2018 Michigan Home Visiting Report

Contents

Introduction **3**

Michigan Home Visiting Models **6**

Michigan's Investment in Home Visiting **8**

Outcomes **10**

- Access to Prenatal Care 11
- Preterm Birth 12
- Breastfeeding 13
- Maternal Tobacco Abstinence 14
- Maternal Depression Referral 15
- Maternal High School Completion 16
- Postpartum Visits 17
- Child Maltreatment 18
- Child Development Referrals 19

Appendices **20**

- Appendix I - Participant Demographic Information 21
- Appendix II - Where are State-Funded Home Visiting Programs Available? 22
- Appendix III - FY 2018 Home Visiting Investment by Model and Source 23

Introduction

"Over the course of our time together and after the birth of my child, with all the work we did and the resources I learned to utilize, I worked my way out of my depression. I began to make decisions based on what was best for my daughter and by extension my own life improved. My self-respect improved. My self-esteem is the best it has ever been. I feel more confident in my own judgments and decision-making skills. I now have a voice and through my struggles, I hope to be a voice for other moms, other parents, children, families, and communities who are struggling." A parent enrolled in Michigan Home Visiting

Home visiting programs work to equip pregnant and parenting families with the tools needed to have a healthy pregnancy and a healthy and happy family, and all address social determinants of health. Home visitors nurture, coach, educate, offer encouragement, and refer families to additional 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, retain and develop healthy habits, and prepare for the birth of the baby. 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 childcare, connecting with community resources for stable housing, or finding a job.

Home visitors' roles extend beyond the parent-child relationships. Topics such as continuing family education, managing family finances, understanding domestic violence, and dealing with trauma are often discussed. 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.

The FY 2018 report:

- Reflects data reporting for program and administrative data as currently available.
- Reflects funding for all state-funded programs.
- Maps home visiting programs that operate with funds appropriated through the state and are implemented with fidelity (i.e. programs that are accredited, affiliated).

Executive Summary - Public Act 291

Strength of Michigan Home Visiting FY18

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

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 a child is five years old.

Michigan's Home Visiting Continuum

Not every family needs the same type of supports - that is why there are currently eight home visiting models serving our families. Seven are evidence-based and one is considered a promising practice.

- Early Head Start - Home Based
- Family Spirit
- Healthy Families America
- Infant Mental Health (promising practice)
- Maternal Infant Health Program
- Nurse - Family Partnership
- Parents as Teachers
- Play and Learning Strategies - Infant

"It's nice to have confidence that you're doing the right things and your family is on track." - Parent enrolled in Michigan Home Visiting

29,329
Families Served

235,369
Total Home Visits

Home Visiting Maternal Demographics

1.6% American Indian/AN
1.4% Asian
37.5% Black
0.1% Native Hawaiian/PI
43% White
2.1% Multiple Races
14.2% Unknown

Nearly 90% of mothers carried to full term

72% of mothers enrolled in home visiting were connected to recommended prenatal care

Nearly 85% of women enrolled in home visiting did not use tobacco during and after home visiting enrollment

"If I could tell another newly pregnant woman about home visiting, I'd stress that the home visitors are really kind and understanding, and above all, are there to help out with any questions you might have. Home visiting has been a life saver for me. I don't know where I'd be without it." - Parent enrolled in Michigan Home Visiting

Michigan Home Visiting Models

Michigan implements a continuum of eight evidence-based and promising home visiting models. Each has specific strengths that contribute to a community's support for families. The chart below lists pertinent information about the models, including outcomes achieved by families (as indicated on the research based Home Visiting Evidence of Effectiveness website). The Maternal Infant Health Program (MIHP) serves the largest number of women and infants through home visiting in Michigan, so much of the data in this report is driven by that model. Conversely, only a small number of Early Head Start - Home Based (EHS-HB) programs are included in this report as the majority of EHS-HB programs receive federal funding and do not receive any state dollars. Additionally, only programs that are affiliated or accredited with their national/state model office are included in this report.

Michigan Home Visiting Models

Model	Intensity	Population Served	Outcomes
Early Head Start—Home Based (EHS-HB)[1]	Weekly home visits (a minimum of 48 visits annually) of 90 minutes each. Two group socialization activities per month.	Parents who are lower-income 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)[1]	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. Visits generally last 45–90 minutes.	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)[1]	During pregnancy, families receive twice monthly to weekly home visits. Following birth, they receive one home visit per week for six months. After the first six months, visits depend on the families' needs. Home visits generally last 60 minutes.	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)[2]	The intensity of IMH services varies based on family needs. Generally, families receive weekly home visits, though visits may be more frequent if the family is in crisis.	Families in which the parent-infant attachment is challenged. 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)[1]	Participating pregnant women 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 a substance exposed infant may receive up to 18 additional visits.	Pregnant women and infants up to 18 months of age.	Promotes healthy pregnancies, positive birth outcomes, and healthy infant growth and development via a standardized, system-wide process of case management.
Nurse-Family Partnership (NFP)[1]	Families receive weekly, biweekly, or monthly visits dependent initially on length of enrollment and then age of the child. Visit schedule is determined by the family and can change based on family needs.	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)[1]	Families with one or fewer stressors receive at least 12 personal visits annually and families with two or more stressors receive at least 24 visits annually. Home Visits are generally 60 minutes in duration. Families are also offered at least 12 group connections across the program year.	Parents and their children from prenatal through kindergarten.	Increases parent knowledge of early childhood development and improves parent practices, provides early detection of developmental delays and health issues, prevents child abuse and neglect, and increases children's school readiness and success.
Play and Learning Strategies Infant (PALS-Infant)[1]	Families participating in PALS-Infant receive 10 weekly home visits lasting a minimum of 90 minutes.	Parents of children age 5 to 15 months who are low income.	Strengthens the attachment between parent and child stimulates early language, cognitive, and social development.

[1] Evidence-based Model
[2] Promising Model

Michigan's Investment in Home Visiting

Michigan invests state, federal, and private funds to support home visiting. Roughly 45 percent of Michigan's total investment is made up of state resources, 54 percent federal resources, and less than 1 percent from 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. Additional home visiting programs operate with direct federal or local funds and are not reflected in this report (Appendix III – Fiscal Year 2018 Home Visiting Investment by Model and Source).

State Funding

General Fund

Michigan provides direct support to Nurse-Family Partnership (NFP) programs through MDHHS General Fund appropriations. In addition, the Legislature continues to support evidence-based home visiting and appropriated additional state funds for home visiting programs in FY19. The Michigan Home Visiting Initiative continues to partner with community agencies to identify the model that best fits the needs of the community that will be supported with state funding. 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. General Fund dollars are also used to support an NFP and PAT program in Flint, Michigan.

State School Aid

The Legislature appropriates funds to the Michigan Department of Education (MDE) that may be used for home visiting through the State School Aid Act, Sections 32p and 32p(4). Local programs funded through the State School Aid Act include Parents as Teachers, Healthy Families America, Early Head Start-Home Based, Nurse-Family Partnership, and Play and Learning Strategies Infant.

Federal Funding

Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

MIECHV is a federal program that is awarded on a formula grant basis. The MIECHV funding allows Michigan to increase evidence-based home visiting services in communities identified as high-risk through a statewide needs assessment. Early Head Start-Home Based, Healthy Families America, and Nurse-Family Partnership are implemented with MIECHV funding. MIECHV legislation requires that 75 percent of the 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. In Michigan, funds are administered by the MDHHS Public Health Administration.

Child Abuse Prevention and Treatment Act (CAPTA)

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 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 distribute these funds in Michigan (CAPTA Title II Funds).

Medicaid

Medicaid funds are also used to support several evidence-based home visiting models in Michigan. Home visiting has proven outcomes in maternal and child physical and mental health and lowers overall health care costs.

Private Funding

Children's Trust Fund (CTF)

The Michigan Children's Trust Fund raises funds from private sources, which are granted to local communities for secondary prevention programs such as home visiting programs. Secondary prevention programs focus on families at risk for abuse and neglect in order to strengthen and support families while preventing child abuse and neglect. Children's Trust Fund dollars support Parents as Teachers and Healthy Families America home visiting programs.

Appendix III-FY 2018 Home Visiting Investment by Model and Source provides a more detailed look at the funding supporting evidence-based home visiting in Michigan.

Outcomes

Michigan is committed to understanding, evaluating, and improving our home visiting efforts. To do this, state-funded home visiting programs assess progress against nine common indicators:

- Access to prenatal care
- Preterm birth
- Breastfeeding
- Maternal tobacco abstinence
- Maternal depression referrals
- Maternal high school completion
- Postpartum 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.

MHVI Fiscal Year 18 data in this report is coded to indicate progress:

Green = Improvement in this indicator

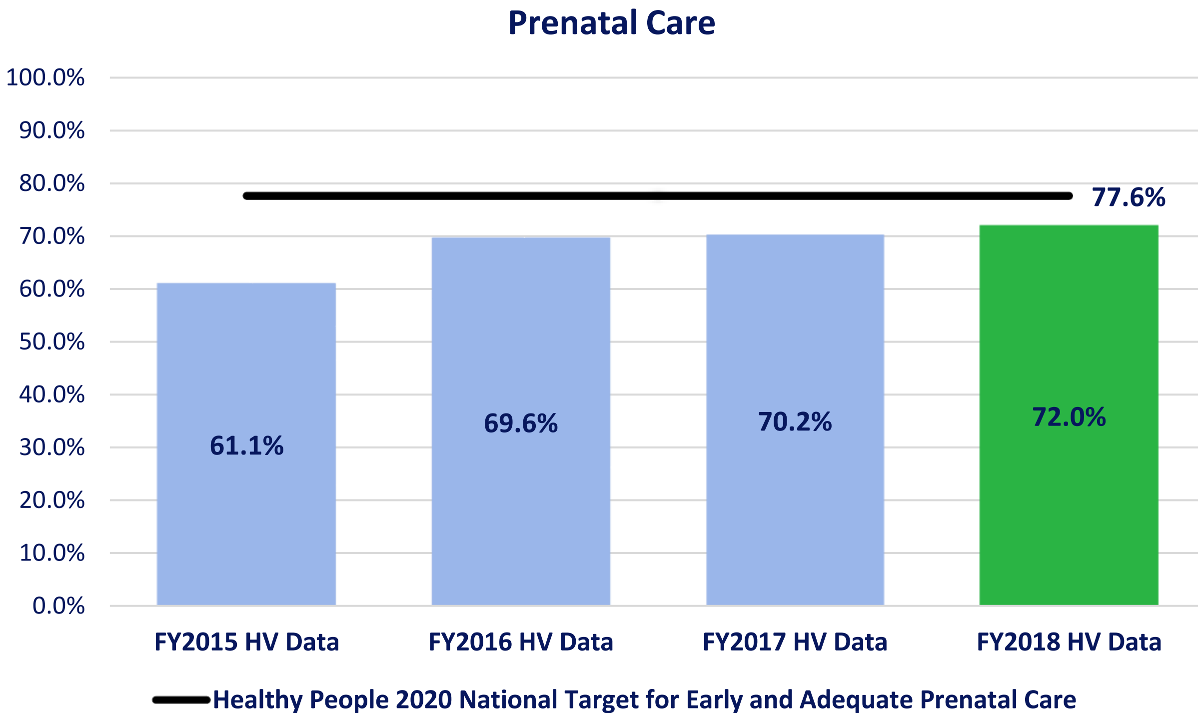
Yellow = Monitor due to slight decline

Red = Decrease that is being investigated

Healthy People 2020 national target data has been included, where available, to provide context on Michigan's indicator data. Michigan is aligning well with these national targets and the home visiting system is continuing to improve quality and services to families in Michigan to achieve positive outcomes.

Access to Prenatal Care

Prenatal care can reduce the risk of infant health problems such as low birth weight, and cognitive impairments, and can assist in addressing chronic health conditions for mothers and link them to medical care. All women are encouraged to begin prenatal care early (ideally in the first or second month of pregnancy) and continue prenatal visits regularly until delivery. Home visitors emphasize the importance of prenatal care and help resolve barriers to accessing care. The percentage of women enrolled in home visiting during pregnancy who received adequate or adequate plus prenatal care has increased each year since 2015.



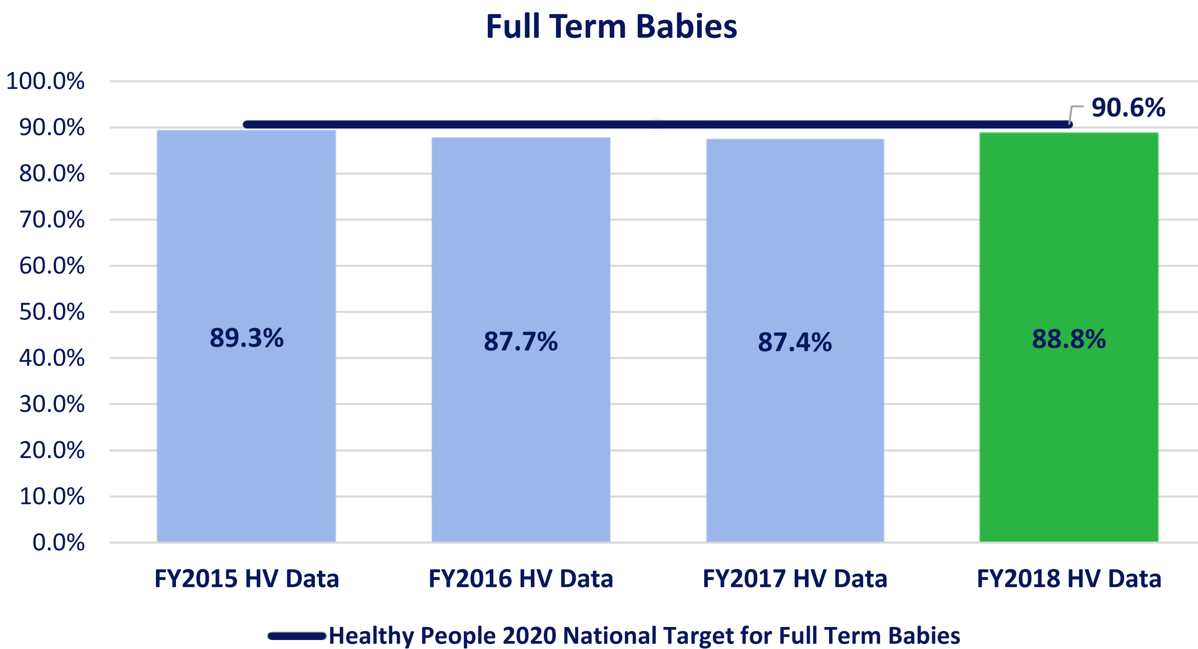
Calculation	
Percent of women enrolled in home visiting services during pregnancy who received adequate or adequate plus prenatal care	$\frac{\text{Number of women enrolled in home visiting during pregnancy who received “adequate” or “adequate plus” prenatal care}}{\text{Number of women enrolled in home visiting during pregnancy}}$

Data Source	Models Reporting
Vital Records	FS, MIHP, EHS-HB, NFP, HFA

Note: Adequate or adequate plus prenatal care is defined as a woman who begins prenatal care by the fourth month of pregnancy and receives 80 percent or more of the expected visits

Preterm Birth

Babies born before 37 weeks of gestation miss out on important periods of development, which could lead to short and long-term challenges and an increased risk of infant death. For example, premature babies can experience breathing and feeding difficulties, and are at greater risk for vision problems and hearing loss. Several factors can contribute to preterm birth including continued health disparities that are products of institutional/structural racism which leads to inequity. Home visitors work with women on healthy eating and getting exercise, avoiding exposure to tobacco or other drugs, and reducing stress. The percentage of women enrolled in home visiting during pregnancy who had a full-term birth has varied over the past four years and increased from 2017 to 2018.



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

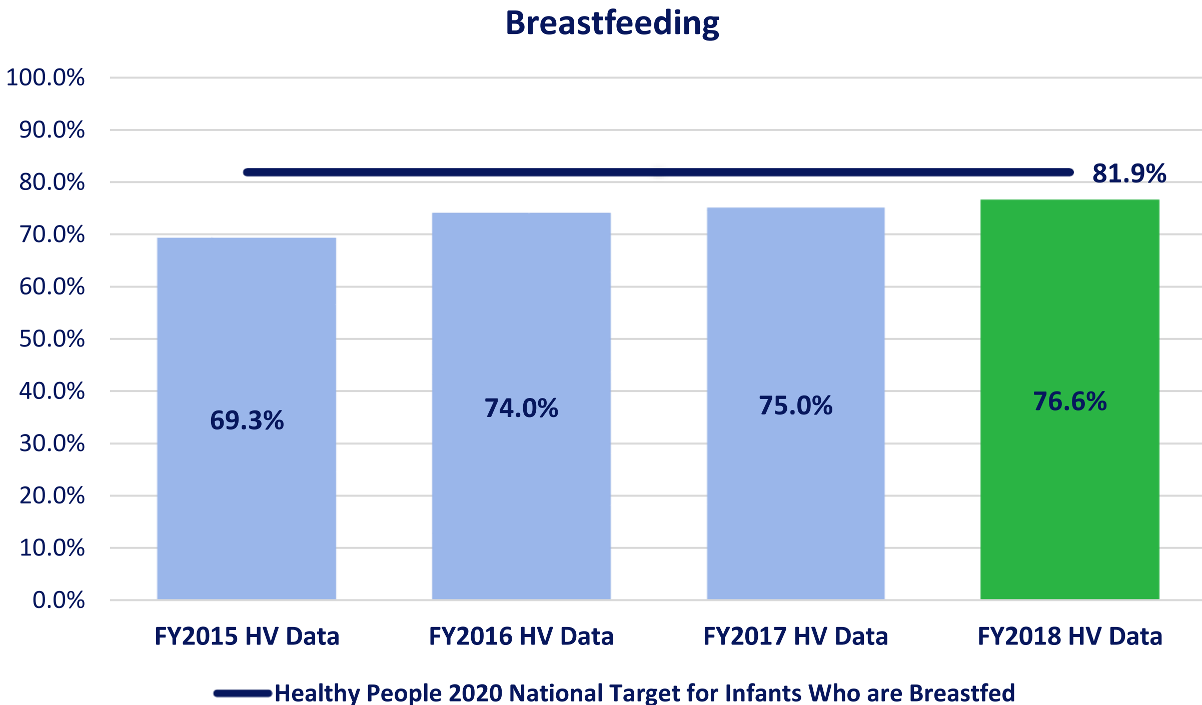
Vital Records

Models Reporting

FS, MIHP, EHS-HB, NFP, HFA

Breastfeeding

Evidence shows that breastfeeding provides strong support for healthy infant development and protects infants from common childhood illnesses. In addition, children experience long-term benefits, such as reduced risk for obesity and type-2 diabetes. Home visitors provide education and promote breastfeeding to women before and after delivery. After delivery, home visitors support mothers through regular discussions about breastfeeding and referrals for additional lactation support, when needed. The percentage of women enrolled in home visiting during pregnancy who initiated breastfeeding has increased each year since 2015.



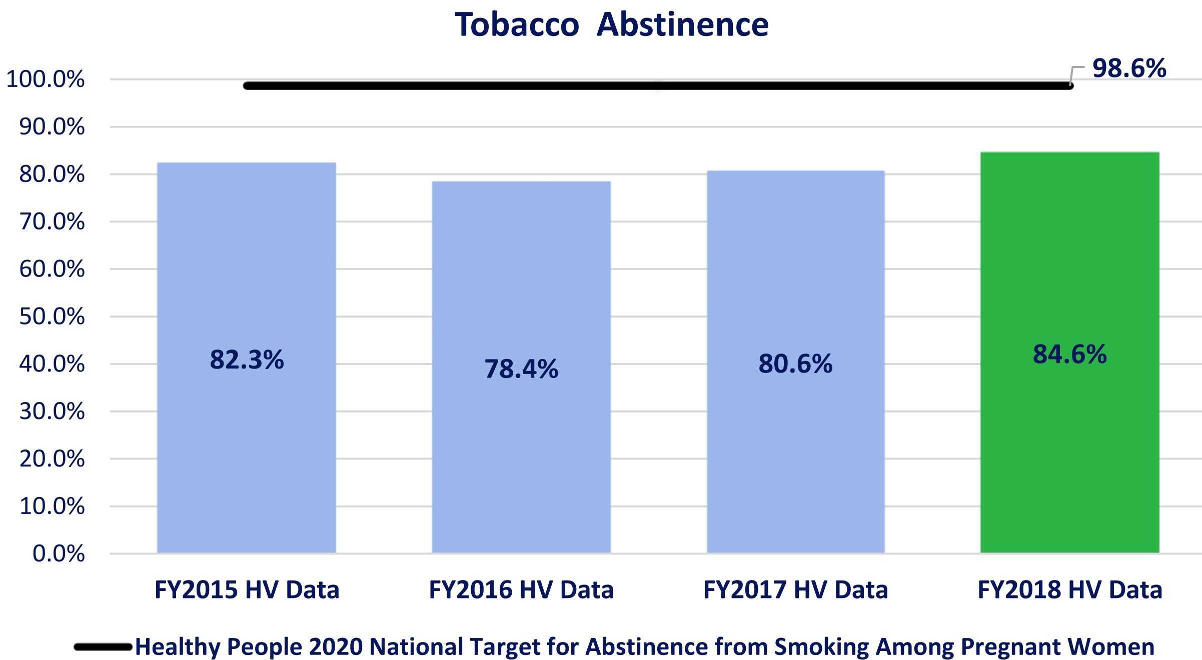
Calculation

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

Data Source	**Models Reporting**
Vital Records	FS, MIHP, EHS-HB, NFP, HFA

Maternal Tobacco Abstinence

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. Home visitors encourage women to quit, reduce, and/or avoid being around smoking during and after pregnancy and connect women with programs and services to help them quit smoking. The percentage of women enrolled in home visiting for at least six months who were not using tobacco or smoking at six months post-enrollment (or at program exit) has increased each year since 2016.



Calculation

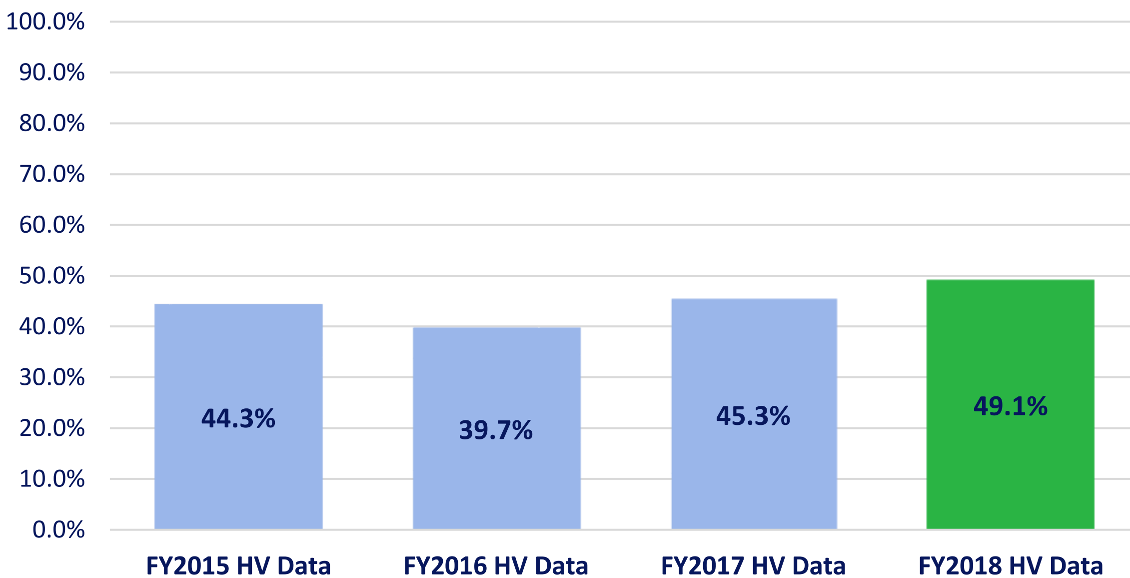
Percent of women enrolled in home visiting services for at least six months who were not using tobacco or smoking at six months or upon program exit

$$\frac{\text{Percent of women enrolled in home visiting services for at least six months who were not using tobacco or smoking at six months or upon program exit}}{\text{Number of women enrolled in home visiting for six months}}$$

Data Source	**Models Reporting**
Program Data	MIHP, EHS-HB, NFP, HFA

Maternal Depression Referral

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. Children whose mothers are depressed are at increased risk for difficulties with attachment and other long-term social-emotional effects, including difficulties in school. Home visitors work with women to identify and screen for signs of depression, refer women to appropriate supports, and help women overcome challenges with accessing services. The percentage of women enrolled in home visiting who received a referral based on a depression screening has increased each year since 2016.



Calculation

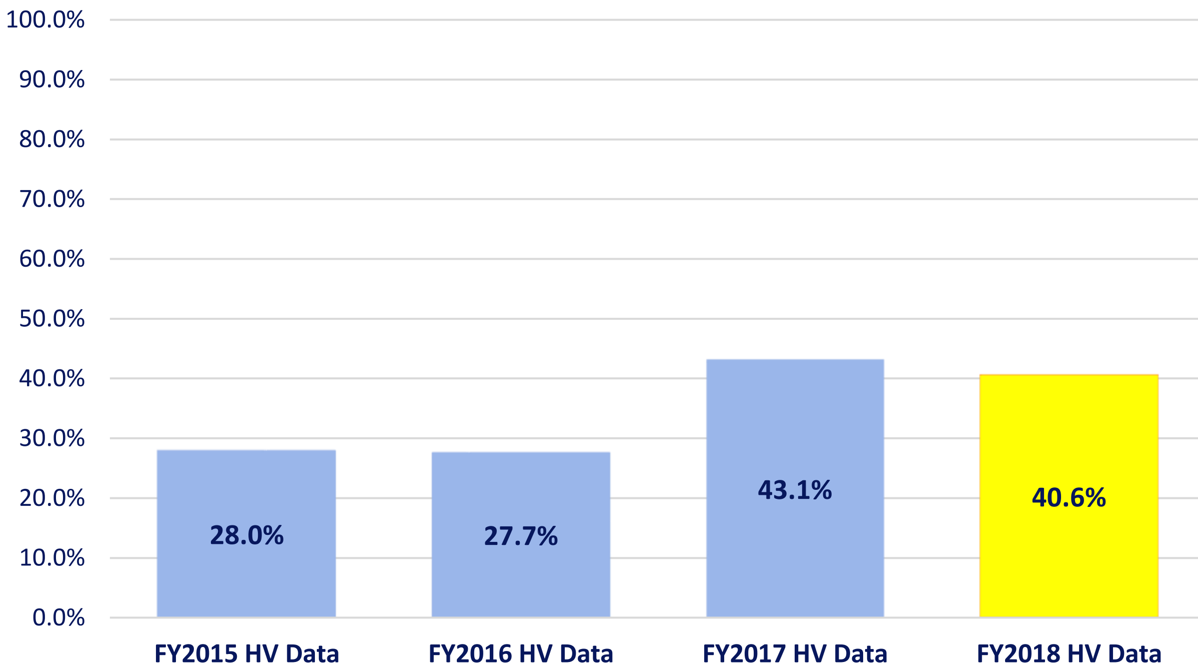
Percent of women enrolled in home visiting services with need for follow-up depression evaluation and intervention who received referral for these services	Number of women enrolled in home visiting services who received maternal depression screening with a validated tool whose results indicated need 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	**Models Reporting**
Program Data	FS, MIHP, EHS-HB, NFP, HFA, PAT

Note: A referral is considered to have occurred when program staff have identified a need and provided appropriate information to the client for additional services outside the home visitation program.

Maternal High School Completion

Young mothers can face significant barriers to completing their education, including access to quality childcare, lack of stable housing, working during school hours, social stigma, and wanting time with their children. 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. Home visitors work with women to overcome the challenges to school completion. 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. The percentage of women enrolled in home visiting who made progress toward or completed a high school diploma or GED increased in 2017 but dipped again in 2018.



Calculation

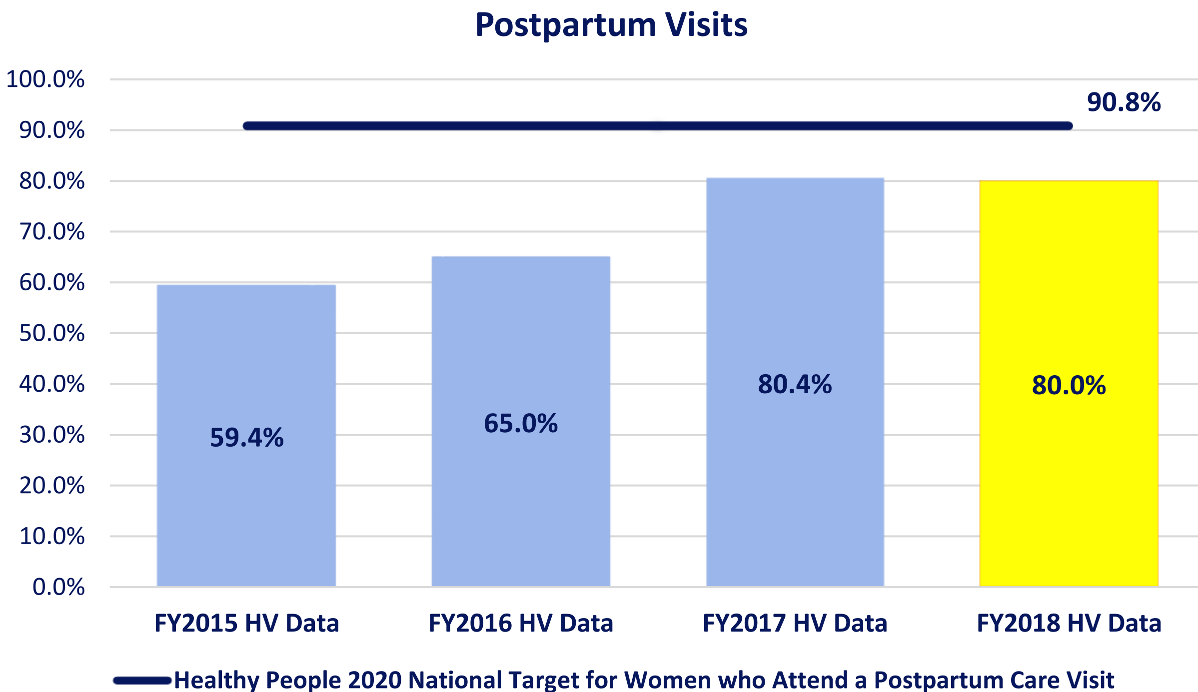
Percent of women entering home visiting without a high school diploma/GED who were still enrolled in or completed high school/GED by the end of FY 2018

$$\frac{\text{Percent of women who enter the program without a high school diploma or GED certificate who are either still enrolled in school or a GED program, or who have successfully completed high school or received a GED certificate}}{\text{Number of women who enter a home visiting program without a high school diploma or GED completion}}$$

Data Source	**Models Reporting**
Program Data	EHS-HB, NFP, HFA, PAT

Postpartum Visits

In the weeks after delivery, mothers can 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. Home visitors encourage women to follow up with their doctor and work to increase the number of women who receive postpartum care. Home visitors can also help women identify and address barriers to attending a postpartum visit. The percentage of women enrolled in home visiting who received a postpartum visit with a health provider within two months (60 days) following birth has increased and then remained relatively stable during 2017 and 2018.



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

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

Data Source

Program Data, Managed Care Encounter,

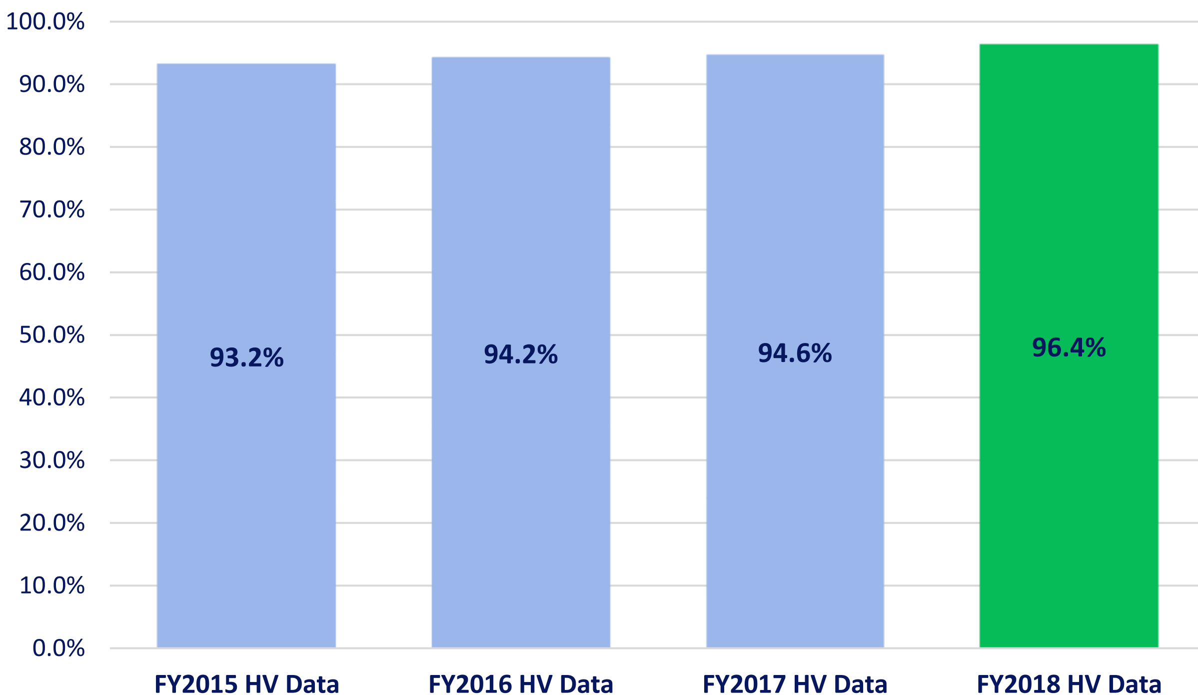
Fee for Service Claim Data

Models Reporting

MIHP, EHS-HB, NFP, HFA

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. Home visitors work with families to promote positive parenting practices and prevent child maltreatment. They also work closely with mothers and caregivers to reduce family stress and increase social supports. Both strategies impact the home environment and can assist in the prevention of child abuse or neglect. The percentage of children in families who participated in home visiting for at least six months without confirmed child maltreatment increased from 2017 to 2018.



Calculation

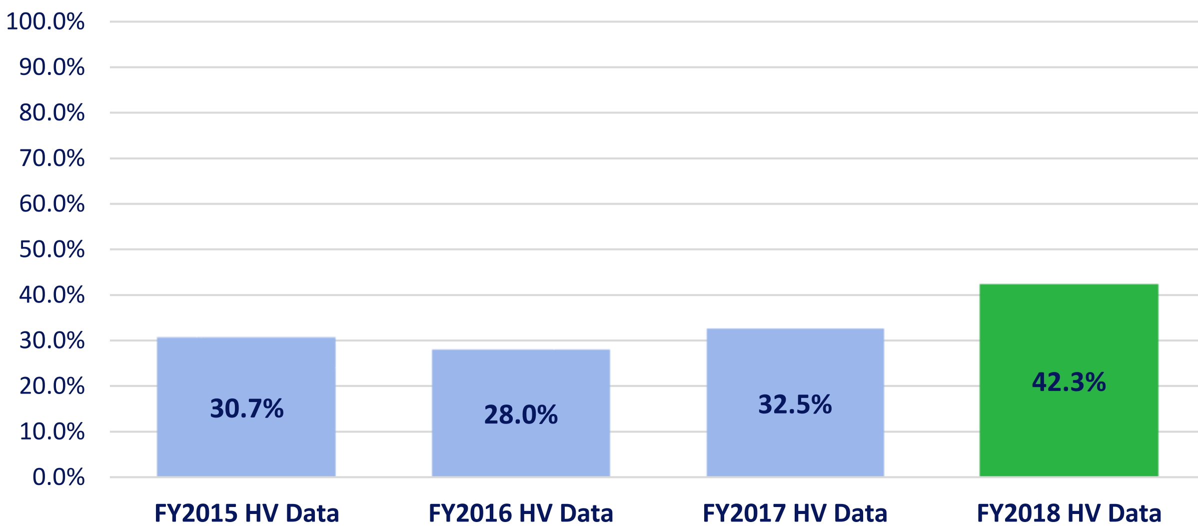
Percent of children enrolled in home visiting without confirmed child maltreatment	Number of children who participated in home visiting without confirmed child maltreatment / Number of children participating in home visiting

Data Source	**Models Reporting**
Children's Protective Services	MIHP, EHS-HB, NFP, HFA, PAT

Note: Confirmed child maltreatment is defined as substantiated Category I and II maltreatment as investigated and confirmed by Child Protective Services.

Child Development Referrals

Developmental screening provides the best opportunity to identify children with potential delays early and connect them to intervention services. Home visitors complete the Ages and Stages Questionnaires, Third Edition® (ASQ-3™) and the Ages and Stages Questionnaire®: Social-Emotional, Second Edition (ASQ: SE-2™) for every child they serve. Home Visitors also make referrals for other community services, such as *Early On®*, when there are questions or concerns about a child's development. The percentage of children participating in home visiting who received a referral based on developmental screening has increased each year since 2016.



Calculation

Percent of children in home visiting referred for follow-up evaluation and intervention if need 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	**Models Reporting**
Program Data	MIHP, EHS-HB, NFP, HFA, PAT

Note: A referral is considered to have occurred when program staff have identified a need and provided appropriate information to the client for additional services outside the home visitation program.

Appendices

Appendix I Participant Demographic Information

Appendix II Where are State-funded Home Visiting Programs Available?
Program Offices and Number of Models Per County

Appendix III FY2018 Home Visiting Investment by Model and Source

Appendix I - Participant Demographic Information[3]

Service Statistics	
Total Home Visits	**235,369**
Total Families Served	29,329
Total Children Served	24,614
Total Women Served	19,277
Pregnant Women Served	10,641

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.
Note: The majority of families who received EBHV in FY18 were served by the Maternal Infant Health Program.

Household Demographic Characteristics

Federal Poverty Level:	**18,367 (#)**	**100.0%**
<= 50%	11,175	60.8%
51–100%	2,915	15.9%
101–133%	1,684	9.2%
134–250%	971	5.3%
251% +	479	2.6%
Unknown	1,143	6.2%

Child Demographic Characteristics

Insurance:	**24,614 (#)**	**100.0%**
None	130	0.5%
Medicaid	22,541	91.6%
TRICARE	8	0.0%
Private/Other	677	2.8%
Unknown	1,258	5.1%
Ethnicity:	**24,614**	**100.0%**
Hispanic	2,468	10%
Not Hispanic	21,465	87.2%
Unknown	681	2.8%
Race:	**24,614**	**100.0**
American Indian/AN	298	1.2%
Asian	402	1.6%
Black	7,731	31.4%
Native Hawaiian/PI	14	0.1%
White	10,917	44.4%
Multiple Races	1,012	4.1%
Unknown	4,240	17.2%
Age:	**24,614**	**100.0%**
< 1 Year	14,494	58.9%
1–2 Years	7,499	30.5%
3–5 Years	2,444	9.9%
Unknown	177	0.7%
Gender:	**24,614**	**100.0%**
Female	11,963	48.6%
Male	12,607	51.2%
Unknown	44	0.2%

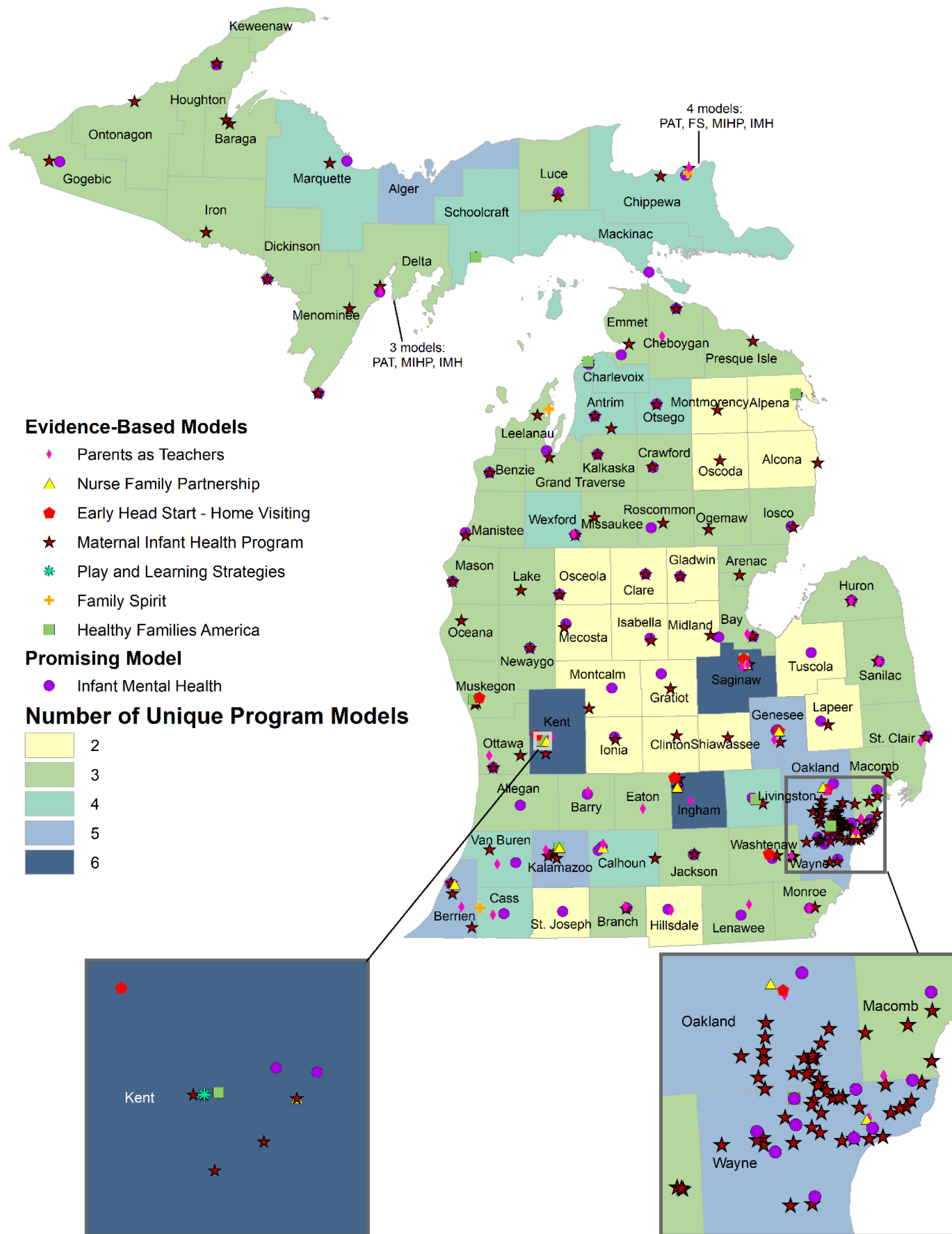
3 – Program level demographic data

Maternal Demographic Characteristics

Insurance:	**19,277(#)**	**100.0%**
None	192	1.0%
Medicaid	16,811	87.2%
TRICARE	6	0.0%
Private/Other	933	4.8%
Unknown	1,335	6.9%
Ethnicity:	**19,277**	**100.0%**
Hispanic	1,738	9.0%
Not Hispanic	16,360	84.9%
Unknown	1,179	6.1%
Race:	**19,277**	**100.0%**
American Indian/AN	316	1.6%
Asian	270	1.4%
Black	7,225	37.5%
Native Hawaiian/PI	16	0.1%
White	8,298	43.0%
Multiple Races	412	2.1%
Unknown	2,740	14.2%
Marital Status:	**19,277**	**100.0%**
Married	4,844	25.1%
Widowed	32	0.2%
Separated	221	1.1%
Divorced	451	2.3%
Never Married	13,083	67.9%
Unknown	646	3.4%
Education:	**19,277**	**100.0%**
< High School	4,660	24.2%
HS Diploma/GED	10,944	56.8%
Some College/Tech	1,927	10.0%
Bachelor's Degree +	1,015	5.3%
Other	114	0.6%
Unknown	617	3.2%
Age:	**19,277**	**100.0%**
< 18 Years	645	3.3%
18–19 Years	1,620	8.4%
20–24 Years	6,043	31.3%
25–29 Years	5,377	27.9%
30–34 Years	3,165	16.4%
35–44 Years	1,924	10.0%
45 + Years	106	0.5%
Unknown	397	2.1%
Primary Language:	**19,277**	**100.0%**
English	16,603	90.2%
Spanish	495	2.7%
Arabic	382	2.1%
Other	179	1.0%
Unknown	1,618	4.0%

Appendix II - Where are State-Funded Home Visiting Programs Available?

Program Offices and Number of Models Per County



(This map does not indicate if one program serves more than one county)

Appendix III - FY 2018 Home Visiting Investment by Model and Source

Home Visiting Model	Funding Source	Federal Funding	State Funding	Private Funding
Early Head Start – Home Based (EHS-HB) (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	$958,545		
	State School Aid Act, Section 32p and 32p(4) Block Grant Funds		$498,692	
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	
Health Families America (HFA)	MIECHV	$2,254,074		
	Community Based Abuse Prevention Grants (CBCAP)	$65,227		
	CTF (license plates, donations, tax check off, etc.)			$130,454
	State General Fund		$1,822,478	
	State School Aid Act, Section 32p and 32p(4) Block Grant Funds		$392,141	
Infant Mental Health (IMH)	Medicaid			
	State General Fund	$6,477,467	$3,514,261	
Maternal Infant Health Program (MIHP)	Medicaid	$9,891,546	$5,047,540	
Nurse Family Partnership (NFP)	MIECHV	$2,273,071		
	Medicaid	$763,132		
	State General Fund		$1,971,405	
	State School Aid Act, Section 32p and 32p(4) Block Grant Funds		$180,236	
Parents as Teachers (PAT)	State School Aid Act, Section 32pand 32p(4) Block Grant Funds		$4,479,069	
	Community Based Abuse Prevention Grants (CBCAP)	$207,622		
	CTF (license plates, donations, tax check off, etc.)			$415,244
	State General Fund		$140,895	
Play and Learning Strategies (PALS) (MDE funds one model in the state for its evidence-based infant component only)	State School Aid Act, Section 32pand 32p(4) Block Grant Funds		$77,000	
All Models =		**$22,890,684**	**$18,323,717**	**$545,698**