2017

MICHIGAN HOME VISITING REPORT

HOW HOME VISITING SUPPORTS MICHIGAN FAMILIES

Prepared and submitted as required by Public Act 291 (PA 291) of 2012, Michigan's Voluntary Home Visiting Programs

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Home Visiting in Michigan

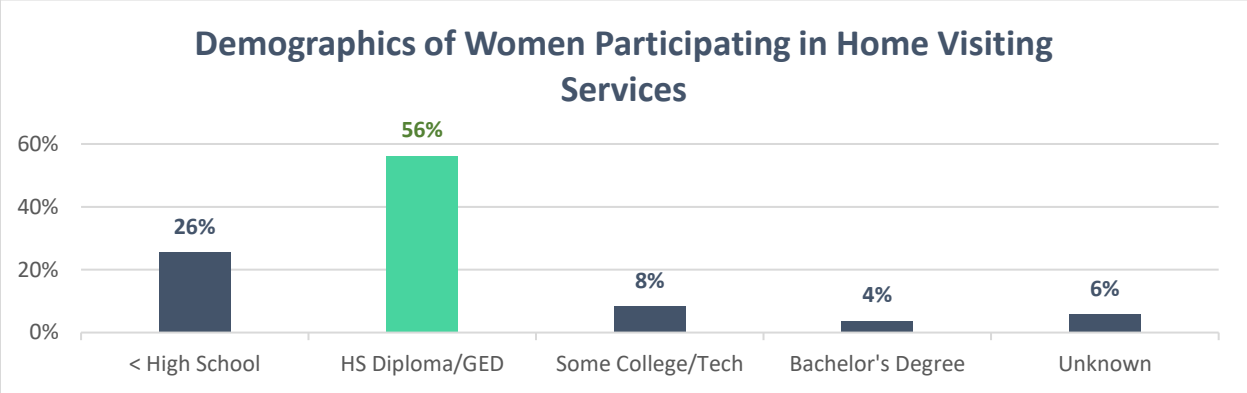
Home visiting programs work to equip parents with the tools needed to overcome challenges, providing services in a family's home. They nurture, coach, educate, offer encouragement, and refer families to services to achieve a shared goal: building a safe, healthy, and stimulating environment for their child.

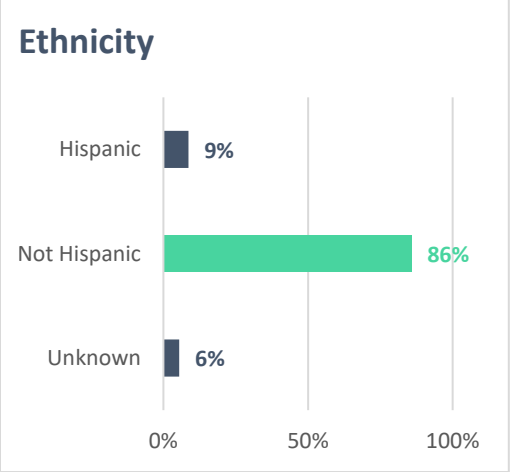
During pregnancy, home visitors encourage mothers to receive regular prenatal care, avoid risky behaviors, and retain healthy habits. Once the baby is born, home visitors coach parents on positive parenting practices, support breastfeeding, help parents prepare for well-child visits, teach parents about child development and nutrition, conduct developmental screenings, support older children when a new baby arrives, and encourage parents to attend to their own health care needs. Home visitors also help families connect with community-based resources and state and federal programs. This could include applying for health insurance, accessing early intervention services, finding child care, connecting with community resources for stable housing, or finding a job.

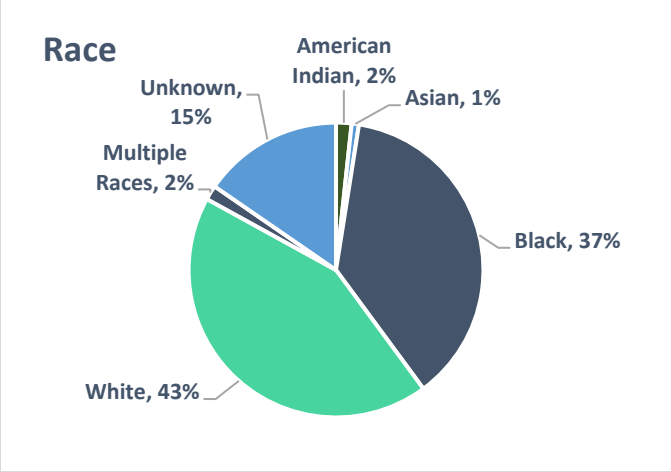
Home visitors' roles extend beyond the parent-child relationships. Topics such as continuing family education, managing family finances, understanding domestic violence, and dealing with trauma are often discussed. Nurses, social workers, and other trained professionals help families build the knowledge and skills they need to maintain a healthy home environment for their child. In other words, home visiting programs support and empower parents to be their child's first, and most important, teacher.

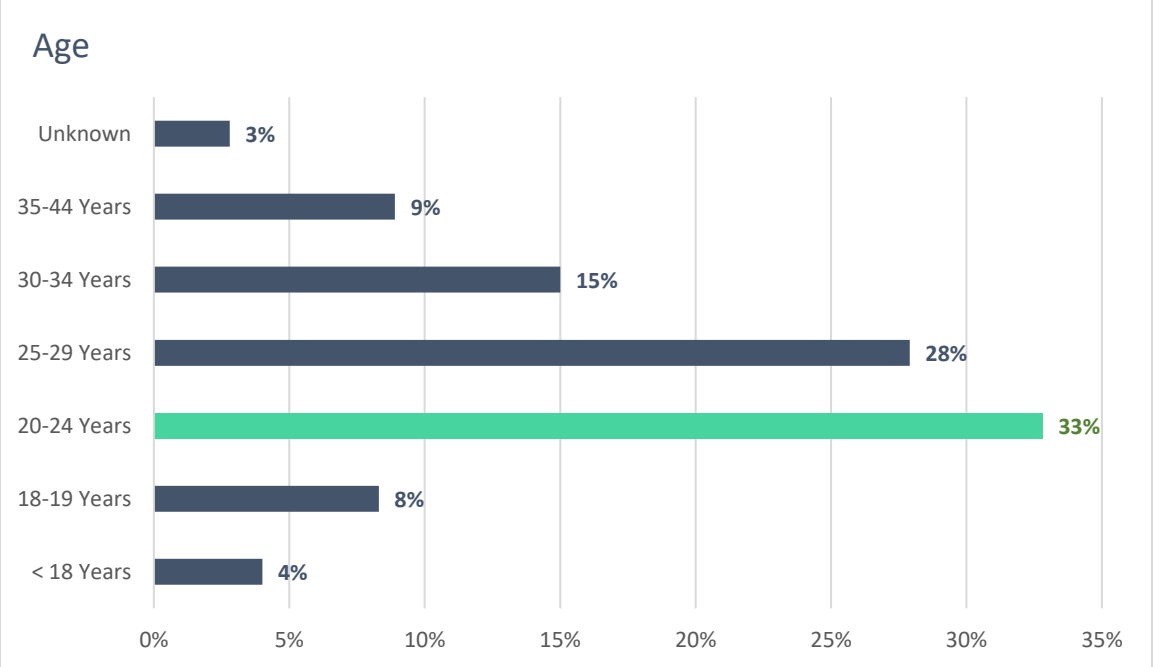
These voluntary, evidence-based, prevention-focused programs match their supports to specific family and community needs. Across the state, Michigan's Home Visiting Initiative includes seven different home visiting models each tailored to a specific set of needs. The goal of this continuum is to meet families where they are and offer the type and intensity of services that are most likely to improve outcomes for families and young children. The specific models available in each community vary. Appendix II – *Where are Home Visiting Services Available*, includes a map of home visiting programs available by county in Michigan. Additional maps that depict state-funded, accredited home visiting models and the counties served can be found at: www.michigan.gov/homevisiting.

Who are We Serving?









Home Visiting by the Numbers		
	**Total Home Visits**	**245,584**
	**Total Women Served**	**24,119**
	**Total Children Served**	**23,029**

Home Visiting Works

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

Improved Family Health

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

Improved School Readiness

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

Improved Self-sufficiency for Families

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

Michigan Home Visiting Models[1]

Model	Acronym	Evidence Level[2]	Population Served	Outcomes
Early Head Start—Home Visiting	EHS-HV	Evidence-based	Low-income parents and their children from prenatal through age three	Promotes child development and school readiness, reductions in child maltreatment, positive parenting practices, family self-sufficiency, and service referrals.
Family Spirit	FS	Evidence-based	Native American families and their children from prenatal through age three	Promotes maternal health, child development and school readiness, and positive parenting practices.
Healthy Families America®	HFA	Evidence-based	Families at risk for adverse childhood experiences, including child maltreatment. Services start prenatally or within three months after the baby's birth and are available until age five.	Promotes child health, maternal health, child development and school readiness, reductions in child maltreatment, reductions in juvenile delinquency, positive parenting practices, family self-sufficiency, and service referrals.
Infant Mental Health	IMH	Promising, currently engaged in a rigorous evaluation to establish the model's evidence base	Families in which the parents' condition and life circumstances, or the condition of the infant, threaten parent-infant attachment. Families generally begin services after birth, although services may begin during pregnancy, and continue until their child is age three.	Promotes parent-infant attachment and positive social, emotional, behavioral, and cognitive development of the infant/toddler.
Maternal Infant Health Program	MIHP	Evidence-based	Pregnant women and infants up to 12 months of age (infants who are substance exposed may be served up to 18 months of age).	Promotes healthy pregnancies, positive birth outcomes, and healthy infant growth and development via a standardized, system-wide process of case management.
Nurse-Family Partnership	NFP	Evidence-based	First-time mothers (enrolled before the 28th week of pregnancy) and their children to age two	Promotes child health, maternal health, child development and school readiness, reductions in child maltreatment, reductions in juvenile delinquency, positive parenting practices, and family self-sufficiency.
Parents as Teachers®	PAT	Evidence-based	Parents and their children from prenatal through age five	Promotes child development and school readiness, reductions in child maltreatment, positive parenting practices, and family self-sufficiency.

1. Appendix IV, Home Visiting Models provides a comprehensive description of each model.

2 As defined by PA 291 of 2012

Michigan's Investment in Children and Families

Michigan invests state, federal, and private funds to support home visiting. Roughly 36 percent of Michigan's total investment is made up of state resources, 64 percent is federal resources, and less than 1 percent consists of private investment. Each of these investments include specific program requirements and accountability metrics. Michigan deploys each funding stream strategically to achieve improved outcomes for children and families and to invest public resources effectively and efficiently Additional home visiting programs operate with direct federal or local funds and are not reflected in this report. (Appendix V – 2017 Home Visiting Investment by Model and Source).

General Fund

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

State School Aid

The legislature appropriates funds to the Michigan Department of Education (MDE) that may be used for home visiting through the State School Aid Act, Sections 32p and 32p4. Local programs funded through the State School Aid Act include Parents as Teachers, Healthy Families America, Early Head Start—Home Visiting, and Nurse-Family Partnership.

Federal Funding

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

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

Child Abuse Prevention and Treatment Act (CAPTA)

Michigan receives Child Abuse Prevention and Treatment Act funds to develop, operate, expand and enhance community-based, prevention-focused programs and activities designed to strengthen and support families and to prevent abuse and neglect. Title II funds, called *Community-based Child Abuse*

Prevention Grants (CBCAP), can be used for home visiting. The Children's Trust Fund (CTF) is the entity designated to apply for, receive, and use these funds in Michigan.

Medicaid

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

Private Funding

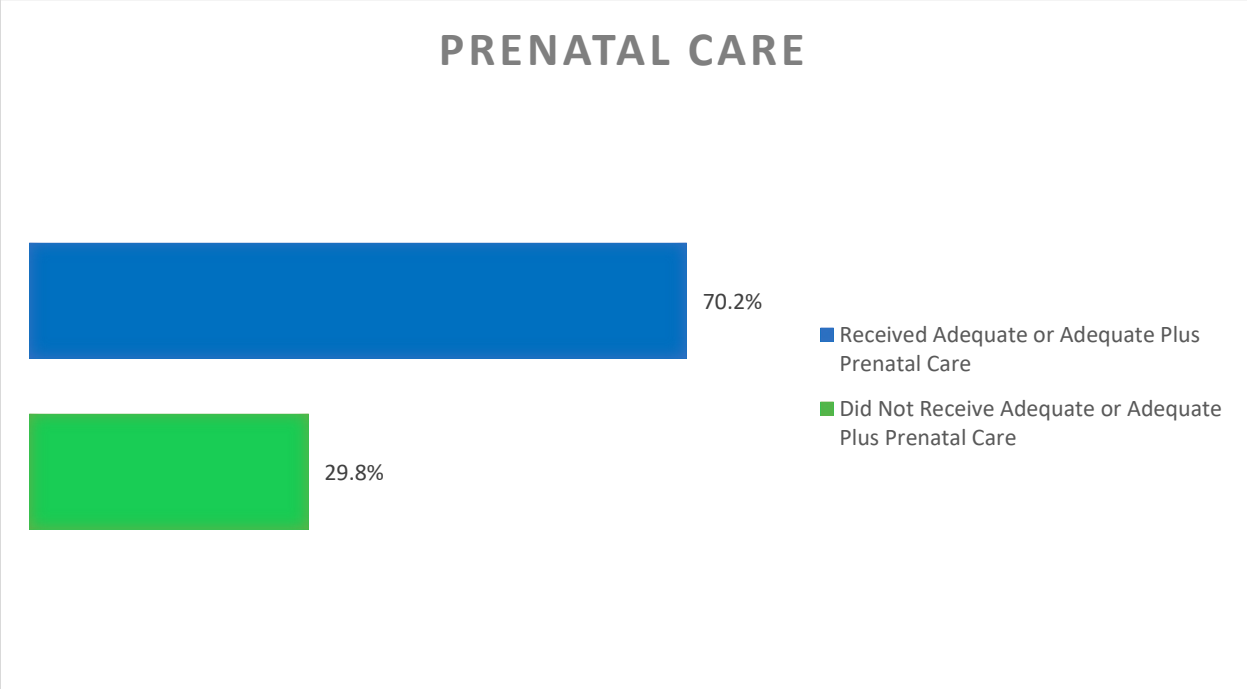
Children's Trust Fund (CTF)

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

Outcomes

Access to Prenatal Care

Prenatal care can reduce the risk of infant health problems such as low birth weight, and cognitive impairments. Home visitors encourage women to begin prenatal care early (ideally in the first or second month of pregnancy) and continue prenatal visits regularly until delivery.



Calculation

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

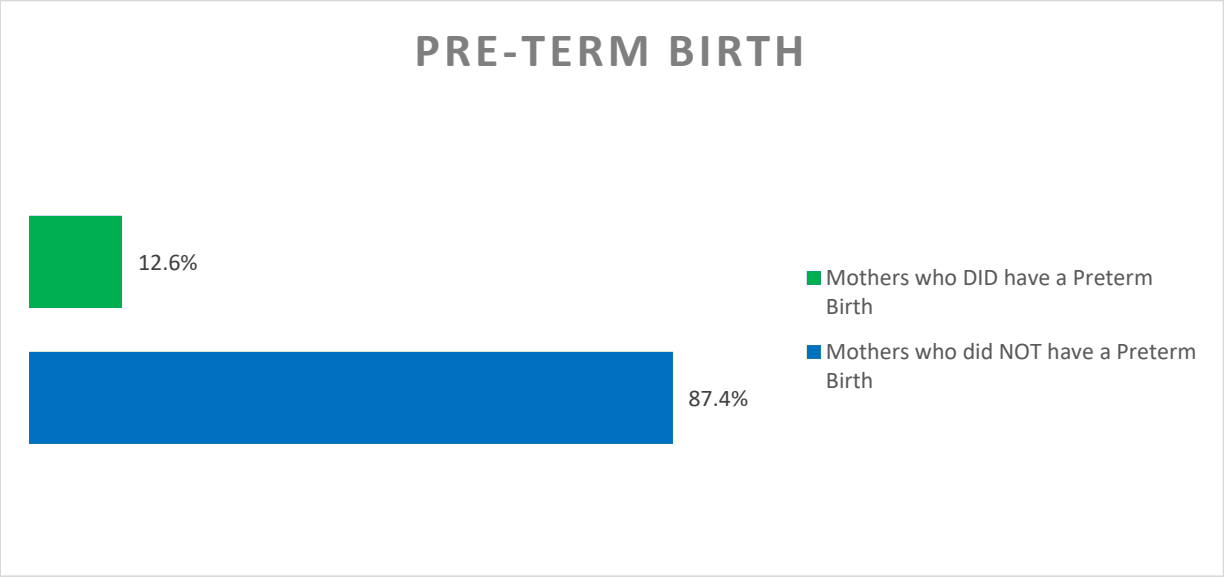
Data Source
Vital Records

Models Reporting:
FS, MIHP, EHS-HV, NFP, HFA

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

Preterm Birth

Babies born before 37 weeks of gestation miss out on important periods of development, which could lead to short- and long-term health challenges and an increased risk of infant death. For example, premature babies can experience breathing and feeding difficulties, and are at greater risk for vision problems and hearing loss. Home visitors work with women on healthy eating and getting exercise, avoiding exposure to tobacco or other drugs, and reducing stress. Nationally, nine in ten infants are considered full term, meaning they are born after 37 weeks' gestation.



Calculation

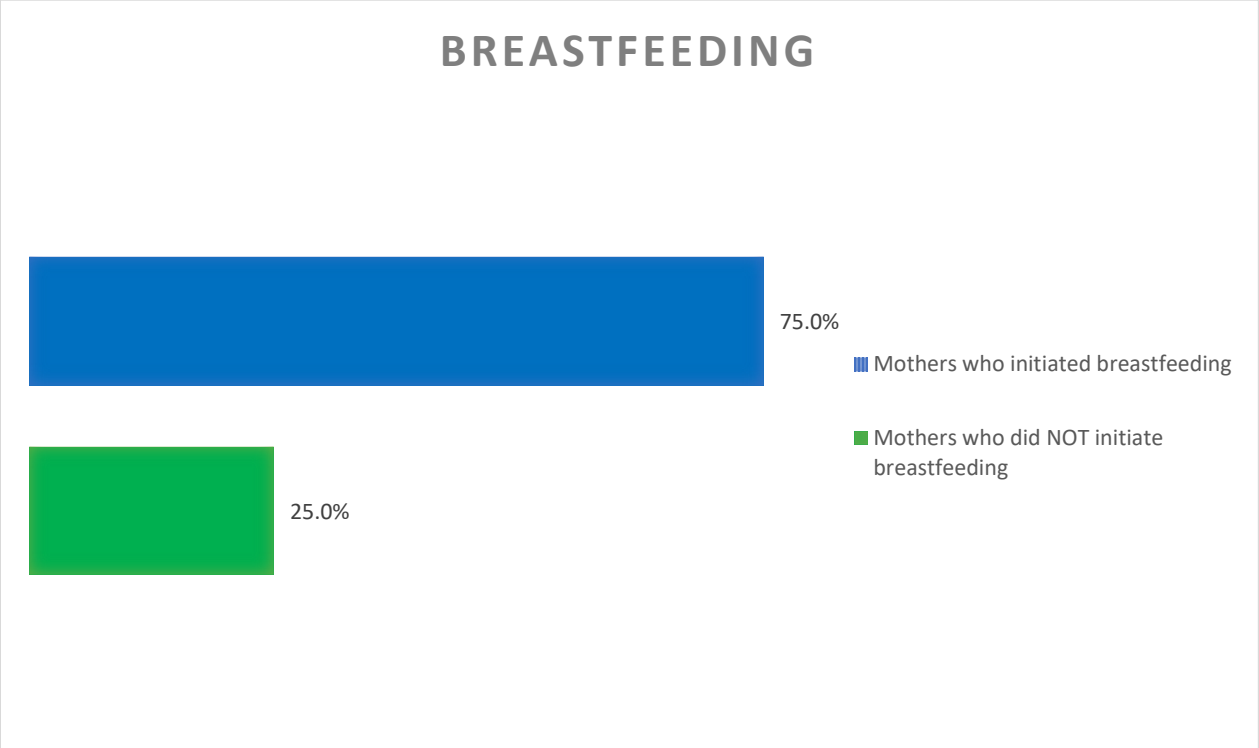
Percent of women enrolled in home visiting services during pregnancy who have a preterm birth (<37 weeks gestation) = Number of women enrolled in home visiting services during pregnancy who have a preterm birth (<37 weeks gestation) / Number of women enrolled in home visiting during pregnancy

Data Source
Vital Records

Models Reporting
FS, MIHP, EHS-HV, NFP, HFA

Breastfeeding

Evidence shows that breastfeeding provides strong support for healthy infant development and protects infants from common childhood illnesses. In addition, children experience long-term benefits, such as a reduced risk for obesity and type-2 diabetes. Home visitors provide education and promote breastfeeding to women before and after delivery. After delivery, home visitors support mothers through regular discussions about breastfeeding and referrals for additional lactation support, when needed.



Calculation

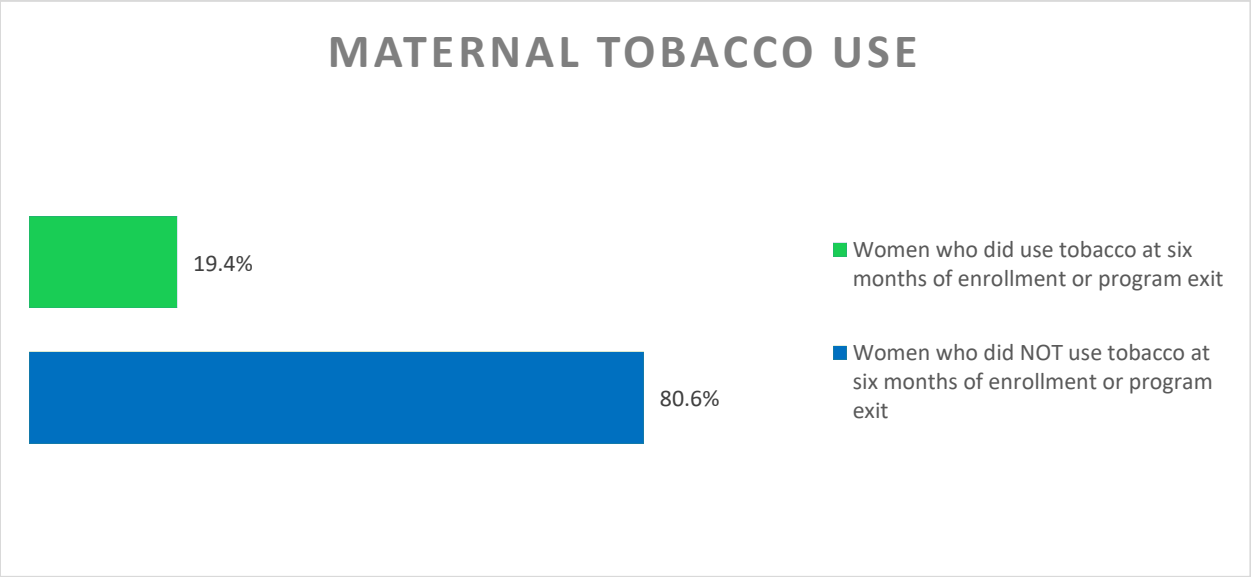
Percent of women enrolled in home visiting services during pregnancy who initiate breastfeeding = Percent of women enrolled in home visiting services during pregnancy who initiate breastfeeding / Number of women enrolled in home visiting during pregnancy

Data Source
Vital Records

Models Reporting
FS, MIHP, EHS-HV, NFP, HFA

Maternal Tobacco Use

Smoking during pregnancy remains one of the most common preventable causes of infant disease, illness, injury, and death. Maternal cigarette smoking during pregnancy increases the risk for pregnancy complications, including serious bleeding and premature birth, as well as increased risk for sudden unexplained death after a baby is born. Home visitors encourage women to quit and/or avoid smoking during and after pregnancy and connect women with programs and services to help them quit smoking.



Calculation

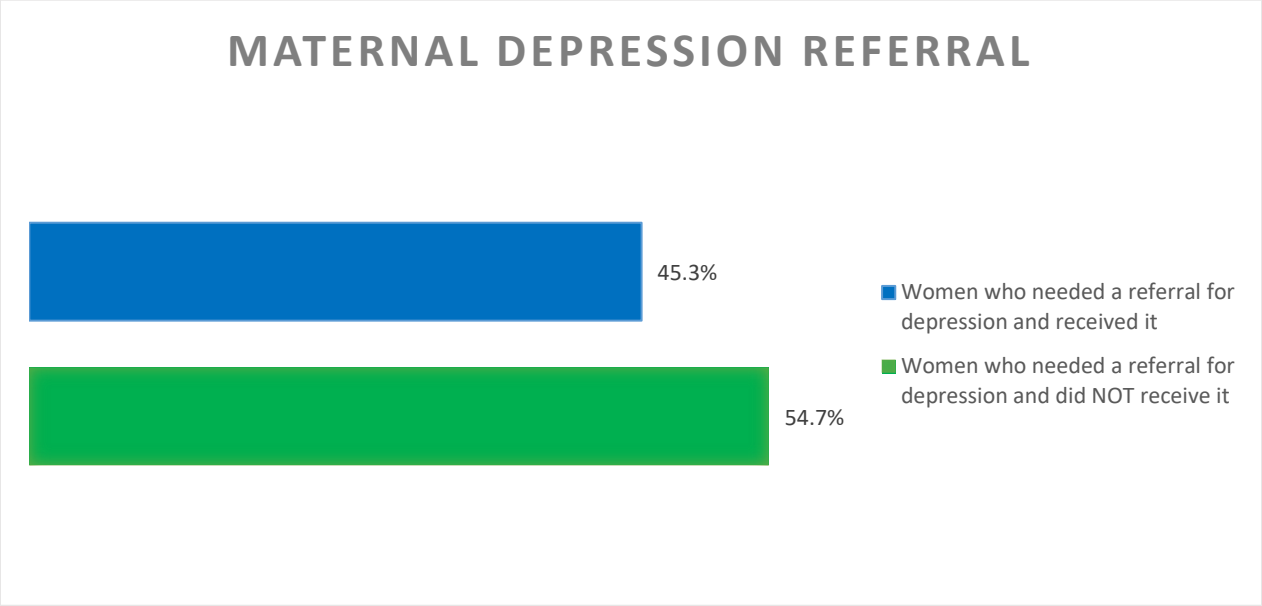
Percent of women enrolled in home visiting services for at least six months who were using tobacco or smoking at six months or upon program exit = Percent of women enrolled in home visiting services for at least six months who were using tobacco or smoking at six months or upon program exit / Number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

Data Source
Program Data

Models Reporting
MIHP, EHS-HV, NFP, HFA, PAT

Maternal Depression Referral

Untreated depression during pregnancy can lead to premature birth, low birth weight of the baby, or other issues depending on the severity of the depression. Children whose mothers are depressed are at increased risk for difficulties with attachment and other long-term effects, including difficulties in school. Home visitors work with women to identify and screen for signs of depression, and refer women to appropriate supports, and also help women overcome challenges accessing services.



Calculation

Percent of women enrolled in home visiting services with need for follow-up depression evaluation and intervention who received referral for these services

=

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

/

Number of women participating in home visiting services who received maternal depression screening with a validated tool whose results indicated need for a referral

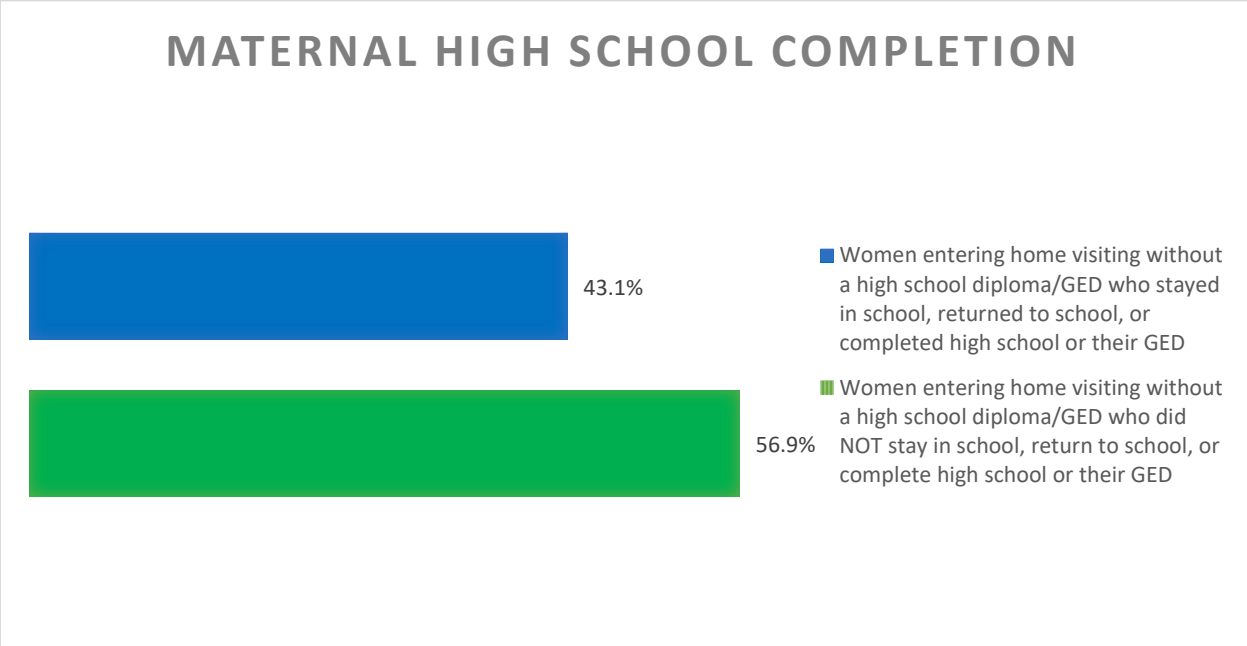
Data Source
Program Data

Models Reporting
FS, MIHP, EHS-HV, NFP, HFA, PAT

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

Maternal High School Completion

Young mothers can face significant barriers to completing their education, including access to quality child care, stable housing, working during school hours, social stigma, and wanting time with their children. Earning a high school diploma increases a mother's ability to be economically self-sufficient by increasing access to better paying jobs and pursuing higher education. Home visitors work with women to overcome the challenges faced to aid in school completion. A goal for home visiting programs is to see an increase in the percentage of women enrolled in or completing a high school diploma or the equivalent.



Calculation

Percent of women entering home visiting without a high school diploma/GED who were still enrolled in or completed high school/GED by the end of FY 2016 =

Percent of women who enter the program without a high school diploma or GED certificate who are either still enrolled in school or a GED program or who have successfully completed high school or received a GED certificate

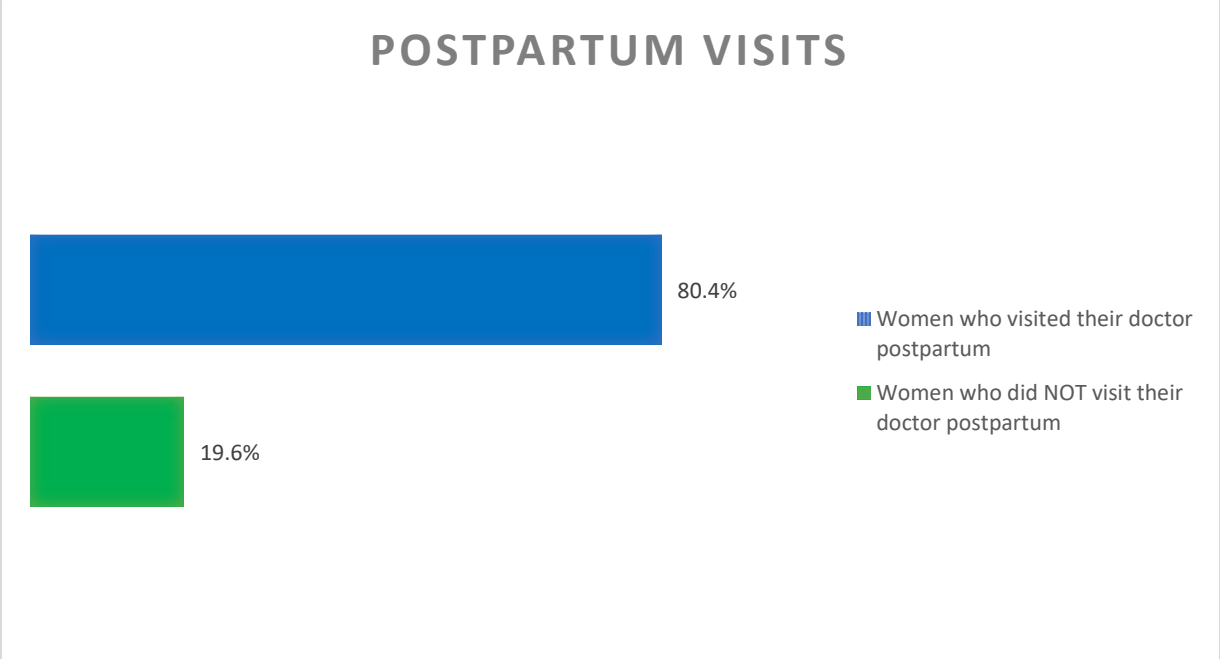
Number of women who enter a home visiting program without high school or GED completion

Data Source
Program Data

Models Reporting
EHS-HV, NFP, HFA, PAT

Postpartum Visits

In the weeks after delivery, mothers can experience significant physical, social, and psychological changes. Postpartum visits are a powerful tool to assess a woman's physical and mental well-being after delivery, follow up on physical complications due to delivery, provide breastfeeding support, answer questions about infant health and safety, evaluate mental well-being, and discuss planning any future pregnancies. Home visitors encourage women to follow up with their doctor and work to increase the number of women who receive postpartum care. Home visitors can also help women identify and address barriers to attending a postpartum visit.



Calculation

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

=

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

Data Source
Program Data, Managed Care Encounter/Fee for Service Claim data

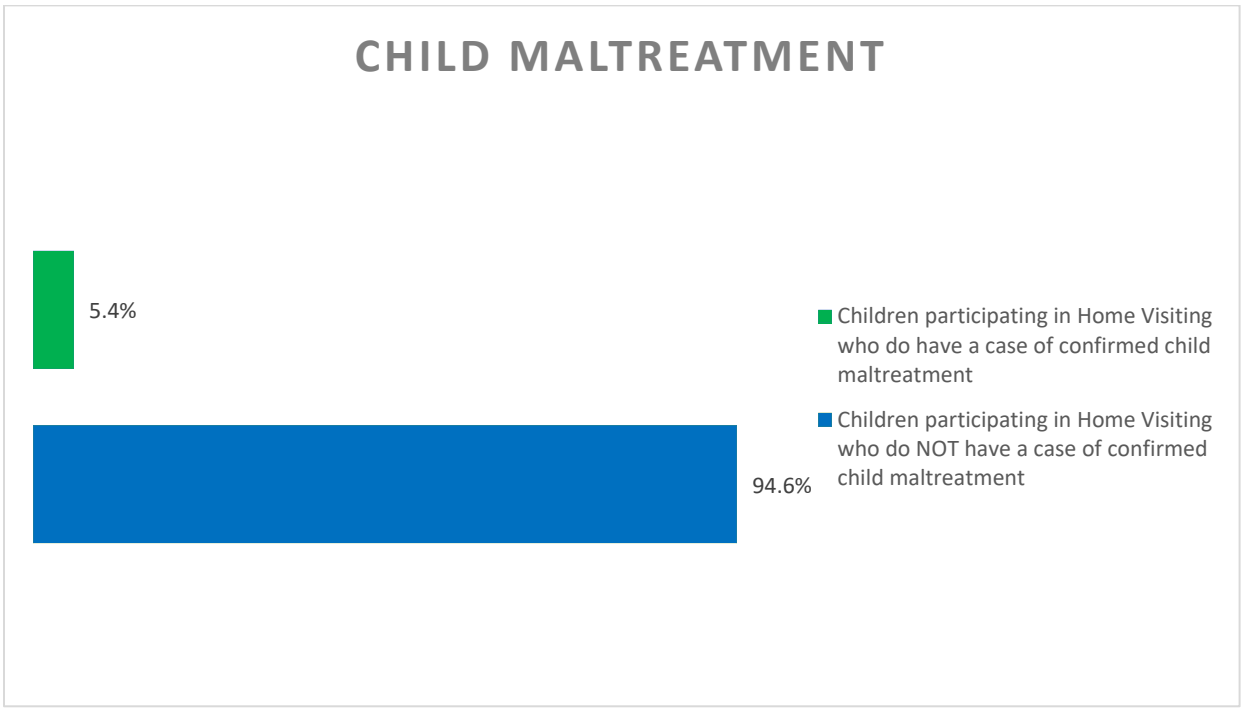
Models Reporting
MIHP, EHS-HV, NFP, HFA, PAT

Well-Child Visits

The guidelines Michigan uses for computing the percentage of children who are up-to-date on their well-child visits changed in 2017. Rather than considering children 'up-to-date' if they received their most recent well child visit, the guidelines shifted to considering children 'up-to-date' only if they received their most recent well-child visit within the window required by the American Academy of Pediatrics. This has required a shift for home visitors in the type of data they collect and it has required changes in how data are pulled from the Medicaid Data Warehouse. This indicator will not be reported this fiscal year in order to ensure the measure is correctly calculated. We do anticipate that this more stringent definition, which emphasizes *on time* well-child visits, will result in a lower percentage for this measure when compared to what was reported in previous years.

Child Maltreatment

Child maltreatment is the abuse and neglect of a child under the age of 18 by a parent, caregiver, or another individual in a custodial role. Child maltreatment includes physical, sexual, and emotional abuse, as well as neglect. Home visitors work with families to promote positive parenting practices and prevent child maltreatment. They also work closely with mothers and caregivers to reduce family stress and increase social supports. Both strategies impact the home environment and can assist in the prevention of child abuse or neglect.



Calculation

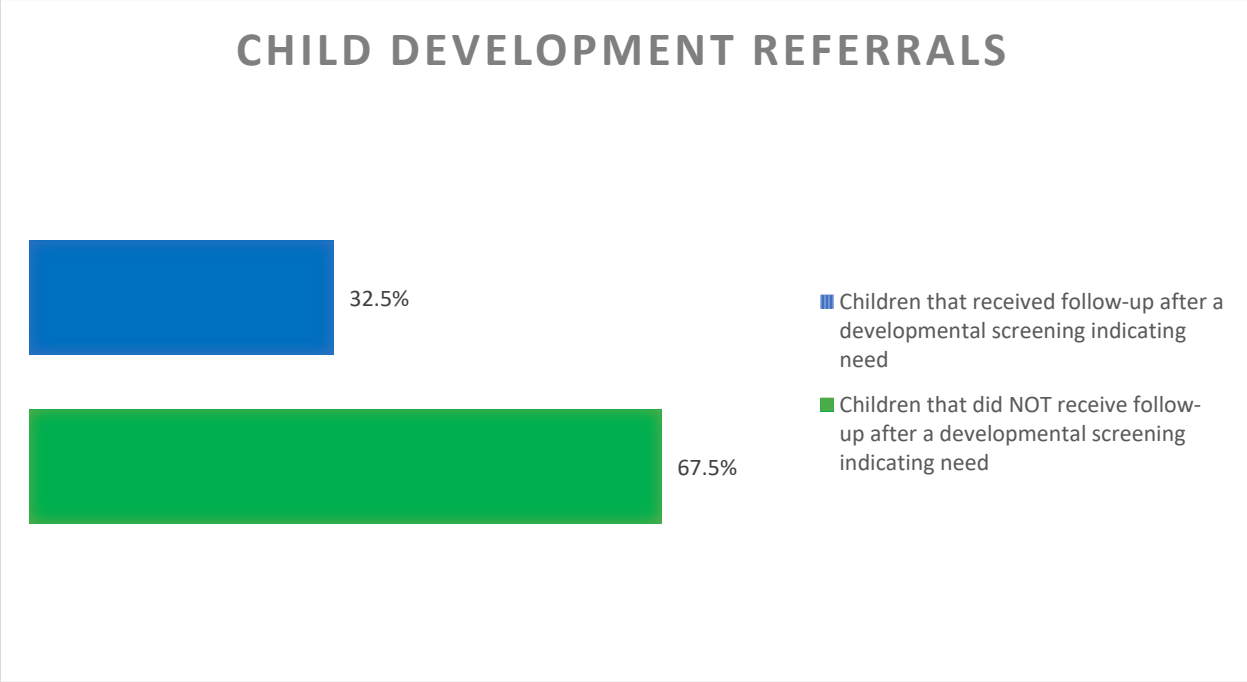
Percent of children in families enrolled in home visiting for at least six months with confirmed child maltreatment = Number of children in families who participated in home visiting for at least six months with confirmed child maltreatment / Number of children in families who participated in home visiting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

Data Source
Child Protective Services

Models Reporting
MIHP, EHS-HV, NFP, HFA

Child Development Referrals

Developmental screening provides the best opportunity to identify children with potential delays early and connect them to intervention services. Home visitors complete the Ages and Stages Questionnaires, Third Edition® (ASQ-3TM) and the Ages and Stages Questionnaires®: Social-Emotional, Second Edition (ASQ: SE-2TM) for every child they serve.



Calculation

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

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

Data Source	**Models Reporting**
Program Data	FS, MIHP, EHS-HV, NFP, HFA, PAT

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

Appendices

- **Appendix I -** Acronyms
- **Appendix II -** Participant Demographic Information
- **Appendix III -** Where are State-funded Home Visiting Programs Available? Program Offices and Number of Models Per County
- **Appendix IV -** Home Visiting Models: Evidence-Based and Promising Models
- **Appendix V -** 2017 Home Visiting Investment by Model and Source
- **Appendix VI -** Home Visiting Indicators – Year-by-Year Comparison

Appendix I:
Acronyms

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

Appendix II:
Participant Demographic Information

Service Statistics	
Total Home Visits	**245,584**
Total Families Served	**34,009**
Total Children Served	**23,029**
Total Women Served	**24,119**
Pregnant Women	13,579

Note: The number of women served is lower than the number of families served because the definition of "family" differs by program. In some cases, it is unknown if there is a mother in the family, and separate demographic data is not available.
Note: The majority of families who received EBHV in 2017 (82%) were served by the Maternal Infant Health Program.

Household Demographic Characteristics		
	#	%
Federal Poverty Level	**21,758**	**100.0**
<= 50%	13,120	60.3
51–100%	3,557	16.3
101–133%	1,782	8.2
134–250%	974	4.5
251% +	322	1.5
Unknown	2,003	9.2

Child Demographic Characteristics		
	#	%
Insurance:	**26,363**	**100.0**
None	193	0.7
Medicaid	23,855	90.5
TRICARE	5	0.0
Private/Other	415	1.6
Unknown	1,895	7.2
Race:	**26,363**	**100.0**
American Indian/AN	257	1.0
Asian	207	0.8
Black	8,351	31.7
Native Hawaiian/PI	13	0.0
White	11,500	43.6
Multiple Races	938	3.6
Unknown	5,097	19.3
Age:	**26,363**	**100.0**
< 1 Year	16,677	63.3
1–2 Years	7,161	27.2
3–5 Years	1,650	6.3
Unknown	875	3.3
Gender:	**26,363**	**100.0**
Female	12,264	46.5
Male	13,259	50.3
Unknown	843	3.2

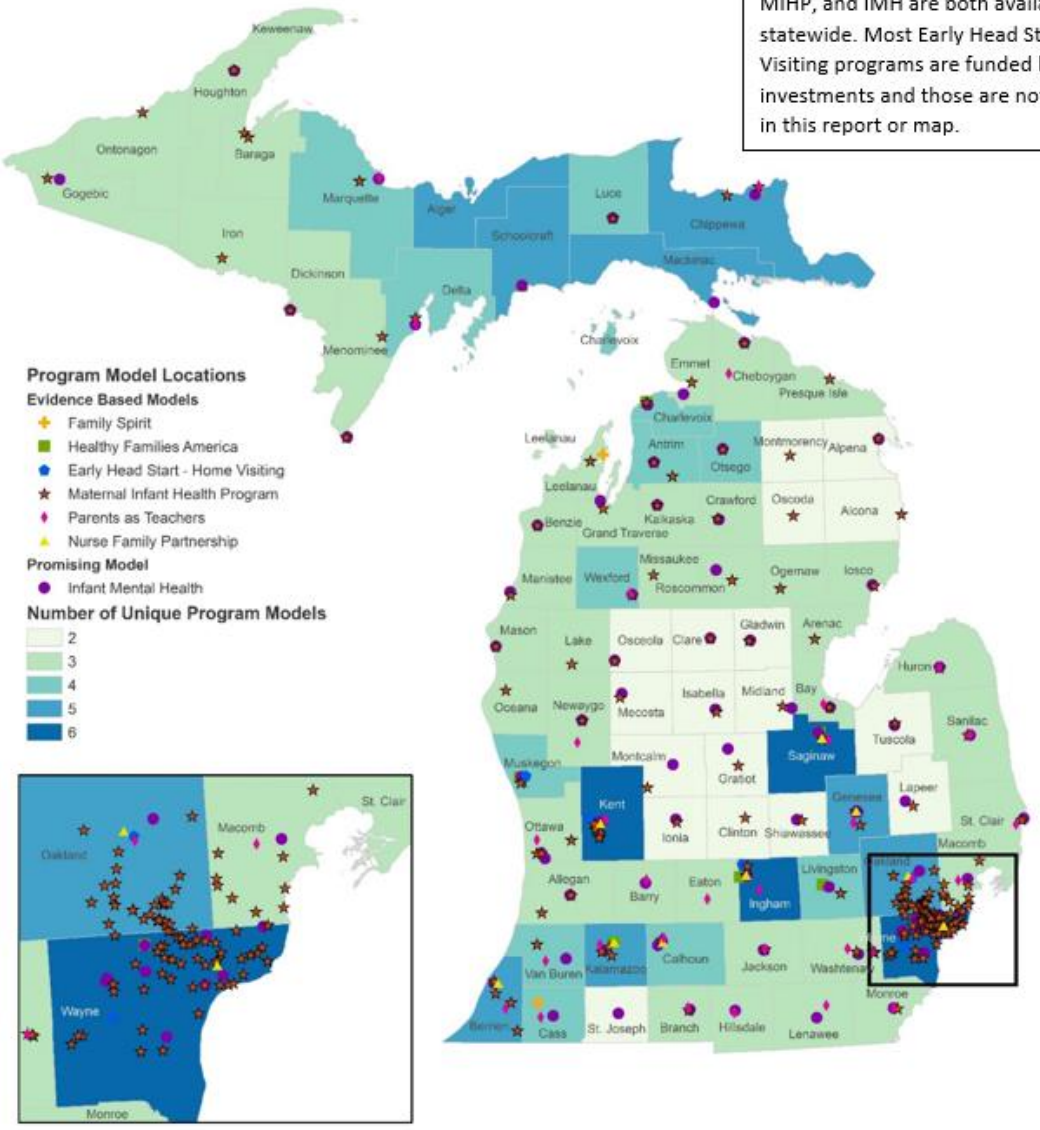
Maternal Demographic Characteristics		
	#	%
Insurance:	**21,397**	**100.0**
None	137	0.6
Medicaid	18,990	88.8
TRICARE	4	0.0
Private/Other	508	2.4
Unknown	1,758	8.2
Ethnicity:	**21,397**	**100.0**
Hispanic	1,852	8.7
Not Hispanic	18,364	85.8
Unknown	1,181	5.5
Race:	**21,397**	**100.0**
American Indian/AN	374	1.7
Asian	169	0.8
Black	7,995	37.4
Native Hawaiian/PI	17	0.1
White	9,220	43.1
Multiple Races	335	1.6
Unknown	3,287	15.4
Marital Status:	**21,397**	**100.0**
Married	5,097	23.8
Widowed	44	0.2
Separated	234	1.1
Divorced	490	2.3
Never Married	14,376	67.2
Unknown	1,156	5.4
Education:	**21,397**	**100.0**
< High School	5,460	25.5
HS Diploma/GED	12,050	56.3
Some College/Tech	1,780	8.3
Bachelor's Degree +	809	3.8
Other	39	0.2
Unknown	1,259	5.9
Age:	**21,397**	**100.0**
< 18 Years	849	4.0
18–19 Years	1,779	8.3
20–24 Years	7,023	32.8
25–29 Years	5,978	27.9
30–34 Years	3,215	15.0
35–44 Years	1,904	8.9
45 + Years	60	0.3
Unknown	589	2.8
Primary Language:	**21,397**	**100.0**
English	19,031	91.6
Spanish	595	2.9
Arabic	489	2.4
Other	152	0.7
Unknown	518	2.5

Appendix III:

Where are State-funded Home Visiting Programs Available?

Program Offices and Number of Models per County

Every county in Michigan offers at least two different home visiting models; MIHP, and IMH are both available statewide. Most Early Head Start Home Visiting programs are funded by federal investments and those are not included in this report or map.



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

Early Head Start—Home Visiting

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

Population Served

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

Target Outcomes

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

Model Intensity

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

Family Spirit

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

Population Served

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

Target Outcomes

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

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

Model Intensity

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

Healthy Families America

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

Population Served

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

Target Outcomes

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

Model Intensity

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

Infant Mental Health

IMH is a promising practice developed and implemented by MDHHS. The program provides support to families that are at increased risk for parent-infant attachment challenges, which affect social, emotional, behavioral, and cognitive development of infants/toddlers. Services are provided locally by community

mental health agencies. The model is currently participating in rigorous evaluations to achieve an evidence-based practice status.

Population Served

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

Target Outcomes

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

Model Intensity

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

Maternal Infant Health Program (MIHP)

MIHP is a population-based management model, meaning that the health of the entire population is addressed in addition to specific participants. Services supplement regular prenatal and infant care, as well as assist healthcare providers in supporting the families' health and well-being. Case Management and Care Coordination services are provided by a Registered Nurse and Licensed Social Worker.

Population Served

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

Target Outcomes

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

Model Intensity

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

Nurse-Family Partnership

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

Population Served

- First-time, low-income mothers and their children
- Enrollment occurs no later than the 28th week of pregnancy
- Services continue until the child is two years old

Target Outcomes

- Improve prenatal health and outcomes
- Improve child health and development
- Improve families' economic self-sufficiency
- Improve school readiness
- Promote positive parenting
- Promote self-sufficiency
- Decrease child injuries and emergency room use

Model Intensity

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

Parents as Teachers

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

Population Served

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

Target Outcomes

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

Model Intensity

Services vary by program, but families with one or no high-needs characteristics generally receive at least 12 home visits annually. Families with two or more high-needs characteristics receive 24 home visits annually. Home visits last approximately one hour. Families are also offered at least 12 group meetings a year and providers screen children for developmental, health, hearing, and vision concerns annually.

Appendix V
2017 Home Visiting Investment by Model and Source

Home Visiting Model	Funding Source	Federal Funding	State Funding	Private Funding
Early Head Start (EHS-HV) (Note: The Administration for Children and Families Federal funding that supports most EHS-HV programs are distributed directly to the grantees and do not flow through the state budget. Those funds are not included in this total).	MIECHV	$657,693		
	State School Aid Act, Section 32p Grant Funds		$224,024	
	State School Aid Act, Section 32p (4) Grant Funds		$239,615	
Family Spirit (The Administration for Children and Families Federal funding that supports many tribal programs are distributed directly to the Inter-Tribal Council and do not flow through the state budget. Those funds are not included in this total).	State General Fund		$200,000	
Healthy Families America (HFA)	MIECHV	$2,309,383		
	CBCAP	$25,935		
	CTF (License plates, donations, tax check off, etc.)			$99,751
	State General Fund			
	State School Aid Act, Section 32p Grant Funds		$51,304	
	State School Aid Act, Section 32p (4) Grant Funds		$271,578	
Infant Mental Health (IMH)	Medicaid	$4,777,664		
	State General Fund		$2,555,666	
Maternal Infant Health Program (MIHP)	Medicaid	$12,393,862	$5,907,489	
Nurse Family Partnership (NFP)	MIECHV	$1,230,722		
	Medicaid	$1,994,754		
	State General Fund		$2,185,999	
	State School Aid Act, Section 32p Grant Funds		$11,023	

Home Visiting Model	Funding Source	Federal Funding	State Funding	Private Funding
	State School Aid Act, Section 32p (4) Grant Funds		$121,707	
Parents as Teachers (PAT)	State School Aid Act, Section 32p Grant Funds		$2,529,701	
	State School Aid Act, Section 32p (4) Grant Funds		$1,611,251	
	CBCAP	$53,866		
	CTF (License plates, donations, tax check off, etc.)			$207,179
	State General Fund		$138,708	
All Models = $39,798,874		**$23,443,879**	**$16,048,065**	**$306,930**

Appendix VI

Home Visiting Indicators – Year-by-Year Comparison

Home Visiting Indicators Year-by-Year Comparison			
	2015	**2016**	**2017**
Prenatal Care	66. 1%	69. 6%	70. 2%
Preterm Birth	10. 7%	12. 3%	12. 6%
Breastfeeding	69. 3%	74.0%	75.0%
Tobacco Use	17. 7%	21. 6%	19. 4%
Maternal Depression	44. 3%	39. 7%	45. 3%
High School Completion	28.0%	27. 7%	43. 1%
Postpartum Visits	59. 4%	65%	80. 4%
Well-child Visits	98. 3%	98%	N/A (please see p. 16 for comments related to this measure)
Child Maltreatment	6. 8%	5. 8%	5. 4%
Developmental Screening Referrals	30. 7%	28%	32. 5%