a home visiting program during pregnancy in FY 2016, the denominator of the preterm birth indicator includes the 9,419 whose records were matched to Vital Records and had complete data on gestational age.
- **Breastfeeding**: Of the 14,686 women enrolled in a home visiting program during pregnancy in FY 2016, the denominator of the breastfeeding indicator includes the 10,195 whose records were matched to Vital Records and had complete data on breastfeeding.
- **Maternal tobacco use:** Of the 20,881 total women served by home visiting in FY 2016, the denominator of the maternal tobacco use indicator includes the 7,057 who had been enrolled for at least six months and had complete data on maternal tobacco or smoking use.
- **Maternal depression:** Of the 20,881 total women served by home visiting in FY 2016, the denominator of the maternal depression indicator includes the 5,331 who had complete data on maternal depression screening/referral and had a screen result indicating a referral to mental health services was necessary. Family Spirit employs a home visitor who is licensed to provide mental health interventions, so not all women with a positive screen needed an external referral for follow-up evaluation or services.
- **Maternal high school completion:** Of the 20,881 total women served by home visiting in FY 2016, the denominator for this indicator includes the 314 who had complete data for educational achievement and did not have a high school diploma/GED upon home visiting enrollment.
- **Postpartum visits:** Of the 14,686 pregnant women served in FY 2016, the denominator for this indicator includes the 10,468 who had enrolled within 30 days of delivery and were matched to Medicaid enrollment data.
- **Well-child visits:** Of the 23,504 children receiving home visiting services in FY 2016, the denominator for this indicator includes the 21,720 who had complete data on well-child visits.
- **Child maltreatment:** Of the 23,504 children receiving home visiting services in FY 2016, the denominator for this indicator includes the 21,083 who sufficiently completed information to be matched to Family Preservation and Reunification Services data.
- **Child development referrals:** Of the 23,504 children served by home visiting in FY 2016, the denominator for this indicator includes the 314 who had a documented ASQ result indicating that a referral was needed and complete data for developmental referral.

Endnotes

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