

Michigan Maternal, Infant and Early Childhood Home Visiting Program Updated State Plan

SECTION 1: Identification of the State's Targeted At-Risk Communities

In the *Michigan Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP) Statewide Needs Assessment (September, 2010)*, ten of the State's 83 counties were ranked as having the highest concentration of risk compared to the statewide average. Rankings were based on the ten indicators specified by HRSA and three additional indicators identified by the Michigan Great Start System Team (GSST) Home Visiting Workgroup (HVWG).

The HVWG identified a multi-step process to follow to select which counties (communities), and which target populations within each county, would receive FY 2010 funding from the project, and for what purpose.

In considering the provision of local home visiting services, the HVWG decided that rather than start new programs, FY 2010 funds would be used to add service slots to existing programs that are operating with fidelity, as verified by the model developer's office. The rationale for this is that expanding the number of families served by existing programs would better position us to meet the federal benchmarks within the required timeframes, as it can take several years for a new program to meet the standards developed by the national model developer's office. It is also more cost-effective to expand existing programs than to start new ones, an important consideration given our FY 2010 funding level. The expansion also facilitates coordination within the local early childhood system since the funding is being added to an existing program, and makes use of existing screening, referral and coordination mechanisms, as well as governance structures and planning efforts.

The process of selecting the at-risk communities for expansion of home visiting services from among the counties identified as being at risk in the State's initial needs assessment, began with a Community Readiness Assessment. The HVWG identified this initial step based on experience through our shared day-to-day work with local communities, and based on our learning through the Early Childhood Comprehensive Systems (ECCS) Grant and the Great Start process that communities vary in their level of understanding of the need to change how we have been approaching and implementing components of the early childhood system; that communities are at different stages in their system building efforts; and that communities fall on a continuum of understanding of the concept of implementation of evidence-based home visiting services with fidelity to a model.

The State asked each county to convene a Local Leadership Group (LLGs) for this initiative. This LLG could be a new or existing group. Each LLG was to be clearly connected with existing Great Start Collaborative bodies to ensure connection between home visiting and the greater early childhood system. The LLG was to include representatives from agencies/projects identified by HRSA as required participants, along with other key county stakeholders, including parents that represented the target population. The role of the LLG is to take the lead for the county in working with the State to implement the Home Visiting Program, which includes participating in State learning opportunities, helping the State to identify and collect necessary information, providing input and feedback on grant activities, to coordinate in-depth analysis of

community needs, and to lead the local discussion and decision-making about activities to be undertaken in the community pertaining to home visiting and this grant. The State provided ‘seed funding’ in the amount of \$8,000 to each county to support the initial activities of the LLG, including conducting a second-cut data analysis and supporting parents to participate as full members of the LLG.

Community Readiness Assessment Process

After the *Statewide Needs Assessment* was completed, the HVWG engaged the LLG for each of the ten counties in an intensive process to assess the county’s readiness to implement evidence-based practices with fidelity to the model and to develop a county-level home visiting system within the context of its overall early childhood system. A four-part process to assess community readiness was used, as described below:

Part I: Written Self-Assessment

The LLG completed an online *Written Self-Assessment*. Focus areas included: the structure and activities of the LLG; the extent of parental involvement in local home visiting programs; coordination efforts among existing home visiting programs; the extent to which local data and information systems are shared; accountability, evaluation and outcome measurement processes; and implementation of evidence-based models with fidelity. The *Written Self-Assessment* template was distributed to the LLGs as a SurveyMonkey questionnaire.

Part II: Information on Existing Home Visiting Programs

Michigan’s *Statewide Needs Assessment* included a chart of State or Federally-Funded Home Visiting Programs. This chart captured preliminary information about home visiting programs that currently exist in Michigan, both at the state and local levels. These are programs that use home visiting as a primary service delivery strategy, are at least partially supported with State or Federal funds, and focus on promotion or prevention.

LLGs were asked to provide additional, more substantial information about existing programs for the *Updated State Plan*. The information served two purposes:

1. To assist the State in cataloging existing home visiting services statewide, to better understand the ‘system’ as it currently exists;
2. To help describe the scope of and gaps in the current local system and match community needs to the most appropriate of the four selected models.

In order to help guide this work, the Michigan MIECHVP Database was developed. The database contains an extensive list of home visiting programs, including the following focus areas: intended recipients; risk factor eligibility requirements; demographic characteristics; numbers served; geographic area served; targeted outcomes; funding sources and amounts, etc. The information required for the database was collected via a series of county-specific SurveyMonkey questionnaires. Although the Database only includes data on the ten top-ranked counties at this time, the HVWG intends to gather home visiting program data from Michigan’s remaining 73 counties during the last months of this fiscal year. The updated home visiting program information is being compiled and will be available upon request.

Part III: Desk Review

The purpose of the Desk Review was to allow the HVWG to assess our internal information and understanding of where each county stood with respect to existing home visiting efforts and implementation. The Desk Review was conducted internally by staff of the Michigan Home Visiting Program and a few members of the HVWG. The Desk Review included the following focus areas: participation in State activities by LLG; existing funding and support for local home visiting programs; and implementation of evidence-based models with fidelity based on information from the national model offices.

Part IV: Site Visit

The purpose of the Site Visit was to allow a small team representing the HVWG to sit down with each LLG and have a face-to-face conversation about the county-level home visiting system. Site Visits were conducted by teams of three to four people, consisting of the staff of the Michigan MIECHVP and other members of the HVWG. Federal Project Officers participated in two of the local site visits as part of their site visit to the State. Although team members varied somewhat from site to site, the State Program Administrator participated in all 10 site visits. Site visits were two hours in length.

At the Site Visit, LLGs were asked a standard set of questions, giving them the opportunity to elaborate on many of the focus areas that were addressed in the *Written Self-Assessment*. They also were asked any questions that arose from the Desk Review and invited to share any other information they believed was relevant to the determination of community readiness. The information gleaned during the Site Visit provided an additional helpful perspective on where each county stood in terms of “readiness.”

Scoring rubrics were developed for Parts I, III and IV. Part II was not scored, as its purpose was collection of information rather than assessment. Each item was scored as follows:

Not ready	0 points
Somewhat ready	1 point
Ready	2 points

The highest possible total score was 62 points. A list of the Community Readiness items from Parts I, III, and IV is attached, in Attachment 2. Results of the Community Readiness Assessment are discussed in depth, below.

Based upon a review of the Community Readiness Assessment results, each county was classified into one of three tiers. The tiers were defined as follows:

Tier 1: Ready and operating one or more existing federally-approved home visiting models with fidelity; eligible for funding to expand the existing program to serve additional families.

Tier 2: Somewhat ready and operating one or more existing federally-approved home visiting models with fidelity; eligible for quality improvement funding to bring existing programs to fidelity.

Tier 3: Not ready, may or may not be operating an existing federally-approved home visiting model with fidelity; eligible for technical assistance to address readiness issues to move toward eligibility for future funding.

A fourth tier had been defined originally (not ready, not operating a federally-approved home visiting model with fidelity), but based on using the process and based on the results of the assessment, the fourth tier was dropped.

A total of 62 points was available across Parts I, III, and IV of the Community Readiness Assessment. The mean score for the readiness assessment across the ten communities was 31.3, the median score was 31.5, with scores ranging from a low of 18.5 to a high score of 43.5. Communities fell into Tiers as follows:

Tier 1 = Ingham, Kent, Muskegon

Tier 2 = Genesee, Saginaw, Wayne

Tier 3 = Berrien, Calhoun, St. Clair, Kalamazoo

The information from the Part II surveys was combined with the data from Parts I, III and IV to guide decisions about funding and expansion of existing programs. Details about Part II and the process used to select models is outlined in Section 3.

Based on the results of the readiness assessment, the six counties in Tier 1 and Tier 2 have been selected to receive funding for expansion of existing evidence-based home visiting models using FY 2010 funds (see below). Concurrent to expansion, all ten counties will receive technical assistance to improve community readiness; additional detail about TA plans is included in Section 8.

Table 1. Risk Scores and Status for FY2010 Expansion Funding

County	Concentration of Risk Score	Selected for FY10 Service Expansion
Genesee	13	Yes
Wayne	12	Yes
Saginaw	11	Yes
Calhoun	10	No
Ingham	10	Yes
Kalamazoo	9	No
Muskegon	9	Yes
Berrien	8	No
Kent	8	Yes
St. Clair	8	No

Michigan Home Visiting Program staff have worked closely with the selected six counties to jointly develop plans detailing how the service expansion would take place. Information about the specific implementation plan in each of the six counties is presented in Attachment 3, organized by county. The plans are individualized to each county, because they are

implementing different models with different target at-risk populations. Attachment 3 contains details about the implementation plans, including:

- Information regarding needs and resources in each county (reference in this Section);
- Information about the at-risk target population within each county that will receive the expansion services (see Section 3); as well as
- Detailed information about how the expansion will be carried out (see Section 4).

The first part of Attachment 3 (Section A) includes detailed assessments of needs and existing resources in each of the six selected counties. The assessments include the following components:

1. Targeted at-risk community.
2. Community risk factors.
3. Community strengths.
4. Characteristics of participants.
5. Needs of participants.
6. Additional factors for consideration in the selection of the at-risk community.
7. Home visiting services for the target population/at-risk community.
8. Explanation as to why more home visiting services are needed and estimation of available service slots compared to the number of families needing services.
9. Referral resources currently available to support families residing in the community.
10. Referral sources needed in the future to support families residing in the community.
11. A plan for coordination among existing programs and resources in those communities.
12. Existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community.
13. Local capacity to integrate the proposed home visiting services into an early childhood system.

Additional information about the six selected counties is also available in Sections 3 and 4, regarding the second cut analysis that lead to the identification of the target populations for expansion, model selection to meet the needs of that target populations, and details about implementation plans.

While four counties (Berrien, Calhoun, Kalamazoo, and St. Clair) will not be receiving expansion funds in FY2010, they will be participating in Technical Assistance opportunities with the other six counties (see Section 8). The State program also plans to provide limited financial support for their existing home visiting staff to participate in learning opportunities that will help them to improve model fidelity for their existing evidence-based home visiting programs (e.g., primarily Parents As Teachers). These trainings will be coordinated to include staff from across sites in order to build knowledge and share information and linkages.

SECTION 2: State Home Visiting Program Goals and Objectives

Michigan's Home Visiting Program is designed to both build the home visiting system in the State and to integrate the home visiting system within the comprehensive early childhood system more broadly.

Additionally, Michigan's Home Visiting Program will work toward a common vision for home visiting through engaging partners in a collaborative process to plan and implement this grant, and by developing and implementing policies, procedures, standards, and funding mechanisms that support common goals. The Home Visiting Program will also strengthen the State's home visiting infrastructure and improve 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. Finally, the State's Home Visiting Program will lead to positive outcomes for children and families by improving child health and safety, supporting healthy development, reducing family violence, improving maternal child health, and encouraging economic self-sufficiency. Because the grant is coordinated by our Title V agency, with oversight by the GSST, positive steps have been taken to link and integrate this grant with other programs and systems (ELAC, LAUNCH, ECCS, etc.) that relate to MCH and overall early childhood well being.

The relationships between the Program's inputs, strategies, outputs, and outcomes are articulated in the Program's logic model, included as Attachment 4.

The specific goals and objectives of Michigan's Home Visiting Program include:

Goals:

1. To create a family-centered, evidence-based, data-driven home visiting system that will improve the health and well-being of families and children in high need communities.
2. To create a well integrated, comprehensive, high-quality early childhood system that will improve the health and wellbeing of families and children in all communities.

Strategies:

1. Achieve a common vision through collaborative planning & partner engagement
2. Use the evidence-base to build the home visiting infrastructure
3. Deliver home visiting services with model fidelity

Three Year Objectives – Infrastructure Building:

By the third year of building the State's home visiting infrastructure, Michigan's Home Visiting Program will have ***used the evidence-base and data to improve the quality of the home visiting system***, as evidenced by achieving the following objectives:

1. The percentage of home visiting programs that report that they use continuous quality improvement methods, including using data to identify problems and improve implementation fidelity, will increase annually.
2. The percentage of programs reporting that they have the training and technical assistance they need to implement an evidence-based model with fidelity will increase annually.
3. The percentage of agencies that administer home visiting funding that report that they use cross-system data to identify poorly performing programs and provide assistance to improve quality or end programs, will increase annually.
4. The percentage of programs reporting that the referral and intake process in their community is effective and efficient will increase annually.
5. The percentage of programs reporting that their home visiting workforce meets core competencies will increase annually.

Five Year Objectives – Infrastructure Building:

By the fifth year of building the State's home visiting infrastructure, Michigan's Home Visiting Program will have *achieved a common vision for home visiting through collaborative planning and partner engagement*, as evidenced by achieving the following objectives:

1. All stakeholders in the home visiting system are included as members of workgroups responsible for the planning and implementation of the Home Visiting Program, including parents and families, state and local partners, and governmental and non-governmental partners.
2. Policies supporting interagency collaboration are implemented, including policies supporting data sharing, integration of data systems, blending and braiding of funding streams, and common outcome measurement.
3. State and local funding for home visiting remains stable or increases and is used to support both achieving model fidelity and expanding evidence-based services to more families.

By the fifth year of building the State's home visiting infrastructure, Michigan's Home Visiting Program will have *used the evidence-base and data to improve the quality of the home visiting system*, as evidenced by achieving the following objectives:

1. The number of families that can be served by home visiting programs that are implementing an evidence-based model with fidelity in high need communities will increase annually.
2. The percentage of home visiting programs in Michigan that are implementing an evidence-based model with fidelity will increase annually.
3. The number of families served by home visiting programs in Michigan that are implementing an evidence-based model with fidelity will increase annually.

Three Year Objectives – Participant Outcomes:

By the third year of program expansion, Michigan's State Home Visiting Program will *expand home visiting programs that demonstrate model fidelity and reduce child injuries, child abuse, neglect, or maltreatment and reduce emergency room visits*, as evidenced by achieving the following objectives:

1. By the third year of program expansion, 90% of Home Visiting Program participants will be provided with information on injury prevention, safe sleep, and car seat safety.
2. By the third year of program expansion, the percentage of Home Visiting Program participants with a CPS referral by their home visitor will have decreased annually.
3. By the third year of program expansion, the percentage of Home Visiting Program participants with a CPS category 1, 2, or 3 substantiated case of child maltreatment will have decreased annually.
4. By the third year of program expansion, the percentage of Home Visiting Program participants with a first time CPS category 1, 2, or 3 substantiated case of child maltreatment will have decreased annually.

By the third year of program expansion, Michigan's State Home Visiting Program will *expand home visiting programs that demonstrate model fidelity and improve school readiness and achievement*, as evidenced by achieving the following objectives:

1. By the third year of program expansion, Home Visiting Program participants will demonstrate statistically significant and positive changes between baseline and one year

on a standardized instrument designed to measure support for learning and development in the home environment such as the Parenting Stress Index.

2. By the third year of program expansion, Home Visiting Program participants will demonstrate statistically significant and positive changes between baseline and one year on a standardized instrument designed to measure knowledge of child development such as the Protective Factors Survey.
3. By the third year of program expansion, Home Visiting Program participants will demonstrate statistically significant and positive changes between baseline and one year on a standardized instrument designed to measure parenting behaviors such as the Parenting Stress Index.
4. By the third year of program expansion, Home Visiting Program participants will demonstrate statistically significant and positive changes between baseline and one year on a standardized instrument designed to measure parent stress such as the Parenting Stress Index.
5. By the third year of program expansion, children participating in the Home Visiting Program will demonstrate statistically significant and positive changes between baseline and one year on a standardized instrument designed to measure social behavior and emotional regulation such as the Parenting Stress Index.

By the third year of program expansion, Michigan's State Home Visiting Program will ***expand home visiting programs that demonstrate model fidelity and decrease the risk of domestic violence***, as evidenced by achieving the following objectives:

1. By the third year of program expansion, 90% of Home Visiting Program participants will be screened for domestic violence.
2. By the third year of program expansion, 90% of Home Visiting Program participants who are experiencing domestic violence will be referred to services.

By the third year of program expansion, Michigan's State Home Visiting Program will ***expand home visiting programs that demonstrate model fidelity and improve coordination and referrals for other community resources and supports***, as evidenced by achieving the following objectives:

1. By the third year of program expansion, 90% of Home Visiting Program participants will receive an assessment to identify their referral needs.
2. By the third year of program expansion, 90% of Home Visiting Program participants with a need for additional services will receive needed referrals.
3. By the third year of program expansion, agencies administering the Home Visiting Program will increase the number of MOUs or other formal agreements they have in place with social service agencies.

Five Year Objectives – Participant Outcomes:

By the fifth year of program expansion, Michigan's State Home Visiting Program will ***expand home visiting programs that demonstrate model fidelity and improve maternal and child health***, as evidenced by achieving the following objectives:

1. By the fifth year of program expansion, the percentage of Home Visiting Program participants who are pregnant at the time of enrollment that receive the recommended number of prenatal visits will have increased annually.

2. By the fifth year of program expansion, the percentage of Home Visiting Program participants with subsequent pregnancies 0-12 months postpartum will have decreased annually.
3. By the fifth year of program expansion, 90% of Home Visiting Program participants who are mothers will have been screened for maternal depressive symptoms and, if needed, received a referral.
4. By the fifth year of program expansion, the percentage of children served by the Home Visiting Program who are up-to-date with well child visits will have increased annually.

By the fifth year of program expansion, Michigan's State Home Visiting Program will ***expand home visiting programs that demonstrate model fidelity and improve family economic self-sufficiency***, as evidenced by achieving the following objectives:

1. By the fifth year of program expansion, the mean number of hours per week Home Visiting Program participants spend in paid work, education, or unpaid child care will increase between baseline and one year of enrollment.
2. By the fifth year of program expansion, 90% of Home Visiting Program participants will receive an assessment regarding their health insurance status and, if needed, received a referral.

SECTION 3: Selection of Proposed Home Visiting Model(s) and Explanation of How the Model(s) Meet the Needs of Targeted Community(ies):

The *SIR for the Submission of the Updated State Plan for a Home Visiting Program* stated that seven home visiting models were determined to meet the evidence-based criteria established by HRSA and ACF on the basis of a systematic review conducted through the HomVEE study (<http://homvee.acf.hhs.gov/>) and the public comments received in response to the Federal Register Notice regarding evidence criteria. Soon after the *SIR* was issued, the Michigan HVWG decided that it would select four of the seven models for possible implementation.

This decision was based on the fact that these four models were already being implemented in two or more of the ten top-ranked counties, providing a foundation upon which to build. This was deemed an important consideration, given that we must begin to show progress toward meeting legislatively-mandated benchmarks by March 2013, only about 18-20 months after our *Updated State Plan* is approved and funds can be expended for direct services. We expect to proceed to full implementation more quickly using models with which we have some experience, thereby increasing the likelihood that we will be able to reach the benchmarks on time. Also, there are fiscal efficiencies to be realized in limiting the number of models to be funded in the early stages of this system-building initiative.

The four selected models are as follows:

1. Healthy Families America (HFA)
2. Nurse-Family Partnership (NFP)
3. Parents as Teachers (PAT)
4. Early Head Start – Home-Based Option

The HVWG also decided that rather than start new programs from scratch, FY2010 funds would be provided to add service slots to already-existing programs that are operating with fidelity, as

verified by the model developer's office. Again, the rationale for this was that expanding the number of families served by existing programs would better position us to meet the benchmarks within the required timeframes, as it can take several years for a new program to meet the standards developed by the national model developer's office. It is also more cost-effective to expand existing programs than to start new ones, an important consideration given our FY2010 funding level.

As referenced in Section 1, the purpose of *Part II* of the Community Readiness Assessment was to gather additional, more substantial information about existing home visiting programs for the *Updated State Plan*. The chart below summarizes the findings of the surveys, listing the results for the evidence-based models that are most frequently implemented in Michigan:

Table 2. Existing Evidence-Based Models Operating in Fidelity

	PAT	EHS	NFP	HFA
Genesee	O	X		
Saginaw	O	X		
Kent	O	X	X	X
Kalamazoo	-		X	
Calhoun	O	X	X	
Berrien	-	X	X	
St. Clair	O	X		
Wayne	-	X		O
Ingham	O	X		
Muskegon	-	X		X

X = operating in fidelity per the national model office (EHS varies in % of services that are home-based)

O = operating full model, not in fidelity but working toward current fidelity standards

- = operating using parts of model, not yet working toward fidelity

Full tables that include the additional, updated information about the existing home visiting programs in each county were provided in the Supplemental Information Request: Needs Assessment. Updated tables are being compiled and will be available upon request.

Subsequent to the Community Readiness Assessment described in Section 1, the six counties selected to receive service expansion funding conducted a second-cut data analysis in order to identify the targeted at-risk population (highest-risk community) within the county. The six counties identified their respective targeted at-risk communities using the best available national, state and local data. Several data resources were provided to the counties by the State:

- American Community Survey
- Kids Count National Data Center, and Kids Count in Michigan

- State Vital Records data
- State data about infant mortality, low birthweight and preterm birth rates, by Minor Civil Division
- State data about mortality rates, by race
- Analysis used for the Statewide Needs Assessment risk scoring

Some counties had other data sources.

The State held a conference call with each of the six communities to discuss the results of their analysis, including which target population they had decided to focus on due to a high level of risk/need, what types of service gaps existed for that population, and which model would best address the needs of that population. Results of the second cut data analysis for each of the six counties are included in Attachment 3 (Section B). These descriptions address how the model(s) will meet the needs identified in the targeted at-risk populations, including the following:

1. The evidence-based home visiting program model has been selected for implementation in the targeted at-risk community.
2. How the selected model addresses the particular risks in the targeted community and the needs of the families residing there.
3. How the targeted community will be involved on an ongoing basis throughout the duration of this program (other than as program participants).
4. The county's current and prior experience with implementing the selected model.
5. The county's current capacity to increase the number of families served using this model.
6. A plan to ensure implementation with fidelity to the model.
7. Anticipated challenges and risks of the selected program model, and the county's proposed response to these challenges.
8. Anticipated technical assistance needs.

The home visiting models selected for expansion were identified based on the fact that they were:

1. Already operating with fidelity in the communities, and
2. Addressed the needs of the targeted at-risk populations that were identified in the second cut analysis.

Based on these two pieces of information, it was determined that Michigan would expand two different models in FY2010. The chart below specifies the model that will be implemented, with which target populations within each of the six selected counties, and the projected number of families to be served each year (number to be served is based on the requirements/restrictions of the national model).

Table 3: Expansion Plans

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

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

An exception to the fidelity requirement was made for Wayne County; the county was deemed ‘Somewhat Ready’ to move forward with system development and expand services, however there are no evidence-based models operating in fidelity to the national model that provide services to their selected target population/selected geographic area. There are, however, two Healthy Families America models operating that can serve that population/geographic area, that with some support can first become affiliated, then develop a clear plan with milestones and timelines for becoming certified with HFA. Before agreeing to this exception, the State Home Visiting program staff worked with staff from the national Healthy Families America office to discuss a tentative plan to ensure that fidelity is achieved, and in as short a timeline as possible.

Because we are expanding existing programs, each of the local communities (and the State) have prior experience with implementing these models. The models are already operating with fidelity, and are already receiving support to measure and ensure quality implementation. The models will continue to be assessed for fidelity based on standards established by the national program offices (e.g., Early Head Start and Healthy Families America, see Attachment 1). We have obtained letters of support from each of these offices, and will work with them to establish and carry out a plan for continuous quality improvement, and for technical assistance should we have, at either state or local level, challenges or barriers to ongoing, high quality implementation. Our State-level HVWG includes representatives from the Head Start State Collaboration Office and from other State agencies that provide funding for and monitor Healthy Families America programs in the State, thus state-level experience with these models has been brought to bear. Because the communities have selected these models for expansion, their ongoing involvement with the program is assured.

SECTION 4: Implementation Plan for Proposed State Home Visiting Program

Because the expansion plan (e.g. implementation plan) is individualized to each of the six local communities, information about implementation plans was collected from the LLGs in each county using a *County-Level Home Visiting Program Implementation Template*. The template required responses to the following questions; detailed information is captured, by county, in Attachment 3 (Section C):

1. The name of the entity that will receive Michigan MIECHVP funds to expand service slots.
2. A plan for recruiting, hiring, and retaining appropriate staff for all positions. List each position to be filled.

3. If subcontracts will be used, a plan for recruitment of subcontractor organizations, and how they will recruit, hire, and retain staff.
4. A plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors.
5. The estimated number of families that will be served annually.
6. How program participants be identified and recruited.
7. A plan for minimizing the attrition rates for participants enrolled in the program.
8. An estimated timeline to reach maximum caseload.
9. An operational plan for the coordination between the proposed home visiting program and other existing programs and resources in the community.
10. A plan for obtaining or modifying data systems for ongoing continuous quality improvement (CQI).
11. Anticipated challenges to maintaining program quality and fidelity, and how these challenges will be addressed.
12. A list of collaborative public and private partners (Local Leadership Group member names and organizations).
13. Provision of the following assurances:
 - a. Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments
 - b. Assurance that services will be provided on a voluntary basis
 - c. Assurances that priority will be given to serve eligible participants who:
 - 1) Have low incomes
 - 2) Are pregnant women who have not attained age 21
 - 3) Have a history of child abuse or neglect or have had interactions with child welfare services
 - 4) Have a history of substance abuse or need substance abuse treatment
 - 5) Are users of tobacco products in the home
 - 6) Have, or have children with, low student achievement
 - 7) Have children with developmental delays or disabilities
 - 8) Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

On top of the specific local implementation plans detailed in Attachment 3, the State Home Visiting Program has a more general implementation plan that crosses programs and communities:

- Quality of the expansion programs/slots will already be monitored by the associated national program offices; we will also monitor model quality via our Continuous Quality Improvement teams at both the state and local levels. Because we are expanding existing models, we are tapping into existing local plans for training and supervision, curriculum being used, etc. Each community was asked to include costs for expansion in those areas in their budget and implementation plan, which is detailed in Attachment 3.

- The LLG that was established in each community will be responsible for CQI efforts, and will help coordinate this new home visiting funding with other home visiting programs and efforts, and ensure it is connected and integrated with the local early childhood system. This connection is established, in part, through the requirement that the LLG be a subcommittee of or clearly linked to the local Great Start Collaborative, which is responsible for larger early childhood system work in each county. Technical assistance to the six local communities will focus on coordination with other home visiting programs and other components of the larger system; a recent evaluation of Great Start Collaboratives by the Early Childhood Investment Corporation (ECIC) used network mapping to reveal existing connections, resource sharing, and coordination. Through the resources of both the ECIC and this grant, improvements to coordination and networking will be made, which will help build the local system.
- At the State level, the Great Start System Team is responsible for reviewing and initiating action to address policy issues and barriers. The agencies represented by the GSST have signed the Memorandum of Concurrence (see Attachment 5), and are working on a more detailed Memorandum of Understanding pertaining to home visiting. In addition, the GSST has or is establishing subcommittees to work on improving developmental screening efforts, messaging about early childhood and especially the importance of social-emotional wellness, and workforce development/core competencies for home visitors. With the concurrence of the GSST, another subcommittee could be established to look at infrastructure related to paperwork, as well as coordinated intake and collection of standardized demographic data for home visiting programs and perhaps beyond. The HVWG will continue to spearhead efforts related to home visiting, working in close connection with the GSST. A list of State partners for this home visiting initiative is included in Section 6.
- The GSST is starting to study means to move forward with establishing a coordinated point of entry to access services, which would address issues identified by both parents and providers regarding access. It would also assist the State to ensure that available service slots are filled, and reduce duplication of services. Efforts in this area are also being driven by a CMS Patient Centered Medical Home grant, which focuses on access to community resources and services; a subcommittee examining this component for the pediatric population has been meeting with some components slated for development and review this summer.
- Under the Early Learning Advisory Council, work has begun to analyze data system barriers and issues; this work is linked to a similar, broader effort currently underway through the Governor's office, with the goal of being more effective and efficient in the way in which the State collects, stores, and shares data to support measurement of progress and outcomes.
- As referenced earlier, we have obtained letters from the four national program offices that we originally identified as most common in Michigan – NFP, HFA, PAT, and EHS. We have had discussions with both HFA and EHS about our specific implementation plans. HFA will be working closely with programs in Wayne County to improve fidelity, and will also work with us regarding expansion of the HFA programs in Muskegon and Kent counties. EHS has indicated that they are available to provide TA and assistance as needed. Working across

communities, we will seek to establish a regular call with HFA and with EHS to review progress and issues, and identify plans to address any issues identified.

- The State will be establishing contracts with the local agencies that are identified as expanding home visiting programs as soon as our Updated State Plan is approved (see Attachment 3 for information about local agencies). The contracts will specify required activities to be accomplished by the subcontractors, such as obtaining training, curriculum, supplies, and will also include specifications around hiring, training, reporting, data collection, TA participation, and maintaining fidelity to model standards related to supervision, staffing requirements, data collection, timeline to reach caseload size. Contracts will also address expansion in terms of agreed upon recruitment and screening mechanisms, and use of the national program offices and their TA to assist with quality expansion and service provision.

The State assures that:

- The Michigan Home Visiting Program is designed to result in participant outcomes as noted in the legislation; details about our measurement plan follow in Section 5;
- Individualized assessments will be conducted of participant families of participant families and that services will be provided in accordance with those individual assessments;
- Services will be provided on a voluntary basis;
- The State will comply with the Maintenance of Effort requirements; information about Maintenance of Effort baseline expenditures is included in the Budget Narrative (Attachment 6);
- Priority will be given to serve participants representing the targeted at-risk population in each of the six communities receiving expansion funding, which may include families who:
 - Have low incomes;
 - Are pregnant women who have not attained age 21;
 - Have a history of child abuse or neglect or have had interactions with child welfare services;
 - Have a history of substance abuse or need substance abuse treatment; Are users of tobacco products in the home;
 - Have, or have children with, low student achievement;
 - Have children with developmental delays or disabilities;
 - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

SECTION 5: Plan for Meeting Legislatively-Mandated Benchmarks

The Home Visiting Program requires that Michigan make progress in six benchmarks identified in the Affordable Care Act. In order to demonstrate progress in these legislatively-mandated benchmark areas, Michigan will collect data on all benchmark areas and all constructs under each benchmark area. Michigan's Plan for measuring progress in each construct under each

benchmark is described in detail in Table 4 in Attachment 7. Table 4 includes a list of all benchmarks and constructs, measures, data sources, the population assessed by each measure, data elements, Michigan's data collection schedule, and definitions of improvement. This component of the program will be administered by an outside contractor, the Michigan Public Health Institute (MPHI), in collaboration with the State HWWG and other project partners.

Participants

Data will be collected and reported for all eligible families who have been enrolled in the home visiting program and receive services funded with the MIECHV Program. In its first year, the Program will fund expansion in six counties delivering two model programs. Approximately 72 families will be served by Early Head Start and 150 families will be served by Healthy Families America using this funding mechanism for a total potential $n = 222$. Data will be collected on this population as a whole, no sample will be drawn. Sampling may be used as the program expands. As noted in Table 4, Attachment 7, the specific population assessed varies by construct. Definitions are given below.

- Adult program participants include adult caregivers who are present during at least half of the home visits. Adult caregivers who participate in supplemental programming, such as play groups or parent education, but who do not participate in home visits will not be included. Each family will include one or more adult program participants.
- Mothers include female adult caregivers who participate in the program.
- Mothers who are pregnant at enrollment include mothers who are pregnant or who become pregnant while enrolled in the program.
- Child program participants and target child/children include the young children in the family who are the responsibility of adult program participants who are targeted by the program according to the definition provided by the model.
- All children in the home include the target child/children and other children in the home who are the responsibility of the adult program participants but may not meet model eligibility requirements (i.e., older children).
- Home visiting agencies include the agencies in the six expansion communities that are delivering home visiting services with MIECHV funding.

In addition to collecting data regarding progress toward benchmarks, demographic and service utilization data will be collected from participating families and expansion programs. Every effort will be made to ensure demographic data are collected in a way that aligns with demographic data collected by other early childhood initiatives. For example, conversations are underway with the evaluators from Michigan's Maternal and Infant Health Program (MIHP) and Michigan's Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) to coordinate and align data collection efforts. Additionally, the Great Start System Team (GSST) and the ELAC are moving forward with work (as described in Section 6) that will propose strategies for improving data alignment across programs. In anticipation of improved alignment between data systems, it will be important to define demographic data elements at a very detailed level (e.g., income in dollars rather than income categories) initially to allow for comparability across programs and other data systems.

Demographic data elements will be collected and maintained in an electronic database (or MIS system once it becomes available) on all adult program participants and the children they care for

and will include racial and ethnic background, gender, birth date, marital status, type of housing, adult level of education, insurance status, child's exposure to languages other than English, and family socioeconomic indicators including family income and employment status. Data will also be gathered on the types of public assistance received by participating families. Families will be screened for substance abuse, domestic violence, and maternal depression; and the results will be documented in the family's record as well. Data will be analyzed to assist with understanding and evaluating the progress of families being served by the program funded through MIECHV.

Additionally, service-utilization data will be collected on each family, documenting the intensity and duration of home visiting services, the other services provided by the home visiting program, and the referral needs addressed by the program. Variables collected will include date the family began the program, date the family exited the program, and the reason they exited the program. In addition, the types of services the family received will be documented, including the number of service hours planned and received by the family and, more specifically, the number of hours of home visiting planned and received. As noted, referral needs and completed referrals will be documented as well. All data collected will be used for CQI, to set improvement targets, and to contextualize progress against benchmarks.

Measures

At least one measure has been identified for each construct within each benchmark, as described in Table 4, Attachment 7, and articulated in the program objectives in Section 2. Several of these measures require the use of developmentally appropriate, standardized instruments or scales from instruments. Instruments and scales were selected based on several considerations, including alignment with the constructs, reliability and validity, prevalence of instrument use among early childhood programs in the State, time to complete, training requirements, cost, and overall burden of data collection.

Given the need to balance these considerations, the Michigan Home Visiting Program intends to implement the use of these tools with some degree of flexibility. Local home visiting service providers will have the option to propose the use of a comparable tool to measure a construct, and these proposals will be considered by the State CQI team (the team is described in Section 7). Additionally, the Michigan Home Visiting Program intends to move toward a more standardized approach to data collection that crosses home visiting and other programs in the State. As this work unfolds, the Program may make adjustments in the instruments used to measure progress on constructs. Finally, the HVWG would like to identify strategies to gather more rigorous data on developmental progress, using instruments such as the Devereux Early Childhood Assessment or the Infant and Toddler Development Assessment, but is concerned about data collection burden. However, over time, the Michigan Home Visiting Program intends to shift toward more rigorous measures of developmental outcomes.

The following measures were selected to measure progress toward benchmarks. The reliability and validity of each measure is described, as is the population targeted by each measure, and the training and qualifications required for administering and scoring. The benchmarks and constructs addressed by each measure are listed as well, and this information is repeated in Table 4, Attachment 7.

Parenting Stress Index

The Parenting Stress Index (PSI) long form includes 120 items and is intended to produce a diagnostic profile of both parent and child stress. The PSI long form takes about 20 to 30 minutes to complete. The instrument contains thirteen sub-scales within four major domains including total stress, child domain, parent domain, and life stress. Sub-scales contained within the child domain measure the child's distractibility/hyperactivity, adaptability, reinforcement of the parenting experience, demandingness, mood, and acceptability. The remaining sub-scales are found within the parent domain and measure competence, isolation, attachment, health, feeling of role restriction, depression, and spousal support. Data collected through the PSI will address the following constructs within Benchmark III Improvement in School Readiness and Achievement:

- Parent support for children's learning and development
- Parenting behaviors and parent-child relationship
- Parent emotional well-being or parenting stress
- Child's positive approaches to learning including attention
- Child's social behavior, emotional regulation, and emotional well-being

Internal consistency and test-retest reliability has been tested in multiple studies and has consistently reached acceptable levels of reliability with an alpha coefficient of .65 or higher. Concurrent validity has been measured across studies at .50 or higher. Formal training on the PSI is not required, reviewing the manual provided is sufficient; however, the instrument must be scored by a trained psychologist or social worker or someone with a similar background. Parents completing the PSI must have at least a 5th grade reading level. The PSI can either be hand scored or scored using the software package offered by the publisher. If the instrument is hand scored, basic division skills are required. If the instrument is administered using the software, then the instrument will be automatically scored through the software package.

Protective Factors Survey

The Protective Factors Survey (PFS) is designed to be used with parents or caregivers receiving child maltreatment prevention services. The instrument measures protective factors in five areas including family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. Data collection through the PFS will address the following constructs within Benchmark III Improvements in School Readiness and Achievement:

- Parent knowledge of child development and of their child's developmental progress
- Parent emotional well-being or parenting stress

Additionally, data collection will address the following construct within Benchmark V Family Economic Self-Sufficiency:

- Household income and benefits

The PFS has established reliability and validity through four national field tests. The reliability of each subscale of the PFS is as follows: Family Functioning/Resiliency .89; Social Support .89;

Concrete Support .76; and Nurturing and Attachment .81. The PFS user manual lays out each step of the assessment process and serves as a training guide for those administering the survey. The instrument is a paper and pencil survey and can be completed in about 10-15 minutes. The first section of the survey is completed by program staff and the second section by the parent or caregiver. Each item on the survey is answered using a seven-point response scale and specific instructions for scoring completed surveys are addressed in the PFS user manual.

Ages and Stages Questionnaire (Third Edition)

The Ages and Stages Questionnaire (ASQ) 3rd edition is a series of nineteen parent-completed thirty item questionnaires that help screen infants and young children for developmental delays during the first five years of life. The ASQs' are completed by the parent or caregiver of children ages 2 to 60 months. Five key developmental areas are covered in the questionnaires including communication, gross-motor, fine-motor, problem solving, and personal-social. Data collected through the ASQ will be used to identify delays in each of these areas, and they will be used specifically to address the following constructs within Benchmark III Improvements in School Readiness and Achievement:

- Child's communication, language, and emergent literacy
- Child's general cognitive skills
- Child's physical health and development

Test-retest reliability is 94 percent and inter-rater reliability between observers is 94 percent. Concurrent validity between the ASQ and other measures including the Revised Gesell and Armatruda Developmental and Neurological Examination and the Bayley Scales of Infant Development measured 84 percent overall and ranged from 76 percent for the 4-month questionnaire to 91 percent for the 36-month questionnaire. Questionnaires are written at a 6th grade reading level and take approximately 15 minutes for the parent or caregiver to complete and 1 minute to score. Minimal training is required to score the ASQ.

Conflict Tactics Scale (Revised)

In order to screen families for domestic violence, programs will be required to use a standardized assessment instrument. The instrument that will be recommended is the Revised Conflict Tactics Scale (CTS2), which is used to provide rates of prevalence and annual prevalence (or incidence) of spousal violence as well as the occurrence and severity of specific aspects of spousal conflict including negotiation, physical aggression, physical assault, physical injury, and sexual coercion. The CTS2 is a thirty-nine item self-report measurement tool. Data collection through the CTS2 will address the following construct within Benchmark VI Crime or Domestic Violence:

- Screening for domestic violence

Reliability ranges from .79 to .95 and the CT scales have been studied extensively to establish their validity. The thirty-nine items are rated on an eight-point frequency scale: never, once, twice, 3-5 times, 6-10 times, 11-20 times, more than 20 times, and it did happen before but not in the past year. Additionally, five subscales are associated with each scale containing minor and severe levels.

Pregnancy Risk Assessment Monitoring System Survey

A subset of items from Michigan's Pregnancy Risk Assessment Monitoring System (PRAMS) Survey will be used to gather data elements related to maternal and child health. The PRAMS Survey collects population-level information about maternal health status, health behavior, knowledge, and experiences before, during, and shortly after pregnancy. The survey is completed by the mother. The data burden of completing the PRAMS in its entirety would be too great; however using PRAMS questions will provide structure to data gathering efforts in this construct area and will provide comparability to population data. Data collected via PRAMS Survey items will address the following constructs within Benchmark I Improved Maternal and Child Health:

- Prenatal care
- Interbirth intervals
- Well-child visits
- Prenatal use of alcohol or illicit drugs
- Preconception care
- Breastfeeding
- Maternal and child health insurance status

Additionally, data collected through the PRAMS Survey will be used to address the following construct within Benchmark V Family Economic Self-sufficiency:

- Health insurance status

The PRAMS Survey has been used extensively by the CDC across the country and across multiple populations.

Edinburgh Postnatal Depression Scale

In order to screen pregnant women and mothers for symptoms of depression, programs will be required to use a standardized screening instrument. The Edinburgh Postnatal Depression Scale is used to screen women of childbearing age for depression during the postpartum period. The measurement tool is composed of ten questions and is completed by the mother. The instrument is designed to detect symptoms of postnatal depression but it is not used to detect the severity of depression symptoms. Data collection through the Edinburgh will address the following construct within Benchmark I Improved Maternal and Child Health:

- Screening for maternal depressive symptoms

The concurrent validity of the instrument has been found to be .50 or higher across studies. Training on the Edinburgh is not necessary and the instrument can be accessed online. The instrument typically takes about 5 minutes to complete and another 5 minutes to score. Responses are scored on a scale of 0, 1, 2, or 3 according to increased severity of the symptom. Items that are marked with an asterisk are reversed scored (3, 2, 1, or 0) and the total score is determined by adding together the scores for each of the ten items.

Beck Depression Inventory II

When the Edinburgh is not an appropriate instrument to use to screen for depression (i.e. the adult completing the instrument is not in the perinatal period) the Beck Depression Inventory II will be used to screen for depression. The Beck Depression Inventory II (BDI-II) is designed to screen and assess the severity of depression in individuals ranging from 13 to 80 years of age. It is a self-administered tool containing twenty-one items to assess the severity of depression in diagnosed patients as well as detect possible depression in undiagnosed patients. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. Data collected through the BDI-II will address the following construct within Benchmark I Improved Maternal and Child Health:

- Screening for maternal depressive symptoms

Internal consistency and test-retest reliability have been found to be at .65 or higher for the BDI-II and concurrent validity has been measured at .50 or higher. Training on the BDI-II is not required; staff need only to familiarize themselves with the inventory. It takes 5-10 minutes to complete the inventory and it takes only a few minutes to score. Responses are scored on a four-point scale ranging from 0-3 and the total score is calculated by adding together each of the twenty-one items' scores.

In addition to collecting data through the above instruments, existing data sources within Michigan as well as an annual survey will be used including:

Michigan Department of Human Services (DHS) Child Protective Services (CPS) Data

The Michigan DHS CPS registry will be used to obtain information about reported and substantiated child abuse and neglect. The names of program participants will be provided to DHS on an annual basis and DHS will run the names against the CPS database. These data will be used to measure progress on following constructs within Benchmark II Child Injuries, Child Abuse, Neglect, Maltreatment & Reduction in ER Visits:

- Reported suspected maltreatment for all children in the program
- Reported substantiated maltreatment for children in the program
- First-time victims of maltreatment for children in the program

Michigan Care Improvement Registry (MCIR)

The MCIR will be used to obtain information about immunizations and lead testing. MCIR is a statewide system used to collect reliable information about immunizations and share it with registered users through an online interface. MCIR has expanded beyond immunization data over the years and now includes information about blood lead testing. Home visiting programs will work in partnership with authorized MCIR users at their local health departments to look up the names of children participating in their Home Visiting Program in MCIR to identify if they are up-to-date with their immunizations and, if the child is eligible, if they have had a blood lead test. Data collected through the MCIR will address the following construct within Benchmark III Improvements in School Readiness and Achievement:

- Child's physical health and development

Client Record

Each of the data elements described above will be documented in the client records. Several additional data elements will be documented in the client records. Data collected through the client record will address the following benchmarks and constructs:

Benchmark II: Child Injuries, Child Abuse, Neglect, Maltreatment & Reduction in ER Visits:

- Information provided or training of participants on prevention of child injuries
- Visits for children to the ED from all causes
- Visits of mothers to the ED from all causes
- Incidence of child injuries regarding medical treatment

Benchmark III: Improvements in School Readiness and Achievement:

- Child's communication, language, and emergent literacy (documented referral)
- Child's general cognitive skills (documented referral)
- Child's physical health and development (documented referral)

Benchmark VI: Coordination of Referrals for other Community Resources and Supports:

- Number of families identified for necessary services
- Number of families that required services and received a referral to available community resources
- Number of completed referrals

Benchmark I: Improved Maternal and Child Health:

- Prenatal Care (documented referral)
- Breastfeeding (documented referral)

Benchmark V: Family Economic Self-sufficiency:

- Employment or education of adult members of the household
- Health insurance status

Home Visiting Agency Survey

Michigan will develop/modify and complete an annual Home Visiting Agency Survey to capture information about the agencies that receive expansion funding. This survey may build on existing instruments and data collection efforts currently underway through other programs and partnerships to reduce data collection burden and to improve coordination and collaboration across the early childhood system. The information captured through the survey will address objectives related to infrastructure building, as well as the following constructs within

Benchmark VI: Coordination of Referrals for other Community Resources and Supports:

- MOUs or other formal agreements with other social security agencies in the community
- Number of agencies with which the HV provider has a clear point of contact in the collaborating community agency that includes regular sharing of information

Data Collection & Submission

Upon program enrollment, each family will undergo a consent process. This consent process will include multiple components, including consent to access MCIR and CPS records to collect information about immunization, lead testing, and CPS referrals and substantiations.

Data will be collected from program participants by home visitors and other agency staff. Baseline data will be collected within the first few home visits and annual data will be collected 12 months after the date of enrollment. MCIR data will be collected from local health departments by agency staff as well. Initially, data will be entered by program staff into an electronic database developed and distributed to each program by MPHI. Eventually, data will be entered into an online home visiting Management Information System (MIS) (see Section 7 for more information regarding the MIS).

Home visiting programs will be required to submit complete and up-to-date data regarding program participants, including the results of all measures described above in Table 4, Attachment 7, on a quarterly basis. The State CQI team will review these datasets each quarter for completeness and quality of the data (see Section 7 for more information regarding the role of the CQI team and the CQI process). The State CQI team will provide regular feedback to Local CQI teams based on the State CQI team's review of the data. These discussions will guide local and State CQI efforts, and they will be utilized to identify training and technical assistance needs.

Data will be collected from CPS records by DHS. Each program will provide DHS with the names and last four digits of the SSN for the adults and children in each family served by the program. DHS will run this list against the CPS database and provide a report that includes the number of families with a CPS report and Category 1, 2, 3, and 4 substantiated case of child abuse or neglect. They will be asked to breakdown results in several different ways, including by program, by target child v. other children in the home, by type of maltreatment, and by participating adult v non-participating adults. Findings will be reported, in aggregate, to MPHI and to the home visiting agencies.

Agency level data will be collected on an annual basis through a survey. The survey will be administered electronically, and standard follow up procedures will be implemented to ensure a high response rate. The survey will be programmed by MPHI and data will be downloaded to and housed on MPHI's secure server. This method may be modified if it is possible to align this survey with other, similar data collection efforts underway in the State.

Data Analysis

Michigan will demonstrate improvement in three years in four of the benchmark areas as measured by half the constructs in each benchmark areas. In five years, Michigan will demonstrate progress in all six benchmark areas as measured by half of the constructs in each area. The benchmarks targeted for improvement in three years include: child injuries, child abuse, neglect, or maltreatment and reduction in ER visits; improvements in school readiness and achievement; crime or domestic violence; and coordination and referrals for other community resources and supports. The benchmarks targeted for improvement in five years include: improved material and child health, and economic self sufficiency. The constructs that will be

reviewed to indicate improvement on a benchmark are listed in bold text in Table 4, Attachment 7.

In large part, the analysis plan will align with the definition of improvement articulated in Table 4. Data will be collected so that it can be aggregated across programs through the use of common data elements and reporting requirements; however, data will also be used at the local level to identify indicators of program improvement and model fidelity. Local analyses will be designed to align with CQI targets and projects as described in Section 7. State level data will be analyzed by characteristics of the population served, including factors such as income, employment, education, race and ethnicity, and presence of major risk factors including maternal depression, substance abuse, and/or domestic violence. State level data will also be analyzed by characteristics of the programs including the model used, service provision, and model fidelity.

Reporting

Michigan will use the template developed by HHS to report aggregate data on benchmark progress at three and five years. Additionally, MPHI will provide quarterly and annual reports to the State HVWG describing CQI activities, state and local program implementation, and progress toward benchmarks. Once implemented, the MIS system will be designed to provide real time reports, as described in Section 7.

Data Safety & Monitoring

Data collected by the home visiting programs funded through MIECHV will be provided to MPHI. Data will be transmitted through an encrypted file that will be stored on the MPHI network in a project folder that restricts access to only project staff. Any hard copy data provided will be stored in a locked file cabinet inside a locked office of project staff. Additionally, MPHI maintains the following security, confidentiality, data access, use, and disclosure policies throughout the institute.

Security

Security of sensitive information is a high priority for MPHI. As such, MPHI uses a combination of an electronic alarm system, locked building, suite, and office doors to maintain the physical security of data stored at MPHI. MPHI network servers are stored in a physically secure room that is locked at all times. Keys to this room are only given to authorized network support personnel. MPHI maintains a firewall to isolate its own internal network from the Internet, and has systems in place to detect unauthorized access to the internal network resources.

Confidentiality & Data Access, Use, and Disclosure

It is MPHI policy that all employees with access to confidential records, reports and data files have the obligation to maintain their accuracy, completeness and confidentiality. It applies equally to information and data processing and communication, whether or not data are owned by or located at the Michigan Public Health Institute. Guidance on principles and specific procedures to assure this confidentiality are provided to all employees at MPHI.

When the project ceases to be funded paper files containing personal identifiers will be destroyed. Back-up files will remain in storage. Research files of data with no names, addresses, dates of birth, or race may be retained. Any published analyses of data will present information

in aggregate form only. All data collected for all phases of the project are subject to the same physical security protocols. All MPHI staff that will have access to individually identifiable data about the respondents have attended MPHI sponsored trainings on the importance of maintaining confidentiality of sensitive data and signed agreements to keep the respondent information confidential.

Anticipated Barriers & Challenges

An initiative of this size and scope will not unfold without challenges. The structure of the project will require MPHI to gather data from multiple programs across multiple communities and multiple models. Implementing a data collection and reporting structure that meets the needs of each program, the needs of the State home visiting system, and the federal reporting requirements will, at times, demand balancing competing interests. In order to address this concern, required measures and data elements must strike a balance between being overly general and overly specific, and both demographic and service utilization data must be collected at a very detailed level to allow for comparability across programs and models.

Additionally, Michigan's ability to report progress will be highly dependent on the quality of the data collected locally. Training and technical assistance resources will be in place to encourage quality data collection and entry, and the State CQI team will be highly engaged in reviewing data for quality concerns and providing feedback to local teams.

The design of the programs themselves may provide a barrier to achieving the benchmarks. Early Head Start and Healthy Families America do not have strong, demonstrated outcomes in the area of maternal and child health, for example. However, the model developers recognize the need to meet the benchmarks and, as such, this concern may be unfounded as models expand to include strategies designed to address all benchmarks and constructs.

Finally, in the first year of program expansion the number of participating families at each local agency will be relatively small. As such, program level data will be more useful for program improvement than it will be for making inference from findings. Small numbers will also limit state-level data analysis to some degree; however, as expansion continues, this will become less of a concern.

Qualifications of Investigators

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

actively and effectively participate on State level advisory boards. Dr. Cameron brings extensive knowledge of home visiting evaluation and early childhood system building to the project team.

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

SECTION 6: Plan for Administration of State Home Visiting Program

The Michigan Home Visiting Program is administered by the Michigan Department of Community Health, the Title V agency for the State. The program is a component of Michigan's *Great Start* initiative, which was established in February of 2005 to build a comprehensive early childhood system for young children prior to school entry. The Home Visiting work will be guided by the *Great Start* System Team (GSST). The GSST is made up of the directors of early childhood programs administered by State government. The GSST serves as the State team for the Early Childhood Comprehensive Systems (ECCS) initiative, the State Wellness Council for Project LAUNCH, and now in an advisory role for the new Home Visiting Program. The GSST is co-convened by the Michigan Department of Community Health (MDCH) and the Early Childhood Investment Corporation (ECIC). In 2009, the GSST charged a Home Visiting Workgroup (HVWG) to study existing home visitation programs in the State in order to develop a set of interdepartmental recommendations to more effectively address financing, coordination, administration, common messaging and future investment in home visiting. The workgroup and its subcommittee members will help develop the State applications to respond to the current and future Funding Opportunity Announcements (FOA).

An organizational chart describing the current relationship amongst the State-level agencies and entities, relationship to the GSST and HVWG, and relationship to local partner agencies and entities is in Attachment 8.

The following State agencies and entities have participated in the work of the GSST or in the HVWG related to the funding through the ACA:

Table #5: Participants in the Home Visiting Work Group

STATE LEVEL MICHIGAN DEPT OF EDUCATION	
Name	Role
Lindy Buch	Director, Office of Early Childhood Education and Family Services (which includes both Part C and Part B 619 preschool).
Renee DeMars-Johnson	Supervisor, Infant/Toddler & Family Services (including Part C)
Colleen O'Connor	Education Consultant (Part C and Great Parents, Great Start)
STATE LEVEL MICHIGAN DEPT OF HUMAN SERVICES	
Lisa Brewer-Walraven	Director, Office of Early Education and Care/Federal Liaison
Guy Thompson	Program Director, Children's Protective Services and Family Preservation Program Offices
Jeremy Reuter	Director, Head Start State Collaboration Office
Teresa Marvin	Part C Parent Representative
STATE LEVEL CHILDREN'S TRUST FUND	
Mike Foley	Executive Director
Sarah Davis	Senior Program Development Coordinator
M. Jeffrey Sadler	Departmental Analyst
STATE LEVEL EARLY CHILDHOOD INVESTMENT CORPORATION (ECIC)*	
Joan Blough	Vice-President, Great Start System Planning and Evaluation & ECCS Coordinator
Alissa Parks	Director, Great Start Collaborative Development and Assistance
STATE LEVEL MICHIGAN LEAGUE FOR HUMAN SERVICES	
Jane Zehnder-Merrell	Project Director, Kids Count in Michigan
STATE LEVEL MICHIGAN DEPT OF COMMUNITY HEALTH	
Alethia Carr	MCH Director, Bureau of Family, Maternal and Child Health
Deborah Hollis	Director, Bureau of Substance Abuse and Addiction Services
Sheri Falvay	Director, Mental Health Services to Children and Families
Virolanda Grigorescu	Director, Division of Genomics, Perinatal Health and Chronic Disease Epidemiology
Brenda Fink	Director, Division of Family & Community Health
Nancy Peeler	Manager, Child Health Unit; Project Director for Home Visiting Program

Sheila Embry	Manager, Quality Improvement and Program Development Section, Medical Services Administration
Jackie Prokop	Manager, Ambulatory Benefits Section, Medical Services Administration
Deb Marciniak	Senior Project Coordinator
Joni Detwiler	Public Health Consultant, Perinatal Health Unit
Mary Ludtke	Early Childhood and Collaboration Consultant
Carolyn Foxall	SPF-SIG Coordinator, Substance Abuse
Angela Smith-Butterwick	Women's Treatment Specialist, Substance Abuse
Tiffany Kostelec	Public Health Liaison to Part C
Lin Dann	Project Director for Project LAUNCH
Mary Kleyn	Newborn Screening Epidemiologist
Penny Verran	Home Visiting Program Analyst
LOCAL LEVEL TEN IDENTIFIED COUNTIES	
Name	Role
Great Start Collaborative Directors	Helped gather Home Visiting Program information from partner agencies, member
Local Public Health, Health Officer	Helped gather Home Visiting Program information in Public Health
Head Start Directors	Provided data regarding Head Start Community Needs Assessments
Local CAPTA Grantees	Provided data from CAPTA Needs Assessments
Local Substance Abuse Coordinating Agencies or Providers	Shared information about programs and potential connections.
Local Leadership Group for Home Visiting	Includes all of the above, plus additional members, to guide local component of ACA Home Visiting Program. Will act as local CQI team.

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

As outlined above, Michigan's *Great Start* initiative was established in February of 2005 to build a comprehensive early childhood system for young children prior to school entry. The Great Start State Team (GSST) is made up of the directors of early childhood programs administered by State government. It is co-convened by the Michigan Department of Community Health (MDCH) and the Early Childhood Investment Corporation (ECIC). The GSST serves as the State team for the Early Childhood Comprehensive Systems (ECCS) initiative, the State Wellness Council for Project LAUNCH, and now provides oversight to the Michigan Home

Visiting Program. The GSST will also be taking on a role in relation to guiding the State's Strengthening Families initiative.

In 2009, the GSST charged a Home Visiting workgroup (HVWG) to study existing home visitation programs in the State in order to develop a set of interdepartmental recommendations to more effectively address financing, coordination, administration, common messaging and future investment in home visiting. When DHHS announced the *Maternal, Infant, and Early Childhood Home Visiting Program* in June 2010, it was determined that the HVWG would serve in an advisory role for the Michigan's new Home Visiting Program. Since then, the HVWG has developed a number of sub-committees to prepare Michigan's response to the FOA: Database, Data, Infrastructure, Benchmarks.

The existing elements of Michigan's infrastructure that will support a successful statewide home visiting program are as follows:

1. In May 2011, the Governor released a special message about Education, in which he announced the creation of the Office of Great Start, to be a focal point within State government for early childhood service delivery. Among its contributions will be ensuring the coordination of key programs across departments for the purpose of integration, continuity, accountability and also for maximizing direct service. An Executive Order with more details about the new Office is pending. Once the Executive Order is released, and Memoranda of Understanding amongst the State agencies are established, the project's organizational chart will be updated. The Governor has indicated that he also plans to release a special message about Public Health in the Fall of 2011; the home visiting program organizational chart will also be updated to reflect any changes that result from that message
2. There has been concurrence on the part of the Governor, the State department heads, and the Early Childhood Investment Corporation that collaboratively building a statewide home visiting program system should be a key component of Michigan's early childhood comprehensive system.
3. The Great Start System Team (GSST), which was created as part of Michigan's ECCS grant, was charged with overseeing the development of the home visiting system. The GSST appointed the HVWG to operationalize this charge. The HVWG includes representatives of all entities required by DHHS, and several of the HVWG members also participate on the GSST as well as the Early Learning Advisory Council (ELAC). Nearly all of the members have collaborated on many other early childhood initiatives and have developed strong working relationships with each other. Group members are personally committed to building a sound home visiting system as a key component of a comprehensive early childhood system. The HVWG is chaired by the MDCH Director of the Division of Family & Community Health who reports directly to the Title V Director.
4. The process of hiring a Program Coordinator for the Home Visiting Program at MDCH is still underway, with the anticipation that (s)he will play a key role in coordinating the State's implementation plan, and helping to develop future responses to funding

opportunities. A number of area already in place: Program Administrator/Director (.20 FTE in-kind); .50 FTE Program Consultant; 1.0 FTE Program Analyst. Position descriptions and resumes are in Attachment 9.

5. The Kellogg Foundation funded the development of a report titled *Financing Evidence-Based Home Visiting Programs in Michigan: A Strategic Financial Planning Toolkit*, May 2010. This report lays out specific action steps that the HVWG has considered as it begins to focus on systems-building.
6. The HVWG is in the process of collecting information from other States that have more advanced systems (e.g., descriptions of their systems, lessons learned, assessment tools, etc.), as offered through webinars and conference calls sponsored by national TA providers and DHHS. For example, we are particularly interested in the central intake project in New Jersey, and the personnel development/core competencies project in Virginia.
7. Michigan participants at the Early Childhood 2010 Summit have been share the work of Dr. Jack Shonkoff and the work of the Harvard Center on the Developing Child, as it raises important considerations as we move forward with early childhood system building and implementation of this Home Visiting Program.
8. Michigan will apply for continuation and competitive ACA home visiting funds to help build state and local infrastructure to support effective implementation of evidence-based home visiting models in communities with high concentration of risk.

While many efforts are underway to build Michigan's home visiting system, the overall infrastructure is still in development. The State is still developing consistent means to reliably determine the extent to which existing home visiting programs are meeting the needs of eligible families; some programs use family surveys, but those tend to measure satisfaction rather than outcomes/whether needs are met. Lessons learned from the process of working with local communities to conduct a second-cut data analysis will influence how we assess system needs and gaps in the future.

The State and local partners are continuing to assemble the pieces of the home visiting puzzle, including accurately cataloging the existing programs, the outcomes these programs address, models used, funding sources, target populations, and service gaps. This effort is underway, slated to be completed by October 2011.

The site visits conducted with ten local counties, along with the Community Readiness Assessment, also shed light on important areas of follow up for our program and for home visiting in the state as a whole. This information (some of which is captured in Section 8) will greatly inform and influence future decisions about both state and local infrastructure development to be undertaken with the federal home formula visiting funds, and influence competitive grant applications.

Early in the process, the GSST and the HVWG identified need for Michigan to address three components that are critical to building an effective and efficient system of home visiting services within the context of an early childhood system:

- Statewide infrastructure and quality
- Local infrastructure and quality
- Expansion of local home visiting services

Plans for expansion of existing home visiting services in six communities have been detailed above in Sections 1, 3 and 4. The federal home visiting funding is only supporting expansion of one home visiting program in each county, however, coordination of referrals, assessment, and intake across models is a critical infrastructure component that the State intends to pursue and address. Because the State is expanding existing home visiting programs that are already operating with fidelity (e.g. according to standards set by the national program offices), the state and local programs ensure that well-trained, competent staff will be hired, with the necessary high quality supervision in place. The selected organizations have demonstrated strong organizational capacity to implement home visiting activities, as evidenced by the fact that they are operating programs in fidelity and achieving outcomes for children and families. They are also showing they are able to obtain referrals to the programs through strong referral and service networks.

Our evaluation plans are detailed in Sections 2 and 5, with CQI plans detailed below, in Section 7. Some of the ten counties are also conducting evaluations, related to other funding streams, or in some cases, across home visiting programs. As we implement the evaluation plan for this funding, it will be aligned as much as possible with other evaluations. One of the evaluators for this project also leads the evaluation for another funding stream for home visiting (TANF funds at DHS), and evaluators from other federal projects – ECCS, Project LAUNCH, and for the State-developed Maternal Infant Health Program (MIHP)-are linking via our Benchmarks Committee to share information and explore opportunities for collaboration and alignment. The State elected not to fund or evaluate promising approaches using FY2010 funds, however, we expect the Home Visiting Program will be linked with an expected State-supported evaluation of our largest, State-developed home visiting program, the Maternal Infant Health Program.

As described in Section 4, the State has identified several priorities for infrastructure building efforts:

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

Efforts to address cross-system procedures and standards will be undertaken as part of our TA efforts; similarly, workforce development related to core competencies will move forward with some funding support in this Updated State Plan. Per Section 4, the GSST will be leading efforts to pursue the means to address issues related to centralized point of referral, and the ELAC will continue with its project to address integrated data systems and reporting mechanisms.

SECTION 7: Plan for Continuous Quality Improvement

Michigan's Home Visiting Program recognizes the importance and value of a continuous quality improvement (CQI) approach and will embrace a CQI approach throughout the State's home visiting system. CQI is a systematic approach to specifying the processes and outcomes of a program or set of practices through regular data collection and the application of changes that may lead to improvements in performance. CQI is a method that has been proven effective at improving performance and outcomes in a variety of settings from the automotive industry to public health. Michigan will employ CQI methods and tools to improve the home visiting system within the State to ensure that programs are delivered with model fidelity and are meeting legislatively mandated benchmarks over time.

Research suggests that CQI is most effective when it takes place in a culture of quality. A culture of quality is characterized by:

- Embracing an attitude that values learning and improvement;
- Using data to set targets and track changes over time;
- Working as a team to review data, understand root causes, and test improvements;
- Analyzing work processes to find opportunities to make progress toward targets;
- Looking to best practices to find opportunities to make progress toward targets; and
- Possessing the necessary training and leadership support to engage in CQI

Michigan's Home Visiting Program will work to create a culture of quality throughout the home visiting system by working with each MIECHV funded home visiting program in the State on using CQI methods and tools and building a culture of quality. Michigan's goal is to bring the State home visiting system as a whole, as well as individual local programs, to the point where they use CQI on a regular, ongoing basis in a culture of quality.

The Michigan Home Visiting Program's Plan for Continuous Quality Improvement (CQI) involves four components, each of which is described below:

1. Establishing state and local CQI teams
2. Developing the capacity to ensure data availability and access
3. Monitoring progress toward objectives
4. Sustaining CQI as the way of doing business

Establishing State and Local CQI teams

CQI teams will be formed at the State and local levels to oversee the implementation of the CQI plan. The State CQI team will include members of the HVWG, as well as representatives from local programs receiving expansion dollars. Local program members will include not only program administrators, but also home visitors and individuals responsible for data entry and management. The team will include members with expertise in evaluation and quality improvement, as well as members with expertise in service delivery. As such, the State CQI team will include members that offer a variety of perspectives regarding the home visiting system. The State CQI team will meet bi-monthly.

The State CQI team will be responsible for overseeing the implementation of both state and local activities and ensuring progress toward targeted outputs and outcomes. As such, the State CQI team will review data related to each of the objectives of the Michigan Home Visiting Program,

as described in Section 2. The State CQI team will review data to (1) identify data gaps and data quality issues, (2) identify strengths and challenges in program implementation at the state and local levels, and (3) to track progress toward outcomes. Based on their review of the data, the CQI team will set specific targets, where appropriate and will use these targets to monitor progress over time. Additionally, the State CQI team will make recommendations to local programs based on the data submitted by local programs. The State CQI team will also be responsible for providing local CQI teams with training and technical assistance, and, as such, the State CQI team will engage local teams in conversations regarding their CQI needs. Local CQI teams will be established at each site receiving funding to expand their home visiting program. These teams will include members of Local Leadership Groups, as well as home visiting program staff, including home visitors and individuals responsible for data entry and management. The Local CQI teams will meet bi-monthly to oversee the implementation of the CQI plan at the local level.

The responsibilities of Local CQI teams will parallel the responsibilities of the State CQI team. They will review their data to identify data quality issues and gaps that should be addressed. They will also use their data to identify strengths and challenges in program implementation and outcomes. As they become familiar with their data, the Local CQI teams will set targets and monitor progress toward these targets. In order to make progress toward their targets, local CQI teams will utilize the Plan-Do-Study-Act (PDSA) approach to CQI. Once a problem is identified, Local CQI teams will complete a root cause analysis and process map, develop an improvement theory, test that theory, and make informed decisions based on the results of their test. They will receive training and technical assistance in CQI and PDSA from the State CQI team as they begin to incorporate this approach into their everyday work process.

Develop Capacity to Ensure Data Availability & Access

CQI is fundamentally a data driven process that requires ready access to high quality data on system performance over time. One of the limitations of Michigan's existing early childhood and home visiting systems is that data are not readily available that speak to program implementation and outcomes. As such, one of the key infrastructure building strategies that will be implemented through this grant is an effort to establish and align robust data systems that can be used to support decision making at all levels from individual home visitors to State agencies. This effort will involve two components. First, an MIS system will be established that home visiting programs will use to track information about enrolled families. Second, policies and systems will be put in place to align the various existing data systems that capture information about children and families in the state.

Michigan's Home Visiting Program will develop and support an MIS system designed to align with the objectives of this Program and meet the needs of local home visiting agencies. Given that Michigan's program will support the expansion of multiple models across multiple agencies, Michigan must have an MIS system that is user-friendly for both (1) agencies that will be using it as their only system for case management, and (2) agencies that use the MIS system of a model program that would be uploading data into this system. Additionally, the data elements in the system must align with the Program's objectives and the measures that will be used to monitor progress toward the federally mandated benchmarks. Finally, the system must be modifiable over time as policies and systems are put in place to align data across the early childhood system.

The State CQI team will lead the process of developing the home visiting MIS system. The team will ensure that the system is equipped to meet multiple objectives, including objectives related to using data for CQI. For instance, the system must be capable of producing reports that speak to performance at multiple levels. It must be able to produce reports specific to a home visitor, a supervisor, a family, an agency, a model, a community, and the state as a whole. Additionally, the system must be able to produce real time reports that are easily accessible to all partners that use the system. The system must also be capable of tracking trends over time, such that performance can be monitored, and it must be able to produce data that can be used to set and track performance against targets. In designing this system, the CQI team will work closely with local program staff to ensure that the system is capable of producing information they will find meaningful and that aligns with their program goals and objectives.

There are multiple data systems used in the state that capture information about children and families. These data systems were developed for a wide variety of purposes, are housed in various agencies, use inconsistent systems for identifying individuals and families, capture demographic data in a variety of ways, and, in general, do not communicate with one another well. This lack of alignment across data systems presents significant barriers to ensuring programs serving children and families are operating in an efficient, effective, and coordinated manner. In order to address this challenge, the Early Learning Advisory Council, which shares members with the GSST, has undertaken an effort to address barriers and issues, as described in Section 5. The State CQI team will provide feedback to the Workgroup regarding what cross-system data would be useful in informing CQI in home visiting and across the early childhood system. In addition, the State CQI team will ensure that the home visiting MIS system is developed in a way that allows it to communicate with other data systems in the state and captures data in a way that aligns with the policies developed by this Workgroup.

Monitoring Progress toward Objectives

One of the most critical functions of the State and Local CQI teams will be to monitor progress toward the Home Visiting Program's objectives as described in Section 2. In order to monitor progress toward meeting the objectives of the program, the State CQI team will develop a set of core indicators and, where appropriate, targets. The objectives of the Program are related to infrastructure building, program implementation, and progress toward legislatively mandated benchmarks, and, as such the indicators will address each of these levels. Indicators will be shared with Local CQI teams, which will use the indicators as a starting point for developing locally-specific indicators that align with each objective.

Performance on indicators will be reviewed at the State and local level on a bi-monthly basis. Progress toward objectives will be tracked over time and against established targets. In addition, data will be used to identify opportunities for improvement, to develop improvement strategies, and to assess the success of these strategies.

Sustaining CQI as the Way of Doing Business

This grant will help the home visiting system in the state build the capacity to use CQI to make data driven decisions that will improve program implementation and outcomes. This capacity will be sustained beyond the life of the grant if Michigan's Home Visiting Program is successful in creating a culture of quality as described above. As home visiting professionals become

comfortable with CQI and see its value, support for CQI is built among leadership, and programs learn to use their data to set targets and drive improvement, CQI will become part of the way home visiting programs operate regardless of the expectations associated with a particular grant. Additionally, this grant will be used to build the infrastructure necessary to make data driven decisions, which is fundamental to CQI. This infrastructure will remain in place after the grant ends and can be used to sustain state and local CQI efforts.

SECTION 8: Technical Assistance Needs

Our original application indicated the State's desire to take full advantage of TA that would be offered. Special topics identified at that time, that are still priorities now, include: communication and marketing, fiscal leveraging, data and information systems at the state and local levels related to electronic-medical records and Health Information Networks, workforce expansion, strategies for coordination and providing TA to programs within the State, coordinated training efforts, outreach and access, sustainability, and comprehensive community involvement.

Several parallel and more specific TA needs for counties were identified during our Community Readiness Assessment. The Community Readiness Assessment developed by the HVWG included 32 items. Each item was scored on a scale of 0-2 points (Not ready=0, Somewhat Ready=1, Ready=2). With readiness scores ranging from 18.5 to 43.5, out of 62, it is clear there is need for technical assistance and support to improve readiness across all sites. When averages were computed across the ten LLGs, fifteen items had an average score of < 1, meaning that the average fell below the 'Somewhat Ready' category. The 15 items and average scores are given in the table below:

Table 5: Community Readiness Assessment Average Scores

Community Readiness Assessment Items with Lowest Average Scores	Average Scores
1. Shared use of Authorization to Share Information form	.45
2. Extent to which shared Authorization to Share Information forms comply with privacy laws	.50
3. Extent to which communities are coordinating efforts to maximize use of Medicaid	.50
4. Extent to which HV programs in community use a shared data base	.50
5. # of HV programs in the county that are working toward fidelity (if not in fidelity)	.55
6. Local Leadership Group has and implements policy to promote authentic family involvement (including financial support and mentoring)	.65
7. Extent to which HV programs have defined shared outcomes and collect data to measure these outcomes across programs	.70
8. LLG is developing infrastructure needed to support HV system	.80
9. LLG grasps that infrastructure development requires major change to current system	.80
10. Extent to which families representing the service population are	.80

authentically involved in LLG	
11. # of evaluations involving more than one HV program	.80
12. # of programs in community implementing HV programs that meet fidelity	.80
13. Extent to which HV programs in community use common forms	.90
14. Extent to which feedback is given to Primary Care Providers who refer to HV programs	.90
15. # of HV programs that can demonstrate program/policy changes as a result of CQI	.90

Using the above information, the HVWG identified the following as the top three immediate technical assistance priorities:

1. Ensuring that families representing the service population are authentically involved in the LLG.
2. Using a shared *Authorization to Release Information* form that is compliant with all relevant privacy laws (HIPAA, FERPA, and IDEA).
3. Implementing evidence-based home visiting programs with fidelity.

In the course of completing their local implementation plans, the six communities that are engaged in service expansion also identified the following TA needs:

Model Implementation

- Ongoing training and support to maintain fidelity to the model
- Authentic Hispanic/Latino community involvement that is integrated into the HFA model

Systems Building

- Development of a common database for use by county programs
- Home visiting database
- Tracking of prenatal visits in PIMS (HFA database), which is our database system
- Tracking/follow-up with clients, particularly as children enter and progress through the public school system
- Development of cross-systems forms/approvals

Funding

- Support with Medicaid billing/maximizing use of Medicaid

Professional Development

- Professional development for expanded staff
- HRA staff training
- Establishing an HFA learning community
- Annual or biennial conference on home visiting or evidence-based models where programs can share successes and challenges

Planning and Evaluation

- Detailed information on outcomes to be measured
- Outcomes reporting for the expansion
- Program evaluation and tools
- Evaluation requirements

Other

- Project timelines and reporting requirements
- Project budgeting requirements

Each of the ten at-risk counties has strengths, as well as expertise and information about procedures, policy, and funding strategies that can be shared with other counties. One aspect of our TA plan is to facilitate information sharing and learning across the sites, to take advantage of the strengths of each to support mutual learning and progress. This information will also be shared beyond the ten initial counties, with the other 73 counties in the state that may be able to start to learn from and use the information. We will accomplish this, in part, through the use of recorded and archived webinars and conference calls. The State will also assist counties to make site visits to each other for more direct learning and individualized TA opportunities.

After identifying the above technical assistance topic areas, the HVWG determined which could be addressed by the model developers. At this juncture, we anticipate that we will need technical assistance during FY 10-11 as delineated in the following table:

Table 6: Technical Assistance Needs

Topic area	TA likely needed FY 10-11	TA available from existing resources (e.g., model developer)	TA needed from or via HRSA
Model Implementation			
1. Selecting home visiting model(s) to meet the target populations' needs		X	
2. Implementing and supporting home visiting programs/conducting a home visiting program			X
3. Implementing models with fidelity	X	X	X
4. Special topical issues (e.g., substance abuse, mental health, domestic violence, tribal, and rural issues)		X	
5. Participant recruitment and retention		X	X
6. Authentic Hispanic/Community involvement in HFA		X	

System Building			
1. Developing a statewide early childhood system	X		X
2. Collaboration and partnerships			X
3. Communication and marketing		X	
4. Shared release forms compliant with privacy laws			X
5. Centralized Intake			X
6. Authentic parent involvement in LLG			X
Financing			
1. Fiscal leveraging	X		X
2. Sustainability	X		X
3. Maximizing Medicaid funds			X
Professional Development			
1. Developing training systems	X	X	X
2. Workforce issues	X		X
3. Reflective supervision			X
4. Establishing an HFA learning community		X	
5. Opportunities for HVPs to share successes and challenges			X
Planning and Evaluation			
1. Conducting ongoing needs assessments			X
2. Strategic planning			X
3. Shared Data and information systems			X
4. Tracking prenatal visits in PIMS (HFA)		X	
5. Shared outcomes and measures			X
6. Identifying benchmarks			X
7. Program evaluation			X
8. Continuous quality	X		X

improvement/quality assurance			
9. Conducting an evaluation of a promising approach			X

SECTION 9: Reporting Requirements

The State assures that we will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program; reports will be submitted according to the timelines and using formatting requirements provided by HRSA. The reports will address the following:

State Home Visiting Program Goals and Objectives

- Progress made under each goal and objective during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them;
- Any updates/revisions to goal(s) and objectives identified in the Updated State Plan; and
- As needed, a brief summary regarding the State's efforts to contribute to a comprehensive high-quality early childhood system, using the State's logic model as a template for reporting.

Implementation of Home Visiting Program in Targeted At-risk Communities

- Updates on the State's progress for engaging the at-risk community(ies) around the proposed State Home Visiting Plan;
- Updates on work-to-date with national model developer(s) and a description of the technical assistance and support provided to-date through the national model(s);
- Based on the timeline provided in Updated State Plan, an update on securing curriculum and other materials needed for the home visiting program;
- Updates on training and professional development activities obtained from the national model developer, or provided by the State or the implementing local agencies;
- Updates on staff recruitment, hiring, and retention for all positions including subcontracts;
- Updates on participant recruitment and retention efforts;
- Status of home visiting program caseload within each at-risk community;
- Updates on the coordination between home visiting program(s) and other existing programs and resources in those communities (e.g., health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services); and
- A discussion of anticipated barriers and challenges to maintaining quality and fidelity of each home visiting program, and the proposed response to the issues identified.

Progress Toward Meeting Legislatively Mandated Benchmarks

- Updates on data collection efforts for each of the six benchmark areas and on all constructs within each benchmark area including definitions of what constitutes improvement, sources of data for each measure utilized, barriers/challenges encountered during data collection efforts, and steps taken to overcome them.

Home Visiting Program's CQI Efforts

- Updates on State's efforts regarding planning and implementing CQI for the home visiting program. As available, copies of CQI reports addressing opportunities, changes implemented, data collected, and results obtained will be shared.

Administration of State Home Visiting Program

- Updated organization chart, if applicable;
- Updates regarding changes to key personnel, if any;
- An update on State efforts to meet legislative requirements, including a discussion of any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges:
 - Training efforts to ensure well-trained, competent staff;
 - Steps taken to ensure high quality supervision;
 - Steps taken to ensure referral and services networks to support the home visiting program and the at-risk communities; and
- Updates on new policy(ies) created by the State to support home visiting programs.

Technical Assistance Needs

- An update on technical assistance needs anticipated for implementing the home visiting program or for developing a statewide early childhood system.

The State will utilize the Goals and Objectives from Section 2, the implementation plans detailed in Sections 1, 3, and 4, the Benchmarks identified in Section 5, the CQI process outlined in Section 7, program administration information from Sections 6, and information about Technical Assistance needs and requests from Section 8 to address the required reporting requirements.

BUDGET INFORMATION - Non- Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non- Federal (f)	Total (g)
1. ACA HomeVisiting	93.505	\$	\$	\$ 2,133,673	\$	\$ 2,133,673
2.		\$	\$	\$	\$	\$ 0.00
3.		\$	\$	\$	\$	\$ 0.00
4.		\$	\$	\$	\$	\$ 0.00
5. TOTALS		\$ 0.00	\$ 0.00	\$ 2,133,673	\$ 0.00	\$ 2,133,673
SECTION B - BUDGET CATEGORIES						
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)	
	(1)	(2)	(3)	(4)		
a. Personnel	\$	\$	\$ 0	\$	\$ 0.00	
b. Fringe Benefits	\$	\$	\$ 0	\$	\$ 0.00	
c. Travel	\$	\$	\$ 2,000	\$	\$ 2,000	
d. Equipment	\$	\$	\$ 0	\$	\$ 0.00	
e. Supplies	\$	\$	\$ 5,300	\$	\$ 5,300	
f. Contractual	\$	\$	\$ 1,893,451	\$	\$ 1,893,451	
g. Construction	\$	\$	\$ 0	\$	\$ 0.00	
h. Other	\$	\$	\$ 232,922	\$	\$ 232,922	
i. Total Direct Charges (sum of 6a -6h)	\$ 0.00	\$ 0.00	\$ 2,133,673	\$	\$ 2,133,673	
j. Indirect Charges	\$	\$	\$ 0	\$	\$ 0	
k. TOTALS (sum of 6i and 6j)	\$ 0.00	\$ 0.00	\$ 2,133,673	\$ 0.00	\$ 2,133,673	
7. Program Income		\$	\$ 0	\$	\$	\$ 0

SECTION C - NON- FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	\$	\$	\$	\$ 0.00
9.	\$	\$	\$	\$ 0.00
10.	\$	\$	\$	\$ 0.00
11.	\$	\$	\$	\$ 0.00
12. TOTALS (sum of lines 8 and 11)	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 0.00	\$	\$	\$	\$
14. Non- Federal	\$ 0.00	\$	\$	\$	\$
15. TOTAL (sum of lines 13 and 14)	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00

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

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. ACA HomeVisitingProgram	\$ 2,133,673	\$ 3,013,935	\$	\$
17.	\$	\$	\$	\$
18.	\$	\$	\$	\$
19.	\$	\$	\$	\$
20. TOTALS (sum of lines 16 -19)	\$ 2,133,673	\$ 3,013,935	\$	\$

SECTION F - OTHER BUDGET INFORMATION

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



228 S. Wabash, 10th Floor
Chicago, IL 60604
312.663.3520
healthyfamiliesamerica.org

June 6, 2011

Nancy A. Peeler, Ed.M.
Manager, Child Health Unit
MI Department of Community Health
109 W. Michigan Avenue
Lansing, MI 48913

Re: Documentation of Approval to Utilize the HFA Model

Dear Ms. Peeler:

This letter is in response to the requirement of the Supplemental Information Request (SIR) from the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program (MIECHV Program) to obtain documentation of approval by the model developer to implement the model as proposed. We have had an opportunity to review the information you provided regarding implementation of the Healthy Families America (HFA) model in Michigan and any intentions to implement adaptations to the HFA model. **This letter outlines the approval from the HFA national office at Prevent Child Abuse America to use the HFA model in Michigan (herein referred to as "the State").** Approval to make adaptation to the model has not been granted as adaptations were not proposed.

Currently, HFA is present in 35 states and D.C., including 5 existing HFA program sites in Michigan.

We understand that given the current funding available in the initial year through the MIECHV program the State has made its decision about the distribution of funds and the selection of home visiting models. Specific to HFA, the funds will be used to implement HFA in 4 locations identified as being at highest risk based on the State's Home Visiting Needs Assessment. These locations include:

1. Kent County through the Kent County Health Department (as part of an existing HFA affiliate)
2. Muskegon County through Catholic Charities West Michigan (as part of an existing HFA affiliate)
3. Wayne County through Spaulding for Children (a new HFA affiliate)
4. Wayne County through the Wayne County Health Department (a new HFA affiliate)

The State agrees to require that all program sites choosing to implement the HFA model will complete the application process to affiliate with HFA if the program is not already affiliated. Should any additional HFA sites

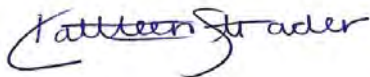


be established in Michigan at a later time, those sites will also be required to affiliate with the HFA National Office. The State has also agreed to pay the required annual fees (\$1,350/program site in 2011) and to purchase necessary HFA training for program staff utilizing in-state certified HFA trainers primarily and national trainers when the need in the State exceeds current in-state capacity. The State has indicated its intent to work in partnership with the HFA National Office to obtain model specific technical assistance and support related to site planning, development, implementation, and accreditation. Technical assistance will be made available to you and the above mentioned sites from the HFA National Office's Central Region Director at no cost via phone and email, and at a cost of \$1,250 per day plus travel for on-site technical assistance. Finally, when curriculum decisions are known for any HFA program sites that will be receive funds, the State agrees to provide this information to the HFA National Office as soon as it has been determined.

In order to maintain HFA affiliation and the right to use the Healthy Families America name and to insure model fidelity, the State agrees that within the first 3 years of site affiliation, each HFA site will complete the accreditation process and again every 4 years thereafter. The State also agrees to complete, or to require that each site complete, an annual site survey (distributed by PCA America on an annual basis), and to utilize a data management system to better provide information to the National Office. It is PCA America's intention to affiliate individual program sites and multi-site systems and to authorize use of the name "Healthy Families" and use of variations of the name (*i.e.*, Healthy Families Place, County, or City), provided they are committed to the best practice standards identified by PCA America through research. Should there be any instance that would impede the program's ability to implement the critical elements (such as a loss of funding, etc.), it is understood that it is the program's responsibility to notify PCA America immediately. It is also understood that PCA America is the sole grantee of the right to use the HFA name and/or affiliation with the HFA initiative. PCA America reserves the right to revoke use of the name, and/or affiliation with the Healthy Families initiative, at any time before, during, or after the community/program enters the HFA Accreditation process. Finally, once entering the HFA Accreditation process, it is understood that the program will be subject to the policies and procedures of that process.

We are pleased to grant approval to the State of Michigan's Department of Community Health to implement the HFA model. If you would like to discuss this further, I can be reached at kstrader@preventchildabuse.org or 248.988.8990. I applaud your commitment to Michigan's children and families and look forward to working together in partnership with you.

Sincerely,



Kathleen Strader, MSW
Director, HFA Central Region
Prevent Child Abuse America

Cc: Cydney M. Wessel, MSW
Senior Director of HFA
Prevent Child Abuse America



Prevent Child Abuse America



DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of Head Start
8th Floor Portals Building
1250 Maryland Avenue, SW
Washington, DC 20024

Nancy Peeler
Michigan Department of Health
PO Box 30195
Lansing, MI 48909

Dear Ms. Peeler,

Thank you for your interest in implementing the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program project in your state, using the Early Head Start (EHS) Home-Based Model.

As Director of the Office of Head Start I am pleased to give you initial approval for implementing the EHS Home Visiting Model. This approval is contingent upon full review of the proposed home visiting implementation plan. The information below is key to implementing the Early Head Start Home-Based Program option in full compliance with all Head Start Program Performance Standards, as they apply to Early Head Start.

Quality services have been the keystone for Early Head Start across its history. In 1994, the Advisory Committee for Services to Infants and Toddlers provided the Federal government with a set of principles to guide the creation of the Early Head Start program. These principles continue to be both a guide and inspiration for quality EHS services. They are designed to nurture healthy attachments between parent and child (and child and caregiver), emphasize a strengths-based, relationship-centered approach to services, and encompass the full range of family needs from pregnancy through a child's third birthday. In short, these principles articulate what a quality EHS program truly delivers to families. They include:

- ***An Emphasis on High Quality*** which recognizes the critical opportunity of EHS programs to positively impact children and families in the early years and beyond.
- ***Prevention and Promotion Activities*** that both promote healthy development and recognize and address atypical development at the earliest stage possible.
- ***Positive Relationships and Continuity*** which honor the critical importance of early attachments on healthy development in early childhood and beyond. The parents are viewed as a child's first, and most important, relationship.
- ***Parent Involvement*** activities that offer parents a meaningful and strategic role in the program's vision, services, and governance.
- ***Inclusion*** strategies that respect the unique developmental trajectories of young children in the context of a typical setting, including children with disabilities.

- **Cultural competence** which acknowledges the profound role that culture plays in early development. Programs also recognize the influence of cultural values and beliefs on both staff and families' approaches to child development. Programs work within the context of home languages for all children and families.
- **Comprehensiveness, Flexibility and Responsiveness** of services which allow children and families to move across various program options over time, as their life situation demands.
- **Transition planning** respects families' need for thought and attention paid to movements across program options and into—and out of—Early Head Start programs.
- **Collaboration** is, simply put, central to an Early Head Start program's ability to meet the comprehensive needs of families. Strong partnerships allow programs to expand their services to families with infants and toddlers beyond the door of the program and into the larger community.

The EHS Home Visiting model provides high quality, culturally competent child development and parent support services with an emphasis on the role of the parent as the child's first, and most important relationship. The home-based option is designed for families in which the home is the child's primary learning environment. Participants in the EHS home-based model receive a combination of weekly home visits and regularly scheduled group socializations.

Home visits are conducted with parents or the child's primary caregiver for 90 minutes, generally on a year-round basis. The purpose of the home visit is to support parents in their roles as primary caregivers of their child and to facilitate the child's optimal development within their home environments.

Group socializations are offered twice a month and are designed to support child development by strengthening the parent-child relationship. In the context of a group of families, socialization experiences address child growth and development, parenting, and the parent-child relationship.

For EHS programs enrolling pregnant women, home visits are conducted to ensure pregnant women have access to comprehensive prenatal and postpartum care. A home visit is also used to provide prenatal education on topics such as fetal development, labor and delivery, postpartum recovery (including maternal depression), and the benefits of breastfeeding.

In order to meet the needs of the children and families, a Family Partnership Agreement is created that defines the individualized focus for each enrolled child and family. Through this process, parents are integrally involved in determining the goals and experiences that comprise their child's curriculum, and in identifying goals for themselves that best support their healthy development and self-sufficiency.

The scope of services in the home-based program option is comprehensive, including the following services:

- Developmental screening, ongoing observation and assessment, and curriculum planning
- Medical, dental, and mental health

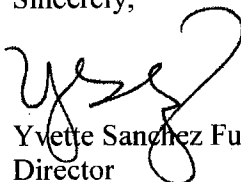
- Child development and education
- Family partnerships and goal setting
- Community collaborations to meet additional family needs

The relationship of the home visitor with parents or expectant parents is central to effective delivery of this program model. Through ongoing interactions in home visits and socializations, this continuity of the relationship becomes the vehicle through which home visitors support and strengthen parents' or expectant parents' abilities to nurture the healthy development of their children.

The Office of Head Start looks forward to continuing to work with your state.

For additional information, please contact Angie Godfrey at angie.godfrey@acf.hhs.gov.

Sincerely,



Yvette Sanchez Fuentes
Director

**MI Home Visiting Program
Community Readiness Assessment Items**

Assessment Items
Indication of the extent to which the Great Start Collaborative has identified Home Visiting Programs as a strategic planning priority
Indication that required representatives are members of the Local Leadership Group
Indication that recommended representatives are members of the Local Leadership Group
Indication of the extent to which the Local Leadership Group is in the process of developing (or agrees to develop) the infrastructure necessary to support implementation of Home Visiting Programs
Indication of the extent to which the Local Leadership Group grasps that infrastructure development requires MAJOR CHANGES to the current system and is willing to make these changes
Indication of the extent to which there are passionate local champions (movers and shakers) who will make this MAJOR CHANGE effort happen
Indication of the extent to which families, representing the identified service population, are authentically involved as Local Leadership Group members (families are at the table, are heard and are partners in decision-making)
Indication that the Local Leadership Group has (and implements) a policy to promote authentic family involvement (including financial support and mentoring)—attach a copy of the policy
Description/documentation of how the Local Leadership Group is formally related to the Great Start Collaborative
Description/graphic illustration showing how the county will embed the Home Visiting Program in a high-quality Early Childhood System that promotes maternal, infant and early childhood health, safety and development and strong parent-child relationships
Indication/documentation that a Home Visiting Program network (e.g. a group comprised of the HV programs in the geographic area that meet on a regular basis for the purposes of professional development, coordination, etc.) exists in the county
Indication of the extent to which referrals to Home Visiting Programs are coordinated in the county, in order to reduce duplication of services
Indication of the extent to which professional development activities are conducted across Home Visiting Programs
Indication of the extent to which Home Visiting Programs in the county use common forms (e.g. screening, consent to participate in services, authorization to release information, intake, assessments, etc.)
Indication of the extent to which feedback is given to primary care providers (PCPs) who refer to Home Visiting Programs (should be included in graphic illustration)

Indication of the extent to which Home Visiting Programs in the county use a common database
Indication of the number of Home Visiting Programs in the county with evaluations (planned, underway or completed)
Indication of the number of evaluations involving more than one local Home Visiting Program in the county
Indication of the extent to which Home Visiting Programs in the county have defined share outcomes and collect data to measure these outcomes across Home Visiting Programs.
Indication of the extent to which funding for each Home Visiting Program can be “unbraided” in order to report child/family outcomes by funding stream
Indication of the extent to which communities are coordinating efforts in order to maximize use of Medicaid to fund Home Visiting Programs
Indication of use of a shared Authorization to Release Information form
Indication of the extent to which shared Authorization to Release Information form complies with HIPAA, FERPA, and IDEA laws
Indication of the number of Home Visiting Programs that use a continual quality improvement (CQI) process
Indication of the number of Home Visiting Programs that can demonstrate program and policy changes resulting from CQI and/or evaluation results
Indication of the number of Home Visiting Programs in your county that are implementing models that meet federal evidence-based criteria
Indication of the number of Home Visiting Programs in the county being implemented with fidelity to the model as defined by the national model developers
Indication of the number of Home Visiting Programs in the county that are working toward fidelity to the model, as defined by the national model developers
Indication of the number of Home Visiting Programs in the county supported by more than one funding source (public or private)
Indication of the extent to which local funding sources help support Home Visiting Programs in the county
Indication of the extent to which the Great Start Collaborative is linked to a county-level coordinating body comprised of director-level/upper management reps
Indication of the extent to which the Local Leadership Group has participated in state Home Visiting Program learning opportunities
Indication of the extent to which the Local Leadership Group is cooperating with the HVWG to develop the Updated State Plan (e.g. completing assessment, cataloging HVPs, etc.)

Michigan Maternal, Infant and Early Childhood Home Visiting Program
COUNTY-LEVEL HOME VISITING PROGRAM IMPLEMENTATION PLANS

County: **GENESEE**
Contact Person/Agency: Beth Hackett
Phone: (810) 591-5588
Email: bhackett@geneseeisid.org

A. Identification of Genesee County's Targeted At-Risk Community

- 1. What is the targeted at-risk community (e.g., city, township, zip code, population group, etc) that the Local Leadership Group (LLG) and the Home Visiting Workgroup (HVWG) have jointly agreed upon?**

The Genesee County Local Leadership Group and the Home Visiting Workgroup have selected teen parents living in the City of Flint as the targeted at-risk community. Early Head Start Home-Based services will be expanded in Genesee County to serve this population.

- 2. What are the risk factors in this community?**

RISK FACTORS	ENTIRE COUNTY: GENESEE	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
1. Premature birth	11.5%	15%	Kids Count http://datacenter.kidscount.org/data/byeystate
2. Low-Birth Wt Infants	619 (10.4%)	13.8	Michigan Dept of Community Health
3. Infant Mortality	Per /1,000 (3 year avg Yr 2008) White 5.6/1,000 (22) Black 16.9/1,000 (28) Hispanic 23.5/1,000 (4)		Genesee Co Health Dept
4. Poverty	Children living in poverty age 0-17 years 23.3%		Kids Count Michigan Dept of Community Health http://datacenter.kidscount.org/data/byeystate/stateprofile.aspx?state=MI&loc=3768
	Medicaid Births (2008) 51.6% ^a	Medicaid Births (2008) 73.8% ^b	
5. Crime	Year 2010 Murders: 60	Murders: 50 84% of county total	Michigan State Police. Michigan Incident Crime Reporting. Crime in Michigan. http://www.mi.gov/msp . Flint Police Department. Crime Stats City of Flint, Michigan. http://www.cityofflint.com/police/stat.asp .
	Rape: 246 victims	Rape: 108 victims 44% of county total	

RISK FACTORS	ENTIRE COUNTY: GENESEE	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
	Robbery: 941 cases	Robbery: 574 cases 61% of county total	
	Burglary: 5,397 cases	Burglary: 3,940 cases 73% of county total	
6. Domestic Violence			
7. School Drop-Out Rates	13.3% ^a	19.55% ^b City of Flint Schools – numbers reflect students that transfer to alternative education programs and do not graduate on time but are still enrolled in a school system.	http://datacenter.kidscount.org/data/ystate/stateprofile.aspx?state=MI&loc=3768 and Center for Educational Performance and Information http://www.michigan.gov/documents/cepi/2010-2009_MI_Grad-Drop_Rate_345879_7.pdf
8. Substance abuse			
9. Unemployment	April 2011 10.8% ^a	April 2011 11.8% ^b	^a Michigan Department of Technology, Management and Budget ^b Bureau of Labor Statistics http://www.bls.gov/news.release/pdf/metro.pdf
10. Child maltreatment	Birth -17 years: 1,002		Michigan League for Human Services
11. Proportion of total pop of American Indians living in community compared to total pop in county			
12. Proportion of total pop of African Americans living in community compared to total pop in county	2010 Census – 21% of total state	2010 Census – 59% of total county	http://www.michigan.gov/documents/cgi/cgi_census

RISK FACTORS	ENTIRE COUNTY: GENESEE	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
If you were unable to provide community-level data on more than 5 risk factors , explain how you determined that this is the highest-need community in the county.			

3. What are the strengths of this community?

COMMUNITY STRENGTHS/ASSETS	
1. What is this community proud of?	
2. Faith communities	
3. Neighborhood associations	
4. Cultural/ethnic associations	
5. Other community organizations	
6. Business investment	
7. Philanthropic investment	Urban Gardening Initiatives and Flint Farmer's market supported by the Ruth Mott and C.S. Mott Foundations
8. Major community events	
9. Other assets/resources (<i>specify one or more</i>)	Stork's Nest Baby Pantry (sponsored by sorority)

4. Briefly describe characteristics of potential HVP participants from the at-risk community (e.g., income level, mother's education level, percentage of single parents, percentage of first-time parents, employment rate, race/ethnicity, and/or other characteristics).

After considering the data, the Home Visiting Leadership Group selected teen parents from the City of Flint as the group that could most benefit from the expansion of home-based Early Head Start services. There are 98 families on the waiting list for Early Head Start in Flint currently. Teen parents will be the group of focus as the teens struggle with maturation issues, high school completion, low financial resources and intergenerational family issues. Teen parents are usually single parents and may have relationship challenges with the baby's father and other boyfriends which leads to problems of the bonding/attachment with the baby and safety concerns as the child may be in homes with drugs or violence. The teen parents WILL NOT need to be enrolled in school as a condition of program enrollment. The teens will be encouraged to enroll in a high school completion program as part of the coordinated services.

The families will be selected to participate based on risk factors. Community data confirm that minority status (i.e. African American, Hispanic, etc.) is a risk factor for infant mortality. Therefore, minority status will be one risk factor considered. Other risk

factors include teen parents that have a history of involvement in the foster care system or involvement with Child Protective Services.

- 5. Below is a list of possible needs of potential HVP participants. Indicate whether or not individuals residing in the targeted at-risk community have each of these needs. Add any other needs that you have identified at end of list.**

NEEDS OF PARTICIPANTS	Yes or No
1. Child development/parenting education and support to assist families to form stable and responsive relationships with their young children	Yes
2. Safe and supportive physical, chemical, and built environments, which provide places for children that are free from toxins and fear, allow active, safe exploration, and offer families raising young children opportunities to exercise and make social connections	Yes
3. Sound and appropriate nutrition	Yes
4. Health education and care	Yes
5. Education on promoting literacy and early learning	Yes
6. Access to quality child care/early childhood education experiences	Yes
7. Domestic violence resources	Yes
8. Substance abuse services	Yes
9. Mental health services	Yes
10. Training and jobs	Yes
11. Transportation	Yes
12. Other: Basic Needs – Food, hygiene items	Yes
13. Other :Stable Housing	Yes
14. Other: Physical Activity	Yes
15. Other (<i>specify</i>)	
Provide any additional comments you may have about needs of potential program participants:	

- 6. Identify any other factors considered in the selection of this at-risk community.**

The City of Flint has a high density of teen parents. Access to services is limited due to lack of transportation. Home Visiting services are an appropriate delivery mode to reach teen parents that may not be in school or have no way to participate in other programs.

- 7. Review the updated list of home visiting programs operating in your county and list each program that serves your targeted at-risk community below.**

- a) Early Head Start Home-Based Program
- b) Maternal Infant Health Program (MHIP) for Medicaid eligible mothers provided by the Genesee County Health Department through hospital subcontractors

- c) Infant Mental Health Services provided by Community Mental Health
 - d) Children's Trust Fund Home visiting programs (administered by Genesee Intermediate School District)
 - e) Healthy Start (administered by Genesee County Health Department)
 - f) Prevention Pilot Home Visiting Program (Department of Human Services subcontractors)
- 8. If there are home visiting services currently serving the targeted at-risk community, why are additional home visiting services needed (e.g., existing programs don't have capacity to meet the need, long waiting lists, program eligibility restrictions, etc.)? What is your estimate of the number of service slots available compared to the number of families who need home visiting services?**
- a) The existing programs do not have the capacity to serve all the eligible children.
 - b) The existing programs do not use the curricula/programs approved for use in the Michigan MIECHVP application.
 - c) There are currently 98 families on a wait list for Early Head Start in Flint.
- 9. Identify referral resources (services to which the home visiting program can refer) currently available to support families residing in the community.**
- a) Mott Children's Health Center – provides pediatric physical, behavioral and dental care to all children living at 200% of poverty and below.
 - b) Mission of Peace – Housing resources and budgeting
 - c) One Stop Housing Resource Center – Services to Homeless
 - d) Breastfeeding Peer Mentors (Health Department)
 - e) Public High Schools (local school districts and academies), Alternative or Adult Education programs, Virtual High School (on-line)
 - f) Community Mental Health Substance Abuse screening and treatment programs
 - g) Community Mental Health Infant Mental Health Programs
 - h) Genesee County Health Department - WIC, family planning, STD, Immunizations

- i) Hamilton Health Network – Federally Qualified Health Center for adult and pediatric services and dental services for persons with Medicaid, no insurance or private insurance.

10. Identify referral resources (services to which the home visiting program could refer) that are needed in the community.

Additional intensive programs that are evidence-based, such as Nurse Family Partnership

11. Describe your plan for coordination among existing programs and resources in the community, including how the program will address existing service gaps.

The Genesee County Home Visiting Leadership Group will continue to meet as a workgroup of the Great Start Collaborative to review implementation of this grant, develop strategies for coordination, and identify gaps.

12. Identify existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the community level). To what extent are you coordinating referrals and intake across home visiting programs?

A coordinated screening system for families does not exist in Genesee County. The referral coordination is usually between two community partners as a client of one program qualifies for services in another program. The Home Visiting Leadership Group would like to work toward a family centered model to match the family with the service that provides the best fit and avoids duplication.

13. Describe county capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level, such as a governance structure or coordinated system of planning.

The partners in the Home Visiting Leadership Group are committed to continued development of an early childhood system. The work would be organized under the Great Start Collaborative pediatric workgroup and Home Visiting Leadership Group. The Governance of the Great Start Collaborative also provides guidance for the support of parent members of the workgroup by providing honorariums for attendance at meetings, mileage to and from meetings and child care resources.

B. Selection of Genesee County's Home Visiting Model and Explanation of How the Model Meets the Needs of Genesee Targeted Community

1. Which evidence-based home visiting program model has been selected for expansion in the targeted at-risk community, as agreed jointly determined by the LLG and the HVWG?

The Early Head Start Home-Based model will be expanded in Genesee County.

2. How does the selected model address the particular risks in the targeted community and the needs of the families residing there?

The Early Head Start Home Based model provides intensive services to at-risk families in their community, in their homes. As is customary in Early Head Start, this model will provide crucial supportive services, parent education, physical and mental health services, and early childhood education, while prioritizing needs and goals with each at-risk teen parent. Education, employment, quality child care, support systems, and stable housing are ongoing needs of this population and will be addressed through community partnerships and close collaboration with existing resources. The Early Head Start model will provide a trained home visitor who will assist the teen parent in accessing needed resources and support, while helping the teen parent to be their child's most important teacher.

3. How will the targeted community be involved on an ongoing basis throughout the duration of this program (other than as program participants)?

The targeted community (teen parents in Flint) will be included in program planning and implementation, just as other targeted families are included as an essential and required part of operation of Early Head Start and Head Start. Targeted teen parents will be asked to join the Head Start Parent Policy Committee and Parent Policy Council, giving them an opportunity to be a meaningful part of the program operation and evaluation. Teen parents involved in the program will also be asked to mentor other program participants to assist in helping with each participant's success.

4. Describe your county's current and prior experience with implementing the selected model.

Genesee County has operated Head Start programs through Genesee County Community Action Resource Department (GCCARD) since 1965 and Early Head Start programs since 1998. The Early Head Start Program Home-Based model has operated through GCCARD in the Out-County program for 101 families during this time and in Flint Schools for 90 families during this time. GCCARD as the grantee, and Flint Schools as the delegate, have had extensive training and experience in successfully operating this model. Meeting Performance Standards, implementing research-based assessment and curriculums, establishing a system of community partnerships, providing a wide array of health services, and completing extensive reporting mechanisms to be measured by, are several of the key areas included in this successful operation over time.

5. Describe your county's current capacity (e.g., funding, staff, administration, etc.) to increase the number of families served using this model.

Genesee County currently serves many families throughout the area with a wide array of parent education, early childhood education, and health related services. The county has a

strong support system through Genesee Intermediate School District, Great Start, GCCARD, the public schools, and health partners, which allows for expanded services to be implemented and supported through collaborative efforts as needed. Our county's capacity to increase the number of families served in Early Head Start is excellent because of these strong collaborative relationships. Given funding to implement services for additional families, programming can begin quickly by merging these services with existing services that already have oversight, structure, and quality systems in place. Given the extensive experience the county, and the individual community agencies have had in successfully offering home visitation services, we anticipate that an increase in numbers of families served would be a welcome opportunity for collaborating to further meet the needs of families in this community.

6. Describe your plan to ensure implementation with fidelity to the model.

The Early Head Start model is clearly described in the Head Start Performance Standards and is adhered to in all programs operated in Genesee County through GCCARD, Flint Community Schools, Beecher Schools, and Carman Ainsworth Schools. It would be our intent to merge the Michigan MIECHVP service slots with the existing Early Head Start program through GCCARD to provide seamless Early Head Start services to teen parents, following the prescribed home-based Early Head Start model used currently. The program would be monitored throughout the grant period, as are all Early Head Start programs in the county, to ensure fidelity to the model and program quality.

7. Discuss anticipated challenges and risks of the selected program model, and your proposed response to these challenges.

The teen parent population is one of the most difficult to serve because of ongoing challenges with stability, consistency, follow through, and willingness to comply with all requirements. In addition, home visitation is often difficult when teens are in school full time, and when teens are living with parents or guardians who are not comfortable with the home visitation model. Thorough screening of potential program participants, including parents and guardians, will be essential in determining those who are able to participate in required program components. In addition, close collaboration with the local high schools will assist in implementing supportive services and practices that will help to encourage participation and retention of teen parents.

8. Identify any anticipated technical assistance needs to be addressed by the state or the model developers.

Detailed information regarding outcomes to be measured, evaluation requirements, and reporting requirements will be needed. In addition, information on timelines will be needed as well as budget requirements. The group would also like to receive technical assistance as part of a learning community organized by the state partners to improve the community infrastructure including cross program data collection, data management, development of funding sources through insurance billing and grants.

C. Implementation of Genesee County's Selected Model

- 1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots? (Note: This is the entity that is already implementing the selected model, unless the LLG and HVWG have agreed upon an alternative entity, based on how the alternate approach will maximize funding and services.)**

The Genesee County Community Action Resource Department (GCCARD) will receive the Michigan MIECHVP funds to expand service slots in the Early Head Start Home-Based Program in Genesee County. The program will serve participants who are pregnant mothers and children through age 3. The Parents as Teachers Curriculum, The Creative Curriculum (Infant and Toddler Curriculum) and the Partners for a Healthy Baby Curriculums are all used in their service provision.

- 2. Describe the plan for recruiting, hiring, and retaining appropriate staff for all positions. List each position to be filled.**

Two Home Visitors will be hired to serve 24 teen parent families. The Home Visitors will be required to have a Bachelor's Degree in Early Childhood or a related field. The positions will be posted and advertised in the Flint Journal, local colleges with Early Childhood programs (Baker College, Mott Community College and UM-Flint), and on various websites such as GCCARD and the Michigan Head Start Association website. A team of representatives from the LLG will develop interview questions and be a part of the interview and hiring process for the Home Visitors. Timelines for recruitment and hiring will be dependent on the grant start date. The home visitors will receive appropriate background checks and references follow up.

In addition to the Home Visitors, a small portion of some of the existing Early Head Start support staff will be charged to this grant. These staff members include a Home Visitor Supervisor, Family Service Worker, Behavioral Health Specialist, Support Service Assistant and Fiscal Assistant. This will allow us to provide the needed supervision (including reflective supervision) family support and record keeping to ensure the EHS Home-Based model is being fully implemented.

Retaining consistent staff throughout the grant period will be a priority and will be addressed in the selection and hiring process.

- 3. If subcontracts will be used, describe the plan for recruitment of subcontractor organizations, and the plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s).**

GCCARD Head Start currently has a fiduciary contract with the Oakland Livingston Human Service Agency (OLHSA) to provide human resource services for the Head Start and Early Head Start programs. OLHSA provides payroll processing, fringe benefits and human resource support. GCCARD recruits, hires and supervises the staff as mentioned

above, but subcontracts with OLHSA to provide payroll and fringe benefits. This same process would be implemented for the staff hired for this grant.

4. Describe the plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors.

Supervision and support for professional growth of the staff members will be paramount to insure that the staff members are supported in their roles and can provide support to the families served. High quality clinical supervisors currently coordinate the Behavioral Health component in Head Start/Early Head Start. These supervisory staff members have a Master's Degree in Social Work and have been trained in reflective supervision.

These supervisors are assigned to provide oversight and reflective supervision to Early Head Start staff and will do this also for the Early Head Start staff working with families in the Michigan MIECHVP portion of the program.

5. What is the estimated number of families that will be served annually with the expansion funds provided by the Michigan MIECHVP? (Do not count families being served with funds from other sources.)

Twelve families/ per home visitor hired /per year (24 total)

6. How will program participants be identified and recruited?

Current Early Head Start waiting lists will be reviewed to see if any one currently on the waiting list is an eligible teen parent. These eligible families will be recruited first. If additional families are needed, they will be identified in cooperation with existing partners, schools, and health agencies who will receive information about the available home visitation program, eligibility, and the referral process. As is the practice in Early Head Start recruitment county wide, a priority point system will be used to determine the most at risk families who will be offered services, as long as they are willing to participate in all program components. Identifying twenty four teen parent families will not be difficult; there are currently 98 families on the Early Head Start waiting list in Flint alone.

7. Describe the plan for minimizing the attrition rates for participants enrolled in the program.

Thorough screening of potential participants will assist the program in identifying participants who are able to commit to the Early Head Start program for intensive services over the course of one to three years. Understanding that retention and intensity over time in the home visiting program are critical to success for participants, the first goal will be to identify the participants that are willing to make a long term commitment and agree to sign a Family Partnership Agreement that states this. The second goal is to provide the necessary support services, incentives, and relationships that will help participants to stay in the program over time.

8. What is the estimated timeline to reach maximum caseload?

The estimated timeline to reach the maximum caseload of twelve families is by September 15, 2011. This will allow us to use the summer to identify the most at risk teen parents who are not currently attending school, and the beginning of the school year to identify at risk teen parents who are currently in high school and not a part of an existing home visit program. This timeline will also be dependent on the official start date and grant authorization given to us by the State.

9. Describe the operational plan for the coordination between the proposed home visiting program and other existing programs and resources in the community, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services.

Within the Head Start and Early Head Start program, as well as through the Great Start Collaborative, extensive coordination of services and resources is already in place. Existing collaborative agreements, both formal and informal, currently support the work of providing quality services to parents and children in this community. This collaboration and coordination of resources will be an integral part of the expansion slots provided through the Michigan MIECHVP funds. Particularly in the area of teen health, mental health, and substance abuse, Early Head Start will seek the cooperation of existing agencies in the community who have been at the table as the Genesee County MIECHVP grant has been planned. Mott Children's Health Center has partnered with Head Start to provide dental and behavioral services upon referral and has a patient-centered medical home pediatric clinic to serve low-income children. Throughout the grant period, the Home Visiting Leadership Group will meet as a workgroup of the Great Start Collaborative to assure that resources have been identified and utilized as needed for the target population.

10. How are you already collecting process and outcome data for the existing home visiting program that has been chosen to receive MMIECHVP funds? Will you be using the same process with the expansion slots?

As required by Early Head Start, we collect and report on data using a variety of tools including: child assessment tools (Brigance, ASQ-SE, Creative Curriculum Developmental Continuum); health screening tools (vision, hearing, dental, physical, nutrition survey, newborn assessment, well baby visits, blood pressure, heights & weights, immunizations, physical exam for pregnant mom, Edinburgh scale); family goal setting tools (contact logs, family interest inventories, partnership agreements, goal sheets, case notes); and COPA database (enrollment, attendance, health tracking, home visits, parent involvement, male involvement, staff qualifications, disabilities, etc.). The same data collection process will be followed for the expansion slots funded with MMIECHVP. Additional requirements for data collection for the MMIECHVP slots will be completed as needed also.

11. Describe anticipated challenges to maintaining program quality and fidelity, and how these challenges will be addressed.

It is not anticipated that it will be difficult to maintain program quality and fidelity. We currently must follow the program model and meet all required standards, maintaining fidelity to the Early Head Start Performance Standards as a practice over time. In addition, we are measured annually on our ability to meet specific program indicators of quality and have had success in meeting those indicators consistently. Collaboration with community partners will be an area that will need focus and work so that the at-risk teen population can have their needs met consistently. This will be an area that the LLG will need to work together on.

12. Provide a list of collaborative public and private partners (Local Leadership Group member names and organizations).

See Attachment A

13. Indicate that you are providing each of the following assurances:

- a. *Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments within the scope of the model, and assuring fidelity to the model, (e.g., assessment does not eliminate components of the model).*
- b. *Assurance that services will be provided on a voluntary basis*
- c. *Assurance that priority will be given to serve eligible participants who:*
 - 1) *Have low incomes*
 - 2) *Are pregnant women who have not attained age 21*
 - 3) *Have a history of child abuse or neglect or have had interactions with child welfare services*
 - 4) *Have a history of substance abuse or need substance abuse treatment*
 - 5) *Are users of tobacco products in the home*
 - 6) *Have, or have children with, low student achievement*
 - 7) *Have children with developmental delays or disabilities*
 - 8) *Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.*
- d. *Assurance that funds will be used to service the at-risk target population agreed upon with the state, the characteristics of which are documented in Section A above.*

See Attached Statement of Assurance

Attachment A

GENESEE County Early Childhood Home Visiting Leadership Team

Name of Local Primary Contact Person: Beth Hackett
 Agency: Genesee ISD/Great Start Collaborative
 Role: Coordinator
 Mailing Address: 2413 W. Maple Ave., Flint, MI 48507
 E-mail Address: bhackett@geneseeisd.org
 Telephone Number: (810) 591-5588

Name	Agency	Role	Telephone / E-mail
Marcia Franks	Genesee County Health Department 630 S. Saginaw Street, Suite 4 Flint, Michigan 48502	Public Health Supervisor Maternal/Infant Health and Mortality Programs	(810) 257-3202 mfranks@gchd.us
Lisa Coleman	Genesee County Community Mental Health 420 W. 5th Avenue Flint, MI 48503	Manager of Substance Abuse Prevention	(810) 496-5544 lcoleman@gencmh.org
Jonquil Bertschi	Weiss Advocacy Center (formerly C/CAN and CAC) 515 East Street Flint, MI 48502	Executive Director	810-234-3680 jonquil@weissadvocacycenter.org
Catrina Wiskur	Genesee Intermediate School District 2413 W. Maple Ave. Flint, MI 48507	Parent Education Facilitator	(810) 591-5596 cwiskur@geneseeisd.org
Mary Flynn	GCCARD Head Start 719 Harrison St. Flint, MI 48502	Out-County Director GCCARD Head Start	(810) 235-5613 mflynn@co.genesee.mi.us
Carol Piechocki	GCCARD Head Start 719 Harrison St. Flint, MI 48502	Director GCCARD Head Start	(810) 235-5613 cpiechocki@co.genesee.mi.us

Name	Agency	Role	Telephone / E-mail
Carol Osborn	Genesys Health System 1 Genesys Parkway Grand Blanc, MI 48439	Coordinator of MIHP home visiting program	(810) 762-4273 cosborn@genesys.org
Beth Hackett	Genesee Intermediate School District 2413 W. Maple Ave. Flint, MI 48507	Coordinator of Great Start Collaborative	bhackett@geneseeisd.org
Lauren Chom	Flint Community Schools	Director of Early Childhood Programs and Head Start	(810) 760-1344 lchom@flintschools.org
Jennifer Lee	Genesee Intermediate School District 2413 W. Maple Ave. Flint, MI 48507	Principal, Early Childhood Programs and Services (including Early On)	(810) 591-4883 jlee@geneseeisd.org
Toni McCrum	Genesee County Health Department 630 S. Saginaw Street, Suite 4 Flint, Michigan 48502	Title V Coordinator	tmccrum@gchd.org
Evilia Jankowski	Genesee Intermediate School District 2413 W. Maple Ave. Flint, MI 48507	Coordinator, School Health Services	(810) 591-5144 ejankows@geneseeisd.org
Connie Moran	725 Bloor Ave Flint, MI 48507	Parent	
Sara Morrow	10035 McKinley Court Montrose, MI 48457	Parent	
Brenda Jarbou	3245 Centennial Oak Ct. Clio, MI 48420	Parent	

Statement of Assurance

Genesee County

As the grantee, GCCARD Head Start assures that the funds will be used to provide a high quality program that is delivered with fidelity to eligible families who volunteer to participate in the program. Specifically, GCCARD Head Start will provide a home-based Early Head Start program and commit to the following:

- a. Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments within the scope of the model, and assuring fidelity to the model, (e.g., assessment does not eliminate components of the model).
- b. Assurance that services will be provided on a voluntary basis
- c. Assurance that priority will be given to serve eligible participants who:
 - 1) Have low incomes
 - 2) Are pregnant women who have not attained age 21
 - 3) Have a history of child abuse or neglect or have had interactions with child welfare services
 - 4) Have a history of substance abuse or need substance abuse treatment
 - 5) Are users of tobacco products in the home
 - 6) Have, or have children with, low student achievement
 - 7) Have children with developmental delays or disabilities
 - 8) Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.
- d. Assurance that funds will be used to service the at-risk target population agreed upon with the state, the characteristics of which are documented in Section A above.



Signature of GCCARD Head Start Director
Carol Piechocki, Director

5-31-11

Date

Michigan Maternal, Infant and Early Childhood Home Visiting Program
County-Level Home Visiting Program Implementation Plan

County: Ingham
Contact Person/Agency: Ken Sperber, Ingham Great Start Collaborative
Phone: Office: (517) 332-6516
Cell Phone: (517) 285-0193
Email: KenSperber@comcast.net

A. Identification of Ingham County's Targeted At-Risk Community

- 1. What is the targeted at-risk community (e.g., city, township, zip code, population group, etc) that the Local Leadership Group (LLG) and the Home Visiting Workgroup (HVWG) have jointly agreed upon?**

The Ingham County Local Leadership Group and the Home Visiting Workgroup have selected the City of Lansing, Southside, in USPS zip code 48911 as the targeted at-risk community. Early Head Start Home-Based services will be expanded in Ingham County to serve this population.

- 2. What are the risk factors in this community?**

RISK FACTORS	COUNTY: INGHAM	AT-RISK COMMUNITY LANSING/zip 48911	SOURCE FOR AT-RISK COMMUNITY DATA
1. Premature birth: using calculated gestational age	9.2% MDCH Vital Stats 2007-2009	12.4% for 48911	MDCH Vital Statistics: 2007-2009
2. Low-birth wt infants	7.8 % in 2009	10.5% for 48911	MDCH Vital Statistics 2007-2009
3. Infant mortality: Rate per 1000	7.4 ± 1.4 MDCH Vital Stats 2007-09	9.1 ± 2.3 for Lansing City	MDCH Vital Stats 2007-2009
4. Poverty	19.1% SAIPE for all ages	32.23% children < 6 years in Lansing City, Ingham Co. (ACS); 30.62% Ages 5-17 in Lansing Public School District (SAIPE)	American Community Survey 2005-2009; SAIPE

RISK FACTORS	COUNTY: INGHAM	AT-RISK COMMUNITY LANSING/zip 48911	SOURCE FOR AT-RISK COMMUNITY DATA
5. Crime: Rate per 1000 [all crime types]	82.62 MICR 2009	109.29 for Lansing City, Ingham Co.	MICR 2009
6. Domestic violence: Rate per 1000	11.53 MICR 2008	N/A	
7. School drop-out rates	11.8% MLHS Kids Count	25.47% for Lansing Public School District	Center for Educational Performance & Information, State of Michigan 2010 Cohort 4 Year Graduation & Dropout Rate Report
8. Substance abuse: Binge alcohol use	28.02% in past month, SAMHSA 2006-2008	29.9% in past 2 weeks, Capital area 12 th grade students	Ingham Substance Abuse Prevention Coalition, data from 2008 Mid-South Substance Abuse Commission Prevention Needs Assessment Survey
9. Unemployment	9.1% LAUS March 2011	12.0% for Lansing city, Ingham Co.	Local Area Unemployment Statistics, March 2011
10. Child maltreatment: Rate per 1000	27.3 Confirmed victims of abuse and/or neglect ages 0-5 in 2009	NA	MDHS/CPS via Kids Count
11. Proportion of total pop of American Indians living in community compared to total pop in county	[2.79% in SNA] Single race identified: 1546/269757 (0.57%) An additional 2006 persons identify as AIAN & White or Black	Lansing city Single race identified: 882/1546 (57.0%) Two races: 888/1614 White & AIAN; 307/402 Black & AIAN	2010 Census. Note: Ingham County, particularly the Lansing area, has a relatively large proportion of people who identify as more than one race.
12. Proportion of total pop of African Americans living in community compared to total pop in county	[2.24% in SNA] Single race identified: 33047/269757 (12.25%)	Lansing city Single race identified: 27138/33047 (82.1%) Two races: 3440/4612 White & Black; 307/402 Black & AIAN	2010 Census

3. What are the strengths of this community?

COMMUNITY STRENGTHS/ASSETS	
1. What is this community proud of?	Community gardens
2. Faith communities	Over 100 Churches and Faith-based organizations, including Trinity AME Church which has extensive congregant and community programs
3. Neighborhood associations	Southside Community Coalition
4. Cultural/ethnic associations	- Lansing Area Hispanic Business Association - Cristo Rey Church
5. Other community organizations	- City of Lansing Southside Community Center - South Lansing Community Development Association (SLCDA) - Food Movers
6. Business investment	Summer Place Townhomes, Medallion Management
7. Philanthropic investment	- Capital Area United Way & Capital Area Regional Foundation : Birth to Five Youth Initiative (Countywide) - WK Kellogg Foundation : Birth to Work Initiative (City of Lansing)
8. Major community events	-SLCDA Farmers Market -Cristo Rey Church Fiesta -Southside Annual Picnic -Potter Park Zoo Days
9. Other assets/resources (specify one or more)	- City of Lansing Benjamin Davis Park - Lansing School District Hill Voc Tech Center - Boys & Girls Club of Lansing - Oak Park YMCA

4. Briefly describe characteristics of potential HVP participants from the at-risk community (e.g., income level, mother's education level, percentage of single parents, percentage of first-time parents, employment rate, race/ethnicity, and/or other characteristics).

Characteristics of HS and EHS currently enrolled families living in 48911:

- Head Start (265 families/290 children)
 - Race and ethnicity: 1 Native American; 9 Asian; 141 Black; 40 Multi-racial; 99 White
 - Single parent: 86%
 - Poverty: 87% below 100% of federal poverty guidelines including 162 families below \$10,000 annual income
 - Unemployment: 49%
 - Less than High School Education: 30%, including 9 below 10th grade
- Early Head Start (33 families/38 children)
 - Race and ethnicity: 2 Native American; 21 Black; 10 Multi-racial; 5 White

- Single parent: 84%
- Poverty: 97% below 100% of federal poverty guidelines including 23 families below \$10,000 annual income
- Unemployment: 45%
- Less than High School Education: 30%, including 4 below 10th grade

5. Below is a list of possible needs of potential HVP participants. Indicate whether or not individuals residing in the targeted at-risk community have each of these needs. Add any other needs that you have identified at end of list.

NEEDS OF PARTICIPANTS	Yes or No
1. Child development/parenting education and support to assist families to form stable and responsive relationships with their young children	Yes
2. Safe and supportive physical, chemical, and built environments, which provide places for children that are free from toxins and fear, allow active, safe exploration, and offer families raising young children opportunities to exercise and make social connections	Yes
3. Sound and appropriate nutrition	Yes
4. Health education and care	Yes
5. Education on promoting literacy and early learning	Yes
6. Access to quality child care/early childhood education experiences	Yes
7. Domestic violence resources	Yes
8. Substance abuse services	Yes
9. Mental health services	Yes
10. Training and jobs	Yes
11. Transportation	Yes
12. Other (<i>specify</i>): GED completion	Yes
13. Other (<i>specify</i>): Service for children with disabilities	Yes
14. Other (<i>specify</i>):	
Provide any additional comments you may have about needs of potential program participants: The experiences, training, etc. listed above must support the development of children with disabilities and the needs of their parents.	

6. Identify any other factors considered in the selection of this at-risk community.

As noted in our Second Cut Needs Analysis, all data show a substantial proportion of the Lansing City population is characterized by multiple risks. Although preliminary 2010 MICR data (January-June) shows crime rates falling across Michigan, crime rates (violent, property, and overall) in the Lansing metro area are rising. Local coalition counts identified the Southside (area code 48911) as having extensive unmet needs and as the section of the city with the highest number of children and families currently in home visiting services (181 clients, 24% of the preliminary Ingham County coalition total). It should be noted that home visiting services are provided by a variety of agencies, target different populations, and vary in content depending upon the needs of the family. Ingham ISD has identified 83 children with disabilities who are eligible for Early On Michigan in the 48911 area.

7. Review the updated list of home visiting programs operating in your county and list each program that serves your targeted at-risk community below.

Each of these Ingham Home Visiting Programs serves the south side of Lansing: CACS Early Head Start, Ingham ISD Early On & Great Parents Great Start, ICHD Family Outreach Services & Public Health Nursing, CAPS Family Preservation Services, St. Vincent's Catholic Charities Therapeutic Home Visiting, and CMH: Parent Infant Program, Parent Young Child Program, and KEEP programs.

8. If there are home visiting services currently serving the targeted at-risk community, why are additional home visiting services needed (e.g., existing programs don't have capacity to meet the need, long waiting lists, program eligibility restrictions, etc.)? What is your estimate of the number of service slots available compared to the number of families who need home visiting services?

It is estimated that nearly 5,800 Lansing children under the age of six years live below 185% of poverty level, with 57% of those children living below the poverty line (ACS 2005-2009). Home visiting programs in our coalition currently serve less than 10% of that number (preliminary client count: 541 for Lansing, with 181 in the 48911 zip code). Head Start currently serves 290 three to four year old children in the 48911 service area. Projecting three additional age-cohort groups (ages 0-1, 1-2, & 2-3 years) indicates a potential of 870 age birth to three year old children at or below 100% of poverty. Existing programs do not have the capacity to meet the needs of families in this area, and families sometimes experience difficulty in qualifying for programs with strict income cutoffs.

9. Identify referral resources (services to which the home visiting program can refer) currently available to support families residing in the community.

Ingham County Health Department Family Outreach Services, Capital Area Community Services (CACS) [variety of services including food assistance, weatherization, homeless assistance, shelter and utility assistance], WIC, Child Health, Public Health Nursing, Smoking Cessation Programs [including 'House Calls' for pregnant and parenting women], Ingham DHS, Clinton-Eaton-Ingham CMH (KEEP), Ingham ISD (Great Parents Great Start), substance abuse treatment programs and homeless shelters, and GED completion programs.

Ingham ISD Early On and Clinton-Eaton-Ingham CMH (Parent Young Child Program, Parent Infant Program) are mandated to serve all eligible families and do not maintain waiting lists.

10. Identify referral resources (services to which the home visiting program could refer) that are needed in the community.

Same list as above – most programs listed do not have enough spaces for all the families

needing services. There is also a need for substance abuse day treatment and residential facilities that provide arrangements for child care for parents of young children.

11. Describe your plan for coordination among existing programs and resources in the community, including how the program will address existing service gaps.

We will build on current programming by recruiting additional children and families into the Early Head Start (EHS) program of CACS. EHS partners, including the Ingham County Health Department, Community Mental Health, and Early On, meet monthly to discuss program needs, services, and capacity. The partners review individual family needs and make referrals for services. EHS families and partners are represented on Policy Council and the Health Service Advisory Committee, advisory boards for the Head Start and Early Head Start programs of CACS. In addition, the Great Start Collaborative (GSC) meetings provide an opportunity for additional agencies to share resources. Ingham GSC works to recruit and include new agencies to address gaps in county services.

12. Identify existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the community level). To what extent are you coordinating referrals and intake across home visiting programs?

Community Mental Health, the Health Department, and EHS use the same intake form, and families may put in an application at any of these agencies. The initial screening is done at intake and referrals are made to the most appropriate center-based or home visiting service. Early Head Start and the Ingham County Great Parents Great Start program use ASQ and ASQ-SE screenings. Referrals to EHS are also made by Early On and the Great Parents Great Start program. All agencies are made aware of individual program eligibility requirements and specialization of services provided.

13. Describe county capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level, such as a governance structure or coordinated system of planning.

The Parent Education & Home Visiting Workgroup of the Great Start Collaborative meets monthly to discuss capacity and available services for families. They are the governance and planning structure for parent education and home visiting services in Ingham County. The Workgroup has developed a New Parent Resource Guide which describes Home Visiting Programs, Parenting Classes & Groups, and Parent-Child Activities including Play & Learn groups.

B. Selection of Ingham County's Home Visiting Model and Explanation of How the Model Meets the Needs of Targeted Community

1. Which evidence-based home visiting program model has been selected for expansion in the targeted at-risk community, as agreed jointly determined by the LLG and the HVWG?

The Early Head Start Home-Based model (EHS-HB) will be expanded in Ingham County.

2. How does the selected model address the particular risks in the targeted community and the needs of the families residing there?

The EHS-HB Program provides measurable, comprehensive services for both the child and family. Weekly one and a half hour home-visits, and bi-weekly socialization group experiences are provided to families with children ages 0 to 3. Children and families transition from EHS to Head Start at age 3. Comprehensive services include health and nutrition, child development, mental health, special needs, and parent involvement. EHS has a history of working with families in poverty and addressing multiple risk factors through partnerships in the community. A close relationship is established with each family to work collaboratively identifying family strengths, goals, and needed services. The relationship also assists and supports families as the primary nurturer of their children and enhances the sensitivity and responsiveness to their children's growth and development. A variety of curricula, including Parents as Teachers (PAT), will be used to address particular risk factors. PAT provides a variety of literacy levels in the materials which will be helpful in working with parents who have a variety of educational needs.

3. How will the targeted community be involved on an ongoing basis throughout the duration of this program (other than as program participants)?

Parents will be provided with information on community events, socializations, Play & Learn Groups, and other Head Start sponsored activities to share with other community members. Parents will be encouraged to join the Ingham Great Start Parent Coalition to provide input to services in their community, advocate for the needs of children, and develop new, supportive relationships with other parents. Parents from the community are welcomed at all CACS parent education opportunities.

4. Describe your county's current and prior experience with implementing the selected model.

CACS has provided EHS services since 2001 and Head Start services since 1965. They both provide home visiting services directly and contract with multiple community partners. CACS has expanded home visiting services in the past two years under ARRA funding. EHS has participated in three federal reviews and has been found in compliance with the Head Start Performance Standards. Child and family outcome data is submitted

annually in the Program Information Report for federal review, and the program participates in an annual Risk Management review. The program has been found to be in full compliance.

5. Describe your county's current capacity (e.g., funding, staff, administration, etc.) to increase the number of families served using this model.

The EHS-HB program of CACS has been selected to provide the evidence-based model for Ingham County. CACS will hire and train two home visitors to provide services to the 24 families. Support services and administrative services will be cost allocated for existing CACS staff. Additional services for reflective supervision, mental health and health consultations will be added to existing sub-contracts with the ICHD and CMH agencies. The new home visitor will collect data to be added to the county's PAT Annual Report.

6. Describe your plan to ensure implementation with fidelity to the model.

The new EHS home visitor will be trained on the Head Start Program Performance Standards, PAT curriculum, Ages and Stages Screenings, OUNCE Scale Assessment, and other supportive curricula. Observations will be conducted at socializations, parent meetings, and on home visits. Each week, the EHS supervisor will monitor attendance, lesson plans, paperwork and record keeping. Data from the new EHS-HV will be included in the annual self-assessment.

7. Discuss anticipated challenges and risks of the selected program model, and your proposed response to these challenges.

We anticipate challenges such as residential moves by the client population and a lack of parent engagement during and between home visits. To address these challenges, the home visitor will offer home visits at flexible hours and will make up missed home visits. The home visitor will retain families on their caseload if they move within the county. The home visitor will recognize the families' participation efforts by offering incentive gifts and access to a lending library of books and toys. To ensure parent/child participation in bi-monthly socialization experiences, EHS-HV will assist each family with transportation services.

8. Identify any anticipated technical assistance needs to be addressed by the state or the model developers.

- Tracking/follow-up with clients, particularly as children enter and progress through the public school system
- Development of a common database for use by county programs

C. Implementation of Ingham County's Selected Model

- 1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots? (Note: This is the entity that is already implementing the selected model, unless the LLG and HVWG have agreed upon an alternative entity, based on how the alternate approach will maximize funding and services.)**

The Capital Area Community Services, Inc. will receive the Michigan MIECHVP funds to expand service slots in the Early Head Start Home-Based Program in Ingham County. The program will target participants age birth to 18 months, but may serve children through the age of three years. The Parents as Teachers Curriculum is used in their service provision.

- 2. Describe the plan for recruiting, hiring, and retaining appropriate staff for all positions. List each position to be filled.**

The home visitor job positions will be posted in the local newspaper, sent out to all the agencies working with Ingham GSC, forwarded to minority service organizations, and posted both internally and at CACS work sites throughout the community. The positions will provide competitive wages and a substantial benefit package. Initial and ongoing training, support and reflective supervision are built into the EHS program. Each staff member has a professional development plan created by the staff member and supervisor. Monetary assistance for conferences, college courses, and books will be available. Monthly staff meetings provide all EHS staff with training, networking opportunities, and peer support. The home visitors will be co-located with another home visitor for support.

- 3. If subcontracts will be used, describe the plan for recruitment of subcontractor organizations, and the plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s).**

EHS will expand on existing inter-agency contracts. All sub-contracting partners are public agencies and follow EOE practices and similar procedures as outlined above.

- 4. Describe the plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors.**

The EHS Manager holds a MSW degree and provides individual reflective supervision with the CACS home visitors on a regular basis. CACS contracts with CMH to provide Infant Mental Health Consultation services for EHS home visitors.

- 5. What is the estimated number of families that will be served annually with the expansion funds provided by the Michigan MIECHVP? (Do not count families being served with funds from other sources.)**

Twenty Four (24)

6. How will program participants be identified and recruited?

Participants will be identified and recruited in coordination with Great Start Collaborative partners and programs (through existing processes) and also via targeted recruitment in the 48911 zip code area through community organizations and events listed in A-3.

7. Describe the plan for minimizing the attrition rates for participants enrolled in the program.

Ingham County will minimize attrition rates by continuing to work with families even if they move out of the target area; offering flexible scheduling of home visits and make-up visits; and offering participation incentives and transportation assistance (see B-7).

8. What is the estimated timeline to reach maximum caseload?

It is anticipated that maximum caseload will be reached within three months of receiving implementation funding.

9. Describe the operational plan for the coordination between the proposed home visiting program and other existing programs and resources in the community, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services.

Families will be referred to community agencies for services as soon as needs are identified. For complete details, see A-9, 11.

10. How are you already collecting process and outcome data for the existing home visiting program that has been chosen to receive MMIECHVP funds? Will you be using the same process with the expansion slots?

CACS EHS will use its existing data collection processes for the new home visiting program caseload. Data from the OUNCE Scale Assessment, Ages & Stages screenings, PAT, dental and health examinations and treatments (including immunizations), and parent/child outcomes will be collected, analyzed, and used as a basis for continuous improvement.

11. Describe anticipated challenges to maintaining program quality and fidelity, and how these challenges will be addressed.

Experience suggests that the primary challenges will be parents' commitment and full participation in the program. To ensure parents are present and engaged during home visits the EHS home visitor will provide makeup visits and will be flexible about the time and place of visits. EHS-HV will also provide incentives to encourage regular participation.

12. Provide a list of collaborative public and private partners (Local Leadership Group member names and organizations).

Ingham County Health Department:	Julie Dingerson
Mid-South Substance Abuse Commission:	Joel Hoefpner
Ingham Substance Abuse Prevention Coalition:	Harriet Dean
Child Abuse and Neglect Council:	Lisa Chambers
CACS Head Start:	Lucy McClintic
CACS Early Head Start:	Wendy McBride
Great Start Collaborative:	Ken Sperber
Clinton-Eaton-Ingham Community Mental Health:	Fran Jozefowicz
Ingham ISD:	Michelle Nicholson
Parents:	MC Rothhorn
	Jamie Yeomans
	Chris Singer
	Jessica Baker
	Tami Smith

13. Indicate that you are providing each of the following assurances:

- a. *Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments within the scope of the model, and assuring fidelity to the model, (e.g., assessment does not eliminate components of the model).*

Each family will develop a Family Partnership Plan identifying family and child goals based on individual assessment. Home visits, scheduled according to the model, will be individualized to meet the needs of children and parents. Progress will be monitored on a regular basis.

- b. *Assurance that services will be provided on a voluntary basis.*

The EHS program will be thoroughly explained to families. The decision to enroll in the program will be voluntary.

- c. *Assurance that priority will be given to serve eligible participants who:*

- 1) Have low incomes*
- 2) Are pregnant women who have not attained age 21*
- 3) Have a history of child abuse or neglect or have had interactions with child welfare services*
- 4) Have a history of substance abuse or need substance abuse treatment*
- 5) Are users of tobacco products in the home*
- 6) Have, or have children with, low student achievement*
- 7) Have children with developmental delays or disabilities*

- 8) *Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.*

EHS will select participants experiencing the greatest need for services, targeting families with the youngest children and the greatest risk (multiple risk factors) as defined above. Current data shows most families entering EHS in Lansing have three or more risk factors.

- d. *Assurance that funds will be used to service the at-risk target population agreed upon with the state, the characteristics of which are documented in Section A above.*

Services will be targeted to families within the 48911 service area which has been defined as the community with greatest risk.

Michigan Maternal, Infant and Early Childhood Home Visiting Program
County-Level Home Visiting Program Implementation Plans

County: KENT
Contact Person/Agency: Candace Cowling/Family Futures
Phone: 616 454-4673
Email: ccowling@familyfutures.net

A. Identification of Kent County's Targeted At-Risk Community

1. What is the targeted at-risk community (e.g., city, township, zip code, population group, etc) that the Local Leadership Group (LLG) and the Home Visiting Workgroup (HVWG) have jointly agreed upon?

The Kent County Local Leadership Group and the Home Visiting Workgroup have selected the Hispanic/Latino population as the targeted at-risk community. Healthy Families America services will be expanded in Kent County to serve this population.

2. What are the risk factors in this community?

RISK FACTORS	COUNTY: KENT	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
a. Premature birth	9.7 % were premature	8.7% of births to Hispanic women were premature.	2008-2010 Michigan Resident Birth File
		10% of births to Hispanic teens were premature compared to 8.5% of births to older Hispanic women.	
		56.6% of all Hispanic births occurred in the city of Grand Rapids and 23.2 % of births occurred in the city of Wyoming.	
		62.2% of births to Hispanic teens occurred in the city of Grand Rapids and 20% of teen births occurred in Wyoming.	
		Although the largest number of Hispanic pre-term births occurred in the city of Grand Rapids, a greater percentage of pre-term births occurred in Kentwood (9.4%) and Comstock Park (13.0%) than Grand Rapids (8.4%).	

RISK FACTORS	COUNTY: KENT	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
b. Low-birth wt infants	7.3% were low-birth weight	6.3% of births to Hispanic women were less than 2500g.	2008-2010 Michigan Resident Birth File
		9.2% of births to Hispanic teens were less than 2500g compared to 5.8% of births to older Hispanic women.	
		Although the largest number of Hispanic LBW births occurred in the city of Grand Rapids, a greater percentage of LBWs occurred in Wyoming (7.5%), Kentwood (8.6%), and Comstock Park (7.1%) than Grand Rapids (5.5%).	
c. Infant mortality	7.7 per 1000	The three year average (2006-2008) for Hispanic infant mortality rate was 12.7 per 1,000 live births compared to 5.5 per 1,000 among Kent County Caucasians and 10.2 per 1,000 among Michigan Hispanics.	Michigan Resident Infant Death File, Division for Vital Records & Health Statistics, Michigan Department of Community Health 2010 Fetal Infant Mortality Review Report: Nine Years of FIMR
		60% of Hispanic infant deaths involved a mother who had not completed a high school education.	
d. Poverty	14.6%	77% of births to Hispanic women were paid for by Medicaid.	2008-2010 Michigan Resident Birth File 2000 United States Census
		86% of births to Hispanic teens were paid for by Medicaid.	
		22% of the Kent County Hispanic population lived below the federal poverty level in 1999 compared to 26% of African Americans and 5.7% of Caucasian, non-Hispanics.	
		81% of Hispanic births in Grand Rapids, 80% of Hispanic births in Comstock Park, and 75% of Hispanic births in Wyoming were paid for by Medicaid compared to 61% for the rest of the county.	
e. Crime	# reported crimes/1000 residents-cat. A crimes only-37.0	Ethnicity data is not available in the reports available via the Michigan Incident Crime Reporting System.	

RISK FACTORS	COUNTY: KENT	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
	# reported crimes/1000 residents-96.61 # crime arrests age 0-19/1000 juveniles age 0-19-95.31	** Chart of incarceration rates in Kent County-Source-Community Research Institute-See table that immediately follows this table.	
f. Domestic violence	6.20 rate per 1000	Ethnicity data is not available in the reports available via the Michigan Incident Crime Reporting System.	
g. School drop-out rates	12.3	50% of Hispanic females in Kent County had less than a high school education, compared to 27.2% of African Americans and 11.2% of Caucasian, non-Hispanics. Among Hispanic females delivering babies between 2008 and 2010, 56.4% had less than a high school education. Although drop out statistics are not available by ethnicity, Hispanic mothers are concentrated in Kent County communities with relatively high dropout rates; Comstock Park (14.8%), Grand Rapids (22.5%), Kentwood (13.3%) and Wyoming (20.4%). 63.5% of Hispanic mothers in Grand Rapids, 57.4% of Hispanic mothers in Comstock Park, and 52% of Hispanic mothers in Wyoming had less than a high school education.	2000 United States Census (population 25 years and older) State of Michigan 2009 Cohort 4-year Graduation and Dropout Rate Report, Michigan Department of Education Center for Educational Performance and Information 2008-2010 Michigan Resident Birth File
h. Substance abuse	Prevalence rate: Binge alcohol use in past month-24.39% Non-medical use of prescription drugs in past month-5.24%	A greater percentage (5.3%) of Hispanic adults reported heavy drinking (1 or more drinks per day for females/2 or more drinks per day for males) than non-Hispanics (1.7%).	2009/2010 Michigan Profile for Healthy Youth, Michigan Department of Education 2008 Kent County Behavioral Risk Factor Survey

RISK FACTORS	COUNTY: KENT	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
	<p>Marijuana use in past month-5.76%</p> <p>Use of illicit drugs, excluding marijuana in past month-3.70%</p>	Based on a survey of Kent County high school students, 63.4% of Hispanic respondents indicated that it was easy to get marijuana, 34.4% of Hispanic students have tried marijuana at least once, and 18.7% indicated use within the past month. These statistics are similar to African American respondents, but are considerably increased compared to Caucasian respondents.	
i. Unemployment	17% (June 2010)	In 1999, 8.9% of Hispanics in the labor force were unemployed compared to 11.2% of African Americans and 3.4% of Caucasian, non-Hispanics. However, the overall unemployment rate at the time was 4.4% compared to 8.5% in December 2010.	<p>2000 United States Census</p> <p>Bureau of Labor Statistics</p>
j. Child maltreatment	Rate of reported substantiated treatment-12	Ethnicity data was not available in the reports that were readily accessible via the Department of Human Services.	
k. Proportion of total pop of American Indians living in community compared to total pop in county	5.04%		
l. Proportion of total pop of African Americans living in community compared to total pop in county	4.11%		

RISK FACTORS	COUNTY: KENT	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
If you were unable to provide community-level data on more than 5 risk factors , explain how you determined that this is the highest-need community in the county.			

**Incarceration % in Kent County Correctional Facility by race				
Year	Caucasian	African American	Hispanic	other
2006	47.70%	40.50%	11.00%	0.80%
2007	46.60%	41.10%	11.30%	1.00%

3. What are the strengths of this community?

COMMUNITY STRENGTHS/ASSETS	
1. What is this community proud of?	Grand Rapids has a small town feel that is very family friendly, but has the amenities of a larger urban area in regard to cultural events, the various universities-GVSU, Calvin, Aquinas, Cornerstone, Kendall, a growing medical mile, and a vibrant alive downtown. It has natural beauty with the Grand River, the most trees for an urban city in the entire US, and a commitment to green space. Grand Rapids is evolving to be more diverse and has a commitment to inclusion with 'Partners for a Racism Free Community' providing leadership.
2. Faith communities	Grand Rapids has strong faith communities. There is a diverse representation of faiths and venues in which to worship ranging from house churches to mega churches. The faith community plays a large role in this community. Many churches in the urban areas provide additional supports to families such as after school tutoring, food pantries, clothing, etc. They are a huge asset.
3. Neighborhood associations	Neighborhood associations are active and vibrant. They focus on fostering community within neighborhoods. Neighborhood citizens work to bring about desired changes and to highlight neighborhood uniqueness. They sponsor many community activities providing a great way to get to know the people in their neighborhood. They work to preserve and improve the unique human and physical characteristics of the neighborhood through resident involvement.
4. Cultural/ethnic associations	Various ethnic groups in Grand Rapids have cultural associations. The Hispanic Center of Western Michigan is a non-profit organization serving the needs of the Hispanic and broader community. They strive to provide an avenue for education and to promote open discussion regarding the distinctions and values of different nationalities and cultures. The Center also focuses on the common thread that unites all people: a desire for understanding and respect of our differences. There are other cultural and ethnic associations as well as neighborhoods that are characterized by a strong representation of people from similar cultures/heritages.

COMMUNITY STRENGTHS/ASSETS	
5. Other community organizations	There are many community organizations focused on the special interests of their respective members. There is one organization particularly working on place based community development, LINC. LINC is working directly with residents to increase their leadership and voice in decision-making, in at least four neighborhoods in the core city area.
6. Business investment	Kent County businesses invest in the community. There are many public /private partnerships working for improvements in the community. We have the Sechia Medical School, the VanAndel Arena, and the DeVos Children's Hospital. Business has taken the lead to ensure a vibrant downtown. The Marriott and Amway hotels are top rated hotels that show business investment in the downtown area. We are home to Amway, Meijer, Steelcase, and other major companies.
7. Philanthropic investment	Our community has many "heavy hitters" in this area. It's a real strength that we have people willing to give their money to help support the community. We have people who have invested in area hospitals, cultural organizations, and social services. Both ArtPrize and Meijer Garden are the results of philanthropic investment that have put Grand Rapids on the map nationally.
8. Major community events	ArtPrize, the 5/3 rd River Run, numerous festivals that highlight various cultures/interests, LaughFest, and unique events sponsored by Rob Bliss have created a spark around Grand Rapids. People love these events that provide an opportunity for people from all over the city to come together to interact and have fun.
9. Other assets/resources (specify one or more)	<p>a) Four-Seasons Outdoor Play: Bike trails, parks, golf, the lakeshore, skiing, racing, Whitecaps games</p> <p>b) Cultural Venues/Events: Van Andel Arena, concerts, sporting events, museums, DeVos Place, the Symphony</p> <p>c) An ever evolving improved Transit System</p>

4. Briefly describe characteristics of potential HVP participants from the at-risk community (e.g., income level, mother's education level, percentage of single parents, percentage of first-time parents, employment rate, race/ethnicity, and/or other characteristics).

In the past ten years, the Hispanic/Latino population of Kent County has grown 45.4%. Hispanics/Latinos comprise 9.7% of the population and are now the largest minority group. According to the Community Research Institute, "Forty-two percent of the Hispanic population in Grand Rapids and Kent County was under age 18 in 2010. This compares to the Non-Hispanic white population's 16 percent and 22 percent under age 18, respectively. The percent of the Non-Hispanic white population under 18 has fallen since 1990 while the percent under age 18 in the Hispanic population has stayed relatively constant. Thus, only 1 in 6 Grand Rapidsians is Hispanic, but 1 in 4 Grand

Rapidians under 18 is Hispanic.” The growth of the Hispanic population has not been limited to the central city. Fifty percent of the Hispanic population lives in the suburbs.”

The Hispanic/Latino population in Kent County is predominantly of Mexican descent at 70%. Others of Hispanic/Latino origin are from Puerto Rico (8.2%), Guatemala (7.6%), Cuba (2.7%), and the Dominican Republic (2.5%).

Below are some of the characteristics of Hispanic/Latino families Kent County Healthy Start is currently serving.

Income

Mother's Race	Under \$5,000	\$5,000 - \$9,999	\$10,000 - \$14,999	\$15,000 - \$19,999	\$20,000 - \$24,999	\$25,000 - \$29,999	\$30,000 - \$39,999	\$40,000 - \$49,999	\$50,000 and up	Unknown	Total
(Hispanic) #	25	24	28	4	7	1	2	-	3	57	151
(Hispanic) %	17%	16%	19%	3%	5%	1%	1%	0%	2%	38%	100%

Mother of Baby's Education

Mother's Race	Less than 7th grade	7th-9th Grade	10th-11 th Grade	High School Diploma	Post HS or some college	Associate Degree	Bachelor Degree	Some Grad School	Grad Degree	Unknown	Total
(Hispanic) #	23	34	28	45	12	3	3	-	1	2	151
(Hispanic) %	15%	23%	19%	30%	8%	2%	2%	0%	1%	1%	100%

Marital Status

Mothers Race	Single	Live together	Married, 1st time	Re-married	Separated	Divorced	Unknown	Total
(Hispanic) #	59	56	30	1	5	-	-	151
(Hispanic) %	39%	37%	20%	1%	3%	0%	0%	100%

Mother of Baby's Employment

Mother's Race	Full Time	Part Time	Odd Jobs/ Irregular PT	Medical Leave/ Disability	Stay-at-home mom	Unemployed / Looking	Unemployed / Not Looking	Unemployed / FT Student	Unemployed PT Student	Other	Unknown	Total
(Hispanic) #	5	8	2	14	2	11	93	11	3	1	1	151
(Hispanic) %	3%	5%	1%	9%	1%	7%	62%	7%	2%	1%	1%	100%

First Time Moms

Mother's Race	Yes	No	Unknown	Total
(Hispanic) #	130	19	2	151
(Hispanic) %	86%	13%	1%	100%

Kent County Healthy Start is currently serving Hispanic/Latino families whose primary risk factors demographically are poverty and lack of formal education.

- 5. Below is a list of possible needs of potential HVP participants. Indicate whether or not individuals residing in the targeted at-risk community have each of these needs. Add any other needs that you have identified at end of list.**

NEEDS OF PARTICIPANTS	Yes or No
1. Child development/parenting education and support to assist families to form stable and responsive relationships with their young children	Yes
2. Safe and supportive physical, chemical, and built environments, which provide places for children that are free from toxins and fear, allow active, safe exploration, and offer families raising young children opportunities to exercise and make social connections	Yes
3. Sound and appropriate nutrition	Yes
4. Health education and care	Yes
5. Education on promoting literacy and early learning	Yes
6. Access to quality child care/early childhood education experiences	Yes
7. Domestic violence resources	Yes
8. Substance abuse services	Yes
9. Mental health services	Yes
10. Training and jobs	Yes
11. Transportation	Yes

NEEDS OF PARTICIPANTS	Yes or No
12. Health care that is culturally sensitive	Yes
13. English as a second language	Yes
14. Literacy-both language and financial literacy	Yes
15. Legal services particularly dealing with immigration issues	Yes
16. Interpretation Services	Yes
17. Housing-Safe and affordable	Yes
Provide any additional comments you may have about needs of potential program participants:	

6. Identify any other factors considered in the selection of this at-risk community.

The Hispanic/Latino population is the fastest growing population in Kent County and in the 2010 census was identified as the largest minority population. While the Hispanic/Latino population is often described as a very tight-knit community which is a strength, our Family Support Workers often have to assist families with interpretation and access to community resources due to language barriers. Lack of access to needed resources due to language barriers makes service to this population imperative. Other community home visiting programs either target African-Americans i.e. Nurse Family Partnership and Strong Beginnings or target the general community. No program specializes in the Hispanic/Latino community.

7. Review the updated list of home visiting programs operating in your county and list each program that serves your targeted at-risk community below.

No program specifically targets the Hispanic/Latino population. According to their websites and program information:

- a) Strong Beginnings is a community program created to improve health care and health education for African American mothers and their babies – from pregnancy through early childhood. Strong Beginnings was designed to eliminate the huge difference in infant death and low birth weight between African Americans and Whites.
- b) Nurse Family Partnerships serves first time, low income, pregnant women of diverse cultures residing in the City of Grand Rapids. The demographics statewide in Michigan for NFP are: 70% African American, 16% Non-Hispanic White, 6% Multiracial/other, 5% Hispanic, 1% Asian, 1% Native American.
- c) The Kent ISD Bright Beginnings Program is a partnership between Kent ISD and its constituent districts. The program provides services to families with children birth to kindergarten entry throughout Kent County and uses the Parents as Teachers program. Their first quarter of 2011 demographics were 1% American Indian/Alaska Native, 3% Asian American, 4% African American, 78% Caucasian, 10% Hispanic/Latino, 1% multi-racial, and 2% not reported.

- d) Early Head Start (EHS) is a federally funded community-based program for low-income families with infants and toddlers and pregnant women. Its mission is simple: to promote healthy prenatal outcomes for pregnant women; to enhance the development of very young children; and to promote healthy family functioning.

8. If there are home visiting services currently serving the targeted at-risk community, why are additional home visiting services needed (e.g., existing programs don't have capacity to meet the need, long waiting lists, program eligibility restrictions, etc.)? What is your estimate of the number of service slots available compared to the number of families who need home visiting services?

Kent County Healthy Start serves the greatest number of Hispanic families in Kent County other than the Maternal Infant Health Program (a home visiting program for all Medicaid eligible women and infants). Our four Spanish-speaking staff always have caseloads of about 30 even though the Healthy Families America standard for caseload size is 25. We have allowed this overage to occur because of the needs of the Hispanic/Latino community. It is difficult to estimate the number of slots available as compared to the need. We currently have capacity to serve between 100 and 120 Hispanic/Latino families. Based on the number of Hispanic/Latino births (1382 in 2009), and knowing that 77% of Hispanic births are paid for by Medicaid, we would estimate that at least 1000 families would benefit from services with 500 actually voluntarily agreeing to services.

9. Identify referral resources (services to which the home visiting program can refer) currently available to support families residing in the community.

- a) Hispanic Center (assistance with interpreting, immigration, employment, education, etc., resources)
- b) Grand Rapids Public Schools English as a Second Language classes
- c) Clinica Santa Maria (medical needs)
- d) Food Pantries (South End Community Ministries)
- e) Academy of Arts (classes of the arts, resources)
- f) Head Start (Spanish speaking class)
- g) In the Image (clothing/household)
- h) Salvation Army/ Goodwill services

10. Identify referral resources (services to which the home visiting program could refer) that are needed in the community.

- a) Additional English as a Second Language classes
- b) Homeless shelters/traditional housing (for undocumented)
- c) Safe/Affordable housing
- d) Additional Spanish speaking day-care providers
- e) Additional immigration services
- f) Additional counseling services (relationships/substance abuse/ mental health services)

g) Employment/training services

11. Describe your plan for coordination among existing programs and resources in the community, including how the program will address existing service gaps.

Kent County Healthy Start currently collaborates with a number of programs within our community.

- a) We partner with First Steps' Welcome Home Baby program to gain access to referrals of families in our target population. Welcome Home Baby serves as the front door access to early childhood services in Kent County. Through much collaboration, Welcome Home Baby is designed to meet with families, provide them with information about services that are the best fit for them, and assist them in the registration process. This coordination allows for quality referrals to enter the system in a timely (within 3 weeks) after the baby is born so that families can be supported as quickly as possible.
- b) Kent County Healthy Start is coordinated by Family Futures and is a partnership between four agencies that work together to provide quality services for families. The Kent County Health Department, Arbor Circle, and Catholic Charities West Michigan all work together to provide Kent County Healthy Start home visiting services to families. As a result of having home visitors sit at each agency, Family Futures and Kent County Healthy Start have access to the additional supportive services provided by each of these agencies. This coordination of services and programs allows families to access Maternal Infant Health Programs, Infant/Toddler Mental Health Services, and other therapeutic services in a seamless manner while continuing to receive Kent County Healthy Start services as well. With these partnerships, if there is a gap in the services provided by the Kent County Healthy Start program itself, we can access the services offered by our partner agencies in a fluid manner.
- c) In an effort to increase coordination among existing programs and services, Kent County Healthy Start sits on the Home Visit Provider Network: a group of leadership staff from local home visiting programs. This network of service providers shares resources and assists each other in accessing services. If there is a gap in a program, the group discusses ideas on how to bridge that gap and provide for families. This group also shares information/data, survey results, service ideas, etc.

12. Identify existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the community level). To what extent are you coordinating referrals and intake across home visiting programs?

First Steps Kent's Welcome Home Baby program is the referral coordination site for targeted newborn referrals in Kent County. They identify, screen, and refer families to home visiting programs in the community. Welcome Home Baby nurses provide home

visits to first time parents and parents under the age of 25 to explain local support/home visit options. The family is provided with a menu of service options to meet their needs. Together with the Welcome Home Baby nurse, the family chooses the service that is the best “fit” for their needs. Welcome Home Baby then sends referrals to the direct service provider agency. There is documented policy and procedure for this coordination process.

Currently Kent County Healthy Start does not coordinate referrals across programs. We accept referrals from other local agencies of eligible families. We assist ineligible families seeking Kent County Healthy Start services to find other resources and services to meet their needs’

Kent County does not have a systematic way to engage families prenatally in home visitation services. Kent County Healthy Start has relationships with some OB/GYN offices and provides them with brochures and information for their patients about Kent County Healthy Start.

13. Describe county capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level, such as a governance structure or coordinated system of planning.

There are three major ways that the proposed home visiting service will be integrated into an early childhood system. The first is through Welcome Home Baby. Welcome Home Baby is a program that seeks to introduce available early childhood resources to parents upon the birth of a baby. Welcome Home Baby will refer Hispanic/Latino mothers desiring home visiting services to Kent County Healthy Start. Welcome Home Baby staff will also recommend any other needed resources to these same families.

Kent County also has a home visiting provider network, a sub-committee of Healthy Kent 2020, which meets regularly. During meetings, they share best practices, discuss ways to improve data collection, deliberate what outcome measurements make sense to track, and other topics that will assist in maximizing coordination and collaboration among home visiting programs.

Finally, the Kent County Great Start Collaborative is working to assure a coordinated system of community resources and supports to assist families in providing a great start for their children from birth through age five. It envisions a single, interconnected and intertwined network of public and private services and supports working together in the community to accomplish better results for young children and families. As with any system, there are both key programmatic components, and also infrastructure elements that ensure coordination and sustainability.

B. Selection of Kent County's Home Visiting Model and Explanation of: How the Model Meets the Needs of Targeted Community

1. Which evidence-based home visiting program model has been selected for expansion in the targeted at-risk community, as agreed jointly determined by the LLG and the HVWG?

Kent County Healthy Start, a Healthy Families America program, was selected to serve the targeted at-risk community of Hispanic/Latino families.

2. How does the selected model address the particular risks in the targeted community and the needs of the families residing there?

Healthy Families America is committed to providing services that are culturally sensitive. Ethnic, racial, language, demographic, and other cultural characteristics identified by the program must be taken into account in overseeing staff-family interactions. Staff receives training designed to increase understanding and sensitivity of the unique characteristics of the service population. The program analyzes the extent to which all aspects of its service delivery system (assessment, home visitation, and supervision) are culturally sensitive. We will provide services and materials in Spanish when Spanish is the preferred language for the family and workers will be minimally bi-lingual. We will attempt to hire staff that are also culturally Hispanic/Latino.

Healthy Families America is able to address the following risk factors in the Hispanic/Latino Community:

Prematurity/Low birth weight: For families that begin services prenatally, we will connect them if not already connected to prenatal care. We will assist as needed with transportation and interpretation at medical visits. We have curriculum to that will inform the family about the danger of smoking and substance use during pregnancy.

Poverty: Family Support Workers will address poverty by assisting families to increase their financial literacy. We will connect families to needed supportive services such as English as a Second Language classes, food pantries, public assistance, and G.E.D. classes. We will support and assist families in attaining further education and/or employment when that is a goal set by the family.

Health Risks: We will assist families when needed to connect to a medical home for their children. We will provide transportation to medical visits and interpretation at visits when necessary. We will ensure children receive the immunizations required by the American Association of Pediatricians as well as the well-baby check ups. We will regularly do the Ages and Stages Questionnaire (ASQ) with families. We will assist the family to address any developmental concerns identified by the ASQ.

We also will assist families to increase their protective factors. We will connect families to needed concrete supports in times of need in the community whether it be dealing with

lack of food or clothing, issues such as substance abuse, domestic violence or other needs. We will teach families about child development and parenting. We will encourage parental resilience to deal with the stresses in their lives. There will be small group meetings so that parents can reduce social isolation and enjoy activities with other parents. Both Kent County Healthy Start Family Support Workers and parents will foster social and emotional competence in the families' children.

3. How will the targeted community be involved on an ongoing basis throughout the duration of this program (other than as program participants)?

We will begin by informing major agencies serving the Hispanic/Latino population of this service expansion. This will include social service agencies, such as the Hispanic Center and South End Community Outreach Ministries; business entities, such as the Hispanic Chamber of Commerce and The Source; the medical community, such as Clinica Santa Maria and Cherry Street Health; and neighborhood associations in predominantly Hispanic/Latino neighborhoods.

We currently have small groups of Kent County Healthy Start families meeting monthly. We will implement a monthly small group in Spanish. We will foster parent leadership of this group which will include opportunities for feedback about Kent County Healthy Start programming as well as the opportunity for this group to focus any areas of interest to them.

4. Describe your county's current and prior experience with implementing the selected model.

Kent County Healthy Start has been affiliated with Healthy Families America and has been implementing its model since the program began in 1995. Kent County Healthy Start set its goals/objectives to match that of Healthy Families America and implemented practices and procedures to achieve them. In February of this year, Kent County Healthy Start had its accreditation site visit. During this visit it was shown that our program is effectively adhering to the HFA model and are meeting many of the goals established by the organization. Any areas that aren't being achieved have an implementation plan in place and that plan is currently being carried out. As a result of this visit, our program is currently in good standing with Healthy Families America as we move forward in the final steps of the accreditation process.

5. Describe your county's current capacity (e.g., funding, staff, administration, etc.) to increase the number of families served using this model.

Kent County Healthy Start will be able to increase capacity provided funding remains constant. There are two funding sources that are in jeopardy beginning October 2011- Zero to Three Secondary funding (\$448,758) and Zero to Eighteen Prevention Funding (\$385,274). Loss of these funding sources would result in a need to reduce the number of Kent County Healthy Start Family Support Workers.

Our ability to increase capacity to serve this population is strong. We historically have had a minimum of four Spanish speaking Family Support Workers and plan to maintain that level. We have monthly Continuous Quality Improvement meetings that focus on both the quality and quantity of service we are providing. Healthy Families America requires that we review both cultural sensitivity and the demographics of who we serve annually. We pay special attention to engagement and retention of families by race, ethnicity, income level, marital status, and other key characteristics. If we find our engagement and retention rates are poorer for any specific population, we create an improvement plan to better address the needs of that population.

6. Describe your plan to ensure implementation with fidelity to the model.

Kent County Healthy Start currently monitors adherence to the HFA model on a monthly basis with our home visiting team. Supervisors are given a Kent County Healthy Start “dashboard” for each of their Family Support Workers to use during supervision meetings so that workers know where they stand in respect to what the model requires of them. This tool has been helpful in allowing workers to more easily achieve goals and see the work that is being completed each week/month. Kent County Healthy Start mid-level managers and partner executives also meet on a monthly or bi monthly basis to review Results Based Accountability reports that also discuss adherence to the HFA model. Workers or agencies that do not meet HFA goals for an extended period of time have to write a program improvement plan that addresses the issues and show improvement within a 3 month time frame.

7. Discuss anticipated challenges and risks of the selected program model, and your proposed response to these challenges.

We have been serving the Hispanic/Latino population with this model successfully since the Kent County Healthy Start’s inception. We find Hispanic/Latino families very receptive to the model and to our staff. The biggest challenge will be to involve the targeted community on an ongoing basis throughout the duration of this program (other than as program participants). We have not focused on doing that in the past, but would like to improve in this area not only with Hispanic/Latino population, but with other populations we serve as well.

8. Identify any anticipated technical assistance needs to be addressed by the state or the model developers.

Our anticipated need for technical assistance will be for authentic Hispanic/Latino community involvement that is integrated well into the Healthy Families America model. Our goal would be that Hispanic/Latino community involvement would enhance our outcomes. Technical assistance could help us incorporate community involvement seamlessly in our work rather than being an awkward add on, increase our understanding of the Hispanic/Latino community and potentially develop additional support and resources for families. We also may need some assistance with tracking of prenatal visits in the PIMS system which is our database system.

C. Implementation of Kent County's Selected Model

1. **What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots? (Note: This is the entity that is already implementing the selected model, unless the LLG and HVWG have agreed upon an alternative entity, based on how the alternate approach will maximize funding and services.)**

Family Futures will receive the Michigan MIECHVP funds to expand service slots in the Healthy Families America Program in Kent County. The program will serve participants who are pregnant mothers and children until the age of 3. The Partners for a Healthy Baby, Growing Great Kids, and Healthy Babies...Healthy Families-San Angelo (in Spanish) Curriculums are used in their service provision.

2. **Describe the plan for recruiting, hiring, and retaining appropriate staff for all positions. List each position to be filled.**

We plan to fill these positions with our sub-contractor's (Catholic Charities West Michigan) most experienced bi-lingual/bi-cultural Hispanic/Latino staff. We will move those staff to these two full-time Family Support Worker positions and fill behind them with Spanish speaking staff who ideally will also be bi-cultural. We will also pay for minimally 1/3 of a supervisor's position to provide supervision at the level required by the HFA model.

3. **If subcontracts will be used, describe the plan for recruitment of subcontractor organizations, and the plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s).**

We will use a sub-contractor, Catholic Charities West Michigan. They are a current sub-contractor that is committed to service to the Hispanic/Latino population. They will recruit using publications that advertise and appeal to the Hispanic/Latino population in an effort to find qualified bi-lingual/bi-cultural staff. Because of their commitment to serve this population, we have never had any issues with Catholic Charities hiring or maintaining Spanish speaking Family Support Workers.

4. **Describe the plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors.**

HFA and thus Kent County Healthy Start policy and procedure requires that Supervisors and Family Support Worker staff meet for supervision meeting once a week for at least an hour and a half each time. During these supervision meetings, there is discussion regarding the following items:

- a) Fidelity to the model
- b) Families' achievement of goals (via the assessment and Individualized Family Service Plan) and issues being faced, etc
- c) Caseloads

- d) Worker well being, etc.

Documentation for these practices can be found in each family file.

5. What is the estimated number of families that will be served annually with the expansion funds provided by the Michigan MIECHVP? (Do not count families being served with funds from other sources.)

We anticipate serving 50 families annually.

6. How will program participants be identified and recruited?

Program participants will be identified and recruited by publicizing the program throughout the Hispanic Community. We will supply agencies who primarily serve the Hispanic community with brochures and information. We will assign Hispanic families to this program who come through our normal referral channels of Welcome Home Baby, the Department of Human Services, our Birth Certificate mailing and self-referrals through our website.

7. Describe the plan for minimizing the attrition rates for participants enrolled in the program.

We will minimize attrition for participants by:

- a) Employing seasoned workers in the program. (Sites with greater retention of Family Support Workers (FSWs) for at least 24 months were associated with higher family retention from 3 to 24 months-HFA website)
http://www.healthyfamiliesamerica.org/downloads/hfa_impl_family_retention.pdf
- b) Employing bi-lingual/bi-cultural workers. (Family retention was greater when mothers and FSWs were of the same race/ethnicity—HFA website).
- c) Using experienced contractors who excel in staff retention. Older sites and those with high staff retention had higher family retention. Catholic Charities West Michigan is an older site with high staff retention.
- d) Being consistent and reliable. FSWs will show up when they say they will. They will be honest and down-to earth with families and not be judgmental. All these qualities will help staff build trusting relationships with families.
- e) Employing staff who show enthusiasm for the program.
- f) Utilizing Maslow's Hierarchy of Needs. FSWs will listen closely and find out where the parents are when they enter the program. By identifying their needs, they will together with the family develop strategies to address those needs. Consequently, parents will be more likely to want to be part of the program.

- g) Providing resources and educational materials to address the family's identified needs.

Note: Above points are part of the HFA model and taken from their website at http://www.healthyfamiliesamerica.org/network_resources/is_family_retention.shtml

8. What is the estimated timeline to reach maximum caseload?

We will reach the maximum caseload in three months or less.

9. Describe the operational plan for the coordination between the proposed home visiting program and other existing programs and resources in the community, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services.

Because Kent County Healthy Start is an existing well developed program in the community and has staff with longevity in the community, we have good coordination with other programs and resources in the community. Our partners provide expertise in many of the areas listed above. Catholic Charities provides expertise in child welfare and mental health. Arbor Circle provides expertise in substance abuse and early childhood development. The Health Department provides expertise in physical health, provides us with access to the Birth Certificate Registry to invite parents to be part of Kent County Healthy Start, and provides expertise with the evaluation of Kent County Healthy Start. Over years of service, we have developed strong connections to both the YWCA and with Safe Haven for domestic violence services. We also have Kent County Healthy Start Family Support Worker's co-located with Spectrum Community's MOM's MHIP program. These FSW's serve families that are also served by MOM's MHIP. These are the needier families who benefit from a service array that includes access to a nurse, a dietician, a social worker and a Family Support Worker. We make referrals for mental health and substance abuse services through our local mental health/substance abuse authority, network180. Family Futures is part of the Kent County Family and Children's Coordinating Council which strives to ensure a system of services that works for families.

10. How are you already collecting process and outcome data for the existing home visiting program that has been chosen to receive MMIECHVP funds? Will you be using the same process with the expansion slots?

We collect information through the Healthy Families America Program Information Management System (PIMS). PIMS consists of two interrelated modules: the Program Management Component and the Participant Tracking Component.

- a) Program Management Component: This component tracks information about site infrastructure, including:
 - Site resources
 - Staff characteristics

- Staff training
- Target community characteristics
- Funding resources
- Collaborating agencies, hospitals, and medical clinics

Sites use this information to track staff development, manage collaborative relationships, and identify future resource needs.

b) Participant Tracking Component: This component records a family's participation and progress in the HFA program, including:

- Participant demographics
- Screening, assessment and intake of new participants
- Participant activities including home visits, medical visits, instrument administration, and referrals
- Child activities, including well baby visits, immunizations, and child development screens

Sites use this information to manage their services, identify key participant characteristics, and evaluate the level and quality of services participants receive.

PIMS generates over 70 pre-packaged reports to support data-driven advocacy and fundraising efforts. Furthermore, PIMS features a custom reporting tool which facilitates the development of creating custom reports based on over 850 data elements collected in PIMS.

We will use this system for the expansion slots. We are looking at a matrix developed by Healthy Families America that identifies how PIMS and MIECHV intersect and what will need to be tracked outside of our current PIMS system.

We will use this system as well for providing data to SRA, our outside program evaluator, who is doing a longitudinal matched cohort comparison study of families served by Kent County Healthy Start.

11. Describe anticipated challenges to maintaining program quality and fidelity, and how these challenges will be addressed.

We currently address challenges to maintenance of program quality and fidelity through our monthly Continuous Quality Improvement meetings with all partners. This group has designed and implemented a dashboard of objectives to measure quality and fidelity at the worker level as a results based accountability report to measure quality and fidelity at the agency and total program level. We use the data provided by these reports to monitor our performance individually and collectively. We have improved both productivity and fidelity to the model through these tools.

12. Provide a list of collaborative public and private partners (Local Leadership Group member names and organizations).

Peggy VanderMeulen: Strong Beginnings/Spectrum Health
 Barb Hawkins: Palmer-Kent County Health Department
 Brandi Berry: Department of Human Services
 Brian Harl: Kent County Health Department
 Candace Cowling: Family Futures
 Darlene VanOveren: Healthy Start-Native American
 Denise Herbert: Network180
 Diana Baker: Kent County Health Department
 Erin McGovern: Kent County Intermediate School District
 Jack Greenfield: Arbor Circle Corporation
 Jennifer Raffo: Michigan State University
 Jill Eldred: First Steps Kent County
 Joann Hoganson: Kent County Health Department
 Kathy Freiburg: Network180
 J. Risley: Grand Valley State University
 Kristin Gietzen: Arbor Circle Corporation
 LeeAnne Roman: Michigan State University
 Marian Deese: Kent County Health Department
 Mark Witte: Network180
 Mary Hockwalt: Head Start for Kent County
 Matthew VanZetten: Kent County Administrator's Office
 Rebekah Fennell: First Steps Kent County
 Savator Selden-Johnson: Kent County Department of Human Services
 Stephen Borders: Grand Valley State University

13. Indicate that you are providing each of the following assurances:

Kent County Healthy Start had its accreditation site visit in February of this year. As a result, we are currently in good standing in our affiliation with Healthy Families America. This would prove that we can provide the following assurances. Further details about each assurance can be found below:

- *Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments within the scope of the model, and assuring fidelity to the model, (e.g., assessment does not eliminate components of the model).*

Healthy Families America requires that a standardized assessment (KEMPE) be done on every client entering the program. It is our policy that Family Support Workers have the KEMPE assessment completed within two home visits with the family. In accordance with the HFA model, workers then use the KEMPE assessment to guide program services and to write Individual Family Service Plans with the client. The model and thus our program requires that the assessment be referenced through out

the participant's time in the program and that personal/family goals are being achieved as a result (adherence to this practice is documented at supervision meetings and in the family case notes). All of these activities align with and adhere to the HFA model of service.

- *Assurance that services will be provided on a voluntary basis.*

All HFA services are required to be provided on a voluntary basis. Families are empowered to accept or deny services based on their needs and desires. However, Family Support Workers are trained and encouraged to do as much as possible to engage the family. Creative Outreach policies are in place to reach out to families who do not engage in services. However, families always have the right to refuse services or disengage without any penalty to them or their family. Families that choose to participate in Kent County Healthy Start sign a participant agreement form that states that they are participating of a voluntary nature.

- *Assurance that priority will be given to serve eligible participants who:*

- 1) Have low incomes
- 2) Are pregnant women who have not attained age 21
- 3) Have a history of child abuse or neglect or have had interactions with child welfare services
- 4) Have a history of substance abuse or need substance abuse treatment
- 5) Are users of tobacco products in the home
- 6) Have, or have children with, low student achievement
- 7) Have children with developmental delays or disabilities
- 8) Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Special priority is given to families who participate in Kent County Healthy Start who are first time parents or are under the age of 25 and have at least one of the following risk factors:

- Family history of child abuse and/or neglect
- Family who is homeless
- Parent with negative or ambivalent attitude regarding pregnancy or parenting
- Parent with a destructive temperament who has unrealistic expectations of the child and/or views harsh punishment as appropriate
- Parent with substance abuse or addiction (including use of tobacco)
- Family who is isolated with inadequate support system (including low income)
- Parent with diagnosed mental/physical condition that interferes with parenting ability
- Family history of delinquency
- Teen parent
- Family with incarcerated parent

- Child with long-term or chronic illness
 - Child with diagnosed handicapped condition
 - Child with a diagnosed mental health condition or documented behavioral issue
 - Family that is clinically positive as determined by the referent, the Family Support Worker, and with supervisor approval of the identification of the factor or factors that qualify the family as clinically positive—in order to address suspected underlying risk factors.
 - Families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States
- *Assurance that funds will be used to service the at-risk target population agreed upon with the state, the characteristics of which are documented in Section A above.*

The funds provided will be used by two bilingual Kent County Healthy Start Family Support Workers located at Catholic Charities West Michigan for the sole purpose of serving the identified target population. Caseloads and outcomes will be monitored on a weekly basis by the supervisors at this home visiting site.

Michigan Maternal, Infant and Early Childhood Home Visiting Program
County-Level Home Visiting Program Implementation Plan

County: MUSKEGON
Contact Person/Agency: Jane Clingman-Scott/ Great Start Muskegon
Phone: 231-767-7285
Email: jclingma@muskegonisd.org

A. Identification of Muskegon County's Targeted At-Risk Community

1. What is the targeted at-risk community (e.g., city, township, zip code, population group, etc) that the Local Leadership Group (LLG) and the Home Visiting Workgroup (HVWG) have jointly agreed upon?

The Muskegon County Local Leadership Group and the Home Visiting Workgroup have selected the young parents 16 to 25 years of age in Muskegon County as the targeted at-risk community. Healthy Families America services will be expanded in Muskegon County to serve this population.

2. What are the risk factors in this community

Please see the table on the next page.

RISK FACTORS	COUNTY: MUSKEGON	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
1. Premature birth	10.2%		
2. Low-birth wt infants	8.4%		
3. Infant mortality	6.9%		
4. Poverty	17.9%	91%	PIMS
5. Crime	46%		
6. Domestic violence	9.95%		
7. School drop-out rates	11.1%	39%	PIMS
8. Substance abuse	23.92%		
9. Unemployment	13.9%	72%	PIMS
10. Child maltreatment	16.8%		
11. Proportion of total pop of American Indians living in community compared to total pop in county	.83%	1%	PIMS
12. Proportion of total pop of African Americans living in community compared to total pop in county	13.52%	44%	PIMS

RISK FACTORS	COUNTY: MUSKEGON	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
13. If you were unable to provide community-level data on more than 5 risk factors , explain how you determined that this is the highest-need community in the county.	<p>The data on the risk factors for the at-risk community missing from the chart above are not broken down for the identified population through MDCH, Kids Count or Census material.</p> <p>The need was identified through PIMS of Catholic Charities Healthy Families Program of 2008-2009, the last year of full operation.</p>		

3. What are the strengths of this community?

COMMUNITY STRENGTHS/ASSETS	
1. What is this community proud of?	<p>Muskegon County has worked collaboratively on a number of important infrastructure issues such as the Wastewater Treatment Center, a state of the art sewage treatment system that serves all of Muskegon County and managed by an authority from each unit of government. This system has allowed us to attract a great number of high tech and chemical companies since its inception; it is now in partnership with an area foundry to capture and use excess methane as a energy source. Collaboration was also important in redeveloping a lakefront that was ravaged by abandoned industries and converted into a beautiful public park, Heritage Park, that is the site of music festivals from summer to fall. Muskegon County has wonderful public access to Muskegon Lake and Lake Michigan with more free beachfront than any other community on Lake Michigan and has excellent bike trails that virtually connect the entire county - also a collaborative effort. In recent years Muskegon County has become a research site for Grand Valley State University with their Annis Water Research Center and the Michigan Alternative Resource and Energy Center. Muskegon is rebuilding its downtown virtually from scratch after the old downtown mall was razed leaving</p>

COMMUNITY STRENGTHS/ASSETS	
	only a few historic buildings. The Community Foundation for Muskegon County purchased the land and become the developer and we now have many new buildings including the Culinary Institute of Baker College – a world class culinary school. We have a strong history of collaboration for the good of the community.
2. Faith communities	The Muskegon Area Cooperating Churches is supportive and invested in the initiatives of Great Start.
3. Neighborhood associations	EnCompass; 15 neighborhood associations in City of Muskegon dating back to 1970.
4. Cultural/ethnic associations	<ul style="list-style-type: none"> ▪ Muskegon Area District Libraries established early childhood literacy as primary goal ▪ Lakeshore Museum – strong education component ▪ West Shore Symphony ▪ Hackley Art Museum ▪ Urban League ▪ NAACP
5. Other community organizations	Rotary Club is spearheading community health initiative as well as a number of education and youth leadership programs
6. Business investment	<p>The Chamber of Commerce has a strong interest in education and especially in the area of 0-5years old; the Chamber is planning on featuring this issue in their September Breakfast Meeting.</p> <p>Great Start Muskegon has received private funding from Alcoa-Howmet, PNC Bank and individual businesses.</p>
7. Philanthropic investment	<p>The Community Foundation for Muskegon County is a member of the Great Start Collaboration and a Great Start Fund has been established within the Foundation.</p> <p>United Way of the Lakeshore is a member of the Great Start Collaborative and active in our governance and Early Literacy Work Group.</p>
8. Major community events	<ul style="list-style-type: none"> • May Fest – a community family festival of the Muskegon Community College that includes Great Start. • TLC Early Childhood Conference of the Muskegon Area Intermediate School District • Summer Celebration – music festival • Irish Festival – music festival • Various small community festivals throughout summer
9. Other assets/resources (specify one or more)	<ul style="list-style-type: none"> • Community Coordinating Council • Family Resource Centers in 11 of 12 school districts • Two Federally Qualified Health Centers; Hackley Community Care and Muskegon Family Community Care • 211 Call Center • Trinity Health Care System • DeVos Children's Center Satellite Program

4. Briefly describe characteristics of potential HVP participants from the at-risk community (e.g., income level, mother's education level, percentage of single parents, percentage of first-time parents, employment rate, race/ethnicity, and/or other characteristics).

The data collected from the 2008-2009 PIMS system of the Healthy Families America program indicates that the client base is 91% Medicaid eligible, 71% were first time parents, 88% lived in the urban core communities, 39% has less than a high school diploma and 42% had no more than a high school diploma or GED, 72% were unemployed; 46% were Caucasian, 44% African American, 3% were Hispanic, 1% American Indian and 6% multi-racial.

It is well researched that a high prevalence of teen pregnancy in a community adversely affects child development and ultimately, a child's readiness for school and success in life. Data suggests that teen motherhood adversely affects important child welfare indicators such as timely prenatal care, health outcomes such as low birth weights, poverty, effective parenting skills, child maltreatment, educational attainment, and school readiness.

Compared to state norms Muskegon County is significantly higher in terms of the rate of teen pregnancies and births and other corresponding indicators. The issue can be reasonably labeled a 'crisis' as a high rate of teen births impact other community demographic factors highlighted below. The percent of all births to teenage mothers at 13.8% in Muskegon County is 38% higher than the state average; births to unwed mothers is 29% higher; and the percent of babies born to mothers without a high school diploma is 19% higher.¹

5. Below is a list of possible needs of potential HVP participants. Indicate whether or not individuals residing in the targeted at-risk community have each of these needs. Add any other needs that you have identified at end of list.

NEEDS OF PARTICIPANTS	Yes or No
1) Child development/parenting education and support to assist families to form stable and responsive relationships with their young children	Yes
2) Safe and supportive physical, chemical, and built environments, which provide places for children that are free from toxins and fear, allow active, safe exploration, and offer families raising young children opportunities to exercise and make social connections	Yes
3) Sound and appropriate nutrition	Yes
4) Health education and care	Yes
5) Education on promoting literacy and early learning	Yes
6) Access to quality child care/early childhood education experiences	Yes
7) Domestic violence resources	Yes

¹ Kids Count 2010 Report, 2008 calendar year birth data.

8) Substance abuse services	Yes
9) Mental health services	Yes
10) Training and jobs	Yes
11) Transportation	Yes
12) Other (<i>specify</i>) Education	Yes
13) Other (<i>specify</i>) DHS services and resources (% of Medicaid)	Yes
14) Other (<i>specify</i>) Concrete needs, food, cribs, car seats, clothing	Yes
15) Other (<i>specify</i>)	
Provide any additional comments you may have about needs of potential program participants:	

6. Identify any other factors considered in the selection of this at-risk community.

Unintended/unplanned pregnancy and parenting by young parents ages 16 - 24 powerfully increases child poverty and maltreatment issues within a community. Muskegon County's childhood poverty rate (the percentage of children under the age of five living in poverty) is 22% higher than the state average.² One of four children under the age of five in Muskegon County lives below the federal poverty limit. The percent of young children participating in WIC (35%) is higher; nearly three-fourths of children birth to age four participate in WIC. Six of ten births in Muskegon County are paid for by Medicaid.³ Sadly, the rates of substantiated abuse and neglect are also higher in the county versus statewide averages. Substantiated abuse of children birth to four is 17% higher while substantiated neglect is 32% higher.

7. Review the updated list of home visiting programs operating in your county and list each program that serves your targeted at-risk community below.

- a) Healthy Families America
- b) Early Head Start
- c) MIHP
- d) Early On
- e) Muskegon Teen Parent Program
- f) Lakeshore Coordinating Council - PCAP (substance abuse)
- g) Community Mental Health -Infant Mental Health

² United States Census Bureau, 2008 ACS Survey.

³ Kids Count 2010 Report, 2009 calendar year data.

- 8. If there are home visiting services currently serving the targeted at-risk community, why are additional home visiting services needed (e.g., existing programs don't have capacity to meet the need, long waiting lists, program eligibility restrictions, etc.)? What is your estimate of the number of service slots available compared to the number of families who need home visiting services?**

Additional home visit services are needed. Our current Healthy Families America home visitation program does not have capacity to meet existing need and serve those on our waiting list. We estimate that we currently have a long waiting list for eligible families who wish to be assigned a Healthy Families America Family Support Worker. Two years ago we had 5 full-time Family Support Workers, 1 full-time Family Assessment Worker, and 1 full-time Supervisor and were providing services to 148 families annually with a wait list. Currently, through local support, we have funding for only 1 full-time Family Support Worker to meet our entire county's needs.

- 9. Identify referral resources (services to which the home visiting program can refer) currently available to support families residing in the community.**

Muskegon County referral resources include: Muskegon Family Care Center; Hackley Community Care Center; WIC; Maternal Infant Health programs; the Muskegon County Department of Human Services; Work First; Muskegon Promise; Love INC (budgeting); Every Woman's Place (domestic violence services); West Michigan Therapy and PCAP (substance abuse); Community Mental Health; EnCompass, Muskegon Housing, and Muskegon Homeless Coalition (housing); and Catholic Charities West Michigan Child Welfare and Behavioral Health programs.

- 10. Identify referral resources (services to which the home visiting program could refer) that are needed in the community.**

Although the County does have a number of referral resources, we need additional capacity in each of the above listed services.

- 11. Describe your plan for coordination among existing programs and resources in the community, including how the program will address existing service gaps.**

Catholic Charities West Michigan home visitation programs enjoy a positive working relationship with other community agencies providing services to Muskegon County families. We expect to continue this positive working relationship and formalize our referral process. The program identifies individual family needs and coordinates existing services for each family's success. We expect to work closely with the Community Coordinating Council and the Great Start Collaborative to address these service gaps.

12. Identify existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the community level). To what extent are you coordinating referrals and intake across home visiting programs?

There is a procedure in place for all families giving birth in a hospital in Muskegon County to be screened using a Kempe Family Screening Tool. Because services to new parents in Muskegon County are so limited, all programs make every effort not to duplicate services to families.

13. Describe county capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level, such as a governance structure or coordinated system of planning.

The proposed home visiting services will be provided by Catholic Charities West Michigan, a very active and involved member of the Great Start Collaboration of Muskegon County. The Great Start Collaborative includes more than 45 agencies, schools and parent representatives that represent all modalities of service relating to children ages 0 to five years old. The Great Start Collaborative serves as a community planning agency for early childhood development issues and is a very effective referral network. The GSC is the home for the Local Leadership Council for home visitation and includes Community Mental Health Infant Mental Health Services, Public Health of Muskegon County, Maternal and Infant Health Programs, Lakeshore Coordinating Council PCAP, Department of Human Services, and Catholic Charities West Michigan.

B. Selection of Muskegon County's Home Visiting Model and Explanation of How the Model Meets the Needs of Targeted Community

1. Which evidence-based home visiting program model has been selected for expansion in the targeted at-risk community, as agreed jointly determined by the LLG and the HVWG?

The Catholic Charities West Michigan Muskegon County Healthy Families America Program has been selected for expansion.

2. How does the selected model address the particular risks in the targeted community and the needs of the families residing there?

It targets all families screening positive for the following risk factors:

- a) single/separated/widowed
- b) unemployed parent/partner
- c) inadequate income
- d) unstable housing
- e) less than high school education

- f) history of substance abuse
- g) late/prenatal care
- h) marital problems
- i) history of depression
- j) history of psychiatric care

3. How will the targeted community be involved on an ongoing basis throughout the duration of this program (other than as program participants)?

Program participants will participate in an advisory group and will continue to participate in both the Great Parents/Great Start Collaborative and Great Start Parent Coalition.

4. Describe your county's current and prior experience with implementing the selected model.

Catholic Charities West Michigan has educated and experienced staff who have been providing Healthy Families America program services in Muskegon County since 1999. Staff has developed effective and efficient screening procedures assessment and home visitation delivery systems, as well as strong working relationship with other providers.

5. Describe your county's current capacity (e.g., funding, staff, administration, etc.) to increase the number of families served using this model.

Catholic Charities West Michigan has staff and administration available to immediately increase the numbers of families served using the Healthy Families America model if funding is provided.

6. Describe your plan to ensure implementation with fidelity to the model.

Our current Healthy Families America program accreditation (through 2015) requires continued fidelity to the program model. We currently implement the Healthy Families America with all the critical elements in place to assure fidelity.

7. Discuss anticipated challenges and risks of the selected program model, and your proposed response to these challenges.

Our largest challenge will be adequate funding to provide service to all families wanting service in the County.

8. Identify any anticipated technical assistance needs to be addressed by the state or the model developers.

We anticipate providing our staff with updated Healthy Families America (i.e. Healthy Families America Family Support Worker, Family Assessment Worker, and supervisory) training.

C. Implementation of Muskegon County's Selected Model

1. **What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots? (Note: This is the entity that is already implementing the selected model, unless the LLG and HVWG have agreed upon an alternative entity, based on how the alternate approach will maximize funding and services.)**

Catholic Charities West Michigan will receive the Michigan MIECHVP funds to expand service slots in the Healthy Families America Program in Kent County. The program will serve participants age 14 to 24 years of age and children from the prenatal period until five years. The Healthy Families America's Growing Great Kids Curriculum is used in their service provision.

2. **Describe the plan for recruiting, hiring, and retaining appropriate staff for all positions. List each position to be filled.**

Staffing will be based on the amount of funding available. The Healthy Families America model requires specific ratios for the Healthy Families America supervisor, Family Support Worker, and Family Assessment Worker. Catholic Charities West Michigan has staff employed that were previously trained and experienced in delivering the Healthy Families America model. Funding would allow interested staff to return to this model and would recruit and train additional staff as needed.

3. **If subcontracts will be used, describe the plan for recruitment of subcontractor organizations, and the plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s).**

N/A

4. **Describe the plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors.**

We currently have two (2) supervisors with a minimum of 10 years experience providing clinical supervision and reflective practices to new parent home visitation staff. Both supervisors are also trained and certified as Healthy Families America supervisors.

5. **What is the estimated number of families that will be served annually with the expansion funds provided by the Michigan MIECHVP? (Do not count families being served with funds from other sources.)**

It is expected that our program could serve 25 families per new Healthy Families America Family Support Worker, annually.

6. How will program participants be identified and recruited?

Primarily identification and recruitment will take place through the hospital screening process at birth, prenatally through clinics, physicians' offices, and other service providers.

7. Describe the plan for minimizing the attrition rates for participants enrolled in the program.

Catholic Charities West Michigan's current Healthy Families America Program has very low rates of attrition for family's service. We expect this to continue.

8. What is the estimated timeline to reach maximum caseload?

We expect the program would have a maximum caseload within 3-4 months.

9. Describe the operational plan for the coordination between the proposed home visiting program and other existing programs and resources in the community, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services.

Catholic Charities West Michigan's Healthy Families America Program currently has developed effective coordination among existing programs and resources. Current Healthy Families America actively participates in collaboratives, coalitions, and other community initiatives to assist use in developing an operational plan.

10. How are you already collecting process and outcome data for the existing home visiting program that has been chosen to receive MMIECHVP funds? Will you be using the same process with the expansion slots?

We currently use the Healthy Families America PIMS data system and we would continue to utilize this system.

11. Describe anticipated challenges to maintaining program quality and fidelity, and how these challenges will be addressed.

No challenges are anticipated due to our experience with the model and the provision of services to Muskegon County families.

12. Provide a list of collaborative public and private partners (Local Leadership Group member names and organizations).

- Nan Andrews and Pamela Cohn, Catholic Charities West Michigan
- Stuart Jones, Muskegon Area Intermediate School District and Early Head Start
- Jane Clingman-Scott, Great Start Collaborative of Muskegon County

- Samantha Cutler, Great Start Parent Coalition
- Kate Bissot, Lakeshore Coordinating Council (PCAP-Substance Abuse)
- Pat Krehn, Public Health Muskegon County
- Lisa Myers, Muskegon County Community Mental Health- Infant Mental Health
- Lori Wiltenburg, Maternal Infant Health Program
- Courtney Biesdiada, Jill Lynn and Sara Schalk – Parent Representatives

13. Indicate that you are providing each of the following assurances:

- 1) *Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments within the scope of the model, and assuring fidelity to the model, (e.g., assessment does not eliminate components of the model).*

Catholic Charities West Michigan assures that all participant families will receive an assessment utilizing the Healthy Families America assessment tool.

- 2) *Assurance that services will be provided on a voluntary basis*

Participant agreement indicating voluntary participation is signed and dated by participant and worker.

- 3) *Assurance that priority will be given to serve eligible participants who:*

1. *Have low incomes*
2. *Are pregnant women who have not attained age 21*
3. *Have a history of child abuse or neglect or have had interactions with child welfare services*
4. *Have a history of substance abuse or need substance abuse treatment*
5. *Are users of tobacco products in the home*
6. *Have, or have children with, low student achievement*
7. *Have children with developmental delays or disabilities*
8. *Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.*

Catholic Charities West Michigan assures priority will be given to the listed documentation.

- 4) *Assurance that funds will be used to service the at-risk target population agreed upon with the state, the characteristics of which are documented in Section A above.*

Assurance form will be signed by both the Catholic Charities West Michigan CEO/President and the CFO, as well.

Michigan Maternal, Infant and Early Childhood Home Visiting Program
County-Level Home Visiting Program Implementation Plan

County: SAGINAW
Contact Person/Agency: Julie Kozan/Saginaw ISD
 Great Start Collaborative
Phone: 989-399-7452
Email: jkozan@sisd.cc

A. Identification of Saginaw County's Targeted At-Risk Community

1. **What is the targeted at-risk community (e.g., city, township, zip code, population group, etc) that the Local Leadership Group (LLG) and the Home Visiting Workgroup (HVWG) have jointly agreed upon?**

The Saginaw County Local Leadership Group and the Home Visiting Workgroup have selected African American children at-risk of child maltreatment, poor health outcomes, trauma due to crime/violence and school failure; who reside in the City of Saginaw, as the targeted at-risk community. Early Head Start Home-Based services will be expanded in Saginaw County to serve this population.

2. **What are the risk factors in this community?**

RISK FACTORS	COUNTY SAGINAW	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
1. Premature birth	11.1%	12.8%	Kids Count 2008
2. Low-birth wt infants	10.2% <i>(a)</i> low birth weight 10% (243/2422) <i>(b)</i> very low birth weight 2.5% (61/2422) <i>(b)</i> Premature 11.4% <i>(b)</i>	12.7% <i>(a)</i> low birth weight 12.7% (131/1034) <i>(b)</i> very low birth weight 3.6% (37/1034) <i>(b)</i>	<i>(a)</i> Kids Count 2008 <i>(b)</i> Michigan Department of Community Health website – 2009 data ** low birth weight is less than 2500 grams ** very low birth weight is less than 1500 grams
3. Infant mortality	9.2% (rate per 1,000 births) <i>(a)</i> 26 deaths with a rate of 10.7% (7 White deaths with a rate of 4.2% and 18 Black deaths with a rate of 25.7%) <i>(b)</i>	12.2% (rate per 1,000 births) <i>(a)</i> City of Saginaw: 22 deaths with a rate of 21.3% compared with Saginaw Township: 1 death – too small of a numerator to create a rate <i>(b)</i>	<i>(a)</i> Kids Count 2008 <i>(b)</i> Michigan Department of Community Health website – 2009 data

RISK FACTORS	COUNTY SAGINAW	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
4. Poverty	26.1% (Ages 0-17) 19.1% (All ages) <i>(a)</i>	28.5% (more than double Michigan's poverty rate of 12.5%) <i>(b)</i>	<i>(a)</i> Kids Count 2008 <i>(b)</i> "Poverty Rates In Michigan: Working Full Time Isn't Enough To Be Self-Sufficient" (July, 2008) – Michigan League for Human Services
5. Crime	128.58 (number per 1,000 residents) <i>(a)</i>	3,295 incidents per 100,000 people. This compares with a rate of 695 in Michigan <i>(b)</i>	<i>(a)</i> Crime In Michigan Annual Report 2008 <i>(b)</i> FBI Uniform Crime Rate database for 2008
6. Domestic violence	17.6% <i>(a)</i>	The rate of reported DV in Saginaw is 1 per 90, Saginaw has the highest pro-rata rate in the state of Michigan. DV is not tracked separately for the city, although the largest number are reported to the Saginaw Police Department.	<i>(a)</i> Michigan Incident Crime Reporting 2008 <i>(b)</i> Michigan Uniform Crime Report
7. School drop-out rates	11.1% <i>(a)</i>	16.61% (Arthur Hill High School) <i>(b)</i> 16.94% (Saginaw High School) <i>(b)</i> 2.38% Saginaw Arts and Sciences Academy <i>(b)</i>	<i>(a)</i> 2009 Michigan League for Human Services Kids Count <i>(b)</i> www.michigan.gov/Documents/cepi/2010-2009_MI_Grad-Drop_Rate_345879_7.pdf
8. Substance abuse	25.74% (binge alcohol use) 6.95% (marijuana use) 5.58% (nonmedical prescription drug use) 3.76% (illicit drug use)	N/A	SAMHSA 2006-2008 www.oas.samhsa.gov/Substate2k10/toc.cfm
9. Unemployment	12.5% <i>(a)</i>	17.8% <i>(b)</i>	<i>(a)</i> Kids Count 2009 <i>(b)</i> March 2011 DELEG

RISK FACTORS	COUNTY SAGINAW	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
10. Child maltreatment	29.4% (confirmed abuse and/or neglect)	N/A	Kids Count 2009
11. Proportion of total pop of American Indians living in community compared to total pop in county	.5% <i>(a)</i>	.4% <i>(b)</i>	<i>(a)</i> wonder.cdc.gov/bridged-race-v2008.html on Aug. 31, 2010 <i>(b)</i> www.city-data.com/city/Saginaw-Michigan.html
12. Proportion of total pop of African Americans living in community compared to total pop in county	43.3% <i>(a)</i>	19% <i>(b)</i>	<i>(a)</i> wonder.cdc.gov/bridged-race-v2008.html on Aug. 31, 2010 <i>(b)</i> www.city-data.com/city/Saginaw-Michigan.html
If you were unable to provide community-level data on more than 5 risk factors , explain how you determined that this is the highest-need community in the county.			

3. What are the strengths of this community?

COMMUNITY STRENGTHS/ASSETS	
1. What is this community proud of?	<p>Based on our most recent Promise Neighborhood application from 2011, we have current information relative to Community Strengths/Assets. In late May 2011, the Saginaw Community Foundation/Alignment Saginaw and Saginaw Valley State University convened several focus groups to discuss the assets and needs in the City of Saginaw. Diverse focus group participants from the City of Saginaw cited many needs. However, a couple frequent strengths were as follows:</p> <ul style="list-style-type: none"> • "The churches" have been active in attempting to mobilize and inspire the community. Several faith-based groups (i.e., Parishioners On Patrol - POPs, The Ezekiel Group, 1st Congregational, Mission in the City, Bethel AME, etc.) have been "working to bring hope to the community." POPs has organized four (4) "good giveaways" in four months, bring truck load of good to the most at-risk sections of the City of Saginaw. Moreover, several of the faith-based leaders have spoken out and given community speeches in attempts to "stop the killing" in the City of Saginaw. These efforts are aimed at reducing stress and crime in the

	<p>City and focus groups participants have been proud to participate in these community-led initiatives.</p> <ul style="list-style-type: none"> • A number of neighborhood associations (i.e., the Cathedral District and Covenant District in the City) and community watch groups have sprung up to work closely with the police department. These groups have been organizing to help prevent and report criminal activity. Over the past year, the City of Saginaw has data to show that these efforts are working. The crime rate for the City, as recently reported by the county prosecutor Michael Thomas, is on the decline. Many participants in our focus group cites this as an emerging strength. Indeed, last year (2010), the City of Saginaw reported one of the lowest homicide rates in over 20 years.
2. Faith communities	<ul style="list-style-type: none"> • Numerous churches throughout Saginaw County are participating in Great Start University • Ezekiel Project • Parishioners on Patrol is very active in Saginaw • Old Town Baby Pantry provides mothers-to-be with baby supplies and necessities • Abortion Alternatives • The Green House Center of Hope • Mission in the City provides recreation and after school programs for children living in high-risk neighborhoods within Saginaw
3. Neighborhood associations	<ul style="list-style-type: none"> • Houghton Jones Neighborhood Association • There are many grass roots neighborhood watch groups throughout Saginaw
4. Cultural/ethnic associations	<ul style="list-style-type: none"> • Mexican American Council Inc. • Cultural publications: Mi Gente and Word Up • Tri-City LINKS • SVAALTI (Saginaw Valley African American Leadership Training Institute)
5. Other community organizations (do not include health and human services agencies/programs/services here)	<ul style="list-style-type: none"> • PRIDE in Saginaw Inc. • Junior League of Saginaw Valley • Heroes for Kids • Saginaw Children's Zoo • Mid-Michigan Children's Museum
6. Business investment	<ul style="list-style-type: none"> • Lunch & Learn program – participation by several area businesses • Consumers Energy sponsors printing of resource document for families • Hemlock Semiconductor helps sponsor Imagination Library • PNC Bank is providing employee volunteers for two early childhood agencies that serve at-risk families
7. Philanthropic investment	<ul style="list-style-type: none"> • Saginaw Community Foundation and United Way, along with several area businesses, were instrumental in bringing Geoffrey

	<p>Canada to Saginaw in March 2011</p> <ul style="list-style-type: none"> • We have numerous philanthropic groups within Saginaw County who are charged with making lives better for children and families
8. Major community events	<ul style="list-style-type: none"> • Geoffrey Canada presented in Saginaw (March 2011) • Month of the Young Child event at the Saginaw Children's Zoo (April 2011) brought 2,400 parents and children • Friday Night Live (runs every Friday night throughout the month of August) • D.E.A.R. at the Zoo (Drop Everything and Read) takes place every June at the Saginaw Children's Zoo • Summer Reading Program takes place every summer through the Public Libraries of Saginaw
9. Other assets/resources (<i>specify one or more</i>)	<ul style="list-style-type: none"> • Imagination Library in 3 of our 13 school districts. Our local United Way is working to raise funds to expand Imagination Library county-wide

4. Briefly describe characteristics of potential HVP participants from the at-risk community (e.g., income level, mother's education level, percentage of single parents, percentage of first-time parents, employment rate, race/ethnicity, and/or other characteristics).

Proposed participants would be at or below the 100% of federal poverty threshold. The would be families living in poverty and also African American. Within the City, over 70% of the mothers are single. The rate of single parent households is extremely high for the at-risk area and major community concern. Unemployment in the City of Saginaw persists at record levels (above 12%) Moreover, as required under Early Head Start, at least 10% of the participants would qualify for special education. In the target community, the special education rate is near 20%, so many of the proposed participants would also be at high risk for needing remediation support through Early On and/or Michigan Mandated Special Education, which begins at birth.

5. Below is a list of possible needs of potential HVP participants. Indicate whether or not individuals residing in the targeted at-risk community have each of these needs. Add any other needs that you have identified at end of list.

NEEDS OF PARTICIPANTS	Yes or No
1. Child development/parenting education and support to assist families to form stable and responsive relationships with their young children	Yes
2. Safe and supportive physical, chemical, and built environments, which provide places for children that are free from toxins and fear, allow active, safe exploration, and offer families raising young children opportunities to exercise and make social connections	Yes

3. Sound and appropriate nutrition	Yes
4. Health education and care	Yes
5. Education on promoting literacy and early learning	Yes
6. Access to quality child care/early childhood education experiences	Yes
7. Domestic violence resources	Yes
8. Substance abuse services	Yes
9. Mental health services	Yes
10. Training and jobs	Yes
11. Transportation	Yes
12. Safe and affordable housing	Yes
13. Healthy social support networks	Yes
14. Other (<i>specify</i>)	
15. Other (<i>specify</i>)	
Provide any additional comments you may have about needs of potential program participants:	

6. Identify any other factors considered in the selection of this at-risk community.

The following factors are also included on our Priority Criteria (risk factor rating) that gives families priority for EHS enrollment: child has a diagnosed disability, child has a suspected disability, child's age (the younger the child, the higher the priority), parental low education level, multi-family circumstance (family is sharing housing), more than four children living in the home, family is in crisis, family is isolated, and child is in foster care.

7. Review the updated list of home visiting programs operating in your county and list each program that serves your targeted at-risk community below.

- Early Head Start
- Saginaw Public Schools Birth-5 Program
- Healthy Start
- Teen Parent Services

8. If there are home visiting services currently serving the targeted at-risk community, why are additional home visiting services needed (e.g., existing programs don't have capacity to meet the need, long waiting lists, program eligibility restrictions, etc.)? What is your estimate of the number of service slots available compared to the number of families who need home visiting services?

The only evidence-based home visiting services that exist in the at-risk community is the current Early Head Start program. However, the gap for these services is substantial, creating a large unmet need for expansion. The target geographic area (at-risk community) would be the City of Saginaw and the target population would be African American families who have children ages 0-3.

Based on census, there are 989 children by cohort (or a total of 2,967 children ages 0-3 in the City of Saginaw). The percent of those that are African American children is 43.3%, so there would be about 428 African American children in each cohort, or a total of 1,284 children ages 0-3 potentially eligible for expansion Early Head Start services.

Currently, the existing Early Head Start program targets the City of Saginaw, Buena Vista, Bridgeport and Carrollton. The existing program is funded for 108 home-based slots and serves approximately 70 families each year from the City of Saginaw.

Therefore, with a pool of 1,284 potentially eligible children, the need for services is not being met with the current capacity to service 70 families.

9. Identify referral resources (services to which the home visiting program can refer) currently available to support families residing in the community.

- 1) Great Start Collaborative,
- 2) Birth-5,
- 3) Early On, 2-1-1 (beginning Fall 2011),
- 4) Head Start,
- 5) GSRP,
- 6) MIHP,
- 7) Infant Mental Health,
- 8) housing services,
- 9) WIC,
- 10) health and dental services through Health Delivery, Inc.,
- 11) Regional Coordinating Agency for individuals with substance abuse use

10. Identify referral resources (services to which the home visiting program could refer) that are needed in the community.

- 1) Shelters (i.e. Women's Resource Center)—home visitor reports that URR and Rescue Mission fill up fast.
- 2) An area that families can access clothing, food, diapers, etc.—home visitor reports that many resources in town limit how often and the quantity of household items, and clothing a family can access per year.
- 3) Job training opportunities outside of Work First
- 4) Fatherhood programs – groups, outreach to fathers on parenting, bonding, etc.
- 5) Co-Parenting programs – how to parent when you are separated from the child's other parent, or groups on how to parent together to overcome areas that they disagree on (i.e., discipline, budget, etc).
- 6) Housing assistance – some families have been on the subsidized housing waiting list for three years and have not yet received services. Some large apartment complexes are limiting the number of subsidized housing vouchers they will accept, therefore finding a safe home is becoming difficult.

11. Describe your plan for coordination among existing programs and resources in the community, including how the program will address existing service gaps.

The coordination of services will be maximized through a common enrollment system, including common intake paperwork and data systems, which are tethered in order to track families and avoid duplication of services. For example, Early Head Start uses the Child Plus data management system, but also imports this information into the Michigan Student Data System (MSDS) and assigns every child a Unique Identifying Code (UIC). The other home visiting program, Birth-5 Saginaw County, uses a common data system that was customized for Saginaw County (i.e., the Work Life Systems B-5 Database).

The system was created to afford several home visiting programs the ability to access and monitor participant data and outcomes. This system is also tethered to the MSDS via periodic uploads and UIC assignments for every participant. Finally, the Part C/Early On program and service coordinators all use a state system, called the Michigan Compliance Information System.

This, too, has automated functionality to link to the MSDS, assign UICs and is accessible. Thanks to a common Authorization to Share information form across all these programs and provided we have informed written consent, we are able to share participant data across these partners to further track the families and monitor which services are being rendered.

As this evolves, we have other community partners that serve the at-risk population in the community further considering adoption of this uniform, common Authorization to Share form. This includes the community mental health authority and their Infant Mental Health program, the FQHC's Maternal and Infant Health Program, and public health's Healthy Start program, however, this is a work in progress.

In addition, the programs are convened regularly via the Great Start Collaborative. Frequent meetings enable the partners to meet, review data, monitor which families are enrolled in which program, and work on continuous improvement. One area under constant development is our collective/collaborative decision tree for appropriate referrals. This is on-going and stems from work under our Early On system. For example, under CAPTA and Early On rules, all children with levels 1 or 2 substantiations of child abuse and/or neglect are automatically referred for an evaluation.

After the evaluation, families are then "triaged" to services, based on the evaluation results. If the child is not deemed to qualify for Early Head Start but has developmental risks, they may be referred to the Birth-5 program for PAT home visits and family service coordination. If the child has developmental risks and is eligible for Early Head Start, they are referred to Early Head Start, who provides the Early Head Start program and coordinates services under Part C. If the child is at risk of developmental delay in the area of social-emotional development, they may be referred to Infant Mental Health. If the child is eligible for Michigan Mandated

Special Education, they would be referred to the most appropriate early childhood specialist.

The level of sophistication at the systems-level to ensure the best placement of families is high. The Great Start Collaboration, Early On LICC and partners work hard to ensure the system is effective, family-focused, and results-oriented.

12. Identify existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the community level). To what extent are you coordinating referrals and intake across home visiting programs?

Some NICU discharges go to the CSHC nurse, who scans them for possible eligibility for Early On. Those not eligible are referred to either Birth-5 (through MSUE or the Saginaw Public Schools) or Teen Parent Services. In some cases they are referred to Early Head Start.

All CAPTA referrals go to Child & Family Services where intake and evaluation is done when the parent consents and shows up. Home visiting services (Birth-5 or Teen Parent Services) are always offered as part of their Early On services. 0-3 referrals to special education that do not result in eligibility for special education are referred to either Birth-5 or Teen Parent Services.

Saginaw Public School's Birth-5 program recruits newborn referrals every day of the year from Covenant Hospital. Any referral that does not reside in the City of Saginaw is turned over to MSUE or Teen Parent Services (if the referral was a teen parent).

13. Describe county capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level, such as a governance structure or coordinated system of planning.

The Great Start Collaborative has an established governance structure for coordinated planning for our community's early childhood system. Great Start members include: parents, home visiting programs, child care providers, Head Start, preschool providers, parenting education programs, major county departments, counseling providers, non-profit organizations, other providers working with families with young children, as well as members of the business and faith-based communities. The proposed new program will be easily integrated into our existing GSC and the LAUNCH driven Home Visiting Partners meeting. In addition, our GSC has a Parent Education & Family Support subcommittee that addresses strategic planning for parenting and early childhood programs. Organizations providing home visiting programs and parents have a strong presence on this subcommittee.

B. Selection of Saginaw County's Home Visiting Model and Explanation of How the Model Meets the Needs of Targeted Community

1. Which evidence-based home visiting program model has been selected for expansion in the targeted at-risk community, as agreed jointly determined by the LLG and the HVWG?

The Early Head Start Home-Based model (EHS-HB) will be expanded in Saginaw County.

2. How does the selected model address the particular risks in the targeted community and the needs of the families residing there?

The Saginaw ISD Early Head Start (EHS) program is an established home visiting program that serves families living below the federal poverty level and has significant risks. The EHS program has an established waiting list of families that live in the City of Saginaw interested in participating in home based services.

The program provides various family support efforts to decrease the risk level of the family and increase positive child and family outcomes. The EHS program offers weekly ninety minute home visits to families. The program engages both the child and the parent(s) with ninety minute socialization opportunities at least two times per month. By providing a high dosage of services, staff and families are able to work together in setting goals of achieving a higher level self sufficiency and increased parenting skills. Families in need of transportation services can receive assistance directly through EHS or by receiving bus tokens. Transportation services are provided to assist families in obtaining housing, promoting child health and wellness, and accessing crisis assistance.

3. How will the targeted community be involved on an ongoing basis throughout the duration of this program (other than as program participants)?

Many of our community leaders participate in the Great Start Collaborative (GSC) meetings and events. Through the GSC our community leaders share opportunities with the EHS program to participate in coordinated events. During such events the targeted community has the opportunities to receive research-based educational materials, and participate in parenting classes.

4. Describe your county's current and prior experience with implementing the selected model.

The Saginaw ISD Early Head Start program was established in January 2010 with funds from the American Recovery and Reinvestment Act. The EHS program began home visiting services with families in March of 2010 and was fully enrolled by May 2010. The EHS program is an expansion of the Head Start program that has been operating successfully with the Saginaw ISD since 2006.

5. Describe your county's current capacity (e.g., funding, staff, administration, etc.) to increase the number of families served using this model.

The EHS program has been enrolled at capacity of 132 pregnant women and children birth to three years old since May 2010. The program maintains a waiting list of at least ten percent of capacity therefore, has children and families eligible and ready to receive services immediately.

The EHS home based program option is fully staffed with qualified home visitors that carry a case load between eight and twelve pregnant women and children. If awarded expansion funding additional staff would need to be hired. The current administrative staff has the ability to support additional enrollment slots and staff with expanded funding.

6. Describe your plan to ensure implementation with fidelity to the model.

The expanded EHS enrollment slots will follow the guidelines established by the Office of Head Start's Performance Standards. The current EHS administrative team has an established a monitoring system that ensures fidelity. The program will participate in the tri-annual monitoring completed by a team of qualified national peer reviewers.

The local monitoring system includes weekly and monthly data examination. Program staff spend a minimum of two hours per month participating in professional development opportunities to meet program requirements. The expanded enrollment slots will be subject to the agency's annual self assessment to assure fidelity to the federal guidelines.

7. Discuss anticipated challenges and risks of the selected program model, and your proposed response to these challenges.

One challenge the LLG has faced during the expansion process is gaining a higher understanding of Medicaid billing for home visitation services. The group continues outreach efforts within the community in order to gain better comprehension of Medicaid billing procedures and to identify potential partners. The LLG and the Great Start Collaborative have relationships with many community leaders and are having conversations around potential Medicaid billing for home visitation services.

8. Identify any anticipated technical assistance needs to be addressed by the state or the model developers.

The program anticipates technical assistance with regards to outcomes reporting for the expansion. The EHS expansion could potentially need technical assistance support with Medicaid billing, and providing additional professional development for the expanded staff.

C. Implementation of Saginaw County's Selected Model

- 1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots? (Note: This is the entity that is already implementing the selected model, unless the LLG and HVWG have agreed upon an alternative entity, based on how the alternate approach will maximize funding and services.)**

The Saginaw ISD will receive the Michigan MIECHVP funds to expand service slots in the Early Head Start Home-Based Program in Saginaw County. The program will serve participants who are pregnant mothers and children through age 3. The Partners for a healthy Baby and the Parents as Teachers Curriculums are used in their service provision.

- 2. Describe the plan for recruiting, hiring, and retaining appropriate staff for all positions. List each position to be filled.**

The expansion of EHS home-based services to the targeted community of the City of Saginaw will utilize administrative staff that is already in place.

The program will fill two full time employment slots for home visitors. The Saginaw ISD will post the vacant positions internally for current staff to consider and externally on the agency's website, and with local partners online. The staffing vacancies will recruit Bachelors level candidates for the positions. The hiring process will include a panel interview that includes EHS administrative staff and parents. The candidates that receive the highest interview scores may be invited back for a second interview that consists of going on a home visit.

Once the candidates are hired they will receive curriculum and local training to prepare for the job responsibilities. The staff persons will continue with professional development opportunities that support higher learning and retention of the positions.

- 3. If subcontracts will be used, describe the plan for recruitment of subcontractor organizations, and the plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s).**

The Saginaw ISD Early Head Start program does not have plans to subcontract with another organization for Michigan MIECHVP expansion services.

- 4. Describe the plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors.**

Direct supervisors and service providers for Saginaw ISD Early Head Start participate in monthly reflective supervision with a Level II Infant Mental Health Specialist. The sessions are driven by staff conversations and discussion includes how to provide appropriate and quality services to children and families. In addition to structured supervision the Infant Mental Health Specialist employed with the Saginaw ISD Head

Start/Early Head Start program is available to staff for consultation and support as requested by direct service staff.

The EHS program model has instilled reflective practice throughout the program and into the curriculum (Parents as Teachers). Direct service staff meet at a minimum monthly with the program supervisors for reflective case management. In addition to the structured case management sessions, the program supervisors are available to staff for consultation and support as requested.

5. What is the estimated number of families that will be served annually with the expansion funds provided by the Michigan MIECHVP? (Do not count families being served with funds from other sources.)

The Saginaw ISD EHS program is proposing expanded enrollment slots for twenty four pregnant women and/or children with the Michigan MIECHVP funds. The program currently has a 26% attrition rate in the home based program option.

6. How will program participants be identified and recruited?

The EHS program maintains a waiting list of children and pregnant women that are eligible and interested in home based services. The expanded enrollment slots will first be offered to those families on the established waiting list.

The agency will increase recruitment efforts in the targeted community of the City of Saginaw by participating in community events, posting and mailing fliers, and increasing partner relationships with local leaders.

7. Describe the plan for minimizing the attrition rates for participants enrolled in the program.

Consistent and regularly scheduled home visits provided in a year-long setting minimize participant attrition. We have found that providing supplemental services such as transportation, field trips, play groups, and referral services also contribute to low attrition rates.

It is the goal of the program to employ staff long term so that children and families have continuity of care throughout their participation in the EHS program.

8. What is the estimated timeline to reach maximum caseload?

It is the program's goal to reach maximum enrollment within eight weeks of receiving the expansion funding. The eight weeks will be utilized for recruitment, hiring, and training of the home visitor staff person. Simultaneously, the program will recruit and finalize enrollment for the expanded slots.

9. Describe the operational plan for the coordination between the proposed home visiting program and other existing programs and resources in the community,

especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services.

The Saginaw ISD Head Start/Early Head Start program has an active membership in the Great Start Collaborative and the home visiting local leadership group. Both of the groups provide coordination of health and human services that are available throughout the community.

The EHS program works closely with the Saginaw County Health Department and the Federal Qualified Health Center as well as private physicians to ensure that the children enrolled in the program are up to date on immunizations and well baby checks. The EHS program has formal agreements with community agencies to provide support and training for staff. Staff receive two hours per month of professional development training including prevention and referral/resource. Our Infant/Toddler Specialist has a Masters degree in Early Childhood Education and provides consultation/training and support to direct service staff.

10. How are you already collecting process and outcome data for the existing home visiting program that has been chosen to receive MMIECHVP funds? Will you be using the same process with the expansion slots?

The Saginaw ISD EHS program uses the Child Plus data warehouse system to collect and process outcome data. The expanded enrollment slots will use the same EHS process that has been implemented since January 2010.

11. Describe anticipated challenges to maintaining program quality and fidelity, and how these challenges will be addressed.

Continued funding of the expanded enrollment slots is imperative in maintaining quality and fidelity of the EHS program. The Saginaw ISD and LLG will explore alternative funding sources to ensure continuity of care for the children and families served by the EHS program.

12. Provide a list of collaborative public and private partners (Local Leadership Group member names and organizations).

Amy Murawski (Treatment and Prevention Services)
Angie Percy (Early Head Start)
Barb Russell (Early On)
Dianne Dalton (Saginaw Public Schools)
Dawn Shanafelt (Public Health)
Angela Harris (MSUE - Birth-5)
Jamila Barnes (Department of Human Services)
Rita Truss (Department of Human Services)
Janet Timbs (Saginaw Intermediate School District Spec. Ed)

Jill Armentrout (Great Start Parent Coalition)
Janet Topham (Saginaw Public Schools Birth-5)
Lisa Burnell (Health Delivery, Inc.)
Linda Schneider (Community Mental Health)
Mary Ellen Johnson (Teen Parent Services)
Phylis Isanhart (Saginaw Intermediate School District)
Rich Van Tol (Saginaw Intermediate School District)
Sabrina Beeman (Head Start)
Suzanne Greenberg (Child Abuse and Neglect Council)
Yalonda Freeman (Parent)
Julie Kozan (Great Start Collaborative)

13. Indicate that you are providing each of the following assurances:

- a) *Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments within the scope of the model, and assuring fidelity to the model, (e.g., assessment does not eliminate components of the model).*

The Saginaw ISD EHS Program assures individualized developmental, and health assessments will follow the fidelity of the Ages and Stages Questionnaire model, and the Bright Futures prevention and health promotion model.

- b) *Assurance that services will be provided on a voluntary basis*

The Saginaw ISD EHS Program assures families enrolled in the program volunteer his/her time and participation in the services that are offered.

- c) *Assurance that priority will be given to serve eligible participants who:*
- 1) *Have low incomes*
 - 2) *Are pregnant women who have not attained age 21*
 - 3) *Have a history of child abuse or neglect or have had interactions with child welfare services*
 - 4) *Have a history of substance abuse or need substance abuse treatment*
 - 5) *Are users of tobacco products in the home*
 - 6) *Have, or have children with, low student achievement*
 - 7) *Have children with developmental delays or disabilities*
 - 8) *Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.*

The Saginaw ISD EHS Program assures families with the lowest income and highest need documented on the agency's Priority Criteria form receive priority enrollment slots. The Priority Criteria form includes the following risk factors; low income, age of parent(s), current involvement with child abuse or neglect cases, history of substance abuse, have children with identified or suspected developmental delays or

disabilities. The EHS program will need to collect information from the family and give priority to the applicant if the household has users of tobacco products living in the home, and to families that include individuals who are serving or have formerly served in the armed forces.

- d) Assurance that funds will be used to service the at-risk target population agreed upon with the state, the characteristics of which are documented in Section A above.*

The Saginaw ISD program assures that the funds will be used to serve the at-risk target population outlined in the grant application.

Michigan Maternal, Infant and Early Childhood Home Visiting Program
County-Level Home Visiting Program Implementation Plan

County: WAYNE
Contact Person/Agency: Deborah Strong
 Great Start Collaborative-Wayne
Phone: 734-649-9804
Email: ddsdds33@hotmail.com

A. Identification of the County's Targeted At-Risk Community

1. What is the targeted at-risk community (e.g., city, township, zip code, population group, etc) that the Local Leadership Group (LLG) and the Home Visiting Workgroup (HVWG) have jointly agreed upon?

The Wayne County Local Leadership Group and the Home Visiting Workgroup have selected pregnant and parenting African American teens residing in the City of Highland Park, Michigan as the targeted at-risk community. Healthy Families America services in Wayne County will be expanded to serve this population.

2. What are the risk factors in this community?

RISK FACTORS	COUNTY <i>(copy from Statewide Needs Assessment)</i>	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
1. Premature birth	12%	11.4%	LBW and PTD by MCD in Select Counties Spreadsheet
2. Low-birth wt infants	10.6%	11.4%	LBW and PTD by MCD in Select Counties Spreadsheet
3. Infant mortality	10.5 deaths per 1,000 live births	17.7 deaths per 1,000 live births (2007-2009 average)	Michigan Resident Death Files and Michigan Resident Birth Files, Vital Records and Health Statistics Section, MDCH
4. Poverty	20.5%	42.5%	2005-2009 American Community Survey
5. Crime	116.79 crimes per 1,000 residents	Not available	
6. Domestic violence	14.7 per 1,000 residents	Not available	
7. School drop-out rates	16.1%	26.5%	http://www.localschooldirectory.com/district-schools/82070/Highland-Park-City-Schools-District/MI
8. Substance abuse	3.74% illicit drug use	Not available	
9. Unemployment	15.4%	29.7%	2005-2009 American Community Survey

RISK FACTORS	COUNTY <i>(copy from Statewide Needs Assessment)</i>	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
10. Child maltreatment	9.3 children confirmed victims of abuse and neglect per 1,000	Not available	
11. Proportion of total pop of American Indians living in community compared to total pop in county	Wayne County has 9,875 Native American residents (0.4% of the total population of Wayne County)	Highland Park has 73 AI/AN residents (0.5% of the total population of Highland Park and 0.7% of the total AI/AN population of Wayne County)	2005-2009 American Community Survey
12. Proportion of total pop of African Americans living in community compared to total pop in county	Wayne County has 809,686 African American residents (40.9% of the total population of Wayne County)	Highland Park has 13,614 African American residents (93.1% of the 14,623 residents of Highland Park and 1.6% of the total African American population in Wayne County)	2005-2009 American Community Survey
If you were unable to provide community-level data on more than 5 risk factors , explain how you determined that this is the highest-need community in the county.	<p>We provided community level data on 8 risk factors. More detailed community-level information is provided in the following narrative.</p> <p>In addition, Right Start in Michigan (2010), part of the state level Kids Count Project, rated Highland Park as the highest risk Michigan community. The risk score was based on the percent of Medicaid births and the Right Start indicators. Highland Park had the highest composite risk score of the 13 cities included in the High Risk group.</p>		

3. What are the strengths of this community?

COMMUNITY STRENGTHS/ASSETS	
1. What is this community proud of?	Highland Park is proud of its rich heritage, its citizenry, its history, its architecture, its resilience, and its ongoing work to rebuild. The Highland Park Ford Plant, where mass production of the automobile began, is a national historic landmark. The Chrysler Corporation was founded in Highland Park.
2. Faith communities	There are many churches in this small community. They range from small store fronts to large historic churches with multiple

COMMUNITY STRENGTHS/ASSETS	
	ministries. For example, St. Benedict, the oldest Catholic church in the community houses a school and the comprehensive Infant Mortality Project. Soul Harvest Ministries, housed in another historic building, has a Family Life Development Center that offers programs and resources including reading enrichment and supervised activities for teens from 15-19 years old.
3. Neighborhood associations	Several active block clubs are scattered throughout the city. Highland Park Weed and Seed and Highland Park Men's Forum provides youth services and mentoring.
4. Cultural/ethnic associations	Cultural/ethnic associations include a Holistic Development Center as well as African American fraternities and sororities.
5. Other community organizations	Highland Park is part of the ongoing Woodward Avenue Action Association, working to revitalize the entire Woodward corridor. Additionally, the Boys & Girls Club provides education, youth serves, mentoring, parenting and recreation; the Ruth Ellis Center provides youth services (e.g. food, showers, laundry facilities, clothing support groups, crisis intervention to lesbian, gay, bi-attractional, transgender & questioning youth), education, housing and recreation.
6. Business investment	There are approximately 300 businesses located in HP. There has been investment in renovation of existing structures as well as new construction including two commercial strips along Woodward, the main thoroughfare. There has also been considerable construction of new housing units in the past 10 years. Also, HP Devco, Inc. is a non-profit agency that is dedicated to community development and economic growth. Since 1987, they have been involved in 75% of the \$350 million in new investments and development in Highland Park.
7. Philanthropic investment	The Reggie McKenzie Foundation offers academic, sports and life skills programming for youth designed to prepare young people for success. The Skillman Foundation and the State Farm Youth Advisory Board have supported the work of the McKenzie Foundation via capacity building grants and the implementation of a Safe Routes to Schools program. Additionally, the (Super All Year) S.A.Y. Detroit Family Health Clinic located in Highland Park, was opened in 2008 with Mitch Albom's S.A.Y. Detroit funds. The health center is operated by The Detroit Rescue Mission Ministries and provides 24 hour, 7 days a week maintenance and preventative healthcare for homeless women and their children.
8. Major community events	Ongoing community events include annual clean ups and parades. Also, a Michigan Week Parade has been held for 88 years; and the Highland Park Jazz Festival is held annually. An annual community Baby Shower, organized by the Early Childhood Education Center at Highland Park Schools, provides

COMMUNITY STRENGTHS/ASSETS	
	community agency resources, layettes and gifts.
9. Other assets/resources (specify one or more)	A community center, the Ernest T. Ford Recreation Center, was renovated and re-opened in 2008. The space, equipment, and programs are available to all residents. The McGregor Library, a historic landmark with architectural significance, has been closed since 2002. It is undergoing renovation with plans to reopen soon. Also, Saturday morning tutoring program, provided by the Highland Park Schools, is available for all school-aged children. Breakfast and lunch are provided; Highland Park has been identified as an eligible City of Promise-Michigan by the Michigan State Housing Development Authority (MSHDA). This program allows the state to engage in partnerships with the city to address their concerns and prioritize their needs using existing state resources.

4. Briefly describe characteristics of potential HVP participants from the at-risk community (e.g., income level, mother's education level, percentage of single parents, percentage of first-time parents, employment rate, race/ethnicity, and/or other characteristics).

The potential HVP participants, pregnant and parenting African American teens residing Highland Park, are one of the highest risk groups in Wayne County. They live in a highly segregated community that is severely impoverished. Ninety three percent of the population is African American. Almost half (42.5%) of the residents live in poverty and over half (61%) of female headed households with children live in poverty. The median household income is \$18,712 compared to \$42,232 for Wayne County as a whole. The per capita income is \$12,121, second lowest in Wayne County and less than 1/5 of that of the wealthiest community in the County. In addition, a staggering 29.7% of the civilian labor force is unemployed.

According to the 2005-2009 American Community Survey Data Set, there are few married residents and the educational attainment is low. Of those over 15 years of age, only 18% of males and 15% of females were married. Of adults 25 years of age and older, 76% were high school graduates and only 8% had a bachelor's degree or higher. Substance use is common among teens in Michigan. According to the 2009 Youth Risk Behavior Survey, 72% of 11th graders in Michigan had used alcohol and 45% had used marijuana. Fifty two percent of 12th graders had used tobacco. Among African American students, 21% used marijuana in the past 30 days, while 28% recently drank alcohol and 17% had recently used tobacco.

Maternal and child health indicators in Highland Park are equally alarming. During 2008, 17.4% of women who gave birth in Highland Park had inadequate or no prenatal care, the highest percent in Wayne County. From 2005-2009, the annual birth rate among 15-19 year olds in Highland Park was 19 births per 1,000 women. In 2009, more

than one in five live births (21.1%) in Highland Park was to African American teen mothers. Less than half of the teen mothers (46.2%) received prenatal care during the first trimester of their pregnancies. Furthermore, in 2008, 17.1% of births to teen mothers were to teens that already had at least one child.

High risk maternal behaviors are prevalent. In 2008, almost one in five pregnant women (19.5%) smoked during their pregnancy and 39.2% of 2007 births in the city were to mothers who had less than 12 years of education. From 2004-2008, over 80% of births in Highland Park were to unwed mothers and more than half of births in that time period had no paternity established.

Birth outcomes reflect the high level of risk. In 2009, 11.4% of babies born in Highland Park had a birth weight of less than 2,500 grams and 2.2% of infants were born weighing less than 1,500 grams. Additionally, from 2007-2009, the average infant mortality rate in Highland Park was 17.7 deaths per 1,000 live births. This compares to an infant mortality rate of 10.4 for Wayne County and 7.6 for Michigan.

- 5. Below is a list of possible needs of potential HVP participants. Indicate whether or not individuals residing in the targeted at-risk community have each of these needs. Add any other needs that you have identified at end of list.**

NEEDS OF PARTICIPANTS	Yes or No
1. Child development/parenting education and support to assist families to form stable and responsive relationships with their young children	Yes
2. Safe and supportive physical, chemical, and built environments, which provide places for children that are free from toxins and fear, allow active, safe exploration, and offer families raising young children opportunities to exercise and make social connections	Yes
3. Sound and appropriate nutrition	Yes
4. Health education and care	Yes
5. Education on promoting literacy and early learning	Yes
6. Access to quality child care/early childhood education experiences	Yes
7. Domestic violence resources	Yes
8. Substance abuse services	Yes
9. Mental health services	Yes
10. Training and jobs	Yes
11. Transportation	Yes
12. Other: Access to a level of preparation and training that will lead to employment in areas other than entry level and minimum wage jobs	Yes
13. Other: Quality, affordable housing	Yes
14. Other: Education to provide family planning options and about sexually transmitted infections	Yes

15. Other: High school completion reinforcement	Yes
Provide any additional comments you may have about needs of potential program participants: Adult mentors are needed to discuss adolescent concerns/serious problems, to encourage positive life choices, to provide feedback and to model responsible behaviors. Family planning education options are needed to delay future pregnancies. STI education is needed to maintain health and wellness. Reinforcing high school completion helps to ensure minimal economic instability.	

6. Identify any other factors considered in the selection of this at-risk community.

A major factor in the selection of this community is the significant lack of economic and social resources at the individual and community levels, due in large part to high levels of poverty and unemployment in Highland Park. With limited overall employment, few teens have the opportunity to work in family or neighborhood businesses. Such opportunities provide young people with the experiences and references that facilitate access to broader career options, the type of employment that can help move them out of poverty. Another factor in the selection is the high level of risk in the adult population. Risk behaviors in the adult population limit positive role models and decrease the ability of adults to support vulnerable teens. For example, the 2008-2010 MI BRFSS revealed that 35% of adult Wayne County residents were overweight and 28.5% were obese. Almost 1/5 smoked cigarettes (19.5%), 5% were heavy drinkers, and 18.4% reported binge drinking.

Although this population has many risk factors, they also have demonstrated strengths. The percentage of African American teens that use alcohol, tobacco, and marijuana is lower than that of white teens. To illustrate, the 2009 YRBS found that 45% of white teens had recently used alcohol compared to 28% of African American teens. Fewer teens are using of tobacco. The 1997 YRBS found that 75% of high school students had ever used tobacco; by 2009 that number had fallen to 46%.

There have also been positive changes in Highland Park on which the HVP can build. There has been a decrease in the percent of teens giving birth as well as repeat births to teens. For 1998-2000, 22.3% of all births in Highland Park were to teens. The percentage of teen births decreased to 21.3 for 2006-2008. There was also a 40% decrease in the percent of births to teens who were already parents between 2000 and 2008.

7. Review the updated list of home visiting programs operating in your county and list each program that serves your targeted at-risk community below.

- a) Infant Mortality Project
- b) Wayne County Babies
- c) Early Head Start
- d) Maternal Infant Health Program (MIHP)
- e) Spaulding—upon MIECHV expansion

- 8. If there are home visiting services currently serving the targeted at-risk community, why are additional home visiting services needed (e.g., existing programs don't have capacity to meet the need, long waiting lists, program eligibility restrictions, etc.)? What is your estimate of the number of service slots available compared to the number of families who need home visiting services?**

There is insufficient capacity in the existing programs to meet the level of need in the community. There are approximately 200 births in Highland Park annually. In 2009, there were 39 teen births. The pregnancy rate for teens is 1.5 to 1.6 times the birth rate. Thus there are over 60 teen pregnancies annually.

None of the programs listed above serve only Highland Park. The Infant Mortality Project, with a capacity of 60, serves Highland Park, Hamtramck, and Detroit. Wayne County Babies has a current capacity of 80 clients and serves both Highland Park and Hamtramck. Early Head Start has a capacity of 64 and serves Inkster, Taylor, Dearborn Heights, Dearborn, Redford, Garden City, Wayne, Westland, Livonia, Plymouth, Canton, and Northville. There are 20 plus MIHP providers that serve Wayne County, but most also serve Oakland and Macomb Counties. The capacity of most MIHP programs is 100-200 clients. Thus there are an estimated 4,100 service slots currently available. In 2009, there were 5,602 teen births in Wayne County alone. Overall, there were more than 47,000 births in Wayne, Oakland and Macomb Counties.

Although the available home visiting programs serve teen parents, none are specifically designed to meet the unique needs of this vulnerable population. Furthermore, several programs work with families for a relatively short period of time. Both MIHP and Wayne County Babies serve families only during pregnancy and through the infant's first year of life.

- 9. Identify referral resources (services to which the home visiting program can refer) currently available to support families residing in the community.**

Available referral resources to support families include supplemental food programs (WIC and Focus: HOPE), state insurance programs (Healthy Kids and MI Child), medical care (Title X family planning clinics, federally qualified health centers, and area hospital systems), economic supports (DHS), early education programs (Head Start, Great Start Readiness Program), mental health (community mental health providers, infant mental health services, family counseling), substance abuse services (Bureau of Substance Abuse Prevention, Treatment and Recovery), special care services (Children's Special Health Care Services and Early On), and workforce preparation (MI Works).

10. Identify referral resources (services to which the home visiting program could refer) that are needed in the community.

Referral resources needed in the community include housing, education for at risk teens, employment preparation and training, child care, services that address marijuana use, life skills, and parenting support.

11. Describe your plan for coordination among existing programs and resources in the community, including how the program will address existing service gaps.

The initial step in assuring coordination is to develop awareness of the expansion of services via an orientation to the federal HVP and HFA for all entities and programs serving the target population. The service gap HFA is intended to fill as well as program eligibility, referral procedures, and lines of communication will be addressed. The Local Leadership Group will actively support the central data base and referral system currently being developed by Great Start in partnership with D3, the Skillman Foundation, and the Detroit Department of Health and Wellness Promotion. The purpose of the data base is to assure coordination among existing programs, minimize duplication, and assure families are linked to the resources that best meet their needs. The goal is to improve service delivery by pursuing the system changes that are needed.

12. Identify existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the community level). To what extent are you coordinating referrals and intake across home visiting programs?

Several agencies in Wayne County actively screen, identify, and refer families to home visiting programs, including residents of Highland Park. There are two major telephone services, the United Way 211 Helpline and the Detroit Department of Health Wellness Promotion's Family & Baby Helpline. Each service has a series of questions to determine need and eligibility for home visiting programs. Callers are given information on available programs and make contact themselves. The Detroit Department of Health Wellness Promotion also houses the Pathway Center. Families who visit the Center are screened using a 'Universal Intake' Intake. Referrals are generally made by staff, but families have the option to contact programs on their own. There are several Family Resource Centers that assist families in accessing available programs based on an evaluation of needs. Great Start Connect, an online service, is available to all families. Common screening and intake mechanisms are not utilized. Referrals across programs are not currently coordinated in a systematic way.

13. Describe county capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level, such as a governance structure or coordinated system of planning.

The Great Start Collaborative-Wayne is in the process of developing a real time centralized data base that would link existing early childhood programs and services. The goal is to strengthen a county-wide system as well as facilitate awareness and access for families. Available infrastructure resources will be used to further these efforts. Great Start will also establish mechanisms for coordination and communication among providers. The Home Visiting Program services will be embedded into existing agencies providing home visits to expand capacity.

B. Selection of Wayne County's Home Visiting Model and Explanation of How the Model Meets the Needs of Targeted Community

1. Which evidence-based home visiting program model has been selected for expansion in the targeted at-risk community, as agreed jointly determined by the LLG and the HVWG?

The evidence-based home visiting program model selected for expansion in Wayne County (Highland Park), by the LLG and the HVWG, is Healthy Families America.

2. How does the selected model address the particular risks in the targeted community and the needs of the families residing there?

Healthy Families America (HFA), an evidence-based model, is particularly suited to our targeted teen population because of its comprehensive, wrap around approach; ability to deliver services as intensively as needed; and its effectiveness with at-risk parents and children, prenatally or after birth. Additionally, HFA's program goals include:

- a) to systematically connect families, prenatally or at birth, and provide appropriate linkages to home visiting services, along with other information and referrals,
- b) foster nurturing parent-child relationships,
- c) promote healthy childhood growth and development, and
- d) to enhance family functioning by reducing risk and building protective factors.

Further, thirty-four randomized control trials and quasi experimental designs in 25 states have documented the effectiveness of this model. It has produced results (particularly with young mothers) that include (but are not limited to):

- a) Reduced child abuse and neglect
- b) Increased utilization of prenatal care resulting in decreased preterm, low
- c) birth weight babies
- d) Improved parent-child interaction and school readiness
- e) Decreased dependency on welfare, TANF or other social services
- f) Decreased incidence of intimate partner violence

- g) Increased access to primary care medical services, and
- h) Increased immunization rates.

Finally, the HFA model is culturally sensitive to the needs of the family and the community within which they reside.

3. How will the targeted community be involved on an ongoing basis throughout the duration of this program (other than as program participants)?

The target population will be engaged in the implementation of this initiative through a variety of modalities on an ongoing basis. Representative/s of the target population may participate in:

- a) Our Wayne County HV System building workgroup;
- b) Client satisfaction surveys or other opportunities for input regarding needs or services;
- c) Parent education opportunities;
- d) The Great Start Collaborative Wayne parent coalition, and
- e) Informational meetings open to the community.

Further, many of the partner agencies also have built in feedback process for gathering input from family representatives and will also share that information with this program.

4. Describe your county's current and prior experience with implementing the selected model.

Wayne county has two different HFA program sites (one public and one private), but due to limited resources neither site has been able to reach full credentialing. This funding will allow Wayne County to bring these programs into full compliance and facilitate the ongoing training, technical assistance, peer reviews, and other activities required to maintain this level of quality.

5. Describe your county's current capacity (e.g., funding, staff, administration, etc.) to increase the number of families served using this model.

Both programs are experienced with many aspects of the model and capable of ramping up quickly to expand services to the identified target population and geographic area.

6. Describe your plan to ensure implementation with fidelity to the model.

Wayne County will assure implementation with fidelity via state and local efforts. In addition to the ongoing oversight and support given by the state, the two HFA sites will be required to develop a plan and timetable for moving to full credentialing in collaboration with the LLG and HVWG. The plan will require approval by the state lead and HFA Technical Assistance Regional Director before the release of allocated funds. Benchmarks will be built into this timetable and the local LLG/HVWG will

provide ongoing assurances. The entire program must meet this standard and not just the program expansion component.

7. Discuss anticipated challenges and risks of the selected program model, and your proposed response to these challenges.

If sufficient financial resources are made available to fulfill the initial and ongoing credentialing requirements and training, we anticipate minimal challenges to the implementation and credentialing of this model. Both sites currently use this model, but have been unable to comply with all of the credentialing requirements due to cost. Although local resources could be utilized for the development of cross-systems components (e.g. HV database, universal forms) that would enhance the integration of HFA into the Wayne County family support system, additional funding would be helpful and expedite the process. This is particularly true this during this current period of fiscal constraint in the county and state.

8. Identify any anticipated technical assistance needs to be addressed by the state or the model developers.

Technical assistance needs include ongoing training and support to maintain fidelity to the model; the development of cross-system forms/approvals and a HV database; program evaluation and tools; and establishing a HFA learning community. Annual or biannual HV or EVB conferences where programs can share successes and challenges would be useful.

C. Implementation of Wayne County's Selected Model

1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots? (Note: This is the entity that is already implementing the selected model, unless the LLG and HVWG have agreed upon an alternative entity, based on how the alternate approach will maximize funding and services.)

As stated previously, Wayne county has two different HFA program sites, Wayne County Babies and Spaulding for Children. Both of these entities will receive the Michigan MIECHVP funds to expand service slots in the Healthy Families America Program in Wayne County. These programs will serve participants who are pregnant mothers and children age birth to 47 months. The Healthy Families America Curriculum is used in their service provision. The two entities are discussed separately below.

Spaulding for Children

Spaulding for Children is the second entity that will receive the Michigan MIECHVP funds in Wayne County. Spaulding will expand its current Healthy Families -secondary prevention program- to include the City of Highland Park, and targeting pregnant females under the age of 21 and mothers under the age of 21 with a child(ren) under age 4.

Organizational History

Spaulding for Children is a private, non-profit child welfare agency, established in 1968. Originally developed to help those children deemed unadoptable, the Agency has expanded its service continuum today to include three service entities, the National Resource Center for Adoption, the Spaulding Institute for Family and Community Development and Child and Family Services that includes foster care, adoption, and the 0-3 Healthy Families Program. The Agency is governed by a diverse 22 person board of directors; its Child and Family Service programs are accredited by the Council on Accreditation and are licensed by the State of Michigan. The Agency has a staff of 50 persons, is completely solvent with a budget of \$9 million and annually is given the highest audit rating that can be issued by its external financial auditors.

Spaulding has provided 0-3 secondary prevention services for more than ten years including coordinating a consortium of up to fourteen agencies that provided a comprehensive continuum of services for the 0-3 program population. The Agency currently has three prevention contracts with the State of Michigan covering Wayne County and Macomb County (0-3) and the Osborn Community. The Agency provides a comprehensive continuum of services including home visitation, assessments, service plan development/implementation, training, parent education, case management, community capacity building, information and referral, and linking, coordinating, and monitoring of services using nationally recognized models and curricula including Healthy Families America.

2. Describe the plan for recruiting, hiring, and retaining appropriate staff for all positions. List each position to be filled.

Wayne County Babies

The home visitor position(s) will be posted at various community agencies (e.g. Detroit Department of Health & Wellness Promotion (DDH&WP), Wayne County Department of Public Health (WCDPH), Wayne State University), through Great Start Collaborative Wayne and its partners and in the local newspapers. A generous benefit package and supportive supervision will help in the selection and retention of appropriate staff. Wayne County Babies presently has 1 Supervisor and 3 Community Health Workers (county classification for these HFA program staff) that conduct home visits. One additional Community Health Worker will be hired for the expansion of this home visiting program model to serve the Highland Park community.

Spaulding for Children:

Staffing would include .25 Program Director and 1 FTE Outreach Worker. Spaulding's current Healthy Families program director will also supervise this program. Because Spaulding currently delivers services using the Healthy Families model, the Program Director has already been trained and has more than three years experience directing the program. The Agency currently has a staff that has been interviewed and approved for an Outreach Worker position, upon grant award, she can immediately transfer. She has more than 20 years of experience in child welfare working with both families and young

children. Because Spaulding also has on staff a person certified as a trainer by Healthy Families America, staff can immediately be trained in the model. Additionally, Spaulding maintains a data base of resumes in its Human Resources Department and has the capabilities to recruit prospective staff through a number of mediums as necessary.

Spaulding provides a comfortable environment for staff to work and has in place systems to acknowledge and reward work performance. The Agency has an Employee Recognition Committee (ERC) comprised of representatives from each unit. They plan activities throughout the year including: monthly birthday recognitions, support staff day celebration, bosses day celebration, annual holiday party, and spring fling staff meeting. They facilitate the awarding of the quarterly GEM award to people who worked as a team to accomplish a non-job assigned task, the Peer Award to an individual identified by their peers as doing an outstanding job, the trophy for the employee of the year and a ham or turkey to the ham of the year (person who is the biggest ham)!

The Agency has flexible working hours, can accommodate staff children during an emergency, all managers have an open door policy, and staff can participate in national conferences and training as funds allow. Time can be allotted for college attendance and based on funds, tuition reimbursement.

Program Director: .25 FTE - Responsible for the overall direction of the program including: managing and monitoring the day-to-day activities of the Healthy Families Program, ensuring the implementation of activities, goals and objectives attainment, directly supervising program staff, being the representative to the Advisory Committee Meetings, overseeing the development of the marketing strategy, facilitating the evaluation, and being the managerial liaison.

Outreach Worker 1FTE – Responsible for the provision of intensive outreach services to families. This includes completion of family assessments and service plans, facilitation of plan services including in-home visitations, monitoring of plan, information and referral, advocacy, assisting in accessing resources including health services for families.

- 3. If subcontracts will be used, describe the plan for recruitment of subcontractor organizations, and the plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s).**

Wayne County Babies

Wayne County Babies presently hires through the Southeastern Michigan Health Association (SEMHA) and plans to continue with this association. Based on guidance from the Wayne County Health Department, its Wayne County Babies (HFA) program and the state requirements, SEMHA will facilitate the recruitment, hiring and some of the retention strategies. The Wayne County Babies program itself and supervisor will be responsible for the provision or facilitation of additional and ongoing staff education, support and retention strategies. Additionally, the administration will track and analyze, formally and informally, issues of retention (both staff and parents), through a variety of

tools/modalities including exit interviews and discussions with parents, staff and others regarding program concerns.

SEMHA is a 501 (c) 3 nonprofit organization that is a consortium of health officers who direct the local health departments in southeastern Michigan. Since its inception SEMHA, has proven to be valuable resource to the local governmental jurisdictions, as well as to the health departments, and the public they serve. They are able to move more quickly and efficiently than many of the large bureaucracies they represent, and they also provide an additional level of assurances and safeguards. Some of the supports that they are able to provide to local health departments include administrative functions, fiscal management and oversight, record-keeping systems, and other functions needed.

Spaulding for Children: N/A

4. Describe the plan to ensure high quality clinical supervision and effective practice for all home visitors and supervisors.

Wayne County Babies: Wayne County Babies will adhere to the identified Healthy Families of America clinical supervision and reflective practice requirements.

Spaulding for Children: The Outreach Worker will be directly supervised by the Director of the Healthy Families program. The Director reports to the Vice President of Child and Family Services. All of the aforementioned staff is housed in the same unit of the Agency. The Outreach Worker will always have access to supervisory staff in person or by cell phone. There is always a Supervisor, Director, or Vice President on call. The Agency contracts with the Emergency Telephone System (ETS) to address emergencies during non-work hours. Families will have access to the service and the President/CEO is always available by cell phone. Because the Agency has several staff that are trained in the Healthy Families Program, there will always be a staff available to back-up the Outreach Worker.

The Vice President and Program Director will attend weekly Executive meetings with the President/CEO and other Agency administrators to present status of program and any issues or concerns. The Vice President will meet weekly with the Program Director.

The Outreach Worker will meet with the Director weekly in regularly scheduled meetings and more often based on the need. During supervision each case will be reviewed, barriers to service plan completion will be identified and discussed, and plans will be made to address the barriers identified. Case file documentation including progress notes, updated service plans, expenditures on behalf of the family, etc. will be reviewed by the supervisor. Additionally, the Supervisor will address any infidelity to the model and facilitate additional training.

5. What is the estimated number of families that will be served annually with the expansion funds provided by the Michigan MIECHVP? (Do not count families being served with funds from other sources.)

Wayne County Babies: At least 25 families will be served.

Spaulding for Children: At least 25 families will be served.

6. **How will program participants be identified and recruited?**

Wayne County Babies: Wayne County Babies will continue to recruit from the Department of Human Services offices, physician offices, Community Baby Showers, Women, Infants and Children (WIC), and through word of mouth referrals. Outreach for this target population will also be expanded to the Highland Park School District.

Spaulding for Children: Building on its past successful program, Spaulding will be able to attract appropriate families as clients for the program. Building on its relationship with the Director of Children's Services Administration for Wayne County, Spaulding will make a program presentation to the Wayne County's Child Protection Staff offices located on Hamilton in Highland Park and establish referral protocols. Spaulding will include information regarding the Healthy Families Program in all of its Agency marketing materials and it will be identified as a program of Spaulding in all advertisements. Spaulding will also do the following:

- Include information regarding Spaulding for Children's Healthy Families Program in all presentations regarding Agency services
- Contact DHS to facilitate appropriate referrals
- Contact domestic violence shelters and alternative schools and establish office hours within those entities
- Disseminate public information targeted at the parents of newborns and young children at the Public Health Department, medical clinics, Focus Hope, and other organizations serving the target population. Materials will include information regarding developmental delays and disabilities; strategies for lessening the effects of a variety of disabilities; and notification about the availability of 0-3 secondary prevention services.

Clients will be engaged through a thorough presentation of the Program's services and benefits in clear understandable terms delivered by culturally competent and responsive staff. Clients will be given information on:

- The availability of and qualifications necessary to receive incentives including gift cards, food, consumables.
- The availability of transportation, including Agency vans and bus passes that are available.
- The availability of child care at every training/meeting.
- The availability of services that are delivered in the home or at locations recommended by the family.

7. Describe the plan for minimizing the attrition rates for participants enrolled in the program.

Wayne County Babies: Program participants will continue to sign a Pledge Form, agreeing to complete the program requirements. Incentives will continue to be provided at specific times during the program's duration. Presently, incentives are provided at program entrance (a program bag and resources); at the 8th month of pregnancy (a crib); at birth (a layette, thermometer and medicine dropper); and at the child's 1st birthday (a gift certificate for mom and an infant toy). Also, engaging parents in the ongoing education and supports of the program and implementing some of the suggested HFA retention strategies.

Spaulding for Children: Research has shown when individuals have their needs met, see a benefit from participating in an event, or make social connections, they are more likely to continue participation. Based on Spaulding's prior program, we know that providing concrete resources such as gift cards, toiletry items, or household goods at strategic points was very instrumental in maintaining a high level of participation. Additionally, providing child care so families could attend training without having to bring children, or providing child care at the training so they could enjoy a session, without children, worked to increase attendance at training. Providing transportation, food at meetings, and assistance with connecting the family to resources that they identify as needed, also helped maintain a high level of participation.

Therefore, parents will play a major role in their plan development and in identifying the types of training that they think would be beneficial for them. The Program will provide stipends, gift cards or other desired items to families for participation in activities. Child care and transportation will be provided to facilitate attendance.

Spaulding will identify a parent to serve on the Advisory Committee; they will be an equal participant and help guide service delivery and program development. Time will be provided during each formal training for networking and socializing. This will help families establish a social network for additional support.

8. What is the estimated timeline to reach maximum caseload?

Wayne County Babies: Within 6 to 8 months Wayne County Babies anticipates reaching maximum caseload.

Spaulding for Children: Due to Spaulding's long standing reputation as a Healthy Families Program 0-3 Secondary Prevention provider, and building on our established relationship with Wayne County's Child Protection staff, referrals for the expansion program should be easily attained. It is anticipated that the program could reach a maximum caseload within a 30-60 day timeframe.

9. Describe the operational plan for the coordination between the proposed home visiting program and other existing programs and resources in the community,

especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services.

Wayne County Babies: Wayne County Babies plans to continue to provide written or phone referrals to local community agencies according to the program participant's needs. Referral processes are already in place with Hegira for parenting and substance abuse services; with the Development Center for infant mental health; with the Maternal Infant Health Program (MIHP) for home visit education from social work, health, and nutrition professionals; with WIC for nutrition assistance; with WCDPH/DDH&WP for insurance assistance; with Department of Human Services (DHS) for social services, child welfare and child maltreatment prevention services; and with primary providers for health care. Domestic violence concerns could be referred to First Step and early childhood developmental concerns referred to Early On.

Spaulding for Children: Spaulding has a long history of collaboration and community involvement. It currently has significant relationships with many relevant community organizations, and if awarded a grant, will rejoin relevant collaborative groups. As a 0-3 award recipient, the Agency will continue activity in the Great Start Collaborative in Wayne County, the Wayne RESA, and the Detroit Parent Network. Spaulding will work to spearhead an effort to bring together the two MIECHV HFA sites in Wayne County, in order to work collaboratively to sponsor trainings, as well as community education and outreach. Spaulding is currently working collaboratively and has worked with a number of organizations that will prove beneficial to the target population. They include the following:

- a) ***Faith-Based Collaborations:*** Over the years, Spaulding has partnered with numerous faith-based organizations in mutually beneficial programs. One such program was the Family Help Centers located within 14 churches in the metropolitan Detroit area. These churches allowed us to use their facilities for community meetings and training and assisted in recruiting participants through their congregations and the surrounding community. We would continue this relationship to help facilitate marketing and community education and training.
- b) ***Alternative Schools:*** Spaulding established relationships with two alternative schools—the Highland Park Career Academy in Highland Park and Trombley Alternative High School on the east side of Detroit. These schools allowed us to have an office and provide services within the school. They were also instrumental in obtaining parental permission for services provided. The Outreach worker worked with the school nurse and social worker to coordinate and deliver services.
- c) ***Domestic Violence Shelter:*** Spaulding was permitted to provide services on a regular basis to eligible women and children in the shelter. The Outreach worker was able to successfully continue service delivery to many of the families after leaving the shelter and worked with other providers to address service needs.
- d) ***Food Bank:*** Spaulding has a relationship with county food banks that allows us to provide food to families.

- e) ***Volunteer Networks:*** A key component of our program will be the use of volunteers to support families. Wayne State University provides social work student interns who assist families to meet service plan goals and objectives, and Spaulding has a relationship with a number of volunteer organizations, including the Urban League that provides trained volunteers to support our families per service plans. This will provide for a greater intensity of service.
- f) ***Private Foundations:*** Spaulding has an on-going program to leverage donations to support Agency programs. During the past several years foundations provided funds to purchase clothing, toiletries, furniture, gift cards, and other concrete resources for 0-3 Families. In 2009 The MGM Casino provided partial funds to purchase a van that would serve as a source of transportation to Agency clients including 0-3 Families. Efforts continue to obtain monetary donations to support families.
- g) ***Recreation:*** Spaulding is often provided tickets to recreational activities and funding to pay for activities from external donors and businesses. Spaulding continually markets program services and needs to the business community.
- h) ***Housing/Employment:*** Spaulding works with the Urban League, Housing and Urban Development, the Department of Human Services, and other community resources to assist families with housing and employment needs.
- i) ***Medical:*** Spaulding has identified providers in the community that accept Medicaid and has identified, in addition to Children's Hospital and their affiliates, providers who service infants, toddlers, youth, as well as pregnant women and teens.
- j) ***Transportation:*** In addition to Agency provided transportation, Spaulding has donors who have donated buses to transport clients to recreational activities including the Agency's annual Ice Cream Social held at Metropolitan Beach.

The Outreach worker has access to Spaulding's community resource guides and research capabilities, useful in identifying resources; as well as access to a laptop and wireless internet to help parents learn how to research resources, identify, and contact needed resources. When needed, the worker will demonstrate proper advocacy techniques.

10. How are you already collecting process and outcome data for the existing home visiting program that has been chosen to receive MMIECHVP funds? Will you be using the same process with the expansion slots?

Wayne County Babies: Monthly reports are sent to DHS indicating the number of referrals received from their agency and the number of DHS recipients that have completed the Operation Safe Sleep training offered by Wayne County Babies. Monthly reports are also sent to the Wayne County Health Officer providing data such as: number of visits per month, number of prenatal visits, number of postnatal visits, number of clients referred to WCB, number of enrolled clients, number of phone contacts, number of quarterly phone contacts, number of children who reached their first birthday, total number of infants to date reached their first birthday, number of clients receiving condoms, and number of condoms given. The current monthly report also presents information on administrative concerns, subcontracts, marketing updates, collaboration

and outreach updates, age of current clients, ethnicity, current communities being serviced, updated budget information and staff education and updates. Wayne County Babies will also comply with any data collection requirements required by the State.

Spaulding for Children: As a provider of current 0-3 services, Spaulding is currently collecting and inputting data per State and Agency evaluation procedures. Evaluation of Spaulding for Children's Healthy Families Program is conducted by a local and state evaluator and includes implementation and outcome components, including quantitative and qualitative data necessary to determine its successes, challenges and document its processes. Standardized assessment tools are used including Ages and Stages and the Adult-Adolescent Parenting Inventory (AAPI-1 and 2). In addition to the evaluation administered by the state evaluator, an external evaluator provides evaluation services to determine program success in meeting goals and objectives. If awarded, evaluation services will be extended to the expansion program by our local evaluator, Public Research and Evaluation Services (PRES) and if requested the State evaluators, Michigan Public Health Institute. (MPHI).

11. Describe anticipated challenges to maintaining program quality and fidelity, and how these challenges will be addressed.

Wayne County Babies: Challenges that are anticipated: 1) retraining staff to the uphold the fidelity of the Healthy Families of American model will take time and attention away from serving present program participants, 2) learning the new approach to the program model and materials may increase stress on present staff, and 3) measuring and documenting additional program model outcomes will require process changes in order to validate and meet the requirements of the program model.

Spaulding for Children: If awarded, it is Spaulding's intention to become an accredited provider of Healthy Families America. As the lead in a consortium of Agencies, some of our partners are not as progressive. We anticipate some challenges in getting everyone on-board and trained. We intend to address this issue by educating them on the value of accreditation and developing a plan to systematically bring them on board. Because they all are currently using the model, we do not anticipate that this process will be lengthy.

12. Provide a list of collaborative public and private partners (Local Leadership Group member names and organizations).

Wayne County Babies: See the attached lists for the LLG, HVWG, and Great Start Collaborative Wayne. All have pledged to assist with the development, implementation, support, evaluation and oversight of this initiative. Additionally, the LLG/HVWG has expressed interest and support for utilizing this model as a possible system change vehicle.

Spaulding for Children: See list following the Assurances for Spaulding for Children at the end of the Wayne County Section.

13. Indicate that you are providing each of the following assurances:

Wayne County Babies:

a. Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments within the scope of the model, and assuring fidelity to the model, (e.g., assessment does not eliminate components of the model).

Wayne County Babies is presently using an assessment for each participant. The program will use the Healthy Families of America assessment after training is complete.

b. Assurance that services will be provided on a voluntary basis.

Wayne County Babies participants must sign a form indicating that program services are voluntary.

c. Assurance that priority will be given to serve eligible participants who:

- 1) Have low incomes. **All participants must be Medicaid eligible and the Netwerkes eligibility system is checked upon enrollment. Poverty Income Guidelines are also used, if needed.**
- 2) Are pregnant women who have not attained age 21. **A State ID is required upon enrollment.**
- 3) Have a history of child abuse or neglect or have had interactions with child welfare services. **This priority is listed on the Wayne County Babies Risk Screening Tool.**
- 4) Have a history of substance abuse or need substance abuse treatment. **This priority is listed on the Wayne County Babies Risk Screening Tool.**
- 5) Are users of tobacco products in the home. **This priority is listed on the Wayne County Babies Risk Screening Tool.**
- 6) Have, or have children with, low student achievement. **This priority is listed on the Wayne County Babies Risk Screening Tool.**
- 7) Have children with developmental delays or disabilities. **This priority is discussed when completing the Individual Family Support Plan and the In-person Contact Record.**
- 8) Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States. **This is not covered in Wayne County Babies paperwork at this time; but will be assessed in the new screening.**

d) Assurance that funds will be used to service the at-risk target population agreed upon with the state, the characteristics of which are documented in Section A above.

The at-risk target population agreed upon with the state is Highland Park, Michigan African-American teens. The Wayne County Babies Demographic Sheet includes the participant's address and birth date which is taken from their State ID and the race of the participant.

6. Indicate that you are providing each of the following assurances:

Spaulding for Children:

- a) *Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments within the scope of the model, and assuring fidelity to the model, (e.g., assessment does not eliminate components of the model).*

Spaulding currently has in place policy and procedures addressing assessments and service plan delivery that are in accordance with the Healthy Families model. All of our staff is trained per the model and a Healthy Families certified trainer is on staff. It is the responsibility of the Director, Supervisor, and Coordinator to make sure subordinate staff is delivering services per the model. Model fidelity will be reviewed during regular, weekly supervision. Additionally, Spaulding has a quality review process that will also review for model fidelity. Training will be on-going and address a number of areas including service delivery per the model.

- b) *Assurance that services will be provided on a voluntary basis*

- Spaulding currently has marketing materials that state the Healthy Families Program is a free service to families in the community and participation in the program is strictly voluntary.
- This information is reviewed with families and all families must sign a consent form prior to service delivery that states that participation is voluntary.

- c) *Assurance that priority will be given to serve eligible participants who:*

- 1) *Have low incomes*
- 2) *Are pregnant women who have not attained age 21*
- 3) *Have a history of child abuse or neglect or have had interactions with child welfare services*
- 4) *Have a history of substance abuse or need substance abuse treatment*
- 5) *Are users of tobacco products in the home*
- 6) *Have, or have children with, low student achievement*
- 7) *Have children with developmental delays or disabilities*
- 8) *Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.*

Staff will be trained in the eligibility criteria and will verify during intake. Spaulding will publicize the eligibility criteria in marketing materials and at presentations. When an intake is performed, the staff will ask about CPS involvement, income, education, and other questions designed to elicit information regarding family functioning to determine what if any risk factors apply. We currently have policy and procedures in place to verify risk factors.

- d) Assurance that funds will be used to service the at-risk target population agreed upon with the state, the characteristics of which are documented in Section A above.*

Spaulding's Business Office, encompassing accounting, personnel, and management information functions, is headed by a Vice President who has a MSW, MSPA and a CMA. Under her direction, Spaulding's debts are paid in the month incurred and all audits have indicated that the Agency has excellent internal fiscal controls and is in excellent financial condition. This Department manages all funds and pays expenses per program budget. Spaulding develops annually an Agency budget that is always balanced, prepares monthly financial statements that are reviewed by Executive staff and the Board of Directors and has an annual audit conducted by an external auditor. All audits have been clean and the Agency has received an unqualified audit for every audit. In addition to ensuring funds are spent in accordance with the budget, the Agency uses an external evaluator to ensure the program serves the targeted population. Based on data entered into the data base, case files, and participant surveys, the evaluator will be able to verify if the target population is being served. Program reports and financial reports are reviewed monthly to ensure services are being provided per service descriptions and program budgets. If there are any discrepancies, they are immediately addressed.

Membership Roster Wayne County Home Visitation System Building Workgroup		
NAME	AGENCY	E-MAIL ADDRESS / PHONE NO.
Anderson, Shayla	Department of Human Services (DHS)	Andersons@michigan.gov 313.456.4903
Bonk-Foley, Cynthia	Starfish Family Services	cfoley@sfish.org 734.727.3116
Crafton, Kim	County Department of Human Services (WCDHS)	kcrafton@co.wayne.mi.us
Cullors, Gail	GSCW	gculloor@childrensctr.net
Kleinglass, Emily	The Guidance Center (TGC)	ekleinglass@guidance-center.org
Lentz, Catherine	The Guidance Center (TGC)	clentz@guidance-center.org 734.629.7571
Lilly, Jametta	Wayne Childrens Health Care Access Program (WCHAP)	jamettal@gmail.com
Locker, Cheri	Starfish Family Services/EHS	clocker@sfish.org 734.727.3133
Oliver, Catherine	Wayne County Department of Health (WDCH)	coliver@co.wayne.mi.us 734.727.7046
Quarterman, Carole	Detroit Department of Health & Wellness Promotion (DHWP)	cejqman@aol.com 313.999.6722
Rowland, Carolynn	Development Centers Inc.	313.876.4161
Schmitt, Marilyn	Child Care Coordinating Council (4C)	mschmitt@develctrs.org 313.531.2500 X 2112
Shane, Elizabeth	Wayne County Department of Health (WDCH)	eshane@co.wayne.mi.us
Smith, Tanya	Wayne County CMH	Tsblessed540@gmail.com
Snowden, Donna	Great Start Collaborative Wayne (GSCW)	Dcsnow1966@aol.com
Strong, Deborah	Detroit Department of Health & Wellness Promotion (DHWP)	Ddsdds33@hotmail.com 734.649.9804
Tarr, Harolyn	DHWP/Substance Abuse	tarrh@detroitmi.gov 313.876.4343
Thomas, Kara	DHWP/Child's Hope	thomaskw@detroitmi.gov
Valdez, Annemarie		valdezat@umd.umich.edu
Webster, Theresa	Southeastern Michigan Community Agency (SEMCA) Parent	Theresa.webster@semca.org
Davis, Loretta	Wayne County Head Start	Ldavis4@co.wayne.mi.us
Hartke, Toni	GSCW	toni@greatstartcollaborativewayne.org
Kalas, Ann	Starfish Family Services	akalass@sfish.org
Mobley, Cecilia	Wayne County CMH	cmobley@co.wayne.mi.us

Membership Roster Wayne County Home Visitation System Building Workgroup		
NAME	AGENCY	E-MAIL ADDRESS / PHONE NO.
Montgomery, Lena	Wayne RESA	montgol@resa.net
Murray, Nancy		murRAIN@michigan.gov
Nichols, Carlynn	Wayne County DHS	Cnichols1@co.wayne.mi.us

Great Start Collaborative-Wayne Staff

Toni Hartke
Director, Great Start Collaborative-Wayne
One Heritage Place, Suite
230
Southgate, MI 48195
734-285-4001
734-283-3725 fax
toni@greatstartcollaborativewayne.org

Deborah Strong
Fund Developer
One Heritage Place, Suite
230
Southgate, MI 48195
734-285-4001
734-283-3725 fax
deb@greatstartcollaborativewayne.org

Gaylotta Murray
Community
Liaison
One Heritage Place, Suite
230
Southgate, MI 48195
734-285-4001
734-283-3725 fax
gaylotta.murray@partneringforimpact.net

Linda Stanko
Administrator, Everybody Ready/GSCW

One Heritage Place, Suite 220
Southgate, MI 48146
734-285-4001
734-283-3725 fax
linda@greatstartcollaborativewayne.org

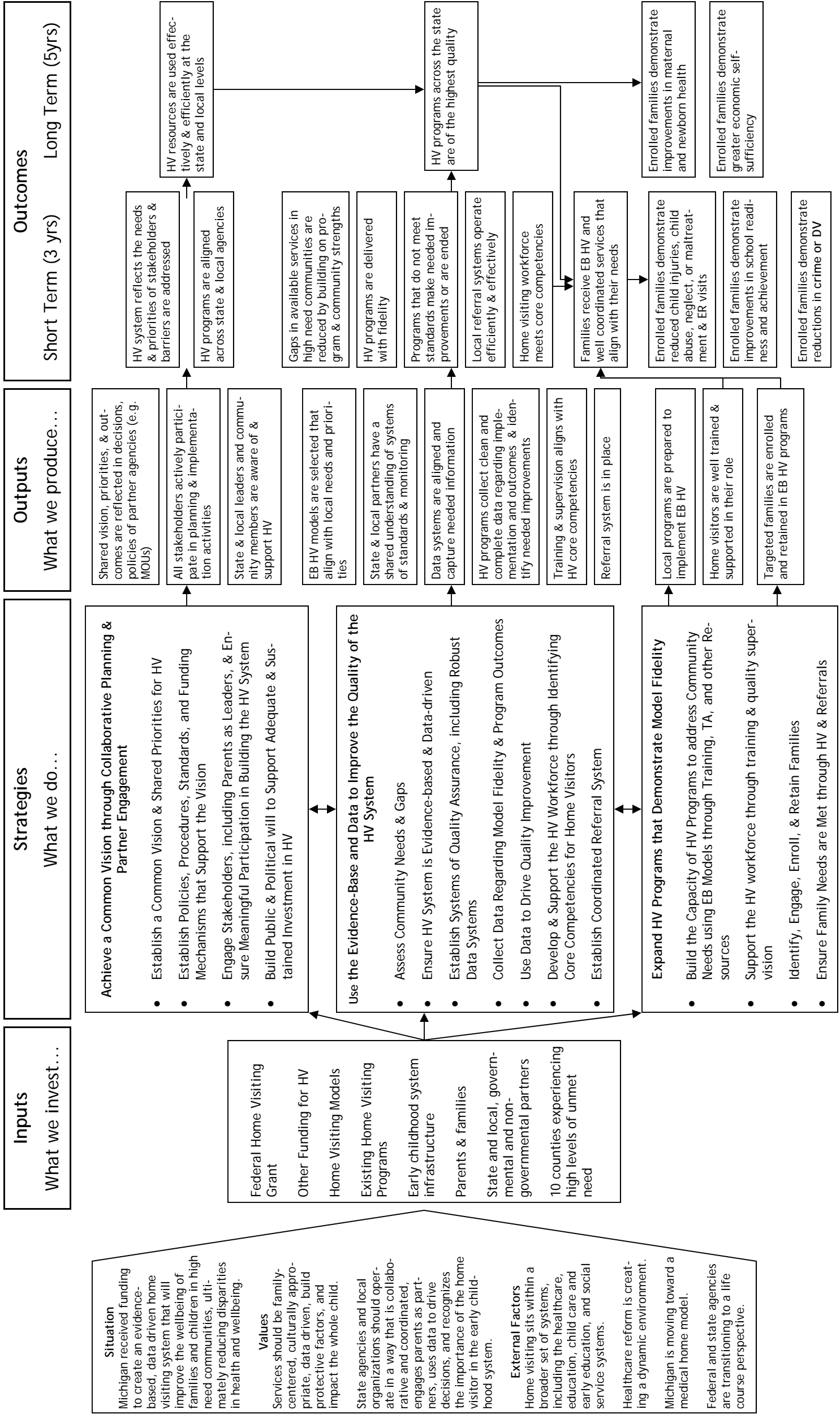
Angela Bermudez

Marketing/Communications Consultant
One Heritage Place, Suite 230
Southgate, MI 48195
734-285-4001
734-283-3725 fax
angelakbermudez@yahoo.com

Ramana Roberson

Parent Liaison
One Heritage Place, Suite 230
Southgate, MI 48195
734-285-4001
734-283-3725
blessed326@yahoo.com

Michigan’s Maternal, Infant, and Early Childhood Home Visiting Program
Working Logic Model—May, 2011



Memorandum of Concurrence

Michigan Maternal, Infant and Early Childhood Home Visiting Program

This agreement is established between State agencies and entities involved in the administration and provision of maternal, infant, and early childhood home visiting services to:

1. Ensure that home visiting is part of a continuum of early childhood services within the State;
2. Demonstrate our commitment to ongoing participation and collaboration in the development of an early childhood system that includes evidence-based home visiting services; and
3. Affirm our agreement with the proposed implementation plan for the Michigan Maternal, Infant and Early Childhood Home Visiting Program.

On behalf of the **Michigan Department of Community Health**, which serves as the State's:

- Public Health and Title V agency;
- Mental Health agency;
- Single State Agency for Substance Abuse Services;
- Medicaid/Children's Health Insurance program and is responsible for Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program;
- Supplemental Nutrition Assistance Program agency; and
- Injury Prevention and Control (Public Health Injury Surveillance and Prevention) program.



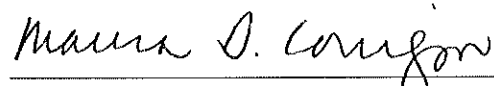
Olga Dazzo, Director

5/31/11

Date

On behalf of the **Michigan Department of Human Services**, which serves as the State's:

- agency for the Child Abuse Prevention and Treatment Act (CAPTA), and houses the Children's Trust Fund, which administers Title II of CAPTA-Community Based Child Abuse and Prevention (CBCAP);
- Child welfare agency (Title IV-E and IV-B);
- State's Temporary Assistance for Needy Families agency;
- Child Care and Development Fund (CCDF) Administrator;
- Head Start State Collaboration Office; and
- State's Domestic Violence Coalition.




Maura D. Corrigan, Director

May 25, 2011

Date

On behalf of the **Michigan Department of Education**, which serves as the State's:

- lead agency for the Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619;
- Elementary and Secondary Education Act Title I and State pre-kindergarten program.




Michael P. Flanagan, Superintendent of Public Instruction

6/2/2011
Date

On behalf of the **Early Childhood Investment Corporation**, which:

- convenes the State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act;
- houses the Director of the Head Start State Collaboration Office through an agreement with the Department of Human Services.



Judy Y. Samelson, Chief Executive Officer

6.2.11
Date

Benchmarks & Constructs	Measure(s)	Data Source	Population Assessed	Data Elements	Data Collection Schedule	Definition of Improvement
Child Injuries, Child Abuse, Neglect, or Maltreatment & Reduction in ER Visits – Year 3						
Information provided or training of participants on prevention of child injuries	Participants are provided with information on injury prevention	Client Record – Home visitor self-report	Adult program participant(s)	# provided info on injury prevention	Documented by one year of enrollment	90% of participants are provided with information on injury prevention
	Participants are provided with information on safe sleep	Client Record – Home visitor self-report	Adult program participant(s)	# provided with info on safe sleep	Documented by one year of enrollment	90% of participants are provided with information on safe sleep
	Participants are provided with information on car seat safety	Client Record – Home visitor self-report	Adult program participant(s)	# provided with info on car seat safety	Documented by one year of enrollment	90% of participants are provided with information on car seat safety
Reported suspected maltreatment for all children in the program	Home visitors do not suspect child maltreatment while participants enrolled in the program	DHS CPS Registry	Adult program participant(s) & all children in the home	# with a CPS report by the home visitor	Pulled annually from DHS records	% participants with a CPS referral by the home visitor decreases annually
Reported substantiated maltreatment for children in the program	Participants do not have a substantiated finding of maltreatment while enrolled in the program	DHS CPS Registry	Adult program participant(s) & all children in the home	# with a substantiated CPS finding	Pulled annually from DHS records	% participants with a CPS category 1, 2 or 3 substantiated case of maltreatment decreases annually
	Participants do not have a substantiated finding of abuse while enrolled in the program	DHS CPS Registry	Adult program participant(s) & all children in the home	# with a substantiated CPS finding of abuse	Pulled annually from DHS records	% participants with a CPS substantiation (category 1, 2 or 3) of abuse decreases annually
	Participants do not have a substantiated finding of neglect while enrolled in the program	DHS CPS Registry	Adult program participant(s) & all children in the home	# with a substantiated CPS finding of neglect	Pulled annually from DHS records	% participants with a CPS substantiation (category 1, 2 or 3) of neglect decreases annually
First-time victims of maltreatment for children in the program	Children do not become victims of child maltreatment for the first time while enrolled in the program	DHS CPS Registry	Target child/children	# children with a first time substantiated CPS finding	Pulled annually from DHS records	% children with a first time CPS substantiation (category 1, 2, or 3) decreases annually

Benchmarks & Constructs	Measure(s)	Data Source	Population Assessed	Data Elements	Data Collection Schedule	Definition of Improvement
Visits for children to the ED from all causes	Children's use of the ED for emergency/urgent care decreases while enrolled	Client Record – Client self-report	Target child/children	# using ED for primary care at enrollment # using ED for primary care while enrolled	Documented at enrollment & at one year	# children using ED for primary care at enrollment > # using ED while in program
	Children do not require emergency care for injury or ingestion while enrolled	Client Record – Client self-report	Target child/children	# visits to ED by cause of visit	Documented at one year of enrollment	% children with one or more ED visit for injury or ingestion decreases annually
Visits of mothers to the ED from all causes	Mother's use of the ED for emergency/urgent care decreases while enrolled	Client Record – Client self-report	Mother	# using ED for primary care at enrollment # using ED for primary care while enrolled	Documented at enrollment & at one year	# mothers using ED for primary care at enrollment > # using ED while in program
	Mothers do not require emergency care for injury	Client Record – Client self-report	Mother	# visits to ED by cause of visit	Documented at one year of enrollment	% mothers with one or more ED visit for injury decreases annually
Incidence of child injuries regarding medical treatment	Children do not require medical care for injury or ingestion while enrolled	Client Record – Client self-report	Target child/children	# received medical care for injuries/ingestions	Documented at one year of enrollment	% children requiring medical care for injury or ingestion decreases annually
Improvements in School Readiness & Achievement– 3 year						
Parent support for children's learning and development	Scores on parent scales improve by one year of enrollment as compared with baseline	Parenting Stress Index	Adult Program Participants	Scale scores at enrollment & at one year	Completed by program participants at enrollment & one year	Statistically significant and positive change in score from baseline to one year
Parent knowledge of child development & of their child's developmental progress	Participants demonstrate an increase in their knowledge of child development at one year of enrollment as compared with baseline	Protective Factors Survey – Child Development/Knowledge of Parenting Scale	Adult Program Participants	Scale score at enrollment & one year	Completed by program participants at enrollment & one year	Statistically significant and positive change in score from baseline to one year

Benchmarks & Constructs	Measure(s)	Data Source	Population Assessed	Data Elements	Data Collection Schedule	Definition of Improvement
Parenting behaviors and parent-child relationship	Scores on parent scales improve by one year of enrollment as compared with baseline	Parenting Stress Index	Adult Program Participants	Scale scores at enrollment & at one year	Completed by program participants at enrollment & one year	Statistically significant and positive change in score from baseline to one year
Parent emotional well-being or parenting stress	Participants report less parenting stress at one year of enrollment as compared with baseline as measured by a standardized tool	Parenting Stress Index Protective Factors Survey – SE Support & Concrete Support	Adult Program Participants	Scale score at enrollment & one year	Completed by program participants at enrollment & one year	Statistically significant and positive change in score from baseline to one year
Child's social behavior, emotional regulation, and emotional well being	Scores on child scales improve by one year of enrollment as compared with baseline	Parenting Stress Index	Target child/children	Score at enrollment & one year	Completed by program participants at enrollment & one year	Statistically significant and positive change in score from baseline to one year
Child's positive approaches to learning including attention	Scores on child scales improve by one year of enrollment as compared with baseline	Parenting Stress Index	Target child/children	Score at enrollment & one year	Completed by program participants at enrollment & one year	Statistically significant and positive change in score from baseline to one year
Child's communication, language, and emergent literacy	Children receive screenings to identify developmental delays in communication and are referred for services if a developmental delay is indicated	ASQ – Communication area Client Record – Home visitor self-report	Target child/children	# up-to-date with developmental screening # with screening result indicating delay # referred for services	Documented by one year of enrollment	90% of children up-to-date with developmental screening 90% of children with developmental delay referred for services

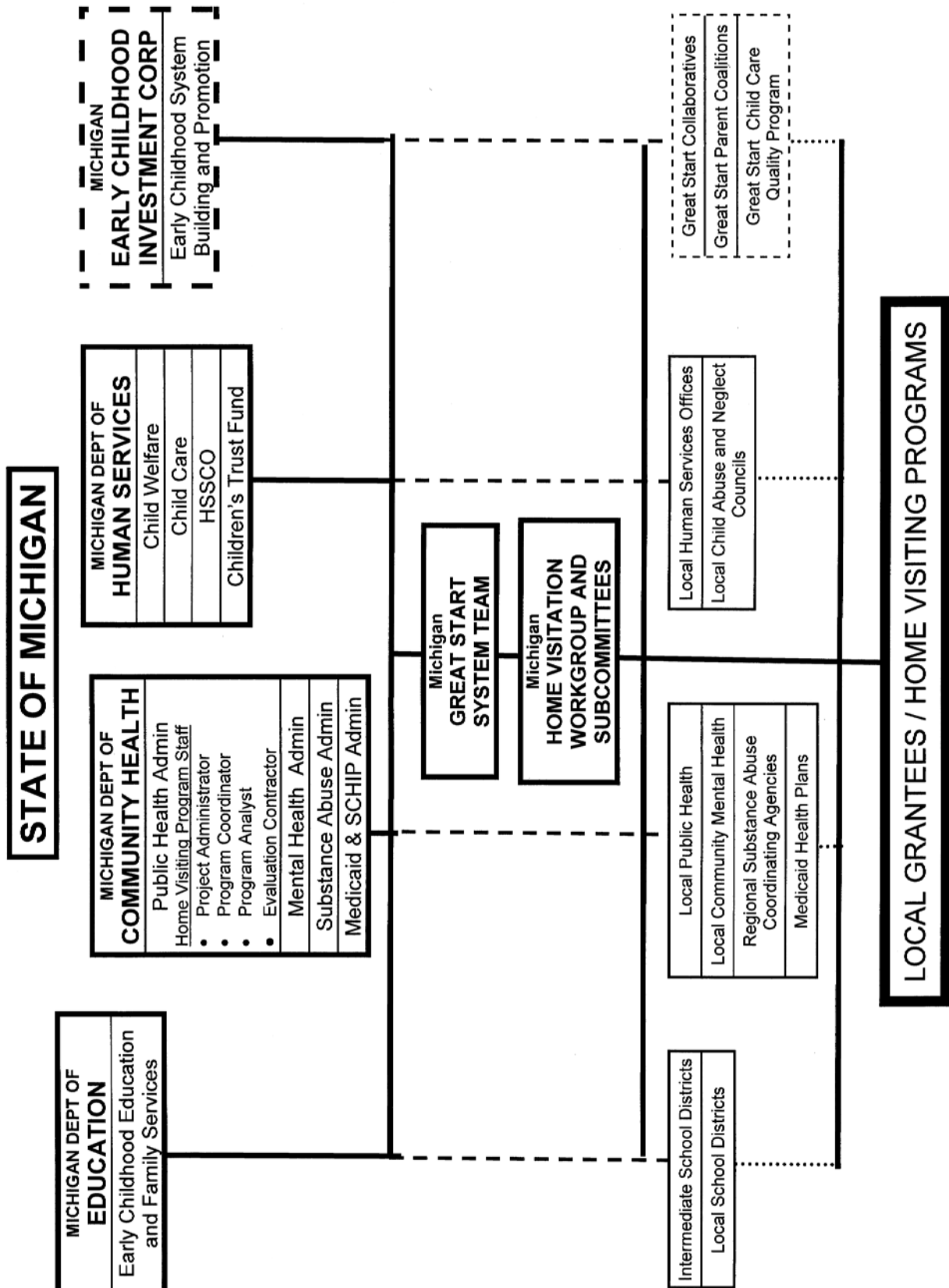
Benchmarks & Constructs	Measure(s)	Data Source	Population Assessed	Data Elements	Data Collection Schedule	Definition of Improvement
Child's general cognitive skills	Children receive screenings to identify developmental delays in problem solving and are referred for services if a developmental delay is indicated	ASQ – Problem Solving area Client Record – Home visitor self-report	Target child/children	# up-to-date with developmental screening # with screening result indicating delay # referred for services	Documented by one year of enrollment	90% of children up-to-date with developmental screening 90% of children with developmental delay referred for services
Child's physical health and development	Children receive all required age appropriate immunizations	Michigan Care Improvement Registry (MCIR)	Target child/children	# up-to-date with age appropriate immunizations	Documented by one year of enrollment	90% children up-to-date with age appropriate immunizations
	Children have a blood lead test completed	MCIR	Target child/children	# up-to-date with lead screening	Documented by one year of enrollment	90% children up-to-date with lead screening
	Children receive screenings to identify developmental delays in gross motor and fine motor skills and are referred for services if a developmental delay is indicated	ASQ – Gross motor & fine motor areas Client Record – Home visitor self-report	Target child/children	# up-to-date with developmental screening # with screening result indicating delay # referred for services	Documented by one year of enrollment	90% of children up-to-date with developmental screening 90% of children with developmental delay referred for services
Crime or Domestic Violence - DV Selected – Year 3						
Screening for DV	Participants are assessed for domestic violence (DV)	Conflict Tactics Scale – 2	Adult Program Participants	# screened for DV	Completed by program participants at enrollment & one year	90% of participants screened for DV
Of families identified for DV, number of referrals made to relevant DV services	Participants who are experiencing DV are referred to DV services	Client Record – Home visitor self-report	Adult program participant(s)	# experiencing DV referred to services	Documented by one year of enrollment	90% of participants experiencing DV referred to services

Benchmarks & Constructs	Measure(s)	Data Source	Population Assessed	Data Elements	Data Collection Schedule	Definition of Improvement
Of families identified for DV, number of families for which a safety plan was completed	Participants who are experiencing DV complete a safety plan	Client Record – Home visitor self-report	Adult program participant(s)	# experiencing DV who have a safety plan	Documented by one year of enrollment	90% of participants experiencing DV have a safety plan
Arrests	Participants are not arrested while enrolled in the program	Client Record – Client self-report	Adult program participant(s)	# arrested	Documented at one year of enrollment	% participants arrested <i>decreases annually</i>
Convictions	Participants are not convicted of a crime while enrolled in the program	Client Record – Client self-report	Adult program participant(s)	# convicted of a crime	Documented at one year of enrollment	% participants convicted of a crime <i>decreases annually</i>
Coordination and Referrals for Other Community Resources & Supports – Year 3						
Number of families identified for necessary services	Participants service needs are assessed	Client Record – Home visitor self-report	Adult & child program participant(s)	# whose referral needs were assessed	Documented by one year of enrollment	90% of families will receive an assessment to identify their referral needs
Number of families that required services and received a referral to available community resources	Participants who require services receive a referral	Client Record – Home visitor self-report	Adult & child program participant(s)	# with a service need who received a referral # with a service need who did not receive a referral	Documented by one year of enrollment	90% of families with a service need will receive a referral
MOUs or other formal agreements with other social security agencies in the community	Programs have formal relationships with other social service agencies	Home Visiting Agency Survey	Home Visiting Agency	# formal relationships with other social service agencies	Administered annually	# formal relationships with other social service agencies will increase over time
Number of agencies with which the HV provider has a clear point of contact in the collaborating community agency that includes regular sharing of info	Programs have formal relationships with other social service agencies	Home Visiting Agency Survey	Home Visiting Agency	# formal relationships with other social service agencies	Administered annually	# formal relationships with other social service agencies will increase over time

Benchmarks & Constructs	Measure(s)	Data Source	Population Assessed	Data Elements	Data Collection Schedule	Definition of Improvement
Number of completed referrals	Programs can document the disposition of each referral they provide	Client Record – Home visitor self-report	Adult & child program participant(s)	# referrals # with documented referral disposition	Documented by one year of enrollment	% of referrals with documented disposition increases each year of the program
Improved Maternal & Child Health – Year 5						
Prenatal Care	Pregnant women receive recommended # of prenatal visits following enrollment in the program	Client Record – Client self-report	Mothers who are pregnant at enrollment	# visits expected # visits received	Documented by one year of enrollment	% pregnant women receiving recommended number of visits will increase annually
	Pregnant women access prenatal care the trimester they become enrolled in the program	Client Record – Client self-report	Mothers who are pregnant at enrollment	Trimester enrolled Trimester prenatal care began	Documented by one year of enrollment	% pregnant women receiving prenatal care the trimester of enrollment will increase annually
	Babies are not born low birth weight or very low birth weight	PRAMS Items or Similar	Mothers who are pregnant at enrollment	Weight at birth	Documented by one year of enrollment	% babies born low birth weight or very low birth weight will decrease annually
Interbirth Intervals	Participants' need for family planning services is assessed and referrals are completed	PRAMS Items or Similar	Adult Program Participants	# assessed # referred	Documented by one year of enrollment	90% of participants will be assessed for family planning needs 90% of participants with a need for family planning services will receive a referral
	Mothers adequately space their first and second pregnancies	PRAMS Items or Similar	Adult Program Participants	# months between first and second pregnancy	Documented by one year of enrollment	% of mothers with subsequent pregnancies 0-12 months postpartum will decrease annually
Screening for Maternal Depressive Symptoms	Maternal depressive symptoms are screened and referrals are completed	Beck Depression Inventory or Edinburgh Postnatal Depression Scale (Postnatal mothers only)	Mothers	# screened # referred	Documented by one year of enrollment	90% of mothers will be screened for maternal depressive symptoms 90% of mothers with depressive symptoms will receive a referral

Benchmarks & Constructs	Measure(s)	Data Source	Population Assessed	Data Elements	Data Collection Schedule	Definition of Improvement
Well-Child Visits	Children are up-to-date with well child visits while enrolled in the program	PRAMS Items or Similar	Target child/children	# well child visits expected # well child visits completed	Documented by one year of enrollment	% of children up-to-date with well child visits will increase annually
Prenatal Use of Alcohol or Elicit Drugs	Pregnant women's use of alcohol or illicit drugs is assessed and referrals are completed	PRAMS Items or Similar	Mothers who are pregnant at enrollment	# assessed # referred	Documented by one year of enrollment	90% of pregnant women are assessed for alcohol/drug use 90% of pregnant women using alcohol or drugs are referred for services
Preconception Care	Mothers have a medical home	PRAMS Items or Similar	Mothers	# reporting medical home	Documented by one year of enrollment	% of mothers with medical home increases annually
	Mothers have access to family planning services	PRAMS Items or Similar	Mothers	# reporting access to family planning	Documented by one year of enrollment	% of mothers with access to family planning increases annually
Breastfeeding	Mothers of infants receive information about breastfeeding	Client Record – Home visitor self-report	Mothers who are pregnant or have an infant at enrollment	# provided with breastfeeding information	Documented by one year of enrollment	90% of mothers of infants will be provided with information about breastfeeding
	Mothers of infants initiate breastfeeding	PRAMS Items or Similar	Mothers who are pregnant or have an infant at enrollment	# initiating breastfeeding	Documented by one year of enrollment	% of mothers that initiated breastfeeding increases each year
	Mothers of infants continue breastfeeding through 6 months	PRAMS Items or Similar	Mothers who are pregnant or have an infant at enrollment	# months child received breast milk	Documented by one year of enrollment	% of mothers breastfeeding at 6 months increases each year
Maternal & Child Health Insurance Status	Mothers have health insurance	PRAMS Items or Similar	Mothers	# insured	Documented by one year of enrollment	% mothers with health insurance increases annually

Benchmarks & Constructs	Measure(s)	Data Source	Population Assessed	Data Elements	Data Collection Schedule	Definition of Improvement
	Children have health insurance	PRAMS Items or Similar	Target child/children	# insured	Documented by one year of enrollment	% children with health insurance increases annually
Family Economic Self-Sufficiency – Year 5						
Employment or education of adult members of the household	Families total hours of paid work, participating in education program, & unpaid work devoted to child care increases after one year of program enrollment	Client Record – Home visitor self	Adult Program Participant(s)	Hours per week in paid work, education, & unpaid child care at baseline & one year	Documented at enrollment & at one year	Mean hours greater at one year of enrollment as compared with baseline
Health insurance status	Families' health insurance status is assessed and referrals are completed	Client Record – Home visitor self-report	Adult Program Participant(s)	# assessed # referred	Documented by one year of enrollment	90% of families are assessed for health insurance status 90% of families without health insurance receive a referral
	Participants and their children have health insurance	PRAMS Items or Similar	Adult Program Participant(s)	# with health insurance	Documented by one year of enrollment	% of participants with health insurance increases annually % of children with health insurance increases annually
Household income and benefits	Families total household income and benefits increase after one year of enrollment in the program	Protective Factors Survey	Adult Program Participant(s)	Income from all sources at baseline and one year of enrollment	Completed by program participants at enrollment & one year	Mean income greater at one year of enrollment as compared with baseline



POSITION TITLE: Program Administrator .2 FTE**POSITION SUMMARY:**

The *Maternal, Infant, and Early Childhood Home Visiting Program* is a federally-funded grant promoting the delivery of evidence-based early childhood home visiting services and the state and local infrastructures needed to support quality services and achieve outcomes for children and families. This position will serve as Administrator with responsibility for the day-to-day supervision of the *The Maternal, Infant, and Early Childhood Home Visiting Program* Coordinator, as well as for supporting and managing *The Maternal, Infant, and Early Childhood Home Visiting Program* across comparable levels within other state departments. The Program Administrator is responsible to assure the program is focused and following the required work plan and timeframes, alerting higher administrative staff if/when additional support is needed to address issues. This position will participate in the Great Start System Team and its Home Visiting Work Group, and will collaborate with management peers across state departments and within the ECIC. At times, this position will also support and interact with stakeholders in various counties throughout the state, as needed and appropriate, in order to facilitate the achievement of *The Maternal, Infant, and Early Childhood Home Visiting Program* goals.

ESSENTIAL FUNCTIONS:

- Daily use of personal computer and telephone.
- Attending and facilitating meetings.
- Coordination and communication within and across state and local agencies.
- Travel, as required, throughout the State of Michigan.
- Periodic travel out-of-state for national project meetings.
- Occasional need for work in the evenings and on weekends.

JOB QUALIFICATIONS:

- Extensive knowledge of and experience with:
 - Grant management and implementation.
 - Systems-level planning and planning models.
 - Systems-level fiscal planning and development of fiscal policy.
 - Systems-level collaborative approaches.
 - State-level policy development and analysis.
 - Consultation in complex maternal, infant and early childhood initiatives.
 - Design, implementation, and evaluation of collaborative initiatives.
- Successful administrative management experience with complex projects and statewide programming.
- Successful leadership experience in federal, state-to-state and state-local contexts.
- Successful staff supervisory experience with master's plus professional staff.
- Successful management experience with large, complex, statewide programs.
- Excellent written and verbal communication skills.
- Ability to prioritize assignments and duties.
- Ability to work independently and manage time effectively.
- Valid State of Michigan driver's license.
- Reliable transportation.

SUPERVISORY RESPONSIBILITY:

The Project Administrator reports to the Director of the Division of Family and Community Health within the Bureau of Maternal, Child and Family Health, in the Public Health Administration of the Michigan Department of Community Health.

ADDITIONAL RESPONSIBILITIES:

- Maintain records and reports.
- Meet deadlines for work assignments.
- Considerable travel.
- Moderate physical demand.
- Short time frames for assignments that can result in considerable stress.

EDUCATION AND EXPERIENCE:

- Master's Degree related to public health, nursing, health education, public administration, etc.
- At least four years of professional, post-master's experience as a consultant in a field related to public health.

Southeastern Michigan Health Association
200 Fisher Building 3011 Grand Blvd
Detroit, MI 48202-3011

POSITION TITLE: Program Coordinator

Full Time

POSITION SUMMARY:

The *Maternal, Infant, and Early Childhood Home Visiting Program* is a federally-funded grant promoting the delivery of evidence-based early childhood home visiting services and the state and local infrastructures needed to support quality services and achieve outcomes for children and families. This position will serve as Coordinator and statewide consultant with responsibility for a highly complex major program initiative, and will perform the full range of advanced, professional, consultative activities utilizing the laws, regulations, rules, policies, and procedures of a complex major public health/early childhood program initiative. The Program Coordinator will work in close collaboration with the Project Administrator, coordinate with the Great Start System Team, its Home Visiting Workgroup and other subcommittees, act as a liaison to other state and local offices and agencies involved in home visiting efforts, and provide guidance to other program staff and the Evaluation contractor to carry out their tasks. This position will support the development and implementation of the Program's Updated State Plan, manage the day-to-day implementation of the evidence-based home visitation initiative at the state level, coordinate state-level collaborative activity, develop agreements, contracts, and policy relevant to project goals, participate in learning opportunities and apply research/information to support successful program implementation, assure that the initiative is focused and following the required work plan and timeframes.

ESSENTIAL FUNCTIONS:

- Daily use of personal computer and telephone.
- Convening and facilitating meetings.
- Coordination and communication within and across state and local agencies.
- Travel, as required, throughout the State of Michigan.
- Periodic travel out-of-state for national project meetings.
- Occasional need for work in the evenings and on weekends.

JOB QUALIFICATIONS:

- Extensive knowledge and experience with public health, early childhood, and community organizations or agencies; experience with home visiting programs/services is highly desired.
- Experience with statewide consultation in public health-related initiatives that are highly complex in nature.
- Experience in the design, implementation, and evaluation of collaborative initiatives.
- Experience with fiscal planning and policy development.
- Ability to lead and work with diverse individuals and groups in a culturally and linguistically competent manner.
- Excellent written and verbal communication skills.
- Knowledge of grant management and implementation.
- Ability to prioritize assignments and duties.
- Ability to work independently and manage time effectively.
- Valid State of Michigan driver's license.
- Reliable transportation.

SUPERVISORY RESPONSIBILITY:

Nancy Peeler, Child Health Unit Manager and Project Administrator, will oversee daily activities, provide direct supervision and monitor overall performance.

ADDITIONAL RESPONSIBILITIES:

- Maintain records and reports.
- Meet deadlines for work assignments.
- Considerable travel.
- Moderate physical demand.
- Short time frames for assignments that can result in considerable stress.

EDUCATION AND EXPERIENCE:

- Master's Degree related to public health, nursing, health education, public administration, etc.
- At least four years of professional, post-master's experience as a consultant in a field related to public health.

Southeastern Michigan Health Association
200 Fisher Building 3011 Grand Blvd
Detroit, MI 48202-3011

POSITION TITLE: Program Analyst

Full Time

POSITION SUMMARY:

The *Michigan Maternal, Infant, and Early Childhood Home Visiting Program* is a federally-funded grant promoting the delivery of evidence-based early childhood home visiting services and the state and local infrastructures needed to support quality services and achieve outcomes for children and families. This position will serve as Program Analyst with responsibility to complete a variety of professional research and analysis assignments for the purpose of evaluation, assessment, planning, development, and implementation of the Home Visiting Program. The Program Analyst will work in close collaboration with the Program Coordinator and Project Administrator, coordinate with the Home Visiting Workgroup and other subcommittees, interact with the Evaluation contractor, and serve as the program liaison for central administrative services in areas such as budgeting, information technology, and/or human resources. This position will help develop and submit the comprehensive state plan that reflects the Needs Assessment results; establish and monitor contracts for compliance with departmental policies and procedures related to grant program plans and budgets, track expenditures, recommend needed revisions; design, implement and document personal computer-based data collection, processing and reporting systems related to program implementation and reporting requirements; analyze on-going program operations and recommend modifications of policies and procedures to achieve greater efficiency and effectiveness, participate in learning opportunities and apply research/information to support successful program implementation.

ESSENTIAL FUNCTIONS:

- Daily use of personal computer and telephone.
- Coordinating meetings.
- Coordination and communication within and across state and local agencies.
- Travel, as required, throughout the State of Michigan.
- Periodic travel out-of-state for national project meetings.
- Occasional need for work in the evenings and on weekends.

JOB QUALIFICATIONS:

- Experience with public health, early childhood programs, and community organizations or agencies is required; personal or professional experience with home visiting programs/services is highly desired.
- Developing knowledge of the principles of administrative management, including budgeting techniques, office procedures, and reporting.
- Ability to analyze, synthesize, and evaluate a variety of data for use in program development and analysis.
- Ability to prepare requests for proposals and program agreements.
- Ability to organize, evaluate, and present information effectively.
- Ability to learn and utilize computer processes.
- Ability to prioritize assignments and duties.
- Ability to work independently and manage time effectively.
- Valid State of Michigan driver's license.
- Reliable transportation.

SUPERVISORY RESPONSIBILITY:

Nancy Peeler, Child Health Unit Manager and Project Administrator, will oversee daily activities, provide direct supervision and monitor overall performance.

ADDITIONAL RESPONSIBILITIES:

- Maintain records and reports.
- Meet deadlines for work assignments.
- Considerable travel.
- Moderate physical demand.
- Short time frames for assignments that can result in considerable stress.

EDUCATION AND EXPERIENCE:

- Bachelor's Degree in any major.
- At least one year of professional experience related to the responsibilities of this position.

Michigan Public Health Institute
2364 Woodlake Drive, Ste. 180
Okemos, MI 48864

POSITION TITLE: Program Consultant

Part Time

POSITION SUMMARY:

The *Maternal, Infant, and Early Childhood Home Visiting Program* is a federally-funded grant promoting the delivery of evidence-based early childhood home visiting services and the state and local infrastructures needed to support quality services and achieve outcomes for children and families. This position will serve as a consultant to the Program, working in close collaboration with the Project Administrator, Program Analyst and Program Coordinator. The Consultant will participate in planning and implementation of the Program, serving on the Great Start System Team Home Visiting Workgroup and its subcommittees, and will assist provision of technical assistance to local projects.

ESSENTIAL FUNCTIONS:

- Daily use of personal computer and telephone.
- Writing documents and publications.
- Assisting with planning and facilitation of meetings.
- Travel, as required, throughout the State of Michigan.
- Occasional need for work in the evenings and on weekends.

JOB QUALIFICATIONS:

- Extensive knowledge and experience with public health, early childhood, and community organizations or agencies; experience with home visiting programs/services is highly desired.
- Experience with statewide consultation in public health-related initiatives that are highly complex in nature.
- Experience in the design, implementation, and evaluation of collaborative initiatives.
- Experience with fiscal planning and policy development.
- Ability to lead and work with diverse individuals and groups in a culturally and linguistically competent manner.
- Excellent written and verbal communication skills.
- Knowledge of grant management and implementation.
- Ability to prioritize assignments and duties.
- Ability to work independently and manage time effectively.
- Valid State of Michigan driver's license.
- Reliable transportation.

SUPERVISORY RESPONSIBILITY:

Nancy Peeler, Child Health Unit Manager and Project Administrator, will oversee daily activities, provide direct supervision and monitor overall performance.

ADDITIONAL RESPONSIBILITIES:

- Maintain records and reports.
- Meet deadlines for work assignments.
- Considerable travel.
- Moderate physical demand.
- Short time frames for assignments that can result in considerable stress.

EDUCATION AND EXPERIENCE:

- Master's Degree related to public health, nursing, health education, public administration, etc.
- At least four years of professional, post-master's experience as a consultant in a field related to public health.