Michigan Home Visiting Initiative:
Developing a Continuum of Models Project

September 2014
Established in 2005, the Early Childhood Investment Corporation’s mission is to promote and implement innovative, high-quality, research-based early childhood practices and policies that support a comprehensive system in order to ensure every child’s future success and the future success of the state of Michigan.
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Background

Michigan has a long history of using home visiting as a method for addressing problems that exist in Michigan families and communities. State agencies have worked together over the last twenty years to support these programs including financial support of home visiting models through local organizations.

In 2010, Congress established the Maternal, Infant, and Early Childhood Home Visiting Program administered by the Health Resources and Service Administration (HRSA) and the Administration for Children and Families (ACF). This program provides voluntary, evidence-based home visiting during pregnancy and to parents with young children up to age five. The program focuses on families at risk; seeking to improve child and family outcomes through the positive parenting, increased understanding of child development and school readiness, and removing risks that could worsen child health and family development.

With the focus and funding from the federal government also came new requirements that only specific evidence-based home visiting models would be supported with federal funds. Michigan has five evidence-based home visiting models that meet the federal definition:

- Early Head Start Home Visiting;
- Healthy Families America;
- Nurse Family Partnership;
- Parents as Teachers; and
- Family Spirit.

The Michigan legislature also created Michigan’s own definition of “evidence-based”. The Maternal Infant Health Program meets this state definition.

There are also more practices, namely Infant Mental Health and Healthy Start, which operate in communities throughout the state. Given the large number of home visiting models, communities often struggle to link families with the best model to meet their needs, coordinate services between models, and make the most efficient use of resources.

Project Purpose and Process

Using federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) program funds, The Michigan Department of Community Health – Division of Family and Community Health (MDCH) brought together an ad hoc work group. This group’s goal was to develop initial recommendations and considerations at the state and local level for building a continuum of home visiting models. MDCH contracted the Early Childhood Investment Corporation to provide staffing and overall coordination of the project, including the preparation of this report. The focus of the recommendations outlined in this report will primarily target the eleven MIECHV funded home visiting sites; however, it should be assumed that some recommendations may also be used by other Michigan communities with multiple home visiting models/programs.
**Workgroup Participants**
Stakeholders on the ad hoc workgroup represented all home visiting models in Michigan and included:

<table>
<thead>
<tr>
<th>Work Group Participant</th>
<th>Organization</th>
<th>Home Visiting Model Representing (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cynthia Zagar</td>
<td>Department of Community Health</td>
<td>Healthy Families model</td>
</tr>
<tr>
<td>Rosemary Fournier</td>
<td>Department of Community Health</td>
<td>Nurse Family Partnership</td>
</tr>
<tr>
<td>Kaitlin Ferrick</td>
<td>Head Start State Collaboration Office</td>
<td>Early Head Start Home Visiting</td>
</tr>
<tr>
<td>Deb Marciniak</td>
<td>Michigan Public Health Institute</td>
<td>Maternal Infant Health Program</td>
</tr>
<tr>
<td>Joni Detwiler and</td>
<td>Department of Community Health</td>
<td>Maternal Infant Health Program</td>
</tr>
<tr>
<td>Mary Ludtke</td>
<td>Department of Community Health – Behavioral</td>
<td>Infant Mental Health model</td>
</tr>
<tr>
<td>Tomoko Wakabayashi</td>
<td>High Scope (formerly with the Parents as Teachers)</td>
<td>Parents as Teachers model</td>
</tr>
<tr>
<td>Renee DeMars-</td>
<td>Department of Education – Office of Great</td>
<td>Parents as Teachers model</td>
</tr>
<tr>
<td>Alejandro Barnes</td>
<td>Department of Community Health</td>
<td>N/A</td>
</tr>
<tr>
<td>Bryn Fortune</td>
<td>Early Childhood Investment Corporation</td>
<td>N/A</td>
</tr>
<tr>
<td>Nancy Peeler</td>
<td>Department of Community Health, Public</td>
<td>N/A</td>
</tr>
<tr>
<td>Alissa Parks,</td>
<td>AKP Consulting, LLC - Consultant with the Early</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The workgroup met in person four times between June and September 2014. One of the first steps was to decide which models to include as part of the project. Based on the focus of the MIECHV initiative, the following models were included. Links to additional information about each model is included in Appendix A.

In order to help those at the state level understand each model, a chart was created that included the federal outcomes, eligibility criteria, target population, and type of funding. This model chart is located in Appendix B.

Progress updates were shared monthly with the Michigan Home Visiting Initiative State Work Group, the state’s collaborative group that serves as advisors to MDCH for the overall MIECHV initiative.
This final report of initial recommendations, considerations, and next steps will be shared with that work group as well as Michigan’s Great Start Operations Team and Great Start Systems Team. Once the recommendations are approved, these groups will decide on the structural oversight for implementation and MDCH staff will provide coordination.

Continuum of Home Visiting Models

To begin its work, the work group used four questions developed by Deborah Daro, Senior Research Fellow, Chapin Hall at the University of Chicago. The work group also added a fifth question to further explore outreach efforts for connecting families with home visiting models.

1. How could home visiting models work together to extend home visiting service to families longer (when program model ends and family still has needs for the service)?

2. How could home visiting models work together to expand coverage of the at-risk population?

3. How could home visiting models work together to deepen (more than one model working with the family at the same time) services to families with the highest need?

4. How could home visiting models work together to adopt shared curriculum/resources and share information?

5. How could families learn about and enroll in the home visiting model that best addresses their needs?

The work group also examined the idea of a continuum from the family’s perspective to understand what a continuum might look like in any given community. They discussed responses to the following question: “If a successful continuum of home visiting models existed in a community, what would families experience?” Responses included:

- **Families would have a voice and choice in their services.** They would feel heard, respected, and services would be built on their strengths.

- **The model would fit the need of the family,** encourage family growth, and link with other models or services if necessary.

- **Services would be high quality.** Families would gain new knowledge, skills, and opportunities.

- **There would be a continuity of services with multiple models available.** Providers would be working together to provide seamless services. Families wouldn’t feel competition between service providers.

- **Providers would help families to identify needs and strengths and make connections as needed.**

- **Accessing and using the home visitation system would be easy.**
Using these “success indicators” from the family’s perspective, along with the guiding questions, the group brainstormed recommendations for what would need to happen locally and at the state level to develop a continuum of home visiting models. After ranking the brainstormed strategies in order of priority, they made the following initial recommendations.

Initial Recommendations

These recommendations were prioritized through a voting process using criteria regarding feasibility (could steps be taken to implement the strategy) and impact (would the strategy help to build a continuum). The following list represents the recommendations that received two-thirds or more of work group member votes (at least six out of nine members).

- Hold shared professional development opportunities for home visitors – (example topics: motivational interviewing, shared curriculum, domestic violence, social and emotional health, maternal depression, etc.).
- Coordinate locally to conduct creative outreach with the goal of reaching the hardest to reach families and connecting them with a home visiting model.
- Utilize shared curriculum between home visiting models.
- Increase “voice, choice and access” for families through shared values for these items among state level and local level stakeholders representing each model. Below are potential strategies for “implementing” these values:
  - Increase use of family centered practice within home visiting models.
  - Increase family choice for participation and continuing with the program.
  - Better communicate family rights (e.g. grievance, the quality improvement process, etc.).
- Use the strengths of each model to develop linkages between models when serving families – this is also a value statement both state and local stakeholders should utilize when collaborating.
- Develop written agreements to support transition processes between models (e.g., assist in the transition when another model is more appropriate to meet the family’s need(s), the family is interested in lengthening service, etc.).
- Develop written agreements between models at the state level as necessary to symbolize shared values and outline shared agreements in support of building a continuum.
- Initiate conversation with Medicaid to modify language in the Medicaid Health Plan (MHP) contracts to allow referrals from Medicaid Health Plans to evidenced based home visiting programs that meet the federal and/or state definitions.
The work group reviewed the list through the lens of each home visiting model to determine whether the recommendations provided the most opportunities for multiple model collaboration with the least regulatory restrictions. The following priorities from the above list were identified as the initial top four key opportunities for moving forward at both the state and local level. Given the shared commitment amongst the state level stakeholders representing each model, these four recommendations would provide small wins, energy, and momentum for addressing some of the other recommendations in subsequent months and years.

The chart on the following pages outlines these four recommendations; the benefits identified by the work group, and proposed strategies for implementation.
<table>
<thead>
<tr>
<th>Initial Recommendations</th>
<th>Benefits</th>
<th>Proposed Strategies</th>
</tr>
</thead>
</table>
| Hold shared professional development opportunities for home visitors. Example topics include: - Motivational interviewing - Shared curriculum - Domestic violence - Social and emotional health - Maternal depression - Home visiting models - Family centered practice | • Strengthened relationships and trust among home visitors. • More efficient use of professional development resources. • Shared knowledge, understanding, and skills among home visitors. | State Level *(MDCH Lead in Collaboration with HV Model Partners)*  
• Send communication to home visiting programs encouraging them to collaborate with other programs on shared professional development.  
• Provide technical assistance to support joint planning.  
• Provide problem solving assistance if policy or resource barriers are identified.  
Local Level  
• Utilize local home visiting leadership groups to identify potential shared professional development opportunities. Ensure input from home visitors and families as part of planning process.  
• Utilize state partners and technical assistance if barriers arise. |
| Coordinate locally to conduct creative outreach with the goal of reaching the hardest to reach families and connecting them with a home visiting model. | • Increased access to services for the hardest to reach families. • Decreased stigma for families to participate in home visiting services. • More efficient use of program resources (staff, materials, etc.). • Sharing of best practices across models. • Shifting of mindsets toward collaboration instead of competition. | State Level  
• Send communication to home visiting programs encouraging them to collaborate with each other on outreach.  
• Collect and disseminate best practice information related to creative outreach to the hardest to reach families.  
• Provide technical assistance to support joint outreach.  
• Provide problem solving assistance if policy or resource barriers are identified.  
Local Level  
• Learn from each home visiting program how outreach is conducted currently as well as successes and challenges.  
• Gather data to determine specific geographic areas or family types that are not being reached.  
• Decide on outreach strategies utilizing research and learning from other communities as well as input from families.  
• Create common messages across models to utilize during outreach.  
• Be creative in outreach strategies – often the usual strategies do not work for the hardest to reach families.  
• Utilize state partners and technical assistance if barriers arise. |
<table>
<thead>
<tr>
<th>Initial Recommendations</th>
<th>Benefits</th>
<th>Proposed Strategies</th>
</tr>
</thead>
</table>
| Utilize shared curriculum and supplemental materials between home visiting models.       | • Increased use of common language between home visitors and with families.                                                               | State Level<br>• Send communication to home visiting programs encouraging them to share supplemental materials and utilize a shared curriculum (e.g. Parents as Teachers, Growing Great Kids, etc.). **Note:** An only exception to this is Nurse Family Partnership and Parents as Teachers. All other evidence-based models stated in September 2014 that flexibility exists for choosing a curriculum.  
• Collect and disseminate best practice information related to shared curriculum and supplemental materials.  
• Provide technical assistance to support shared curriculum and supplemental materials.  
• Provide problem solving assistance if policy or resource barriers are identified.  |
|                                                                                         | • More efficient use of program resources (training, materials, etc.).                                                                  | Local Level<br>• Utilize local home visiting leadership groups to identify opportunities for shared curriculum and supplemental materials.  
• Shared knowledge and ability for continuous improvement between model staff.           |                                                                                   |
|                                                                                         | • Shifting of mindsets toward collaboration instead of competition.                                                                     | Local Level<br>• Utilize state partners and technical assistance if barriers arise.  |
|                                                                                         | · Agreement on values collaborative activities in writing to support implementation.                                                        |                                                                                   |
|                                                                                         | · Modeling of collaboration at the state level to support local collaboration.                                                              |                                                                                   |
| Develop written agreements between models at the state level as necessary to symbolize shared values and outline shared agreements in support of building a continuum. |                                                                                                                                          | State Level<br>• Develop a written agreement between state level stakeholders and models that outlines their shared values and commitments to collaboration at the state level and support for collaboration for building a continuum at the local level.  |
|                                                                                         |                                                                                                                                          | Local Level<br>• Develop similar written agreement between home visiting programs, including language regarding collaborative activities (e.g. strategies listed in these recommendations).  |
Considerations Regarding Remaining Recommendations

Although four recommendations were prioritized for immediate action, there are foundational steps that may occur in the near term for the remaining priorities.

<table>
<thead>
<tr>
<th>Remaining Recommendations</th>
<th>Potential Strategies in FY15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase voice, choice and access for families through shared values for these items among state level and local level stakeholders representing each model. Below are potential strategies for “implementing” these values:</td>
<td>Within a written agreement between state-level stakeholders and models, include shared values including “voice, choice, and access” and building on model strengths.</td>
</tr>
<tr>
<td>• Increase use of family centered practice within home visiting models.</td>
<td>Collect current processes and successes regarding these strategies and share with home visiting sites.</td>
</tr>
<tr>
<td>• Increase family choice for participation and continuing with the program.</td>
<td></td>
</tr>
<tr>
<td>• Better communicate family rights (e.g. grievance, the quality improvement process, etc.).</td>
<td></td>
</tr>
<tr>
<td>Utilize the strengths of each model to develop linkages between models when serving families.</td>
<td></td>
</tr>
<tr>
<td>Develop written agreements to support transition processes between home visiting programs (e.g., assist in the transition when another model is more appropriate to meet the family’s need(s), the family is interested in lengthening service, etc.).</td>
<td>Explore the research and best practices related to transition and share this information with the local home visiting leadership groups. Create an ad hoc group for this purpose to research and develop a guidance document and hold a related webinar based on this guidance.</td>
</tr>
<tr>
<td>Initiate conversation with Medicaid to modify language in the Medicaid Health Plan (MHP) contracts to allow referrals from Medicaid Health Plans to all evidenced based (both PA 291 and Federal) HV programs.</td>
<td>Future item to be considered.</td>
</tr>
</tbody>
</table>
Challenges

Throughout the work group process, several challenges were identified related to developing a continuum of home visiting models and implementing the proposed recommendations contained within this report. One of the biggest challenges identified was the attitudes, values, and beliefs – essentially the mindsets that are currently shaping behaviors in home visiting. Several types of mindsets were identified as challenges to developing a continuum of home visiting models including the mindset of competition and the belief that “my” model is the best fit for the family.

Policies and regulations were also identified as potential challenges to developing a continuum. More specifically, the policies included in the funding of the models sometimes create competition for referrals and families between models in communities. Differences in characteristics of the models and the passion of those involved in the models can also make collaboration difficult.

The work group for this project identified that these challenges exist, and they also recognized that there are often perceived challenges (i.e., the program policies won’t let us do that…) that when explored do not exist. Both real and perceived challenges must be considered and addressed in order to implement a home visiting continuum.

Proposed Next Steps

The four initial recommendations are only the starting point for developing a continuum of home visiting models in Michigan. Processes for continuous learning based on implementation, communication and feedback loops, and remaining action oriented and considering what’s possible will best support these recommendations to occur.

Staffing to support the development of a continuum through these initial recommendations is also critical. Staff for technical assistance as well as staff at the state level for responding to challenges/barrier issues, developing agreements between state level organizations, and overall coordination of collaborative efforts is essential to ensure action occurs. Small wins (i.e., actions that can be accomplished within 3-6 months) build momentum, energy, and optimism that change can occur and building a continuum is possible. Without adequate staffing, opportunities to implement these proposed recommendations might be lost.

To assist the work group with planning next steps, below are recommended steps with suggested timelines:

<table>
<thead>
<tr>
<th>Next Steps</th>
<th>Timeline for Completion</th>
<th>Responsible Group/Staff (the lead group for each step needs to be determined)</th>
</tr>
</thead>
</table>
| Review, modify and approve recommendations and next steps within this report. | October 2014 | - Home Visiting Initiative State Workgroup  
- Great Start Operations Team  
- Great Start Systems Team |
<table>
<thead>
<tr>
<th>Task</th>
<th>Due Date</th>
<th>Responsible Parties</th>
</tr>
</thead>
</table>
| Send communication to local home visiting leadership groups where developed and home visiting models with report and encouragement from state partners to implement recommendations locally. Letter should be co-signed by lead state level staff and offer technical assistance beginning in January 2015. | December 2014  | - Home Visiting Initiative State Workgroup  
- Great Start Operations Team  
- Great Start Systems Team |
| Develop state-level agreement regarding values and joint projects that each model commits to working toward together. Share copy of agreement broadly and specifically to local home visiting leadership groups, where developed. | February 2015  | - Home Visiting Initiative State Workgroup  
- Great Start Operations Team  
- Great Start Systems Team |
| Provide technical assistance to communities for planning and implementation of the recommendations. | Beginning in January 2015 | - Home Visiting Initiative State Workgroup  
- Great Start Operations Team  
- Great Start Systems Team |
| Collect best practices and successes for each of the recommendations and disseminate via the home visiting website. | Beginning in January 2015 | - Home Visiting Initiative State Workgroup  
- Great Start Operations Team  
- Great Start Systems Team |
| Set up process for receiving and discussing barriers/challenges that arise from communities. These could be implemented as part of quarterly meetings with MIECHV sites, Communities of Practice calls, the annual Home Visiting Conference, etc. | January 2015   | - Home Visiting Initiative State Workgroup  
- Great Start Operations Team  
- Great Start Systems Team |
## Appendix A

### Additional Information about Home Visiting Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Website Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Family Partnership</td>
<td><a href="http://www.nursefamilypartnership.org/about/fact-sheets">http://www.nursefamilypartnership.org/about/fact-sheets</a></td>
</tr>
<tr>
<td>Healthy Families</td>
<td><a href="http://www.healthyfamiliesamerica.org/home/index.shtml">http://www.healthyfamiliesamerica.org/home/index.shtml</a></td>
</tr>
<tr>
<td>Infant Mental Health</td>
<td><a href="http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_7145-14659--,00.html">http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_7145-14659--,00.html</a></td>
</tr>
<tr>
<td>Maternal Infant Health Program</td>
<td><a href="http://www.michigan.gov/mihp">http://www.michigan.gov/mihp</a></td>
</tr>
</tbody>
</table>
## Appendix B

<table>
<thead>
<tr>
<th>Evidenced Based Models</th>
<th>According to federal and state definitions</th>
<th>Promising Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Head Start (HV)</td>
<td>Nurse Family Partnership</td>
<td>Healthy Families America</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evaluated Outcomes/Benchmarks</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved maternal and child health</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Reduction of child injuries, child abuse/neglect or maltreatment, and reduction of ER visits</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Improvement in school readiness and achievement</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Decreased crime or domestic violence</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Increased family economic self-sufficiency</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Increased coordination and referrals for other community resources and supports</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Improved positive parenting practices</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### Eligibility Criteria and Service Period

**Entry Criteria**
- Prenatal – 30 months<sup>i</sup>
- Prenatally, before 28 weeks gestation
- Prenatal – 3 months
- Prenatal – 36 months
- Any age eligible for service
- Prenatal – 60 months
- Prenatal – 12 months
- Prenatal – 6 months
- Prenatal – 5 years
- Prenatal – K
- Prenatal – 18 months
- Prenatal – 12 months
- Prenatal – 24 months
- Prenatal – 36 months
- Prenatal – 24 months

**Range of Service Period**
- Prenatal – 36 months
- Prenatal – until 2<sup>nd</sup> birthday
- Prenatal – 5 years
- Prenatal – 36 months
- Prenatal – K
- Prenatal – 60 months
- Prenatal – 6 months
- Prenatal – 12 months
- Prenatal – 36 months
- Prenatal – 18 months
- Prenatal – 24 months

### Target Population

- Families with multiple challenges<sup>ii</sup> | X | X | X | X | X | X | X | X |
- Children with emotional/behavioral or developmental/learning difficulties | X | X | X | X | X | X | X |
- Must be low income as defined by the program | X | X | X | X | X | X | X | X |
- First child | X | X | X | X | X | X | X | X |
- Specific race/ethnicity groups determined by community population assessments | X | X | X | X | X | X | X | X |

### Funding

- Federal MIECHV | X | X | X | X | X | X | X | X |
- Federal Medicaid | X | X | X | X | X | X | X | X |
- Other Federal | X | X | X | X | X | X | X | X |
- State | X | X | X | X | X | X | X | X |
- Local | X | X | X | X | X | X | X | X |
EHS grantees may develop local program eligibility criteria so long as they are in alignment with Performance Standards.

\[ \text{such as: extreme poverty, maternal depression, domestic violence, substance abuse, homelessness, abuse and neglect, incarceration, isolation} \]

\[ \text{Tribal MIECHV funding} \]

\[ \text{EHS (and Head Start) is funded by ACF} \]

\[ \text{Inter-tribal Healthy Start is funded by HRSA} \]

\[ \text{Individual MIHP programs use other Federal Funds (FQHC wrap around dollars) and local funds (County General Fund) as well as grants in addition to Medicaid Fee for Service Reimbursement} \]

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**Acknowledgement of Federal Funding**

As required by HHS appropriations acts, all HHS recipients must acknowledge Federal funding when issuing statements, press releases, requests for proposals, bid invitations, and other documents describing projects or programs funded in whole or in part with Federal funds. In accordance with this requirement, we disclose that $16,195 were used to support the compilation of this report through a grant from the Administration for Children and Families, Maternal, Infant and Early Childhood Home Visiting program.