

PROJECT ABSTRACT

Michigan Maternal, Infant and Early Childhood Home Visiting Program

Michigan Department of Community Health

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Problem

Michigan has a long history of providing prevention-focused home visiting services. Currently two programs are available statewide, while at least seven others are implemented on a county or community by community basis, depending on the availability of funding, local priorities, level of interest, and other factors. The State is taking significant steps toward building an effective and efficient home visiting system through its MIECHV FY2010 and FY2011 Formula grants. However, the current system lacks several key features that research suggests drive successful implementation.

- The system is decentralized and has lacked a shared vision and common goals.
- Home visiting programs are not consistently integrated or targeted at the state or local level, and meaningful commitment to sustained partnerships across agencies is limited.
- Michigan has not aligned home visiting model selection with community need, nor required the use of models that have evidence that they achieve the State's high-priority outcomes.

Goals and Objectives

The MIECHV is designed to both build the home visiting system in the State and to integrate the home visiting system within the comprehensive Great Start early childhood system. The MIECHV 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.
- 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.
- 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.

Methodology

In order to achieve these goals, the state will:

1. Build and expand the capacity of home visiting programs to address community needs using evidence-based models implemented with fidelity, with efforts targeted in the highest risk communities;
2. Build the infrastructure necessary to support the success of direct home visiting services, including: cataloging the full range of existing home visiting services across the State's 83 counties; reviewing and updating state-level policy, procedures and fiscal strategies; piloting a coordinated system for outreach, intake, referral and follow-up for home visiting; establishing a set of core competencies for home visitors; and establishing learning communities, by model, to support quality improvement.

Coordination

The MIECHV is administered by the Michigan Department of Community Health, the Title V agency for the State. The State is using an interdepartmental structure and team process to address early childhood systems and services integration and coordination. Primary partners include the Michigan Department of Education (which houses the new Office of Great Start), the Department of Human Services, and the Early Childhood Investment Corporation. This structure links and integrates this grant with other programs and systems (Early Learning Advisory Council, Project LAUNCH, Early Childhood Comprehensive Systems, CMS Multi-payer Advanced Primary Care Practice Demonstration project, etc.) that relate to maternal child health and overall early childhood well-being.

Annotation

Michigan has identified a clear need to strengthen the state-level infrastructure, as well as policy and procedures, in order to support a high-quality, evidence-based home visiting system; and a need to expand evidence-based home visiting programs implemented with fidelity to address the state's high priority outcomes. Michigan proposes to implement a series of activities that will address these needs, build the home visiting system in the State, and integrate the home visiting system within the comprehensive Great Start early childhood system.

Evaluation

The State assures that the project will participate in national evaluation activities for the MIECHV, as requested by HRSA.

PROJECT NARRATIVE: HRSA-11-187

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

In the *Michigan Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) 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 select which counties (communities), and target populations within each county, that 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 developers' offices. The rationale 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. 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 our learning through the Early Childhood Comprehensive Systems (ECCS) Grant and the Great Start process, that communities vary in their levels of understanding of the need to change how they have been approaching and implementing components of the early childhood system. We learned 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 who 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 MIECHV, which includes: participating in State learning opportunities, helping the State to identify and collect necessary information, providing input and feedback on grant activities, coordinating in-depth analysis of community needs, and leading 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, which included 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 in 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 guide this work, the MIECHV 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 internal information and understanding held by the MIECHV and by partner agencies of where each county stood with respect to existing home visiting efforts and implementation. The Desk Review was conducted internally by staff of the MIECHV 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 MIECHV and other members of the HVWG. HRSA Federal Project Officers participated in two of the local 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 was included in the *Updated State Plan*. 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.

Of the 62 points available, the mean score 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 were selected to receive funding for expansion of existing evidence-based home visiting models using FY 2010 funds (see Table 1). For FY2011 Formula funding, another two counties will receive funding, while the original six will receive a second year of expansion funding (see specific plans in Sections 3 & 4). 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 Expansion Funding

County	Concentration of Risk Score	Receiving Service Expansion Funding
Genesee	13	2010, 2011
Wayne	12	2010, 2011
Saginaw	11	2010, 2011
Calhoun	10	No
Ingham	10	2010, 2011
Kalamazoo	9	2011
Muskegon	9	2010, 2011
Berrien	8	2011
Kent	8	2010, 2011
St. Clair	8	No

In developing the *Updated State Plan*, MIECHV program staff worked closely with the first six counties to jointly develop plans detailing how the service expansion would take place. The plans were individualized to each county, because they are implementing different models with different target at-risk populations. The *Updated State Plan* contains details about the implementation plans, including information about:

1. The needs and resources in each county;
2. The at-risk target population within each county that receives the expansion services; as well as
3. The plan for expansion (see also Section 4 and Attachment 6 to this Formula grant).

The implementation plans submitted in the *Updated State Plan* are still in effect for the second year of funding for the original six sites.

For the two sites being added in FY2011 (Berrien and Kalamazoo), a detailed assessment, using the *County-Level Home Visiting Program Implementation Plan Template* that was employed for the original six counties, is available in Attachment 6. The information about Berrien and Kalamazoo counties is in three parts; Part A includes 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 original six selected counties and the two additional counties is also available in Sections 3 and 4 of this Narrative, 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 there are still two counties (Calhoun and St. Clair) that will not be receiving expansion funds in FY2010 or FY2011, they will be participating in several activities related to home visiting:

- A number of Technical Assistance opportunities through this grant will available across all counties (see Section 8).
- Calhoun County is fortunate to be the home of the W.K. Kellogg Foundation; the Foundation is providing significant support to the county and the City of Battle Creek to support both home visiting and early childhood system building efforts, including current funding for Nurse Family Partnership and Parents as Teachers programs in Battle Creek. The State anticipates being more involved in funding direct home visiting services in Calhoun once the current private funding ends.
- The Early Childhood Investment Corporation (ECIC) is providing direct TA to St. Clair County in support of developing an early childhood strategic plan; the MIECHV will dovetail with that work by providing additional TA specific to home visiting, and by asking St. Clair to pilot a proposed new tool developed by MIECHV, with technical assistance from HRSA, that will help local communities assess the fit of an evidence-based home visiting model to their local population and needs. The results of the strategic planning process and from that tool/analysis of need and model fit will guide future funding decisions for St. Clair.

SECTION 2: State Home Visiting Program Goals and Objectives

MIECHV is designed to both build the home visiting system in the State and to integrate the home visiting system within the comprehensive Great Start early childhood system more broadly.

Additionally, MIECHV 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 MIECHV 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 MIECHV 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 1.

The specific goals and objectives of MIECHV 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 assure that home visiting is a component of a comprehensive, high-quality, early childhood system that improves the health and well-being 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, MIECHV 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, MIECHV 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, including parents and families, state and local partners and governmental and non-governmental partners, in the home visiting system are included as members of workgroups responsible for the planning and implementation of the Home Visiting Program.
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, MIECHV 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 Child Protective Services (CPS) referral by their home visitor will decrease 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 decrease 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 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.¹

2. By the third year of program expansion, Home Visiting Program participants will demonstrate statistically significant positive changes between baseline and one year on a standardized instrument designed to measure knowledge of child development such as the Protective Factors Survey.²
3. By the third year of program expansion, Home Visiting Program participants will demonstrate statistically significant positive changes between baseline and one year on a standardized instrument designed to measure parenting behaviors such as the Parenting Stress Index.¹
4. By the third year of program expansion, Home Visiting Program participants will demonstrate statistically significant positive changes between baseline and one year on a standardized instrument designed to measure parent stress such as the Parenting Stress Index.¹
5. By the third year of program expansion, children participating in the Home Visiting Program will demonstrate statistically significant 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.¹

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 increase annually.
2. By the fifth year of program expansion, the percentage of Home Visiting Program participants with subsequent pregnancies 0-12 months postpartum will decrease annually.
3. By the fifth year of program expansion, 90% of Home Visiting Program participants who are mothers will be screened for maternal depressive symptoms and, if needed, receive 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 increase 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, receive 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):

Based on the Home Visiting Evidence of Effectiveness study results (<http://homvee.acf.hhs.gov/>),³ coupled with a review of current home visiting programs in the state, the Michigan HVWG chose to impact Participant Outcomes by focusing on four of the seven (now eight) federally recommended 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 selected 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 FY2010 funding can begin to 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)⁴
2. Nurse-Family Partnership (NFP)⁵
3. Parents as Teachers (PAT)⁶
4. Early Head Start – Home-Based Option⁷

FY2010 Direct Service funding

For FY2010 funding, the HVWG decided that rather than start new programs from scratch, 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 described in the FY2010 *Updated State Plan, Part II* of the Community Readiness Assessment was to gather additional, more substantial information about existing home visiting programs. The chart below summarizes the findings of Part II, listing the results for the evidence-based models that are most frequently implemented in Michigan:

Table 2. Existing Evidence-Based Models Operating in Fidelity (as of spring 2011)

County	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*.

For the *Updated State Plan*, the six communities 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.

The MIECHV program staff 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. The specific results of the second cut data analysis and the justification for the selection of a model for each of the six original counties were attached to the *Updated State Plan*.

For FY2010, Michigan chose to expand two models. Table 3, below, specifies the model that were chosen, by county, the 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).

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 with 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 extensive support can first become affiliated with HFA 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 time 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 8). 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.

FY2011 Direct Service funding

For FY2011, the State has chosen to provide a second year of funding to the six communities and programs identified in the *Updated State Plan* to receive program expansion funds. As detailed in Table 3, this includes funding to three communities for Early Head Start, and three communities for Healthy Families America.

Prior to establishing a contract for the second year of funding, the State will work with the Local Leadership Groups to review the success of the implementation of the expansion slots (e.g., CQI data), review updated community data, and assess whether the model is still the best fit for the needs and population identified in that particular community.

Table 3: Direct Service Funding in FY2011

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 in Highland Park	HFA	50
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
Berrien	African American families in urban areas	NFP	100
Kalamazoo	African American families in urban areas	NFP	100

In addition to continued funding in the original six communities, the State will add funding for another two of the ten communities with highest need, Berrien and Kalamazoo Counties. As shown in Table 2, Berrien and Kalamazoo have active Nurse Family Partnership programs. Berrien originally received State funding starting in 2004 for NFP, with services targeted to first-time African American mothers, primarily in Benton Harbor, but also in adjoining urban areas. Kalamazoo began receiving State funding in 2007, with services targeted to African American mothers primarily in Kalamazoo. Unfortunately, due to significant state budget cuts, as of June 2009 state funds for NFP programs (Berrien, Kalamazoo, and another three sites) were eliminated from the state budget. Since then, both sites have been struggling to patch together funding for the programs.

In January 2011, four months after our *Statewide Needs Assessment* was submitted to HRSA, Michigan's newly-elected governor, Rick Snyder, took office. Shortly thereafter, Governor Snyder released the MIDashboard,⁸ which will be used to track progress on Michigan's performance with respect to 21 priority indicators. Two of the priority health indicators identified by the Governor that are related to early childhood are infant mortality rates and obesity rates. MDCH staff has been asked to direct resources toward activities that will "move the needle" on these two indicators. With the Governor's charge in mind, combined with the information from the Community Readiness Assessment and history of implementation of evidence-based home visiting programs in the communities, the HVWG proposes to use FY2011 formula funding to provide part of the funding needed to maintain the NFP programs in Berrien and Kalamazoo counties. Additional funding to help each county maintain a full NFP team will be provided through new state resources and Medicaid matching funds, as described in Section 4.

In 2009, Michigan ranked 37th in the United States in infant mortality rates. The death rate for all Michigan infants is 7.6 per thousand (three-year moving average, 2007-2009).⁹ The death rate for Medicaid infants is 8.8 per thousand, while the death rate for non-Medicaid infants is 6.6 per thousand; poverty is clearly related to infant mortality. However, the racial disparity is much more glaring than the income disparity. The death rate for black Michigan infants is 15.4 per thousand (three-year moving average 2007-2009), twice the State rate. This wide racial disparity is extremely troubling and highly unacceptable. This pattern of disparity holds true in both Berrien and Kalamazoo counties.

For Berrien and Kalamazoo, MIECHV program staff worked with local staff to complete the *County-Level Home Visiting Program Implementation Plan Template* that includes results of the second cut data analysis, and identifies in Part B how the chosen 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.

Detailed information from the *Template* is in Attachment 6, however, a description of each county follows:

BERRIEN COUNTY

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

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

Berrien County's infant mortality rate is 9.0 per 1000 births (2007-2009 moving average), tying it for fourth overall in the state.⁹ Berrien also ranks fifth in the state for infant mortality rates among black infants, at 16.7. In 2009, the infant death rate in the city of Benton Harbor was 23.5, with a three year moving average (2007-2009) of 14.9. The rate of live births in Berrien County to first-time mothers is 36.4% overall, with 36.0% being to first-time black mothers.

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

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

KALAMAZOO COUNTY

Kalamazoo County is located in the southwest corner of Michigan and has a population totaling 248,407. Its square footage totals 562 miles with a blend of rural and urban communities. Kalamazoo County is comprised of four cities (including Kalamazoo) and five villages and is the eighth largest county in the state. Kalamazoo County is home to the fourth largest university in the state, as well as three private colleges and one community college, which contribute to a thriving international culture in the county. A stabilizing factor in Kalamazoo County's economy is the presence of two world-class hospitals.

Kalamazoo exceeded state averages on nine indicators of risk: low birth weight; poverty; binge alcohol and prescription drugs; category A crime, all crime, and juvenile crime; domestic violence; child maltreatment; a high proportion of both American Indians and African Americans living in the county as compared to the total population of American Indians and African Americans in the state; and presence of an urban center.

Kalamazoo County's infant mortality rate is 8.3 (2007-2009 moving average), making it fifth overall in the state. Kalamazoo also ranks second in the state for infant mortality rates among black infants, at 19.1.⁹ The city of Kalamazoo ranks second among Michigan cities with an infant mortality rate of 19.3. The rate of live of births in Kalamazoo County to first-time mothers is 41.1% overall, with 31.1% being to first-time black mothers.

Kalamazoo County identified a total of seven home visiting programs. In addition to the two statewide programs (Maternal Infant Health Program and Community Mental Health Home-based Services), there are four programs that target families with risk factors. One of these programs specifically targets Latino and African American families. Approximately 1,113 individuals/children/families with risk factors were served by these six programs in a 12-month period. There is also one program with "no income or risk factor requirements." It served 562 families in a 12-month period.

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

Because we are providing funding to maintain existing programs, both Kalamazoo and Berrien counties (and the State) have prior experience with implementing NFP. 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., the NFP National Service Office, see Attachment 8).

We have obtained a letter of support from the NFP NSO, 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 Michigan Department of Community Health, which helps fund and works in partnership with the NFP NSO to monitor NFP programs in the State, thus state-level experience with these models has been brought to bear. Because the two communities are currently implementing this model and have been actively seeking funds to maintain the programs, their ongoing involvement with the program is assured.

SECTION 4: Implementation Plan for Proposed State Home Visiting Program

Implementation plan for direct services/Participant Outcomes

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

1. The name of the entity that will receive MIECHV funds to expand service slots.
2. A plan for recruiting, hiring, and retaining appropriate staff for all positions and a list of these positions.
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 had 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.

Because these implementation plans serve as the basis for establishing a contract with the local communities, the plans are included in Attachment 6, Descriptions of Proposed Contracts. Attachment 6 includes Part C of the *Template* for Genesee, Wayne, Saginaw, Ingham, Muskegon, and Kent counties, drawn from the *Updated State Plan*.

For Berrien and Kalamazoo counties, full implementation plans with detailed information (e.g., Parts A, B, and C of the *Template*) are included, developed with the community for the purposes of this application.

The State will be establishing or renewing contracts with the local agencies that are identified as expanding home visiting programs as soon as our Notice of Grant Award is received. 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, 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.

On top of the specific local implementation plans detailed in Attachment 6, 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, (see Attachment 6).
- 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 (available from ECIC). 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.
- As referenced earlier, we have obtained letters from the national program offices for models that we are expanding/maintaining in Michigan – NFP, HFA, and EHS (see Attachment 8). 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. NFP already has close working relationships with staff in Berrien and Kalamazoo counties. Working across communities, we will seek to establish a regular call with HFA, EHS, and NFP to review progress and issues, and identify plans to address any issues identified.

Implementation plan for Infrastructure Building

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 and messaging about early childhood and especially the importance of social-emotional wellness. 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 Attachment 9 (Table 4).

The GSST is proposing to use funding for FY2011 to support a number of specific infrastructure building activities, drawn from the list of priorities for infrastructure building efforts in our *Updated State Plan*. The proposed activities include the following:

1. Michigan proposes to conduct a comprehensive state-level environmental scan to identify, prioritize, and ultimately update and implement state level policy/procedures that will help establish and implement high quality, evidence-based home visiting systems at the state and local levels:
 - a. Establish how models currently operating or that could be added will compose a system that addresses the state's priority outcomes/benchmarks across the targeted age groups, and establish statewide funding strategy to begin to fill the gaps.
 - b. Create a common set of outcomes/benchmarks and common measurement structure through which the state can assess the effectiveness of the system – both process and impact.

- c. Create common program standards (e.g., expectations for needs assessment that ensures service delivery to high need populations; to prioritize services to achieve desired outcomes; to require use of evidence-based models with fidelity that fit the target population; require use of model with best fit).
 - d. Coordinate efforts with the Great Start P-8 Data Mapping and Planning Initiative (through the ELAC) and the state's CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) project to streamline efforts and establish a common data registry/system into which enrollment and benchmark data could be entered and analyzed.
2. The state proposes to hire a 1.0 FTE TA/Policy Specialist to work with the Home Visiting program, the HVWG, and the GSST to facilitate the environmental scan process, and carry out activities necessary to update and implement policy and procedures that will address needs and help achieve the defined outcomes (see Position Description in Attachment 4). Through the TA/Policy Specialist, the state will also collaborate with the Pew Home Visiting Campaign efforts to identify opportunities for advancing state policies in Michigan that strengthen the quality of home visitation programs and expand the use of evidence-based research.

On June 22, Governor Snyder signed the FY2012 State budget, which included a new provision stating that MDCH shall use at least 50% of funding for home visiting for evidence-based models, or for models that conform to a promising approach that are in the process of being evaluated for effectiveness, with a goal of being evidence-based by January 1, 2013. This provision will support the MIECHV work to implement evidence-based home visiting programs throughout the state. The FY 2012 MDCH budget also contains a provision requiring that the department establish an integrated benefit for Medicaid evidence-based home visiting services to be provided by Medicaid health plans for eligible beneficiaries. This provision will likely have a significant impact on fiscal strategies and sustainability strategies for home visiting programs in Michigan.

3. In order to establish solid infrastructure that will enhance the success of home visiting programs and efforts, Michigan proposes to pilot local coordinated/centralized outreach, intake, referral, and follow-up systems intended to:
- a. Improve access; make it easier for families to be linked to home visiting programs and for health care and other providers to make referrals.
 - b. Ensure that families are matched to the programs that best meet their needs.
 - c. Reduce costs by conducting joint outreach activities.
 - d. Increase efficiencies by making sure available slots across programs are filled.
 - e. Reduce duplication of services.
 - f. Utilize a Data Registry to guide and document efforts.

The HVWG will issue an RFP to counties in which the state has expanded home visiting programs to solicit applications to develop and pilot centralized/coordinated outreach, intake, referral, and follow-up for home visiting programs, in order to use services and funding in the most effective and efficient manner, while still taking family preference into account. Applicants would be asked to:

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

Based on the quality of their grant applications, entities in two of the eligible communities would be selected to conduct the pilots. They will be required to collaborate closely with state activities and efforts (under this grant, under the overall Home Visiting program, the MAPCP project, and with other related projects), and to share lessons learned with the rest of the State to support growth and sustainability of the system.

Working closely with the MAPCP primary care medical home initiative sites and coordinating with the Great Start P-8 Data Mapping and Planning Initiative (along with other projects/programs identified for inclusion in the individual pilot sites) will allow the state to achieve shared outcomes, maximize use of multiple, varied funding sources, and support sustainability of the centralized/coordinated intake, referral and follow-up systems that are

piloted in the two pilot communities. This strategy also positions Michigan to take a major step forward in building infrastructure that supports the effectiveness and success of evidence-based home visiting systems and supports the achievement of priority outcomes.

In order to support these activities, Michigan proposes to hire a 1.0 FTE TA/Policy Specialist to provide training and technical assistance to pilot sites (see Position Description in Attachment 4). Michigan will also allocate funds to purchase external TA/consultation from other states or entities that have successfully implemented coordinated systems for outreach, intake, referral and follow-up; this could include site visits to Michigan or to the external site, presentations, conference calls, webinars, etc. In addition, the state will also release a Request for Proposals to establish a contract with a to be determined entity or individual to research and map the specifications for a Data Registry to be used in conjunction with central/coordinated outreach, intake, referral and follow-up pilot sites. A subcommittee of the GSST will work in close collaboration with the TA Specialist and external consultant on this project.

4. In order to successfully implement and support the proposed NFP programs, the state will establish a .5 FTE position for an NFP State Coordinator/Clinical Nurse Consultant (see Position Description in Attachment 4). This position will work closely with the NFP National Service Office to support successful fiscal and administrative program implementation, and facilitate communications between the NSO and the program sites. The NFP State Coordinator/Clinical Nurse Consultant will be responsible for coordinating the efforts in Berrien and Kalamazoo counties with NFP activities in the rest of the state, and for the monitoring function, as well as for providing program assessment, support, and technical assistance.

In the FY 2012 State budget, the Michigan Legislature allocated \$1.5 million in new state funds specifically to support NFP programs. In addition, a major foundation has given a preliminary commitment to allocate funds to help support NFP in some targeted communities. Funds from these two sources will be leveraged to generate additional funds for NFP through Medicaid matching strategies, then combined with funding requested in this Formula grant application. This funding strategy was chosen because it helps the state to maximize available funding and service delivery, and it supports program sustainability by using multiple, varied funding sources. The strategy also positions Michigan to take a major step forward in building its evidence-based home visiting system and addressing priority outcomes. While funding from the FY2011 Formula grant will support NFP in Berrien and Kalamazoo counties, the State, private, and Medicaid match funding will support the continuation of NFP in other counties (including Kent County), and the re-establishment of NFP in Wayne County. Calhoun County also operates an NFP program with funding directly from the Kellogg Foundation, which also provides support to the overall early childhood system building effort in the Battle Creek community.

5. As originally described in the *Updated State Plan*, the State is undertaking a project to develop a set of Core Competencies for home visitors. With funding from the FY2011 Formula grant, the state proposes to extend for a second year a contract with an external Consultant to coordinate the work of a subcommittee of the Great Start System Team to conduct an environmental scan regarding existing core competency documents/policy, propose a set of core competencies for Michigan home visitors, help to establish a tracking system, and identify existing trainings and resources to help meet core competency requirements.
6. Based on what the State has learned from implementing the NFP model, and based on TA requested from communities, the State will pursue the creation of learning communities built around specific evidence-based models. This will enable shared training and support across communities implementing the same model, create opportunities for home visitors to share successes and challenges, and represents an effective use of professional development funds. This project is still at the development stage, and will require consultation with national model offices to develop fully, since their input and participation would be critical to implementation of this idea. The State may choose to use some funding to bring home visitors together for a training/mini-conference; the agenda could include one day organized by model (opportunity for training, etc.), and a second day devoted to cross-model and cross-system issues and activities.

The State assures that:

- The MIECHV is designed to result in participant outcomes as noted in the legislation; details about our State measurement plan follow in Section 5. The State will participate in national evaluation activities for the MIECHV as requested by HRSA.
- Individualized assessments will be conducted 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 was included in the *Updated State Plan*;
- 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 had 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 Attachment 9, Table 5. This table 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. Table 5 (in Attachment 9) was recently updated, based on a conference call with our Federal Project Officer and staff from the Design Options for Home Visiting Evaluation (DOHVE). Within the table, the Definition of Improvement was modified for each item at DOHVE's suggestion, to reflect the expected change, rather than a specific target (although the original targets may be retained and used as part of the CQI process). As of July 18, 2011, additional feedback was provided by DOHVE staff, which the state will review and respond to directly with the Federal Project Officer in early August.

The evaluation/CQI component of the Michigan Home Visiting Program is being administered by an outside contractor, the Michigan Public Health Institute (MPHI), working in close collaboration with the State HVWG 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 and second years, the Program will fund expansion in six counties delivering two model programs. In year one, 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 $n = 222$. In addition, FY11 formula grant funds will be used to support the expansion of Nurse-Family Partnership programs in two communities for approximately $n = 200$ African American first time parents. 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 5, 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. 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 and maintained in an electronic database (or MIS systems once it becomes available) 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 the date the family began the program, and the date and reason why the family 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

One measure has been identified for each construct within each benchmark, as described in Table 5 (Attachment 9), 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 Developmental 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 5, Attachment 9.

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.^{1, 10} 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.^{2, 11} 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.¹² The ASQs' are completed by the parent or caregiver of children ages 2 to 60 months. Five key developmental areas including communication, gross-motor, fine-motor, problem solving, and personal-social are covered in the questionnaires. 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.¹³ 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.¹⁴ 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 reverse 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.¹⁵ 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.

Home visiting programs funded through MIECHV will be asked to report the tool used to screen for maternal depression, as well as the result of the screening. As such, the data from both tools can be combined to measure progress against the benchmark, which requires a count of the total number of women enrolled who received an assessment that indicated they have symptoms of maternal depression.

In addition to collecting data through the selected 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

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 I: Improved Maternal and Child Health:

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

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 V: Family Economic Self-sufficiency:

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

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

Data collected through the client record will be entered by each home visiting program funded through MIECHV by the home visitor(s) or specified agency staff and entered into an electronic database (or MIS system once it becomes available) in a specified format. Progress will be documented in client records on an ongoing basis and entered into the electronic database (or MIS system once it becomes available) on a quarterly basis.

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 CPS records to collect information about 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. Initially, data will be entered by program staff into an electronic database developed and distributed to each program by MPH. 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 (See also Table 5 in Attachment 9), 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, or 4 substantiated case of child abuse or neglect. They will be asked to breakdown results in several 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 MPH 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 MPH and data will be downloaded to and housed on MPH'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 area. In five years, Michigan will demonstrate progress in all six benchmark areas as measured by half of the constructs in each area. The constructs that will be reviewed to indicate improvement on a benchmark are listed in Table 5.

In large part, the analysis plan will align with the definition of improvement articulated in Table 5 (Attachment 9). 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; for example, Early Head Start and Healthy Families America do not have strong, demonstrated outcomes in the area of maternal and child health. 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 MIECHV is administered by the Michigan Department of Community Health, the Title V agency for the State. MDCH is responsible for a comprehensive range of publicly funded health services, resources, policies and outcomes across the state. These are directed to fulfill the Department’s stated mission: “MDCH will **protect, preserve, and promote** the health and safety of the people of Michigan with particular attention to providing for the needs of vulnerable and under-served populations.” The Department includes the State Medicaid Agency, Public Health, Behavioral Health and Developmental Disabilities (including Substance Abuse), Health Policy and Planning, Office of Services to the Aging. It also includes the administrative fiscal, legal, contracting and operational support necessary for managing the over fourteen-billion-dollar annual budget that supports this range of responsibility and accountability.

MDCH approaches its work with an understanding shared across its administrations that the health and wellness of Michigan’s citizens requires an integrated system that is seamless, supports the individual and family across the life course, and that health is holistic. “Holistic” encompasses individual health and development, including mental and relational health. However, it also includes the individual as impacted by his/her home and community environment, and recognizes the impact of social and economic determinants of health, including racism. Hence, all areas within MDCH work together to provide an integrated system of care at any given point in time, as well as over time—recognizing that health begins

prior to conception and must be maintained and protected through older age. MDCH's established vision reflects this systems approach: "Improve health, improve care, lower costs through a competitive and collaborative organized system of care."

Michigan is using an interdepartmental structure and team process to address early childhood systems and services integration and coordination. The three involved state departments are MDCH, the Michigan Department of Education (MDE) and the Department of Human Services (DHS). Each department contributes experience, resources and services to impact early childhood outcomes. Another partner in early childhood system building is the Early Childhood Investment Corporation (ECIC). ECIC was founded in 2005 to be a focal point for information and investment in early childhood, including serving as a bridge for public-private funding partnerships on behalf of early childhood systems-building. These four agencies/organizations partner in forming the Great Start System Team (GSST), which has been functioning as the means through which early childhood systems resources, strategic direction and system-building is occurring for Michigan's young children and their families.

As a component of Michigan's *Great Start* initiative, the home visiting work will be guided by the GSST, which also serves as the State team for the Early Childhood Comprehensive Systems (ECCS) initiative, the State Wellness Council for Project LAUNCH, and will have an important role in developing the State's application for the Race to the Top-Early Learning Challenge grant. 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 help develop the State applications to respond to the current and future Funding Opportunity Announcements (FOA).

Michigan's Governor recently created a new Office of Great Start that will reside within the Michigan Department of Education.¹⁶ It will combine early learning and child care programs and resources, and work to coordinate funding streams related to early childhood. This will strengthen the focus and accountability on early childhood outcomes for which all of the involved departments share responsibility. Collaborative planning, combined with fiscal strategies to maximize resources across departments, and alignment of policies and priorities will be necessary. All of this speaks to the necessity and clear intent to continue and grow the support for early childhood, including home visitation, into the future. Each of the state departments involved is committed to maintaining, and whenever possible, expanding the resources directed to home visitation. The Executive Order establishing the new Office was released on June 30, 2011; provisions of the Governor's Executive Order are effective August 29, 2011.

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 3. The new Office of Great Start is reflected in the updated Project Organizational Chart; the chart has also been updated to include other early childhood agencies/partners that are represented in the Memorandum of Concurrence (Attachment 5). A list of State agencies and entities that have participated in the work of the GSST or in the HVWG related to the Home Visiting program was included in the *Updated State Plan*; an updated Partners list is included in Table 4, Attachment 9.

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 MIECHV. 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 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.

Additional 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, which is included in our revised Project Organizational Chart (Attachment 3). 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 be updated to reflect any changes that result from the Fall 2011 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. Their support of the State's plan is documented in the Memorandum of Concurrence in Attachment 5.
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 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 GSST has or is establishing subcommittees to work on a) improving developmental screening efforts; b) messaging about early childhood and especially the importance of social-emotional wellness; c) coordinated/centralized outreach, intake, referral, and follow-up systems; and d) core competencies for home visitors. The GSST itself will play a key role in reviewing, updating, and collaboratively implementing policy and procedures that will address outcomes and system coordination in support of the State's home visiting system. Their work on a detailed Memorandum of Understanding pertaining to home visiting will be a critical component in addressing how the system will be built and coordinated.
5. 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 help to develop future responses to funding opportunities. This is has proven to be a difficult position to fill, as the State is looking for a candidate with experience working across systems, and with broad knowledge of early childhood. Fortunately, a number of project staff are already in place: Program Administrator/Director (.20 FTE in-kind); .50 FTE Program Consultant; 1.0 FTE Program Analyst. Position descriptions are in Attachment 4. Additional positions will be created related to the infrastructure pieces related to state policy, central intake, and NFP.
6. Several members from the HVWG are involved in the state's CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) project. One of the key components of this project is that the patient centered medical homes, which are the project focus, must be linked functionally to community resources. To achieve this, starting the second year of the project physicians will be required to maintain data registries as a part of their conversion to electronic medical records. These registries can help track referrals and follow-up status across a patient cohort, which means they can become a valuable tool for linking to the coordinated/centralized outreach, intake, referral, and follow-up systems we are seeking to establish related to home visiting. The effective coordination between medical homes and community resources and the infrastructure needed to accomplish this is a key deliverable of the project.
7. Michigan participants at the Early Childhood 2010 Summit have been sharing 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.¹⁷
8. Michigan applied for Competitive ACA home visiting funds to help build state and local infrastructure and services to support effective implementation of evidence-based home visiting models in communities with high concentration of risk. Some of the activities in this Formula grant duplicate those in the Competitive grant application; if Michigan receives a Competitive grant, the State will work closely with the Federal Project Officer to modify the activities of this Formula grant to shift to focus on the next priorities and activities for the State.

While many efforts to build the home visiting system in the State and to integrate the home visiting system within the comprehensive early childhood system are underway, other infrastructure components are still in development.

- The State is still developing the 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 is interested in developing a methodology/tool to help local communities assess the fit of a model to their local population and needs. This would help to assure that the strongest models are being used for appropriate audiences, and to achieve outcomes that match their evidence of effectiveness.
- 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 visiting formula funds, and influence competitive grant applications.
- 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 being to become more effective and efficient in the way in which the State collects, stores, and shares data to support measurement of progress and outcomes.

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 expanding or supporting maintenance of existing home visiting services in eight communities have been detailed above in Sections 1, 3 and 4. 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 and Project LAUNCH), and 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 or FY2011 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.

Activities to address the first four of these infrastructure components were described in Section 4. The development of a Dashboard to help track outcomes achieved by the overall system is a priority for future funding.

SECTION 7: Plan for Continuous Quality Improvement

MIECHV 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 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

MIECHV 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 MIECHV'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 MIECHV, 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 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.

MIECHV 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 MIECHV 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 6: 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 authentically involved in LLG	.80
11. # of evaluations involving more than one HV program	.80
12. # of programs in community implementing HV programs that meet 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 this 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 addition, the State is also interested in TA to help us develop two tools, which can be used at both the State and local levels related to infrastructure building:

- A methodology/tool to reliably determine the extent to which existing home visiting programs are meeting the needs of eligible families, in lieu of a family survey that would be more likely to measure satisfaction rather than outcomes/whether needs are met;

- A methodology/tool to help the State and local communities assess the fit of a model to their local population and needs. This would help to assure that the strongest models are being used for appropriate audiences, and to achieve outcomes that match their evidence of effectiveness.

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.

The following table summarizes TA needs that have been identified at the State or at the local level:

Table 7: 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. A tool for selecting home visiting model(s) to fit the target populations' needs	X	X	X
2. A tool for determining the extent to which existing home visiting programs are meeting the needs of eligible families	X	X	X
3. Implementing and supporting home visiting programs/conducting a home visiting program			X
4. Implementing models with fidelity	X	X	X
5. Special topical issues (e.g., substance abuse, mental health, domestic violence, tribal, and rural issues)		X	
6. Participant recruitment and retention		X	X
7. Authentic Hispanic/Community involvement in HFA		X	
System Building			
1. Building home visiting into the 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		X
5. Centralized Intake	X		X
6. Authentic parent involvement in LLG			X

Financing			
1. Fiscal leveraging	X		X
2. Sustainability	X		X
3. Maximizing Medicaid funds	X		X
Professional Development			
1. Developing training systems		X	X
2. Workforce issues	X		X
3. Reflective supervision			X
4. Establishing learning communities	X	X	
5. Opportunities for HVPs to share successes and challenges	X		X
Planning and Evaluation			
1. Conducting ongoing needs assessments			X
2. Strategic planning			X
3. Shared Data and information systems	X		X
4. Tracking prenatal visits in PIMS (HFA)		X	
5. Shared outcomes and measures	X		X
6. Identifying benchmarks			X
7. Program evaluation			X
8. Continuous quality improvement/quality assurance	X		X
9. Conducting an evaluation of a promising approach	X		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.

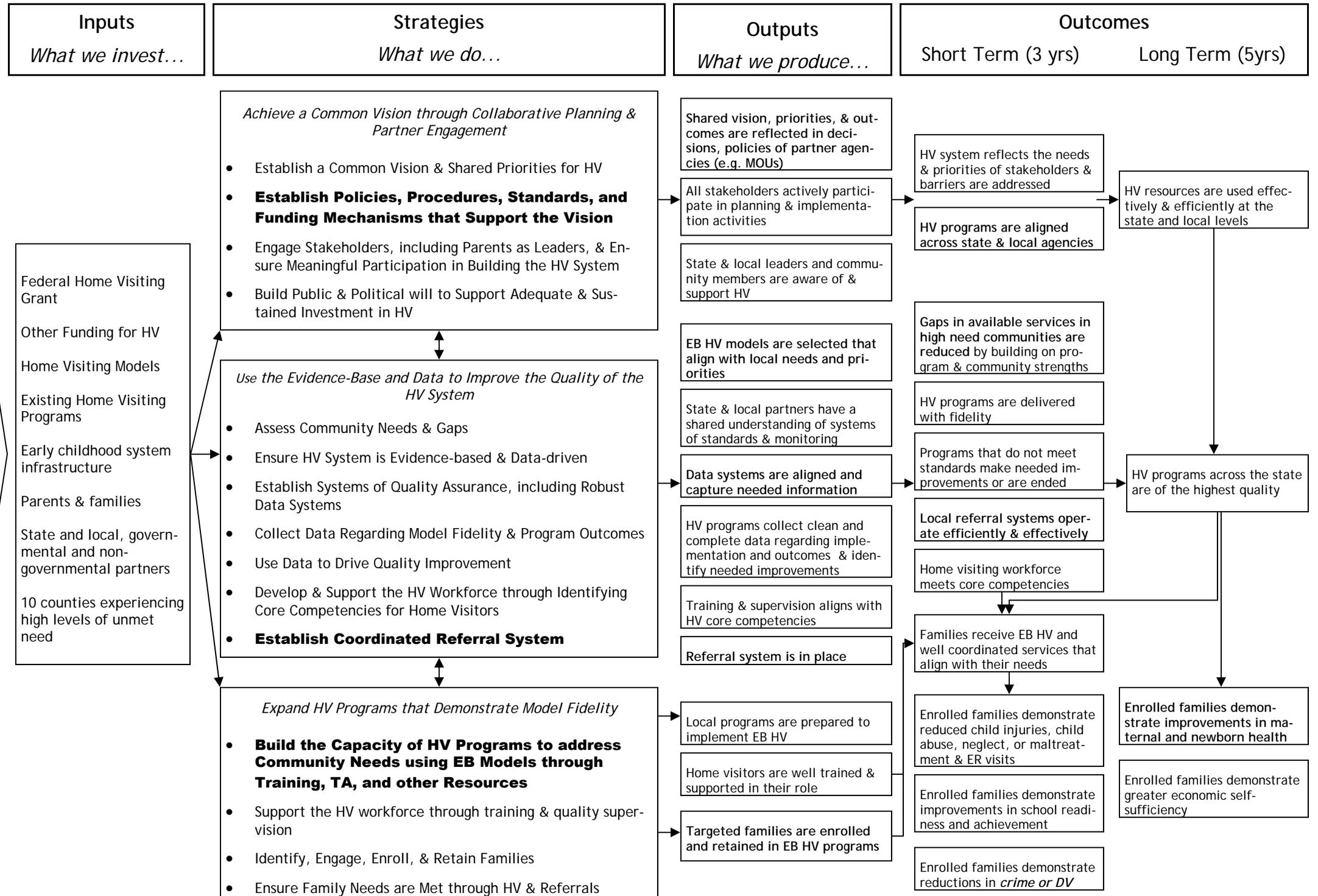
Technical Assistance Needs

- 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 Section 6, and information about Technical Assistance needs and requests from Section 8 to address the required reporting requirements.

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

Figure 2



**MICHIGAN Maternal, Infant and Early Childhood Home Visiting Program
Continuation Grant Application**

WORK PLAN—TIMELINE

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

Program Element I: Continuation of FY 2010 Plan											
Michigan will build the capacity of home visiting programs to address community needs using evidence-based models by implementing a second year of expansion funding in the initial six high-need communities, as evidenced by achieving the following objectives:											
PLAN	STAFF			FY1 Q1	FY1 Q2	FY1 Q3	FY1 Q4	FY2 Q1	FY2 Q2	FY2 Q3	FY2 Q4
OBJECTIVE 1: Assess first year performance of initial six high-need communities.											
1. Assess adherence to state-level plan for implementing selected models with fidelity.	Program Analyst										
2. Assess adherence to implementation plans developed for each local community.	Program Analyst										
3. Provide individual and group TA for six sites, as needed.	Program Analyst										
4. Report progress to HVWG/GSST.	Program Analyst										
5. Share lessons learned to stakeholders across state.	Program Analyst										
OBJECTIVE 2: Assess model fit to community needs in initial six high-need communities.											
1. Access federal TA to develop a methodology to assess model fit.	Program Analyst HVWG										
2. Apply methodology to initial expansion sites.	Program Analyst HVWG										
OBJECTIVE 3: Make adjustments to initial six expansion sites/models accordingly.											
1. Develop new funding strategies, as needed.	Program Analyst HVWG										
2. Develop new implementation plans, as needed.	Program Analyst HVWG										
OBJECTIVE 4: Establish new contracts for initial six expansion sites.											
1. Develop second-year contracts with six local agencies in initial communities.	Program Analyst										

2. Manage contracts with six local agencies in initial communities.	Program Analyst																		
<p align="center">Program Element II: NURSE-FAMILY PARTNERSHIP EXPANSION</p> <p>Michigan will build the capacity of home visiting programs to address community needs using evidence-based models by expanding NFP in two communities, as evidenced by achieving the following objectives:</p> <p>OBJECTIVE 1: Monitor rates of infant mortality, especially among the African American population.</p>																			
1. Ongoing data analysis to monitor communities with highest infant mortality rates.	MDCH																		
<p>OBJECTIVE 2: Expand NFP in selected communities with high infant mortality for African Americans.</p>																			
1. Develop contracts with two local agencies in chosen communities.	Program Analyst																		
2. Manage contracts with two local agencies in chosen communities.	Program Analyst																		
<p>OBJECTIVE 3: Ensure NFP programs receiving home visiting funds are implemented with fidelity.</p>																			
1. Hire 0.5 FTE NFP Coordinator/Nurse Consultant.	Project Director Perinatal Unit Mgr.																		
2. Implement funding strategy for expanded NFP sites.	NFP Coord./NC																		
3. Develop state-level plan to ensure programs implement NFP with fidelity.	NFP Coord./NC HVWG																		
4. Develop implementation plans with each local community, including training and TA.	NFP Coord./NC HVWG																		
5. Provide individual and group TA for NFP sites.	NFP Coord./NC																		
6. Monitor progress of NFP sites.	NFP Coord./NC																		
7. Report progress to HVWG/GSST.	NFP Coord/NC																		
8. Share lessons learned to stakeholders across state.	NFP Coord/NC																		
<p>Program Element III: COORDINATED SYSTEM OF OUTREACH, INTAKE, REFERRAL AND FOLLOW-UP</p> <p>Michigan will develop a coordinated system for outreach, intake, referral and follow-up, as evidenced by achieving the following objectives in two pilot communities in order to enhance the success of NFP and other home visiting programs:</p>																			

2. Develop and implement outreach plan in pilot communities.	TA/Policy Specialist Pilot Sites GSST WG								
OBJECTIVE 4: Develop and implement a coordinated intake process.									
1. Research intake efforts implemented within other initiatives.	TA/Policy Specialist Pilot Sites GSST WG								
2. Develop and implement intake plan in pilot communities.	TA/Policy Specialist Pilot Sites GSST WG								
OBJECTIVE 5: Develop and implement referral policies that connect families with home visiting services that best meet their needs while honoring family preferences.									
1. Research referral policies implemented in other initiatives.	TA/Policy Specialist Pilot Sites GSST WG								
2. Develop and implement referral plan in pilot communities.	TA/Policy Specialist Pilot Sites GSST WG								
OBJECTIVE 6: Develop and implement a data registry for central intake.									
1. Develop RFP for Data Registry Consultant.	TA/Policy Specialist GSST WG								
2. Research/determine specifications for a data registry.	Consultant								
OBJECTIVE 7: Measure referral success.									
1. Develop plan for measuring referral success.	TA/Policy Specialist Pilot Sites GSST WG								
2. Develop necessary tools for measuring referral success.	TA/Policy Specialist Pilot Sites GSST WG								
3. Report progress to HVWG/GSST.	TA/Policy Specialist								
4. Share lessons learned to stakeholders across State.	TA/Policy Specialist								

OBJECTIVE 8: Ensure integration with CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) project.									
1.	Develop plan for integrating home visiting intake system with CMS MAPCP project.	TA/Policy Specialist GSST WG							
2.	Participate in CMS MAPCP system-building efforts and subcommittees.	TA/Policy Specialist							
3.	Develop and issue RFP to determine entity or individual to research and map the specifications for a Data Registry.	TA/Policy Specialist GSST WG							
4.	Develop and manage contract with chosen entity/individual	TA/Policy Specialist Program Analyst							
5.	Develop and manage work plan with chosen entity/individual.	TA/Policy Specialist GSST WG							
Program Element IV: STATE-LEVEL POLICIES AND PROCEDURES									
Michigan will establish and implement State-level policies, procedures, standards, and funding mechanisms that support high-quality, evidence-based home visiting, as evidenced by achieving the following objectives:									
OBJECTIVE 1: Develop a framework for aligning home visiting models as part of an integrated local and state system.									
1.	Hire a 1.0 FTE Technical Assistance (TA)/Policy Specialist (will work half time on state-level policies & procedures).	Project Director							
2.	Conduct a state-level environmental/policy scan.	TA/Policy Specialist							
3.	Develop GSST policy work plan.	TA/Policy Specialist GSST							
OBJECTIVE 2: Create a common set of outcomes/benchmarks for the home visiting system.									
1.	Determine a common set of outcomes/benchmarks across home visiting programs.	TA/Policy Specialist GSST							
2.	Develop plan to integrate common outcomes/benchmarks within agencies and funding streams.	TA/Policy Specialist GSST							
3.	Develop a scheme for measuring local communities' achievement of common outcomes/benchmarks.	TA/Policy Specialist GSST							
4.	Monitor local communities' achievement of common outcomes/benchmarks.	TA/Policy Specialist GSST Local QI teams							

OBJECTIVE 2: Create learning communities built around specific evidence-based models.									
1. Research learning communities developed by other initiatives.	CC Consultant GSST WG								
2. Consult with model developers.	CC Consultant GSST WG								
3. Develop plan for learning communities to be implemented.	CC Consultant GSST WG								
4. Plan and conduct training/conference.	CC Consultant GSST WG								
Program Element VI: Development of Home Visiting Program Database									
Michigan will continue to assess the Home Visiting system needs and gaps by continuing the existing project to catalog exiting home visiting services in all 83 counties, as evidenced by achieving the following objectives:									
OBJECTIVE 1: Bring database development to full completion.									
6. Continue to develop methodology to collect data from additional counties.	Program Analyst GSST WG								
7. Integrate data into online searchable database.	Program Analyst								
8. Develop mechanisms for making queries/pull reports.	Program Analyst								
Program Element VII: Project Evaluation									
Michigan will develop an evaluation protocol for measuring program implementation and outcomes at both the state and local levels, as evidenced by achieving the following objectives:									
OBJECTIVE 1: Refine existing state evaluation plan for MIECHV.									
Modify data collection tools and protocol, as needed.	Evaluation Team								
Establish procedure for receiving data from NFP NSO.	Evaluation Team								
Submit evaluation for IRB review.	Evaluation Team								
Develop and provide training on evaluation and using evaluation data.	Evaluation Team								
Disseminate tools and protocol	Evaluation Team								

STATE OF MICHIGAN

MICHIGAN DEPT OF EDUCATION
Office of Great Start <i>(eff: 8/29/11)</i>
<ul style="list-style-type: none"> • IDEA Part C, Part B/619 • HSSCO • Child Care • State Pre-K
Elementary & Secondary Education Act Title I

MICHIGAN DEPT OF COMMUNITY HEALTH
Public Health Admin
<ul style="list-style-type: none"> • Home Visiting • Title V • WIC • Injury Prevention
Mental Health Admin
Substance Abuse Admin
Medicaid & SCHIP Admin

MICHIGAN DEPT OF HUMAN SERVICES
Child Welfare
<ul style="list-style-type: none"> • Title IV-E • Title IV-B • TANF
Child Care Licensing
Children's Trust Fund
Domestic Violence Board

MICHIGAN EARLY CHILDHOOD INVESTMENT CORP
Early Childhood System Building and Promotion
Early Learning Advisory Council

Michigan GREAT START SYSTEM TEAM

Michigan HOME VISITING WORKGROUP & SUBCOMMITTEES

Intermediate School Districts
Local School Districts

Local Public Health
Local Community Mental Health
Regional Substance Abuse Coordinating Agencies
Medicaid Health Plans

Local Human Services Offices
Local Child Abuse and Neglect Councils

Great Start Collaboratives
Great Start Parent Coalitions
Great Start Child Care Quality Program

LOCAL GRANTEES / HOME VISITING PROGRAMS

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.

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.

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.

Title: Project Administrator/Director

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

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

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

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

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

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

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

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

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

Title: Technical Assistance (TA)/Policy Specialist

Description of duties and responsibilities: The Specialist is responsible for working with the Home Visiting Work Group to assist pilot communities to develop a centralized/coordinated point of outreach, intake, referral and follow-up across home visiting programs. The Specialist will provide the pilots with training and technical assistance in partnership building and service coordination, and assist them to build the infrastructure of the centralized system, including development of local interagency agreements and policies and procedures designed to connect families with home visiting services that best meet their needs while honoring family preferences, and ensuring that the outcome of every referral is reported back to the referral source. The Specialist will integrate centralized intake activities related to this grant with Michigan’s CMS Multi-payer Advanced Primary Care Practice Demonstration pediatric pilots, focusing on how data linkages are developed within the context of the larger health care reform effort and Michigan’s early childhood system building activities. The Specialist will document the process used by the pilots as they build the infrastructure to support a centralized system so that other communities can replicate their efforts.

The Specialist is also responsible for assisting in the identification and development of policy, procedures and standards that support high quality, evidence-based home visiting systems. The Specialist will work with Great Start System Team to identify policies to be reviewed and/or developed, and will scan policies and procedures across State departments to identify those that need to be aligned. The Specialist also will investigate home visiting policies, procedures and standards being implemented in other states. Based on the results of the policy scan, the Specialist will develop state-level policy, procedures, and standards that support local infrastructure (centralized/coordinated outreach, intake, referral and follow up; data collection; use of evidence-based models; etc.) for home visiting program systems. The Specialist will coordinate activities with the Project Administrator/Director and the Great Start System Team, report on a regular basis to the Home Visiting Work Group, and serve as a communication/facilitation link between the Home Visiting Program and other relevant projects.

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

Skills and knowledge required: Knowledge of systems-level and State-level collaborative approaches for development and implementation of policy required. Knowledge of systems-level planning and planning models, including conducting an environmental scan. Knowledge of systems-level collaborative approaches to facilitate local centralized outreach, referral, intake and follow-up system planning and implementation activities. Skills in cross-system strategic planning, policy analysis, program development, and group facilitation. Ability to relate fiscal strategies to program and system concepts and infrastructure.

Prior experience required: Expertise in, and experience with, the public health model and state-level policy in human services. Extensive experience in the design, implementation and evaluation of collaborative initiatives, including experience in cross-system planning and implementation.

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

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

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

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

Title: NFP State Coordinator/Nurse Consultant

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

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

Supervisory relationships: The NFP State Coordinator/Clinical Nurse Consultant will report to the Manager of the Perinatal Health Unit, Division of Family and Community Health, MDCH.

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

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

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

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

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

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

Memorandum of Concurrence
Michigan Maternal, Infant and Early Childhood Home Visiting Program
FFY2011

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

7/15/11

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;
- State's Domestic Violence Coalition.



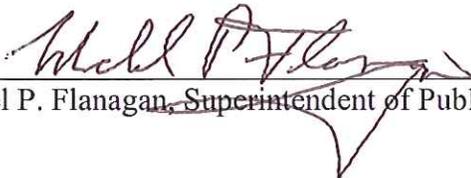
Maura D. Corrigan, Director

July 13, 2011

Date

On behalf of the **Michigan Department of Education**, which:

- Serves as the State's Elementary and Secondary Education Act Title I and State pre-kindergarten program;
- Houses the Office of Great Start, which includes the:
 - lead agency for the Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619;
 - Child Care and Development Fund (CCDF) Administrator (effective August 29, 2011);
 - Director of the Head Start State Collaboration Office (effective August 29, 2011).



Michael P. Flanagan, Superintendent of Public Instruction

7-14-2011
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;



Judy Y. Samelson, Chief Executive Officer

7.15.11
Date

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).

- Marcia Franks, Genesee County Health Department
- Lisa Coleman, Genesee County Community Mental Health
- Jonquil Bertschi, Weiss Advocacy Center
- Cantrina Wiskur, Genesee Intermediate School District
- Mary Flynn GCCARDS Head Start
- Carol Piechocki, GCCARD Head Start
- Carol Osborn, Genesys Health System
- Beth Hackett, Genesee Intermediate School District
- Lauren Chom, Flint Community Schools
- Jennifer Lee, Genesee Intermediate School District
- Toni McCrum, Genesee County Health Department
- Evilia Jankowski, Genesee Intermediate School District
- Connie Moran, Parent
- Sara Morrow, Parent
- Brenda Jarbou, 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.

Carol M. Piechocki 5-31-11
 Signature of GCCARD Head Start Director Date
 Carol Piechocki, Director

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

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?

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

Contact Person/Agency: Beth Hackett
Phone: (810) 591-5588
Email: bhackett@genesecisid.org

1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots?

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.

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.

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.

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 MMECHVP 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.

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

1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots?

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?

Twenty Four (24)

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

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.

5. What is the estimated number of families that will be served annually with the expansion funds provided by the Michigan MIECHVP?

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

Contact Person/Agency: Candace Cowling/Family Futures
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Email: ccowling@familyfutures.net

1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots?

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 subcontractor 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.

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

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

1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots?

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?

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?

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

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.

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

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 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.

- 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:

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).

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.

b) 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.

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)
- Phyllis Isanhart (Saginaw Intermediate School District)
- Rich Van Tol (Saginaw Intermediate School District)
- Sabrina Beeman (Head Start)

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?

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 with in 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

Contact Person/Agency: Julie Kozan/Saginaw ISD
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Email: jkozan@sisd.cc

1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots?

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.

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).

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

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

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

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.

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

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.

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

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.

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

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.

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 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?

Wayne County Babies: At least 25 families will be served.

Spaulding for Children: At least 25 families will be served.

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

1. What is the name of the entity that will receive the Michigan MIECHVP funds to expand service slots?

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.

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.

Suzanne Greenberg (Child Abuse and Neglect Council)
Yalonda Freeman (Parent)
Julie Kozaan (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.

- 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.

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

Shayla Anderson, Department of Human Services
 Cynthia Bonk-Foley, Starfish Family Services
 Kim Crafton, County Department of Human Services
 Gail Collors, GSCW
 Emily Kleinglass, The Guidance Center
 Catherine Lentz, The Guidance Center
 Jametta Lilly, Wayne Childrens' Health Care Access Program
 Cheri Locker, Starfish Family Services/Early Head Start
 Catherine Oliver, Wayne County Department of Health
 Carole Quarterman, Detroit Department of Health & Wellness Promotion
 Carolynn Rowland, Development Centers Inc.
 Marilyn Schmitt, Child Care Coordinating Council
 Elizabeth Shane, Wayne County Department of Health
 Tanya Smith, Wayne County CMH
 Donna Snowden, Great Start Collaborative Wayne
 Deborah Strong, Detroit Department of Health & Wellness Promotion
 Harolyn Tarr, DHWP/Substance Abuse
 Kara Thomas, DHWP/Child's Hope
 Annemarie Valdez,
 Theresa Webster, Southeastern MI Community Agency Parent

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 Network's eligibility system is checked upon enrollment. Poverty Income Guidelines are also used, if needed.**

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.

as needed, also helped maintain a high level of participation.

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: Faith-Based Collaborations, Alternative Schools, Domestic Violence Shelter, Food Bank, Volunteer Networks, Private Foundations, Recreation, Housing/Employment, Medical, Transportation.

Information for Pending Contractual Agreement with Wayne County

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, has excellent internal fiscal controls and is in excellent financial condition. This Department manages all funds and pays expenses per program budget. 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.



CENTRAL OFFICE

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WWW.MPHI.ORG

July 18, 2011
Nancy A. Peeler, Ed.M.
Manager, Child Health Unit
Michigan Department of Community Health
109 West Michigan Avenue
Lansing, MI 48913

Dear Ms. Peeler:

This letter is written on behalf of the Michigan Public Health Institute (MPHI), Center for Healthy Communities and Systems Reform programs in support of the Michigan Department of Community Health's (MDCH) application to the Health Resources and Services Administration (HRSA) for the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP) for FY 11 formula funding to further develop the State's home visiting system by expanding/enhancing evidence-based home visiting programs in Michigan.

MPHI has a long, collaborative working relationship with MDCH through several grant funded programs, especially in the area of program evaluation. Currently, MPHI serves as the evaluator for the statewide evaluation of Michigan's Zero to Three Secondary Prevention Program, which funds home-based child abuse prevention programming in the areas of the State with the highest rates of abuse and neglect.

Additionally, MPHI is serving as the evaluator for Michigan's MIECHVP. MPHI will carry out all evaluation activities associated with Michigan's MIECHVP including:

- Participating on the Home Visiting Workgroup (HYVWG) as well as other workgroups as applicable;
- Assisting with the development of a data system(s) to collect data on all benchmarks and constructs;
- Collecting data on all benchmarks and constructs from each program funded under MIECHVP, including obtaining data from the Department of Human Services;
- Analyzing data collected on each benchmark and construct;
- Assisting the State and local funded programs in identifying areas for continuous quality improvement (CQI) based on the data collected pertaining to each benchmark and construct; and

- Providing quarterly and annual reports to the State HYVWG describing CQI activities, state and local program implementation, and progress toward benchmarks and constructs.

MPHI will carry out all evaluation activities proposed in MDCH's FY11 formula grant application. MPHI understands that the evaluation activities carried out through this FY 11 formula grant will be tied into the existing FY 10 evaluation activities for MIECHVP.

MPHI looks forward to continued collaborative work with MDCH through Michigan's MIECHVP and is excited about this opportunity to further develop the State's home visiting system.

Sincerely,

Julia Heany, Ph.D.
Program Director
MPHI, Center for Healthy Communities

07-20-11
Berrien

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

County: Berrien
Contact Person/Agency: Cheryl Bury, Berrien County Health Department
Phone: (269) 927-5631
Email: cbury@berriedmi.org

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 will be served?

The targeted at-risk community is African American first-time mothers residing in Berrien County, with a focus on those living in urban areas, especially the City of Benton Harbor. Nurse Family Partnership services will be provided for this population.

2. What are the risk factors in this community? If you are unable to provide community-level data on any of the risk factors listed below, write "not available" in the appropriate box.)

RISK FACTORS	COUNTY (copy from Statewide Needs Assessment)	AT-RISK COMMUNITY City of Benton Harbor	SOURCE FOR AT-RISK COMMUNITY DATA
1. Premature birth	10.3% MDCH Vital Records 2009	Not available	
2. Low-birth wt infants	7.9% MDCH 2009	15.2 % All infants 15.4 % Black infants	MDCH 2009
3. Infant mortality (rate/1000)	9.0 All infants 16.7 Black infants MDCH 2007-2009	14.9 All infants	MDCH 2007-2009
4. Poverty	16.7% 2005-09 American Community Survey	48.1% 2005-2009 American Community Survey	
5. Crime (reported crimes/1000)	138.61 Crime in Michigan Annual Report 2008	147.94	MI State Police
6. Domestic violence (rate/1000)	12.43 Michigan Incident Crime Reporting 2008	Not available	
7. School drop-out rates	10.5% High School Dropouts by County 2009 Kids Count	19.31% in Benton Harbor Area Schools	CEPI State of Michigan Grad/Dropout reports
8. Substance abuse (binge alcohol use in past mo.)	23.9 SAMHSA 2006-2008	Not available	
9. Unemployment	10% May 2011 Bureau of Labor Statistics	Not available	

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07-20-11
Berrien

10. Child maltreatment (rate of reported substantiated maltreatment)	20.1 Kids Count MI League for Human Services 2009	Not available
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.		
Benton Harbor is a small community (approximately 10,000 residents) and so many data sets are not available for the city specifically. However, data is available for those in poverty and African Americans showing great need, and since Benton Harbor has such high proportions of African Americans and those living in poverty is it logical to choose it as a target community.		

3. What are the strengths of this community? (If you are unable to identify strengths in any of the categories listed below, leave the box blank. Do not include health and human services agencies' programs/services here; this information will be captured in subsequent items.)

COMMUNITY STRENGTHS/ASSETS	
1. What is this community proud of?	585 square miles of scenic natural beauty with 42 miles of shoreline on Lake Michigan make Berrien County a choice destination for tourists, artists, and naturalists.
2. Faith communities	The Benton Harbor Street Ministry was originally an outreach program to area street residents – homeless persons, drug users, and the mentally ill. It has evolved into a neighborhood-based operation, focusing on empowering individuals of all ages through the promotion of personal responsibility and education.
3. Neighborhood associations	
4. Cultural/ethnic associations	
5. Other community organizations	The Whirlpool Corporation Headquarters is located in Berrien County.
6. Business investment	
7. Philanthropic investment	The Berrien Community Foundation is a tax-exempt public charity created by and for the people in the area that enables anyone with philanthropic interests to easily and effectively support the issues they care about, immediately and/or through planned gifts (e.g., estate plans).
8. Major community events	Annual Berrien County Youth Fair, as well as numerous "Fruit" festivals celebrating the area's status as a national leader in fruit production.
9. Other assets/resources (specify one or more)	

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 families enrolled in NFP in this community in FY 10:
 Number of families: 120
 Income level: \$9,000
 Percentage of single parents: 99%
 Employment rate: 10% full time; 20% part-time
 Race/ethnicity: 60% African American, 29% Caucasian, 1% Hispanic
 Other (education): Of those without a diploma, 64% in school

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5. Below is a list of possible needs of potential HYP 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

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

The NFP program has been operating in Berrien County since 2000. In 2004, the state of Michigan funded the Berrien County Health Department to continue the NFP program, targeting first-time African American mothers. Situating the program in the local health department allowed for leveraging additional matching funds through Medicaid. As of June 2009, funds for the Berrien program (and four other NFP programs) were eliminated from the state budget. Since then, the local health department has been patching together funds from a variety of sources, struggling to survive. Given that: 1) the State has already made a significant investment in NFP in Berrien County; 2) Berrien County and the City of Benton Harbor have high infant mortality rates; and 3) Berrien County was not selected to receive MIECHVP FY 10 funding, the HWWG has determined that it would be prudent to use MIECHVP FY 11 funds to allow the Berrien NFP program to continue to operate. The Berrien County NFP program will not have the baseline funding amount necessary to be able to operate as of the end of the calendar year 2011; these new grant funds are required in order to continue its operation.

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.

Nurse Family Partnership	Berrien County-Benton Harbor focus
Maternal Infant Health Program	
Cassopolis Family Clinic	Southern Berrien County
InterCare Community Health Network	Entire County
Early Head Start	Entire County
Parents As Teachers (RESA)	Entire County

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?

NFP is one of only three evidence-based programs operating in the Berrien County. Existing programs clearly do not have the capacity to serve all eligible families.

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

The NFP program regularly refers clients to other agencies for needed services. Some of the most common referral sources are: Department of Human Services, InterCare Community Health Network, Early On, WIC, immunization clinics, housing commission, educational programs, and Work First.

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

The most needed programs for NFP clients would be job skills training and a high school graduation/CHD program that provided child care.

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

All programs coordinate with one another through Berrien County's Great Start Collaborative. All programs regularly refer to one another based on which program seems to be the best fit for a potential client. NFP and the Maternal Infant Health Program (MIHP) have a formal arrangement to refer clients between one another after assessing a potential client.

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?

As noted above, intake for NFP and MIHP (the home visiting programs that begin during pregnancy) have a formal arrangement to refer to one another as appropriate.

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 Berrien County Great Start Collaborative (GSC) is the local early childhood comprehensive system governance structure. The GSC Director and the Health Department NFP Administrator are both members of the MIECHVP Local Leadership Group, which is formally linked to the GSC. Also, the GSC director serves on the NFP advisory board. NFP is already incorporated as a critical component of the local early childhood comprehensive system.

- B. Selection of Proposed 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 the targeted at-risk community?

The Nurse Family Partnership Program has been selected for the reasons cited in the section above. The NFP program was designed to help low-income, first-time parents with the tools they need to lead a productive life for themselves and their children, avoiding health and parenting problems that can lead to early development of antisocial behavior. Nurse home visitors work with families in their homes during pregnancy and for the first two years after the birth of the baby. The program is designed to help women improve their prenatal health and pregnancy outcomes; improve the care of infants and toddlers; and improve women's own personal development especially giving attention to future planning and self improvement.

The NFP program involves the exclusive use of specialized nurses who follow extensive, tested, and proven protocols to provide prevention, prenatal, postpartum, and health education. The protocols focus on mother's health, parenting education, and child development; and her plans for life-course including educational achievement, employability, and job attainment. Nurses educate participants on the effects of alcohol, tobacco, and substance use, and encourage women to eliminate use of these substances, educate about nutrition; assist women in obtaining

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prenatal care; promote the emotional and physical care of the child; educate women on how to obtain a safe environment; and prepare a child for academic success. Nurses also educate about goal-setting, help participants identify the timing of subsequent pregnancies; educate about methods of birth control; help women secure childcare and transportation arrangements; and assist women in searching for, securing, and retaining a job.

Nurses utilize a client-centered, strength-based service delivery model by providing 50-70 home visits beginning in the 20th week of gestation, and continuing throughout the first two years of the child's life. A nurse carries a caseload of no more than 25 families. The nurses follow a rigid schedule that varies from weekly to monthly visits in accordance with the developmental stages of pregnancy and early childhood. These are six domains for the program: 1) Personal health; 2) Environmental health; 3) Life course development; 4) Maternal role; 5) Family and Friends; 6) Health and human services. The NFP program focuses on the prevention of infant mortality, crime, alcohol and substance abuse, smoking, child abuse and neglect, teen pregnancy, and injuries.

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

Several years ago, Michigan established Nurse Family Partnership (NFP) programs in five counties with high infant mortality rates and high black infant mortality rates, including Berrien County. This decision was based on data that led Michigan to conclude that NFP would be an effective strategy in the State's plan to reduce infant mortality. According to the Office of Minority Health and Health Disparities, promising strategies for reducing infant mortality rates include a "focus on modifying the behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness". Nurse-Family Partnership nurse home visitors utilizing the NFP Visit Guidelines address all of these areas in their work with clients. (OMHD quote retrieved from <http://www.cdc.gov/omhd/amb/facilities/infant.htm>. Accessed on June 17, 2011.)

The NFP program is a national evidence-based program that has been subject to rigorous controlled trials to measure its effectiveness. NFP's creator, Dr. Olds, conducted a 1.5-year follow-up study in Elmira, New York on his early clients. Four hundred women were recruited and followed through their child's 15th birthday. The study yielded the following results:

- 56% fewer days of consuming alcohol by the 15 year old children;
- 44% fewer behavioral problems among the mothers due to alcohol and substance abuse;
- 28% fewer cigarettes smoked by the 15 year olds;
- 79% fewer verified reports of child abuse and neglect through the child's 15th birthday
- 31% fewer subsequent births;
- 81% fewer arrests and convictions among mothers;
- 66% fewer arrests among 15-year old children;
- 81% fewer arrests and convictions among mothers;
- 58% fewer sexual partners among these 15 year olds;
- More than two years greater interval between the birth of the first and second child;
- 30 fewer months' use of welfare after the birth of the first child

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

The Berrien County NFP Advisory Council includes a representative of the population served by the program. Clients are regularly invited to serve on the board.

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

The Berrien County Health Department (BCHD) has been operating an NFP program since 2000. The program has consistently met all of the requirements specified by the NFP National Service Office and has a strong working relationship with the Midwest Region Program Developer. Results have been positive for clients including babies born at healthy weights, low rates of early childhood injuries, and up-to-date immunizations.

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

The current capacity of BCHD's NFP program is four nurses, but the program has been approved by the National Service Office to expand to six nurses and one full-time supervisor if extra funding were to become available. The program has a supervisor who oversees the nurses directly, and the supervisor reports to a service area manager who is also involved in overseeing the program. NFP has strong support from BCHD's administrative team including department leadership and other areas such as accounting, grant writing, etc. BCHD manages an over \$8 million budget including significant state and federal grant funds and is prepared to administer additional funding.

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

BCHD will ensure implementation with fidelity to the model by continuing to meet all of the requirements specified by the NFP National Service Office, and by using the COI process described in Michigan's MIECHVP State Plans.

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

BCHD has been successfully utilizing the NFP program model for over 10 years and has found it to be extremely effective partly due to the ongoing support of the National Service Office and comprehensive training of staff. Some challenges have included having ongoing adequate funding to support qualified staff members, and the difficulty of finding a highly qualified nurse.

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

BCHD's NFP program has a close relationship with representatives from the NFP National Service Office who provide ongoing technical assistance with program delivery as well as data collection and maintenance.

C. Implementation of Selected Model

1. What is the name of the entity that will receive the Michigan MIECHVP funds to maintain or increase the number of families served?

Berrien County Health Department
769 Pipestone Road (P O Box 706)
Benton Harbor, Michigan 49023
Phone: (269) 926-7121
www.bchdmi.org

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

Currently the program is short one nurse due to relocation, so the program is actively recruiting an additional nurse. (Note: Funding is already secured to hire the additional nurse, but MIECHVP funds will allow us to continue to operate when our current funds are eliminated at the end of the year.) Staff retention is assured by the nurse membership in an employee union which guarantees regular pay raises. Additionally, reflective practice with the supervisor helps alleviate the stress of the job and keep motivation to continue.

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).

Subcontracts will not be used; all program staff will be employees of BCHD.

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

All NPP staff is trained by the NPP National Service Office and complete client and program records in accordance with their standards. The NPP National Service Office performs periodic site visits to local programs to ensure compliance. There are also monthly calls between the national and local office, and ongoing meetings with training updates.

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

The estimated number of families that will be served annually is 100, using a combination of MIECHV funding, along with State GF and Medicaid matching funds. All 100 will be considered to be enrolled in the MIECHV program. If extra funds are available (e.g. local funds), a greater number might be served.

6. How will program participants be identified and recruited?

Many program participants are recruited through the WIC (Women, Infants, and Children) program when they enroll in early pregnancy. Clients are also recruited from other services providers, schools, and prenatal care clinics serving Medicaid clients.

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

Because the program is based on a close relationship between the nurse and client, it is the ongoing contact between them that keep clients engaged. Nurses have small enough caseloads that they are able to keep close track of all clients and follow up with them multiple times in cases of missed visits or other signs that clients may be considering not continuing with the program. Weekly reflective supervision also helps give nurses perspective on client situations and the ability to come up with new strategies to re-engage clients in the program.

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

Because a new nurse is being hired, it will be approximately 6-9 months after this hire until the full program is at maximum capacity. This is the time frame recommended by the national office to fill a nurse's caseload.

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.

A formal plan for coordination is being developed by the Great Start Collaborative.

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

Extensive process and outcome data is collected for the NPP program in accordance with national evaluation tools. Data collected includes process information such as times of visits and content covered, and well as detailed outcome data such as: baby's weight (birth and ongoing), developmental milestones using Ages and Stages assessment, records of medical care by mothers and babies, immunization records, emergency room visits, second pregnancies, and employment and educational information for mothers.

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

BCHD is confident of its ability to maintain the highest quality and fidelity to the program model, as has been the case for the past ten years. BCHD works closely with the national NPP office to assure fidelity to the program, and follows all protocols. Nurses meet with the supervisor weekly to go over cases and assure complete compliance with all program content.

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

- | | |
|-------------------|--|
| John Nelson | Berrien County Health Department - Title V |
| Mike Mortimore | Berrien County Health Department - Title V |
| Carol Klukas | Berrien County Health Department - Title V |
| Cheyl Bury | Nurse Family Partnership Program, Berrien County Health Department - Title V |
| Jamie Rossow | Berrien County Dept. of Human Services/Child Abuse & Neglect Council |
| Marla Parlike | Tri-County Early Head Start/Head Start |
| Ranona Borowiec | Tri-County Early Head Start/Head Start |
| Amanda Williamson | Berrien County Great Start Collaborative (Director) |
| Gale Sylvester | Riverwood Center - Berrien County Community Mental Health Authority |
| Karanda Applebey | Parents As Teachers, Berrien County Regional Education Service Agency |
| Judy Rayman | InterCare Maternal Infant Health Program |
| Tara Willis | Parent Member |

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.
- BCHD assures that the NPP program will comply with all of the above.

Note: since clients enter the NPP program during pregnancy, it is not possible to give priority to families with children with developmental delays as this is not known at program entry.

07-20-11 Kalamazoo

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

County: Kalamazoo
Contact Person/Agency: Deb Lenz, Kalamazoo County Health and Community Services Department.
Phone: 269-373-5024
Email: dlrenz@kalecounty.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 will be served?

The targeted at-risk community is African-American first-time mothers residing in Kalamazoo County, with a focus on those living in urban areas, especially the City of Kalamazoo. Nurse Family Partnership services will be provided for this population.

2. What are the risk factors in this community? If you are unable to provide community-level data on any of the risk factors listed below, write "not available" in the appropriate box.)

RISK FACTORS	COUNTY (copy from Statewide Needs Assessment)	AT-RISK COMMUNITY	SOURCE FOR AT-RISK COMMUNITY DATA
1. Premature birth	9.8% MDCH Vital Records 2009	City of Kalamazoo 11.1% All infants 15.4% Black infants (City of Kalamazoo)	MDCH Vital Records 2008 (compiled by Kalamazoo County Health & Community Services Dept. using GIS)
2. Low-birth wt infants	8.9% MDCH Vital Records 2009	8.4% All infants 10.7% Black infants (City of Kalamazoo)	MDCH Vital Records 2008 (compiled by Kalamazoo County Health & Community Services Dept. using GIS)
3. Infant mortality (rate/1000)	8.3 All infants 19.1 Black infants MDCH 2007-2009	8.7 All infants 19.3 Black infants (City of Kalamazoo)	MDCH Vital Records 2008 (compiled by Kalamazoo County Health & Community Services Dept. using GIS)
4. Poverty	15.9% 18.6% SAIPE - Co Level American Community Survey, 3-year Estimates, 2007-2009	35.4% (City of Kalamazoo)	American Community Survey, 3-year Estimates, 2007-2009
5. Crime (reported crimes/1000)	130.51 Crime in Michigan Annual Report 2008	213.3 incidents per 1,000 citizens (City of Kalamazoo)	Kalamazoo Department of Public Safety for crime incidents, American Community Survey 2009 for City population

1

07-20-11 Kalamazoo

6. Domestic violence (rate/1000)	13.5 Michigan Incident Crime Reporting 2008	NA	
7. School drop-out rates	11.1% High School Dropouts by County 2009 Kids Count	16.6% (Kalamazoo Public Schools)	Michigan Center for Educational Performance and Information
8. Substance abuse (binge alcohol use in past mo.)	26.1 SAMHSA 2006-2008 Binge in the past month: 17.6% Kalamazoo County Behavioral Risk Factor Survey 2009-2010	Binge in the past month: 24.5% (City of Kalamazoo)	Kalamazoo County Behavioral Risk Factor Survey 2009-2010
9. Unemployment	10.9% http://www.data.bls.gov/cgi-bin/dsxy June 2010	13.4% (City of Kalamazoo)	U.S. Census Bureau, American Community Survey 1-Year Estimate, 2009
10. Child maltreatment (rate of reported substantiated maltreatment)	18 http://www.datacenter.f-kidscount.org/data/bystate/Rankings.asp?x:State=MI&kind=1677Y ear?2	NA below county level	
11. Proportion of total pop of African Americans 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			

3. What are the strengths of this community? If you are unable to identify strengths in any of the categories listed below, leave the box blank. Do not include health and human services agencies' programs/services here; this information will be captured in subsequent items)

2

COMMUNITY STRENGTHS/ASSETS	
1. What is this community proud of?	The Kalamazoo Promise scholarship program was announced in November 2005 and provides four years of tuition and fees at any public college or university in Michigan for students who have attended Kalamazoo Public Schools. It is unique in its scope and basis. While most other scholarship programs are based on merit or need, the Kalamazoo Promise is based only on location. The program seeks to remove the financial barriers to enrolling in college for those students who have attended Kalamazoo schools and lived within its boundaries for at least the four years of high school.
2. Faith communities	ISAAC has been an intricate advocate at the legislative level
3. Neighborhood associations	Multiple neighborhood associations are active in the City of Kalamazoo.
4. Cultural/ethnic associations	The Black Arts & Cultural Center develops potential and creativity in Blacks in the Kalamazoo Area, advances the awareness of Black artistic ability, helps to preserve black cultural heritage, and enhance interactions among diverse groups.
5. Other community organizations	Downtown Kalamazoo remains the site of Pfizer's offices, manufacturing facilities, and research labs following its buyout of the homegrown Pharmacia & Upjohn Company (whose presence in the community dated back more than a century) which has helped to keep the local economy somewhat stable. <i>Items and goods produced:</i> fruit, flowering plants, peppermint, and other agricultural products; pharmaceuticals; paper and paper products; meal products; machinery; guitars.
7. Philanthropic investment	The Kalamazoo Community Foundation was established in 1975 with a gift of \$1,000 from one person who had a vision of a better community. Today it is one of the oldest, most respected and successful community foundations in the county, supported by thousands of philanthropists from all walks of life.
8. Major community events	Local festivals featuring live music, arts and crafts, food and drinks attract crowds in the tens of thousands. The Kalamazoo Art Fair held annually on the first weekend in June is the second oldest community art fair in America, attracting 60,000 visitors over two days.
9. Other assets/resources (specify one or more)	Located in Southwest Michigan, about 2 hours from Chicago, Kalamazoo is home to the nationally recognized Western Michigan University, several colleges and a variety of cultural institutions. Kalamazoo is one of the <u>25 best cities</u> in the country for young college graduates, according to a 2011 study that looked at relative affordability, housing, and employment opportunities, and size of the age 22-24 population.

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 families enrolled in NFP in this community in FY 10:

Number of families: 100
 Income level: \$9000.00 (median)
 Percentage of single parents: 94%
 Employment rate: 20% working part-time, 50% not working, 30% unknown
 Race/ethnicity: 92% non-hispanic, 35% black, 49% white, 5% multiracial, 11% declined to report
 Other:

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	Y
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	Y
3. Sound and appropriate nutrition	Y
4. Health education and care	Y
5. Education on promoting literacy and early learning	Y
6. Access to quality child care/early childhood education experiences	Y
7. Domestic violence resources	Y
8. Substance abuse services	Y
9. Mental health services	Y
10. Training and jobs	Y
11. Transportation	Y
12. Other (specify)	
13. Other (specify)	
14. Other (specify)	
15. Other (specify)	

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.

In 2007, Michigan funded the Kalamazoo County Health and Community Services Department to implement an NFP program, targeting first-time African American mothers. Situating the program in the local health department allowed for leveraging additional matching funds through Medicaid. As of June 2009, funds for the Kalamazoo program (and four other NFP programs) were eliminated from the state budget. Since then, the local health department has been patching together funds from a variety of sources, struggling to survive. Given that: 1) the State has already made a significant investment in NFP in Kalamazoo County; 2) Kalamazoo County and the City of Kalamazoo have high infant mortality rates; and 3) Kalamazoo County was not selected to receive MIECHVP FY 10 funding, the HWWG has determined that it would be prudent to use MIECHVP FY 11 funds to allow the Kalamazoo NFP program to continue to operate. The project is funded through County General fund and United Way grants through December 31, 2011.

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.

Nurse Family Partnership	Entire County – City of Kalamazoo focus
Maternal Infant Health Program	
Magdalene Care	Entire County
New Beginnings	Entire County
Silver Linings Family Services	Entire County
Healthy Babies, Healthy Start	Zip Codes: 49001, 49007, and 49008
Great Start Plus	Entire County
Ready, Set, Succeed!	Entire County
Ujima	Urban Zip codes

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?

As we continue to struggle economically, we are discovering a newer population of families needing additional services that may not necessarily fall below the established Federal Poverty levels for some services. We are looking at a "new working poor" population. As Federal and State dollars shrink, our communities are struggling to maintain staff to service these clients. Many resources that were a part of our community network are no longer servicing clients, which then overwhelms the existing programs. There still continues to be a great need for prenatal case management services.

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

Outside of agencies offered through the Health Dept, others include food pantries, housing services, child care resources, social service needs.

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

More resources are needed to help in the mental health environment.

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

Potentially collaborate through the Great Start Collaborative to develop a common avenue for multiple agencies to communicate and discuss family needs.

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?

Not applicable at this time in our community. Our plan over the next year is to work through the Great Start Collaborative to establish this community-wide referral system.

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 Kalamazoo Great Start Collaborative (GSC) is the local early childhood comprehensive system governance structure. The GSC Director and the Health and Community Services Department NFP Administrator are both members of the MIECHVP Local Leadership Group, which is formally linked to the GSC. The GSC Director also serves on the NFP Advisory Council. NFP is already incorporated as a critical component of the local early childhood comprehensive system.

5

B. Selection of Proposed 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 the targeted at-risk community?

The Nurse Family Partnership Program has been selected for the reasons cited in the section above.

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

Several years ago, Michigan established Nurse Family Partnership (NFP) programs in five counties with high infant mortality rates and high black infant mortality rates, including Kalamazoo County. This decision was based on data that led Michigan to conclude that NFP would be an effective strategy in the State's plan to reduce infant mortality. According to the Office of Minority Health and Health Disparities, promising strategies for reducing infant mortality rates include a "focus on modifying the behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness". Nurse-Family Partnership nurse home visitors utilizing the NFP Visit Guidelines address all of these areas in their work with clients. (OMHD quote retrieved from <http://www.cdc.gov/omhd/amh/factsheet/infant.htm>. Accessed on June 17, 2011.)

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

The Kalamazoo Great Start Collaborative Parent Coordinator is an active member of the MIECHVP Local Leadership Group.

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

The Kalamazoo County Health and Community Services Department has been operating an NFP program since 2007. The program has consistently met all of the requirements specified by the NFP National Service Office and has a strong working relationship with the Midwest Region Program Developer.

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

Funding continues to be an issue as more resources/money are eliminated at the Local Public Health level. Until the funding can be stabilized, the capacity could not be increased even if the need is there.

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

The Kalamazoo County Health and Community Services Department will ensure implementation with fidelity to the model by continuing to meet all of the requirements specified by the NFP National Service Office, and by using the CQI process described in Michigan's MIECHVP State Plans.

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

NFP has 4 seasoned Home Visitors who are dedicated to serving this population. The challenges arise with locating clients and moving the client toward self-sufficiency and responsibility.

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

6

C. Implementation of Selected Model

- 1. What is the name of the entity that will receive the Michigan MIECHVP funds to maintain or increase the number of families served?**

Kalamazoo County Health and Community Services Department
 3299 Gill Road
 Kalamazoo, MI 49048
 269-373-5200
www.kalcounty.com/hsc/

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

Currently the only vacant position is the RN Supervisor, which is currently being posted and reviewed. The new Supervisor would attend National NFP training as well as County orientation. The hiring and training of any subsequent staff would follow the recommendation and requirements of both NFP and County policies.

- 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 currently do not subcontract these services. The NFP program is housed in the Health & Community Services department. They work closely with community agencies regarding case management efforts.

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

NFP has annual trainings for Supervisors regarding reflective practice. Staff attend trainings as required. Kalamazoo County also has a contract with a Mental Health Specialist, who attends monthly 2 hour case management sessions with Home Visitors and the Supervisor. This has proven to be an invaluable addition to our NFP program.

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

The estimated number of families that will be served annual is 100.

- 6. How will program participants be identified and recruited?**

Several community agencies are committed to identifying potential first time moms and completing the referral paperwork. Key agencies are WIC, community OB/Gyn clinics, FQHC clinic, community faith-based agencies, and community hospital women's services programs.

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

Unfortunately, this population has a high attrition rate. Our Home Visitors try to develop rapport in the early stages of the pregnancy, and project a learning environment. Many of these women are at different stages of that learning curve, but our staff will make every effort possible to remain in contact with the client and ensure education is provided through the infant's 24th month.

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

Per the National Service Office (NSO) NFP, the timeline should be within 9 months for a new agency or a new home visitor.

- 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.**

Continue to work with existing community network groups as we move forward to a more centralized reporting system. The Great Start Collaborative will hopefully be the avenue that this can happen through.

- 10. How are you already collecting process and outcome data for the existing home visiting program that has been chosen to receive MIECHVP funds? Will you be using the same process with the expansion slots? NFP maintains its own database, so staff will continue to enter data into the ETO system for reporting purposes.**

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

Challenges include reviewing quarterly data to ensure we are within the benchmarks established by the NFP National Office, and then determining what changes our agency may need to develop in order to meet those benchmarks.

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

Deb Lenz	Kalamazoo County Health and Community Services Department-Title V
Lisa Velez	Elizabeth Uplight Community Healing Centers - Substance Abuse
Mimi Ott	Kalamazoo County Department of Human Services/CAN Council
Susan Siegfried-Wilson	Kalamazoo County Early Head Start/Head Start
Jacque Eaton	Kalamazoo County Great Start Collaborative(Director)
Lisa Velez	Kalamazoo County Community Mental Health Services Authority
Kristi Carambula	Kalamazoo Regional Education Service Agency
Sarah Dyrnum	Parent Member

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

- 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).

- Assurance that services will be provided on a voluntary basis

- 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.

- 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.

**Michigan Maternal, Infant and Early Childhood Home Visiting Program
Formula Funding Grant Continuation Application
References and Citations**

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July 18, 2011

Ms. Nancy Peeler, Program Administrator
Michigan Maternal, Infant and Early Childhood Home Visiting Program
Michigan Department of Community Health
PO Box 30195
Lansing, MI 48993

Dear Ms. Peeler:

Based on the information provided to your program developer, I am pleased to grant approval from the Nurse-Family Partnership National Service Office (NFP NSO), so you may include the Nurse-Family Partnership® Program (NFP) in your FY11 state submission for formula funds to the Health Resources and Services Administration as part of the Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP). Specifically:

- NFP NSO verifies that we have reviewed Michigan's proposed application and that it includes the specific elements required in the FY11 FOA; and
- NFP NSO is supportive of Michigan's participation in the national evaluation and any other related HHS effort to coordinate evaluation and programmatic technical assistance.

By requesting a model developer letter of support, Michigan and its designee, agree to provide NFP NSO with a copy of the state application once submitted to HRSA that outlines how NFP will be included and any additional documentation to help support how the State will support implementation of NFP with fidelity to the model.

As part of our ongoing partnership to support implementation with fidelity to the model, and as part of our required processes, as referenced in the FY11 FOA, NFP NSO expects that Michigan will enter into a service agreement with NFP NSO and implement NFP in accordance with that agreement. This agreement will outline what supports will be provided by the NFP NSO and the State's obligations, including:

- Working directly with the NFP NSO and designated program development staff to implement NFP as designed, including:
 - Understanding the 18 required model elements;
 - Using NFP-specific implementation planning tools;
 - Accessing NFP support as appropriate with RFP processes and a list of program requirements for inclusion in such processes; and
 - Adhering to NFP agency selection requirements contained in the Implementation Plan and Guidance documents.
- Ensuring that every team of nurses employed to deliver NFP will:
 - Receive NFP-specific education as well as expert NFP nursing practice consultation to develop basic competencies in delivering the program model successfully;
 - Receive adequate support and reflective supervision within their agencies;
 - Receive ongoing professional development on topics determined by nursing supervisors to be critical for continued growth. Professional development may be offered within a host agency or through more centralized or shared venues;

1900 Grant Street, Suite 400 | Denver, CO 80203-4304
303.327.4240 | Fax 303.327.4260 | Toll Free 866.864.5226
www.nursefamilypartnership.org

- Engage in individual and collective activities designed to reflect on the team’s own practice, review program performance data, and enhance the program’s quality and outcomes over time; and
- Utilize ongoing nurse consultation for ongoing implementation success.
- Participating in all NFP quality initiatives including, but not limited to, research, evaluation, and continuous quality improvement;
- Ensuring that all organizations implementing NFP use data and reports from our web-based Efforts to Outcomes™ data system to foster adherence to the model elements in order to achieve outcomes comparable to those achieved in the randomized, controlled trials. This may include creating necessary interfaces between local or state-based data and information systems with our national web-based data system.

Nurse-Family Partnership will decline requests to implement NFP with adaptations which may compromise model fidelity. For any evaluation plan that will require participation of the agency staff or clients, the state commits to submit for approval to the NFP Research and Publication Communication (RAPComm). The RAPComm committee works directly with the evaluator to review client and site burden and to assure IRB approval as appropriate. Additional information on the RAPComm process can be found by clicking [here](#).

This letter also affirms our commitment to work with you as your state implements NFP using designated funds from the MIECHVP. In order to further assist you, we have a set of [online resources](#) that can serve as your guide for our continued work together. We are particularly eager to partner with you to consider the kind of support that would enable you to successfully establish NFP in the communities identified in the statewide needs assessment.

Successful replication of Nurse-Family Partnership as an evidence-based home visitation program is dependent on both unwavering commitment to program quality as well as creative and sensitive adaptability to local and state contexts and available resources. We are excited to partner with you to plan how best to support the successful development of Nurse-Family Partnership.

Sincerely,



Erika Bantz
Director of Program Development
Nurse-Family Partnership National Service Office



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
P.O. Box 30195
Lansing, MI 48909

Dear Ms. Peeler,

Thank you for requesting an approval letter for your state's Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program FY 2011 formula-based grant application from the Office of Head Start (OHS).

As Director of the Office of Head Start (OHS), I am pleased to give you approval for implementing the Early Head Start (EHS) Home-Based Model for the FY 2011 formula-based grant project period. We have reviewed and approved your state's FY 2010 Updated State Plan and proposed plan for FY 2011 to build upon components in the EHS Home-Based Model. Further, OHS supports your state's participation in the national evaluation and other related efforts to coordinate evaluation and programmatic technical assistance through the U.S. Department of Health and Human Services (HHS).

To ensure full compliance with all Head Start Program Performance Standards and model fidelity, the Office of Head Start requires each state to direct all questions and needs for technical assistance to OHS. This will help OHS to facilitate ongoing communication and support to your state.

We look forward to continuing to work with your state and its partners in implementing the EHS Home-Based Model.

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

Sincerely,

Yvette Sanchez Fuentes
Director



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

July 13, 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 FY 11 Formula Grant 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 have not been proposed at this time. Should any adaptations be proposed at a later time, the HFA National Office will review them on a case by case basis to determine if any shall be granted.

Currently, HFA is present in 34 states and D.C., including 5 currently affiliated HFA program sites in Michigan. We understand that given the funding available in FY11 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, funds will be used to continue the HFA programs implemented as part of the State’s FY 10 plan. These include the following 4 counties/locations:

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)

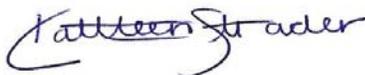


The State agrees to require that all new program sites choosing to implement the HFA model will complete the application process to affiliate with HFA. Should any additional HFA sites be established in Michigan at a later time, those sites will also be required to affiliate with the HFA National Office. The State has agreed to insure programs will pay the required annual fees (\$1,350 in 2011), and purchase necessary HFA training for program staff utilizing both in-state and national certified HFA trainers (as needed). 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 from the HFA National Office's Central Region Director at no cost via phone and email (contact information is below), and at a cost of \$1,250 per day plus travel for on-site technical assistance

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

Table 4

Participants in Developing Michigan's MIECHVP Continuation Grant Application

Agency	Name	Role	STATE LEVEL	Contribution
MICHIGAN DEPARTMENT OF EDUCATION	Lindy Buch	Director, Office of Early Childhood Education and Family Services (which includes both Part C and Part B 619 preschool)	Director, Office of Early Childhood Education and Family Services (which includes both Part C and Part B 619 preschool)	HVWG member/grant reviewer
	Renee DeMars-Johnson	Supervisor, Infant/Toddler & Family Services (including Part C)	Supervisor, Infant/Toddler & Family Services (including Part C)	HVWG member/grant contributor & reviewer
	Colleen O'Connor	Education Consultant (Part C and Great Parents, Great Start)	Education Consultant (Part C and Great Parents, Great Start)	HVWG member
	Lisa Brewer-Walraven	Director, Office of Early Education and Care/Federal Liaison	Director, Office of Early Education and Care/Federal Liaison	HVWG member
MICHIGAN DEPARTMENT OF HUMAN SERVICES	Guy Thompson	Program Director, Children's Protective Services and Family Preservation Program Offices	Program Director, Children's Protective Services and Family Preservation Program Offices	HVWG member/grant reviewer
	Jeremy Reuter	Director, Head Start State Collaboration Office	Director, Head Start State Collaboration Office	HVWG member/grant contributor & reviewer
	Teresa Marvin	Part C Parent Representative	Part C Parent Representative	HVWG member/grant reviewer
	Mike Foley	Executive Director	Executive Director	HVWG member
CHILDREN'S TRUST FUND	Sarah Davis	Senior Program Development Coordinator	Senior Program Development Coordinator	HVWG member
	M. Jeffrey Sadler	Departmental Analyst	Departmental Analyst	HVWG member
EARLY CHILDHOOD INVESTMENT CORPORATION (ECIC)	Joan Blough	Vice-President, Great Start System Planning and Evaluation & ECCS	Vice-President, Great Start System Planning and Evaluation & ECCS	HVWG member/grant contributor & reviewer

Table 4

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

Table 4

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

Table 4

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

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

Table 5: Benchmark Measurement Table

Benchmark 1: Improved maternal and newborn health										
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability/ Validity of (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)
1) Prenatal care	Proportion of women who received early and adequate prenatal care (HP2020)	% of women enrolled prenatally who recommend # of prenatal visit following enrollment in the program Numerator: Number women enrolled prenatally who report that they received recommended # of prenatal visits following enrollment Denominator: Number of women enrolled prenatally	Administrative	NA	An increase in the % of women enrolled prenatally who receive early and adequate prenatal care between baseline and years 3 and 5	HV agency staff	Client	Women who enroll in the HV program while pregnant	NA	Collected by HV agency staff at point of child's birth Data submitted quarterly to the state
2) Parental use of alcohol, tobacco, or illicit drugs	Proportion of pregnant women who abstain from alcohol, cigarettes, and illicit drugs (HP 2020)	% of women enrolled prenatally who need services for alcohol, tobacco, or illicit drug use that are receiving services Numerator: Number of women enrolled prenatally who received an assessment that indicated they are using alcohol, cigarettes, or illicit drugs that are receiving services Denominator: Number of women enrolled prenatally who received an assessment that indicated they are using alcohol, cigarettes, or illicit drugs	Screening tool such as the Alcohol, Smoking and Substance Involvement Screening Test Administrative	Yes NA	An increase in the % of women enrolled prenatally who need services that are receiving services for alcohol, cigarette, and illicit drug use between baseline and years 3 and 5	HV agency staff	Client	Women who enroll in the HV program while pregnant that are using alcohol, cigarettes, and illicit drugs	NA	Collected by HV agency staff at point of enrollment for pregnant women Data submitted quarterly to the state
3) Preconception care	Proportion of women who received preconception care services (HP 2020)	% of women enrolled in the program who report that they have access to family planning services Numerator: Number of	Administrative	NA	An increase in the % of women enrolled in the program who report that	HV agency staff	Client	Women who are enrolled in the program	NA	Collected by HV agency staff annually while client is enrolled in the program

			women enrolled in the program who report that they have access to family planning services	Denominator: Number of women enrolled in the program			they have access to family planning services between baseline and years 3 and 5	HV agency staff	Client	Women who are enrolled in the program	NA	Data submitted quarterly to the state
4) Inter-birth intervals	Proportion of women who adequately space their pregnancies	% of women enrolled in the program who become pregnant fewer than 12 months following childbirth	Numerator: Number of women enrolled in the program who become pregnant fewer than 12 months following childbirth	Denominator: Number of women enrolled in the program	Administrative	NA	A decrease in the % of women enrolled in the program who become pregnant fewer than 12 months following childbirth between baseline and years 3 and 5	HV agency staff	Client	Women who are enrolled in the program	NA	Month/year start and end for each pregnancy collected by HV agency staff while client is enrolled in the program Data submitted quarterly to the state
5) Screening for maternal depressive symptoms	Proportion of women who experience maternal depression	% of women enrolled in the program who need services for maternal depression that are receiving services	Numerator: Number of women enrolled in the program who received an assessment that indicated they need services for maternal depression that are receiving services	Denominator: Number of women enrolled in the program who received an assessment that indicated they have symptoms of maternal depression	Screening tool: Beck Depression Inventory or Edinburgh Postnatal Depression Scale Administrative	Yes NA	An increase in the % of women enrolled in the program who need services that are receiving services for maternal depression between baseline and years 3 and 5	HV agency staff	Client	Women who are enrolled in the program	NA	Collected by HV agency staff at point of enrollment and at least annually Data submitted quarterly to the state
6) Breastfeeding	Proportion of infants breastfed at 6 months postpartum	% of women enrolled prenatally who breastfeed their infants at 6 months of age	Numerator: Number of		Administrative	NA	An increase in the % of women enrolled prenatally who	HV agency staff	Client	Women who enroll in the HV program while pregnant	NA	Collected by agency staff when infant is 6 months old Data submitted

	Measure		(Tool or Administrative)	Validity (Yes or No)	Improvement	responsible	Client	Clients of the program	g	(Frequency)
16) Parent support for children's learning and development	Change in parent support for children's learning and development	Scores on parent scales of the Parenting Stress Index at enrollment and one year	Parenting Stress Index (PSI)	Yes	A statistically significant improvement in parent scale scores on PSI at one year of enrollment as compared with baseline (paired t-test)	HV agency staff	Client	Clients of the program	NA	Collected by program staff at baseline and annually Data submitted to the state annually
17) Parent knowledge of child development and of their child's developmental progress	Change in parent knowledge of child development	Scores on Child Development/Knowledge of Parenting scale of Protective Factors Survey at enrollment and one year	Protective Factors Survey (PFS)	Yes	A statistically significant improvement in scale scores on PFS at one year of enrollment as compared with baseline (paired t-test)	HV agency staff	Client	Clients of the program	NA	Collected by program staff at baseline and annually Data submitted to the state annually
18) Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)	Change in parenting behaviors and parent-child relationship	Scores on parent scales of the Parenting Stress Index at enrollment and one year	Parenting Stress Index	Yes	A statistically significant improvement in parent scale scores on PSI at one year of enrollment as compared with baseline (paired t-test)	HV agency staff	Client	Clients of the program	NA	Collected by program staff at baseline and annually Data submitted to the state annually
19) Parent emotional well-being or parenting stress (note: some of these data may also be captured for maternal health under that benchmark area).	Change in parent well-being and parenting stress	Scores on SE Support and Concrete support scales of Protective Factors Survey and parent scales of Parenting Stress Index at enrollment and one year	Protective Factors Survey Parenting Stress Index	Yes	A statistically significant improvement in parent scale scores on PFS and scale scores of PFS at one year of enrollment as compared with baseline (paired t-test)	HV agency staff	Client	Clients of the program	NA	Collected by program staff at baseline and annually Data submitted to the state annually
20) Child's communication,	Developmental delays	% of children enrolled in the program who are up-to-date	Ages and Stages	Yes	An increase in the % of	HV agency staff	Client	Children served by	NA	Collected by program staff at

language, and emergent literacy	identified and addressed	with developmental screening Numerator: Number of children up-to-date with developmental screening Denominator: Number of children enrolled in the program	Questionnaire-Communication Area (ASQ)	Yes	children who are up-to-date with developmental screening between baseline and 3 and 5 years	HV agency staff	Client	the program	baseline and as indicated by the ASQ Data submitted to the state annually
21) Child's general cognitive skills	Developmental delays identified and addressed	% of children enrolled in the program who are up-to-date with developmental screening Numerator: Number of children up-to-date with developmental screening Denominator: Number of children enrolled in the program	Ages and Stages Questionnaire-Problem Solving Area	Yes	An increase in the % of children who are up-to-date with developmental screening between baseline and 3 and 5 years	HV agency staff	Client	Children served by the program	Collected by program staff at baseline and as indicated by the ASQ Data submitted to the state annually
22) Child's positive approaches to learning including attention	Change in children's approach to learning and attention	Scores on child scales of Parenting Stress Index at enrollment and one year	Parenting Stress Index	Yes	A statistically significant improvement in child scale scores on PSI at one year of enrollment as compared with baseline (paired t-test)	HV agency staff	Client	Children served by the program	Collected by program staff at baseline and annually Data submitted to the state annually
23) Child's social behavior, emotion regulation, and emotional well-being	Change in children's social behavior, emotional regulation, & emotional well being	Scores on child scales of Parenting Stress Index at enrollment and one year	Parenting Stress Index	Yes	A statistically significant improvement in child scale scores on PSI at one year of enrollment as compared with baseline (paired t-test)	HV agency staff	Client	Children served by the program	Collected by program staff at baseline and annually Data submitted to the state annually
24) Child's physical health and development.	Developmental delays identified and addressed	% of children enrolled in the program who are up-to-date with developmental screening	Ages and Stages Questionnaire-Gross & Fine Motor Areas	Yes	An increase in the % of children who are up-to-date with	HV agency staff	Client	Children served by the program	Collected by program staff at baseline and as indicated by the ASQ

Benchmark 4: Crime or Domestic Violence										
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability/ Validity (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)
		Numerator: Number of children up-to-date with developmental screening Denominator: Number of children enrolled in the program			developmental screening between baseline and 3 and 5 years					Data submitted to the state annually
<i>Crime</i>										
25) Arrests	Proportion of persons who are arrested	% of clients who are arrested while enrolled in the program Numerator: number of clients who are arrested during the reporting year Denominator: number of clients who are enrolled in the program during the reporting year	Administrative	NA	A decrease in the % of clients who are arrested while enrolled in the program between baseline and 3 and 5 years	HV agency staff	Client	Clients of the program	NA	Collected by agency staff at least annually while the client is enrolled in the program Data submitted to the state quarterly
26) Convictions	Proportion of persons who are convicted of a crime	% of clients who are convicted of a crime Numerator: number of clients who are convicted of a crime during the reporting year Denominator: number of clients who are enrolled in the program during the reporting year	Administrative	NA	A decrease in the % of clients who are convicted of a crime while enrolled in the program between baseline and 3 and 5 years	HV agency staff	Client	Clients of the program	NA	Collected by agency staff at least annually while the client is enrolled in the program Data submitted to the state quarterly
<i>Domestic Violence</i>										
27) Screening for domestic violence	Proportion of persons who experience domestic violence	% of clients enrolled in the program who are screened for domestic violence Numerator: Number of clients enrolled in the program who have received a screening for domestic violence	Screening tool: Conflict Tactics Scale-2 Administrative	Yes NA	An increase in the % of clients enrolled in the program who receive a screening for domestic violence	HV agency staff	Client	Clients who are enrolled in the program	NA	Collected by HV agency staff at point of enrollment and at least annually Data submitted quarterly to the state

28) Number of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries);	Proportion of persons who experience domestic violence	Denominator: Number of clients enrolled in the program % of clients enrolled in the program who need services for domestic violence that are receiving services Numerator: Number of clients enrolled in the program who received a screening that indicated they need services for domestic violence that are receiving services Denominator: Number of clients enrolled in the program who received a screening that indicated they need services for domestic violence	Screening tool: Conflict Tactics Scale-2 Administrative	Yes NA	between baseline and years 3 and 5 An increase in the % of clients enrolled in the program who need services that are receiving services for domestic violence between baseline and years 3 and 5	HV agency staff	Client	Clients who are enrolled in the program	NA	Collected by HV agency staff at point of enrollment and at least annually Data submitted quarterly to the state
29) Number of families identified for the presence of domestic violence, number of families for which a safety plan was completed.	Proportion of persons who experience domestic violence	% of clients enrolled in the program who received a screening that identified domestic violence who have a safety plan Numerator: Number of clients experiencing domestic violence who have a safety plan Denominator: Number of clients experiencing domestic violence	Screening tool: Conflict Tactics Scale-2 Administrative	Yes NA	An increase in the % of clients enrolled in the program experiencing domestic violence who have a safety plan in place between baseline and years 3 and 5	HV agency staff	Client	Clients who are enrolled in the program	NA	Documented in the client record by HV agency staff at point of completion Data submitted quarterly to the state
Benchmark 5: Family Economic Self-Sufficiency										
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability/ Validity (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)
30) Household income and benefits (See SIR for definitions.)	Proportion of households living below the poverty level	Household income and benefits at enrollment and after one year in the program	Protective Factors Survey	Yes	A statistically significant increase in household income and benefits at one year of	HV agency staff	Client	Clients who are enrolled in the program	NA	Collected by HV agency staff at baseline and annually Data submitted quarterly to the state

31) Employment or Education of adult members of the household	Proportion of households living below the poverty level	Household total hours of paid work, participating in education program, & unpaid work devoted to child care at enrollment and after one year in the program	Administrative	NA	NA	enrollment as compared with baseline (paired t-test) A statistically significant increase in mean hours (total paid work, education, and child care) at one year as compared with baseline (paired t-test)	HV agency staff	Client	Clients who are enrolled in the program	NA	Collected by HV agency staff at baseline and annually Data submitted quarterly to the state
32) Health insurance status	Proportion of families that lack health insurance	% of clients and children enrolled who lack health insurance that have received a referral Numerator: Number of clients and children who lack health insurance that have received a referral Denominator: Number of clients and children enrolled who lack health insurance	Administrative	NA	NA	An increase in the % of clients and children who lack health insurance that have received a referral between baseline and years 3 and 5	HV agency staff	Client	Clients & children enrolled in the program	NA	Collected by HV agency staff at enrollment and at least annually Data submitted quarterly to the state
Benchmark 6: Coordination and Referrals for Other Community Resources and Supports											
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability/ Validity (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)	
33) Number of families identified for necessary services	Proportion of families with service needs that are met by community resources	% of clients and children who receive a comprehensive assessment of their service needs Numerator: Number of clients and children who receive a comprehensive assessment of their service needs during the reporting year	Administrative	NA	An increase in the % of clients and children who receive a comprehensive assessment of their service needs between baseline and	HV agency staff	Client	Clients & children enrolled in the program	NA	Completed by HV agency staff at enrollment and at least annually Data submitted quarterly to the state	

BUDGET INFORMATION - Non- Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non- Federal (f)	Total (g)
1. ACA FY2011 Home Visiting Formula grant	93.505	\$	\$	\$ 3,013,935	\$	\$ 3,013,935
2.		\$	\$	\$	\$	\$
3.		\$	\$	\$	\$	\$ 0.00
4.		\$	\$	\$	\$	\$ 0.00
5. TOTALS		\$ 0.00	\$ 0.00	\$ 3,013,935	\$ 0.00	\$ 3,013,935
SECTION B - BUDGET CATEGORIES						
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)	
	(1) Year 1	(2) Year 2	(3)	(4)		
a. Personnel	\$ 0	\$	\$	\$	\$ 0	
b. Fringe Benefits	\$ 0	\$	\$	\$	\$ 0	
c. Travel	\$ 3,000	\$	\$	\$	\$ 3,000	
d. Equipment	\$ 0	\$ 0	\$	\$	\$ 0	
e. Supplies	\$ 6,200	\$	\$	\$	\$ 6,200	
f. Contractual	\$ 2,866,906	\$	\$	\$	\$ 2,866,906	
g. Construction	\$ 0	\$ 0	\$	\$	\$ 0	
h. Other	\$ 137,829	\$	\$	\$	\$ 137,829	
i. Total Direct Charges (sum of 6a -6h)	\$ 3,013,935	\$	\$	\$ 0.00	\$ 3,013,935	
j. Indirect Charges	\$ 0	\$	\$ 0	\$	\$ 0	
k. TOTALS (sum of 6i and 6j)	\$ 3,013,935	\$	\$	\$ 0.00	\$ 3,013,935	
SECTION C - PROGRAM INCOME						
7. Program Income		\$	\$ 0	\$	\$	\$ 0

SECTION C - NON- FEDERAL RESOURCES

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

SECTION D - FORECASTED CASH NEEDS

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

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

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

SECTION F - OTHER BUDGET INFORMATION

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