Michigan P3 Policy Agenda-Setting
Executive Summary: Home Visitation Action Team Responses

Number of Conversations Held (as of 11.1.19)	15
Number of Action Team Participants	219
Number of Survey Responses (as of 11.1.19)	42

In Michigan, there are currently 167,000 infants and toddlers in families who live at or below 200% of the federal poverty level ~ 23,838 infants and toddlers are being served by home visiting services. (Michigan Home Visiting Report FY17, MDHHS)

Overall themes:

- Parents that have participated in HV have had a positive experience and learned about it from a broad variety of personal connections.
- Parents not using HV reported that they were not aware of it or did not qualify.
- The largest barriers to participation expressed by parents were: waiting lists, unclear information about options, not knowing or trusting the home visitor and their intentions, scheduling, and income requirements for participation.
- When asked about what is going well in 0-3 they mentioned positive connections between services, especially for pregnant women.
- Deterrents to participating included – home visiting is often equated with CPS and that often the home visitor does not mirror their race/ethnicity.
- Providers/administrators felt that what is going well is the diversity of programs offered, the collaboration among agencies and the ability to work with parents and children in the home is beneficial.
- Challenges expressed by providers/administrators included: too little funding, getting parents to participate, the name Home Visiting has a negative connotation, Medicaid rules, work/case load is too high, scheduling, staffing and the "occupational hazards" involved for staff.
- In addition to more funding and better compensation, there are opportunities to increase collaboration among providers that are working with the same families and adjust the intensity/frequency of services needs to be more flexible – some need more, others need less.
- Workforce a significant problem – staff are hard to find with the necessary skills and credentials and it is challenging to keep good staff due to low pay, high burn out and a lack of overall staff support – both for having manageable caseloads, social-emotional well-being of staff and having more resources to help families immediately.
- Many have blended funds from other resources and have gotten creative in staffing to meet the needs.
- All but one participant was supportive of the idea of optional/universal home visiting – they believed that all new parents could use support and that it would decrease the stigma.

Recommended Policy Solutions:

1. Increase home visiting funding.
2. Include home visiting in broader advocacy efforts to promote workforce development and increase early childhood workforce compensation.
3. Improve referrals and expand parent choices.
4. Examine geographic and racial/ethnic disparities and cultural concerns that may deter or prevent families from enrolling in home visiting services.

Home Visitation Action Team Responses – Full Text

Parent Responses

1. **Have you utilized home visiting services? If yes, what was your experience?**
   - Great
   - I am pleased with my home visitor, she peaks my son's interest
   - It has been mostly positive
   - Very positive, supporting, uplifting and resourceful
   - It was enjoyable
   - Very positive
   - Didn't personally use home visiting but does have friends who have used home visiting services, Early On, GSRP, Head Start
   - One parent in the group utilized home visiting services but not an evidence-based program.

2. **Where did you learn about Michigan's Home Visiting options that are available to you?**
   - Healthy futures will come visit at hospital and tell you about this information.
   - At well baby visits- captive audience
   - Different modes of delivery- in person visits, flyers, cards, etc. the time will be different for all parents after birth when they need help/support.
   - As children develop, the relationship with parent changes- parents will need help at different stages depending on needs.
   - Play groups you hear other children's milestones - and you wonder how they got that support.
   - Downstate we have portals
   - Referral forms office will contact them
   - Contact a person for that support NMCAA
   - Personal counselor
   - Pediatrician referral to Intermediate School District
   - Focus Hope (Detroit)
   - NICU at hospital (St. Mary's in Grand Rapids, Kent County)
   - Local MDHHS office – directly from a Healthy Families America worker who spoke about additional models/programs as well
   - Foster care
   - Great Start
   - GSC and Development Center
   - At my local hospital and MIHP
   - WIC and focus hope
   - A friend

3. **If not, why not?**
   - No knowledge of the programs available and didn't understand the purpose of visits. People should be aware that they can be in a public place not their home.
   - I didn't find out about it until my child was too old
   - As a parent I was not eligible based on the FPL, but I so desperately wanted/needed the help.

- FPL prohibits people from utilizing these services. All services listed on infographic are income-based services.
- As a new parent, my pediatrician never communicated that these services listed on the infographic were available.
- Pediatricians should include these as a standard routine in post birth visits. Best way to market these services
- Most parents were unsure of what home visiting was. Need more clarity on what home visiting is. If they had heard of it, would have loved to have it especially. with their first child.
- Wasn't aware of any home visiting program in Farmington (Oakland county) – other parents may not know about this either. Had a early childhood background and didn't put daughter into childcare from 0-3.

4. What would need to be different to make home visiting an early childhood service you would use?

- I think that it needs to be all over Michigan
- A lot of families in my area have transportation barriers so there might be great programs and parents might enroll but if there are transportation barriers and you will see children not coming to school as regularly

5. What barriers, if any, made it difficult for you to access home visiting services?

- Income requirements
- Waiting lists
- Not giving families information about other resources to help until it's time to get off a waiting list
- Contradicting information [about families who receive more than one service] so programs not having the same info and being on the same page
- Transitioning from/to another program or out of a home visiting program
- Not knowing the future and not knowing the new people coming into the house
- Communication
- Perceptions in the community by others who know you receive home visiting services like the child's teacher
- Transparency between programs and classroom/preschool [when a family transitions]
- Nervous about having someone in the home.
- Postpartum Depression
- Stigma
- Didn't know what to expect from a home visiting program
- Lack of knowledge – didn't know there were home visiting programs available
- Lack of knowledge about what was available
- Scheduling home visits at times that worked for the family (two parents expressed this barrier)
- It has been a not so bad experience, they come prepared
- Knowing your options and finding out what program style works best for your child, home visitor compatibility. Flexibility and consistency
- Receiving the services and referral
- Awareness of the program and trust of the program

6. **What suggestions do you have that might help remove or reduce the barriers you have faced in trying to use Home Visiting?**
    - The program's ability to not only support what my child needs but also making sure to have resources to support me.
    - More information on programs, explanation of their benefits and flexibility of meetings
    - Continue to be personable and individualized need for clients
    - I think it helps to be referred to by a friend not necessarily a professional. Perhaps you need to equip the people who are receiving home visits to highly recommend it to friends and family.

7. **If you have used home visiting services, did you feel that the service providers who worked with you were knowledgeable and respectful of your family culture?**
    - All participants answered yes.
    - One answered "For the most part, yes. Only one felt 'unqualified.'"

8. **From your perspective, what's working well in your community related to support of pregnant women and families with children ages 0-3?**
    - Parents have option of Head Start, Early On where kids can have child care – My Sister Friend – prenatal program, supports new mothers, let them know what to expect in pregnancy and after baby is born.
    - There are good supports for prenatal care and helping parents be prepared for baby
    - Communication between programs when a family uses more than service or support so that those programs can best help a family
    - Talking to other programs and contacting resources for the family instead of just making a referral to a family or telling them about it
    - Making it easier to coordinate services and for families to get resources
    - Transportation access to medical appointments.
    - Medicaid assistance and scheduling for appointments and rides to appointments.
    - Access to resources and referrals
    - Free diaper programs and access to other needed items for babies
    - Support for pregnancy related matters (such as breastfeeding support groups)
    - Advocating and speaking on behalf of families to other providers.
    - The Ingham Local Leadership Group
    - WIC, Nurses coming out working well

9. **Do you think that a home visit to all new mothers and babies is needed in your community? a. Why or why not?**
    - Absolutely! Home visit would be good because it is personal, one on one, in their environment. Sometimes when ladies go to Dr's office they are in a rush or uncomfortable and a visit would be more personal in the comfort of their own home.
    - YES. Everybody needs help. Whether you are a first-time mom or veteran, every pregnancy, child, and situation is different.
    - Yes, services should be universal because every family could benefit. Most parents felt unsure as a new parent of what to do with a newborn.

- Yes. Motherhood is really hard. There are lots of unknowns. Things pop up people might not know to expect or to reach out [for help]. Having home visiting available would be better for the well-being of adults and kids. It would help with stress and child-abuse related to stress.
- I believe that all new parents should have access to home visiting programs. However, I don't think universal would be good because not every model works for every family. I do think that all parents should have access to home visiting programs. The parents after this parent agreed this this assertion.
- "Not all of us are the same but it should definitely be available."
- "I also agree, there's a variety of programs and that's the best way to go because there's a variety of families and needs."

10. What geographic and racial/ethnic disparities and cultural concerns do you think may deter or prevent families from enrolling in home visiting services?

- "Our community is incredibly rural so unless someone is going to meet us where were at it's pretty hard. It's hard to hear about these things. It's hard to reach out when you're struggling." Talked about the stigma related to home visiting. "People don't want a stranger coming into your house." Talked about families being uncomfortable with people coming into their home, especially without a pre-established relationship.
- Talked about the mentality that *what goes on in the house stays in the house* and I don't want people in my house. There is a stigma. "When people say home visiting people think of CPS or police coming into your home. Because of the whole CPS and all of that they think that's what it's about when it's really not. I think it's basically a lack of knowledge. Some of us don't want to ask for the help even when it's needed." Stigma and lack of knowledge.
- Concern of allowing a stranger into your home. The process of matching the home visitor with the family to be culturally competent and mindful of the implicit biases the home visitor might have. "Even if I meet a home visitor and maybe they don't vibe, what is the process for the family to get a different worker?" Does the family have a way to get a new visitor from the program? Do they know that process/how to do that?
- "Wanting someone that looks like you more and just understands where you're coming from. There's not a variety of home visitors for the variety of clients that are out there. I agree with what the two ladies in front of me said."
- "I agree with the others. There's the stigma of having someone come into your home and watching everything. Are they paying attention to all the little things going on in the home?" Emphasized the previous point about what goes on in the home, stays in the home. Also, the point about diversity in home visitors – that the current workforce isn't demographically representative of the current client-base.
- When you first give birth you are overwhelmed and don't always remember everything that is offered or provided in terms of programs, services and supports. It would be so nice to have someone just check in and assure you that things are normal or make referrals or recommendations
- You may feel you know what is best for your baby. Early on tips and education pattern learning all of the necessary tools for our at home teaching
- Home visits will definitely help new moms prepare for their new reality. I believe that families should select programs during their first prenatal visit and it should be incentivized to create buy

in. A family should work with a program and receive at leas one big ticket item by their delivery date i.e. car seat or crib
- All new mothers need that extra assistance and support in the beginning
- As long as it is not clinical, but friendly

Provider Responses

1. **What's working well with the home visiting system in your community?**
   - Longevity and quality of staff, Consistency
   - The home visitors feel that one of their strengths within their community is their ability to collaborate with one another across different agencies. They discussed their lack of time to meet, but said that it's always positive interactions when they do. They discussed that in many scenarios, their clients know who they are due to the smaller populations in their area and they agreed that using positive self-disclosure has made a positive impact during those instances. Many of the home visitors felt that an important piece of gaining the clients trust has to do with their ability to connect given that they are in "small town" settings where most people either know them or are connected to them in some way.
   - There is great collaboration across programs in the county.
   - There is high quality of care available
   - The ability to reach all areas of the community.
   - Multiple services, EHS, Early On, and Nurses doing NFP. Lots of diverse programs being offered. Home visits build familial relationships which are personal, and the relationships built are really special and have a positive impact on parents. Working with the parents pays off for the children by providing whole family services. More than two gen – grandparents and other family members are also being served who are surrounding the child.
   - I work with CMH and all of my staff are master's level and they support children 0-7. I think that home visiting is the best for infant mental health. Parents have issues – like no transportation, no car seats, etc. and if we didn't come to them we wouldn't be able to serve them. As a continuum of care, we do have outpatient care if their scores are low, but there are a lot of no-shows i.e. this other child is sick etc. We also get to see the layout of the house, if the children don't have toys, if there is no place for tummy time, if there are lots of people living in the home etc. that we wouldn't see if they weren't in the home.
   - The home environment is another way that we learn about and incorporate their culture into our approach to supporting them, and the attachment relationship that we can support between the parent and child is best done in the home.
   - Monthly meetings/home visiting provider network
   - Community outreach; collaboration with other agencies
   - Some pockets of county do not readily accept
   - Home visiting is intimate relationship so build up to that through community engagement is critical
   - Home visiting represent race/culture/gender of who we serve
   - Referrals to early Head Start, Early On, Early Intervention & GSRP home visiting component
   - We have various different providers and titles and we seem to collaborate well
   - I am not sure about other agencies, but at KRESA there seems to be a very compassionate group working very tirelessly to provide the best interventions for all families

- Small case load in a focused zip code for more comprehensive care
- Access to local programs
- Meeting clients at their homes helps break barriers to getting therapy which is vital.
- It allows families easy access to WIC benefits
- Early On communication with team and families
- We are talking to teach other – more trust fewer silos
- The ability to partner with area home visiting and support programs
- What's working well is that we are willing and wanting to be there for the community
- Providing resources and education opportunities to parents.
- Collaboration between the 2 home visiting programs on the reservation.
- incredible history of great home visiting
- Collaboration between home visiting agencies.
- That we identify developmental delays and refer for additional services.
- Parent awareness of home visiting services available is increasing.
- Collaboration across agencies is increasing
- The parents have someone that they can talk to and discuss with their issues/problems with.

2. What are your challenges?

- Reaching parents, Transportation/nature of county, Stigma of Home Visiting services, Consistency with funding, no birthing hospital in county to use as a connection to new parents
- Geographic issue – what we experience in Kent County is very different. The U.P. for example – you could be traveling several hours for a home visit. Right now, it all looks the same while it should look very different.
- Out of the families on here, how many families are open to home visiting? A barrier is getting families to want and be open to the support. "It doesn't make me less of a parent." You don't want to feel like someone is coming to your home judging your home – how do you get past the trust barrier? It's important to build trust. – particularly when there's more than likely the racial dynamic of a white home visitor visiting a black or brown family.
- People's biases can negatively impact the relationship the home visitor has with their family.
- Are there enough home visiting services**?** They all focus on different things – how does that look for Michigan? Are these services getting to families that need them? Many families are not even aware of what is available, which is a common thread.
- It's a challenge to get to informed choice – it's especially difficult in Michigan because different communities have different resources. There are many choices in our differing communities. It's difficult to explain at a state-level. There was a discussion about whether that is the role of 2-1-1 and if there should be someone specialized on home visiting working at 2-1-1.
- A PR effort to remove the stigma – educating the community – and then connecting to the right type of service that families prefer to have.
- Even calling it home visiting – should it be called something else – should it be "rebranded?" It's a loaded term, especially on a cultural and racialized level. It makes the home the focus instead of supporting the family the focus.
- Do our providers offer the opportunity to meet at a neutral place? The answer is yes – the home visitors are willing to.

- Stigma in how they identify they gap – it's "for poor people" – it's just for "this population" that can benefit from it.
- Are we marketing appropriately about home visiting?
- How are we recruiting people who are participating?
- Having evidence-based programs is great, but you want to be flexible enough to meet the needs of the family, and it takes a long time to be innovative in an evidence-based model. It's an unintended consequence.
- More and more families are going to work.
- Time – there's a mom at home with a baby – there's not a lot of time. Families need to see how they benefit from it. How is it going to benefit me in the long run?
- Increase training around cultural competency for home visitors.
- Language barrier – aren't resources for interpretation services other than Spanish, when it is available, and often, even with Spanish, it's the wrong dialect.
- Barriers that many Latinx families are anxious to have people in their homes due to societal issues, or refugee families do not have access after six months.
- Some programs aren't long enough.
- If you want to connect with families, you need to reach out via the communities that are already connected with the communities. The nonprofits in those communities with their trust should be the ones implementing the services. Our community has a lot of community-based organizations, but they are not fully supported.
- Although the home visitors discussed the strength of building connections and self-disclosure they also discussed the challenges that it brings. If they are the only home visitor for a program, they felt as if sometimes families do not want their services because of knowing them or having a connection to them in some way. The home visitors spoke about transportation being a challenge in their community. The home visitors feel that they spend a large amount of time on the road because they cover such a wide range of area which gives them less opportunity to serve more families. They spoke about a lack of resources for families including but not limited to: phones, internet, public transportation, and child care. They feel that the overall lack of child care provided in their area is a huge barrier for families. They also spoke about the ever-changing staff in different capacities and that often they are unsure of what resources are available and/or who to connect with in order to assist their clients.
- Having enough staff to do them – bodies – posting positions and not finding qualified people. Such a shortage in staff. Trying to get creative in who is providing services by connecting them with mentors who are qualified staff.
- Workloads for staff that are doing this work, their loads are unrealistic and the compensation isn't balanced with their workload or the kind of work they are doing. With the populations that we are trying to serve, (special education) we get a referral and by the time we contact the family, we can't reach them – changed contact information, transitions in housing etc. Not able to reach families because in that short time, they have already moved or can't get in touch with them.
- In Wayne county case loads for Early On are really high – can't fit them in quickly. Need to go quickly when the parent is ready – if we wait too long they may not want it any longer. Poverty in general is a barrier and creates stress – trying to survive and adding on parent responsibilities

to engage in these programs is hard. If they are working during the day and there are limitations related to poverty that impacts accessing services.

- From a policy perspective – my therapists and I talk about all of the time that for our IMH program we need to meet 4 hours per month regardless of what is going on. If mom has post partum depression, she might no-show or will send us away after 20 minutes until we build rapport. It seems like a square peg in a round hole. It's not necessarily a good fit to be held to this standard. We don't have other opportunities to make this time up. The work is with the family and child and it's hard to get in the house and work with the parent who can make that change.
- Home visitor issues- bed bugs, nuisances that we can't do anything about. Chronic worry for families - those things are worrisome and preoccupying for the family and the HV bring home bed bugs etc. too.
- The occupational hazards keep people from staying with the work at times. Agency dependent, but most don't have funding to help every family with bed bugs and roaches etc. We take a risk going in and taking things home with us. Drive time when you serve several counties that makes it hard too.
- Scheduling is a huge issue. We try to have a caseload of 12 but come the end of August they get white knuckled because every family will want an after 4:30 and it's a requirement due to union regulations, you can only do so many and work certain hours. Some families handle that differently than others.
- How and where families are being referred to us from is also a challenge, others don't understand what IMH is and what it isn't. So we deal with trying to explain what we do and frustrate parents.
- We have had a huge influx of older children and they need late in the day visits which makes it harder. We are being moved into preschool age instead of little ones. General fund keeps getting cut. Before we had screening appointments and more time, especially when hospitals would call concerned about a new mom going home from the hospital, we could go after them a bit until we could get started, but general fund has shrunk and they now have to come to us, which a lot of them won't.
- Phone numbers change and we can lose them. These are the moms we need to see the most who don't have support – they could be hurting their babies or themselves! To catch people early is so important. When people call us they are at their worst and something has happened and we wish that we could get to them faster before it gets really serious. Sometimes when we see them, it's because CPS has shown up. Then they don't really want us there. We want to be the olive branch before things get bad and that changes the relationship. We have a lot of child welfare cases which are a lot more difficult.
- Nurse Family Partnership is fully staffed and appropriately funded and successful. NFP challenges- they are unable to service all areas due to grant requirements and all their programs are full. Not enough funding for Early Head start. Better compensation for staff. Eligibility requirements for each program are different and confusing and many families are not qualifying because of the vast number of requirements.
- No enough slots for families who are eligible, some families are not aware of services in their community, not enough staff who are trained to do home visits, low salary

- Sometimes our high risk families with substance use disorder seem to have too many home visitors: social services, tribal social services, Healthy Start, Families First, Early On, etc. I'm not at all saying that these serves aren't needed in the home but that can be overwhelming for any family-let alone a family that is already under added stress. This can lead to parent burn out and then we wonder why a parent isn't doing what we ask of them.
- Gaps in availability for current services due to eligibility constraints (age, insurance, income). Perspective from community members that there are no gaps, or that additional services are not needed
- We have a wait list, we need to hire more parent educators
- Poor cooperation from the Health Department & DHHS (no referrals from them to home visiting programs).
- Lack of funding to fully support programs.
- Geography and lack of funding are huge challenges. Reaching families in remote locations. Access to mental health services
- Getting families to enroll
- Not enough staff to meet the needs. Six home visitors covering the entire Upper Peninsula is inadequate. We need at a minimum two more full time family support workers (home visitors) and 1/2 time supervisor. Travel - both to home visits (this is a very big geographic area with only 3% of Michigan's population), and to trainings and meetings (the range of staff time on the road to a meeting in Lansing is 4-9 hours one way depending on location of that staff member in the UP).
- Getting parents to voluntarily participate in a research study program. Parents are not following through on scheduling their appointments and resources given to assist them to improve on their household and self-sufficiency.
- Getting people enrolled
- Keeping clients engaged
- Getting people to realize the value of the program so that signing up is a priority.
- Fear of having people in their homes.
- Fear CPS will be called because of something a visitor sees in the home.
- Large amount of paperwork needed for each client.
- Lack of funding
- Waitlists with clients that go unserved.
- In many programs, risk factors and income are what qualify people. Many people want and need the services despite those qualifiers.
- Stigma around home visiting
- Lack of trust in system
- Underutilizing faith-based organizations to message and encourage connects
- Qualifying by income can change, due to a raise or other factors, and then eligibility changes.
- No
- Some are not willing to participate despite need.
- Some are afraid to participate
- Despite programs helping to eliminate barriers, some people have too many barriers to manage.
- Providers attempt to supply other resources to families

- Providers often lose connections with families, but when they do make contact they try to refer them to other needed resources.
- Priorities come down to compliance, so the teacher has a caseload to manage and evaluations that have to be done in a quick timeline, so the caseload tends to be the service that has to be cut. Evaluation needs to take precedence because it's mandated.
- I manage 3 HV programs – and we need more flexibility for specific funding needs. We serve a lot of families that don't speak English. One program has (and needs) $135k in fees for interpreting. Other expenses are challenging to cover. Refugee families need more time for their visit – especially when the visit is being interpreted and they need a lot of other support. Where other people need less time. We need more funding, but we need to review how funding can be done to compensate for visit changes and the needs of the family.
- For HV in Northern MI and the UP, the travel to the visit is longer than the time we get reimbursed for. For MIHP it has to be a 30 minute visit and with how long it takes to get there, and we are so rural, the drive could be 30 minutes and we have to pay them for the time to drive as well.
- MDHHS – better utilization of community health workers and appropriate services for families more broadly. Incorporate workforce more creatively.
- Hearing what parents said about wanting to see more HVs that represent their culture is important. When we think about our current sites, the strongest ones are where we have mixed teams with the professional background represented and someone from the community (licensed professional) with the visitor is really effective. I see a lack of available people – anything we can do to home-grow with community colleges, community health workers etc. some structure that is supported in the community to engage in the work and pay them a professional wage is important. Reimbursement issues are complicated but desperately needed.
- Agreement with the two prior and reflecting the families they are serving is really important.
- The UP has other challenges with the long travel and when no one is there or doesn't answer the door – there is no compensation if the family is not there.
- Workforce standpoint – there are regional challenges – UP can't find Social Workers – if there are social workers, they aren't working in this field. We are getting waivers to have some without the MSW – trying to pull in new graduates.
- Is anyone already partnering with the colleges regarding social work? Oakland County has Wayne State and Oakland University immersion program with community nurses – not MIHP or other, but we were able to hire one person right out of school.
- Kent County Health Dept with the nursing schools – having positive results – public health in general trying to pull them from the hospitals.
- We have also been inviting nursing school students to do ride-alongs to see what it's like to be a home visitor.
- In Flint we have an in house nurse and she lets her nurses come in and offer suggestions and they come several times a year. At one point, I had nursing students and it worked out. Very few parents object and allow them to join us on the visits.
- Wayne State University Social work interns – do try to bring them into home visiting – not CPS work with Wayne State with MSW students.

- There is currently a pilot launching in First Five CA in LA, with community colleges and partnering with families who went through HV. Getting to the issues of having the HV reflect the families
- Nurses say "this is exactly why I went to nursing school" – and they then get the offer, it's $20k less than the roles in the hospital. Contracting or leasing nurses through the health system itself. They then get the benefits elsewhere. Just got this challenge presented again last week. Not just pay but the number of staff, rate of pay and level. I have a Public health nurse 1 who has been in it for 10 years, and can't move up until there is a vacancy in the PH nurse 2 – not based on merit.
- Ensuring that model specific infrastructure components are in place to better ensure fidelity to the model
- Some parents think the programs are trying to tell them how to raise their baby and not assisting
- Keeping some of the families that I work with engaged. They are often the families that need the most help.
- I have challenges getting high risk families to commit fully to our program. It is also difficult at times to educate parents the importance of early intervention in a way that resonates with parents.
- Parents need quality health care at affordable prices. Parents need transportation to appointments.
- Parents rescheduling visits
- Reaching all Native American families that are eligible for services, as they do NOT have to live on the reservation. Duplication of services if one of the Native American families infant's end up in NICU they get a referral to general Home Visiting Services in the county they live. However, they may already be receiving services from programs here on the reservation (both reservation and county HD have MIHP programs for example)
- sustainable funding
- Funding; Restrictive Eligibility for available programs (most of our programs are for families below 100% poverty); Parent and professional awareness of programs
- False stigma of what home visiting really is.

3. What would it take to remove or reduce these challenges?

- Staffing – paying equitable pay for the work that they do. Staff in Special Ed (K-12) get paid more than Early On staff. Home visitors are on their own a lot and need an administration that supports them with reflective practice.
- Family specific – learn better what are the barriers and address them! Some parents work throughout the night so that they can access services for their children during the day. If the child had comprehensive day care during the working day, they might be able to be served. With 0-3 there aren't many options.
- Are there some quality assurance standards for case loads – with a recommended number of families and visits to help guide staffing issues for things like Early On staff who are required to serve families if they say yes. All things considered, when we run short on time, the visits run short. Can't always commit the frequency or duration needed.
- Trying to find some type of uniformity – create a framework for the delivery of visits especially in Early On – because it really is open to the interpretation of the provider. If some kind of pipeline or regular training and PD specifically for home visitors there is the HV conference etc. every year, but it's a lonely field that isn't widely understood. When you try to hire, it's hard.

Have had some who had a class that focused on what early intervention and HV actually looks like which was great – but it's rare.

- Funding – legislators and people who make the Medicaid guidelines need to go on a visit with us. They don't understand. Especially the 4 hour requirement. I have a mom who is living hotel to hotel, they have lots of factors that where one consistent person that can help them it will make all the difference in the world. Especially for children in foster care – they need someone to help them that they know will end up where they do. This is a prevention program, and Medicaid guidelines make it lose the essence.
- Education piece is important and more of an opportunity to build relationships with parents earlier so that we can be preventative. When they are 3 or 4 we wish that we had been connected earlier because although it's not too late, we could have done more if we had intervened when they were in the 0-3 range.
- We need to destigmatize mental health issues post pregnancy. Get to the moms and babies earlier and have positive support and then when issues come up later, they feel ok reaching out.
- Connecting with pediatricians, OBGYNs etc. to get referrals earlier would be great!!
- Better collaboration between agencies
- Funding for universal programs to reduce stigma, provide a gateway to connect families to available services, and to develop/implement home visiting services that fill gaps in available programs. Flexibility to implement home visiting programs that are truly equitable and can flex to meet the needs of individual families.
- Additional funding
- Seems like there needs to be some "forced" cooperation from the Health Department & DHHS
- Increased revenue
- Funding
- I have teamed up with the early Head Start program in hopes that that will help
- Additional funding. Trainings and meetings in more equitable locations for the WHOLE state, or separate meetings for the Rural Home Visiting Expansion Programs
- Make the research study mandatory or as an additional program that parents have to complete in junction to their mandatory program.
- Ensure that funding opportunities allow for appropriate dollars to be allocated for infrastructure
- More education and awareness
- Act of Congress
- Higher commitment to services by parents - perhaps if they became more knowledgeable of the outcomes.
- Higher commitment to services by parents - perhaps if they became more knowledgeable of the outcomes.
- sustained funding- not grant dependence
- Better marketing and use of funds in the community

4. **Are you able to serve all families you identify as needing home visiting services? If not, what do you do in those instances?**
    - No, the home visitors feel like they are unable to serve all families that they identify as needing home visiting services due to the lack of home visitors and the different guidelines for each program (ex. income based, age based, etc.). They also feel like there is a lack of time and

money to reach everyone within different time zones and long distances of travel in the counties they service.

- The home visitors said that they make as many referrals as possible across the programs that they are aware of. They try to get their current families involved with more than one program if possible so that they can transition and then have time to work with a new client/family.
- Medicaid eligible clients are the only ones that can enroll in some of the programs despite the need for programs for those not Medicaid eligible.
- With EHS, they have waiting lists – they are always full and the staff starts looking for subs to help support them in keeping up. We see that our staff need immediate support and skill development. We sometimes bring others in to sub under direction of the EHS teachers, so we can keep running. Not enough EHS! We try to refer and there are areas where I have no suggestions because there are no options – especially in Detroit. Parents should all have options.
- Transportation is another serious issue for many of the families.
- Medicaid piece – we are grateful to serve this community, but families with private insurance need our services too and they call needing services but can't use ours because they don't quality. That is not helpful to them and they will stop asking for help.
- Some CCBHC can be used. Home based care isn't usually covered by private insurance, but we are finding a few. There are moms that we take on as clients with their babies if they have depression – we will open under the baby instead of mom. It's a way around the system to provide care to mom. Since we hold them both. What filters down from the parent impacts the baby.
- With scheduling - children who are school aged – parents don't want to take their kids out of school and when the evening if full, the clinicians work hard to make it work, but sometimes they close because we can't fit it into the schedule when it's most helpful. The parent/child visit is important. We need more clinicians to fill those specific hours. Balancing their schedule by coming later in the day etc. They work more hours than they get paid for and get stressed out and leave.
- Some see a family for 2 hours every other week instead of weekly, some are on rotating schedules to move it around and then you have to really orient the families will so that they understand we can't do Wednesday at 4 pm etc. We just can't do it. If they are stuck on that they may need another program.
- We have seen an increase of foster care cases and these need to be counted as more than one visit. We serve the Mother, Father, and then the child at the foster care home… And, for waiver children wrap around goes out and meets with them in addition and we can't count our visits as distinct.
- It's [home visiting programs] a voluntary service and there are no caps on service so yes. Outreach may be needed if referrals are not coming in if it appears eligible families are not coming into the program.
- There are more vulnerable populations that need services, but it doesn't seem like they are being reached. Referrals often come from places where families are seeking other services like WIC.
- To serve eligible families, a warm hand off and a doctor actually trying to engage families to get support services and home visiting services. 211 could be helpful also

- No. Some families do not continue contact (or follow up) after the initial contact and appointment. Some families are referred but do not see the need for services.
- No due to requirements families don't meet all necessary to receive services (income, geography, age of child, etc.) For example, NFP can only serve first time moms.
- Try to offer other options that may work (NFP offers community nursing for those families that don't qualify for NFP)
- Utilize play groups and storytimes but there are very limited services for birth to 3.
- No, Parents working, cost, low salary, unsure of what happens during home visits, don't want stranger in their home, lack of awareness
- In one survey – 42% said yes and 59% said no
- In our survey – 24% said yes and 62% said no – 1 person wasn't sure
- Due to a variety of circumstances some families don't get seen beyond the intake process. I try to be flexible and do visits at daycare, phone consults, etc.
- Share information about other providers in our community
- Phone calls and text messages
- I try to cold call and make connections and also do community outreach
- Family circumstances
- Refer to other programs
- Occasionally our families need more support. In those instances, we reach out to Early On for additional services to support the child's development.
- refer to an agency that can see them
- Try to refer to other services - but it is not unusual for there to not be needed services available
- Refer to other programs that may have an opening. Invite them to our our monthly groups so they can be involved until an opening is available.
- Put them on a waitlist; refer to another program that may have space(all HV is full in our area). Refer families to activities and local events to get connected to other families and resources
- We refer to other programs (which we are finding many of them full as well), and we keep them on a contact schedule to check in with the family via phone or text and let them know if an opening is available.
- Some programs have contract requirements that allow only for specific populations to be served
- I am able to serve all of the families wanting help that choose to participate. There are families that need services that do not enter/stay with the program.
- We are able to serve anyone Native American family or white female carrying a Native American fetus. It can also be foster parents, family or dads that have custody of a Native American child.

5. What would help you be able to best serve all eligible families?

- The home visitors feel as if there is a lack of money to assist families with proper resources. They spoke about the importance of eliminating stigmas about home visiting and how there is often a misunderstanding that they are working as or along with CPS, making clients hesitant or unwilling to receive services. They feel that family medical doctors would be a great advocate for home visiting and they believe that more families would respond to a referral from a doctor. Along with that, they believe that public school systems could be beneficial in doing the same. The home visitors also stated that they would like less distance to travel for training but more free/low cost training in the sense of webinars and/or "in house" training. Some particular

topics they identified were trauma training, substance use disorder training, and processing and sensory disorder indicators.

- Make home visiting services universal
- Work to remove the stigma of home visiting
- Work to remove the income eligibility stigma
- People are offended by the “at risk” term.
- Home visiting should be thought of as a “gift” of support to families
- More slots with less restrictions, universal access to benefit all and to reduce stigma. Better coordination between programs. More flexible schedules of home visitors.
- funding for programs that are universal and flexible
- Higher salaries, extra support for families, evening and weekend home visits
- Each family seems to have different needs. It would be nice to have more of a variety of items for them to purchase with their baby bucks but the budget doesn't extend that far.
- Staffing and funding
- Money and personnel
- Better resources within Wayne County address all areas of living that includes but not limiting to adequate/clean/affordable housing, employment, clothes and shoes for children, access to affordable childcare, car vouchers, help with obtaining new appliances, and etc.

6. Do you think families are connected to the home visiting model that best matches their needs? Why or why not?

- The home visitors felt that families are not always connected to the home visiting model that best matches their needs.
- They felt that there is sometimes a lack of understanding on what other programs offer and the criteria to transition into a different program (age, income, etc.). The home visitors also talked about the overflow of families and their worry that a family will have to wait for services or feel as if they are on the back burner or being declined. They felt that some families cannot be in the home visiting model that best matches their needs because they did not fit the criteria to have the service for one reason or another.
- Providers feel families are connected to the right programs if they are not, they refer them out to the correct one.
- Strong collaboration helps
- Being low income does not always mean that there is a need for services. Serve families anyways
- Duplication and repetition of materials across programs is not always a bad thing. Repetition and reflection is important for adult learning.
- When it’s working they feel connected and have someone seeing them regularly. If they let us in. They feel connected and it’s going well when they are working.
- The relationships are the strength – people who love kids and know its not an easy job. There is a lot of talent – the people making these relationships are helping parents access what is needed.
- Not always.
- Families may not be getting what they need in the moment by their program.

- It also depends on how families are referred to services. There are policies and procedures in place that may prevent best fit and choice. There are limitations on how programs have funding and staffing to provide services.
- Families are put in programs based on eligibility requirements not based on needs. Exiting home visits at one, two, or three and there is not always another program to have the families enter into.
- Hard to say; no way to determine this
- Not always. I feel there are gaps in the system that leave some families vulnerable.
- There is tremendous coordination among home visiting providers to connect families to available programs.

7. **Do you feel that families are getting the appropriate intensity/level of services they need?**
   - No, Our local Health Department has a Healthy Family Home Visiting Program-The person in charge (WIC, Dietitian) is so territorial that even when they age out of Healthy Families they won't refer because she has determined that they don't need services from any other agency.
   - No limited availability of highly trained service providers.
   - They are receiving the intensity level as directed in the standards of Healthy Families America. There are families that could use more.
   - 24% said yes, and 29% said no –
   - There are a multitude of reasons for this issue that are both programmatic and family issues

   What would help?
   - Additional funding
   - better collaboration between agencies so that developmental screenings aren't being done multiple times and better education to parents so that they are more likely to stay engaged with the proper level of services for the child.
   - Increased funding to support highly trained service providers\ Funding. We need to add staff in order to serve more families. We have higher costs in travel due to the cast geography. Staff cannot see as many families as they may have to travel over an hour to get to one family.
   - Money and more staff - more staff would mean less time on the road for all home visitors, which means more time to spend working with families.
   - It is hard to recruit when they've been told by the Health Department that they don't need any other service providers.
   - Open up contract restrictions and additional dollars
   - Open enrollment to everyone who is interested.
   - If they were asked on referral form if they were Native American and if they would like a referral to a Native specific program. We teach a curriculum from John Hopkins that is a Native American curriculum
   - Many of the children that I service need IMH and it is often not covered or not available. We need more service providers as well as insurance to cover it without needing a PCP to refer it.
   - Some families need continuous intervention services, beyond the ages served or timeframe of the program
   - Sometimes it is lack of follow through on parent's part. Sometimes it is because the families house hop and are hard to locate. Sometimes it is just an issue of collaborating with client and other programs to see how we can all best serve them.
   - Advertise early intervention programs at more locations to reach a wider population of people

- More federal dollars to serve more children and to raise the income guidelines for poverty.
- Allow parents and case worker to determine when their time is done. Then, offer a warm hand off to the next level of services.
- A team collaborative meeting with all services/providers that family is working with

8. Are you experiencing any challenges related to the workforce?

- Highly qualified workforce is difficult to find.
- Training and education is such an investment, agencies do not want to lose home visitors.
- Retention is challenging.
- The work is challenging.
- The environments families live in is challenging.
- There is a high burnout amongst home visitors
- The program requirements and paperwork is intense
- The challenges, mental health issues, and stressors families face is taxing on home visitors who are seeing several families per day.
- Yes.
- Need to be funded for and compensated for reflective supervision.
- Need to offer scholarships.
- Need to offer mental health days.
- Young people are not even thinking about jobs in home visiting due to no workforce path leading them in that direction. This needs to change.
- Limited benefits, safety, low salaries, work in isolation, paperwork, difficulty families, families resistant to accepting support
- Our geographic location, we have a large population, but we have to travel an hour to a visit in order to see a family. This can be difficult in the winter.
- Yes. Home visiting requires highly trained individuals and presents many challenges including health and safety, exposure to trauma stories, time, good communication skills, time and ability to network with other agencies...it is not primary setting most professionals seek.
- Staff retention is fairly ok. The main factor for those that have left for other jobs is that the pay is much too low for this very challenging work.
- Yes- many programs have experienced turnover as well as workforce that is not adequately trained for the work.
- YES, hard to get teachers for preschool and trained home visitors.
- It is difficult to find qualified case workers with social work and early childhood development experience.
- some duplication of services, maybe not knowing what each program is helping with or doing.

9. Do you feel home visitors are compensated fairly?

- No (6 times)
- Survey: 71% no, 5% yes and 24% unsure
- In Early Head Start yes, not sure what the compensation is in other programs.
- Some programs need to boost compensation, but I am not aware of all programs. Compensation should reflect education and experience.

- Restrictions on hours available and amount of pay make it difficult to earn a comfortable living for those already in the field as well as an unattractive diversion for those wishing to pursue the field
- It depends on the employer/program
- We are compensated enough in terms of salary and mileage reimbursement in comparison to other community agencies that does home visits.

10. Do you feel home visitors change jobs frequently?

- Some change jobs frequently.
- It takes a "certain" person to do the job of a home visitor
- It depends on the demand of the individual program. They vary greatly.
- Turnover is crazy due to pay.
- Need to offer incentives to stay.
- Yes
- I have been in this field for under a year and have already seen many two coworkers leave the program.

11. Would your community be able to hire new home visitors if more home visiting funding was available?

- Rate of pay impacts ability to hire and/or attract suitable candidates
- Yes
- Most in the survey said yes, but one said no: In our area it is difficult to find reliable committed staff. I would love to say yes but am unsure if it is realistic
- Yes, if funding was provided. Our agency is in the process of expanding and building a new office building. This would also help house more staff as we are currently in a hub system and lack personal desks for all employees.
- Unsure
- If we could pay them more
- 90% said yes in the survey
- We would support staff in obtaining required qualifications.

12. What do you think it would it take to stabilize the home visiting workforce?

- Increased pay and/or provide supports for ALICE* population, i.e. basic needs, housing, transportation
- *ALICE –Asset Limited, Income Constrained, Employed
- Consistent funding, Resources to support continuous professional development, Validation/recognition of career choice – Home visitors specifically
- Decrease stigma of receiving home visiting services
- Less program demands
- Funding to hire more staff
- Smaller caseloads
- More support from the general public to remove the stigma of home visiting
- Smaller caseloads
- Flexible hours/better pay
- Job shadowing to increase recruitment in the field

- Stable funding for existing workforce
- Long term funding for program development
- Higher salary, more training, better benefits
- More employees including speech-language pathologists and bring in behavior specialists as home visitors
- More employees/smaller caseloads, better pay, flexible hours
- Long term funding that would allow time for program development
- Consistent staffing and buy in from clients
- Job shadowing
- More money, and more qualified and trained home visitors including health care providers! Get the Doctors in the homes to provide 2, 4, 6 week postpartum visitors for babies and moms
- Need more staff
- I think we need more staff to do home visiting to really all of the families that need us
- It would take people participating on both ends of things.
- Stable funding for the existing workforce – hard to commit long term to a program that may not exist in another year.
- Increased communication with area agencies
- Being able to provide some of the families with things that are needed right away
- better pay and more staff so that time traveling to families is minimized.
- Stable funding and adequate funding to provide full-time benefited positions, adequate training and staff support
- Additional training/ education about home visiting, higher pay, appropriate tools to do their job (laptops, cell phones, hot spots, surface devices, etc...)
- Offer wages that are commensurate to their education and abilities. If minimum wage is being raised to $15.00 per hour then people with a college degree should be receiving more that high school students getting their first job.
- Higher pay/guaranteed work

13. Has your community developed local solutions, such as doing things to work around the system, local funding, etc., to help families who need home visiting services? What are those?

- Utilized United Way funding to support home visiting services providing the ability to serve additional children outside eligibility requirements.
- Community partnerships – i.e. Merging of organizations to maintain Healthy Families program
- Champion who supported Home Visiting services
- Internal supports for Home Visiting services
- Utilization of Advisory Council to provide input and support
- I don't know of any but I have often thought that I wish that there were more parent led organizations (which is hard to ask of parents) that had a co-op preschool or child care in the community.
- Northern MI they are voting in November in a millage to provide universal EC services. They calculate it will cost on average $25 per family in their taxes but it will provide 5 additional staff and support and have been working on it for years. To have an additional funding stream to draw from would be great. We all are currently fighting over the same funding streams.

- (The idea about staffing – using less qualified staff under the supervision of qualified staff to provide support.) Training is important and early childhood is such a specific time of life and people need training on that. People with great educational backgrounds – they might not have the HV experience. They need to be able to handle that part of the work! Being with them early and understanding policies for safety and other issues, even in less high risk they are exposed to a lot in homes and situations that you can't prepare them for.
- I would like to see partnerships with local universities to fill some of our needs – grad students who need practice hours – use them to create mutually beneficial relationships.
- The Ingham LLG has collaboration which improves relationships among Ingham's home visiting programs. One program created a wait list and demonstrated the need for expansion and received additional funding. The community also addresses infant mortality and has focused outcomes based on community data.
- Bringing of more infant mental health experts/social work/behavior consultants to build up families and children's social emotional health
- ASQ used universally by early interventionists
- Partnering with local hospital to do home visits for all new babies, funded through a Title V grant. Currently working toward a millage to create sustainable funding.
- We collaborate monthly with our partner agencies. Alger County has implemented a shared "Earn as you learn" program to support family access to necessary baby care items. The Alger County Baby Closet (ABC) is supported by various community organizations, donations, and diaper drives.
- The state is working on this always
- The use of match funding
- We are also part of the Healthy Start/Family Spirit Team through Inter-Tribal Council who applies for a HRSA grant every 5 years and then sub-contracts with 12 different Native American sites
- hoping to pass a County millage-- we'll find out Tuesday, 11.5

14. Do you think a universal home visiting program available to all new moms and babies is needed in your community? Why or why not?

- Yes
- All parents can use support, resources, knowledge.
- Support breastfeeding
- Postpartum depression monitoring
- Reduce stigma
- YES!
- To reduce the stigma. Not just programs for high risk., low income families.
- To support education for all
- More programs geared toward "dad and children" not just "moms and children"
- Yea! Yes, I think that would be great – some hospitals offer that for moms but I think that it would be great for everyone to have access to.
- One of the pitfalls that surround every corner is that we tend to for needs of the grant and the biggest bang for the buck focus the attention on a targeted audience – while there is a recognized need that every parent at some point in their life needs some support – especially

with a newborn. More and more evident now that people are more isolated and disconnected – especially due to social media. Almost like a disconnection between people.

- I think for my population – if people called and offered it many may turn it down and not see themselves as able to make an appointment – I would be curious if it was coming from a community based format with partnerships with other organizations that provide additional supports if it would bring people would help jump start the relationship.
- If I said I want to come for a home visit – bringing samples, might be more appealing.
- I think it would be fabulous. In the Netherlands they do it and I want to steal that. I also agree. It would be a great idea and the front-loading piece – education around normalizing post-partum and the experience of motherhood and giving birth. It's glamorized like babies latch on immediately and you are excited to have this baby and bring them home. Normalizing that it's hard would help more families to not feel so alone and depressed if they are not feeling connected to their baby.
- Even the safe sleep pieces. I have a MA in IMH and EC and on my best days I do great, but I can empathize - when your child doesn't sleep and cries all of the time, things like safe sleep isn't top of mind – is this a mom who hasn't slept, doesn't have resources to insulate her child? Its' different when you have resources, or you have slept. It's not reality.. We have a free drop of child care site for low income parents where twice a week they can drop off their baby and go home and sleep – take a shower, 2.5 hours twice a week. Those supports are invaluable! Families with higher incomes pay $5
- Medicaid guidelines don't offer the full support. If parents live in a hotel and you are trying to help build capacities of the child, it's nice to take them to Bob Evans or somewhere comfortable. To be able to have a little pot of money for roach treatment etc. People would not believe what we do to help families so that they can focus in. It's not wasted money – it goes a long, long way, but most of us are spending our own money to provide this kind of support.
- Level of payment that home visitors receive as a salary – some are serving the Medicaid population and they are the Medicaid population. This is how we perceive the helping profession in our country.
- Yes. It should not always be income based. Families need support regardless of income
- Of course
- Yes Everyone could use some help because it is hard for some parents to connect with their babies to develop a secure attachment and foster early development
- One survey – 82% yes and 18% no
- Our survey: 81% yes and 10% no
- More than just 1 model though
- It would be great if we could follow the UK's program of home visiting all families regardless of income until age 5.
- No's said: It's important to provide services in the most critical points of motherhood/parenthood
- Already several home visiting programs in the community – would need more information about what a "universal" home visiting program would address – purpose, curriculum, for whom, etc. would it fill a gap or increase competition

- All families should be offered home visiting but the variation among home visiting programs allows for diverse populations to be served. There should be different programs that focus on the different needs and intensity of families. Then work together to promote stronger families.
- I think what we have is sufficient enough as long as we have the resources needed to assist our families the way we like to. We can't do our jobs if we don't have the proper assistance from the resources there are supposed to support us.
- We see many families that are not eligible for any existing program, but would benefit from home visiting. In addition, universal programs remove stigma and become the norm - increasing the likelihood that those that most need services will participate
- I don't think the home visiting model needs to be universal, but the concept of home visiting and its purpose needs to be generalized and normalized.
- In addition to this, a program needs to be made for new birth moms to ensure adequate mental health after baby is born to intervene to prevent, address, and manage their mental health especially post-partum depression. Hire more direct caregivers to assist Moms with completing household chores, educate Mom on new baby development, allowing new Mom to rest or get errands done without the worry or hassle of childcare for new baby.
- while still using all streams of funding coming into the community in the appropriate way.

Reactions to Policy Solutions

Solution One: Improve referrals and expand parent choices.

- Staffing would have to be addressed. Families would take advantage of more EHS. When EHS started, the 3 year old programs in our community closed. More costly due to ratios – as EHS increased, and then GSRP was introduced it caused problems elsewhere. So, the 3 year-old gap continues!
- Some are the EHS/GSRP blends in our community which helps somewhat.
- If there is more funding for 0-3 but not take away from the 3 year olds would be good.
- How can we help families feel more comfortable?
- Build trust, have a conversation, dialogue a couple of conversations (phone, email, letter) a quick conversation can ease the trust – a lot of time people don't want a stranger coming in to their home and so a conversation can build that trust.
- Have a campaign to get the information out to families about services, door to door, to get the word out and talk to parents, a lot of families still don't know that services are going on… I didn't know about this information and I was connected, so there are a lot of families that don't know what is taking place
- Ask if interested in home visiting services at well-baby visits (it's a captive audience)
- Needs change as children grow so families might want to start home visiting when the child is a little older and they experience new challenges
- Yes, explaining the referral information in great detail and following up after doing a referral to ensure clients are actually connected to services.
- Referrals aren't always happening. Parents don't always know what they're qualified for or even that home visiting is available for their family. This parent suggested some sort of go-between to help parents connect with the programs for which they are qualified.

- Spoke about competition between models and models attempting to “keep the family” even if the program isn’t the best fit for the family because the program wants to “count” the family toward their caseload. Suggested needing one centralized agency. Wasn’t sure of the feasibility because of the logistics. Would help connect families with the correct model for them.
- Expanding parent choices-sounds like tailoring programming to family need. There are consistencies across programs even though the curriculums and models are different. Talked about the importance of being able to give families what they need and want – including flexibility (provided an example about scheduling visits outside the home for stay-at-home caregivers when that is what they need).
- Home visiting programs are not well-known. Recommends some way to get knowledge out to the general public of what they are, what is provided, what parents can expect, the positive outcomes, etc. Possibly during all OB visits and/or in the hospital when every baby is delivered. Suggested this take the form of a questionnaire. And/or a central-intake. Possibly a website. Families would answer questions about their needs, lifestyle, etc. This would help ensure the programs were a good fit for the families. Make a universal part of prenatal care.
- Agreed with the need for a centralized something to help families know of all the options available in their county/community. Doesn’t think more variety is needed but better coordination and increased awareness of what is already available.
- I agree with improving referrals but I feel we have a good array of options for families to choose from in this area.
- Our referrals have increased over the few years. Parents appear to have limited understanding of differences between program or awareness in general or the existing programs.
- We have good referral systems - we lack capacity due to funding.
- I don't see a lot of follow through with referrals even when all of the leg work (scheduling the appointment and transportation) is done for them.
- expanding parent choices seems to indicate adding more home visiting models to the mix. We have Healthy Families, Early Head Start, Growing Families (PAT), and MIHP. More competition is not the solution.
- MIHP and EHS programs are pushed harder than any other models and I think that is not creating true choice
- parent choice is key
- I want more people to know where the help is.
- Again as stated earlier, I would like to see on referral system if client or baby is a Native American. Are they aware of the specific Native programs available even if not a tribal member to that area?

Solution Two: Increase home visiting funding.

- Increasing funding AND considering other policy changes that will improve access for all families. This will help families still have choices for programs that fit their needs.
- The early years are so important to help shape thinking, feeling, moving and learning.
- Fully fund the existing programs.
- Again need more funding
- Additional funding is necessary if we are truly going to see an impactful return on investment in five to ten years.

- The scope of services should be expanded to address the culture and basic needs of the families they service
- more funding means more options and services
- More funding will allow for more quality and committed staff and more resources for families.

Solution Three: Increase earnings for the infant-toddler early childhood workforce.

- I don't know that it would solve the problem– it's a start, but one if the issues that I have heard lately is that in this field what is the opportunity for increases in pay do not exist for those that stay in their roles – like – making more based on years of services, (raises over time etc.), more benefits etc. Moving up in the administrative system doesn't exist in the same way in this work as it does in the school districts. We have 20 people – so the size of the K-12 districts doesn't match and those things aren't in place.
- It would be one way to make it more attractive – I have had teachers that look at the pay and say they can't afford to do the EC work.
- More money would bring them in in the beginning – the soft benefits. But the work is so isolated and there is really no supervision – if there was more funding and the staff got more support, it might increase the emotional well-being of the staff and keep them in the role longer.
- For example, when they visit a home with bed bugs – they also need to pay for cleaning this up in their own home because they catch them, and they have to pay for this out of their pocket due to their position.
- The shortages in our fields couldn't be met with additional earnings. There aren't enough specific therapists – narrows the pool and we just don't have people to hire!
- No concerns – I think It's a good idea. My engineer neighbors make like twice what I do. The 6 and under and 3 and under population, you have to be endorsed and there is a lot of love, sweat and tears that go into it, but for getting the credentials alone you should get a bump in pay or a bonus for having that specialty or specific expertise for which you need to be endorsed.
- We are fortunate at the guidance center – when you reach level 2 you get $2000 and then if you get to level 3 you get $3000 which is a huge and important incentive. So, you know that by working hard you will get $5000
- Our work requires a MA – the school loan debt that we have is high – that is coming out of our low paychecks. Paying for the degree that is required and taking that into consideration would be important.
- Yes.
- Consistent qualified staff that want to engage in wrap around work is difficult to find. Early childhood is not considered a priority and there should be engagement in the schools [colleges/universities]. There are wage disparities for earnings and those who work in the position can't afford to feed their own families. There should be a bridge if childcare is costing many families more than a mortgage or rent payment, but the workers are not paid decent wages
- Child care is an issue in our area
- A must in order to attract highly educated and trained individuals.
- If this includes home visitors, yes.
- No childcare in Branch County because home providers can't make a living wage

- We need to make this industry attractive so that retention will not be an issue.
- this means more services and availability
- This would help with the high turnover rate in the workforce.
- At our daycare/EHS the workers are getting paid less that what some McDonald's or Meijer's are paying. AND we expect them to take care of our children :(

Solution Four: Examine geographic and racial/ethnic disparities and cultural concerns that may deter or prevent families from enrolling in home visiting services.

- Yes, it would be helpful – Absolutely, I wish that we had more coordinated ways to screen at hospitals and have a consortium or something where we could track the needs I don't know what all of that would be but I wish that there was more coordination.
- I would be curious about how they would collect the data about underserved children. They are hard to reach usually – culturally there are different beliefs about seeking help or talking about mental health might not be easy.
- How are you going to get at that data? I am supportive of our clinicians and wonder how we would collect that data. We do so much outreach and try to be creative in how we do it.
- We collect that with some – could ask them which is one more thing we'd have to do.
- Politically in this environment some groups are going underground and wouldn't want to share even if we are safe. We have a lot of Hispanic families and bilingual therapists, but the time it takes to build trust is really even more challenging. Collecting data is complex.
- Language barriers – do families understand what we mean by home visiting?
- Cultural stigma – is it okay to allow outsiders into your home?
- Yes. Examining these concerns would help to destigmatizing services, increase rural access and awareness of services, and address racism and discrimination. It would help by having culturally relevant and empathetic messaging, having training in social competency and social justice, and having providers available that look like the population they are serving.
- Another assessment is not needed. We know the geographic and other challenges already.
- In my county certain ethnicities are not being reached
- when you explore the why you can fix the problem with access to services
- Again, trying to get Native clients set up with the best program available for them. Often times our Native program can offer benefits that others cannot
- Rural areas are some of the highest need and most difficult to serve.

Solution Five: Tell us your ideas! What policy solutions would you suggest?

- Provide weekend or evening services because it gives a greater window of opportunity to access services. – could this fit under "Improve referrals" or "examine geographic and racial/ethnic disparities…" (Falls under "Improve referrals and expand parents' choices")
- Sharing of knowledge – we don't have that on a Michigan level anymore. It's somewhat by program. We do it much better on a national level. If we had support from the state, specifically if it was virtual, that would be beneficial. We can tackle problems locally, but we need assistance across the state. There is something to build on. (Falls under "Examine geographic and racial/ethnic disparities and cultural concerns that may deter or prevent families from enrolling in home visiting services.")

- Including funding by Medicaid – be able to bill Medicaid. (Florida does it.) (Falls under "Increase home visiting funding")
- Consistent and mandatory cultural trainings – for home visitors and providers. (Falls under "Examine geographic and racial/ethnic disparities and cultural concerns that may deter or prevent families from enrolling in home visiting services.")
- Suggestion to combine: "Examine geographic and racial/ethnic…" and "improve referrals…" – most teachers are White and those serving students are White, but many of the families are Black or Brown. Putting an emphasis on hiring and training Black and Brown staff.
- Increase earnings – people can't work for low wages.
- Increase home visiting funding – indicates that there already isn't enough funding and we need more assistance.
- Suggested to combine "Increase earnings" and "increase home visiting funds" …
- Baby Scholars offers evening hours. There was a discussion about the other programs and their availability.
- Collaborating with pediatricians – with this specific population I question if they are going, do they have a medical home, can they get there? Could we collaborate with Early On and HV – could we do a day where we bring the doctors to the families at a school or somewhere like the high schools do for sports physicals? We have done a lot with Early On trying to get pediatricians to refer children. We try to follow back up and then follow up to re-refer as needed but it takes time and building relationships.
- I like the idea of a community event way of connecting people with medical resources and it would be nice to also form relationships – with diapers and formula with advertisers that would make them attend for what they need and incentivizing them with food diapers, etc. being met by coming.
- Behavioral health consultants in CMH offices – if mom goes to the pediatrician and they are concerned about the mom and her resources, they bring a consultant in to work with them and then if they need more, they bridge the gap into our system as well where they didn't before. This is helping and we want to expand that idea.
- One of our local agencies, Starfish -does this too. Push for integrative health. Need funds for IMH clinician in their rotation at pediatrician and OBGYN offices, there on the front line to help and tell them about the programs and support the parents.
- Now they are working together to support the family together – with parent's permission and we need more of that to intervene early.
- Universal Health Care approach to home visiting – Universal WIC
- Explore current models to ensure there is something available for ALL families. If families might not qualify for a model, or current models do not meet the needs, what trends in need arise?
- Umbrella Grants
- Communications strategy to normalize requesting and accepting care - break the stigma
- Implement a model that makes sense and could support trends and meet needs of the family
- We are limited by the models we currently have/examine
- All policies will be required to be supported by communication influencing
- More training and consistency for those that do go into the homes.

- Cross-discipline training of home visitors – more "bang for the buck". Train home visitors on dental health so they can educate families and do triage for dental health.
- Every policy idea discussed at this table will benefit from, or be enabled by, a policy requirement about communication as key to implementation: Education, Awareness, Fluency
- Process: 1. Education & awareness – focus on the whole family/whole child education; 2. Surveys/collect data; 3. Use (1) & (2) to drive support for funding request; 4. Increase capacity and staffing to support increased utilization; 5. Increase home visiting funding/education/awareness to keep the cycle going
- Examine other "everyday life" areas of concerns that are directly related to geographic and racial/ethnic disparities such as: living wages, affordable housing, universal daycare, access to healthy food, paid sick parental leave, and healthcare.
- Language and guidelines for continuing parent input. How they plan to use and continue to capture authentic parent voice, input and leadership.
- Focusing toward a centralized intake to improve referrals
- Increase funding and when funds are available consideration needs to be given to the barriers that we face in the rural communities. Addressing geographical barriers is expensive and time consuming. Staff spend alot of time in the car - some of the families that need services the most do not have resources in their community.
- Affordable daycare. We have the early learners program but it is only open to 1pm. Most parents struggle with employment due to not having daycare for working hours.
- We need assistance for buy-in from OBs and hospitals and family docs across the UP to refer their pregnant patients to home visiting. Universal referral process is being tested and rolled out through the UP Home Visiting Network, but we could use assistance in getting the medical community to embrace and use this process
- It needs to be more funded because its not properly funded. More early childhood centers needs to be more accessible to low-income families such as Head Start. Childcare is too costly for families especially low-income families that needs it but can't afford it.
- families cannot afford child care and slots are scarce. Increase poverty level subsidy support to help working families
- choices, availability, information, and funding is key
- The help should be in the hospitals
- In one nursing school (GVSU) they are competitive programs to get into, there is a long waiting list and they have gone on test scores and GPAs – which isn't always an indicator of being a good nurse. There was very little diversity - the most we had was in our ADN programming – maybe if they spoke Spanish. Talked with them about needing a more diverse workforce and they have changed their admission criteria and look at community involvement, have an interview, ask what is driving you to be a nurse, and they look very different than they did before. If more schools did that, we would have a more diverse workforce. Diversity is in our mission/values etc. – wouldn't it be important to have something about equity? (The group liked that.) Admission criterial is one way to drive the workforce.
- Lots of parents don't know where to go – is there any main way to include every program so they know what choices they have an if they need interpreters they can find the right program, make it universal – any center base where programs are offered. Different regions have different needs – how can we help that with funding and admin/better no wrong door – help

families to find home visiting that will help them meet their goals. How can we make it easier and less confusing?

- Having the HV system in MI ensure that all of the infrastructure components are fully functioning
- The parameters are the barriers. Why does Healthy Families have such tight rules about the age of the child to enroll? It is frustrating not to be able to refer to their program when we cannot accept in our program just because the child is too old. That seems counterproductive.
- Check in with families on a regular basis to determine if resources are needed. As the child grows check it at least annually.

Priority Rankings:

1. Increase home visiting funding.
2. Examine geographic and racial/ethnic disparities and cultural concerns that may deter or prevent families from enrolling in home visiting services.
3. Increase earnings for the infant-toddler early childhood workforce.
4. Improve referrals and expand parent choices.

Survey: 0 disagree - 100 agree

- Increase earnings (95)
- Increase funding (93)
- Examine disparities (82)
- Improve referrals (78)

1) Funding

2) Revisit the models we are currently using and make adjustments to create a model that makes sense

3) Awareness and communication

4) Increase education and consistency with home visitors

- #2 would be the top priority- because none of these are possible without the funding to make things happen

  1) Funding
  2) Revisit the models we are currently using and make adjustments to create a model that makes sense
  3) Awareness and communication
  4) Increase education and consistency with home visitors

Ranking A: 1,4,3,2

Ranking B: 1,2,4,3

Ranking C: 1, 4, 2, 3

Ranking D: 4,2,3,1

Ranking E: 4,1,2,3

Ranking F: 1,3,4,2

Ranking G: 1, 2, 3, 4

Ranking H: 4, 3,2,1

Ranking I: 4, 3, 2, 1

2/5 felt that improving parent referrals/parent choice was most important

2/5 felt that increased funding for home visiting was most important

3/5 prioritized increased funding for early childhood professionals last

[1, 4, 2, 3

2, 4, 3, 4

4, 1, 2, 3

2, 1-part 1, 4, 2, 3

1, 2, 3, 4]

Policy Comments:

- I can't imagine that the home visit person makes a lot of money fulfilling that roll. Sustainable funding, and consistent wage admin plan.
- About solutions 1-3 – anxious; of course these are good ideas, but how is that going to happen?
- Number 4 should be priority- rural issues and isolation is big, along with transportation.
- All of these solutions would go into increasing services
- An additional solution would be models- prohibited of people accessing services. Area based design.
- WIC should be universal – everyone needs to know the basics to set a child up for success from the beginning (should be dental component to WIC)
- I would be interested to see overall data capturing ROI surrounding child's health and getting those services from the beginning. Studies, research, data.
- More of a focus on whole child, whole family education and support as opposed to the suggested policies that are so large and not supported by funding.
- Being more intentional with what our goal is. Many of these policies would need to come to the table AFTER education, communication and awareness to families, to support the whole child.
- Umbrella grants to support meet needs of all components of Home Visiting funding.

Uniform credentialing, compensation, define Home Visit- what that would include universally.

Other Comments:

The branding of home visiting – how can we remove the stigma and communicate these services and bring people in. There was a discussion that it was discussed (this phrase "home visiting") 10 years ago and nothing about the branding has changed.

- Consider racial/ethnic perceptions of the phrase.
- Do “wealthy people” have home visiting?
- Is the problem the word “home visiting” or is it the experience?

Where is the money to fund qualified people to provide these services- Do we have capacity to serve this many people?