MICHIGAN HOME VISITING NEEDS ASSESSMENT 2020

REPORT PREPARED BY THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES EARLY CHILDHOOD HOME VISITING UNIT AND THE MICHIGAN PUBLIC HEALTH INSTITUTE CENTER FOR HEALTHY COMMUNITIES

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Introduction

Michigan completed a statewide home visiting needs assessment as required as a Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program under the Social Security Act, Title V, as amended in 2018. Planning for the needs assessment began in October 2018 and the needs assessment was conducted between October 1, 2019 and September 30, 2020, in order to meet the statutorily defined October 1, 2020 deadline for submission to the Health Resources and Services Administration (HRSA). The needs assessment was led by the Michigan Department of Health and Human Services (MDHHS) Early Childhood Home Visiting Unit (ECHVU) within the Public Health Administration.

Purpose

Michigan's home visiting needs assessment was designed to achieve multiple goals as defined by both statute and Michigan's home visiting system. MIECHV awardees were required to complete a needs assessment that:

- Identifies communities with concentration of risk factors;
- Identifies the quality and capacity of existing home visiting services; and
- Discusses capacity to provide substance use treatment and counseling for pregnant women and caregivers of young children.

MIECHV grantees were also required to coordinate with and consider other needs assessments within their states, such as the Title V needs assessment. In addition to pursuing these goals, Michigan's home visiting partners designed the assessment process to:

- Explore the conditions facing families and children across the state;
- Identify patterns in outcomes for children and families across domains impacted by home visiting;
- Uncover the strengths and capacity of home visiting programs, as well as gaps in services;
- Center family voices and home visitor experiences in defining risk and need;
- Create a clear, equitable, and consistent picture of home visiting needs and capacity for every county in Michigan; and
- Inform decisions about targeting expansion of home visiting services.

Although the purpose of this needs assessment was to identify the degree to which communities that face multiple risk factors are well served by quality, evidence-based home visiting programs, it is critical to acknowledge and emphasize two points upfront and throughout this process. First, the risks faced by families are not of their own making. Concentrations of risk factors within specific geographic areas are the product of economic and social policies and practices that systematically disadvantage and oppress certain populations at the benefit other populations. When identifying at-risk communities, this process is not identifying communities where families or parents are 'risky,' but rather it is identifying communities that are suffering from the implications of racism, classism, and gender-based discrimination. Second, in addition to facing unjust and unfair risks to their health and wellbeing, the families living in the at-risk communities identified through this process have many strengths and great resilience. Raising children in a context that, by design, creates barriers and stressors at every turn takes courage, strength, and determination. Bringing home visiting to families in at-risk communities is a social justice strategy, helping to even out an uneven playing field and build on the resilience that already exists.

Process and Methods

The needs assessment followed the steps provided in HRSA's *Guide to Conducting the MIECHV Program Statewide Needs Assessment Update*. Additionally, it used *Michigan's Home Visiting Exploration and Planning Tool* to inform steps three through five. This section will be organized around HRSA's *Guide*, and the Exploration and Planning process will be described as it fits into that organizational structure. For more detail about the Exploration and Planning process, see Appendix A.

Step 1: Assemble Your Team

The MDHHS ECHVU began by engaging the Michigan Public Health Institute (MPHI) to facilitate the process and the Maternal Child Health Epidemiology Section to lead population level data analysis. This Core Team was co-led by the Manager of the HVU who is responsible for the MIECHV grant, and the Home Visiting *Early On*® consultant, who serves as the bridge between home visiting within MDHHS and the larger early childhood system. It also included the manager of the MCH Epidemiology Section, who leads data analysis for the Title V needs assessment, and the home visiting epidemiologist. The staff from MPHI included individuals who supported both MIECHV performance measurement and quality improvement and the Title V needs assessment. Together, this team designed, lead, and implemented the needs assessment.

In addition to the Core Team, the MDHHS ECHVU convened a Stakeholder Group. The role of this group was to provide guidance on each stage of the needs assessment process, make connections to related needs assessment activities, ensure the needs assessment was locally informed and broadly useful, support linkages to data and data collection opportunities, interpret findings and draw conclusions, and identify uses for the needs assessment beyond MIECHV. The Stakeholder Group included representatives from the Michigan Department of Education (MDE), MDHHS ECHVU, the Children's Trust Fund, the Michigan Council for Maternal and Child Health, the Early Childhood Investment Corporation, Title V, the Maternal Infant Health Program (MIHP), the State Office for Healthy Families America (HFA) and Parents as Teachers (PAT), the Nurse Family Partnership (NFP) State Consultant, local representatives from NFP, PAT, and HFA programs, the MDHHS Substance Abuse administration, Child Welfare, the MDHHS Behavioral Health administration, *Early On*, Medicaid, and MDHHS Teen Pregnancy programming. The Core Team reached out to established groups of parent leaders who contribute to the development of the home visiting system, as well as parents served by local implementing agencies. Additionally, parents who are members of the state Home Visiting Advisory were invited to participate. Although typically parents are eager to join opportunities to support the system the Core Team was unable to identify parents who were available to join the Stakeholder Group.

The Stakeholder Group met monthly between January 2020 and September 2020. The Stakeholder Group provided guidance throughout the process and were especially instrumental in: identifying indicators to supplement HRSA's simplified method for the needs assessment; describing Michigan's system for providing substance use disorder (SUD) treatment and counselling services (T/C); informing the adaptation of the Exploration and Planning process and recruiting local partners; encouraging participation in statewide survey of home visiting programs; designing county level reporting; and making adaptations to the needs assessment in the context of the COVID-19 pandemic.

Beyond the Stakeholder Group, Michigan's team also included broader local home visiting system partners and parent leaders from across the state. The Core Team's original ambitious goal was to include home visiting system partners and parents from every one of Michigan's 83 counties in the local

part of the needs assessment, which was guided by the Exploration and Planning process. The timeline and capacity of local partners during this component of the needs assessment was significantly impacted by COVID-19; however, 24 agencies covering 77 of Michigan's 83 counties participated. These community partners recruited and supported the participation of families in each stage of the process. Additionally, 88.3% of counties represented included local partners in in substance abuse, 98.7% included Early Head Start/Head Start, 96.1% included the Health Department, 85.7% included the Department of Human Services, 98.7% included Community Mental Health, 85.7% included Education, 98.7% included their Great Start Collaborative and Parent Coalition, 58.4% included a representative from their medical community, 92.2% included a representative from their Regional Perinatal Quality Collaborative, and 93.5% included representatives from each home visiting program in each county.

Step 2: Create Your Workplan

The first task of the Core Team was to develop a workplan. The workplan aligned with the steps outlined in the *Guide to Conducting the MIECHV Program Statewide Needs Assessment Update,* and it built Michigan's guide to local home visiting needs assessment, the *Exploration and Planning Tool*, into the steps where appropriate. The needs assessment took place over the course of Fiscal Year 2020 (October 1, 2019 – September 30, 2020). This timeline was selected so that the home visiting needs assessment would follow Michigan's Title V Needs Assessment, which was completed in the fall of 2019. It also followed the completion of the birth to five needs assessment conducted under MDE's Preschool Development Grant. The home visiting needs assessment was understood as a deeper dive into the population served by home visiting programs in specific areas of the state, and the findings of these other assessments set the stage for that deeper exploration.

Under the original workplan, Michigan expected to complete Step 3 (identify at-risk communities) by February, setting the stage for completing the Exploration and Planning process in each of Michigan's 83 counties from March through May of 2020. The Exploration and Planning process was designed to deepen Michigan's findings under Step 3 and generate the data needed for Steps 4 (inventory the quality and capacity of home visiting providers) and 5 (assess community readiness). However, the COVID-19 pandemic reached Michigan in March of 2020, leading to a series of stay at home orders and a complete re-imagining of home visiting as a service delivery mechanism.

As a result, the Core Team worked with the Stakeholder Group to revise the timeline and the Exploration and Planning process. The Exploration and Planning tool was moved online into a survey platform called REDCap. Additionally, a series of supportive documents, such as data tables and data collection protocol were collected to guide each step in the process. Also, a series of webinars were produced to train local partners on the process. Finally, although the process was designed to include coaching, more structured coaching guidelines and tools were developed. These resources were created to simplify and support the process for local communities. Following multiple rounds of 'checking-in' with organizations that deliver home visiting services throughout May, the Core Team and Stakeholder Group decided to move forward with the Exploration and Planning Process under an abbreviated timeline. A request for proposals to participate in the process was released in June and community partners were selected in early July, leaving only two months to complete the process.

Although the workplan and timeline did not unfold as expected and the circumstances of the assessment were extraordinarily challenging, state and local partners across the system adapted as best they could to meet the timeline for the needs assessment established in law.

Step 3: Identifying At-risk Communities

The Core Team used the HRSA approved simplified method to begin the process of identifying at-risk communities. Based on the guidance of the Stakeholder Group, several indicators were added to the domains defined by HRSA. This process involved brainstorming potential indicators, working with the MCH Epidemiology Section to determine data availability and quality, pulling available data by county, and incorporating new indicator variables into the appropriate tables. Additionally, the Stakeholder Group recommended exploring sub-county concentrations of risk that could be masked by county level data, particularly within Michigan's high population counties. These processes and findings will be described in more detail in the section titled *Identifying At-risk Counties with Concentrations of Risk*.

The Core Team's approach to phase 2 (adding counties known to be at-risk) was defined by the local Exploration and Planning process. The MCH Epidemiology Section provided county level data for every county in the state and some cities for a series of indicators in three categories: demographics and cultural characteristics, community-level risk factors, and outcomes that can be influenced by evidence-based home visiting. Additionally, the ECHVU and MPHI provided training and support to community partners leading the Exploration and Planning process through webinars and coaching on exploring disparities in race, socio-economic status, and geography. Based on the data provided and local exploration of risk, community partners reported through REDCap the outcomes of greatest concern in their community, along with a justification for their response. Through analysis of this process, the Core Team identified at-risk communities that were not identified through the state-level analysis.

Step 4: Identify the Quality and Capacity of Home Visiting Programs

The Exploration and Planning process and a statewide survey of evidence-based home visiting programs were used to complete this step. The ECHVU maintains a statewide inventory of all known MIECHV and non-MIECHV funded local implementing agencies. This inventory was shared with the community partners in the Exploration and Planning process to assess its accuracy and completeness. The updated list was used to administer a survey to all known evidence-based home visiting programs in Michigan. The survey included sections on: Program administration (e.g., number of home visitors, vacancies, race/ethnicity of staff, accreditation status, funding sources), service delivery (e.g., counties and communities served, number of families enrolled and served, maximum capacity), service population (e.g., target population, ages served, race/ethnicity of families, cultural characteristics of families), incoming referrals, outgoing referrals, and challenges related to COVID-19.

The survey was administered by the Core Team to 262 programs for two weeks in July and two weeks in August through an online survey platform called Qualtrics. State funders of home visiting programs prompted local participation, as did community partners in the Exploration and Planning process. Additionally, multiple reminders were emailed through Qualtrics. At the close of data collection 165 programs responded to the survey for a response rate of 65%. These data were analyzed to identify both gaps and indicators of quality. Additionally, they were shared back with community partners to explore the reach and quality of home visiting, as well as the reach and quality of services for families.

Another resource used to complete step 4 included focus groups facilitated by community partners across the state through the Exploration and Planning process. Community partners received a protocol and a training webinar in conducting focus groups, both of which were adapted for a virtual format. The protocol included questions about strengths and opportunities to improve home visiting programs, access to quality home visiting services, access to other services for families, and parent defined

outcomes of home visiting. A total of 65 focus groups were completed, which included 376 individuals representing 54 counties. The results of these focus groups were summarized, submitted through REDCap, and used to inform both Step 4 and Step 5.

Step 5: Assess Community Readiness

Step 5 was also completed through the Exploration and Planning process. Community partners in each county engaged families, home visiting programs, and other agencies serving families in a dialogue covering six domains of readiness adapted from *Community Readiness: A Toolkit to Support MIECHV Program Awardees in Assessing Community Capacity*. Given the timeline and impact of COVID-19, the process was substantially abbreviated from the method outlined in this guide; however, partners convened to discuss: community knowledge of family needs, community knowledge of home visiting, community climate, community pursuit of equity, community leadership, and community resources.

After responding to a series of discussion questions in each of these domains, partners identified strengths, opportunities for improvement, and ranked their readiness to implement or expand home visiting on a scale of 0=no readiness, 1=limited readiness, 2=moderate readiness, 3=significant readiness, and 4=full readiness. They reported their findings through REDCap. by county.

Step 6: Assess Capacity for Providing Substance Use Disorder Treatment and Counseling Services

The Core Team completed this step through several different methods, beginning with two facilitated dialogues with the Stakeholder Committee. The first conversation walked through each of the requirements outlined in this section of the Supplemental Information Request (SIR) and identified both the group's questions about the topic and available sources of information. The second conversation prioritized unanswered questions and identified strategies for answering those questions.

Using the framework outlined by the Steering Committee as a guide, the Core Team gathered existing documents, including Michigan's Substance Abuse Prevention and Treatment (SAPT) Block Grant application for 2020, Michigan's Title V application and 2020 Needs Assessment Report, and Michigan's Neonatal Opioid Withdrawal Syndrome report. The Team also sought out relevant data, such as data from SAMHSA's Behavioral Treatment Episode Data Set (TEDS), the National Survey on Drug Use and Health (NSDUH), the Pregnancy Risk Assessment Monitoring System (PRAMS), Vital Statistics, SAMHSA's National Survey of Substance Abuse Treatment Services (N-SSATS), and the Michigan Profile for Healthy Youth (MiPHY). Although these datasets vary in the extent to which they identify pregnant women or parents of young children, MDHHS epidemiologists pulled data as relevant to this population as possible.

Finally, the Core Team convened four focus groups, two with families and two with home visitors. The focus group with home visitors was guided by a protocol that explored awareness of local Substance Use Disorder Treatment and Counseling (SUD T/C) systems, strengths and gaps in SUD T/C options, experiences screening and supporting referrals, and experiences supporting families through treatment and recovery. The focus groups with families who received home visiting and SUD T/C explored the strengths and weaknesses of SUD T/C in their community, barriers, the role of home visitors in disclosure and referral, and the role of home visitors in supporting treatment and recovery. The groups were conducted online using Zoom and guided by a trained facilitator. A total of 11 home visitors and program supervisors participated in focus groups, as did 5 parents. The families represented 3 counties (Allegan, Emmet, and Wayne). These mothers had been enrolled in a home visiting program in the last two years and had experienced substance use or recovery themselves while enrolled. They had

participated in Parents as Teachers (2), Maternal Infant Health Program (MIHP) (2), and Early Head Start/Nurse Family Partnership (1). The 11 home visitors and supervisors had wide ranging levels of experience and represented six agencies covering 20 counties. They offered the following home visiting models: Parents as Teachers (3), MIHP (5), and Healthy Families America (3).

Step 7: Coordinate with Other Needs Assessments

The process of coordinating with other needs assessments centered on convening a series of conversations between the individuals leading the many MCH-focused assessment processes in the state. Prior to the kickoff of Michigan's Title V needs assessment in early 2019, Title V leadership and home visiting leadership met to discuss the goals of the two assessment processes and to identify opportunities for connection and collaboration. Similar conversations were held between ECHVU staff and MDE staff regarding both the Head Start assessments and the birth to five assessment required under the PDG. Additionally, one of the leads of this assessment guided the PDG needs assessment. Assessment activities related to home visiting also took place under a Pritzker grant in the year of the needs assessment, and home visiting staff were closely involved with this process. Members of the stakeholder group also participated on the statewide Family First Protection and Services Act (FFPSA) needs assessment that occurred during this same timeline and identified ways in which the two needs assessments might coordinate. Finally, the ECHVU manager reached out to the Children's Trust Fund and Child Protective Services to explore potential to collaborate under the Child Abuse Prevention and Treatment Act needs assessments. In addition to these one on one conversations and participation of ECHVU staff across assessments, the Core Team convened two facilitated conversations that included leads of each of these assessment processes. These conversations involved sharing information about the purpose, timeline, and outcome of each assessment, as well as identifying opportunities to connect and collaborate. Finally, the findings of the Title V, PDG, and Pritzker needs assessments were reviewed to inform and supplement the home visiting needs assessment.

Step 8: Synthesize Your Findings

In September 2020, the Core Team began the process of analyzing data collected through the home visiting survey and Exploration and Planning process. These data were used alongside the simplified method to address the purpose of the needs assessment as defined by law and HRSA guidance. For clarity, analysis methods are presented throughout the report. Following the completion and submission of this report, the Core Team will lead additional analysis based on the purpose defined by stakeholders.

Step 9: Report and Share Findings

In addition to submitting this report under the MIECHV grant, the Core Team will share findings with state and local partners through several mechanisms as described in the conclusion section.

Step 10: Use Your Needs Assessment Data and Findings

The findings of the needs assessment will inform Michigan's FY2021 formula grant application. Findings will also be used to guide requests for and distribution of funding support to expand evidence-based home visiting in Michigan when and if additional funding opportunities are available and as determined by the larger Michigan Home Visiting system. Currently, the results of this needs assessment will be considered along with the needs assessment conducted as part of the Family First Prevention Services Act (FFPSA), to identify communities prioritized for expansion of home visiting as allowed under FFPSA. Findings will also be used to inform interim years of the Title V needs assessment, as well as the ongoing needs assessment under the Preschool Development Grant. Local communities are utilizing the needs

assessment process to understand gaps related to transition between programs, and if there are differences in perception of capacity and quality of home visiting programs by families. It is important to recognize that the state-level population data that was used in this analysis was pre-COVID-19. We are aware the circumstances in many communities have changed directly due to the pandemic. And, despite the pandemic, home visiting and other partners were committed to completing the needs assessment while adapting to fully support families when in person visits were no longer allowed. Home visiting was one of several services that was able to continue to support families through the pandemic and that was demonstrated in the local Exploration and Planning processes.

Parent Leadership & Voice

Michigan home visiting engages parents throughout the home visiting system as parent leaders who contribute to and shape implementation. While parents were not able to join the state level Stakeholder Group, local partners engaged families in the Exploration and Planning process as an expectation of that process. This included identifying specific parent leaders to participate in each step of the process and specifying how parent participation would be supported. Additionally, local partners were encouraged to gather broader parent input on home visiting through focus groups, as described above. Although completing the process over the summer and amid a pandemic was not conducive to parent participation, communities embraced the opportunity to engage and be led by their parent partners.

Parent voice is a value throughout Michigan's early childhood system; however, engagement is a process and the local Exploration and Planning process demonstrated that local community partners are on a continuum of understanding and practice in the area of authentic family involvement. For example, local partners were expected to support parents financially in alignment with MDHHS ECHVU parent financial support polices, which include items such as: gift cards not being allowed and paying parents the state rate for their work, as they would any other professional, in a timely manner. While local partners agreed with this practice, in some cases agency procedures stood in the way.

Home visiting in Michigan can be best understood and improved if processes like this are led by parent voice. Throughout this process, communities have shared how valuable it was to hear things from the parent's viewpoint: what they think of home visiting overall, challenges to accessing home visiting, contribution to lists of strengths and needs of communities, and what is important to consider regarding community readiness. Parent voice is a key component of building an equitable system, and one of the goals of the Exploration and Planning process was to incorporate the voices of parents with a diversity of experiences based on their own background and where they live within the state. Through this process, Michigan heard from hundreds of families from every corner of our diverse state, and their voices, experiences, and insights have deepened and expanded our understanding of risk, need, and readiness.

Organization of this Report

This report is organized in accordance with the outline provided in the SIR. The next section will identify communities with concentrations with risk based on the results of the simplified method and the Exploration and Planning process. The third section will identify the quality and capacity of home visiting programs. The fourth section will describe capacity for providing substance use disorder treatment and counseling services. The fifth section will describe coordination with other needs assessments. The sixth section will summarize findings and describe dissemination. Michigan's Needs Assessment Data Summary is provided as well.

Identifying At-Risk Communities with Concentrations of Risk

Findings Based on the Simplified Method

Michigan's Core Team selected the simplified method for determining at-risk communities with a modified approach. With guidance from the Stakeholder Group, the home visiting epidemiologist added indicators and domains to the analysis and explored risk in selected sub-county areas.

Adding Indicators and Domains

Through a series of discussions with the Stakeholder Group, additional domains and indicators were identified to more fully represent risk factors across domains impacted by home visiting. Additional indicators were explored from previous needs assessments and members went through a consensus process to select indicators to be added based on their experience and expertise. Table 1 describes the domains and indicators provided by HRSA and the domains and indicators Michigan added.

Table 1. Indicators Incorporated into the Simplified Method

Domain	Indicator	Addition
Socioeconomic Status		HRSA domain
	Poverty	HRSA indicator
	Unemployment	HRSA indicator
	HS Dropout	HRSA indicator
	Income Inequality	HRSA indicator
	Households Receiving Public Assistance	MI addition
	Households Speaking Limited English	MI addition
Adverse Perinatal Outcomes		HRSA domain
	Preterm Birth	HRSA indicator
	Low Birth Weight	HRSA indicator
	Neonatal Abstinence Syndrome Rate	MI addition
	Maternal Morbidity	MI addition
Substance Use Disorder		HRSA domain
	Alcohol	HRSA indicator
	Marijuana	HRSA indicator
	Illicit Drugs	HRSA indicator
	Pain Relievers	HRSA indicator
Crime		HRSA domain
	Crime Reports	HRSA indicator
	Juvenile Arrests	HRSA indicator
Child Maltreatment		HRSA domain
	Child Maltreatment	HRSA indicator
Domestic Violence		MI domain addition
	Domestic Violence	MI addition
Education		MI domain addition
	Not Proficient in 3rd Grade Reading	MI addition
	Special Education	MI addition

Once the additional indicators and domains were finalized, the home visiting epidemiologist followed the simplified method algorithm as described in the HRSA Needs Assessment guidance document. The process used for identifying at-risk counties is as follows:

1. Obtained raw, county-level data for each indicator from the listed data source.

2. Computed mean of counties, standard deviation (SD), median, missing n, missing %, interquartile range, min, max, and overall state estimate for each indicator.

3. Standardized indicator values by computing z-scores for each county so that all indicators have a mean of 0 and a SD of 1. The formula to obtain the z- score is as follows: z-score = (county value - mean)/SD.

4. Using the resulting z-scores for each county, calculated the proportion of indicators within each domain for which that county's z-score was greater than 1.

This calculation determined the proportion of indicators for which a given county was in the 'worst' 16% of all counties in the state (16% is the percentage of values greater than 1 SD above the mean in the standard normal distribution). If at least half of the indicators within a domain had z-scores greater or equal to 1 SD higher than the mean, then a county was considered at-risk on that domain. The total number of domains at-risk out of 5 is summed to capture the counties at highest risk across domains. Counties with 2 or more at-risk domains were identified as at-risk.

Subcounty Analysis

Once counties were identified as at-risk, the Stakeholder Group advised the Core Team to devise a strategy to explore sub-county data. The Stakeholder Group recognized that there are areas in Michigan where risk factors are high but masked by county level data. The Core Team decided to identify the cities and townships with the largest populations from counties with populations of over 100,000 people that did not appear to be at-risk based on the original analysis. The final cities and townships selected for sub-county analysis included: Allegan, Ann Arbor, Auburn Hills, Bedford Township, Benton Harbor, Benton Harbor Township, Charlotte, Delta Charter Township, Grand Rapids, Holland, Holland Charter Township, Howell, Kalamazoo, Kentwood, Monroe, Plainfield Charter Township, Pontiac, Port Huron, Portage, Roseville, Southfield, St. Joseph, Warren, Waterford Charter, Wyoming, Ypsilanti, and Ypsilanti Charter Township. After the selection of those subcounty regions, several townships were not able to be included in the subcounty analysis due to lack of data availability including Bedford Township, Benton Harbor Township, Delta Charter Township, Plainfield Charter Township, Waterford Charter Township, and Ypsilanti Charter Township. The process for identifying at-risk counties was repeated for the selected subcounty regions.

Workbook Description

The attached Excel workbook includes the complete analysis, which appear in the tabs as follows.

Tab 1. Simplified Method Overview. This tab contains an overview and explanation of the simplified method as provided by HRSA.

Tab 2. Description of Indicators. This tab contains a list of all the indicators including both those provided by HRSA and the additional indicators selected by the Needs Assessment Stakeholder group. This tab contains the indicator domains, indicator definitions, alignment with statute definition of at-risk

communities, data years, data sources, links to the data sources, source notes, and next planned data updates (if available). HRSA provided this information for all the indicators on the original list, and the Home Visiting Epi entered the information on all the added indicators.

Tab 3. Descriptive Statistics. Tab 3 contains descriptive statistics for all the indicators as well as Michigan's population in 2017. The descriptive statistics included: indicator definition, data year, missing (n), missing %, mean of counties, standard deviation, median, interquartile range, min, max, and state estimate. Again, HRSA provided all these descriptive statistics for the indicators on the original list, and the Home Visiting epi entered the rest of the data for the additional indicators. The indicators provided by HRSA fell into 5 domains: socioeconomic status, adverse perinatal outcomes, substance use disorder, crime, and child maltreatment. Those added by the MI team included: domestic violence and education.

Tab 4. Total Raw Data. Tab 4 contains the raw data for all the indicators by county and subcounty. This data was pulled from the data sources listed in tab 2 by the home visiting epi.

Tab 5. Total Standardized Indicators. Tab 5 contains the standardized data for all counties and sub-counties/city/township. Data was standardized by computing the z-score for each community.

Tab 6. Total At-Risk Domains. Tab 6 uses the z-scores computed in tab 5 to calculate the proportion of indicators considered at-risk within each domain. This involved calculating the proportion of indicators within each domain for which the community's z-score was greater than 1. If at least 50% of the indicators within a domain have z-scores equal to or greater that 1 SD higher than the mean, then the county was considered at-risk in that domain. The process included all seven domains listed in tab 3. The additional domains were domestic violence and childhood education. The domestic violence domain contained only the domestic violence indicator. The childhood education domain included two indicators. Those counties with two or more at-risk domains were considered at-risk per HRSA guidance.

Tab 7. At-Risk Counties. Tab 7 contains the counties deemed at-risk through the process used through Tab 6. In addition, five counties were added to this list as 'known to be at-risk' through the Phase 2 process described below (rows highlighted in YELLOW). Several columns were added to Tab 7 to support analysis of need and capacity in these communities (Column heading in BLUE). The estimated number of families served by a home visiting program located in the county in the most recently completed program fiscal year (Column E) was captured through the Home Visiting Program Survey described in detail in Section 3. The numbers described in the column are limited to programs responding to the survey and do not represent of all the programs in each county. Further, some of the programs that severed multiple counties, did not provide data for the number of families served at the county level. Thus, the response of total families served by those programs was proportionally distributed to the estimated need in the county population (Column I). These numbers are designated with an asterisk.

Tab 8. At-Risk Counties Ranking. Tab 8 shows the counties ranked by number of domains at-risk. Findings were presented in two tables. '2020 Needs Assessment- County' is based on HRSA provided data and '2020 Needs Assessment- Subcounty addition' displays findings after the addition of indicators and subcounty/city/township data. Tab 8 was not a part of the original Needs Assessment template, but it was added to illustrate the impact of the additional of indicators and subcounty analysis.

Table 2 presents the final ranking of at-risk communities identified in Michigan through the Simplified Method only. It is important to note that the order of counties within the rankings is alphabetical such that counties/cities have a ranking of 1, 2, 3, or 4.

Table 2. Findings from the modified Simplified Method **ONLY**: At-risk Counties and Cities

2020 Needs Assessment- Subcounty			
County	**City/Township**	**Number of At-risk Domains**	**Rank**
Wayne County		5	1
Lake County		4	2
Arenac County		3	3
Berrien County	Benton Harbor	3	3
Calhoun County		3	3
Genesee County		3	3
Ingham County		3	3
Jackson County		3	3
Kalamazoo County	Kalamazoo	3	3
Muskegon County		3	3
Newaygo County		3	3
Washtenaw County	Ypsilanti	3	3
Alcona County		2	4
Antrim County		2	4
Bay County		2	4
Clare County		2	4
Crawford County		2	4
Delta County		2	4
Gladwin County		2	4
Huron County		2	4
Mackinac County		2	4
Midland County		2	4
Montmorency County		2	4
Oscoda County		2	4
Oakland County	Pontiac	2	4
St. Clair County	Port Huron	2	4
Roscommon County		2	4
Saginaw County		2	4
Schoolcraft County		2	4
Macomb	Warren	2	4
Wexford County		2	4

*Italics indicate the county was not identified as having 2+ at-risk domains, but a city within the county was identified as having 2+ at-risk domains.

Other Communities Known to be At-Risk

Michigan used its local home visiting needs assessment process, Exploration and Planning, to identify communities that have pockets of risk that are masked by county level data. Through this process, local home visiting partners took a deep dive into local data that speak to community demographics, community risk factors, and outcomes for children and families. This process was guided by the Exploration and Planning tool (see Appendix A), a webinar explaining the process and illustrating how to use publicly available data to identify disparities, a data table prepared by the home visiting epidemiologist, and coaching. After completing the process, communities entered their findings, by county, in an online data capture system called REDCap.

A total of 52 counties were not identified as at-risk through the state level analysis using either the simplified method or the city/township analysis. Of these counties, 46 participated in the Exploration and Planning process. The text and files entered in REDCap were downloaded into Excel for review. The review process involved several steps. After examining their local data, each community was asked to indicate if their data suggested a need to address each of the outcome areas impacted by home visiting. All but one county indicated that they saw evidence of risk in at least one benchmark area. More specifically:

- 49% indicated the need to address Maternal Health
- 47% indicated the need to address Child Health
- 49% indicated the need to address Child Development and School Readiness
- 38% indicated the need to address Positive Parenting Practices
- 69% indicated the need to address Child Maltreatment
- 49% indicated the need to address Family Economic Self-Sufficiency
- 40% indicated the need to address Linkages and Referrals
- 31% indicated the need to address Juvenile Delinquency, Family Violence, and Crime

This indicates that almost all counties not considered 'at-risk' found evidence that children in families experienced adverse outcomes that could be impacted by home visiting. Within each of the benchmark areas almost seven out of ten counties found evidence of concern related to child maltreatment, and nearly half found evidence of concern related to maternal health, child health, child development and school readiness, and family economic self-sufficiency.

Next, each of the counties was reviewed for any evidence that the county level data masked significant areas of risk within the county. Through this process, 10 counties were nominated for further consideration. These 10 counties were reviewed to identify if their response met the following criteria:

- Did they present two or more measures where a racial or ethnic disparity exists in the county?
- Did they present two or more measures where a geographic disparity exists?
- Did they present three or more measures impacted by home visiting that were not included in the state level analysis where the county is doing worse than the state?

Four of the counties met two of these criteria and were added as communities 'known to be at-risk:' Allegan, Ottawa, Van Buren, and Cass. These communities provided persuasive data suggesting that they have pockets of risk that are masked by their county data. A summary of the evidence they provided is included below. Additionally, one county that currently receives MIECHV funds was not

identified as at-risk through the simplified method or the sub-county analysis. They were identified as meeting one of the above criteria, but not two. This county, Kent, will also be described in more detail.

It is important to note that the Exploration and Planning process was delayed due to the COVID-19 pandemic, and the timeframe for completion was abbreviated significantly. While some communities did an exceptionally thorough job under very difficult circumstances, others did not. As such, the process of exploring sub-county areas of risk should be ongoing and not limited to this process.

Allegan, Ottawa, and Van Buren Counties

Allegan County is in West Michigan with a population of 118,081 (US Census Bureau Population Estimate, 2019). The population is 88.2% White alone; however, they have a significant Hispanic/Latino population (7.4%) and 5.8% of the population over five years speaks a language other than English. The median household income is over the state average at $59,883, as its Lake Michigan shoreline has attracted high income Michiganders to the county. Through the Exploration and Planning process Allegan found that this picture does not adequately illustrate the diverse experiences of the people of Allegan County. West Michigan's farms draw migrant families who are not well represented in Census data. Focus group participants noted that many of these families do not have educational experiences past 8th grade, have moved from another country for work, are transient, are either unaware or fearful of public early childhood services, and face multiple risks to their health and wellbeing. They also noted that these families live predominantly in the Fennville, Allegan, and Martin school districts. These same school districts also have the highest rates of children living in poverty in the county. Additionally, according to the National Center for Education Statistics (2019-2020), Allegan has a large population of English-Language Learners (ELL) in Fennville. Fennville's population is 73% white and 25% Hispanic/Latino and has almost double the state's percentage of families with incomes lower than the 100% poverty level. Additionally, Allegan County spoke to concerns regarding high rates of ACEs among middle and high school students, high methamphetamine use, and transportation barriers.

Ottawa County sits just north of Allegan County and shares many of its characteristics. According to the US Census, the county's population is 291,830, and 83.6% of the population is White and 10.0% of the population is Hispanic/Latino. Almost 10% of the population speaks a language other than English. Ottawa County also has a Lake Michigan shoreline, and its median income is higher than the State of Michigan at $67,468. Like Allegan, these data are not representative of all people living in the county. Ottawa County also has a large migrant population. Although it has been decades since a formal migrant health survey has been conducted in the county, a 2001 study found that migrants had poorer health status than the white population with chronic disease beginning at younger ages, less screening for preventable health conditions, differences in smoking and drinking patterns, poorer access to health and dental care, less insurance coverage, and lower incomes. Additionally, Ottawa County identified disparities between Ottawa County's Hispanic/Latino residents and white/other residents across numerous health indicators, including pregnancy and childbirth, youth mental health and substance abuse, and youth obesity. Referencing the United Way's 2018 Community Health Assessment, Ottawa noted that nearly four in ten (37.3%) Hispanic/Latina mothers have less than adequate prenatal care, compared to 25.7% for all mothers. Medicaid-covered births account for 70% of Hispanic/Latina births, whereas they are 29% of births among the population as a whole. Additionally, four in ten Hispanic/Latino adolescents report depression, twice the rate of White adolescents, and one in five Hispanic/Latino adolescents are obese, twice the rate of White adolescents. Racial disparities also exist in third-grade reading levels.

Van Buren county is just south of Allegan County and is also on the coast of Lake Michigan. It has a population of 110,093 (US Census Bureau Population Estimate, 2019). The population is 81.0% white alone, 11.7% Hispanic/Latino, and 4% Black alone. The median household income is a bit lower than Michigan's average at $52,351. Like its neighbors to the north, Van Buren has a significant migrant population that is not well represented in population data. Through its Exploration and Planning process, Van Buren was able to identify patterns of disparities between its white population and both its Latinx and Black populations. They looked to the County Health Rankings and found that the teen birth rate for the white population was 26/1,000, whereas it was 45/1,000 for the Black population and 42/1,000 for the Hispanic/Latina population. They also found that third grade reading proficiency was 53% for white third graders, 21% for Black third graders, and 25% for Hispanic/Latino third graders. They also noted a connection between race and poverty status, with 18% of white children living in poverty, but 74% of children who were black and 36% of children who were Hispanic/Latino living in poverty. Using Michigan's portal for education data, Van Buren also identified specific school districts with high rates of unplanned retention for kindergarten students, dropout rates, and standardized test scores.

These neighboring counties found similar patterns of risk related to their migrant and Latinx families. Their findings suggest that migrant families in West Michigan might face risk that is not accounted for in state level population data. While data about this population are limited, according to the Migrant Families in Michigan Fact Sheet (2014), published by the Michigan Migrant Child Task Force, there were 42,729 children of farmworkers ages 0-19 years old in the state. The need to more deeply understand the risks faced by these vulnerable families was highlighted by Allegan, Ottawa, and Van Buren Counties.

Cass

Cass County is south of Van Buren County and has a population of 51,787 (US Census Bureau Population Estimate, 2019). The population is predominantly white alone at 86.3%, with a Black population of 5.2%. Importantly, Cass County has a relatively large percentage of Native Americans and Alaskan Natives at 1.2% compared to Michigan overall. The Cass County median household income is similar to the State at $53,571. Through the Exploration and Planning process, Cass highlighted risks that were masked in the state level analysis. They noted that the percentage of mothers not receiving adequate prenatal care is increasing in the county and has reached 52.4%, which is 20 percentage points higher than the state average. Cass also has a high rate of sudden unexplained infant deaths. The county also noted that only 64% of children 19-35 months have completed the series of recommended vaccines and only 64% of Medicaid enrolled children 3-6 years old received each of their recommended well child visits. Cass also noted increases in child maltreatment investigation, confirmed child maltreatment, and out of home placement, and in all these areas they have exceeded the state average. Only 31.5% of 3 and 4-year-old children in Cass are enrolled in preschool, and the number of families living in poverty is increasing the county. In addition to identifying a pattern of increasing risk, including risks in areas not included in the state level analysis, Cass noted significant disparities and concern regarding the degree to which services are reaching the county's black, indigenous, and Latinx populations.

Kent

Kent County is the fourth largest county by population in Michigan with over 656,000 residents. It is a relatively diverse county; 73.5% of the population identifies as white alone, 10.5% identifies as African American, and 10.7% identifies as Latinx. Additionally, 8.3% of the population was born outside of the United States, and 12.4 % of community members five and older speak a language other than English in

the home. Prior to the COVID-19 pandemic, the economy was growing, unemployment was decreasing, and the median household income was higher than the state average at $60,351 for a family of four.

In Michigan's initial MIECHV needs assessment in 2010, Kent County ranked as one of the top 10 at-risk counties within the state and has remained in the top 20 using the original methodology for Michigan's needs assessment updates in 2014, 2016, and 2018. However, over the past 10 years, Kent County has invested heavily in prevention and in its early childhood system. This investment has paid off, and outcomes for mothers, infants, and young children have dramatically improved.

However, Kent County continues to have significant disparities in outcomes between its white community members and community members who identify as black, indigenous, or persons of color. In their Exploration and Planning analysis, Kent County noted that white families are much less likely to live in poverty as compared with its black or Latinx families. They also found disparities in adequacy of prenatal care, child maltreatment, reunification rates, and infant mortality. Through focus groups, they identified that families speaking a language other than English have limited access to early childhood services, and that service providers do not represent the diversity of families. Kent County has also been identified through Michigan's Family First Prevention Services Act (FFPSA) needs assessment as a potential geographical service area for the FFPSA funding. Kent County has some of the highest numbers in the state of pregnant and parenting youth in foster care and children receiving child welfare services. In June 2019, the Kent Healthy Families MIECHV grantee submitted a proposal to MDHHS requesting a change in its service area from a focus on their major city, Grand Rapids, to add low income areas just outside the city. They cited the rising cost of housing in Grand Rapids as triggering migration to specific areas outside of the city. They also cited geographic disparities in prematurity, infant mortality, child maltreatment, and early intervention.

Taken together, this evidence suggests that, while Kent County has made significant progress and the investment in prevention has been impactful, this high population, diverse county continues to have pockets of risk.

Michigan's Federally Recognized Tribes and Native American Communities

Michigan is home to 12 federally recognized Tribes with whom the State of Michigan has a government-to-government relationship. In the space of early childhood and home visiting, the Intertribal Council of Michigan (ITCM) plays a key role in supporting MDHHS in understanding the needs of Michigan's native families. ITCM receives funding for home visiting through several sources, including Tribal MIECHV and MDHHS, and assesses need through those processes. MDHHS's funding decisions regarding home visiting programs designed to reach native families are guided by ITCM and the tribes, rather than a State-led needs assessment. Needs assessments completed by ITCM have demonstrated the inter-generational effects of historical trauma resulting in significant disparities in health outcomes. In addition to these disparities many native families do not have access to key services or experience fragmented care, and are impacted by high rates of poverty, unemployment, violence and addiction. In order to provide a system of culturally grounded support for native women and families, ITCM supports 12 Family Spirit sites in rural northern and west Michigan, plus urban southeast Michigan, including the city of Detroit. Of the 36 communities identified as having risk in in this needs assessment, 15 implement a Family Spirit program. Rather than looking to population data or MDHHS led assessment processes, which underrepresent the experiences of native families, MDHHS will continue to partner with ITCM and Michigan's tribal nations to understand and address the needs of native communities.

Quality and Capacity of Michigan Home Visiting Programs

Overview

Michigan serves families through a continuum of evidence-based home visiting models, which varies from community to community. One of the unique features of Michigan's system, is that it includes two Medicaid funded models that were developed, implemented, and evaluated in Michigan. The first of these two Michigan based models is the Maternal Infant Health Program (MIHP). MIHP is the most pervasive home visiting model in the state with the most capacity to serve families. This program serves women during pregnancy and infants during their first 18 months of life. It is funded as a Medicaid entitlement and is designed to reduce rates of maternal and infant morbidity and mortality. During pregnancy, women may receive an assessment visit and up to nine additional visits, and infants are eligible for an assessment and up to nine visits. Infants who are exposed to substances may receive up to 36 visits. This model is included in the HomVEE list of evidence-based models. The second Michigan based model is Infant Mental Health-Home Visiting (IMH-HV). IMH is available to Medicaid-eligible pregnant women and families with young children. This promising practice focuses on families who are facing multiple risk factors for parent-infant attachment challenges, and it is delivered by licensed mental health professionals with an infant mental health endorsement. Although not currently on the HomVEE list, it has undergone a rigorous evaluation and results are in publication.

Michigan also offers several national home visiting models. Nurse Family Partnership (NFP) is available in 10 counties, Healthy Families America (HFA) is available in 39 counties, Parents as Teachers (PAT) is available in 29 counties, Early Head Start-Home Based (EHS-HB) is available in 16 counties, Play and Learning Strategies (PALS) is available in one county, and Family Spirit is available in 9 tribes and through the Urban Indian Health Center in Detroit.

This section focuses on the evidence-based home visiting available in the 36 Michigan counties identified as at-risk (see Figure 1). While not officially considered evidence-based, IMH-HV is included as well as a promising practice with emerging evidence of effectiveness. The capacity of the home visiting programs in these counties will be described in terms of programs, funders, funded enrollment capacity, areas served, and the number of families that have received services in the past year. The quality of existing home visiting in at-risk counties will also be explored, focusing on parent voice and input. Gaps in home visiting will be noted as well, identifying the degree to which home visiting programs are full, rates of enrollment, staffing challenges, barriers faced by programs, funding limitations, and gaps identified through parent feedback. Finally, this section will identify geographic areas where families face risk factors, existing home visiting programs do not have the capacity to meet the demand, and capacity exists to expand evidence-based home visiting.

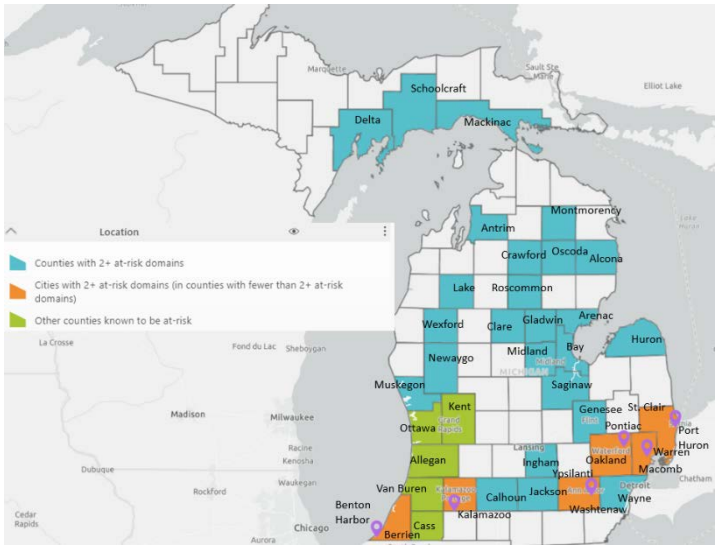


Figure 1. At-risk Communities

Methods

The data reported in this section were gathered through the Exploration and Planning process. One component of the process involved conducting a statewide survey of all known evidence-based home visiting programs. As was noted in the *Introduction* section, the survey was administered to 262 programs and had a response rate of 63%. When interpreting survey findings, it is important to note this gap in representation. Of the total 165 programs that responded to the survey, 112 programs served families in the at-risk counties. Survey data were summarized using frequencies, theming of open-ended questions, and the development of network maps.

A second component of the Exploration and Planning process that spoke the quality of home visiting in at-risk communities and gaps in home visiting services was focus groups conducted by local partners. Of the 36 at-risk communities who participated in the Exploration and Planning process, 29 conducted focus-groups with families. The findings of these groups were themed and used to identify what families see as gaps in home visiting and indicators of quality.

The third component of the Exploration and Planning process incorporated into this section of the report were the responses of local partners uploaded into REDCap. Of the 36 at-risk communities, all uploaded information into REDCap for this analysis. They were asked to respond to a series of forced choice and open-ended prompts or questions specific to each county included in the process. These were summarized using frequencies or themed using qualitative analysis procedures. The prompts and questions incorporated into the analysis included:

- What did you learn about the reach and quality of the home visiting system within this county?
- Does this county have the need and capacity to expand evidence-based home visiting?
- What types of services are well connected with home visiting programs in the county?
- What gaps in the service network are common for home visiting programs in the county?
- How must the service delivery network be strengthened to better meet the needs of families?

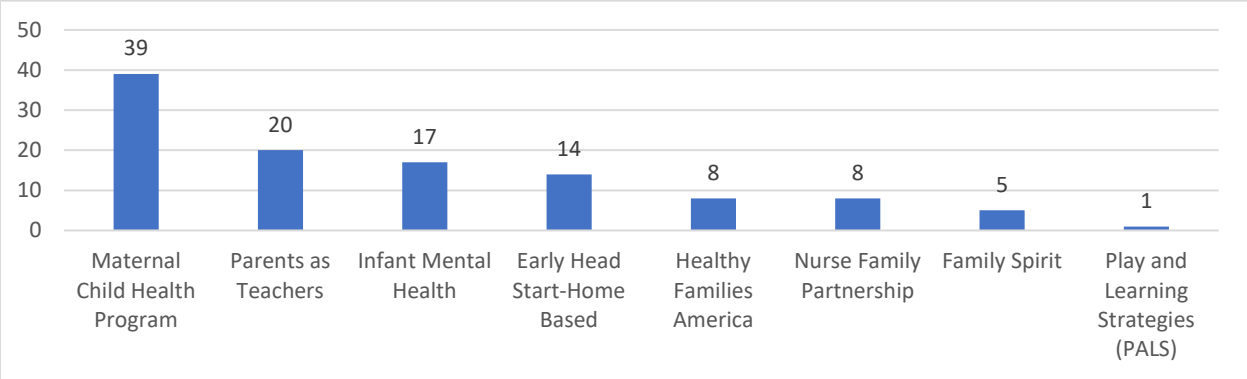
The findings of the Readiness Assessment that was part of the Exploration and Planning process are included as well. During that process, community partners came together to discuss six dimensions of readiness. Based on their discussion they rated themselves as having no readiness, limited readiness, moderate readiness, significant readiness, or full readiness. The findings were summarized across at-risk communities to identify themes and patterns of readiness to expand home visiting.

Capacity

A total of 112 home visiting programs in the 36 at-risk counties are represented in the following findings related to existing capacity. Many of these programs served more than one county (68.5%), and some (9.8%) of these programs were only able to serve some areas of the county, such as a specific city. Four counties were served by 10 or more programs: Wayne county had 18, Oakland had 17, Macomb had 16, and Kalamazoo had 10. All at-risk counties were served by at least one home visiting program, and only one county was served by only one program (Montmorency).

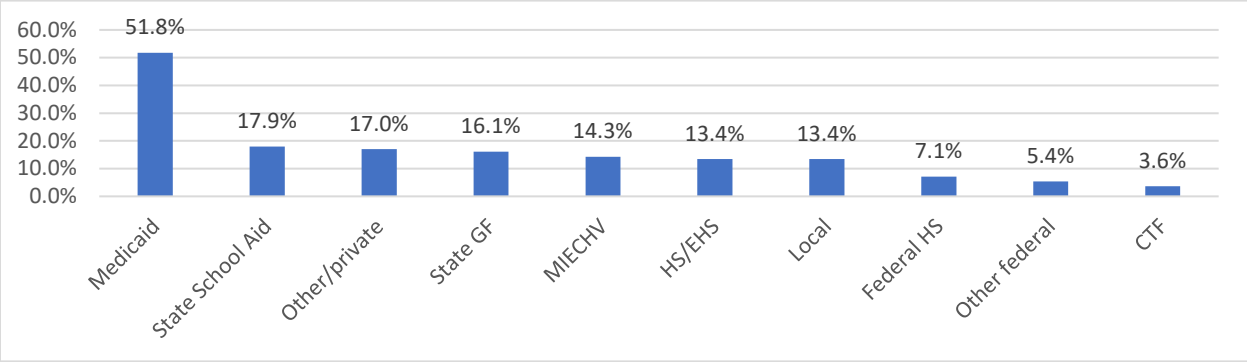
The most common model in the 36 at-risk counties was MIHP, with 39 programs. The second most common model was PAT with 20 programs, followed by IMH-HV with 17 programs, and EHS-HB with 14 programs. The survey responses from the at-risk counties also included 8 HFA programs, 8 NFP programs, 5 Family Spirit programs, and 1 PALS program. See Figure 2.

Figure 2. Evidence-based models represented in home visiting program survey serving at-risk counties



The most frequently reported funder of home visiting programs by the 112 programs in these 36 at-risk counties was Medicaid, with 51.8% reporting Medicaid funding. State School Aid was the second most reported source of funding (17.9%), followed by other/private foundation (17.0%), State General Fund (16.1%), MIECHV (14.3%), Federal Head Start/Early Head Start (13.4%), local funding (13.4%), Federal Healthy Start (7.1%), the Children's Trust Fund (3.6%), and other federal funds (5.4%). Many programs reported more than one funder (43.8%). See Figure 3.

Figure 3. Percent of home visiting programs in at-risk counties reporting each funding source



The programs that responded to the survey varied significantly in size and staffing. Of the 112 programs in the 36 at-risk counties that responded to the survey question about the number of full-time home visitors they have on staff, responses varied from zero full time visitors to 22 full time visitors. Of these 112 programs, 27.7% reported that they had one or two home visitors, and 24.1% reported that they had three or four home visitors. When asked about part-time home visitors, responses varied from zero to 25 part-time staff (n=111). However, 50.5% reported that they have zero part-time staff, and 27.0% reported that they had one or two part time staff.

The funded enrollment capacity was calculated for home visiting programs other than MIHP and IMH-HV, which do not use this concept as part of their model. Of the 56 programs with a funded enrollment capacity that responded to the survey from the 36 at-risk counties, Nurse Family Partnership (NFP) programs reported the capacity to serve 1050 families, Healthy Families America (HFA) programs reported the capacity to serve 900 families, Parents as Teachers (PAT) programs reported the capacity to serve 1910 families, Early Head Start-Home Based (EHS-HB) programs reported the capacity to serve 1404 families, the Play and Learning Strategies (PALS) program reported the capacity to serve 60 families, and the Family Spirit programs reported the capacity to serve 185 families.

The 112 programs across the 36 at risk counties served a total of 15,846 families in fiscal year 2019. This is about half of all the families who receive home visiting during a year in Michigan. Of these families, 9,122 were served by MIHP, 794 were served by IMH-HB, and the remaining 5,930 families were served by the other evidence base models - NFP, HFA, EHS, PAT, and PALS. Some of these programs also served families outside of the 36 at-risk counties. Those families are also included in these counts.

Quality

There are many dimensions of quality in home visiting, some of which were explored in this needs assessment. This section will discuss quality in terms of quality assurance, quality improvement, cultural competence, family voice, and early childhood systems.

Quality Assurance

One dimension of quality is quality assurance or demonstrating adherence to a set of standards. In the case of home visiting, standards are set by individual models, as are processes for demonstrating adherence. Of the 112 programs that responded to the survey 75.0% reported that they meet their model criteria for fidelity, and 6.2% indicated they were somewhere in the process of achieving model affiliation or accreditation. This finding is underscored by the observation that each model is designed around a set of supports that assure quality not only at the point of measuring adherence, but on an ongoing basis. The degree to which these systems are in place in Michigan varies by model. For example, Nurse Family Partnership offers a robust system of supports through their national office, including training, technical assistance, a data system with model aligned reporting functionality, and so forth. The Maternal Infant Health Program has a similar system of supports within the state, which are provided through MDHHS. The Healthy Families America model is designed to offer support for quality assurance (training, technical assistance, data support, and so forth) through a multi-site state system. Michigan is in the process of developing a multi-site state system for Healthy Families America, and in the past year has funded a state system, completed a round of quality assurance visits with Michigan's HFA sites, and applied for and been affiliated with HFA. In the year to come the multi-site state system will work toward accreditation. The Parents as Teachers model operates under a similar structure, and a PAT state office has been established. However, the PAT state office is not yet fully funded to perform its quality assurance responsibilities. While Early Head Start has many supports in place to assure the quality of classroom-based services, supports for EHS-home based are less robust.

Quality Improvement

A second dimension of quality is quality improvement, and Michigan has developed a variety of strategies to support improved implementation and outcomes on a continuous basis. However, these strategies vary by funder. Programs funded through MIECHV, the State General Fund, and the State School Aid Act can receive formal quality improvement training and participate in annual learning collaboratives focused on a topic of importance to the system. All home visiting programs in the state can connect with their Regional Perinatal Quality Collaborative; however, not all collaboratives are focused on home visiting and the collaboratives focus on maternal and infant health outcomes, which are only a subset of the outcomes of interest to home visiting programs. Many models incorporate a requirement to engage in quality improvement activities, but some programs are more prepared than others to meaningfully implement this model requirement.

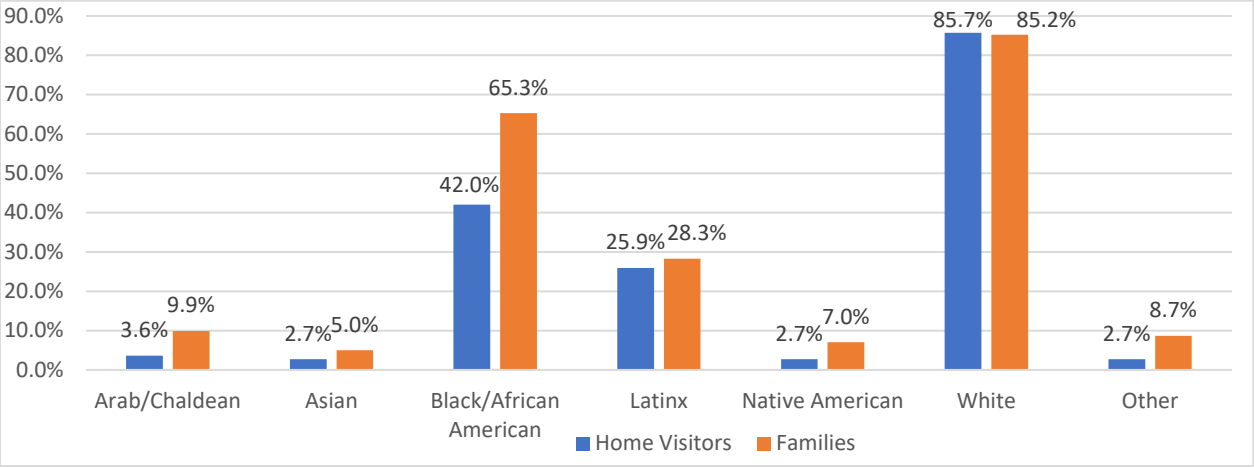
Cultural Competence

A third dimension of quality is alignment between the cultural and language needs of families and the capacity of programs to provide relevant and appropriate services. This is a complex concept, and Michigan is just beginning to explore the degree to which programs are adapting services based on the cultural characteristics of the families they serve. Both Family Spirit and Healthy Families America have features built into the model that support adapting services to family culture. However, many of the concepts that underlie home visiting are reflective of white culture and could alienate the families who face risks caused by contemporary and historical racism and oppression.

One way to begin exploring the capacity of home visiting programs to adapt services to the culture of the families they serve is to explore the diversity of home visitors and the alignment between the race and ethnicity of home visitors and the families served by home visiting programs. The data reported in the home visiting survey were explored using two strategies. First, the survey was used to identify the diversity of staff at the program level. Of the 112 programs, 85.7% of programs had at least one home visitor who identified as white, 42.0% had at least one home visitor who identified as Black/African American, 25.9% had at least one home visitor who identified as Latinx, 3.6% had at least one home visitors who identified as Arab/Chaldean, 2.7% had at least one home visitor who identified as Asian, 2.7% had at least one home visitor who identified as Native American/Alaska Native/Native Hawaiian/other Pacific Islander, and 2.7% had at least one staff person who identified as 'other.'

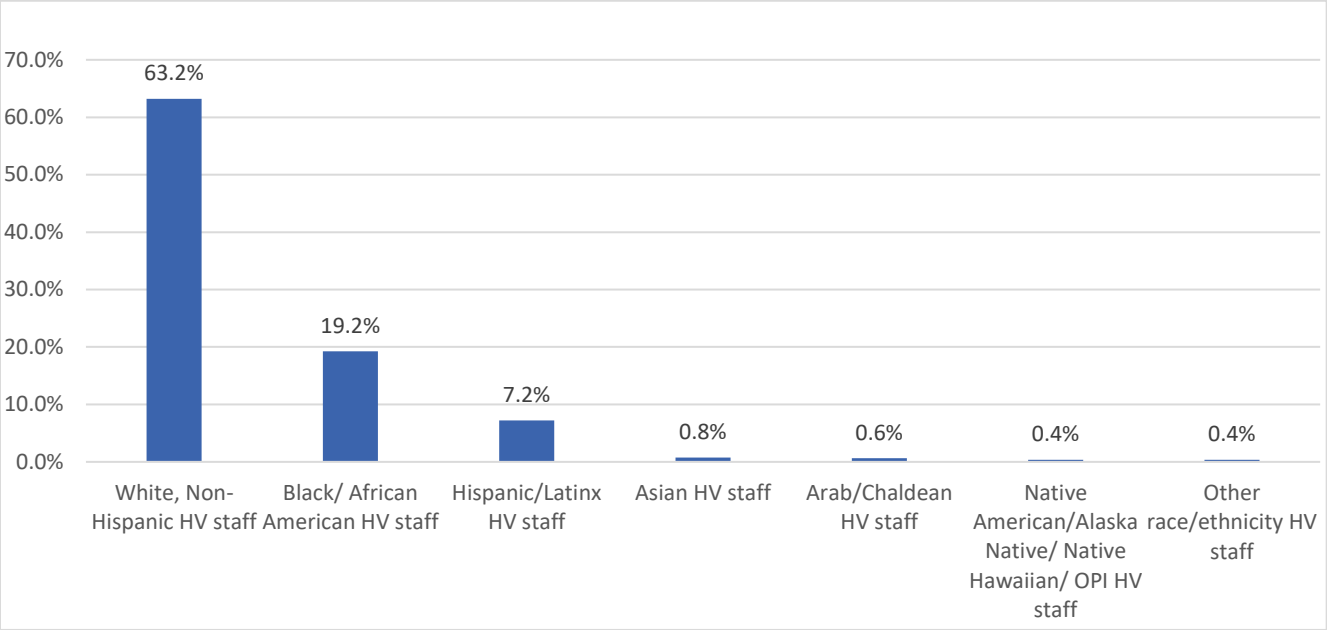
The survey also collected information about the race and ethnicity of families. When asked about the racial and ethnic identity of their caregivers, 9.9% of programs indicated that 10% or more of their service population identified as Arab/Chaldean, 5.0% of programs indicated 10% or more of their caregivers identified as Asian, 65.3% of programs indicated that 10% or more of their service population identified as Black/African American, 28.3% of programs indicated that 10% or more of their service population identified as Latinx, 7.0% of programs indicated that 10% or more of their service population identified as Native American/Alaska Native/Native Hawaiian/other Pacific Islander, 85.2% of programs indicated that 10% or more of their service population identified as white, and 8.7% of programs indicated that 10% or more of their service population identified with another race/ethnicity. See Figure 4.

Figure 4. Percent of programs with at least 1 home visitor of each race/ethnicity; and percent of programs reporting 10% or more of the caregivers they serve identify as each race/ethnicity



Additionally, the survey was used to understand the racial/ethnic distribution of all home visitors represented in the sample. Out of 775 home visiting staff in the at-risk counties, 63.2% identified as white alone, 19.2% identified as Black/African American, 7.2% identified as Latinx, 0.8% identified as Asian. 0.6% identified as Arab/Chaldean, 0.4% identified as Native American/Alaska Native/Native Hawaiian/other Pacific Islander, and 0.4% identified as another race/ethnicity. See Figure 5.

Figure 5. Race/ethnicity of home visiting staff in at-risk counties



Programs were asked how many of their staff can speak languages other than English during home visits. Of the 112 programs that responded, 5 programs (3.6%) had one or more home visitor who could speak Arabic. These home visitors serve families in Ingham, Macomb, Oakland, Washtenaw, and Wayne Counties. Additionally, 33 programs (29.5%) had one or more home visitor who could offer services in Spanish. These home visitors serve families in Allegan, Berrien, Calhoun, Cass, Genesee, Ingham, Kalamazoo, Kent, Macomb, Midland, Muskegon, Newaygo, Oakland, Ottawa, St. Clair, Van Buren, Washtenaw, and Wayne Counties. Finally, 14 (12.5%) programs reported that they have one or more home visitors who can serve families who speak one or more other languages during home visits. Other languages included Algonquian and Ojibwe (indigenous languages), Kinyarwanda (language of Rwanda), Swahili, French, American Sign Language, Burmese, Nepali, and Russian.

Programs provided a wide variety of responses to the question 'To what extent does your staff reflect the linguistic, racial, and cultural backgrounds of the families in the community you serve.' About a third of programs indicated that their staff reflects the diversity of the community they serve and about a third felt that they were making progress toward this goal. However, other programs were either uncertain how to respond or felt their staff do not yet reflect the diversity of the community they serve. Some programs noted that their staff lacked linguistical diversity and had to rely on translators to serve families who speak a language other than the language spoken by their home visitors. Additionally, some programs noted that, while their staff do not represent the diversity of their families, they do educate themselves about their families' cultures and traditions and try to adapt services based on what they learn.

Parents who participated in focus groups provided feedback about the cultural competence of home visiting programs. In some focus groups, families shared that one of the strengths of the programs in their community is the availability of bilingual home visitors to reach non-English speaking families. Other focus groups noted language as a barrier to receiving home visiting services. Generally, families noted that home visitors are accepting of different family cultures, and that this was a strength of home visiting in their community. However, some parents noted that home visiting in their community could benefit from increased diversity of staff and encouraged cultural diversity training. They noted that families feel more comfortable and trust people who look like them and come from similar backgrounds. During focus groups, parents noted that it would be helpful to have home visiting staff with experience as a teen parent. They also noted a need to become more engaging of fathers.

Quality as Defined by the Customer: Family Voice

Another essential component of quality in home visiting is the degree to which families see home visiting programs as providing quality services that align with their needs. During the Exploration and Planning process, families in the at-risk counties participated in focus groups and were asked a series of questions related to quality. When asked about the ***strengths*** of home visiting in their community families shared that home visiting programs and home visitors adapt to the needs of families and make home visiting a positive experience for the whole family. Home visitors are friendly, helpful, caring, supportive, genuine, and reassuring. They also communicate well, and they are responsive. Home visits are flexible, guided by the needs of parents and children, and they are informal, allowing families to feel comfortable. Home visiting is a particularly accessible service because home visitors come into the home, eliminating the need for transportation and childcare.

Parents also emphasized the impact that home visiting has on parenting as a strength of the home visiting programs in their community. Parents noted that home visiting programs help parents gain confidence in their parenting, giving space for parents to ask questions, and giving affirmation. They also shared that home visitors allow parents to ask questions about their children and get to know their child's needs without feeling judgement or pressure. Parents emphasized that home visitors support child development and serve as an educator to both the parent and the child, so that parents know how to help their children achieve developmental milestones. Some parents also mentioned that home visiting materials are helpful and easy to understand.

Another strength of home visiting highlighted by parents was the powerful, trusting, and quality relationship that is created between home visitors and families. They noted that it is this relationship that allows parents to be vulnerable with their home visitor and creates space to address sensitive topics such as domestic violence, substance use, and mental health. Families noted that home visitors serve as an excellent connection to the wider community, providing a link to needed resources and services, as well as connections to other parents. Many parents expressed the benefits of connecting with other families through the socialization offered through home visiting programs. Some families also noted how home visitors serve as effective advocates for and with their families.

Families were also asked about ***opportunities to improve*** home visiting in their communities. They noted several areas where home visiting infrastructure could be strengthened. Families noted that there is not enough public awareness of home visiting programs and that families who could be served are not aware that home visiting exists. They felt that doctors could play more of a role in linking families with

home visiting services, they noted that former home visiting parents could be activated to increase awareness, and that the social media presence of home visiting could be improved.

Parents also spoke to the many restrictions and confusing qualifications for home visiting as a barrier to participation. They also noted that home visiting suffers from the stigma that it is only for low income people. Parents offered the insight that a myth exists among some families that home visiting will be judgmental and burdensome, so they do not seek the service. They also noted that some families conflate home visiting with child protective services and, as a result, fear home visiting.

In addition to barriers to enrollment, parents spoke to opportunities to improve home visiting service delivery. They noted that the paperwork at the beginning of service is overwhelming. They also noted that it is challenging to continue with home visiting while working, as the availability of appointments in the evening or on the weekend is limited. Some parents also noted that they wished they could have more visits each month. Parents also noted the importance of limiting turnover, highlighting how difficult it is to start over with a new home visitor. They also highlighted how they would like home visiting programs to offer more social events. Finally, parents noted the need to make home visiting more broadly available by expanding the number of programs, home visitors, and slots for families.

During the focus groups, parents identified opportunities to improve that are related to the intersection between home visiting and other services for families. Some parents felt it would be helpful if home visiting programs had access to more resources for families experiencing behavioral issues and services for those with special needs. They also noted that it would be helpful if home visiting were offered for children older than five and especially into the teen years. Finally, they noted how challenging transitions between programs can be for families and that transitions could be better managed.

The focus groups took place during July and August of 2020, so the COVID-19 pandemic was a topic of discussion. Generally, parents felt that the transition to virtual visits was handled well; however, they also noted how lack of access to internet or technology has made this approach difficult. Parents felt that home visiting programs have been a crucial link for families during the pandemic, but that it is harder for home visitors to see and address stress in a virtual format.

When asked about the ***outcomes*** of home visiting for children and families in their community, parents noted a wide variety of areas impacted by home visiting. They noted that home visiting improves the physical and emotional health of the entire family. They emphasized the benefits of home visiting for child growth and development, describing how home visiting helps parents develop the knowledge and skills needed to promote good developmental outcomes for children. Parents also spoke to how home visiting improved their parenting confidence, and how home visiting leads families to become informed, engaged, and empowered. They also noted how home visiting helps families learn to set and achieve goals and promotes healthy and positive bonds between family members. Parents highlighted how home visiting improves social connections and decreases isolation. They also noted that home visiting provides linkages to the network of services for families in communities, and helps families address substance use, mental health concerns, and domestic violence.

Early Childhood System

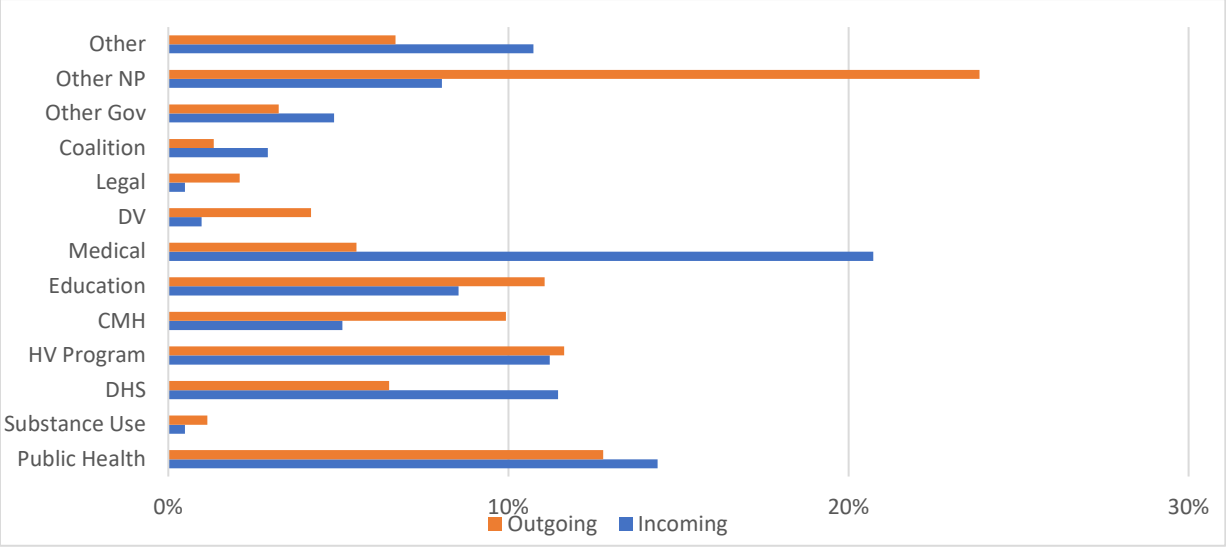
As part of the Exploration and Planning process, home visiting partners came together to review the results of the home visiting program survey and discuss the quality of existing home visiting programs within their county. Across the 36 at-risk counties, local partners noted that their home visiting

programs were of high quality. While they felt their reach was limited by funding levels and eligibility restrictions, they expressed appreciation for home visiting programs designed to serve specific populations, such as indigenous families or families that speak Spanish. Like parents, home visiting system partners were concerned about the lack of awareness about home visiting in their communities, as well as the stigma sometimes connected to home visiting programs (e.g., it is a service for poor families, it is connected to CPS). Partners also noted the capacity for home visiting programs to serve families in coordination with other early childhood and health programs, and they described how important this has been during the COVID-19 pandemic.

The home visiting survey included a section on incoming and outgoing referrals, offering an opportunity to explore how each home visiting program is situated in local referral networks. This section of the survey was lengthy and only 81 programs in the at-risk counties responded. The survey asked programs to report their top 10 sources of incoming referrals. These findings suggested that home visiting programs are especially well connected with medical providers, public health agencies, and their department of human services as incoming referral sources. In contrast, the programs surveyed in the at-risk counties were least likely to receive referrals from substance use agencies, domestic violence agencies, or agencies providing legal services. See Figure 6.

Programs were also asked about their top 20 agencies they refer families to when families need additional supports. The programs who responded to this set of questions indicated that they are especially well connected with community mental health, public health agencies, and local non-profits. However, they were least likely to make referrals to substance use agencies, local coalitions, or legal service providers. See Figure 6.

Figure 6. Agency types connected with home visiting programs in at-risk counties



The home visiting survey included a set of questions for each outgoing referral source that was identified. The survey asked about the capacity of the referral source to meet family needs, the quality of the services provided, the degree to which families are satisfied with services from the organization, and the degree to which families report services from the organization are culturally appropriate. Findings suggest significant variability from agency to agency, sector to sector, and community to community. However, across the 523 outgoing referral sources reflected in the data, 35.6% always had

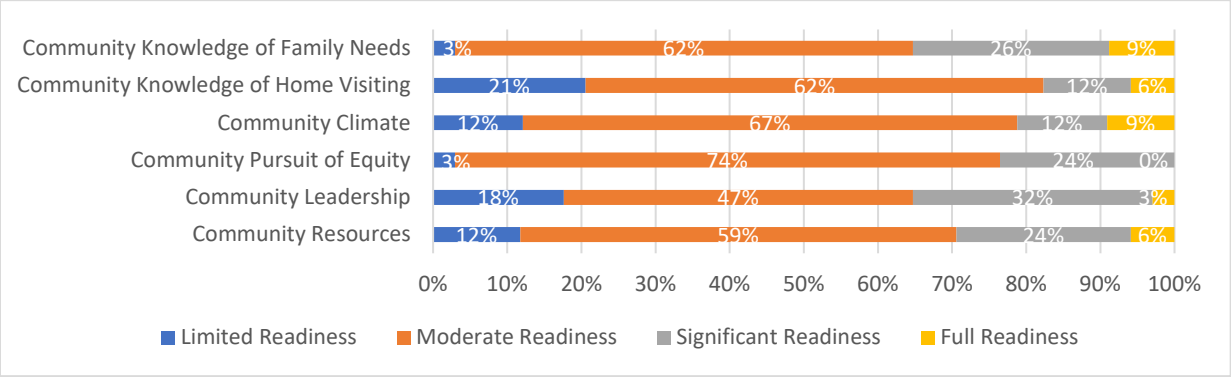
the capacity to meet family needs, and 44.2% usually had the capacity to meet family need. Additionally, across the 521 programs represented in the question about services quality, 53.2% provide high quality services, and 39.0% provide somewhat high-quality services. However, when asked if families report that they are satisfied with services from this organization, across the 521 referral sources, 56.8% received a response of yes families are satisfied and 33.0% received a response of sometimes families are satisfied. Finally, across 520 referral sources, when programs were asked if families report that services from this organization are culturally appropriate, 44.8% received a response of 'yes' and 40.0% received a response of 'unsure.' These data suggest that home visiting programs refer families to services that typically have the capacity to meet family needs and that provide quality services. However, family satisfaction with services was less clear, and, in many cases, programs were unsure if families felt services from programs in their referral network were culturally appropriate.

After the first round of survey data collection, each local partner in the Exploration and Planning process was provided with a set of network maps illustrating incoming and outgoing referrals for each home visiting program that responded to the survey. When examining their local network maps, local home visiting partners identified how the service delivery network could be improved to better meet the needs of families. Many noted an opportunity to improve tracking of referrals and transition planning. They also indicated that they could build stronger, trusting relationships with programs and providers that serve vulnerable communities, and, more broadly, improve their outreach strategies. Many noted gaps in programs for children 3-4 years of age and in services for mental health. Some programs identified gaps in linguistically appropriate services, as well as gaps in services for refugee and immigrant populations. Programs noted challenges in supporting families in accessing transportation, childcare, and housing. Additionally, rural programs noted gaps access to prenatal and postnatal care, highlighting the extensive distance mothers must travel to get to a birth hospital or even to access Ob-Gyn care.

Readiness Assessment Findings

The final component of the Exploration and Planning process involved exploring community readiness to expand home visiting. Through this process, each local community brought together their partners to assess readiness along six domains. The process included group discussion of strengths and opportunities for growth. Each of the 36 at-risk counties completed this process, although 2 did not rate themselves. The findings suggested that communities felt they had the most readiness in the area of community knowledge of family needs. However, they had the least readiness in the areas of community knowledge of home visiting and community climate. Figure 7 summarizes responses across domains and the sections below highlight common strengths and opportunities for improvement.

Figure 7. Readiness ratings by domain



Community Knowledge of Family Needs. When asked to reflect on their communities' knowledge of family needs, many local home visiting system partners mentioned using both community needs assessments and individual family assessments as tools to understand family needs. Often these findings were shared and reviewed with collaborative groups. Parent members of these groups also give voice to needs and inform goal setting for programs. Parent satisfaction surveys, focus groups, and other primary data collection methods were widely utilized. Other secondary data sources reviewed with collaboratives include various nonprofit and government reports. Overall, counties indicated good understanding of family needs among partners. Exceptions were in the business sector and local government; more work needs to be done to raise awareness of family needs among these groups. Medical providers fell somewhere in the middle in terms of understanding family needs, with some indicating strong connections with healthcare and others indicating challenges bringing healthcare partners to the table. Importantly, it was noted by some that continuous improvement is necessary in understanding needs of families of color, providing culturally meaningful services, and earning trust among marginalized populations.

Community Knowledge of Home Visiting. Based on the ratings provided, there is a gap between community knowledge of family needs and community knowledge of home visiting. Local system partners indicated less understanding of home visiting and suggested increasing outreach to system partners and promotion of programs to the public. They felt this could also help reduce the stigma and misperceptions of home visiting; however, they noted that these efforts require funding. Despite these concerns, many cited outreach and strong referral networks as evidence of their capacity to expand home visiting services. Some expressed concern about strict eligibility requirements, especially by income, and wished home visiting services could be opened to all. Local system partners indicated expanded capacity would allow them to serve many more families in need, and that they are eager to do so. It was frequently noted that more needs to be done to educate the public on the benefits of home visiting and reduce stigma associated with home visiting. Toward these ends, some suggested streamlining system navigation, perhaps setting up or improving existing 'no-wrong-door' systems. System navigation was sometimes considered a strength, and sometimes a weakness, depending on if communities had a 'no-wrong-door' approach, as well as how widespread its use had been.

Community Climate. When asked to assess community climate, many counties reiterated that generally there is good support from partners and from the public for early childhood. However, lack of continuous, reliable funding was frequently noted as an issue. Some counties indicated that priorities tend to shift in reaction to crises, rather than focusing on prevention.

Community Pursuit of Equity. Most local system partners expressed the need for more to be done in pursuit of equity. They emphasized the need to address social determinants of health, such as employment, income, and housing. It was common for collaborative groups to regularly review data on disparities and be involved in initiatives to address them. This included partnering with diverse organizations to meet the needs of marginalized populations. It was noted that trust building was necessary to serve families of color and other marginalized groups. Home visiting programs and partners described plans or processes in place to hire diverse staff that represent the families they serve, including efforts to hire former families, although more work needs to be done in this area as well. Many programs have bilingual/bicultural staff or at least have different language resources available, but needs are not always met. Additionally, diversity, equity, and inclusion trainings are required for many home visiting staff across the state but local home visiting partners suggested this is not nearly enough.

Community Leadership. Many local system partners representing at-risk communities concluded that social service leaders are very well-informed and connected to home visiting, but that gaps exist in medicine, business, and government. In some counties, local hospitals, obstetricians and pediatricians do not readily refer and are not well-connected with home visiting programs. In other areas, it was noted that business and local government leaders are not aware of the benefits of home visiting.

Community Resources. Across the board, high-risk counties expressed their appreciation for the many community organizations that work to meet the varying needs of their families and consider these organizations great assets. However, lack of funding for home visiting was frequently the chief concern, as well as inadequate Medicaid reimbursement rates.

Gaps

Excluding MIHP and IMH-HV, 52 programs responded to the question 'Is the program at 85% capacity for at least 9 of the past 12 months.' Of those programs, 32.7% responded 'no' and 67.3% responded 'yes.' This finding was echoed in focus groups conducted through the Exploration and Planning process where parents expressed concern that home visiting programs in their community did not have the capacity to serve as many families as could benefit from home visiting services. The survey also asked home visiting programs if they maintain a waiting list, and of the 112 programs who responded to this question, 31.3% reported that they do maintain a waiting list. Of these programs, 26.5% reported that they had zero families on their waiting list; however, 41.2% reported that they have 10 or more. This also suggests that, in some areas, home visiting programs are full.

The home visiting program survey explored retention by asking programs to indicate why families leave services. When asked, 'Of the families who left the program last year, what percent completed the program, graduated, or met their goals?' 84 of the 112 surveyed programs responded. Responses varied widely from 0% to 100%, however the mean response was 57.7%, while the median was 62.0% and the mode was 60.0%.

One barrier to enrolling and retaining families common among home visiting programs is staff turnover. When asked about home visitor vacancies 22.3% of programs (n=112) reported that they have one or more full-time home visitor positions vacant and 11.6% reported that they have one or more part time home visitor positions vacant.

Funding is also critical to being able to offer services that align with community needs. Of the 111 programs that responded to the survey question about changes in funding in the past year, 17.1% reported a decrease in funding that limited their enrollment capacity and 9.0% reported an increase in funding that expanded their enrollment capacity.

In response to the question, "What are the most significant barriers you face to serving families in your community?" home visiting programs reported several barriers. Common barriers included limited funding to hire enough staff to meet the needs of the community, lack of diverse staff who represent the community served, lack of awareness among community members about home visiting programs, and the reluctance families have about people coming into their home for fear of judgement or CPS involvement. Those that served multi-county, rural regions noted travel as a challenge. Additionally, many programs listed limited referrals as a major barrier. For example, some noted that they receive few referrals from hospitals or their WIC program, who have referral relationships with a specific program. Similarly, competition for families was noted as an issue by some programs. Some programs

also noted that access to reliable technology has proven difficult to many families, especially those located in rural areas during the COVID-19 pandemic.

Despite the barriers and challenges experienced by home visiting programs and early childhood systems, there was broad support for expanding home visiting. Through the Exploration and Planning process, when asked to indicate if their county has the need and capacity to expand evidence-based home visiting 32 out of 36 programs reported that they do have the need and capacity to expand. They noted that they could reach more families if they had more funding, and most indicated that they would use additional funding to expand existing programs rather than to start new programs.

Priorities for Expanding Evidence Based Home Visiting

Using Table 7 in the Needs Assessment Data Summary provided by HRSA, as well as the data reported above, several counties emerged as having risk, need, and capacity to expand evidence-based home visiting. It should be recognized that there is a certain level of risk in every county in Michigan and families have needs that cannot yet be met with the limited resources available. This process was designed to identify communities with the highest levels of risk to support data driven funding decisions. Additionally, as noted in Section 2, the data in Table 7 regarding the number of families served should be interpreted with caution as it was pulled from the home visiting program survey, which did not have a 100% response rate.

Of the 36 at-risk counties, nine were serving more families than HRSAs estimate of need in the county. However, every one of these counties indicated that they have the need and capacity to expand home visiting within their area, suggesting that they operated from a definition of home visiting eligibility that was broader than HRSAs.

On the other end of the continuum, 5 counties were serving less than half of eligible families, indicated that all evidence-based home visiting programs were at capacity, and indicated both the need and capacity to expand home visiting within their area. These five counties included Newaygo County, Oakland County, St. Clair County, Wayne County, and Cass County. Additionally, of the 36 at-risk counties, only two had elevated risk in five or four domains, as well as the need and capacity to expand: Wayne County and Lake County. Exploring the counties with an estimate of need over 1,000 family slots, a different pattern emerges. None of these 13 counties are serving more than 100% of the home visiting eligible families identified in HRSA's estimate. However, one of these counties reported that they do not have the need or capacity to expand. On the other hand, 10 of these counties are serving less than 50% of the estimate of need and they reported the need and capacity to expand: Berrien County, Genesee County, Ingham County, Macomb County, Muskegon County, Oakland County, Saginaw County, St. Clair County, Wayne County, and Ottawa County. Wayne County had five at-risk domains and both Genesee County and Muskegon County had three.

Regardless of the method used, Wayne County emerges as the priority area for expanding evidence base home visiting. Several other existing MIECHV communities appear to have need and capacity to expand, including Berrien County, Genesee County, Muskegon County, Oakland County, and Saginaw County. Finally, several communities not currently funded by MIECHV but who receive various levels of other home visiting funding emerged as priorities: Lake County, Newaygo County, St. Clair County, Cass County, Macomb County, and Ottawa County.

Capacity for Providing Substance Use Disorder Treatment and Counseling Services

This section identifies Michigan's capacity for providing substance use disorder treatment and counseling (SUD T/C) to pregnant women and families with young children. Substance use impacts the health and wellbeing of the whole family system, and, as such, it is critical that home visiting and substance use disorder prevention and treatment systems are well prepared to work in partnership to support pregnant women and families with young children. The goal of this section is to identify the system of care that is available to families served by home visiting programs, and to identify gaps and barriers in access to care to inform system improvements.

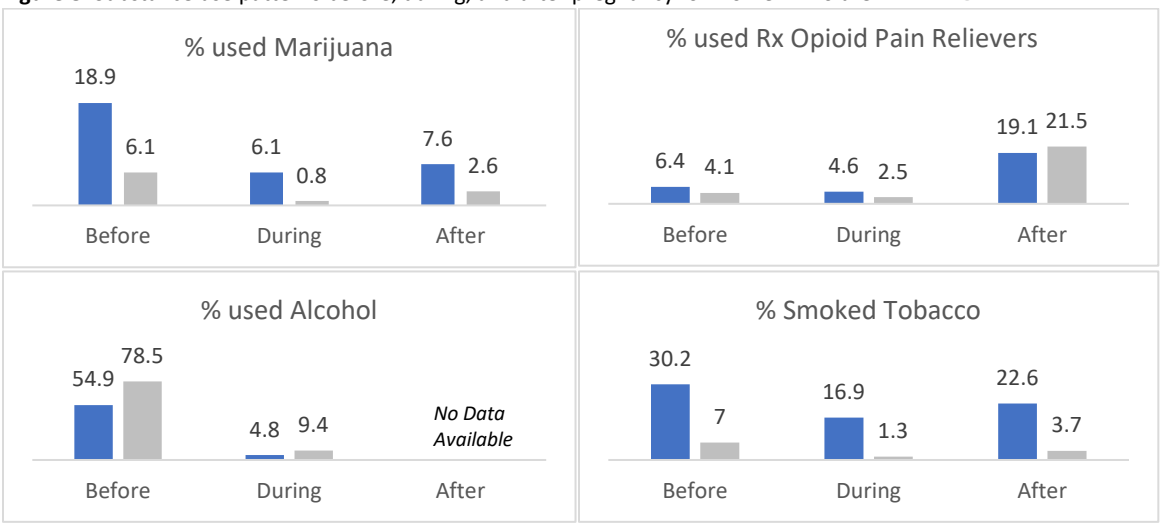
Defining the Population

Substance use disorders (SUDs) affect women and men across all racial and ethnic groups, socioeconomic backgrounds, and geographic areas across the US (McHugh, Wigderson, & Greenfield, 2015). Michigan is no exception; an average of 650,000 people are estimated to have experienced SUD in our state annually (NDSUH, 2015-2017). Certain factors increase the likelihood and speed of developing an addiction, including individual contributors (e.g. family history, mental illness) and environmental contributors (e.g. stressors of violence and poverty, availability of drugs, and lack of social support). Women and men eligible for home visiting may face many of these circumstances within their lives and communities, elevating their risk of developing SUD.

Substance Use Patterns

Information on alcohol and drug use patterns among pregnant and parenting people in Michigan is available from the Pregnancy Risk Assessment Monitoring System (PRAMS). Michigan PRAMS data allows for exploration of drug and alcohol use behaviors, including highlighting behaviors that may be more common among mothers who are Home Visiting-eligible (HVE) when compared with mothers who are not. PRAMS defines HVE as including at least one of the following criteria: Participation in WIC during pregnancy; Medicaid coverage for prenatal care or delivery; Household income less than 195% of the federal poverty level; Maternal age less than 21 years; and Maternal education less than a high school degree. See Figure 8 for information on substance use for women who were and were not HVE.

Figure 8. Substance use patterns before, during, and after pregnancy for women who are HVE v. Non-HVE



Opioid use during pregnancy can lead to birth defects, poor growth, premature delivery, and a condition known as Neonatal Opioid Withdrawal Syndrome (NOWS). Incidences of NOWS, unfortunately, are increasingly common. Diagnoses have risen on a national level, and cases in Michigan increased 690% between 2004 and 2014 (National Institute on Drug Abuse, 2020). As of 2018, American Indian women have the highest incidence of NOWS with 4,691 per 100,000 live births, with White non-Hispanic women next highest with 881 per 100,000 live births (Michigan Inpatient Database, 2018). The Upper Peninsula of Michigan has the highest rates of NOWS in the state with 2,588 per 100,000 live births in 2018.

Additionally, the use of e-cigarettes in Michigan has increased, especially among youth and young adults. The use of e-cigarettes among Michiganders aged 18-24 is 12.8% (2017 BRFSS), higher than cigarette use in this group. E-cigarette use among women three months before pregnancy is 3%, in the last three months of pregnancy drops to 1% (PRAMS 2015-17). Data from young people also suggest trends among young pregnant and parenting persons compared to their peers that put young parents at risk. Data from a survey of 7,620 Wayne County high schoolers found that young men or women who had ever been pregnant or gotten someone pregnant were substantially more likely to have used many substances in the past month compared with their peers (MIPHY, 2017-2018). This included past month usage of cigarettes (31% v. 3%), e-cigarettes (57% v. 24%), alcohol (48% v. 18%), marijuana (59% v. 17%), and prescription pain killers (12% v. 4%). This suggests the youngest parents engaged in home visiting may be more regularly using substances than the general youth population.

Treatment Utilization

An analysis of SAMHSA's Behavioral Health Treatment Episode Data Set (TEDS, 2018) shows an estimated 22,699 pregnant women and 171,448 women with dependent children in need of treatment. This number stands in stark contrast to the mere 1,224 pregnant women and 10,970 mothers who were admitted for treatment in 2018 (FY2020/2021 Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Application; referred to as Block Grant Application).

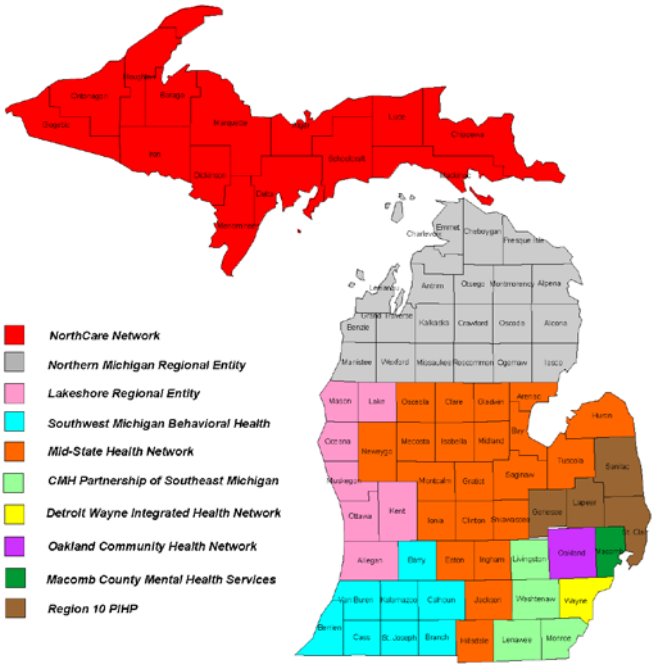
Data on admissions of pregnant women ages 15-44 to publicly funded **substance use treatment** facilities paint an important picture of needs (TEDS, 2020). Between FY 2016-2019, over a third of admissions for this group were for primary use of heroin; 12% were for alcohol; and 10% were for marijuana. The number of admissions for prescription opiate use fell during this time frame, from 348 women in FY16 (29%) to 184 in FY19 (17%), while admission for primary methamphetamine use grew from 26 women (2%) to 113 (10%). (It is important to note that these records represent *admissions* rather than *individuals*, as a person may be admitted to treatment more than once.) Nearly two-thirds of service admissions for this group between FY16-19 were to outpatient programs, with short residential treatment (14%) and residential detox (10%) rounding out the top three service settings. Utilization of medication assisted therapy (MAT) as part of treatment appears to have lessened slightly over this time frame among admissions in this population, falling from 77% of MAT-eligible admissions in FY16 to 73% in FY19.

Data on the race and ethnicity of admissions of pregnant women ages 15-44 in FY19 indicate that white women constituted 78% of admissions and African American/Black women constituted 12%; About 5% of women reported being part of a Hispanic/Latino ethnic group.

Range of SUD Treatment and Counseling Services

In Michigan, SUD early identification, treatment, and recovery support systems are the primary responsibility of MDHHS' Behavioral Health and Developmental Disabilities Administration (BHDDA). BHDDA contracts with 10 Prepaid Inpatient Health Plans (PIHPs) to manage publicly funded SUD specialty services and supports (see Figure 9). The PIHPs are required to provide outpatient services, residential services, sub-acute detoxification, medication-assisted treatment, case management, early intervention, peer recovery and recovery support, and integrated treatment for co-occurring mental health and substance use disorders.

Figure 9. Prepaid Inpatient Health Plan regions in Michigan
Updated 01/21/2020



Each PIHP utilizes an Access Management System (AMS) that acts as a gatekeeper to publicly funded services in their region. Through the AMS, individuals and their families are screened and referred to services. Providers charge on a sliding-fee scale based on income and insurance.

The Substance Abuse Prevention and Treatment (SAPT) Block Grant requires states to spend a set minimum amount each year for treatment and services for "pregnant women and women with dependent children, including women who are attempting to regain custody of their children." In Michigan, women's specific programs (also called gender-responsive programs) assure access to SUD treatment for pregnant women, and custodial postpartum women or single fathers. Michigan has more than 60 programs identified as gender-responsive for pregnant persons and parenting women or men with a substance use disorder (Block Grant Application, 2020). MDHHS requires programs designated as offering women's specialty services to include specific gender-responsive criteria that are thought to lead to greater success in retaining women or parenting families, including specific treatment philosophies and resources, outreach activities to promote and advertise women's programming and priority status, and specific staff training. The state also has provisions for Enhanced Women's Services, which allow for any designated women's program to offer intensive case management programs for women who are pregnant or up to twelve months post-partum with dependent children.

As a priority population, pregnant women are intended to have immediate access to SUD T/C. Specialty services for pregnant and parenting women are available at all levels of care, and children entering treatment with their mothers are also assessed for needs. If a pregnant woman is not able to participate in treatment immediately, she is offered interim services and connected with a treatment coordinator. All individuals who are intravenous drug users (IDU) are considered a priority population, with pregnant women being admitted first to treatment. A search of SAMHSA's Treatment Locator revealed 113 facilities that offer special programs for pregnant/postpartum women.

Parents at risk of losing their children to the child welfare system are also a priority population in Michigan and can access SUD treatment services immediately. Michigan law extends priority population status to men whose children have been removed from the home or are at danger of being removed. There is one residential program in Michigan that can accommodate an entire family (both parents and children) in SUD treatment. Several other residential programs can accommodate women and their children, and at the outpatient level, ancillary services are offered both to mothers and fathers who are primary caregivers (e.g. childcare, transportation, case management, child therapy, and medical care). 221 facilities in Michigan have special programs for adult women.

Focus groups were completed as part of this needs assessment to gather perspectives from home visitors and home visiting families about their experiences with SUD T/C, the strengths and gaps in the system, and changes they would like to see to how home visiting approaches SUD. When asked what options are available for expectant or parenting moms or dads who seek SUD T/C, unique services included peer recovery coaching offered through a local needle exchange, an MIHP social worker who is trained as a SUD counselor, and SUD counselors they can text for support at a moment's notice. Home visitors said they learned about SUD T/C options in their area through local collaboratives, community partners (e.g., needle exchange programs, SUD programs at their agency), from families themselves or other home visitors, resource lists, or simply searching the internet. They reported that the SUD T/C landscape is often changing, so those HV programs with strong local services coordinating bodies that included SUD T/C providers had the best success in staying up to date on changes in the community.

Both home visitors and families from the SUD focus groups saw home visitors themselves as a key component of a families' success in SUD T/C when they were willing and able to discuss SUD openly. In those cases, both groups saw home visitors as system advocates, resource-finders, and barrier-busters; encouragers and cheerleaders who point out the good T/C is bringing to families' lives; accountability buddies and reinforcers of the importance of sticking with treatment; and non-judgmental, caring supports for stress release and processing. This nonjudgmental, invested, and caring relationship with home visitors was very helpful to promoting disclosure and connection to treatment.

Gaps in the Current Level of Treatment and Counseling Services

SUD is a pressing concern for women and children in Michigan, and available data paints a picture of an immense and growing need. However, many data sources point to important gaps in services, summarized below.

Too Few Providers/Long Wait Times. The limited number of treatment options and providers, particularly providers who take Medicaid families, was a prevalent theme in the SUD focus groups with both home visitors and families. Home visitors describe referring families to services that they were excited about, only to find out the desired service was full, and that the wait list was several months long or that they did not maintain a waitlist. This was described as particularly problematic, as a wait time can result in families losing their readiness to seek help and falling back into using substances. The Title V Needs Assessment likewise found a need for more behavioral health providers overall, as did an Altarum report produced in 2019. Home visitors noted that this problem was especially pronounced in rural areas, such as the Upper Peninsula, where families may have very long wait times and long distances to travel to seek treatment (focus groups & statewide survey).

Lack of Services for Fathers. Several groups took note of the lack of services for single fathers. There is only one known residential program in Michigan that can accommodate an entire family in need (both

male and female parents and children) in SUD treatment, and there are no known special residential programs that accept single custodial fathers (SA Block Grant, SUD Focus Groups). Additionally, SUD focus group participants noted that there are a lack of counseling options that focus on the whole family, including fathers; most family services are focused on mothers and children, potentially to the detriment of both the caretaker with SUD and the entire family.

Limits on Services. Focus group participants noted that several SUD T/C options have a maximum amount of services an individual can receive at a time, negatively impacting families' ability to achieve and maintain recovery. Residential programming often has a limit of 30-60 days, leaving newly recovering caretakers to scramble to find a safe, recovery-oriented housing environment for themselves and their children with little to no economic means. Relatedly, families enrolled in home visiting expressed a desire for more flexibility to increase their frequency of counseling and classes, sharing that one meeting a month is not enough.

Care for Pregnant Mothers with SUD. Home visitors who participated in the SUD focus groups described a lack of SUD providers who will treat pregnant mothers with MAT, noting a stigma around providing those services to expectant women. They also described a Catch-22, wherein if a mother is able to access MAT, she may risk losing her prenatal care, as many OBs will not serve mothers on MAT. Furthermore, some OBs will not treat mothers with SUD at all, further limiting parents' willingness to disclose their condition to their doctor.

Residential Treatment & Recovery Housing. Notably, there are only 13 residential centers that have gender-responsive programs, and only a subset of these allow children to enter treatment with their parents (BDHHA representative, 2020). Most of these have a limit around the age of the child, and almost none of these allow children up to age 17. During the SUD focus groups, a participant shared that she would not feel comfortable taking her children into most treatment centers, as they are not great environments for children. She noted that this has been a major challenge for her recovery, as she feels she does not have the option to get the sort of intensive residential treatment she has had before she was a mother. Additionally, there are very few transitional housing/halfway house/sober home options for parents of young children; these facilities only cover 9 of Michigan's 83 counties for pregnant/postpartum women special programs, and 14 counties for adult women special programs.

NAS Rooming-In Treatment Options. Several published studies have demonstrated that babies allowed to room-in with their mothers experience less-severe signs of NAS, are less likely to require pharmacotherapy and prolonged hospitalization, and are more likely to bond with and remain in their mothers' care at the time of discharge (Abrahams, et al., 2007; Hodgson & Abrahams, 2012). The "Eat, Sleep, Console" model is one family-oriented approach to treating NAS that is slated to be implemented in twenty Michigan hospitals; unfortunately, the rollout has been delayed indefinitely due to the pressures of the COVID-19 pandemic on healthcare systems. If an infant does have to enter the NICU, there are very few "rooming-in" options for families in Michigan, meaning that families must travel from their homes or temporary housing to visit their newborns (SUD Focus Groups with Home Visitors). For families in the U.P., this might mean travelling 2.5 hours one way to visit. If the parent(s) are unable to make this journey, child protective services may become involved for perceived neglect.

In-Home Services. Home visitors (statewide survey of home visiting programs, 2020) and families (SUD focus groups) identified a need for in-home SUD T/C services. Both groups noted that having this option

would help overcome many common barriers to treatment and would build on the success of prevention focused home visiting.

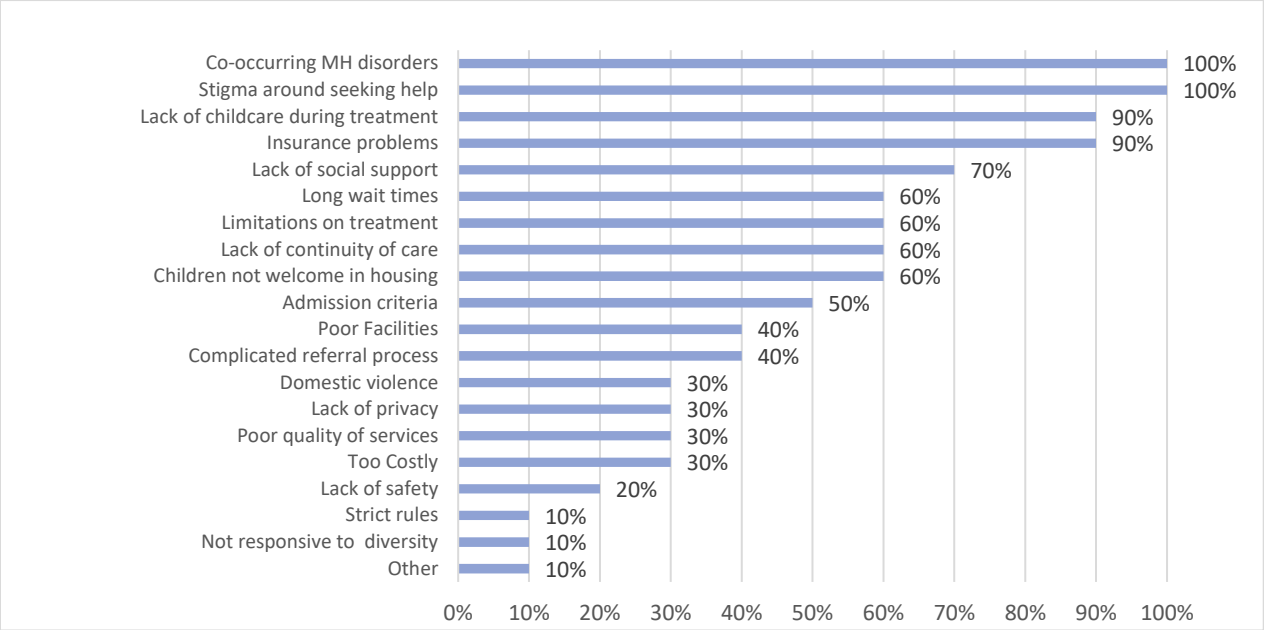
Localized, Specialized Recovery Services. Services to support ongoing recovery are key to long-lasting freedom from substance abuse. Families and home visitors who participated in focus groups both described a lack of Alcoholics/Narcotics Anonymous meetings available in neighborhoods that are easily accessible for families. One mother also described going to AA meetings, but having a hard time connecting with other members who do not have young children. She would like to see AA/NA groups specifically for parents with younger children, as well as more sober socializing options for young families in recovery to meet others with similar goals.

Barriers to Receipt of SUD Treatment & Counseling Services

In addition to the gaps in services described above, several barriers commonly stand in the way of home visiting-eligible families accessing and continuing to receive the SUD T/C they need. These barriers, identified through several data sources (SUD focus groups, focus groups with home visiting-eligible mothers with SUD conducted by MPHI with funding from the Michigan Health Endowment Fund, Title V Needs Assessment) are summarized below. Additionally, home visitors were also asked about the barriers their families face to receiving SUD T/C in a brief survey during the SUD Focus groups. The results of this poll can be found in Figure 10. An asterisk (*) next to the barrier below indicates most home visitors polled reported their families had experienced that challenge when trying to access SUD T/C.

- **Stigma** around behavioral health issues leaves families worried that they will be judged by others in their community (Title V, SUD FG, MHEF FG)*
- Client **denial** of SUD prevents them from facing the problem or desiring to get services (SUD FG)
- **Co-occurring mental health disorders** compound barriers (SUD FG, MHEF FG) *
- Poor fit between client and culture of available programs or staff (SUD FG)
- Provider choice contingent on insurance, not on fit (SUD FG)
- A lack of **social support** to provide tangible or emotional support (SUD FG) *
- SUD T/C patient dismissal policies (SUD FG, Title V)
- Complicated referral, eligibility, admission, and screening criteria/processes (SUD FG, HV survey) *
- Not able/safe to bring children into residential treatment (SUD FG)*
- An **unstable health insurance** system with constantly changing requirements (Title V, SUD FG) *
- Lack of affordable SUD T/C options when insurance does not cover all services needed, particularly as coverage changes between pregnancy and postpartum periods (SUD FG, Title V)
- Lack of gender-responsive services for transgender or non-binary parents; must choose between women's and men's services when neither might be appropriate/safe (SUD FG)
- **Transportation** barriers to getting to treatment (SUD FG, Title V)
- Few providers work in the **evenings**, making appointments difficult for working families (SUD FG)
- Lack of access to affordable, close **childcare** during treatment (SUD FG) *
- There are disparities in access to programs & services in **rural** versus urban areas. (Title V, SUD FG)
- Women experience **gender-based violence** and/or do not feel safe in their homes (Title V, MHEF FG, SUD FG)
- Lifetime exposure to **chronic stress, sexism,** and **racism** are the root cause of SUD in some cases and are not addressed systemically (SUD FG, Title V)

Figure 10. Home visitors' perceptions of barriers to SUD treatment or counseling among MIECHV families (N=10)



Additional information on barriers to treatment through existing SUD programs can be found in the statewide survey of home visiting programs. Programs were asked to list the agencies they are in referral relationship with (incoming or outgoing) and answered questions about the services available therein. Thirty-four home visiting programs (24% of 142 who answered this section) indicated having at least one program with SUD services as an outgoing referral source, representing programs that serve 30 counties. When asked if the SUD programs they referred to had the capacity to meet family needs related to the services they provide, most home visiting agencies with outgoing referral agencies indicated they had at least one SUD program that either always (79%), usually (88%), or sometimes (62%) had the capacity. One-quarter had at least one SUD program they refer to that rarely has the necessary capacity. Most home visiting agencies with an outgoing referral to SUD indicated having at least one SUD program that provides good services, reporting either high quality (85%) or some quality (91%) in these options. Unfortunately, 26% of programs had at least one SUD program they refer to that reportedly provides low quality services. Similarly, most home visiting programs reported having at least one SUD outgoing referral option that families report being satisfied with, either generally (85% of HV programs) or sometimes (82%). Cultural appropriateness of existing SUD programming was an area of less certainty, with 56% of home visiting programs reporting being unsure if at least one of their SUD outgoing referrals was in fact culturally appropriate for their families.

Opportunities for Collaboration with State and Local Partners

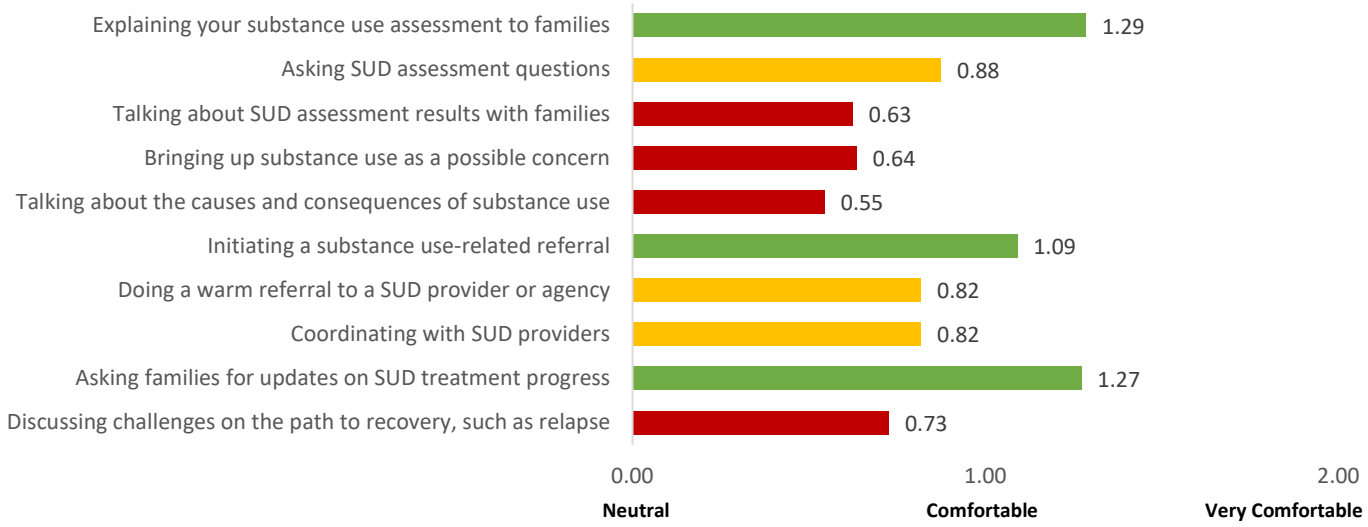
Opportunities for strengthening collaboration between home visiting and other key partners to address gaps and barriers to care for pregnant women and families with young children impacted by SUD are present throughout the state of Michigan, both locally and statewide.

Local Home Visiting Programs' Collaboration with SUD Providers

One opportunity for growth in collaboration exists in the connections between local home visitors and their local SUD providers. This starts with strengthening home visitors' capacity to discuss SUD with the families they support, and to connect those who are interested with SUD T/C options in their area.

Home visitors in the SUD Focus Groups were asked to describe their level of comfort with a variety of SUD assessment, referral, and follow-up tasks that could occur as part of their service provision. Figure 11 describes their levels of comfort/discomfort therein.

Figure 11. How comfortable are home visitors…



Note: None of the response means fell in the range of Uncomfortable (-1)/VERY Uncomfortable(-2), so this portion of the graph was excluded.

Results of the poll indicate that home visitors, on average, feel either neutral or somewhat comfortable engaging families on SUD topics. When it comes to supporting disclosure of SUD, they tend to be more comfortable explaining SUD assessments than discussing results. When asked what strategies they use to support families' disclosure, home visitors discussed leaning on their model's "routine assessment." They normalized it as a non-blaming, non-judgmental check-in that is simply a part of the process for every client—not due to their income level or race. They also described aiming to be open and honest with their families to build trust. While some families are forthright with their substance use patterns, several home visitors shared that families usually do not disclose immediately, but instead wait until they know their home visitor well enough to feel comfortable opening up about their struggles without fear of negative consequences. They noted that this reticence to share the truth can be a huge challenge to meeting the family's needs. The home visiting participants in the focus groups also mentioned finding the integrated SUD assessment to be a normal part of the paperwork when they signed up, and several mentioned they already felt comfortable enough to share the truth at intake. These results suggest that, overall, SUD assessments are comfortable for those that use them, and that they may support disclosure for some families; however, they do not ensure an accurate depiction of a family's needs.

On average, participants in the Home Visitor SUD poll felt less comfortable bringing up SUD as a possible concern or talking about the causes and consequences of SUD when compared to completing assessments. When asked how they approach discussing SUD, one SUD focus group home visitor mentioned that her program has started to use the ACES study more frequently to explain the links between childhood trauma, mental health, and substance use. Another mentioned making safety plans with families for actions caregivers can take to ensure child safety if they choose to use. One home

visiting family SUD focus group participant mentioned that her home visitor had comfortably asked her questions about the underlying causes of her substance use, helped her problem solve immediate solutions to cravings, and encouraged her to seek recovery and additional SUD T/C. These findings suggest that, while promising practices exist for raising SUD concerns and problem solving therein, some home visitors could use additional support to more comfortably implement them with families.

The poll also indicated home visitors felt more comfortable initiating a referral to SUD T/C than doing a warm handoff or coordinating with SUD providers. This might be related to several home visitors' reports that home visiting agencies are not well connected to substance use providers in their area. Additional information on the connections between home visiting programs and SUD programs can be found in the statewide survey of home visiting programs, which found limited incoming or outgoing referrals with SUD providers. These results suggest additional work may be needed to build stronger connections between the home visiting and SUD service systems.

Finally, home visitors reported feeling more comfortable asking families for updates on their SUD treatment progress than discussing challenges on the path to recovery, such as relapse. A home visiting participant in a SUD focus group contrasted her two home visitors' responses to supporting her on her recovery journey. Her first home visitor was very relatable and easy to talk with about SUD, offering her encouragement and resources for her recovery, and allowing her to vent to relieve stress that could contribute to relapse. In contrast, her second home visitor was much dryer, and not as knowledgeable about or supportive of her recovery. She would ask if the caregiver was staying clean and hand her a pamphlet about the dangers of drug use, without offering any additional resources or support. These results suggest that some home visitors may benefit from additional training and practice regarding ongoing coaching with families working toward recovery.

Local Collaborative Efforts

Several promising initiatives for improving local coordination and collaboration between Home Visiting and SUD programs are happening within existing local collaboratives, including Regional Perinatal Quality Collaboratives (RPQC), Great Start Collaboratives (GSC), and Local Leadership Groups (LLG).

RPQC. There are 9 RPQCs in Michigan, each focused on improving birth outcomes for moms, babies, and families. Among the many efforts currently being undertaken by these regional bodies include work to increase substance use screening, referral, and coordination of care for pregnant women; increase implementation of SOPHE's Smoking Cessation and Reduction in Pregnancy Treatment; improve NAS treatment options; increase obstetric providers trained in MAT; and increase access to telehealth.

GSC. The overall purpose of a GSC is to create a single, interconnected, intertwined network of public and private programs, services, and supports, working together in a community to accomplish better results for young children and families. They are informed by Parent Coalitions that bring parent voice to the decision-making process. Several GSC's have led efforts to address SUD among families in their area. Strategies include efforts to increase awareness of the effects of SUD before, during, and after pregnancy among community members via educational opportunities and media campaigns; partnering with local SUD coalitions and workgroups; and increasing appropriateness of SUD T/C for parents.

LLG. Local leadership groups are coordinating bodies that work with the state to implement and improve home visiting programs locally. These groups were mentioned as key sources of networking, information on changing services, and places to troubleshoot other community SUD concerns through

the SUD focus groups and statewide home visiting survey. LLGs are also beginning to offer professional development opportunities on SUD.

Statewide Collaborations

MDHHS has worked to align maternal and infant health efforts with SUD efforts, both internally and with external partners. Examples of these efforts include MIECHV and BHDDA staff partnering to offer training on validated SUD screening tools to MIECHV-funded programs; Maternal child health partners helping to develop Michigan's Opioid Strategic Plan and state level CQI projects aiming to reduce tobacco use; MDHHS support for the Michigan Collaborative Quality Initiative, which engaged 20 Michigan birthing hospitals in improving care for infants with NAS in Neonatal Intensive Care Units; and specialized smoking cessation programming for pregnant and post-partum women through the Michigan Tobacco Quitline.

Other Opportunities for Collaboration

In addition to capitalizing on and expanding these existing efforts through regional/local collaboratives including home visitors, state and local home visiting representatives have opportunity to more robustly reach out to other systems to network, better understand their role and processes, and share resources. Home visiting partners could attend Regional PIHP provider meetings, Regional PIHP Substance Use Disorder Advisory and Policy Board meetings, or statewide meetings of SUD programs for pregnant and parenting women. Home visiting partners could also work with recovery groups such as Families Against Narcotics or referral partners such as 211. Fetal-Infant Mortality Review teams, naloxone providers, and needle exchange programs could also be a point of connection for home visiting programs.

Strategic Approaches to Responding to SUD among Home Visiting-Eligible Populations

While many partners contribute to Michigan's efforts to respond to substance use disorders among pregnant women and families with young children, MDHHS's BHDDA Office of Recovery Oriented Systems of Care's Strategic Plan FY18-20 has laid the groundwork to guide these efforts over the last three years. While this plan includes many relevant goals and objectives across the Office's Strategic Priorities, two goals under the Strategic Priority of "Improve Outcomes for Children, Youth and Families" were geared to supporting pregnant and parenting persons. Goal 3 focuses on reducing substance exposed births, and Goal 5 focuses on reducing the effects of parental substance use on youth.

As part of strategic efforts to move these goals forward, MDHHS has committed to working toward better integration between maternal child health programs and behavioral health systems within its own structure. Within the organizational structure of MDHHS, BHDDA and the Public Health Administration (PHA), where MIECHV funding sits, both fall under the leadership of the Senior Chief Deputy for Health. Additionally, there are close working relationships between BHDDA staff who work with children and families and maternal child health staff. For example, BHDDA's Division of Services to Children and Families leads the implementation of IMH-HV and coordinates closely with public health home visiting programs. Additionally, as noted above, BHDDA's Division of Recovery Oriented Systems of Care supports a network of substance use treatment programs designed specifically for pregnant women and women with young children.

MDHHS also developed and implemented CareConnect360 (CC360), a statewide web-based care management system that allows for the bi-directional exchange of Medicaid beneficiaries' health care information to allow for the coordination of services between state health plans and CMH/PIHPs. CC360 makes it possible to analyze healthcare program data, manage and measure programs, and improve

enrollee health outcomes. CC360 addresses the need for improved communication within MIHP, including sharing care elements that can aid in successful case management by assuring that MIHP is part of the care team. Similar opportunities are being explored related to other home visiting models.

Current Activities to Strengthen the System of Care

In response to the opioid epidemic and the impact of SUD on the health and wellbeing of its communities, Michigan is developing and refining comprehensive strategies designed to meet the needs of pregnant and parenting women with SUD and mitigate its impacts. In addition to strategies already described, the findings from the Title V needs assessment led to a new state priority need to "Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems." Title V has provided resources to the RPQCs to implement two strategies to strengthen the system of care relevant to meeting SUD T/C needs in pregnant and parenting populations: SBIRT and Tele-Behavioral Health.

MDHHS also received a large State Opioid Response (SOR) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), which funded a variety of regional and statewide efforts around three core goals: (1) to increase access to MAT; (2) reduce unmet treatment need; (3) and reduce opioid overdose-related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorders. While few of the efforts specifically focused on pregnant or parenting persons, the efforts created greater availability of resources for all families in Michigan.

Recommendations for Improving Connections to SUD

As Michigan works to maximize resources, overcome barriers, and optimize outcomes for parents and children impacted by SUD, there are additional opportunities for collaboration between the home visiting and SUD T/C systems at the state and local levels. Recommendations on actions that could be taken therein were gathered from the Needs Assessment stakeholder group, and are summarized below:

- Partner with BHDDA to identify a central, easily accessible source of information on SUD services and disseminate to home visiting programs and local home visiting system partners.
- Expand home visitor training on SUD to include home visitor-identified training needs.
- Support home visitors in building comfort exploring nuanced dimensions of SUD with families.
- Provide opportunities for SUD T/C providers to receive training on home visiting.
- Support home visiting programs in establishing relationships with local SUD T/C agencies.
- Create mechanisms for local and state staff who work in SUD T/C and home visiting to collaborate.
- Include families, HV programs, and partners in SUD T/C in opportunities to develop processes for referral and service coordination that work for families.
- Invite home visiting programs to present to PIHPs to increase awareness of home visiting.
- Facilitate connections between the BHDDA Women's' Specialist and home visiting leadership.
- Engage HV programs and families across the state to share strategies for effective screening, referral, and support for families who are in treatment and recovery.
- Support capacity building efforts for home visiting programs to enhance the support they are already offering families coping with SUD.
- Contribute to all statewide efforts to challenge stigma around SUD among pregnant and parenting persons, expand service offerings, and breakdown barriers to treatment and long-term recovery.

Coordinating with Other Needs Assessments

Michigan's home visiting needs assessment was coordinated with and considered other needs assessments focused on pregnancy and children birth to five taking place in the state. This included the Title V MCH Block Grant Five-Year Needs Assessment, the Head Start community-wide strategic planning and needs assessments, and assessments conducted under Title II of the Child Abuse Prevention and Treatment Act. It also included Michigan's Preschool Development Grant- Birth to Five Needs Assessment, the needs assessment required under Michigan's Pritzker Grant, and the needs assessment conducted as part of the Family First Prevention Services Act. As noted in the introduction, this process was facilitated through a series of conversations between the staff responsible for coordinating these assessments at the state level. This section will describe how Michigan coordinated with and considered findings from these needs' assessments. It will also describe how stakeholders convened to review and consider the findings of this home visiting needs assessment, as well as strategies identified to facilitate ongoing collaboration.

Coordination Across Needs Assessments

In order to facilitate coordination across needs assessments, state level coordinators of these processes convened to share information about the purpose and timeline of each assessment and to define coordination strategies. Table 3 documents the outcome of these conversations.

Title V MCH Block Grant Five-Year Needs Assessment

Michigan discovered the most robust opportunities for collaboration between the home visiting needs assessment and the Title V MCH Block Grant Five-Year Needs Assessment. The state coordinators of these processes determined that one way to coordinate these needs assessment activities was to conduct them sequentially. Given that the purpose of the Title V needs assessment is to identify MCH priority needs across the state and that the focus of the home visiting needs assessment is much more focused, the state leads decided to complete the Title V needs assessment first and to use learnings to inform the home visiting needs assessment. They also determined that the findings of the home visiting needs assessment could inform updates to State Action Plans under Title V during years two through four of the Block Grant.

Additionally, each needs assessment was guided by a group of stakeholders that included both MDHHS staff and external partners from the state and local levels. The Title V stakeholder group included home visiting leaders at the state and local level, including members of the Core Team that led the home visiting needs assessment. Conversely, the home visiting needs assessment stakeholder group included partners who were involved in the Title V needs assessment, including the Title V Coordinator and Director. This allowed for robust sharing of data, process, and findings across assessments.

The MCH epidemiologist on the home visiting needs assessment Core Team was also the lead epidemiologist for the Title V needs assessment. This facilitated collaboration between the home visiting epidemiologist and the Title V epidemiologist. The indicators selected and pulled for the Title V needs assessment were shared for the purposes of the home visiting needs assessment, and they were considered during the process of supplementing the simplified method. Moreover, the Title V epidemiologist was able to share processes for pulling and sharing local data, which was adapted by the home visiting epidemiologist for the Exploration and Planning process.

The Title V needs assessment included direct data collection from a variety of partners and community members. As those efforts were designed, care was taken to build in feedback from the partners involved in the home visiting needs assessment. For example, the Title V process included conducting listening sessions with existing groups related to each population domain. One of the groups identified for the Child and Adolescent Health domain was Michigan's Home Visiting Advisory, which convenes state and local home visiting partners and parents. The listening session protocol was adapted to include questions specific to the home visiting needs assessment. The findings will be described below.

Head Start

In exploring the purpose of the community-wide strategic planning and needs assessments conducted by Head Start programs, home visiting needs assessment stakeholders noted similarities with the local dimension of the home visiting needs assessment. The purpose of the Head Start needs assessments is to identify community strengths, needs, and resources related to each Head Start site's service population. There is overlap between the service population of home visiting and Head Start, and similarities how community strengths and needs are defined.

However, challenges in utilizing the Head Start needs assessments to directly inform the home visiting needs assessments were also identified. The Head Start needs assessments vary in timing, process, content, and quality. Additionally, as a program with direct federal funding, state-level capacity to connect with local Head Start and Early Head Start programs is limited, and the MDE Head Start Collaboration Office neither systematically supports or collects these assessments. Also, MDE experienced turnover in the Head Start position during the year of the needs assessment. The planning team felt the best opportunity to support coordination was requiring community partners leading the local Exploration and Planning to include Head Start/Early Head Start as part of their local stakeholder group responsible for guiding the assessment. Through this mechanism, Head Start assessment data and findings could be built into the process of identifying risk and need for home visiting at the local level.

Child Abuse Prevention and Treatment Act

Stakeholders in the home visiting needs assessment included staff from Children's Protective Services and the Children's Trust Fund. These partners within MDHHS were responsible for overseeing Child Abuse Prevention and Treatment Act funding and Community Based Child Abuse Prevention Grants. Through dialogue with these partners, the local assessment activities required under the Community Based Child Abuse Prevention Grants coordinated through the Children's Trust Fund were identified as presenting the best opportunity for collaboration with the home visiting needs assessment. The purpose of these assessments is to identify local needs and capacity related to child abuse prevention, and they are carried out by Michigan's local child abuse and neglect (CAN) Councils. The CAN Councils vary significantly in their local capacity to conduct a robust needs assessment, so the results of these processes cannot easily be compared from community to community. However, stakeholders noted that the CAN Councils provide a linkage to child abuse and neglect data and service systems, and therefore could be a lead entity or partner in the local Exploration and Planning Process. Additionally, stakeholders noted that the results of the home visiting needs assessment could be used to inform home visiting funding decisions that fall under home visiting partners in Children's Protective Services and the Children's Trust Fund.

Families First Prevention Services Act

The reauthorization of the FFPSA ensured that IV-E funds could be used for evidence-based prevention services (e.g., home visiting) as part of prevention of foster care entry. States conducted an assessment to understand risk factors that might impact a child's removal and placement into foster care and to make data driven decisions about expansion of prevention services. State and local level home visiting staff were members of the FFPSA stakeholder group from the beginning of the process, which kicked off late 2018, and members of the Child Welfare staff leading FFPSA joined the MIECHV Needs Assessment stakeholder group at its inception. The FFPSA needs assessment process was delayed, but when completed in October 2020, will provide an understanding of which communities in Michigan experience high levels of removal of children into care, and the numbers of pregnant and parenting foster youth.

Other Needs Assessments

Needs assessment was a significant component of two other early childhood funding opportunities awarded to Michigan in the year prior to the home visiting needs assessment. The Preschool Development Grant included a needs assessment of the birth to five mixed delivery system, which included home visiting. This needs assessment was completed in early 2020. The Pritzker Children's Initiative planning grant awarded to Michigan in 2019 included collecting information from providers and families to inform a Prenatal to Three Policy Agenda. In order to facilitate coordination, the coordinators of these assessment processes sat on one another's steering or stakeholder groups to share information, resources, and findings.

Reflections on Opportunities to Coordinate Needs Assessments

The home visiting needs assessment Stakeholder Group played a key role in facilitating coordination across assessment activities. While this group noted many opportunities to coordinate, they also emphasized that each of these needs assessments has its own unique purpose. They also noted that the assessments focus on different outcomes, systems, and methods, which makes coordination challenging. The group offered the reflection that, while it seems like there should be a more integrated and efficient way to gather similar information, the specific requirements and timeframes of these processes make it very challenging to create a more cohesive system for assessment and planning. They also noted that the level of investment in different assessment processes is related to the ability of partners to complete a robust assessment or to coordinate with other systems. The Stakeholder Group concluded that, across all the needs assessments conducted, it should be possible to construct a full, statewide picture of the prenatal to five system, but that it will take time and resources to achieve that goal.

Table 3. Comparison of Needs Assessments

NEEDS ASSESSMENT	DEADLINE	PURPOSE	COORDINATION STRATEGIES
Title V	July 15, 2020	To identify MCH priority needs, guide the selection of performance measures, and support	Align timing to conduct assessments in sequence Engage needs assessment coordinators/ leads on one another's Steering Committees

		the development of action plans	Identify where population level measures can be shared between assessment processes Share data collected from home visiting funders, providers, and families Share findings from Title V relevant to the population domains served by home visiting
Head Start	Rolling	To identify community strengths, needs, and resources related to each Head Start site's service population	Findings may be helpful in the local Exploration and Planning process
Child Abuse Prevention and Treatment Act Community Based Child Abuse Prevention Grants	Rolling	Inventory of needs and capacity related to child abuse prevention	Findings may be helpful in the local Exploration and Planning process
Family First Prevention Services Act	October 2020	To identify communities experiencing high levels of children experiencing removal to support expansion of prevention services.	Engage needs assessment leads on each steering committee. Share findings from FFPSA relevant to understanding community risk. Share data regarding home visiting capacity within high risk communities.
Preschool Development Grant (PDG)	December, 2019	To identify strengths and gaps in the birth to five mixed delivery system	Share PDG needs assessment findings related to home visiting Share findings of PDG analysis of existing needs assessments
Pritzker Children's Initiative	January 15, 2020	To develop a coalition and prenatal to three advocacy agenda to expand high quality services for children	Share home visiting related data collected through the Pritzker needs assessment collected via community conversations

Home Visiting	October 1, 2020	To identify geographic areas where there is need and capacity to expand HV	Use findings to inform where home visiting can be used as a strategy to address relevant TV priority needs, inform future PDG assessment and evaluation efforts, & inform advocacy efforts under Pritzker The local Exploration and Planning process can inform future Head Start & CB CAP needs assessments

Use of Data and Findings from other Needs Assessments

While many opportunities to connect across needs assessments were identified through dialogue and exploration, the unique nature of the home visiting needs assessment made it very challenging to directly use data or findings from other needs assessments to identify at-risk communities or communities with the infrastructure needed to support expanded home visiting. Those specific and targeted questions required a specific set of methods, which were implemented through this process. However, the learnings from other needs assessment processes informed the design and implementation of the home visiting needs assessment.

Title V MCH Block Grant Five-Year Needs Assessment

The Title V needs assessment took place in the year preceding the home visiting needs assessment. As a broad assessment of the MCH system that leads to state-level priorities and performance measures, it was used to inform the conceptual structure and methods of the home visiting needs assessment. The Title V needs assessment is not designed to identify specific communities that face excess risk, so it's findings could not be used to support that dimension of the home visiting needs assessment.

Through the Title V needs assessment, a listening session was completed with the Home Visiting Advisory Group, which includes state and local agencies, as well as parents. Those findings were shared for the purposes of this needs assessment. When asked to speak to the most pressing needs of families, the group noted: factors related to income and poverty; racism and discrimination and their impact on health and opportunity; stigma connected to services for low income families, as well as mental health and substance use; access to clean water; access to affordable, quality childcare, education, housing, healthcare, specialty care, mental healthcare, substance abuse disorder treatment, and transportation; policies that support families, such as parental leave; and services that are more prevention focused, accessible, and coordinated.

This group also identified strengths of the home visiting system:

- Michigan has multiple evidence-based models available to families, which allows for family choice
- Michigan's home visiting system has mechanisms to support parent leadership and engagement
- Home visiting services are family centered and relationship based
- Home visiting provides linkages to other programs and services, such as early intervention
- Michigan's LLGs are building and strengthening the continuum and elevating family voice
- Michigan's home visiting system prioritizes provider engagement and professional development

- Michigan has partners in home visiting who can advocate and inform policy and budget decisions
- Through partnership with Medicaid, Michigan can reach many families with home visiting services
- Infant mental health has a strong presence within the state and plays a key role across models
- Michigan has taken significant steps toward integrating trauma informed practices in home visiting
- Michigan's home visiting system prioritizes making data driven decisions

When asked about barriers families face when accessing home visiting services, participants noted:

- Families do not always know that home visiting exists or how to access this service
- Families express concern about stigma related to having a home visitor
- Not all families are eligible for home visiting, or for specific home visiting programs
- It can be confusing to untangle what different programs or services offer
- In some places there is competition between programs, which limits family choice
- Not all home visiting models offer the same level of support and professional development, and greater consistency would support higher quality
- Home visiting is not funded at a level that aligns with the need for this service

These findings were used to inform modifications to the simplified method, select data elements to share with community partners in the Exploration and Planning process, structure the statewide home visiting program survey, and design the focus group protocol used as part of the Exploration and Planning Process. As the results of a single focus group, they were used to inform further data collection rather than as stand-alone findings. However, these findings echo findings heard elsewhere.

Additionally, the Title V needs assessment identified three priority needs that will serve as pillars to guide all MCH programs and activities. As a component of the MCH system, the home visiting needs assessment looked to these pillars to guide home visiting needs assessment processes and to inform interpretation of outcomes. The Title V pillars carried into the home visiting needs assessment included:

- Build capacity to achieve equitable health outcomes by understanding and addressing the role of implicit bias and macro-level forces (such as racism, gender discrimination, and environmental degradation) on the health of women, infants, children, adolescents, and children with special health care needs.
- Intentionally and routinely find opportunities to seek the knowledge and expertise of communities and families in all levels of decision-making to build trust and create policies and programs that align with family and community needs.
- Deliver culturally, linguistically, and age-appropriate health education that reflects customer feedback, effectively uses technology, and reaches multiple audiences.

Additionally, several of Michigan's Title V Priority Needs in 2020 are connected to the home visiting system. These included:

- Develop a proactive and responsive healthcare system that equitably meets the needs of all populations, eliminating barriers related to race, culture, language, sexual orientation, and gender identity.
- Improve access to high-quality community health and prevention services in the places where women, children, and families live, learn, work, and play.
- Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems.

- Create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities.

Finally, 7 of Michigan's 12 Title V national and state performance measures are impacted by home visiting. These included:

- Percent of cesarean deliveries among low-risk first births
- Percent of infants who are ever breastfed and breastfed exclusively through 6 months
- Percent of infants placed to sleep on their backs, B) Percent of infants placed to sleep on a separate approved sleep surface, C) Percent of infants placed to sleep without soft objects or loose bedding
- Percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial positive capillary test
- Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4313314 series)
- Percent of women who had a live birth and reported that their pregnancy was intended
- Support access to developmental, behavioral, and mental health services

Given these connections between Title V priority needs and performance measures and the purpose of home visiting, it is not surprising that Title V action plans include strategies that are related to home visiting. For example, Title V's Intended Pregnancy plan includes a strategy is to support the implementation of client-centered reproductive life planning across MDHHS-funded Home Visiting Programs. The Breastfeeding and Safe Sleep plans also intersect with home visiting. Moreover, in Michigan one third of Title V funds are granted to Michigan's 45 local health departments, which can use funds to address locally identified priorities through strategies such as home visiting. Once the home visiting needs assessment is complete, findings will be used to inform updates to the Title V needs assessment and the action plans developed to respond to needs assessment updates.

Head Start, Child Abuse Prevention and Treatment Act, and Other Needs Assessments: Learnings from the PDG Analysis of Existing Needs Assessments

The first step in the Preschool Development Grant needs assessment involved a comprehensive analysis of existing state and local needs assessments focused on the birth to five population. Local Head Start Needs Assessments and the assessments conducted under Community Based Child Abuse Prevention Grants were included in this analysis. Findings indicated that these assessments varied significantly in the process they used, the data they incorporated, and the way they shared findings. Based on this review, the home visiting needs assessment Core Team determined that these assessments could not be compared with one another or used to identify at-risk communities, service gaps, or duplication of services. However, the Core Team noted that the local leaders of these assessments could be important partners in the Exploration and Planning Process. As such, both Head Start and local Child Abuse and Neglect Councils were required Exploration and Planning partners.

Additionally, the PDG analysis of existing needs assessments noted several themes across needs assessments that informed the methods of the home visiting needs assessment. This analysis found that most assessments identified needs related to social determinants that impact multiple outcomes for families, such as income, housing, transportation, health care, and mental healthcare. Social connection or sense of community was also identified as a need across assessments. These findings suggest that it is critical that home visiting and other early childhood programs intentionally foster linkages between the

many programs and services available in communities. The analysis also identified community and population specific gaps in services. Children in rural communities face both unique barriers to accessing services and deep gaps in service availability. Children who are black, indigenous or persons of color were identified as underserved in many of the local assessment processes. Finally, children who are highly vulnerable, such as those who are homeless, immigrants, or refugees, face a delivery system that was not set up to accommodate their unique needs.

These findings impacted the home visiting needs assessment in several ways. Data about social determinants were included in the local Exploration and Planning process to contextualize data about outcomes and deepen exploration of risk. Additionally, the statewide home visiting survey included sections on both the incoming and outgoing referral networks of home visiting programs, as well as a series of questions on the quality and capacity of these partners. Finally, the Exploration and Planning tool provided opportunity to not only highlight geographic areas at risk, but to identify specific population groups at risk that might be invisible in county level population data.

Convening Stakeholders

The Home Visiting Needs Assessment was guided by a stakeholder group that included, among other partners, the coordinators of each of the needs assessment processes referenced in this section. This group reviewed the results of the state level analysis using the simplified method. They also reviewed the findings of the needs assessment. Conversely, the leads of the home visiting needs assessment sat on the stakeholder groups convened as part of these other assessment processes. This offers another venue to share findings, gather insight, and expand the utility of the home visiting needs assessment.

Process for Ongoing Communication

The process for ongoing communication between home visiting and Title V is robust. The Title V coordinator will review the findings of this needs assessment to inform updates to the Title V needs assessment and state action plans. Michigan's MIECHV lead and Title V coordinator plan to meet prior to the next five-year needs assessment to identify opportunities for coordination and collaboration. Additionally, the Title V director and coordinator serve on the Home Visiting Advisory, and both Title V and MIECHV representatives serve on the Great Start Operations Team. Another point of connection relates to Michigan's Parent Leadership in State Government Initiative, which receives Title V funding and offers training to parents to prepare them for serving in a leadership role this includes parents who used home visiting services. Title V also funds RPQCs, many of which are working toward increasing enrollment and retention in home visiting. Finally, state general funds for NFP and the HFAs in rural Michigan are included in the Title V state match.

Although the points of connection with Head Start and the Child Abuse Prevention and Treatment Act are fewer, this process has set the stage for more robust collaboration moving forward. During one of the Stakeholder Group meetings, the partners discussed opportunities presented by better coordinating needs assessments, and they noted that they could better identify similarities across assessments in order to streamline data collection and facilitate sharing data and findings. They also noted that family and provider voices could be more present in establishing the goals of these assessments. Finally, they noted that they could prioritize the data elements that matter most across most processes and pull forward common themes and set common targets for improvement in order to look at how Michigan is leveraging all its funding streams to achieve improved outcomes.

Conclusion

Major Findings

The needs assessment was designed to identify the degree to which communities that face multiple risk factors are well served by quality, evidence-based home visiting programs. Each component of the process offered a unique viewpoint of risk, need, quality, and capacity, resulting in a complex, layered understanding of how Michigan might pursue a more robust home visiting system.

Through identifying at-risk communities, the state and local assessment processes illustrated that there are pockets of risk in every corner of the state that could be ameliorated through home visiting. Additionally, the process demonstrated that risks faced by families are not randomly or equitably distributed. As a result of racism and other forms of oppression, Michigan's residents who identify as Black/African American or Latinx face greater risks to their family's wellbeing. Additionally, both Michigan's indigenous families and its immigrant, refugee, and migrant families face greater risk. Finally, the risks faced by low income families exceed the risks faced by higher income families. These findings suggest that, wherever home visiting is expanded, services must be equitably offered and inclusive. This step concluded with the finding that 36 of Michigan's 83 counties have either two or more at-risk domains or areas 'known to be at risk.' All counties currently receiving MIECHV funding were represented in the 36 counties, suggesting that MIECHV funding continues to be needed to support impact within these counties. MIECHV funding is one of several sources of funding that sustains evidence-based home visiting in Michigan and it will be important to consider changes to MIECHV funding structure as additional funding opportunities are identified, ensuring that funding is used to maximize the reach of home visiting in light of the risks that have been identified through this needs assessment.

The exploration of Michigan's capacity to provide quality, evidence-based home visiting in the 36 at-risk counties highlighted the voices and experience of parents and providers and identified both strengths and opportunities to improve. All but one of the at-risk counties offered more than one home visiting program. This capacity to provide a continuum of home visiting services in at-risk areas of the state was a strength of the system since families vary in their needs and preferences for home visiting services. The ability to offer culturally adapted services in the language spoken by the family was described as an important feature of the continuum of home visiting within a community, and Family Spirit was noted as a model for serving native families that should be supported and expanded. The needs assessment raised the question of offering culturally tailored home visiting to other groups such as migrant families, immigrants, and refugees.

The needs assessment explored additional elements of diversity and inclusion, such as the degree to which home visitors represented the racial and ethnic distribution of the at-risk communities they served. This analysis found that, while home visitors are a much more diverse group than the population of Michigan, families noted that families who identify as black, indigenous or a person of color may not be served by a home visitor who looks like them, which makes connection and relationship building more challenging. Similarly, the assessment found that almost a third of programs in at-risk communities could offer services in Spanish and several programs offered services in other languages spoken in the communities they served. Families noted it is a powerful indicator of quality for families to work with a home visitor who can speak their language, but not all families have access to services in their language. Additionally, families noted that home visitors do not always share the life experiences

of the families they serve, and they noted that, in addition to racial, ethnic, and linguistic diversity, they system would be stronger if programs had greater capacity to adapt services for other groups, like teen parents or fathers.

Family voice is central to defining quality home visiting, and, in addition to speaking to diversity and inclusion, families shared several strengths and opportunities to improve the home visiting system. Family identified strengths included the genuine and accepting approach of home visitors, the informal and flexible nature of the service, and the power of the home visitor-family relationship. They also emphasized the focus of home visiting on building capacity in parenting using a strengths-based, non-judgmental approach. Families shared that home visiting programs also serve as powerful point of connection with the broader community, offering families a bridge to formal and informal supports.

Families also offered opportunities to improve home visiting, many of which spoke to opportunities to improve the infrastructure supporting home visiting programs. One of the strongest themes noted by families was that there was not enough public awareness or positive messaging about home visiting. They also spoke to the stigma and fear some families associate with the service. Families also noted opportunities to improve home visiting service delivery. They described the paperwork completed at and around enrollment as overwhelming. They also noted that it would be helpful to offer home visits outside of business hours, and that more social events and playdates would be helpful. They also noted that turnover is a challenge because it is quite difficult to start over with a new home visitor once the relationships is formed. However, families emphasized that one of the most significant improvements that could be made is in expanding the number of programs, home visitors, and slots for families. It is important to note that many of these findings were echoed in the analysis of home visiting program quality and capacity conducted by providers through the Exploration and Planning process.

When asked what they saw as the outcomes of home visiting, families guided the system to think about outcomes that go beyond those most often measured. They highlighted as outcomes:

- Physical and emotional health of entire family
- Child growth and development
- Parenting knowledge, skills, confidence
- Parent engagement and empowerment
- Ability to set and meet goals
- Stronger, healthier bonds between family members
- Better social connections and reduced isolation
- Linkages to needed services & support to get help when needed

Both families and providers spoke to the strengths and gaps in the network of services available to families within local home visiting systems. Within the at-risk counties, families noted that home visiting is an effective connector, but that transitions and referrals across community agencies could be smoother. Similarly, local home visiting partners noted that they could do more to track referrals to and from home visiting programs. They also noted an opportunity to build relationships with programs and providers that serve vulnerable communities. Specific communities also noted specific gaps in services. The SUD T/C component of the assessment found many opportunities to build connections between these two systems.

Through the readiness assessment completed in the at-risk counties, a clear pattern emerged of moderate readiness across all domains, again suggesting an opportunity to build the infrastructure supporting home visiting programs. In particular, communities noted gaps in readiness associated with community knowledge of home visiting and community climate, which aligned well with findings from other components of the needs assessment.

Although each community noted challenges to expanding evidence-based home visiting, all but one of the at-risk counties reported need and capacity to expand. Two thirds of programs reported being at capacity and most programs that keep a waiting list have families on their list in these communities. Additionally, only 9 of the 36 counties were serving 100% or more of HRSAs estimate of need.

In exploring risk relative to need and capacity, several communities emerged as potential priorities for targeting expansion. Wayne County emerged as the clear priority area for expanding evidence-based home visiting. Existing MIECHV communities also emerged, including Berrien, Genesee, Muskegon, Oakland, and Saginaw. Non-MIECHV communities were also highlighted as priorities, such as Lake, Newaygo, St. Clair, Cass, Macomb, and Ottawa Counties. This process illustrated that the landscape is always changing, and its dynamic natures requires decision making processes driven by emerging data, as well as point-in-time analysis.

The needs assessment focused on risks faced by families and the capacity of an under-funded service delivery system to support those families; however, risk and need are only part of the story that unfolded through this process. While the families and providers that contributed to this needs assessment certainly highlighted the challenges faced by families, they also told a story of strength, commitment, and resilience. Although this state is far from making sure every parent has the resources necessary to raise children that thrive, the parents and providers in the network of home visiting programs in Michigan know how home visiting can contribute to that goal.

Dissemination

In addition to submitting this report under the MIECHV grant, the Core Team has shared findings with state and local partners through several mechanisms. Preliminary findings were presented to the Steering Committee in September 2020. Findings will also be presented to other key leadership groups in the state such as Michigan's Home Visiting Leadership Group, Home Visiting Advisory, Great Start Operations Team, Michigan's Children, MDE's PDG team, Michigan's Early Childhood Support Network, MDHHS and MDE leadership, and the Advisory Board for the State Office for PAT and HFA. The findings will also be shared with local home visiting partners, such as parent groups and home visiting Local Leadership Groups. The needs assessment findings will also be shared widely throughout the early childhood system, with non-MIECHV funded home visiting programs and all MIECHV grantees so the field can understand how the results of this needs assessment will impact the system of home visiting.

In order to support dissemination, reports in addition to this document will be developed. County level reports highlighting each county in the state will be produced in order to summarize the results of the Exploration and Planning process. These will be disseminated to local partners for their own use and posted for use by state level home visiting funders and partners. The Core team is also considering the development of other products, such as a brief highlighting family perspective and a strategy guide. Products will be developed based on the needs of stakeholders as they share how the information can be used to guide action.

Appendix A

Exploration and Planning Tool

HOME VISITING NEEDS ASSESSMENT: EXPLORATION AND PLANNING TOOL

Michigan Department of Health and Human Services and Michigan Public Health Institute

Background

Since 2011, the Home Visiting Initiative has been working with Michigan communities where families face elevated risk to complete home visiting needs assessments, which have guided planning and resource allocation. As additional funding becomes available, it has been important for home visiting partners to be able to use data to describe unmet needs within their communities for home visiting services.

A key component of these assessments has been local assessment of needs and capacity. This process has been guided by an Exploration and Planning Tool that was designed to support communities in making data driven decisions about home visiting. It guides communities through the process of identifying geographic areas and populations facing a high burden of risk. It also guides communities through the process of identifying available services and capacity to meet family needs. Through identifying both areas of risk and the reach of existing services, this tool supports communities in very specifically identifying unmet needs and capacity to expand. This information helps communities seek the services they need, and it helps state agencies make targeted, data driven decisions regarding expanding home visiting.

The Exploration and Planning process will be completed again this year in preparation for the possibility of additional funding for home visiting and in alignment with the requirements of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program funded by the Health Resources and Services Administration (HRSA). Through MIECHV, HRSA supports states to assess needs for home visiting and the next needs assessment is due by September 30, 2020. As a MIECHV grantee, Michigan is in the process of completing a needs assessment that achieves the following goals:

1. Identify counties and other geographic areas where families face the greatest risks.
2. Identify the reach and quality of existing evidence-based home visiting programs.
3. Identify the reach and quality of services for families that partner with home visiting.
4. Describe existing capacity to expand home visiting programs.

In order to meet this goal, the Michigan Home Visiting Initiative is engaging its network of state and local partners and parent leaders. The needs assessment is guided by a Home Visiting Needs Assessment Steering Committee that includes state agency partners, local home visiting representatives, and parent representatives. Based on the guidance of this group, a team of Epidemiologists will pull quantitative, population level data to identify communities where families face elevated risks. Program staff will compile information about local home visiting programs known to the state agencies that fund home visiting. This information will be paired with findings from the locally driven Exploration and Planning process to create a complete picture of home visiting needs and capacity across the state.

Process

The tool is designed to be completed with facilitated guidance from the Michigan Department of Health and Human Services (MDHHS) and the Michigan Public Health Institute (MPHI). The assessment will be organized into a series of six steps. Prior to each step of the assessment, MPHI will facilitate a webinar describing what should be completed and how learning should be documented. Each community will have access to a coach who will answer questions and provide support throughout the process.

The steps in the process are illustrated in Figure 1. Each of these steps is described in detail in this document. After each step is completed for each county included in your scope of work, you will submit results through an online tool in REDCap.

THIS TOOL MUST BE COMPLETED IN ITS ENTIRETY. In order to have a complete picture of community risk, the reach of current home visiting services, and capacity to expand home visiting it is necessary to have comparable information from every county in the state.

At any point in this process you may direct questions to: MDHHS-HVInitiative@michigan.gov

Step 1:

Engage Home Visiting System Partners

Parents and community partners play a critical role in the success of home visiting initiatives. Explore the extent to which you have meaningfully engaged parents as partners in your home visiting system and describe how they will be involved in this assessment. Additionally, identify your existing home visiting system partners, as well as gaps in your network. If you are assessing a multi-county area, please describe how you are being inclusive of partners in each county.

Note: Each of the questions below appeared in your funding application. Simply update your responses for each county in Redcap. Responses must be updated BY COUNTY.

1. Describe the group(s) that will be responsible for coordinating the assessment and completing this tool. Name the group(s), describe its membership, indicate how long it has been in existence, and describe its most recent home visiting related activities.

2. How does this group partner with families and engage them as partners and leaders?

    a. Does the group have a policy in place supporting authentic family involvement, including financial support and mentoring? If yes, please describe and attach to the application.

3. This process must include families with children who represent the identified service population. How will the group actively and meaningfully engage families with children who are five or younger who are or were enrolled in evidence-based home visiting in the assessment process? Describe how families will be invited to participate, the role they will play, and how their engagement will be supported.

4. Describe how home visiting programs in your community work together (e.g., meet regularly, coordinate professional development, coordinate referrals, support transitions, defined shared outcomes, collect the same data, use a common database, etc.).

5. Identify the entities that will be engaged in the assessment process. Each essential partner must be represented. Additional partners may be added at the end of the table. Specify both individual names and organizational affiliation. If multiple counties a response must be submitted for each county.

Table 1: Home Visiting System Partners

Essential Partners	Organization Names	Individual Names
Public Health		
Substance Abuse		
Head Start/Early Head Start		
DHS and/or CAN Council		
Existing Home Visiting Programs in the county/counties		
Community Mental Health		
Education (such as an Intermediate School District)		
Great Start Collaborative & Great Start Parent Coalitions		
Medical community/ Medicaid providers		
Regional Perinatal Quality Collaboratives		
Other – Specify Below		

6. To what extent do the individuals in Table 2 represent the diversity in your community, including racial and ethnic diversity? Do you see any gaps in representation, and, if so, how will those be addressed?

7. If you have any gaps in the membership of your group by organization or sector, please indicate those gaps and explain why all essential partners cannot be engaged, as well as the implications of their absence.

Step 2:

Gather Community Input

Some communities applied for additional funding to gather qualitative data from families using focus groups. While all communities are expected to engage parents as partners in the assessment process, this step will allow communities to hear from a broader group of families about their experiences with home visiting and other services in their communities.

The purpose of this step in the process will be to explore with families the key questions underlying the assessment. Focus group participants will be asked to describe the risks and opportunities families face in their communities; the outcomes they're concerned about and what facilitates wellbeing; strengths and opportunities to improve home visiting programs; and strengths and opportunities to improve the service delivery system.

As with each step in the assessment, the process will begin with a webinar. Focus group facilitators will be trained in focus group methodology, the focus group protocol, how to capture findings, and analysis. Focus groups will be organized and conducted locally, with notes provided using the online system following each group.

The findings of the focus groups will be integrated into each of the other steps in the assessment.

Once focus groups are complete, findings will be entered using the online tool in REDCap. Communities will respond to the following questions and upload their focus group notes:

1. How many focus groups did you complete?
2. How many individuals participated?
3. How many of these individuals were families served by home visiting programs in your community?
4. What were the key takeaways from the focus group(s) you completed?
    a. Strengths of home visiting in your community
    b. Opportunities to improve home visiting in your community
    c. Outcomes of home visiting in your community
    d. Other key take-aways

Step 3:

Assess Community Risk

Parenting is challenging under any circumstances. However, some families face extraordinary challenges based on where they live or due to forces of oppression within our society. Since funding for home visiting is limited and it is not currently possible to serve every family, it is important that those families facing the greatest burden of risk have the first opportunity to receive this supportive service. The purpose of this step of the assessment is to identify those geographic areas where families are facing elevated risk and how those risks are manifesting in outcomes that evidence-based home visiting models are designed to address.

The population-level measures that will guide the identification of geographic areas facing elevated risk were identified by HRSA under the MIECHV program. Additional measures were identified by the Home Visiting Needs Assessment Advisory Group, which includes state and local partners across home visiting models and funders.

During this step each community will examine data provided by MDHHS and MPHI via the RedCap site for each county. Data tables are available in two forms: (1) a three page summary document in Word available by county and for selected cities and (2) an Excel pivot table that includes all counties and selected cities. Each community will also fill in gaps or add additional context to the analysis by using local data sources. Table 2 lists sources of data that may be helpful. The purpose of this process is to describe:

- County demographic and cultural characteristics
- Outcomes of concern for the county as a whole
- Outcomes with evidence of disparities
- Sub-county areas with elevated risk

To complete this step, please view the Step 3 webinar, download the data, gather other community data, and convene your partners to review the data together. Once you have completed these steps, use the following questions to describe this county, the geographic areas facing the greatest burden of risk, and the outcomes of greatest concern that can be impacted by home visiting.

5. Review the key demographic and cultural characteristics of each county.

Demographic Variable	County # or %	MI	US
Total Population			
Births per year			
Persons under 5 years, %			
White alone, %			
Black or African American alone, %			
American Indian and Alaska Native alone, %			
Asian alone, %			
Native Hawaiian & other Pacific Islander alone, %			

Two or more Races, %			
Hispanic or Latino, %			
White alone, not Hispanic or Latino, %			
Veterans			
Foreign born persons			
Owner-occupied housing unit rate			
Language other than English spoken in home			
Households with broadband internet, %			
High school grad or higher, % of persons 25+			
Persons without health insurance			
Median household income			

a. What are the key demographic and cultural characteristics of this county based its Census profile?

b. What are the demographic and cultural characteristics of this county not visible in the data provided? Please describe how you identified the characteristics you share (e.g., family focus groups, staff input).

6. Review data on factors that suggest elevated risk faced by families in communities.

Risk Variable	County # or %	MI	US
Homelessness			
Percent Unemployment			
High School Dropout			
Poverty			
Children in Poverty			
Households Speaking Limited English			
Income Inequality			
Households Receiving Public Assistance			
Childhood Food Insecurity			

a. What do the data suggest about risk within this county?

b. What other data did you review about elevated risk for families in your community? What did you learn?

c. Are there pockets of elevated risk that are masked by county data? If so, describe and provide data.

d. What other evidence of risk for families in this county are not visible in the data provided? Please describe how you identified these risks (e.g., family focus groups, staff input).

7. Review data on outcomes that can be influenced by evidence-based home visiting.

Outcome Variable	County # or %	MI	US
Preterm Delivery			
Breastfeeding at Delivery			
Immunized 19-35 Months			
Low Birth Weight			
Infant Mortality			
Maternal Morbidity			
Maternal Mortality			
Teen Birth Rate			
Neonatal Abstinence Syndrome Rate			
Binge Alcohol Use			
Marijuana Use			
Nonmedical Use of Pain Relievers			
Illicit Drug Use			
Child Maltreatment			
Foster care age 0-8			
Not Proficient in 3rd Grade Reading			
Special Education			
Crime Reports			
Juvenile Crime Arrests			
Domestic Violence			

a. What do the data suggest about outcomes of concern within this county?

b. What other data did you review about outcomes of concern for families in your community? What did you learn? Please see the data source reference table below for potential data sources.

c. What disparities across race, socio-economic status, geography, etc. in outcomes are of concern in this county? Please see the table below for possible disparities to explore.

d. What other evidence of outcomes of concern in this county are not visible in the data provided? Please describe how you identified these outcomes (e.g., family focus groups, staff input).

8. What outcomes impacted by home visiting are of greatest concern in this count? Check those that apply. For each box you check, you will be asked to describe why the areas is of concern. Use data to explain your response.
   - ☐ Maternal Health
   - ☐ Child Health
   - ☐ Child Development & School Readiness
   - ☐ Positive Parenting Practices
   - ☐ Child Maltreatment
   - ☐ Family Economic Self-Sufficiency
   - ☐ Linkages and Referrals
   - ☐ Juvenile Delinquency, Family Violence, and Crime

Potential Data Sources

Source	Web Link
American Community Survey	https://www.census.gov/programs-surveys/acs/
Bureau of Labor Statistics	http://www.bls.gov
Bureau of Primary Health Care/Health Center Program	https://bphc.hrsa.gov/
Center for Educational Performance and Information	http://www.michigan.gov/cepi/
Consumer Assessment of Healthcare Providers & Systems (CAHPS)	http://www.ahrq.gov/cahps/index.html
County Health Rankings	http://www.countyhealthrankings.org/app/michigan/2020/overview
Feeding America	http://map.feedingamerica.org/
Kids Count	http://www.mlpp.org/kids-count
Maternal Infant Health Program (MIHP)	http://www.michigan.gov/mihp/
Michigan Care Improvement Registry (MCIR)	https://www.mcir.org/
Michigan Vital Statistics	http://www.michigan.gov/mdhhs/0,5885,7-339-73970_2944_4669_4681---,00.html http://www.mdch.state.mi.us/pha/osr/chi/Indx/frame.html
MDHHS Health Statistics and Reports	https://www.michigan.gov/mdhhs/0,5885,7-339-73970_2944---,00.html
MDHHS MCH Epidemiology Section	https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_41657---,00.html
MI School Data	https://www.mischooldata.org/Default3.aspx?aspxerrorpath=/DistrictSchoolProfiles2/Kinder%20garten12thGradeLandingPage.aspx
Michigan Incident Crime Reporting	http://www.micrstats.state.mi.us/MICR/Home.aspx
National Child Abuse and Neglect Data System (NCANDS)	http://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/ncands
National Survey of Children with Special Health Care Needs	http://www.childhealthdata.org/learn/NS-CSHCN
National Survey of Children's Health (NSCH)	http://www.childhealthdata.org/learn/NSCH
National Survey on Drug Use and Health (NSDUH)	https://nsduhweb.rti.org/respweb/homepage.cfm
Substance Abuse and Mental Health Services Administration	https://www.samhsa.gov/data/quick-statistics
USDA Economic Research Service	https://www.ers.usda.gov/

Exploring Disparities

Using the table below, consider which indicators to explore in more depth for your community. The indicators inserted in the first row are a starting point, but you are encouraged to explore disparities across as many indicators as possible to better understand the populations most likely to experience adverse outcomes.

Percentage or Rate	Preterm birth	Child maltreatment	3rd grade Reading	Variable 4	Variable 5
Michigan					
Region/County					
Race					
American Indian/Alaska Native					
Asian					
Black, non-Hispanic					
Hispanic/Latino					
White, non-Hispanic					
Other					
Age of Mother					
<20 years					
20-24 years					
25-334 years					
>35 years					
Education					
>High School					
High School Grad					
Some College					
College Grad					
Poverty Status					
At or below poverty level					
Above poverty level					
Geographic Areas at Risk					
[Insert city, school district, zip code, or other boundary]					

Step 4:

Assess the Reach & Quality of Home Visiting

The availability of a continuum of evidence-based home visiting varies across Michigan. Some communities have many programs and models available to families, while others have more limited access. Additionally, the capacity of home visiting programs varies across and within communities. Having a clear understanding of what the continuum of home visiting looks like in your community helps identify existing capacity, as well as gaps in services.

As part of this step, you will update a catalogue of each home visiting program in your community. MDHHS has compiled a list of home visiting programs known to state agencies. You will first review this list to see if it includes all the home visiting programs in the county or counties you are exploring. You will then update the list, adding missing programs and making note of any programs that have closed or have different contact information. When identifying home visiting programs, follow the definition of home visiting in Michigan's Home Visiting Law: "Home visitation means a voluntary service delivery strategy that is carried out in relevant settings, primarily in the homes of families with children ages 0 to 5 years and pregnant women." DO include models such as the Maternal Infant Health Program, Healthy Families America, Early Head Start-Home Based, Family Spirit, Nurse Family Partnership, Parents as Teachers, and Infant Mental Health. DO NOT include Part C/Early On or other intervention programs.

Once you update the list of home visiting programs, you will submit it to MPHI through the online tool. MPHI will send out an online survey to those programs on the list using the email address of a key contact person for each program. Please encourage participation among home visiting programs in your community so that the information you receive back is as complete as possible. The survey is attached as Appendix A.

Survey data for the county/counties you are exploring will be compiled by MPHI and provided back to you for interpretation. Please view the Step 4 and 5 webinar before diving into your survey results. After reviewing your data with your community partners, report your responses to the questions below using the online tool.

Once you receive survey findings for each county, you will use your data to address the following questions.

1. How many home visiting programs are currently available in this county?
   #

2. How many of these home visiting programs are implementing an evidence-based model?
   #

3. How many of these home visiting programs are operating at or near capacity for most of the year?
   #

4. How many of these home visiting programs are in good standing with their model developer or national model office?
   #

5. The Maternal Infant Health Program (MIHP) is an entitlement program that cannot set a cap on enrollment. Excluding MIHP, how many families can be served by evidence-based home visiting programs in this county?
   #

6. Approximately how many families could be reached by evidence-based home visiting in this county?

    a. What is the total number of families with children under 5 in this county?
       #

    b. How many of these families are living at or below the poverty level?
       #

7. What age groups are well served by home visiting programs? What age groups are not well served? Describe how you arrived at these conclusions.

8. What geographic areas are well served by home visiting programs? What geographic areas are not well served? Describe how you arrived at these conclusions.

9. What did you learn about the reach and quality of the home visiting system within this county? Describe how you arrived at these conclusions.

10. Does this county have the need and capacity to expand evidence-based home visiting?
    Y/N
    Please describe your response:

Step 5:

Identify the reach and quality of services for families that partner with home visiting

Home visiting programs sit at the intersection of families and communities. They provide critical linkages between families and community service systems. Home visitors can offer families a point of access to healthcare services, mental and behavioral health services, developmental services, services for domestic violence, and services to meet families' basic needs.

In this step of the assessment process, you will identify the referral networks that have developed around each of your home visiting programs. The survey referenced in Step 4 will also be used to gather information for this assessment. The survey will include a section designed to capture the following information for each organization in each home visiting program's referral network. The survey focuses on referrals to home visiting programs (incoming referrals) and from home visiting programs to other local service providers (outgoing referrals). The data will be compiled by MPHI and used to create network maps for each agency and county. The network maps and survey responses will be sent back to you through the online tool for interpretation and to answer the questions below.

1. What types of services are well connected with home visiting programs in the county? Describe how you arrived at these conclusions.

2. What gaps in the service network are common for home visiting programs in the county? Describe how you arrived at these conclusions.

3. What patterns are noticeable in the degree to which organizations can meet the needs of home visiting clients? Describe how you arrived at these conclusions.

4. What patterns are noticeable in the quality of services provided by programs in the service delivery network? Describe how you arrived at these conclusions.

5. How must the service delivery network be strengthened to better meet the needs of families? Describe how you arrived at these conclusions.

Step 6:

Assess Community Readiness

New or expanded programs and services are most successful in communities that are clear about their readiness to provide a supportive context. In this step of the needs assessment you will explore your community's readiness to expand home visiting, identifying both community strengths and weaknesses.

Complete the Step 6 webinar before you begin this step. This step will be completed by the home visiting system partners identified in step 1. You will convene a meeting of these partners and facilitate a dialogue covering six dimensions of readiness:

- Community knowledge of family needs
- Community knowledge of home visiting
- Community climate
- Community pursuit of equity
- Community leadership
- Community resources

For each of these domains, you will ask a series of discussion questions and record strengths and weaknesses. Following each discussion, you will decide on a rating, scoring each dimension on a scale of 0=no readiness, 1=limited readiness, 2=moderate readiness, 3=significant readiness, and 4=full readiness.

Findings will be entered into the online tool using a structure like the table below:

Community Knowledge of Family Needs • **How does your community regularly identify the needs of pregnant women and families with young children?** • **How are family voices prioritized in discussion of need?** • **What groups are most aware of the needs of families? Where do you see gaps in awareness?** • **What do community partners understand about home visiting as a strategy to address community needs?**	
Strengths	**Weaknesses**
Average Rating	0=no readiness 1=limited readiness 2=moderate readiness 3=significant readiness 4=full readiness

Community Knowledge of Home Visiting • What does your community know about home visiting? • Are early childhood programs visible and well-known in your community? • Are early childhood partners ready to support new or additional home visiting programs?	
Strengths	**Weaknesses**
Average Rating	0=no readiness 1=limited readiness 2=moderate readiness 3=significant readiness 4=full readiness

Community Climate • In what ways does this community prioritize services for families with young children? In what ways does this community de-prioritize services for families with young children? • Does this community support its existing home visiting programs?	
Strengths	**Weaknesses**
Average Rating	0=no readiness 1=limited readiness 2=moderate readiness 3=significant readiness 4=full readiness

Community Pursuit of Equity • In what ways does your community identify and address disparities, as well as the conditions that lead to disparities? • What strategies does your community use to reach and engage the members of your community who are most marginalized (across race, ethnicity, language, culture, religion, sexual orientation, gender identity, and income)? • How does your community adapt programming to represent your service population? • What does your community do to recruit and hire staff who represent your service population?	
Strengths	**Weaknesses**
Average Rating	0=no readiness 1=limited readiness 2=moderate readiness 3=significant readiness 4=full readiness

Community Leadership • In what ways do local leaders prioritize services for pregnant women and families with young children? In what ways do leaders de-prioritize these services? • To what extent are leaders aware and supportive of home visiting?	
Strengths	**Weaknesses**
Average Rating	0=no readiness 1=limited readiness 2=moderate readiness 3=significant readiness 4=full readiness

Community Resources • **What human, organizational, and financial resources are available to support home visiting in this community?** • **Where are there gaps in human, organizational, and financial resources to support home visiting in this community?** • **How does this community support its home visiting workforce?**	
Strengths	**Weaknesses**
Average Rating	0=no readiness 1=limited readiness 2=moderate readiness 3=significant readiness 4=full readiness

Appendix A

Home Visiting Program Survey – Steps 4 & 5

HVNA Survey

Background

Thank you for participating in this survey as part of Michigan's Home Visiting Needs Assessment led by the Michigan Department of Health and Human Services. The purpose of this survey is to:

1) Understand the capacity to provide home visiting services in Michigan
2) Understand strengths and gaps in the network of agencies serving families with young children across Michigan's diverse communities

In addition to informing Michigan's statewide needs assessment, results will be provided back to communities across the state to identify strengths and needs related to home visiting.

This survey will take approximately 30 minutes to complete. You will be able to log out and return if you cannot complete the survey in one sitting.

For the purposes of this survey home visiting programs are defined following Michigan's Home Visiting Law:[1] "Home visitation means a voluntary service delivery strategy that is carried out in relevant settings, primarily in the homes of families with children ages 0 to 5 years and pregnant women." This definition includes models such as the Maternal Infant Health Program, Healthy Families America, Early Head Start-Home Based, Family Spirit, Nurse Family Partnership, Parents as Teachers, and Infant Mental Health. This definition does not include Healthy Start, Part C/Early On, or other intervention programs.

Please answer the questions to the best of your ability. Some questions might require input from others in your organization and you may want to work together to fill out the survey. If your agency administers more than one home visiting program, the survey should be completed for each home visiting program separately.

Contact Information

Please provide contact information for the primary respondent in case additional information is needed:

First Name/Last Name:

Organization Name:

Email Address:

Select the role that best reflects your level of management responsibility within your organization [Drop down]: Executive director, Program manager, Program supervisor, data/evaluation lead, other

[1] https://www.michigan.gov/documents/homevisiting/2012-PA-0291_434967_7.pdf

Home Visiting Program Information

Section: Program Administration

Questions	Response options
What is the name of your home visiting program?	Text field
What home visiting model do you implement?	Drop down menu Early Head Start-Home Based Family Spirit Healthy Families America Infant Mental Health Maternal Child Health Program Nurse Family Partnership Parents as Teachers Play and Learning Strategies (PALS) Other
How many home visitors do you have on staff?	Full time: [Numeric response] Part time: [Numeric response]
How many home visitor vacancies do you currently have?	Full time: [Numeric response] Part time: [Numeric response]
How many of your home visiting staff identify as:?	Arab/Chaldean Asian Black/African American Hispanic/Latinx Native American/Alaska Native/ Native Hawaiian/ OPI White, Non-Hispanic Other race/ethnicity
How many of your staff can speak Spanish, Arabic, or another language during home visits?	Arabic [Numeric response Spanish [Numeric response] Other [Numeric response], please specify
To what extent does your staff reflect the linguistic, racial, and cultural backgrounds of the families in the community you serve?	[Text]
Is your home visiting program currently accredited or certified by your model developer?	No Yes Other, please describe Unsure
List your sources of funding for your home visiting program	[Select all that apply] State General Fund State School Aid (32P and 32P(4)) Medicaid Maternal Infant and Early Childhood Home Visiting (MIECHV)

	Child Abuse Prevention and Treatment Act (CAPTA)/Community Based Abuse Prevention (CBCAP) Children's Trust Fund Federal Head Start/Early Head Start Federal Healthy Start Other Federal Other Private/Foundation Other
Has your program experienced any significant changes in funding in the past year that impacted your program's enrollment capacity?	No Yes, increased enrollment capacity Yes, decreased enrollment capacity Other
What is the typical starting salary for home visitors in your program?	$
Do you maintain a waiting list?	Yes/no
As of today, how many families are on your waiting list?	Number
What are your top three referral sources for your program?	[Three open text boxes]
Does your program participate in these community groups?	Check all that apply ☐ Local Leadership Group ☐ Great Start Collaborative ☐ Child Abuse and Neglect Council ☐ Head Start Advisory ☐ Regional Perinatal Quality Collaborative ☐ None of the above ☐ Unsure
How does your program incorporate family voice into program planning?	

Section: Service Delivery

Questions	Response options
What county or counties do you serve?	Drop down menu of all counties, can select multiple
Are you able to serve families living anywhere in your county or do you target a specific area?	We can serve families living anywhere in the county We only serve families in a specific area of the county Both, depending on the funding source
If you only serve families in a specific area of the county, what area do you serve?	Text Field
What are the most significant barriers you face to serving families in your community?	[Text]
Describe your visit frequency	Text field

For how many months out of the year are you able to serve families in your program?	#
How many families are enrolled in your program as of the date you completed this survey? By 'enrolled' we mean the family has accepted services and has not yet exited.	#
How many families did you serve between 10/1/18-9/30/19? By 'serve' we mean the family enrolled in the program and received at least one completed home visit during the year.	#
Approximately how many families is your program able to serve at maximum capacity? By 'maximum capacity' we mean the number of families you could serve if each of your home visitors had a full caseload.	#
Is program at 85% capacity for at least 9 of the past 12 months?	Yes/No
What else is important to know about enrollment in your program?	Text field
Of the families who left the program last year, what percent completed the program, graduated, or met their goals?	%

Section: Service Population

Questions	Response options
Who would you identify as your program's primary target or priority populations?	[check all that apply] Children and families who are low-income Children with special needs Families that speak a language other than English Families with mental health needs Teen parents Families who receive governmental assistance Other, please describe [TEXT]
Do you enroll families prenatally?	Yes/No
What ages of children do you serve? [select all that apply]	Infants 1 2 3 4 5
Do you have any income related restrictions on what families you can serve?	Yes/No
What percent of the caregivers you currently serve fall into each of the following categories?	Arab/Chaldean Asian Black/African American Hispanic/Latinx

	Native American/Alaska Native/ Native Hawaiian/ OPI White, Non-Hispanic Other race/ethnicity
What percent of the families you currently serve would prefer services to be delivered in a language other than English?	%
What else is important to understand about the culture or other characteristics of the families you serve?	

Community Partners

Section: Incoming referrals

Please identify the programs from which you receive referrals: [Up to 10 – these sections will repeat for each program identified]

Questions	Response options
Program Name	Text field
What services are provided by this program?	Drop down menu, select all that apply: ☐ Health care – maternal ☐ Health care – pediatric ☐ Health care – emergency ☐ Health care – other ☐ Public health ☐ Health education ☐ Nutrition education ☐ Breastfeeding support ☐ Mental health (including depression) ☐ Substance abuse ☐ Intimate partner violence ☐ Early intervention (e.g., *Early On*®) ☐ Speech/audiology ☐ Occupational therapy ☐ Emergency services (e.g., diapers, formula) ☐ Friend of the court ☐ Legal aid/legal assistance ☐ Parent groups ☐ Food assistance ☐ Housing ☐ Transportation

	☐ Utility assistance ☐ Childcare ☐ Care for older adults ☐ Care for adults with disabilities ☐ Education ☐ Employment ☐ Home visiting ☐ Providing referrals (e.g., 211, centralized intake) ☐ Convening community partners ☐ Other
How frequently do you receive referrals from this program?	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than 1 referral/month
Do the referrals from this source align with your program's enrollment criteria?	☐ Yes ☐ Sometimes ☐ No ☐ Unsure
Does this organization participate in these community groups?	Check all that apply ☐ Local Leadership Group ☐ Great Start Collaborative ☐ Child Abuse and Neglect Council ☐ Head Start Advisory ☐ Regional Perinatal Quality Collaborative ☐ None of the above ☐ Unsure

Section: Outgoing referrals

Please identify the programs to which you have referred families: [Up to 20 – repeat for each program name entered]

Questions	Response options
Program Name	Text field
What services are provided by this program?	Drop down menu, select all that apply: ☐ Health care – maternal ☐ Health care – pediatric ☐ Health care – emergency ☐ Health care – other ☐ Public health services ☐ Health education ☐ Nutrition education ☐ Breastfeeding support ☐ Mental health (including depression) ☐ Substance abuse ☐ Intimate partner violence

	☐ Early intervention (e.g., *Early On*®) ☐ Speech/audiology ☐ Occupational therapy ☐ Emergency services (e.g., diapers, formula) ☐ Friend of the court ☐ Legal aid/legal assistance ☐ Food assistance ☐ Housing ☐ Transportation ☐ Utility assistance ☐ Childcare ☐ Care for older adults ☐ Care for adults with disabilities ☐ Education ☐ Employment ☐ Home visiting ☐ Other
How frequently do you refer clients to this program?	☐ Daily ☐ Weekly ☐ Monthly ☐ Less than 1 referral/month
Does this program have the capacity to meet family needs related to the services it provides?	☐ Always has capacity to meet client needs ☐ Usually has capacity to meet client needs ☐ Sometimes has capacity to meet client needs ☐ Rarely has capacity to meet client needs ☐ Never has capacity to meet client needs ☐ Unsure
Does this organization provide high quality services?	☐ Yes, services are very high quality ☐ Yes, services are somewhat high quality ☐ No, services are low quality ☐ No, services are very low quality ☐ Unsure
Do families report that they are satisfied with services from this organization?	☐ Yes ☐ Sometimes ☐ No ☐ Unsure
Do families report that services from this organization are culturally appropriate?	☐ Yes ☐ Sometimes ☐ No ☐ Unsure
Does this organization participate in these community groups?	Check all that apply ☐ Local Leadership Group ☐ Great Start Collaborative ☐ Child Abuse and Neglect Council ☐ Head Start Advisory

	☐ Regional Perinatal Quality Collaborative ☐ None of the above ☐ Unsure

Section: Community Partners

Questions	Response options
What are the strengths of the network of providers that serve families with young children in your community?	[Text]
What are the gaps or limitations of the network of providers that serve families with young children in your community?	[Text]
How does your program support families in accessing their natural support networks, such as family and friends?	
How have the needs of families changed since the COVID-19 pandemic reached Michigan?	
What are the most critical and unmet needs facing families in your community during the COVID-19 pandemic?	