2014 HOME VISITING INITIATIVE REPORT

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MDCH
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DEPARTMENT OF HUMAN SERVICES

MICHIGAN Department of Education

This report was prepared and submitted as required by
Public Act 291 of 2012, Michigan's Voluntary Home Visitation Programs

CONTENTS

EXECUTIVE SUMMARY

Early childhood is a time of tremendous growth and opportunity. Unfortunately, costly social problems such as child abuse and neglect, school failure, poverty, unemployment and crime take root early in a child's life. To mitigate these adverse outcomes for Michigan children, the state is turning to proven strategies like early childhood home visiting programs. Through coaching, education and one-on-one support, home visiting programs are able to increase the likelihood that mothers deliver healthy babies, reduce rates of abuse and neglect, and ultimately ensure that children grow up healthier and better prepared to learn and become successful adults.

Michigan's interest in early childhood home visiting is not new. As far back as 30 years ago, the state adopted policies and programs designed to create the infrastructure and supportive practices needed to achieve better outcomes for at-risk populations. Michigan was an early implementer of numerous parental education and prevention programs encouraging parent engagement in early care—well before early childhood education was a mainstream conversation.

With this year's snapshot, our goal is to provide education about these indicators, report data where possible, and establish a framework for future reporting.

Yet in spite of decades of experience with families, it is still a struggle to quantify what works. Nationwide, implementing adequate data collection and assessment practices to facilitate large-scale program reporting for initiatives like home visiting still is in its infancy. Guided by a successful history with home visiting, as well as strong legislative leadership, Michigan passed accountability legislation in 2012—Public Act (PA) 291 of 2012—putting us ahead of many of our peer states. In addition to standardizing definitions and directing state appropriations to programs that have the strongest evidence base of effectiveness, the statute requires this report to the legislature and Michigan taxpayers.

Over the past year, state agency partners, data experts and early childhood advocates worked diligently to assemble a set of indicators and measures that are critical to the continuous improvement and success of our state's home visiting programs. This was no small undertaking. The decentralized nature of home visiting, multiple funding streams (including state, federal, local and foundation dollars), multi-agency oversight and disparate data collection methodologies all are complicating factors for administrative program data aggregation and reporting.

With an estimated 600 home visitors and more than 25,000 families enrolled statewide, Michigan's programs are strong and offer great potential for future growth. We would like to thank the legislature, partner agencies and local providers for their ongoing investment in our state's future.

Respectfully,

Nick Lyon, Director, Michigan Department of Community Health
Maura D. Corrigan, Director, Michigan Department of Human Services
Michael P. Flanagan, Superintendent, Michigan Department of Education

BACKGROUND

Michigan's early childhood home visiting programs provide voluntary, prevention-focused services in the homes of pregnant women and families with children aged zero-five.

Early childhood home visiting programs connect trained professionals with vulnerable and at-risk mothers and families. These professionals nurture, support, coach, educate and offer encouragement with the goal that all children will grow and develop in a safe and stimulating environment. By concentrating on building trust with families, providers work to develop positive interactions focused on the importance of maternal health before, during, and after pregnancy. Working in a one-on-one environment, providers encourage and assist families in caring for infants and in building strong, healthy relationships with their toddlers and young children.

Understanding Home Visiting

As the name implies, early childhood home visiting is a service that meets families "where they are"—at home. Typically provided in a one-on-one environment (in some cases, two professionals will attend a visit), hallmarks of these programs include free services offered by trained professionals, delivered in a non-threatening, supportive manner. Topics covered in a home visit might include the importance of obtaining prenatal care, how well-child visits benefit growth and development, what to expect in a child's early development, nutritional education, continuing family education, managing family finances, understanding domestic violence, dealing with trauma and many more.

Funding. Home visiting programs are funded by state, federal and private dollars. Enabling legislation at both the state and federal levels provide funding, program requirements and accountability for home visiting programs.

Programs. The term "home visiting program" refers to an agency engaged in home visiting services. These local implementing agencies include public health departments, community mental health departments, and intermediate school districts, as well as non-profit agencies. Most counties have more than one program in operation.

Community Needs. Most home visiting programs select home visiting models based on community needs assessments. In 2014, both the federal Maternal Infant Early Childhood Home Visiting and state act PA 291 of 2012 programs required a needs assessment to help communities prioritize the local areas of highest need. Areas of highest need might include reducing preterm births, reducing infant mortality, improving prenatal health, improving school readiness or reducing reported instances of domestic violence. Poverty rates and other socio-economic data factor into the community needs assessment as well.

Early childhood home visiting programs are designed to provide support to parents and caregivers and to connect them to community resources and services.

Models. Local implementing agencies use a specific service and support strategy for delivering home visiting, known as a model. Models differ in their scope of practice, home visitor education requirements and terms of service for families. Examples of commonly implemented evidence-based models in Michigan include: Early Head Start Home Visiting, Healthy Families America®, Maternal Infant Health Program, Nurse Family Partnership and Parents as Teachers™. A local implementing agency may use multiple models in its program, or different models may be implemented by different agencies within the same community. For descriptions of the five most commonly implemented models in Michigan, see Appendix 2.

State Administration

The Michigan Home Visiting Initiative is a unit located within the Early Childhood Health Section of the Division of Maternal and Child Health in Michigan's Department of Community Health. The goals of the Michigan Home Visiting Initiative are to:

- **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 infrastructure** by improving the quality of the system and supporting the use of evidence-based model programs; and
- **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.

The Michigan Home Visiting Initiative is an integral part of Michigan's early childhood system. It is incorporated into Michigan's early childhood system using an interdepartmental team approach to address early childhood services integration and coordination. Working with the Great Start Steering Team and the Great Start Operations Team, three departments provide resources, strategic direction and system-building expertise for programs focused on Michigan's young children and their families, including home visiting. These partner agencies are the Michigan Department of Community Health, the Michigan Department of Human Services, and the Michigan Department of Education.

This approach ensures that efforts are efficient and not duplicated, and that meaningful connections are made within agencies as well as with the local communities they serve. Our dialogue has helped raise the profile of home visiting services among practitioners and local early childhood and public health administrators who might not otherwise be knowledgeable about home visiting services in their communities.

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HOME VISITING IN MICHIGAN

Administrative System Building

Michigan's Home Visiting Initiative has been designed to build a system of administrative support to expand the capacity of home visiting. It was deliberately constructed as part of Michigan's broader early childhood system in order to facilitate a comprehensive menu of services for Michigan's most at-risk families.

Throughout 2014, the Michigan Home Visiting Initiative developed and issued policies, procedures, standards, and funding awards to support home visiting programs statewide. Numerous trainings, workshops and conference calls were hosted with the goal of improving the quality of the state's home visiting system by supporting the use of evidence-based model programs and ensuring that model programs are delivered with fidelity. In August 2014, the Michigan Home Visiting Initiative hosted over 500 attendees at its second annual home visiting conference.

DID YOU KNOW?

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Over the past year, new funding proposals have focused on expanding the number of at-risk families served by home visiting. Federal grant applications have been submitted with this priority in mind, and state funding was appropriated for this purpose in Prosperity Regions One, Two and Three of northern Michigan. Finally, several activities are occurring statewide—some funded through federal funds, others through state and federal system-building dollars—that will strengthen the home visiting network and foster collaborative interaction between community stakeholders in early childhood. Examples of these activities include:

- **Local Home Visiting Leaderships Groups:** Administrative bodies connected to local Great Start Collaboratives, which have been assembled as the "point people" in communities for issues related to outreach and engagement in home visiting;
- **Home Visiting Hubs:** Eight communities currently participate in Home Visiting Hubs, a central access point where residents can call to receive referrals for home visiting programs based on their specific needs; and
- **Continuous Quality Improvement:** The state has engaged in a Continuous Quality Improvement program designed to increase the number of women identified as needing a domestic violence referral. This process has uncovered an unmet need for training in domestic violence, an objective which the Michigan Home Visiting Initiative has undertaken in 2014 and will continue in 2015.

Looking to the future, the Michigan Home Visiting Initiative will continue building monitoring and program reporting capacity, increase the amount of training and professional development for home visitors, and improve on methods for data reporting while serving more families.

Funding Home Visiting: Federal, State and Private Funding Collaboration

Home visiting programs receive funding by way of multiple streams, including (i) federal (through competitive and formula grants of the United States Department of Health and Human Services, Administration for Children and Families, and Health Resources Services Administration), (ii) state appropriations through the Michigan Department of Community Health budget and the School Aid Act, and (iii) privately-awarded funds.

FEDERAL FUNDING

United States Department of Health and Human Services—Health Resources and Services Administration

- **Maternal Infant Early Childhood Home Visiting.** Over the past five years, the Maternal Infant Early Childhood Home Visiting program has garnered considerable attention, due in large part to the significant dollars provided to Michigan through competitive and formula grant funds. Maternal Infant Early Childhood Home Visiting program funding is administered by the Michigan Department of Community Health, the agency designated for oversight of Title V Maternal and Child Health Services Block Grant for the state. Maternal Infant Early Childhood Home Visiting program funds have assisted with building infrastructure, and provided direct service expansion dollars to increase services for the most at-risk individuals in high need areas of the state. Maternal Infant Early Childhood Home Visiting program funding allows Michigan to achieve a common vision through collaborative planning and partner engagement and use evidenced-based data for planning and quality improvement throughout the system. Moreover, this funding helps expand programs that demonstrate model fidelity, leading to positive outcomes for children and families. As a national initiative, the Maternal Infant Early Childhood Home Visiting program requires program and outcome reporting on numerous indicators related to child and family wellbeing.

  Communities receiving Maternal Infant Early Childhood Home Visiting program funding are identified through a needs assessment process. In 2010, the Michigan Department of Community Health conducted an initial needs assessment using 13 indicators to identify counties with the highest concentration of need. Eleven counties received funding through this process starting in 2010 and, in 2014, the assessment was repeated as part of a competitive expansion grant opportunity. While the award is still outstanding, these new and additional funds would allow for program expansion (i.e., direct services to more families) in five additional communities.

United States Department of Health and Human Services—Administration for Children and Families

- **Tribal Grants.** The Administration for Children and Families issues competitive grants to tribal communities for home visiting program administration and services. In Michigan, the Inter-Tribal Council is the recipient of these funds, providing technical assistance to member tribes in the development of tribal policies and practices around home visiting.

- **Early Head Start Home Visiting.** As with the Federal Tribal Grants, the Administration for Children and Families makes a certain number of federal to local direct awards for early childhood education and support services. These grants are made through the federal Head Start program and each community decides which type of support model best fits local needs. Home visiting is one support service option that communities may choose, or they may choose a childcare-based model, or a combination of both. These grants are made available on a formula basis to communities of highest need and highest risk.

- **Child Abuse Prevention Act Dollars.** The Michigan Department of Human Services receives Child Abuse Prevention and Treatment Act funds from the Administration for Children and Families. Funds are used to develop, operate, expand and enhance community-based, prevention-focused programs and activities designed to strengthen and support families to prevent abuse and neglect. Within the Child Abuse Prevention and Treatment Act is Title II, known as the Community Based Child Abuse Prevention Fund. This fund supports primary and secondary prevention efforts. The Children's Trust Fund is the entity designated to apply for, receive and use the funds which include home visiting programs.

United States Department of Health and Human Services, Center for Medicare/Medicaid Services Funding (Medicaid)

Medicaid funds several home visiting models and many programs throughout Michigan. Some funding is provided through Medicaid State Plan services, such as 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.

STATE FUNDING

Michigan Department of Community Health Appropriations

- **Maintenance and Expansion Dollars.** In 2014, the legislature appropriated state funds for the maintenance and expansion of home visiting programs in Michigan. Expansion was focused on Prosperity Regions One, Two and Three of the state, covering northern Michigan and the upper peninsula. Over the past year, these communities conducted needs assessments, similar to those undertaken by Maternal Infant Early Childhood Home Visiting communities, to identify areas of highest need and potentially greatest impact. All communities are in the process of establishing contracts and starting training.

- **The Nurse Family Partnership** also receives direct funding support from Michigan Department of Community Health appropriations, which are administered by the department's Perinatal Health Unit.

State School Aid Act Funds

In addition to the Michigan Department of Community Health budget, the legislature appropriates funds to the Michigan Department of Education through the State School Aid Act, Section 32p. Programs funded through 32p include Parents as Teachers™, Healthy Families America®, Early Head Start Home Visiting, Nurse Family partnership, and Infant Mental Health.

PRIVATE DOLLARS

Each year the Children's Trust Fund raises private dollars, which are granted to local communities for home visiting programs and administered by the Children's Trust Fund.

Monitoring and Reporting: Building a State-Level Accountability Framework

PA 291 of 2012 is helping to strengthen Michigan's home visiting system by directing funding to programs that rigorously document success in improving outcomes for children and families. PA 291 created a framework for the development of a system of home visiting programs throughout the state, an important first step in ensuring that children and families receive high quality, outcome-based services designed to improve the health, wellbeing, and self-sufficiency of parents and their children.

Accountability highlights of the Act include:

- Ensuring that the Michigan Department of Community Health, Michigan Department of Human Services and Michigan Department of Education invest in voluntary home visiting programs that improve the health, wellbeing and self-sufficiency of parents and their children;
- Creating a definition of an evidence-based program based on a defined model and grounded in relevant, empirically based knowledge including an adherence to model fidelity;
- Creating a definition of promising programs that incorporates data or evidence demonstrating effectiveness at achieving positive outcomes and are either in the process of evaluation or have a plan to be evaluated;
- Requiring affected departments to create an internal process that provides for greater collaboration and sharing of relevant home visiting data and ensure a stronger home visiting continuum of services;
- Allowing for promulgation of rules if necessary to implement the Act; and
- Requiring affected departments to provide a collaborative report on state and federally funded home visiting programs to the House and Senate Appropriations Subcommittees of Community Health, State School Aid, and Human Services, the State Budget Director and the House and Senate Fiscal Agencies.

STATE-LEVEL INDICATOR WORK

In late 2013, a workgroup of key staff from the Michigan Department of Community Health, the Michigan Department of Education and the Michigan Department of Human Services convened to begin the process of identifying indicators that could be used to share outcomes for all state-funded home visiting services. Attempting to measure whether desired outcomes and processes are being achieved, particularly when they involve the social determinants of health, is no easy task. It is also one that is presently taking place in multiple forms at both the state and national level. Debate about what data should be gathered, how it is defined, and how to measure success or improvements using results-based frameworks are all factors driving this discussion. Expert outside facilitation was used to guide the workgroup through a decision-making process focusing on results and performance accountability.

For this process, indicators were designated as either **outcome indicators** or **process indicators**, and defined as follows:

- Outcome indicators measure a final product or result; and
- Process indicators measure how the system works.

The workgroup focused on nine areas of impact for families served, as enumerated by PA 291:

- Reducing preterm birth;
- Promotion of positive parenting practices;
- Healthy parent and child relationships;
- Positive social-emotional development of families;
- Supportive cognitive development of children;
- Improved health of families;
- Family self-sufficiency;
- Reductions in child maltreatment and injury; and
- Increases in school readiness.

In order to be included, indicators had to meet all of the following criteria:

- **Communication power** – The indicator must express something meaningful to experts, policy makers and the general public;
- **Proxy power** –The indicator must reflect broadly on areas of concern and convey something of importance about the desired outcome; and
- **Data power** – The indicator must be measurable now with reliable and readily available data.[1]

Using this process, 10 initial indicators were selected. See Appendix 5 for a full description of these indicators and reported data for 2014.

While Michigan develops its state-level indicators, a national discussion is taking place with participation from federal agencies, national home visiting models, state government staff, home visiting programs, and early childhood advocates about a core set of national indicators that will allow for peer group analysis in home visiting from state to state, model to model, and program to program. The goal is to release this work publicly in 2015. What remains to be seen is the degree to which federal funding and federal rules and regulations will influence and intersect with state indicators. In the future, Michigan may wish to consider incorporating these national indicators into the data set tracked for state-funded home visiting accountability measures.

An important point worth making is the high level of commitment shown by home visiting professionals to finding the most accurate measures of success for families served by home visiting.

While experts struggle to capture the indicators and measures of success, an important point worth making is the high level of commitment shown by home visiting professionals to finding the most accurate measures of success for families served by home visiting. There is a genuine, industry-wide commitment to demonstrating that home visiting, as implemented by different models for families with very different needs, is a successful strategy for moving the needle for individual families and for society.

1 We would like to acknowledge Mark Friedman of the Fiscal Policy Studies Institute, whose framework for results based accountability was used in this work. We also recognize the contributions of the Pew Home Visiting Campaign, including support for expert facilitation provided by Kay Johnson on behalf of the Campaign.

Understanding the 2014 Data Reports

Knowing that statewide data collection—both program and financial—is a relatively new requirement; is conducted without a statewide data system; and must be compiled with differences in data definitions, collection standards and other model considerations in mind; we have worked to create a report that is informative, accurate and sheds light on where dollars originate and how they are spent.

In accordance with these considerations, the 2014 report:

- Covers program delivery for programs funded through the Michigan Department of Community Health (specifically Maternal Infant Early Childhood Home Visiting, Maternal Infant Health Program, state-funded Inter-Tribal Council and state-funded Nurse Family Partnership programs);
- Reflects data reporting for program and administrative data as currently available, with the understanding that additional progress will be made in streamlining data collection and reporting in 2015;
- Reports funding for all state-funded programs; and
- Maps home visiting programs that operate with funds appropriated through the state and are implemented with fidelity (i.e., programs that are accredited, affiliated). There are programs funded by the Michigan Department of Education and Children's Trust Fund that did not meet the model criteria for accreditation or affiliation. Addressing this issue is part of our work in 2015.

CONCLUSION

The desire to provide meaningful program measurement, coupled with the need to support and grow a strong, thriving system of home visiting, are key precursors to ensuring the viability and sustainability of the system. While the present list of indicators is not perfect, it does give important insights into what we know and what we still need to learn about home visiting in Michigan. Different funding streams, different home visiting models, and different intended purposes mean that we must work to create and gather consistent data elements to represent a more accurate report for years to come.

As our understanding and thinking about home visiting matures, so will the key measures and standards of accountability, and so too will the numbers of families served and lives influenced.

APPENDICES

APPENDIX 1

Glossary of Terms

Glossary of Terms

List of Commonly Used Acronyms	
CBCAP	Community Based Child Abuse Prevention
CTF	Children's Trust Fund
DHS	Department of Human Services
EHS-HV	Early Head Start – Home Visiting model
HFA	Healthy Families America
IMH	Infant Mental Health
ITC	Inter Tribal Council
MDCH	Michigan Department of Community Health
MDE	Michigan Department of Education
MIECHV	Maternal Infant and Early Childhood Home Visiting
MIHP	Maternal Infant Health Program
NFP	Nurse Family Partnership
PAT	Parents as Teachers

APPENDIX 2

The Five Most Commonly Implemented Evidence-Based Home Visiting Models in Michigan

Early Head Start Home Visiting (EHS-HV)

Early Head Start Home Visiting serves pregnant women, infants and toddlers, as well as their families. This is a child-focused program whose goal is to increase the school readiness of young children in low-income families.

Healthy Families America®

Healthy Families America (HFA) works with overburdened families who are at risk for adverse childhood experiences, including child maltreatment. HFA is equipped to work with families with histories of trauma, intimate partner violence, and mental health and/or substance abuse issues. HFA services begin prenatally or right after the birth of a baby and are available until age five.

Maternal Infant Health Program

The Maternal Infant Health Program (MIHP) is a home visiting program for pregnant women and infants with Medicaid insurance in Michigan. MIHP provides support services to women and parents to promote healthy pregnancies, good birth outcomes, and healthy infants. MIHP providers are located in rural, urban, and native communities throughout the state. Services are provided through federally qualified health centers, local and regional public health departments, hospital-based clinics, and private providers. Services are offered prenatal–age one.

Nurse Family Partnership

The Nurse Family Partnership (NFP) is a program that helps vulnerable first-time mothers and babies. Through visits from registered nurses, low-income, first-time mothers receive care and support for healthy pregnancies, provide responsible and competent care for their children, and become more economically self-sufficient. Services are offered to first time mothers who enroll prior to the 28th week of pregnancy until age two.

Parents as Teachers™

Parents as Teachers (PAT) believes that parents are their children's first and most influential teacher during the crucial early years of life (from before birth to kindergarten). The program is based on the individual needs of each family and child and is offered prenatal–age five.

Every single one of these models meets the Michigan definition of evidence-based.

APPENDIX 3

2014 Home Visiting Funding

Michigan Home Visiting Model Funding Sources for Direct Home Visiting Services
State Fiscal Year 2014 Unless Otherwise Noted

Home Visiting Model	Model Description / Fidelity	Funding Source	Federal Funding	State Funding	Private Funding
Evidence Based Models					
• **Early Head Start (EHS-HV)** (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).	EHS-HV targets low-income pregnant women and families with children from birth to age three years. Continuous early, comprehensive child development and support services are delivered through home visits. *Fidelity: This model has established performance standards and other regulations that are monitored for compliance and fidelity to the standards every three years by the Office of the Administration for Children and Families.*	MIECHV	$725,905		
		State School Aid Act, Section 32p Block Grant Funds		$398,599	

*** Carryover funds from FY 2013**
****State fiscal year data 2013**

Michigan Home Visiting Model Funding Sources for Direct Home Visiting Services
State Fiscal Year 2014 Unless Otherwise Noted

Home Visiting Model	Model Description / Fidelity	Funding Source	Federal Funding	State Funding	Private Funding
• **Healthy Families America (HFA)**	HFA is a nationally recognized evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. HFA services begin prenatally or right after the birth of a baby and are offered voluntarily, intensively and over the long term (three to five years after the birth of the baby). *Fidelity: This model has established standards and accreditation procedures. Monitoring for compliance with the standards and fidelity to the model is completed by the national Healthy Families America model every three years.*	MIECHV	$656,057		
		CBCAP	$ 87,000		
		CTF (License plates, donations, tax check off, etc.)			$203,000
		State School Aid Act, Section 32p Block Grant Funds		$182,645 $ 1,642*	

*** Carryover funds from FY 2013**
****State fiscal year data 2013**

Michigan Home Visiting Model Funding Sources for Direct Home Visiting Services
State Fiscal Year 2014 Unless Otherwise Noted

Home Visiting Model	Model Description / Fidelity	Funding Source	Federal Funding	State Funding	Private Funding
• **Maternal Infant Health Program (MIHP)**	MIHP is a home visiting program for pregnant women and infants with Medicaid insurance. MIHP provides support services to women and to parents so they have healthy pregnancies, good birth outcomes, and healthy infants. *Fidelity: MDCH MIHP consultants monitor and certify MIHP providers for quality assurance purposes and adherence to the MIHP Operations Manual. Once fully certified, an MIHP provider undergoes periodic recertification reviews in two 18-month cycles for as long as they are providers.*	Medicaid	$12,969,850	$6,819,362	

*** Carryover funds from FY 2013**
****State fiscal year data 2013**

Michigan Home Visiting Model Funding Sources for Direct Home Visiting Services
State Fiscal Year 2014 Unless Otherwise Noted

Home Visiting Model	Model Description / Fidelity	Funding Source	Federal Funding	State Funding	Private Funding
• **Nurse Family Partnership (NFP)**	NFP is an evidence-based, community health program that helps transform the lives of vulnerable mothers pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child's second birthday. *Fidelity: NFP has rigorous program standards. The NFP National Service Office monitors submitted outcome data which is used to inform adjustments to program practice that may be needed to ensure service provision is occurring according to the 18 NFP model elements.*	MIECHV	$1,493,900		
		Medicaid	$1,799,832		
		State General Fund		$1,550,000	
		State School Aid Act, Section 32p Block Grant Funds		$48,411	

*** Carryover funds from FY 2013**
****State fiscal year data 2013**

Michigan Home Visiting Model Funding Sources for Direct Home Visiting Services
State Fiscal Year 2014 Unless Otherwise Noted

Home Visiting Model	Model Description / Fidelity	Funding Source	Federal Funding	State Funding	Private Funding
• **Parents as Teachers (PAT)**	PAT helps organizations and professionals deliver home visits to parents during the critical early years of their children's lives, to help their children develop optimally during the crucial early years of life. *Fidelity: Modified fidelity standards went into effect January 2014. Each program submits an annual affiliate performance report.*	State School Aid Act, Section 32p Block Grant Funds		$2,359,443 $ 469,527*	
		CBCAP	$70,385		
		CTF (License plates, donations, tax check off, etc.)			$164,233

*** Carryover funds from FY 2013**
****State fiscal year data 2013**

Michigan Home Visiting Model Funding Sources for Direct Home Visiting Services
State Fiscal Year 2014 Unless Otherwise Noted

Home Visiting Model	Model Description / Fidelity	Funding Source	Federal Funding	State Funding	Private Funding
• **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).	Designed for Native American families, Family Spirit promotes parenting, coping, and problem-solving skills to address challenges, family problems, and personal stressors. The program is designed to serve families from the prenatal period through three years of age, however many of the lessons are still appropriate after children are older than three years. *Fidelity: Initiating visits by 28 weeks' gestation is recommended; frequency varies from weekly to monthly, tapering to bimonthly visits until the child's third birthday. Para-professionals (or Health educators with higher educational levels) are certified in use of the curriculum and come from the participating community with familiarity with the tribal culture, traditions, and language. Quality assurance visits where home visitors are observed and assessed by certified program supervisors are completed at least twice per year.*	State General Fund		$205,000	

*** Carryover funds from FY 2013**
****State fiscal year data 2013**

Michigan Home Visiting Model Funding Sources for Direct Home Visiting Services
State Fiscal Year 2014 Unless Otherwise Noted

Home Visiting Model	Model Description / Fidelity	Funding Source	Federal Funding	State Funding	Private Funding
Promising Practices					
• **Infant Mental Health (IMH)**	IMH provides home- based parent-infant support and intervention services to families where the parent's condition and life circumstances, or the characteristics of the infant, threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. *Fidelity: Many IMH programs are implemented by Community Mental Health agencies. Program and performance standards are in the process of being developed. Consistent statewide model monitoring requirements have yet to be established.*	Medicaid	$1,598,073**		
		State General Fund		$554,893**	
		State School Aid Act, Section 32p Block Grant Funds		$ 16,000	

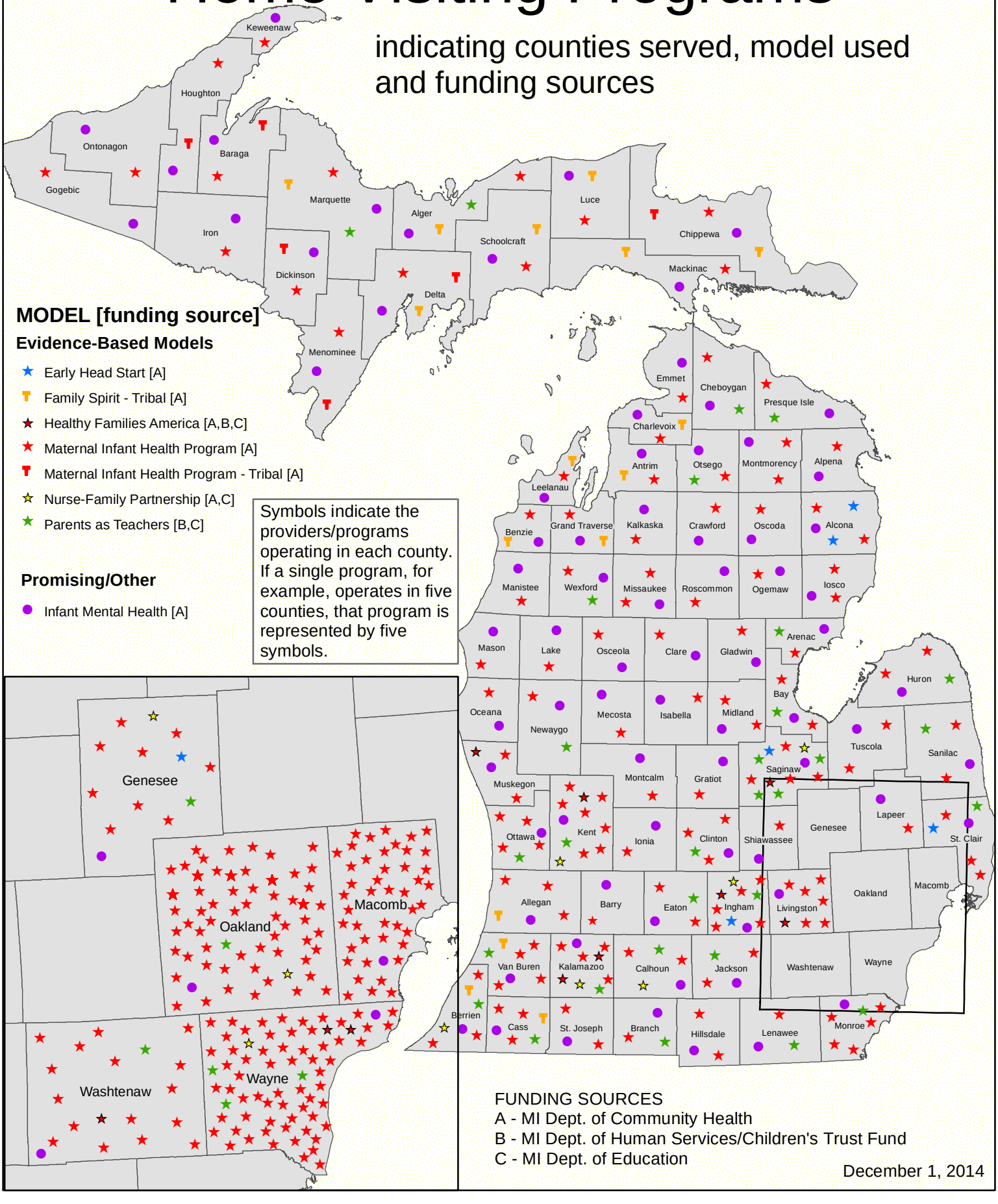
*** Carryover funds from FY 2013**
****State fiscal year data 2013**

APPENDIX 4

Map of State Funded Home Visiting Programs

2014 State-Funded Home Visiting Programs

indicating counties served, model used and funding sources



MODEL [funding source]

Evidence-Based Models

- Early Head Start [A]
- Family Spirit - Tribal [A]
- Healthy Families America [A,B,C]
- Maternal Infant Health Program [A]
- Maternal Infant Health Program - Tribal [A]
- Nurse-Family Partnership [A,C]
- Parents as Teachers [B,C]

Promising/Other

- Infant Mental Health [A]

Symbols indicate the providers/programs operating in each county. If a single program, for example, operates in five counties, that program is represented by five symbols.

FUNDING SOURCES
A - MI Dept. of Community Health
B - MI Dept. of Human Services/Children's Trust Fund
C - MI Dept. of Education

December 1, 2014

APPENDIX 5

State Indicator Outcomes

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 received prenatal care.[1]

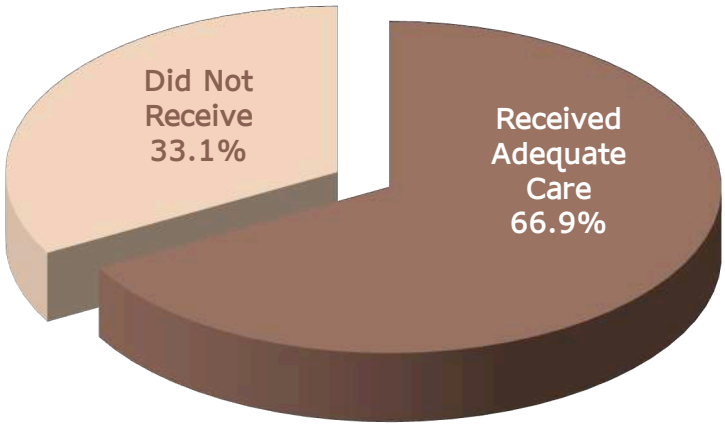
Target Population: Mothers/women enrolled in home visiting services during pregnancy

Measure: Percent of women enrolled in home visiting services during pregnancy who received adequate or adequate plus prenatal care

$$\frac{\text{Number of women enrolled in home visiting services during pregnancy who received adequate or adequate plus prenatal care (as recorded on the birth certificate)}}{\text{Number of pregnant women enrolled in home visiting services during pregnancy who had a live birth}}$$

About This Measure: This is an outcome measure. Over time, the goal is to see an increase in the percentage of women enrolled in home visiting during pregnancy who receive adequate or adequate plus prenatal care.

Data Source: Vital Records Data
Programs Reporting: MIECHV & MIHP[2]



%

of MI women enrolled in home visiting who received adequate prenatal care

[1] Source: U.S. Department of Health and Human Services. Retrieved from http://mchb.hrsa.gov/programs/womeninfants/prenatal.html on Nov. 7, 2014.

[2] Data pending for ITC, 3 state NFP sites

PRETERM BIRTH

Prematurity can cause lifelong physical and mental problems. Finding and treating health problems as early as possible—and preventing premature birth overall—can help babies lead longer, healthier lives.[3]

Target Population: Births to mothers enrolled in home visiting services during pregnancy

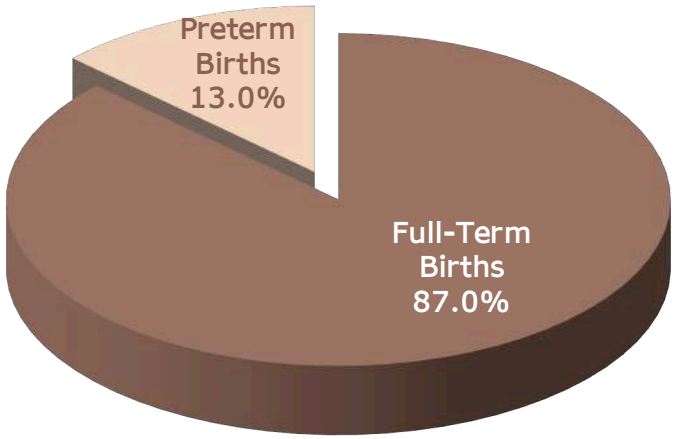
Measure: Percent of pregnant women enrolled in home visiting services during pregnancy who have preterm birth (<37 weeks gestation)

Number of pregnant women enrolled in home visiting services during pregnancy who have preterm (live) birth at <37 weeks gestation

Number of pregnant women enrolled in home visiting services during pregnancy who had a live birth

About This Measure: This is an **outcome measure**. Over time, the goal is to see a decrease in the percent of women enrolled in home visiting during pregnancy who have preterm birth (<37 weeks gestation).

Data Source: Vital Records Data
Programs Reporting: MIECHV, MIHP & ITC[4]



%

of MI women enrolled in home visiting during pregnancy who experienced preterm birth

[3] Source: March of Dimes. Retrieved from http://www.marchofdimes.org/baby/long-term-health-effects-of-premature-birth.aspx on Nov. 7, 2014.

[4] Data pending for 3 state NFP sites

BREASTFEEDING

Breast milk provides strong support for healthy infant development. It contains antibodies that help protect infants from common childhood illnesses. In addition, adolescents and adults who were breastfed as babies are less likely to be overweight or have type-2 diabetes, and perform better in intelligence tests.[5]

Target Population: Mothers enrolled in home visiting

Measure: Percentage of mothers who enroll in home visiting during pregnancy who initiate breastfeeding for their infants

$$\frac{\text{Number of mothers who enroll in home visiting during pregnancy who initiate breastfeeding for their infants}}{\text{Number of pregnant women enrolled in home visiting services during pregnancy who had a live birth}}$$

About This Measure: This measure is an outcome measure. Over time, the goal is to see an increase in the percentage of mothers who initiate breastfeeding for their infants.

Data Sources: Administrative Program Data, Vital Records Data
Programs Reporting: MIECHV, MIHP & ITC[6]

$\frac{138}{180} = 76.7\%$	Percentage of mothers who initiated breastfeeding while enrolled	MIECHV & ITC
$\frac{4,108}{15,732} = 26.1\%$	Percentage of mothers who initiated breastfeeding while enrolled AND were still breastfeeding at program discharge	MIHP

[5] Source: World Health Organization. Retrieved from http://www.who.int/features/factfiles/breastfeeding/en/ on Nov. 7, 2014.

[6] Data definition and reporting vary somewhat between reporting sources for this indicator. For MIHP, the data measure the number of mothers who are currently breastfeeding versus the number who initiated breastfeeding during service. For other reporting streams (ITC, MIECHV and 3 state NFP sites) the data measure if breastfeeding was initiated during the service period.

MATERNAL TOBACCO USE

Smoking and tobacco use during pregnancy are among the most common preventable causes of infant illness and death. Exposure to secondhand smoke after delivery increases an infant's risk for respiratory tract infections (e.g., bronchitis, pneumonia), ear infections, and death from SIDS.[7]

Target Population: Women enrolled in home visiting during and after pregnancy

Measure: Percentage of women enrolled in home visiting for at least six months who are currently using tobacco

$$\frac{\text{Number of women enrolled in home visiting for at least six months who are currently using tobacco}}{\text{Number of women enrolled in home visiting for at least six months}}$$

About This Measure: This measure is an outcome measure. Over time, the goal is to see a decrease in the percentage of women enrolled in home visiting who are using tobacco.

Data Source: Administrative Program Data[8]

Programs Reporting: MIECHV, 3 State NFP Sites, MIHP & ITC

$\frac{51}{392} = 13\%$	Percentage of mothers enrolled in programs for at least six months who are currently using tobacco	Sites Reporting Tobacco Use (MIECHV, 3 state NFP sites, ITC)
$\frac{2,788}{11,816} = 23.6\%$	Percentage of mothers enrolled in programs for at least six months who are currently smoking	Sites Reporting Smoking (MIHP)

[7] Source: Centers for Disease Control & Prevention. Retrieved from http://www.cdc.gov/prams/tobaccoandprams.htm on Nov. 7, 2014.

[8] Data collected for this indicator vary between programs. MIHP collects data on maternal smoking, whereas MIECHV, the 3 state NFP sites, and ITC collect data on tobacco use.

MATERNAL DEPRESSION

Depression affects not only a mother's health and wellbeing, but can have lasting implications for a child's emotional, social and physical development.[9]

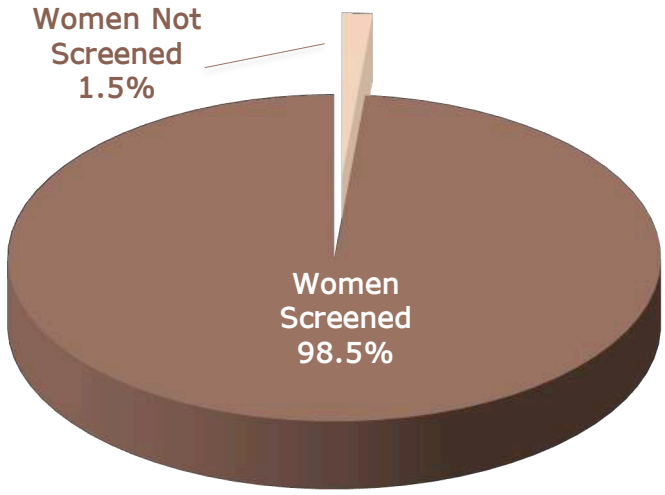
Target Population: Women enrolled in home visiting during and after pregnancy

Measure: Percent of women enrolled in home visiting who had an objective screen for maternal depression

$$\frac{\text{Number of women enrolled in home visiting who had an objective screen for maternal depression}}{\text{Number of women enrolled in home visiting}}$$

About This Measure: This measure is a **program measure**. Over time, the goal is to see an increase in the percentage of women who receive objective maternal depression screens.

Data Source: Administrative Program Data
Programs Reporting: MIECHV, 3 State NFP Sites, MIHP & ITC



%

of MI women enrolled in home visiting who were screened for maternal depression

[9] Center on the Developing Child at Harvard University (2009). *Maternal Depression Can Undermine the Development of Young Children: Working Paper No. 8.* http://www.developingchild.harvard.edu.

CHILD DEVELOPMENT

From pregnancy through early childhood, all of the environments in which children live and learn—and the quality of their relationships with adults and caregivers—have a significant impact on their cognitive, emotional and social development. Providing supportive and positive conditions for early childhood development is more effective and less costly than attempting to address the consequences of early adversity later.[10]

Target Population: Children enrolled in home visiting

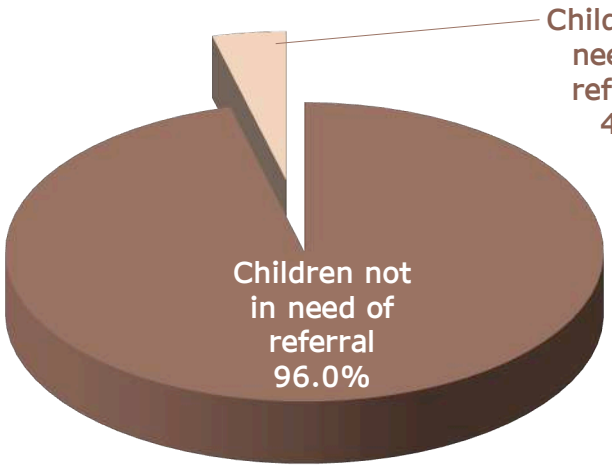
Measure: Percent of children enrolled in home visiting who received objective developmental screen (ASQ) with a result indicating need for referral

Number of of children enrolled in home visiting who received objective developmental screen (ASQ) with a result indicating need for referral

Number of children enrolled in home visiting who received at least one objective developmental screen (ASQ)

About This Measure: This measure is a program measure. Over time, the goal is to see a decrease in the percentage of children in need of a referral.

Data Source: Administrative Program Data
Programs Reporting: MIECHV, 3 State NFP Sites, MIHP & ITC



%

of MI children enrolled in home visiting who indicated need for referral based on objective ASQ

[10] Center on the Developing Child at Harvard University (n.d.). *In Brief: The Impact of Early Adversity on Children's Development."* http://www.developingchild.harvard.edu.

WELL-CHILD VISITS

Well-child visits offer an opportunity not only to monitor children's health and provide immunizations, but also to assess a child's behavior and development, discuss nutrition, and answer parents' questions.[11]

Target Population: Children enrolled in home visiting

Measure: Percent of children enrolled in home visiting who completed their last recommended well-child visit

$$\frac{\text{Number of children enrolled in home visiting who completed their last scheduled (AAP recommended) well-child visit}}{\text{Number of children enrolled in home visiting}}$$

About This Measure: This measure is an **outcome measure.** Over time, the goal is to see an increase in the percentage of children up-to-date on well-child visits.

Data Source: Administrative Program Data[12]
Programs Reporting: MIECHV, 3 State NFP Sites, MIHP & ITC

Across the home visiting programs, as a group, children receiving home visits during FY 2014 are up to date on their well-child care. However, for this year's report, due to variations in how data were collected, we are unable to present a single number for an individual child's level of care.

[11] U.S. Department of Health and Human Services. Retrieved from http://mchb.hrsa.gov/chusa11/hsfu/pages/307wcv.html on Nov. 7, 2014.

[12] Data reported for this indicator vary among programs. MIHP reports the percentage of children who received ALL their recommended well-child visits, whereas, MIECHV, 3 state NFP sites, and ITC report children who received their last regularly scheduled well-child visit.

MATERNAL INSURANCE

Health insurance coverage is an important measure of access to health care, which plays a significant role in maternal and child health and wellbeing.[13]

Target Population: Women enrolled in home visiting

Measure: Percent of women enrolled in home visiting who have health insurance by six months post enrollment

$$\frac{\text{Number of women enrolled in home visiting who have health insurance by six months post enrollment}}{\text{Number of women enrolled in home visiting for six months}}$$

About This Measure: This measure is an **outcome measure.** Over time, the goal is to see an increase in the percentage of women who have health insurance.

Data Source: Administrative Program Data[14]

Programs Reporting: Not Reported FY 2014

[13] The Pew Charitable Trusts. Retrieved from http://www.pewtrusts.org/~/media/Data-Visualizations/Interactives/2014/Health_Indicators/downloadables/SHCS_Health_Indicators_Report.pdf on Nov. 7, 2014.

[14] Data collection and reporting for this indicator vary by program. MIECHV, 3 state NFP sites & ITC measure the percentage of women with health insurance six months post enrollment. For MIHP, enrollees are Medicaid eligible at enrollment and insurance status is not measured for the mother (only the child) post enrollment.

SUBSTANTIATED CHILD MALTREATMENT

Child maltreatment is a significant contributor to child mortality and morbidity and has lasting effects on mental health, drug and alcohol misuse (especially in girls), risky sexual behavior, obesity, and criminal behavior, which persist into adulthood.[15]

Target Population: Children with families who participated in home visiting for at least six months

Measure: Percent of children in families with substantiated child maltreatment

$$\frac{\text{Number of children in families who participated in home visiting for at least six months with substantiated child maltreatment}}{\text{Number of children in families who participated in home visiting for at least six months}}$$

About This Measure: This measure is an **outcome measure**. Over time, the goal is to see a decrease in substantiated child maltreatment.

Data Source: Child Protective Services Data
Programs Reporting: Not Reported FY 2014

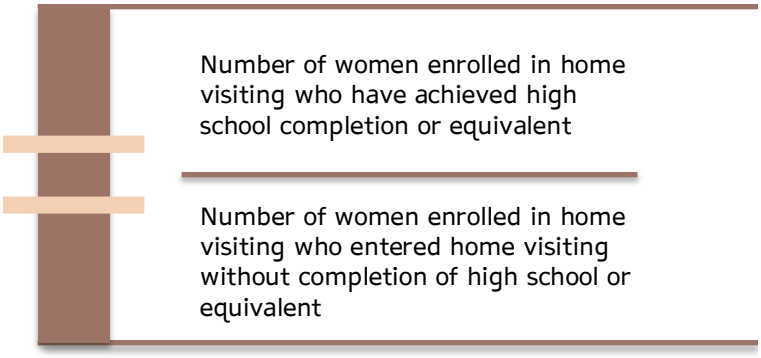
[15] Gilbert, R. et al (2009). "Burden and consequences of child maltreatment in high-income countries." *Lancet*, Vol. 373.

MATERNAL EDUCATION

A parent/mother's educational status is a strong indicator of basic skills, knowledge, and higher-order thinking, which help to shape expectations for her children's health and well-being and enable her to create better economic and home learning environments for their children.[16]

Target Population: Women enrolled in home visiting

Measure: Percent of women enrolled in home visiting who have achieved high school completion or equivalent



About This Measure: This measure is a **outcome measure.** Over time, the goal is to see an increase in the percentage of women served in home visiting who have improved educational status.

Data Source: Administrative Program Data
Programs Reporting: Not Reported FY 2014

[16] Magnuson, K. & Shager, H. (2008). "*The Effects of Increased Maternal Education on Children's Academic Outcomes*." Madison, WI: University of Wisconsin-Madison.

APPENDIX 6

Indicator Outcomes by Model

State Indicators Outcomes By Home Visiting Model

(Data reported only for indicators that can be broken down by model)

Home Visiting Statistics by Model																				
	Family Spirit				*Maternal Infant Health Program*				*Early Head Start – Home Visiting*				*Nurse Family Partnership*				*Healthy Families America*			
Indicator	Num	Den	Yes	No	Num	Den	Yes	No	Num	Den	Yes	No	Num	Den	Yes	No	Num	Den	Yes	No
Maternal Dep Screen	33	33	100%	0%	27,783	28,171	98.6%	1.4%	29	41	70.7%	29.3%	334	361	92.5%	7.5%	55	59	93.2%	6.8%
Tobacco Use**	*	10	*	*	2,788	11,816	23.6%	76.4%	12	39	30.8%	69.2%	29	286	10.1%	89.9%	6	57	10.5%	89.5%
Child Dev Screen	*	17	*	*	321	8,270	3.9%	96.1%	*	21	*	*	12	158	7.6%	92.4%	*	43	*	*

*Data suppressed to protect privacy and confidentiality of individuals.

** Maternal Tobacco Use: The data definition and reporting varies somewhat between reporting sources for this indicator. For MIHP, the data measures the number of mothers who are currently smoking. For other reporting streams (ITC, MIECHV and 3NFPs) the data measures tobacco use during the service period.

APPENDIX 7

Demographic Information

Demographic Information

Number of 2014 Enrollees 50,637 Number of Pregnant Women 25,615 Number of Children* 25,136								
Age of Non-Child Enrollees								
8-12	12-14	15-19	20-29	30-39	40-44	45-49	50+	Unknown
Data suppressed due to small sample size	55	4,026	15,980	4,792	354	20	9	378
Race								
Native American/Alaskan Native	Black/African American	Pacific Islander/Native Hawaiian	Asian	White/Caucasian	Multi-Racial	Arab/Chaldean		Unknown
263	9,941	35	391	10,592	1,074	844		445
Ethnicity**								
Hispanic	Not Hispanic							Unknown
2,207	24,293							115

* Number of pregnant women/children may not add up to total enrollees due to multiple births or other children in household

**Numbers do not add up to total; MIHP reports Hispanic as a racial category

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