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Needs Assessment of Michigan's Prenatal through Age Five Mixed Delivery System

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Executive Summary

In December 2018, Michigan secured a $13.4 million Preschool Development Grant (PDG) funded by the U.S. Department of Health and Human Services, Office of Child Care (HHS-OCC). An initial activity required under the PDG is the completion of a statewide needs assessment of the state's early childhood (EC) mixed delivery system to inform in-depth strategic planning to increase the availability and quality of programs and supports for children birth to age 5 (B-5) and their families. Michigan contracted with the American Institutes for Research (AIR) and its partners to complete the statewide needs assessment.

To accomplish its vision of being one of the best states in which to raise a child, Michigan supports a mixed delivery system—a complex system of programs, services, and supports promoting the health, development, and well-being of B-5 children and their families.

The Michigan PDG needs assessment provides a review of the state's mixed delivery system, with a special focus on services for infants and toddlers, transitions among and between the B-5 and K–12 systems, and barriers to parental choice. See the accompanying box for a note on the methodology used for the needs assessment. Here, we briefly summarize the key findings and next steps.

Methodology

AIR and its partners used five methods to complete the statewide needs assessment summarized in this report. The team (a) reviewed existing needs assessments; (b) conducted interviews, focus groups, and a town hall with various stakeholders across the mixed delivery system; (c) completed an equity assessment; (d) conducted innovative program interviews; and (e) gathered and analyzed extant data sources.

Key Findings

In this section, we summarize the key findings for each HHS-OCC federal needs assessment domain.

Definitions of Key Terms

As a first step in conducting the statewide mixed delivery needs assessment, stakeholders first had to agree on the definitions of key terms. The needs assessment team, in coordination with staff from the Michigan Department of Education (MDE) and the Michigan Department of Health and Human Services, developed the following definitions:

- Quality EC programs and services have well-trained, competent, and caring staff who provide responsive experiences and supports to children and families that meet their needs to ensure that they thrive and succeed. High-quality features include providing meaningful family engagement opportunities; using a comprehensive program assessment to engage in continuous quality improvement through leadership focused on workforce support that includes professional development and reflective practice; uses appropriate child and family assessments to inform instruction and provide ongoing support for the diverse needs of each child; and empowers families to choose the right program/service, at the right time, in the right place.
- EC availability is the access to, easy retrieval of, communication of, and knowledge about appropriate supports, services, and material resources for all children, families, and communities needed to thrive and succeed.

- **Vulnerable children** are children exposed to environments and experiences that make them vulnerable to poor and maladaptive functioning and well-being. Vulnerable children are at risk of low educational attainment or poor health and well-being because of systemic inequities of biological, environmental, and social risk factors, such as low family socioeconomic status (e.g., income, education, migrant and seasonal workers); geographical location (e.g., rural); racial, ethnic, linguistic, and religious background (e.g., American Indian, dual language learners); children with disabilities; children who are experiencing homelessness; children in foster care; and children experiencing adverse childhood experiences and toxic stress.
- **Rural areas** are defined in two ways: *rural metro* (less than 25 miles to an urbanized area) and *rural nonmetro* (more than 25 miles to an urbanized area). Rural communities have less than 500 people per square mile or less than 2,500 residents.

In general, these definitions do not differ from prior definitions in Michigan. However, the rural definition did not always align with public data on rural communities available for analysis. The needs assessment team will continue to examine this challenge and refine the definition of *rural areas* in future iterations of the needs assessment.

Background Characteristics of Children Ages 0 to 5 in Michigan

The needs assessment activities focused on five focal populations: children of color, children from low-income households, rural populations, infants and toddlers, and English learners:

- **Race/ethnicity:** 72% of Michigan's B-5 children identify as White, 16% as Black or African American, 5% as other (including Asian, Native American, or Other), and 7% as two or more races. In addition, 8% of children identify as Latinx or Hispanic.
- **Income status:** 22% of B-5 children live in families with incomes at or below the federal poverty line, and an additional 32% of children live in families between 101% and 250% of the federal poverty line.
- **Geographic concentration:** 80% of B-5 children live in urban areas, 10% live in mostly rural areas, and another 10% live in completely rural areas.
- **Infants and toddlers:** Approximately 332,000 infants and toddlers are in Michigan.
- **English learners and foreign born families:** Using the U.S. Census Bureau 2016 American Community Survey (ACS) data, in 2016 approximately 662,279 foreign born individuals resided in Michigan, accounting for 7 percent of the state population, and this includes about 59,000 children under the age of five. The top five languages spoken in the state are Spanish, Arabic, Bengali, Chinese, and Albanian.

Number of Children Being Served and Awaiting Service

What do you know about the service use by families with children (both children and family members) in the EC system?

The needs assessment combined census population estimates with enrollment data form the state and federally funded EC programs and home visiting models used in Michigan. These estimates suggest the following:

- Existing EC programs have the capacity to serve nearly 340,000 children across the state. At an absolute maximum, child care providers have a licensed capacity to serve slightly less than 50% of Michigan's B-5 population.
- The state-funded preschool (GSRP) and Head Start serve approximately 38,257 and 28,058 B-5 children, respectively. These programs each serve slightly more than half of the eligible children ages 3–5 across the state (60% and 55%, respectively).
- Early Head Start serves 9,355 children ages 0–3 statewide and reaches about 12% of the eligible families.
- Other state-funded home visiting programs reach more than 23,000 families across the state and reach approximately 15% of the eligible families.
- Early intervention and special education programs serve about 11,000 children through Early On/Individuals with Disabilities Education Act (IDEA) Part C, and nearly double that number are served in IDEA Part B (21,624 children).
- Health-based social services, such as Medicaid and Women, Infants, and Children, reach nearly all eligible B-5 children. Medicaid serves 346,515 children, and Women, Infants, and Children serves 270,784 children.

These numbers do not represent an unduplicated count of children and families served in the state.

What data do you have describing the unduplicated number of children being served in existing programs? What are your biggest data gaps or challenges in this area?
Michigan's greatest strength for producing an unduplicated count is the MI School Data portal (https://www.mischooldata.org/). To date, this portal allows a user to calculate an unduplicated count of children participating in the mixed delivery system through the Great Start to Readiness Program (GSRP), Head Start, *Early On®*/early childhood special education (ECSE), home visiting, or receiving a child care subsidy. About half of all children are included in this estimate prior to kindergarten entry. Additional work is needed to fully account for children's participation in Michigan's mixed delivery system prior to kindergarten, including additional data sources to account for participation in private child care and/or preschool as well as no participation in any programming.

What data do you have describing the unduplicated number of children awaiting service in existing programs? What are your biggest data gaps or challenges in this area?
No systematic data are available to describe the number of children awaiting services in existing programs.

Are any initiatives under way to improve these data?
Work is under way through funding from the PDG renewal grant to expand the capacity of the MI School Data portal to address critical data gaps related to understanding program and service delivery and gaps.

Quality and Availability

What would you describe as key gaps in quality of care across settings?
Large gaps exist in the availability of programs and services for B-5 children and their families in Michigan. Across the state, limited EC slots are available to young children. These gaps are more severe for families of infants and toddlers, families living in rural communities, low-income families, families working nontraditional hours, and children needing additional accommodations. For example, at an absolute maximum, child care providers have a licensed capacity to serve slightly less than 50% of Michigan's B–5 population, state funded preschool is available for just more than half of the income-eligible 4-year old children in Michigan, and state-funded home visiting programs reach approximately 15% of the eligible families.

The affordability of programs and services is a critical contributor to the gap in the availability and quality of programs. Affordability is not simply a "low-income" problem; child care is expensive across the state with an average annual cost of $10,861 for just one infant or toddler (19% of the average Michigan family's annual income of $57,054), with average costs varying based on program type, number of children, age of the child, and location in the state. Although child care subsidies can help alleviate the high costs of child care for low-income families, they often are not enough to fully cover the costs of care for most families and providers. Parents therefore have limited choices for selecting programs for their child across the mixed delivery system.

For focus groups with families and professionals from many parts of the early childhood mixed delivery system found that for families in rural communities, transportation is an additional barrier that contributes to the lack of access to high-quality EC programs. In addition to the availability of child care programs, supports such as primary care and specialized health services are significant gaps in many rural communities.

The needs assessment also documented a lack of meaningful and actionable engagement between service providers and communities of color. Namely, Black, Latinx, and recent immigrant families do not feel engaged in the mixed delivery system. Likewise, the needs assessment documented a lack of diversity in providers across the mixed delivery system, further exacerbating the disconnect between families of color and service providers.

Data on Quality and Measurable Indicators of Progress

What are the strengths and weaknesses of the data you have available on quality?

Across the state of Michigan, there is a general lack of data on the quality of services in the mixed delivery system. For home visiting programs, a single measure of quality does not exist to compare the quality of home visiting across program types; however, each program model sets its own quality and reporting standards for documenting quality. To date, no statewide data are available to capture the quality of early intervention/early childhood special education or child health services and providers across Michigan. Given the dearth of statewide quality data, it is difficult to quantify the quality of services

across the mixed delivery system. However, in Michigan, each program typically monitors both program enrollment and quality indicators at a more local level. As such, challenges exist in understanding the quality of available programs.

The one exception is the statewide Quality Rating and Improvement System (QRIS), Great Start to Quality, which provides a singular measure of quality for all licensed and registered EC providers. However, the system is voluntary and only about half of the providers participate.

What measurable indicators currently exist that can be used to track progress in achieving the goals of this grant and your strategic plan? What are the strengths and weaknesses of these indicators?
As mentioned above, few indicators of quality are available to the state, but three exceptions could be used to track progress across time. In addition to program level enrollment data, these additional indicators include the following:

- **Michigan's QRIS (GSQ)** provides a single measure of quality to apply across early learning settings; however, limited participation and recent changes to the rating system diminishes the usefulness of these data.
- **Quality indicators from the home visiting annual reports,** including prenatal care, preterm birth, breastfeeding, tobacco use, maternal depression, high school completion, postpartum visits, well-child visits, child maltreatment, and developmental screening referrals, but these data are not available for all home visiting programs across the state.
- **IDEA State Performance Plan and Annual Performance Reports,** including timely provision of services, services in natural environments, family involvement, and early childhood outcomes for IDEA Part C, as well as services in natural environments and child outcomes for IDEA Part B.

Issues Involving Early Childhood Facilities

Issues involving EC facilities were not a primary focus of the initial needs assessment. However, facilities and infrastructure were consistently mentioned as a barrier to providing affordable, high-quality child care, see Theme 6: Funding Barriers. There are also current and prior initiatives in the state of Michigan, to be examined in more depth in the next iteration of the needs assessment, specifically focused on facilities:

- **Kresge Foundation, W.K. Kellogg Foundation, and PNC Foundation's joint $2.5 million investments** to support EC facilities in Detroit, through *Hope Starts Here*.
- **Former Race to the Top–Early Learning Challenge funding** supported EC program quality across the state, some of which provided for EC program materials and facilities.

Barriers to Funding and Provision of High-Quality Early Childhood Care and Education

What barriers currently exist to the funding and provision of high-quality EC supports?
According to focus groups, as well as prior reports and extant data, cost is the greatest barrier to providing affordable, high-quality care. Low child care subsidy reimbursement rates further contribute to this barrier. EC providers reported that the subsidies are simply not high enough to fully cover the costs of quality care, especially for infants and toddlers.

According to provider focus groups, developing and sustaining a pipeline of high-quality EC educators, home visitors, and early intervention providers is costly and remains a challenge across Michigan. Providers from these focus groups reported struggling with workforce challenges such as turnover, funding, and a lack of culturally and linguistically trained professional staff.

Transition Supports

What are the strengths and weaknesses of the transition supports for children moving from the EC system to school entry?
Information and supports to families regarding kindergarten enrollment vary greatly by and within districts, oftentimes leaving parents responsible for identifying their child's options as well as the procedures for kindergarten enrollment. Likewise, focus group participants reported that information about expectations for children and what it means to be kindergarten ready vary across schools.

How do the supports differ based on the type of EC provider?
Collaboration and supports between EC and the K–12 school system varies by the EC program type. Publicly funded preschools located on the campus of K–12 schools often have the greatest collaboration.

How effective is the communication between early care and education providers and the school systems? What could be done to improve that communication?
Greater collaboration and communication is needed between EC providers and K–12 school systems to support children's school readiness and positive transitions to kindergarten.

What is effective about the supports for children with developmental delays or other special needs? What could be more effective about them?
For children receiving *Early On* services, a gap in services for children occurs when the child turns 3 years old, or when they age out of services. This gap varies on whether a child qualifies for early childhood special education as well as additional programs and services available to a child, such as Head Start.

System Integration and Interagency Collaboration

What policies and practices are in place that either support or hinder interagency collaboration?
In general, focus groups with a diverse representation of mixed delivery system providers, key informants, and families found that system integration and interagency collaboration is a need for the system, including the need for greater collaboration between the following:

- Local programs and services
- Child care centers and preschools
- Home visiting and other mixed delivery providers
- State agencies overseeing EC programs

Next Steps

In the coming months, Michigan will use these needs assessment findings to develop a strategic plan to increase the availability and quality of programs and supports for B-5 children and their families. The strategic plan will build on findings within each federal domain, outlining the key priorities, action steps, and measures of progress aligned with the findings from the needs assessment. This strategic plan will become the foundation for the PDG renewal grant activities.

In addition to the strategic plan, during the PDG renewal grant, the needs assessment team will build on these findings to examine additional components of Michigan's mixed delivery system not covered within the first iteration of this needs assessment (e.g., facilities, transportation, housing, community needs), identify and engage hard-to-reach families not yet represented in the findings, and support the expansion of the MI School Data portal to address existing data gaps.

Introduction

The Preschool Development Grant Birth through Five (PDG B-5) initiative, a $237 million federal grant program created by the U.S. Department of Health and Human Services (HHS; Office of Child Care, 2018), provided 46 states and territories with access to funding to analyze the current landscape of their early learning and care mixed delivery system and to conduct in-depth strategic planning to maximize the availability of high-quality services. Specifically, the PDG initiative supports states and territories in the following activities: (1) conducting a statewide needs assessment, (2) developing a statewide strategic plan, (3) increasing opportunities for parent choice and knowledge about high-quality programs and services, (4) sharing best practices among early childhood service providers, and (5) improving the overall quality of programs and services within the early childhood mixed delivery system.

In December 2018, Michigan received a $13.4 million initial Preschool Development Grant (PDG). For this work, MDE contracted with the American Institutes for Research (AIR), which in turn partnered with the Early Childhood Investment Corporation (ECIC), Michigan Public Health Institute (MPHI), HighScope Educational Research Foundation (HighScope), and the Michigan League for Public Policy (MLPP) to conduct a comprehensive needs assessment to examine the state's capacity to serve families and children, birth through age 5 (B-5), in the state's early childhood mixed delivery system.

This report is a summary of the current state of Michigan's mixed delivery system, including (1) the availability of programs within Michigan's mixed delivery system, (2) the gaps in access to services based on population estimates and enrollment patterns across the state of Michigan, (3) the state's progress toward an unduplicated count of children being served and awaiting services in existing programs, and (4) an in-depth thematic analysis of the most pressing needs across Michigan's EC mixed delivery B-5 system. This needs assessment serves as a starting point for Michigan as it plans for its PDG renewal grant activities over the next 3 years. The needs assessment findings have been structured to respond to the *PDG B-5 Needs Assessment Guidance* provided by the HHS Office of Child Care (OCC).

Methodology

This needs assessment serves as a starting point for Michigan as it carries out its PDG renewal grant activities over the next 3 years. To focus the needs assessment during the initial funding period, the state chose four areas of importance, often referred to as "the guardrails" of Michigan's PDG needs

assessment. These included (1) equitable access to and use of high-quality infant/toddler services; (2) challenges and strengths in supporting transitions between birth B-5 and K-12, within B-5 care coordination, and between B-5 and other family support services; (3) strategies that maximize parental choice within Michigan's mixed delivery early childhood system; and (4) features of innovation throughout the mixed delivery system.

The needs assessment used a mixed-methods approach to address three guiding questions:

1. *What is included in Michigan's mixed delivery system?*
2. *How many families and children are served by programs and services in Michigan's mixed delivery system?*
3. *To what extent is Michigan's mixed delivery system meeting the needs of all families and children, including the needs of vulnerable and underserved populations? Where are there gaps in the system? Where are there gaps in the data and research available?*

In addition to the three guiding questions, the needs assessment addressed one or more questions in each of the federal domains outlined in the *PDG B-5 Needs Assessment Guidance* provided by the HHS Office of Child Care (OCC), see Exhibit A.1 in Appendix A for a crosswalk between the content in the needs assessment and the questions outlined the federal guidance.

To complete the PDG needs assessment, AIR and its partners engaged in six research tasks, including:

- Task 1: Inventory existing needs assessments.
- Task 2: Engage stakeholders through interviews and focus groups.
- Task 3: Assess elements and identify areas of equity in Michigan's mixed delivery system.
- Task 4: Assess the availability and quality of existing early childhood program in Michigan.
- Task 5: Conduct an unduplicated count of children currently being served in programs and those awaiting services at the state, regional, and local levels.
- Task 6: Participate in a collaborative workgroup with the MDE OGS, the strategic planning team, and the evaluation planning team.

AIR and its partners used a mixed-methods approach and incorporated feedback from a diverse set of stakeholders statewide to inform the needs assessment, including the following:

- Fifty-one needs assessments conducted in the last 5 years focused on all aspects of the B-5 mixed delivery system
- Ten focus groups with 118 participants ranging from Michigan families, early child care and learning providers and administrators, home visiting staff, foundation representatives, and social and emotional health care providers
- Six key informant interviews with state-level staff, agency leaders, and subject matter experts who hold unique positions in the EC system
- Five key informant interviews with innovative programs identified by MDE
- One town hall with representatives from GSC and GSPC
- More than fifty different extant data files that capture enrollment patterns and the quality of services provided across the state in the mixed delivery system

Combining data from all these sources, the Michigan PDG needs assessment provides a review of the state's mixed delivery system, with special focus on services for infants and toddlers, transitions among and between the B-5 and K–12 systems, and barriers to parental choice. See Appendix B for a more detailed discussion of the methods used to complete each task.

Definitions of Terms

To develop a set of common definitions to apply to Michigan's mixed delivery system, the needs assessment included a review of existing federal, state, and local definitions of each term. This included several existing definitions from MDE, Head Start, the U.S. Census, U.S. Department of Agriculture, and U.S. Department of Education. The definitions were developed in collaboration with the Michigan PDG Implementation team. In general, these definitions do not differ from those used in the past. Exhibit 1 defines each of the key terms identified in the HHS federal guidance.

Exhibit 1. Key Term Definitions

Term	Definition
Key Terms Required by the Federal Guidelines	
Quality EC	High-quality programs and services have well-trained, competent, and caring staff who provide to children and families responsive experiences and supports that meet their needs to ensure that they thrive and succeed. High-quality features include providing meaningful family engagement opportunities; using a comprehensive program assessment to engage in continuous quality improvement through leadership focused on workforce support that includes professional development and reflective practice; using appropriate child/family assessments to inform instruction and provide ongoing support for the diverse needs of each child; and empowering families to choose the right program or service, at the right time, in the right place.
EC Availability	Availability is the access to, easy retrieval of, communication of, and knowledge about appropriate supports, services, and material resources needed for all children, families, and communities to thrive and succeed.
Vulnerable Children	Vulnerable children are children exposed to environments and experiences that make them vulnerable to poor and maladaptive functioning and well-being. Vulnerable children are placed at risk of low educational attainment or poor health and well-being because of systemic inequities of biological, environmental, and social risks factors. These factors include low family socioeconomic status (i.e., income, education, migrant and seasonal worker); geographical location (e.g., rural); racial, ethnic, linguistic, and religious background (e.g., American Indian, dual-language learners); children with disabilities; children who are experiencing homelessness; children in foster care; and children experiencing adverse childhood experiences and toxic stress.
Children in Rural Areas	Rural is defined in two ways: rural metro (<25 miles to an urbanized area) and rural nonmetro (>25 miles to an urbanized area). Rural communities have less than 500 people per square mile or less than 2,500 residents.[a]

[a] The rural definition did not align completely with quantitative data used in the needs assessment from the U.S. Census Bureau. Specifically, the U.S. Census Bureau defines urbanized areas and urbanized clusters based on geographic distance and population density. However, when defining urbanicity in a larger area, such as a county, the designation is based on the percentage of each county's population that is rural, which may mask a large rural population who live far from an urbanized area. For example, the U.S. Census Bureau defines a "mostly rural" county as one where 50% to 99.9% of the county's population is rural. Following these guidelines, some counties in northern Michigan, such as Chippewa and Marquette, may be classified as "mostly urban" (counties where less than 50% of the population is rural), while close to half of the population live in rural areas with very limited access to services such as transportation within the county. Because of this challenge, we analyzed urbanicity using ZIP Code Tabulation Areas (ZCTA) rather than county level for a number of analyses within this report. We plan to continue to examine this challenge and refine the definition of children in rural areas in future iterations of the needs assessment.

In addition to the four key terms within the federal guidelines, we developed a set of guiding definitions for (1) ***equity,*** (2) ***transitions,*** and (3) ***birth to five*** as requested by MDE (Exhibit 2).

Exhibit 2. Additional Key Term Definitions

Term	Definition
Other Key Terms Developed to Guide the Michigan PDG Needs Assessment	
Equity	Equity means every child has a fair and just opportunity to reach their full potential and succeed. Equity includes providing services according to the needs of each child in the interest of producing better outcomes for all children and families. Equity requires an acknowledgement of racism, sexism, and classism as the root causes of inequities and promotion of increased access to the social determinants of health and well-being, including but not limited to culturally responsive health care and services, safe and affordable housing, and high-quality early learning opportunities.
Transitions	Transitions in early childhood occur when families and children experience a change within their birth to five programs and services, between birth to five programs and services, and from birth to five programs into kindergarten.
Birth to Five (B-5)	Programs and services that serve children and families from birth to kindergarten entry. B-5 spans the developmental continuum of infants, toddlers, and preschoolers and includes multiple entities such as health, mental health, early care and education, early intervention, and family support.

What is included in Michigan's mixed delivery system?

Michigan's mixed delivery system is a complex system of programs, services, and supports promoting the health, development, and well-being of children from birth through age 5 and their families. The system includes EC programs, early intervention and early childhood special education, home visiting, health programs and providers, as well as family supports. In this section, we describe the components of the mixed delivery system included in the PDG needs assessment. It is important to note that this is not an exhaustive list of all programs, services, and supports that influence the overall health and development of Michigan's children birth through age 5 and their families. The system also includes a broad array of other programs and services targeting young children and their families such as child welfare, transportation, housing, social services, prenatal health, and community mental health. Future iterations of the Michigan PDG needs assessment will explore additional components of the system.

Early Childhood (EC)

Michigan's ***EC*** component includes a mix of federal, state and, privately funded programs targeting early learning and care, including the following:

- ***Head Start/Early Head Start*** is a federally funded program serving children up to 100% of the federal poverty level. Head Start/Early Head Start offers a variety of services to children and families up to age 5, including preschool.

- ***The Great Start to Readiness Program (GSRP)*** is a state-funded, high-quality preschool program free to all 4-year-old children from families between 101% to 250% of the federal poverty level.
- The ***Child Development and Care (CDC)*** *program,* with funding through the Child Care and Development Block Grant, provides low-income, working families with subsidies to help cover the costs of child care in licensed and license-exempt programs.
- ***Private Pay Child Care and Preschool Programs,*** including licensed center-based care, licensed family home providers, and license-exempt care. Within these programs, we also considered the extent to which these programs served infants and toddlers (up to age 30 months) as well as preschool-aged children.

Early Intervention and Early Childhood Special Education

Michigan's ***early intervention (EI) and early childhood special education*** component includes the following:

- ***Early Intervention,*** administered through *Early On, Michigan's statewide early intervention system,* provides family centered, home-based services to all infants and toddlers with identified disabilities or developmental delays until the child's third birthday as outlined by the Individuals with Disabilities Education Act (IDEA) Part C.
- ***Early Childhood Special Education,*** administered through the intermediate school districts, provides individualized supports to children age 3 until kindergarten entry as outlined by IDEA Part B, section 619.

Home Visiting

Michigan's ***home visiting*** component includes a mix of federal- and state-funded evidence-based and promising practice models,[1] including the following:

- Early Head Start—Home Visiting
- Family Spirit
- Healthy Families America
- Infant Mental Health
- Maternal Infant Health Program
- Nurse-Family Partnership
- Parents as Teachers
- Play and Learning Strategies

Each program varies slightly in their populations served (e.g., family income, identified family and/or child need) as well as goals (e.g., child development, health, school readiness). They also vary in the intensity

[1] Retrieved from https://www.michigan.gov/documents/homevisiting/Home_Visiting_Initiative_Report_2017_637278_7.pdf

and duration of services offered under the model. They are similar in their service delivery in the home as well as their focus on prevention and wholistic approach to the family system.

Health

Michigan's ***health*** component includes all general, public, and specialized health and mental health programs and services targeting the needs of children and their families. For example, it includes statewide services such as Women, Infants, and Children (WIC) and Medicaid, child and family interactions with health and mental health providers (e.g., pediatricians, obstetricians, dentists, community mental health providers), and specialized services (e.g., occupational therapy, physical therapy). Within the health component, we focused primarily on general health services for this round of the grant.

Family Support

Michigan's ***family support*** component includes all state, regional, and local programs and services focused on supporting families outside of the other components. For example, it includes the following:

- ***Great Start Collaboratives*** **(GSCs)** are local organizations administered at the county level across the state that support the development of a local early childhood system and ensure parent leadership and voice.
- ***Great Start Parent Coalitions*** **(GSPCs)** also local parent organizations within the GSCs that support the development of a local early childhood system and ensure parent leadership and voice.

Within the family component, we focused primarily on general services for this round of the grant. Note that most of the family supports in Michigan are implemented at the local level.

How many families and children are served by programs and services in Michigan's mixed delivery system?

In this section, we present the background characteristics of the focal populations for the grant, the number of children and families served within each component of Michigan's mixed delivery system, and, to the extent practicable, an unduplicated count of the number of children being served and awaiting services across the state. We will further discuss the extent to which these programs serve vulnerable and underserved populations in the discussion of the strengths and needs of Michigan's mixed delivery section that follows (including family income, geography, ability, and race/ethnicity).

Background Characteristics of Children Ages 0 to 5 in Michigan

This subsection describes the demographic characteristics and geographic distribution of young children in Michigan. For this grant, we identified five focal populations within Michigan to focus on for the equity assessment: child of non-White race/ethnicity, children from low-income households, rural populations, infants and toddlers, and English learners. Basic summary statistics about Michigan's population are presented below.

Race/Ethnicity

We based Michigan's B-5 population estimates on data from the American Community Survey (ACS), an annual survey conducted by the U.S. Census Bureau to provide vital information on a yearly basis about the nation and its people (U.S. Census Bureau, 2017). We report that for children age 5 and under in Michigan, 72% are White, 16% are Black or African American, 5% are other races, including Asian, Native American, or other, and 7% are two or more races. In addition, among Michigan's B-5 population, 8% are Latinx or Hispanic.

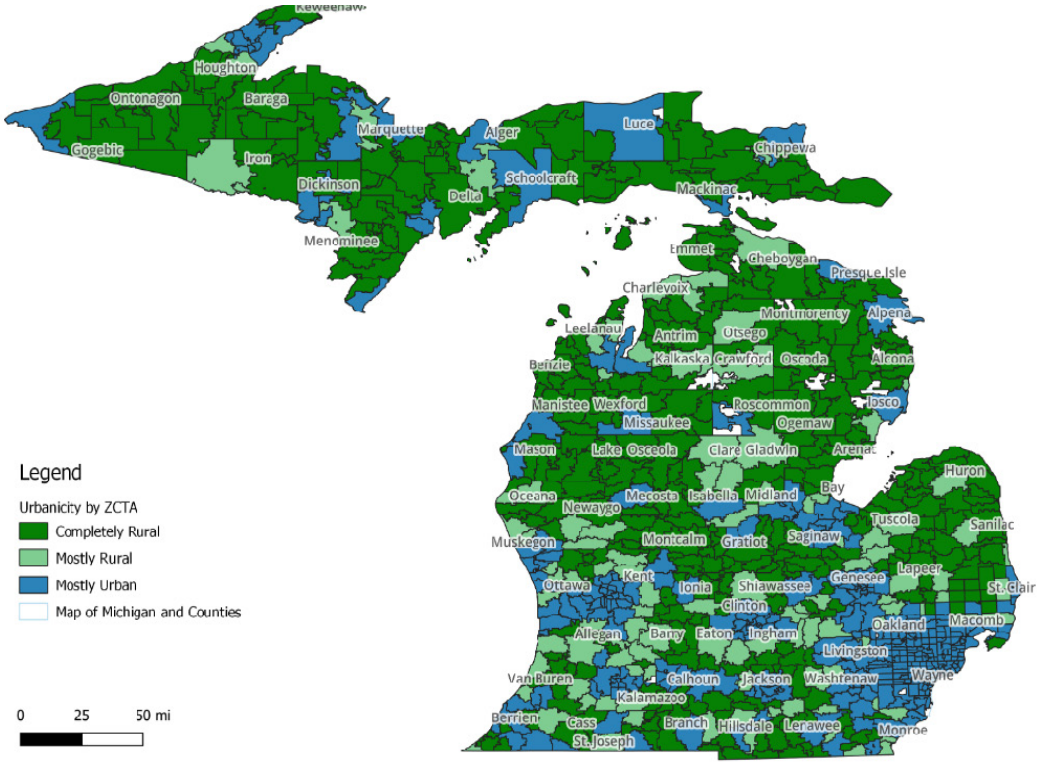
Income Status

In Michigan, approximately 22% of children ages 5 and under live in families with incomes at or below the federal poverty level, and an additional 32% of children live in families between 101% to 250% of the federal poverty level (U.S. Census Bureau, 2017).

Geographic Concentration

We also report the estimated population of children ages 5 and under in Michigan living in mostly urban, mostly rural, and completely rural areas, as defined by applying the U.S. Census Bureau cutoffs to ZCTA. According to the census data, 80% of the children ages 0 to 5 live in mostly urban areas, 10% of the children live in mostly rural areas, and 10% of the children live in completely rural areas. The rural areas are widespread across Michigan (see Exhibit 3). However, the map reveals some challenges with applying a national definition of rural ZIP codes to a state like Michigan. For example, some areas in the Upper Peninsula are shaded blue, suggesting they are "mostly urban," when this is likely not representative of the experiences of families living in these areas. Future needs assessments should potentially include a rural task force to better understand the distribution of children living in rural communities across the state and how best to meet their needs.

Exhibit 3. An Estimated 20% of Michigan's Ages 0 to 5 Population Live in Mostly Rural or Completely Rural Areas, as Indicated on the Map



Infants and Toddlers

Based on Michigan's birth through age 5 population estimates, we also estimated the total number of infants and toddlers compared with the total number of preschool-aged children. There are 332,661 infants and toddlers and 341,262 preschool-aged children in Michigan.

English Learners and Foreign Born Families

Using the U.S. Census Bureau 2016 American Community Survey (ACS) data, in 2016 approximately 662,279 foreign born individuals resided in Michigan, accounting for 7% of the state population—a smaller share compared to immigrants in the United States overall (14%). This includes about 59,000 children under the age of 5. The share of school-aged children with one or more foreign-born parents is smaller in Michigan (13%) than in the United States overall (26%). MDE for the 2017–18 school year reported 97,838 English learners, about 6% of the K–12 student population, but statewide data on EL status in preschool are not available. The Consolidated State Performance Reports from 2015–16 indicate that Spanish was spoken by approximately 40% of Michigan ELs, and Arabic was spoken by 24%, followed by Bengali, Chinese, and Albanian for the top five languages in the state.

Number of Children and Families Served Within Each Component of Michigan's Mixed Delivery System

Michigan's mixed delivery system serves children and families through a variety of programs and services (see Exhibit 4 and Exhibit C.2 in Appendix C). According to most recent enrollment numbers provided by Michigan in 2017 the mixed delivery system

- includes more than 8,000 ***EC programs*** serving 330,000 children from birth to age 6 across Michigan, and programs, such as Head Start and GSRP, reach approximately 38,000 children across the state (50% of income-eligible children);
- serves approximately 10,000 children birth to age 3, and 22,000 children ages 3–5 receive ***EI/ECSE services,*** as of a snapshot in the fall of 2017;
- provides more than 23,000 children with ***home visiting;***
- supports the ***public health*** needs of more than 270,000 children (ages 0-4) through Women, Infants, and Children (WIC) as well as more than 340,000 children (under age 6) through Medicaid, including MIChild; and
- includes other ***family supports*** (because these programs are typically administered at the local and regional levels, we do not have a good estimate of the number and types of services provided).

These numbers do not represent an *unduplicated* count of children and families served across the state. See Appendix C for more detail.

Exhibit 4. Number of Children Served by Michigan's Child Care Mixed Delivery System, Statewide

Mixed Delivery System	Program/Service	State-Level Enrollment
Early Childhood (EC)	Great Start to Readiness Program (GSRP)[a]	38,257
	Head Start[b]	28,058
	Early Head Start	9,355
	Maximum Licensed Capacity in Child Care and Education Programs[c]	333,208
	Child Care Centers	*299,564*
	Family Homes	*14,395*
	Group Homes	*19,249*
Early Intervention and Early Childhood Special Education (EI/ECSE)[d]	Early On	10,527
	Early Childhood Special Education—Ages 3–5	21,624
Home Visiting[e]	Statewide Number of Children Served Across All Home Visiting Programs in Michigan	23,029
Health	Women, Infants, and Children (WIC)	270,784[f]
	Medicaid (including MIChild)—Ages 0–5	345,515[g]

[a] Data retrieved from MISchool website: https://www.mischooldata.org/Default3.aspx?aspxerrorpath=/HelpAndSupport2/SearchForReports.aspx; total enrollment includes children in GSRP and GSRP/Head Start blended programs.

[b] Head Start and Early Head Start enrollment numbers come from the Head Start Program Information Report for the 2017–18 school year. The Early Head Start enrollment number includes both American Indian and Alaska Native (AIAN) Early Head Start and regular Early Head Start programs. The Head Start enrollment number includes both AIAN, the regular Early Head Start program, and migrant Head Start programs.

[c] Licensed child care centers and homes (July 23, 2019), Michigan Department of Licensing and regulatory Affairs. These numbers reflect only those providers whose license was not expired or suspended when the data set was downloaded and who are licensed to serve some age range that includes children less than 72 months old.

[d] The enrollment numbers in this table are specific to IDEA Part B and C programs and are point-in-time counts of children served at the time of data collection. ED*Facts* Metadata and Process System, children and students ages 3–21 served under IDEA Part B as a percentage of population, by age and state, reporting cycle: 2017–18 school year, U.S. Department of Education, data extracted as of August 2019 (retrieved from https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html); ED*Facts* Metadata and Process System, number of infants and toddlers and percentage of population receiving early intervention services under IDEA Part C by age and state, reporting cycle: 2017–18 school year, U.S. Department of Education, data extracted as of August 2019 (retrieved from https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html). Michigan also funds early intervention services through Michigan Mandatory Special Education (MMSE). The enrollment numbers in this table are specific to IDEA Part B and C programs and are point-in-time counts of children served at the time of data collection. ED*Facts* Metadata and Process System, children and students ages 3–21 served under IDEA Part B as a percentage of population, by age and state, reporting cycle: 2017–18 school year, U.S. Department of Education, data extracted as of August 2019 (retrieved from https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html); ED*Facts* Metadata and Process System, number of infants and toddlers and percentage of population receiving early intervention services under IDEA Part C by age and state, reporting cycle: 2017–18 school year, U.S. Department of Education, data extracted as of August 2019 (retrieved from https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html).

[e] Michigan Home Visiting Report, 2017, Michigan Department of Health and Human Services (MDHHS), retrieved from https://www.michigan.gov/documents/homevisiting/Home_Visiting_Initiative_Report_2017_637278_7.pdf.

[f] Number of children, ages 0–4, enrolled in 2017.

[g] Number of children, ages 0–5, enrolled 2017.

Number of Children Served and Awaiting Services in Michigan's Mixed Delivery System (Unduplicated Count)

The needs assessment estimates do not provide an unduplicated count because the data do not yet exist to provide this estimate across the mixed delivery system. Michigan's MI School Data portal provides users with the best as possible unduplicated count of children served within the state's mixed delivery system that exists to date. However, it still represents an incomplete collection of all the children served across the complete mixed delivery system. As of the 2017–18 school year, approximately 130,000 B-5 children participated in one or more state- or federally funded programs for EC, EI/ECSE, GSRP, Head Start, or a GSRP/Head Start blended program. See Theme 10: Data Gaps for a more detailed discussion about the number of children being served and awaiting services in Michigan's mixed delivery system, including a discussion of the biggest gaps, strengths, and weaknesses of data available as well as current initiatives to improve these data.

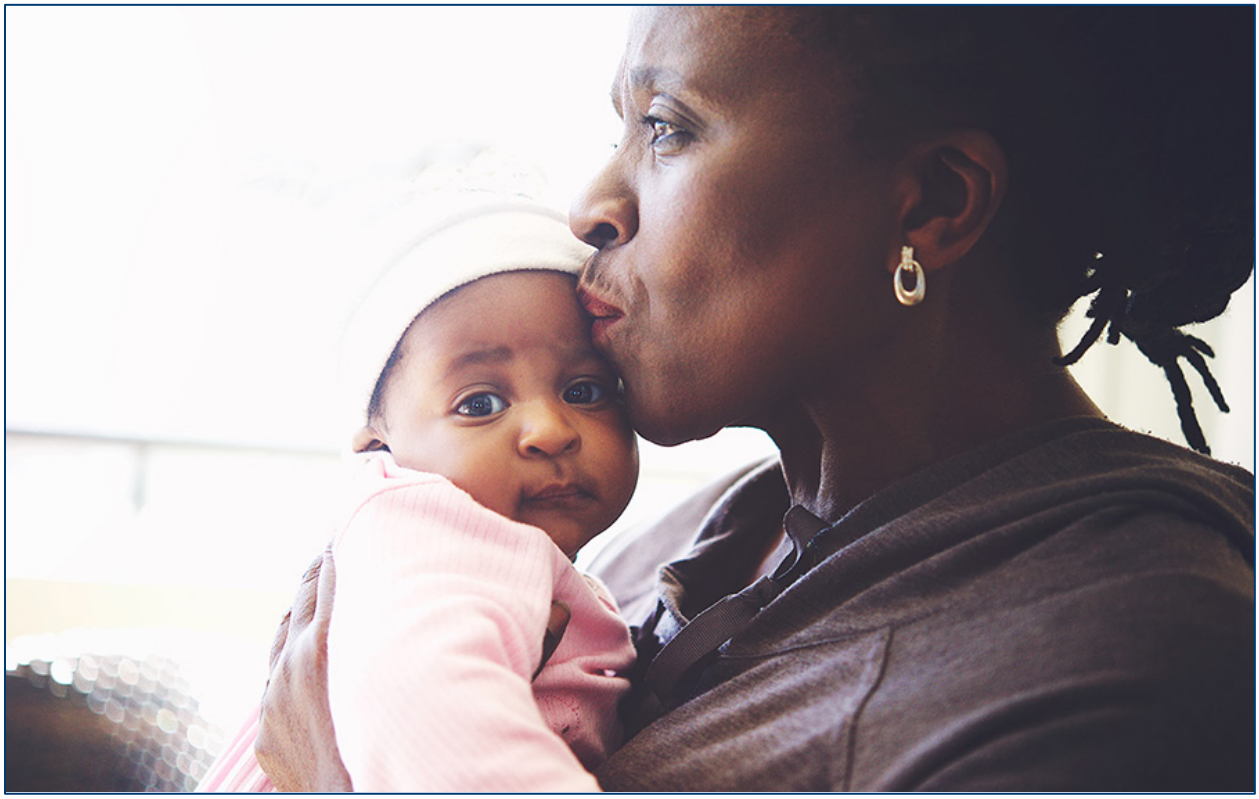
What are the immediate and long-term needs in Michigan's mixed delivery system?

In this section of the report, we summarize the main themes that document the needs across Michigan's mixed delivery system. In total, there were 10 themes across the needs assessment.

- Theme 1: There are large gaps in the availability of programs and services for children ages birth through five and their families.
- Theme 2: A lack of affordable child care is the most pressing need for nearly all families across Michigan.
- Theme 3: Additional gaps exist in program quality and availability within rural communities.
- Theme 4: Families in Michigan struggle to find EC programs that that meet the needs of children with all forms of disability.
- Theme 5: Racial and ethnic disparities also exist in Michigan's mixed delivery system.
- Theme 6: Program costs and workforce issues limit providers' ability to offer high-quality services.
- Theme 7: Transition processes are inconsistent across the state.
- Theme 8: Systems-level collaboration remains a challenge.
- Theme 9: Data gaps limit the extent to which Michigan can document the quality of service provision in the EC mixed delivery system.
- Theme 10: Challenges with existing data limits Michigan's ability to understand the number of children served and awaiting services.

Appendix A provides a crosswalk between each of the questions posed in the federal guidance for all states' PDG needs assessments and the findings included in Michigan's needs assessment (see Exhibit A.1).

Theme 1: There are large gaps in the availability of programs and services for children ages birth through five and their families.



A critical gap across the mixed delivery system is the lack of available programs for infants, toddlers, and preschool-aged children and their families. This pattern is consistent for all ages of children served, from infants through preschool-aged children, and across service type (child care, home visiting, specialized services). For the needs assessment, we considered availability as the extent to which programs and services are (a) currently enrolling children (i.e., have open slots), (b) easy to access (i.e., clear and expedient enrollment criteria), and (c) conveniently located to a child's home and/or parents' place of employment (with particular consideration of reasonable transportation costs). Throughout the quantitative and qualitative needs assessment tasks, we observed this need—there are simply not enough programs or services in the B-5 system. Through our work, we identified the following gaps with regard to availability:

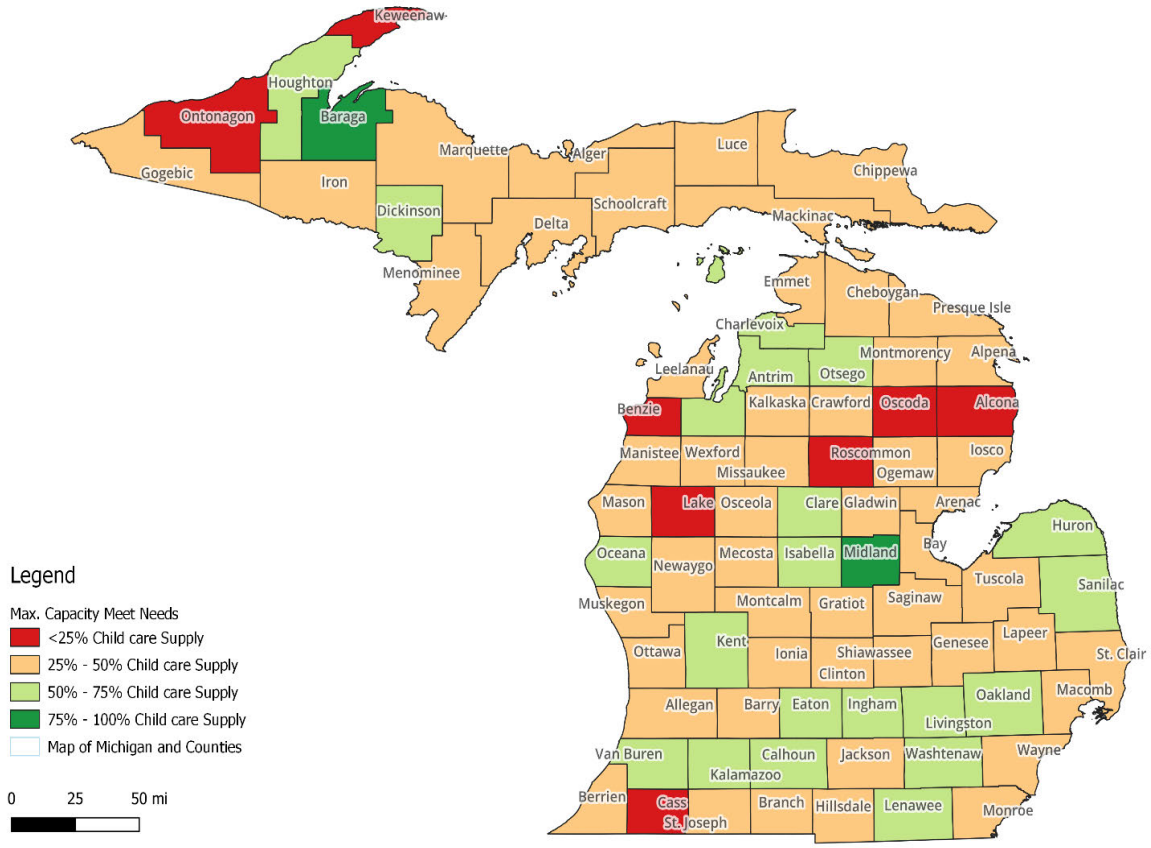
- In general, there are not enough EC slots across the state.
- Infant/toddler EC slots are even more scarce for families.
- These challenges are exacerbated in rural communities and for low-income families.
- Home visiting programs do not have enough slots to serve all families who are eligible and interested in participating in Michigan.
- Specialized care, including health care, pediatricians/specialists, dental health, and mental health care, are limited across the state, especially in rural communities.

However, it should be noted here that availability for some aspects of the mixed delivery system have improved. For example, with the rapid expansion of GSRPs—the publicly funded prekindergarten program in Michigan—the state can now serve roughly half of all 4-year-olds who are income-eligible for the program. And while this is an improvement, the system as a whole is still underserving families in Michigan. In this section, we will examine each of these needs in more detail, describing the extent to which programs and services are currently available as well as the greatest needs identified through our work.

Availability of EC programs is limited across Michigan.

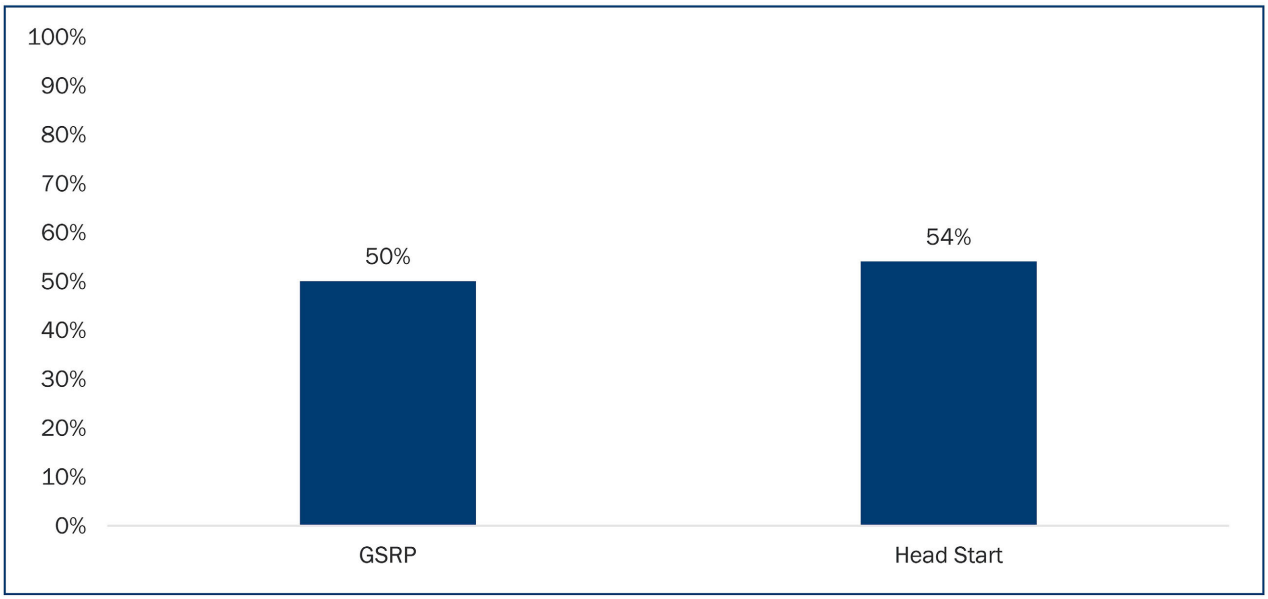
Across Michigan, there are not enough EC slots to meet the demands of families, see Exhibit 5 for a of the availability of child care by county in Michigan. The map demonstrates gaps in access across the entire state.

Exhibit 5. Maximum Percentage of the 0 through 5 Population That Can Be Served by the Number of Available Licensed Child Care Slots, by County



The primary cause of this challenge is that there are simply too few providers across the state. This pattern is consistent for all ages of children served from infants through preschool-aged children. For example, GSRP can meet the needs of roughly 50% of the income-eligible 4-year-old children across the state (Exhibit 6). Head Start also provides slots for just over 50% of income-eligible, 4-year-old children in Michigan.

Exhibit 6. Percentage of Income-Eligible Children and Families Served in GSRPs and Head Start



Source. GSRP data—MI School Data; Head Start data—PIR Report; Early Head Start—PIR Report; Home Visiting data—Enrolled: Michigan Home Visiting Report, 2017, Michigan Department of Health and Human Services, retrieved from: https://www.michigan.gov/documents/homevisiting/Home_Visiting_Initiative_Report_2017_637278_7.pdf; Eligible: American Community Survey (ACS), One-Year Public Use Microdata Sample (PUMS), 2017, U.S. Census Bureau; Eligibility estimates derived from American Community Survey (ACS), One-Year Public Use Microdata Sample (PUMS), 2017, U.S. Census Bureau.
Note. These percentages are based on the estimated number of income-eligible children.

Statewide, Michigan can serve approximately 48% of its 0 through 5 population with the number of licensed child care spots available. However, county-by-county, the capacity to serve the 0 through 5 population with licensed child care varies greatly. Individual counties are equipped to serve anywhere from approximately 5% (Keweenaw County) to 79% (Midland County) of their 0 through 5 population with licensed child care.

In addition, the lack of child care availability is exacerbated for families of infants and toddlers, families living in rural communities, low-income families, families working nontraditional hours, and for children needing additional accommodations.

Understanding the shortage in infant toddler care. The lack of slots of child care is especially challenging for families of infants and toddlers. Families repeatedly mentioned the long waitlists they encountered when trying to find infant and toddler child care, suggesting a severe shortage of child care options that meet family needs. **When we spoke with child care providers about the lack of infant toddler care, they, too, confirmed that it is challenging to provide enough slots to meet the needs in their communities. See Theme 6: Funding Barriers for a more detailed discussion about this challenge.**

> *In our area, home daycare is the only thing that is available before preschool.*
> *– Parent Located in the Upper Peninsula*

All of the programs are full, and when I found a program, it was at least an hour away. – Parent Located in the Upper Peninsula

Likewise, in rural locations, child care options are few. In addition, families shared in the focus groups that the options that are available in rural communities are limited and perceived to be of low quality. In many rural communities, there may be only one child care program. If there is more than one option in rural communities, higher quality providers typically have longer waitlists. Families in rural communities also noted that they must travel long distances to access the infant child care that they need. In rural communities, transportation was mentioned as a major barrier across multiple data sources. We will further discuss the unique needs of rural families in Theme 3.

Low-income families. Access to child care is also a challenge for low-income families. Michigan offers child care subsidies and free, state-funded preschool for low-income families. Although Michigan has rapidly expanded preschool options for 4-year-old children living in poverty (see GSRP enrollment data above), there is still more work to do to meet the needs of low-income families. For example, families that qualify for child care subsidies stated that the application process is confusing.

Families working nontraditional hours. Families that work nontraditional hours, for example, families that work nights or variable shifts, noted that it is very difficult to find child care that can meet their needs. According to the 2019 Michigan licensing data, fewer than 30% of licensed or registered care providers (including home-based providers) cover nontraditional hours (weekend or evening care).

Children needing additional accommodations (e.g., homeless, children with special needs, cultural or linguistic barriers). In the needs assessment inventory, prior needs assessments highlighted barriers to access related to ***accommodation,*** which refers to taking the unique characteristics and needs of families into account when determining how to deliver services. Some of these needs assessments described how services for families with young children are not set up to accommodate families that are particularly vulnerable. For example, a couple of needs assessments noted how difficult it is to support children with special needs, and children in families that are homeless in accessing preschool programs. In addition, some noted cultural or linguistic barriers faced by specific groups within their communities. Importantly, in some needs assessments, the authors noted that they did not uncover enough about the diversity of the families in their community to identify barriers in this area. More work is needed to engage our most vulnerable families to better understand their needs.

Availability and uptake of home visiting is a challenge across Michigan.

The most recent statewide home visiting initiative report (MDHHS, 2017) stated that in 2017 across all home visiting models, state-wide, 245, 584 home visits were provided to a total of 34,009 families. According to analyses that map enrollment data to the number of women, infants, and families that may be potential beneficiaries of home visiting, the state is serving only 15% of potential participants. This number is much higher than the access gaps in child care and may suggest a greater need for equitable access to the continuum of home visiting services across the state.

It should be noted that not all models are available across the state, and many are limited in the number of families they can serve. The most widely available home visiting model is the Maternal Infant Health Program (MIHP). It is available to any pregnant woman or infant who receives Medicaid. Medicaid reimburses MIHP for nine visits during pregnancy and nine visits during infancy, with the option of more visits for substance exposed infants. The other models serves many fewer families but offers higher intensity services for longer time frames.

The needs assessment inventory also confirmed the need for home visiting services. Several needs assessments noted inequities in system capacity to deliver quality evidence-based home visiting. In home visiting, we again see an issue of supply and demand: Communities have more families in need than what local services can adequately serve.

> *Our existing home visiting programs provide services to families throughout the community, but because of the significant need, the majority of families enrolled live in the area that we have targeted. Given the percentage of families living in poverty and the incidence of risk factors, we conclude that there is still substantial unmet need in the [name] area. – Needs Assessment Inventory*

Focus group participants also highlight a gap in availability of home visiting specifically for 2-year-olds after infancy. We heard that although there are enough resources through MIHP to serve pregnant women and young infants under the age of 12 months, in many communities there are no other home visiting programs available for families with older infants, toddlers, and preschoolers. Respondents shared that once children in these communities who benefit from home visiting programs (such as the Maternal Infant Health Program (MIHP), or Nurse Family Partnerships (NFP)) turn 1 to 2 years old, there is often a gap in the services that are available to them and their families.

> *The services for pregnant women and infants (under 1) are readily available. There is a definite gap in services available for those that "graduate" out of MIHP or Healthy Families or NFP. There seems to be capacity in all pregnant/infant programs but very little to transition to. – Home Visiting Provider*

All of these challenges are exacerbated in rural communities. Focus group participants reported that the availability of home visiting programs is further limited in rural areas because of the time and cost required to provide home-based services in large geographic areas.

There also are gaps in the availability of EI/ECSE slots across the state.

EI/ECSE services are mandated for all children and families who need them. The state is required to provide services to any child or family that is eligible as outlined through IDEA Part B and Part C and the Michigan Mandatory Special Education (MMSE) Act. For children under age 3, services are delivered through *Early On*. After the age of 3, children may qualify for ECSE services.

> *In our area…there is only one Early On. It's always full. – Parent*

The needs assessment inventory also noted a gap between the need for ***early intervention*** services and the availability of those services. In addition to gaps in the availability of *Early On*, needs assessments noted gaps in supports for child care providers in meeting the needs of children with special needs or behavioral concerns. Some needs assessments highlighted the missed opportunity to address developmental concerns early so that children enter preschool and kindergarten developmentally on track. Parent and provider reports from our focus groups also indicated that the availability of Early On in some areas did not meet the need. This indicates both a capacity and a compliance issue because Early On is mandated to serve all eligible children.

In addition to gaps in home visiting and early intervention slots, there are challenges with enrolling families in these programs.

One key to enrolling more families in home visiting and early intervention is the use of referrals for eligible families. Because most families are not aware that these services exist, referrals from trusted sources (such as pediatricians, child care and preschool providers) become an essential step in accessing services. Unfortunately, focus groups with home visiting and early intervention providers reported that professionals often fail to make these referrals. This may be because pediatricians or child care providers themselves are unaware of the different types of home visiting and early intervention services available to families. Providers also reported that even when families are referred, they may refuse services. Providers think this refusal of early intervention and home visiting services is likely multifaceted, such as

- families do not understand the purpose of services being offered to them,
- services are offered only during hours when families are working,
- families do not trust outside individuals to enter their homes for fear of judgement and reports to child protective services or U.S. Immigration and Customs Enforcement (ICE),
- families hold cultural and historically legitimized stigma against engaging their child in special education services, and
- families hold a belief that home visiting services are only for very poor and dysfunctional families and that early intervention is only for very disabled children.

Family focus groups confirmed many of these reasons, especially a distrust of inviting strangers into their homes. We heard consistently from families that there is a fear of services provided in the home, which may further limit participation. For example, we heard from families that welcoming any stranger, and especially a government official, into their homes is unnerving. Families reported fears that home visitors would report them to Child Protective Services and potentially remove their children from the home. This fear was particularly salient for Black, Latinx, and recent immigrant families in Michigan. Families also voiced concerns about the data collected by home visiting programs and a general lack of trust for the programs or confidentiality. This fear of participating in home visiting is even stronger in immigrant and non-English-speaking families, where they shared worries that if they invited government officials into their homes they could be deported. Much work is needed to (1) reflect on the truth behind these fears and examine challenges in the system, (2) understand how to assuage family fears about home visiting, and (3) communicate the benefits of home visiting models with eligible families.

> *Because of the U.S. Immigration and Custom's Enforcement (ICE) presence in our county, some of the Latino community are not as trustful of accessing services.*
>
> *– Home Visitor*

I don't want some college book person saying – you need food, I will look into things when I get to the office – then I have CPS at my door because I don't have food! Everything is culture! We do things differently based on our culture. If I say that my house is messy, and you say it's okay and then next time I hear that there are notes about my house and I have problems from CPS again. They should disclose where and what information is going in my file. They tell a social worker and we are labeled, which puts a red X on your back for ever. Happens to minorities all of the time. We have to be our own advocate.

– Parent

Working to overcome these challenges to enroll more families is difficult for providers. Further, participants reported that despite the considerable efforts and resources required to engage families, that process is not reimbursable. In addition, many home visiting and early intervention providers report being underfunded. Providers report unequal access to home visiting funding across the state. As a result, despite difficulties in engaging families, programs that are open to all families still maintain waitlists.

Money is an issue related to accessing high-quality home visiting services for infants and toddlers…. These programs need additional funds. That funding varies across the state, which is a result of our inequity of our funding systems. Some Intermediate School Districts have tremendous resources, while others operate on a shoestring.

– State Director

There are availability and access challenges in family health and wellness, especially for mental health and trauma-based interventions.

The inventory of prior needs assessment also raised a wide variety of concerns related to children's health. Multiple needs assessments described concerns related to dental care, nutrition and childhood obesity, and child abuse and neglect. Other issues were raised as well such as breastfeeding, immunizations, and developmental screening. Needs assessments specifically noted a lack of dental providers that accept Medicaid or the cost of nutritious food.

Participants in focus groups echoed these barriers. Families reported that access to affordable health care (e.g., dental, pediatric, specialty care, and mental health services) is limited, predominantly for families living in rural areas. Rural communities often do not have enough health providers. Families also

reported transportation challenges because the health care providers that do exist are located far from home. For many families, the lack of access to a pediatrician also translates into a lack of access to developmental screenings. These screenings are an important point of referral, and, without them, families cannot access critical early intervention and home visiting services. This cyclical challenge persists in many rural communities in Michigan.

> *We have limited primary care. Many of our Upper Peninsula areas do not have pediatricians, and there is only one pediatric psychiatrist.*
>
> *– Social Emotional Health Care Provider*

Prior needs assessments also underscored the need for more ***mental health services that address trauma exposure.*** Many needs assessments identified concerns related to trauma and its impact on both parent and child well-being. Needs assessments particularly focused on trauma associated with domestic violence and child maltreatment. They linked these adverse experiences to depression and anxiety in parents and to social, emotional, mental, and behavioral health challenges experienced by children. In addition, they highlighted the lack of mental health service providers, the lack of adequate coverage to pay for mental health services, and the lack of support for early care and education professionals working with children who are survivors of traumatic life experiences. However, they also highlighted the need to expand proven solutions such as providing trauma informed services and infant and early childhood mental health consultation, also known as Social Emotional Consultation in Michigan.

The lack of availability across the entire mixed delivery system (EC programs, EI/ECSE, home visiting, health programs and providers, as well as family supports) severely limits family choice.

According to participants from focus groups with families, providers, leaders, and subject matter experts, family choice in Michigan's mixed delivery system is highly limited due to the affordability, availability, and awareness of programs and services. Families reported that they simply do not have choices when it comes to child care and preschool. For many families, most programs cost more than they can afford, and even when families do have access to a child care subsidy, their choice is limited by the fact that so few child care providers are choosing to accept them. It was further reported that families looking for preschool often feel that their choices are limited because of a limited number of high-quality and affordable preschool programs available. As a result, many families feel forced to choose a program outside of their own communities or are having to choose a preschool program based on the provision of transportation.

Likewise, in the inventory of existing needs assessments, parental choice was often described as a lack of choices for parents rather than a variety of choices. Similarly, the inventory revealed limitations due to factors such as geography, family income, and general service availability (including lack of evidence-based home visiting models within their community, decreasing child care options, or inadequate numbers of *Early On* providers).

Theme 2: A lack of affordable child care is the most pressing need for nearly all families across Michigan.

This section focuses on the affordability of EC programs for families. In Theme 6: Barriers to the Funding and Provision of High-Quality Programs, we further explore this issue from the perspective of the provider to offer high-quality programming at an affordable cost to families.

One of the most critical needs related to the availability of high-quality EC programs is the administration of affordable programs for families. This is the most pressing need for nearly all families across Michigan, regardless of income. Affordable child care is defined by the U.S. Department of Health and Human Services (HHS) as care that costs families no more than 7% of their annual income. The average income of Michigan families is $57,054, while the average annual cost of infant toddler care in Michigan is $10,861. On average, Michigan families are spending 19% of their annual income on child care (Economic Policy Institute, 2019). Child care in Michigan is simply too expensive for the average family to afford. Focus group participants included a wide range of families and professionals representing multiple parts of Michigan's mixed delivery system reported consistently—child care in Michigan is beyond the means of the families that depend on it to work.

> *Child care is not financially feasible for us – we can't afford $1,000 a month!*
>
> *– Parent*

Previous needs assessments of Michigan's child care system echoed this point. Our inventory of previous needs assessments of Michigan's mixed delivery system also found that ***affordability*** has been a continuous barrier to accessing services. The high cost of child care was a key concern for communities across the state and was mentioned in the context of other financial strains such as lack of affordable housing, food, transportation, and utilities. Some linked these issues to low wages, underemployment, or a lack of supports for higher education.

Although child care is expensive across the state, additional considerations such as program type, age of child, and location in the state influence the overall cost to families.

The cost of child care varies for families in Michigan, based on the age of the child(ren) being cared for, where the family lives, the type of provider they chose or have access to, and the quality of care provided. On average, child care costs are most expensive for a family of an infant or toddler in a center-based program (Public Policy Associates, 2017). On average, families pay $6 per hour for center-based infant and toddler care compared with $3.75 per hour for family home-based care for a preschool- or school-aged child (Exhibit 7).

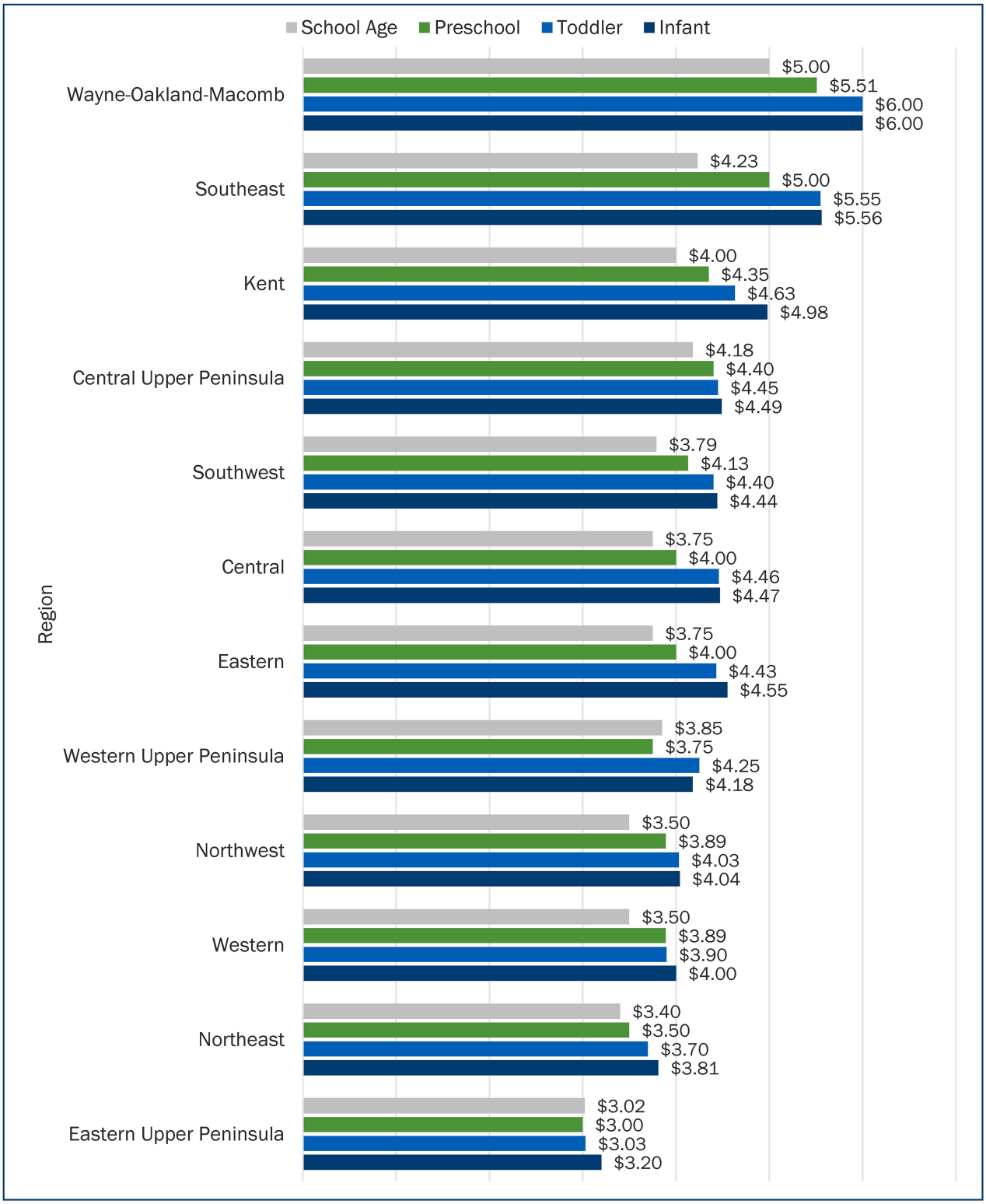
Exhibit 7. Market Rates of Child Care (75th Percentile) in Dollars Hour, by Age Group and Provider Type in Michigan

Provider Type/Age Group	Infant	Toddler	Preschool	School Age
Centers	$6.00	$6.00	$5.25	$4.75
Group Homes	$4.00	$4.00	$3.89	$3.89
Family Homes	$4.00	$3.89	$3.75	$3.75

Source. Public Policy Associates. (2017). *Child care market rate study.* Lansing, MI: Author. Retrieved from https://www.michigan.gov/documents/mde/MRS_Final_Rpt_620152_7.pdf

The cost of child care also differs by location. Across Michigan, child care is most expensive in urban areas, including those in Southeast and Metro Detroit areas. In Southeast Michigan and Metro Detroit, infant/toddler care costs approximately $6.00 and $5.55 per hour, respectively. In contrast, child care is often least expensive in rural regions of the state, with the lowest average costs within the Eastern Upper Peninsula. Exhibit 8 shows the breakdown of the average hourly rate for infant, toddler, preschool, and school-aged care across the state.

Exhibit 8. Market Rates of Child Care in Dollars per Hour for the 75th Percentile, Among All Provider Types, by Region and Age Group



Source. Public Policy Associates. (2017). *Child care market rate study*. Lansing, MI: Author. Retrieved from https://www.michigan.gov/documents/mde/MRS_Final_Rpt_620152_7.pdf

Although child care subsidies, designed to alleviate the high costs of child care for low-income families, can help, they are not enough to fully cover the costs of care for most families and programs.

To improve child care access among low-income working families, OGS administers and disburses the federal child care subsidy funds to eligible parents to expand their choices in the child care market. The hourly rate for reimbursements is determined based on several factors, including the age of the child, the type of provider, and their quality ratings. In general, reimbursement rates are higher for younger children enrolled in highly rated center-based facilities as compared with group home or family home providers. However, we found through multiple focus groups and interviews with families, mixed delivery system providers, early childhood leadership, and subject matter experts that the amount families receive is not enough to truly reduce the financial burden imposed by child care. The inventory of needs assessments also supported this finding.

To begin, focus group participants noted the application process itself as well as requirements to maintain the subsidies as barriers to families. For example, subsidy eligibility is conditional on employment. For families not yet employed, they cannot afford child care while they look for work. In addition, families reported that the child care subsidy process takes too long. The delay between applying for a subsidy and receiving the subsidy often results in families losing their child care slot. Families then have to start their child care search over again to find a new location, which in itself creates an additional barrier to accessing care because of the limited availability of child care across the state. This finding was also supported through the inventory of existing needs assessments.

> *[DHHS] stop sending me letters saying that you are cutting me off from the subsidy because I am not working! It's because I don't have child care! I feel so LOW when I work with DHHS. I have to start all over because it [subsidy process] took so long and now the child care space isn't available any more – it's a complicated and frustrating process. –Parent*

Families reported a stigma towards using the child care subsidy, which acts as a barrier to its use in Michigan.

Several family focus group participants reported that some providers discriminated against families who use the subsidy and have even gone so far as to make classist remarks about them and their children. These reports are concerning, and further efforts should be made to uncover what part, if any, discriminatory beliefs play in child care providers decision to accept the state's child care subsidy.

> *I heard a provider say that parents who have that [subsidy] are ghetto and ratchet and their kids have bad behaviors. – Parent*

> *There are child cares that discriminate against those that use the subsidy. – Parent*

In addition, it is hard to find high-quality child care that will accept the subsidy, and families are forced to settle for lower quality care.

Regardless of income group, families are forced to make difficult choices regarding the quality of care their child receives. Both providers and families reported that finding a child care program that accepts the child care subsidy is difficult. As a result, families reported that to use their subsidy, they had to choose providers that they perceived as lower quality. At times, this meant enrolling in family care or enrolling their child in centers with staffing issues or centers that lacked or had limited curriculum. In general, families reported a lack of choice when using the subsidy.

Affordability Is Not Simply a "Low-Income" Problem

Focus group participants noted that the inability to afford child care extends beyond families who fall below the federal poverty level. The cost of child care is also a barrier for families that are just "over income" and do not qualify for the subsidy. These families earn enough money to make them ineligible for the subsidy but not enough to include child care in their monthly budget. Over-income families also reported that they could not afford high-quality child care in their communities and that they had to make similar quality compromises as families using the subsidies. This issue was also reflected in our inventory of previous need assessments, where several needs assessments referenced small increases in income as a barrier to accessing high-quality services. Program eligibility requirements, including income levels, can be limiting for families who are working but still need services. The state recently started a new initiative, referred to as the Asset Limited, Income Constrained, Employed (ALICE) Project to better understand the needs of these families in Michigan who are working yet still struggling to make ends meet, see https://www.uwmich.org/alice.

> *"There are families residing in "gap" income, over income to qualify for EHS, HS, GSRP, but not sufficient income to pay for quality child care services."*
> *– Parent and Provider Collaborative Group Representative*

Families Are Forced to Leave the Workforce

Families who are ineligible for subsidy are often forced to make career and employment choices based on their inability to afford child care. Multiple family focus group participants reported that it was not uncommon in over-income two parent homes for one parent to stop working and to stay home. In these instances, families have found that the cost of child care either fully or nearly canceled out the income of one family member, sometimes also encroaching on the income of the second parent. It should be noted in the instances reported that the choice to stay home was not a style of care choice. Instead, it was a choice made based on a family's inability to afford child care, regardless of that parent's wish to work. In our focus groups, the cost of child care was reported by families as a barrier to being part of the workforce.

> *I am a stay-at-home mom because I have twins and it's not feasible and affordable for me to work and pay for child care. – Parent*

I had to quit my job because I could not afford to have two kids and work. It would have been a loss to my family. But who has access?…. Of the moms around me, the only ones that use what I consider quality – licensed, educated, etc., teachers are the upper class/doctors/rich people. The above average – the upper class – have access to better care because they have options." – Parent

My partner will have to stay home because it is so damn expensive, it's like a second mortgage, it's not an option. – Parent

One strength of Michigan's mixed delivery system is the provision of high-quality preschool programming for income eligible families

One strategy used across Michigan to ensure access to services for vulnerable children is to tie eligibility for services to family income. This strategy is used most commonly in early learning programs (GSRP and Head Start) in the B-5 mixed delivery system. Although this strategy provides a means for many low-income families to access to early learning programs, health, and mental health care services they would not otherwise be able to afford, interviews with providers and families suggest that the cutoff for eligibility may be too low. Reports from focus group participants indicate that that there is a large population of low-income families who do not meet the poverty threshold but also cannot afford the mixed delivery programs and services their child needs.

I can't go to the one that costs a lot because it wouldn't make it worth it for my wife to work – we had to compromise on quality at a more affordable location so that it makes sense for us financially. – Parent

Theme 3: Additional gaps in program quality and availability exist within rural communities.

Many of the availability, affordability, and quality gaps discussed are further magnified in rural communities. Across Michigan, approximately 20% of children ages birth to 5 live in a rural community. Families living in mostly or completely rural communities face challenges in accessing and affording services for their children ages 0 to 5. The most pressing challenges include the following:

- Transportation challenges are sometimes insurmountable for families to access services and for providers to offer cost-effective in-home services.
- Families within rural communities have few to no options for specialized services, including health care, pediatricians/specialists, dental health, and mental health services.
- The gap between supply and demand for child care is even larger in rural communities.
- Finding high-quality and affordable infant/toddler care in rural communities is a real challenge, and families often turn to family and kin care due to a lack of center- or home-based child care options.

In this section, we describe the unique needs of rural families and the challenges providers face in meeting their needs.

Transportation challenges place a burden on rural families that is sometimes insurmountable.

Like many states across the country, Michigan's residents living in rural communities often travel long distances to reach the services they need. Transportation, in terms of both families' ability to reach services as well as services' ability to reach families, were highlighted as a significant barrier. Prior needs assessments described how families must travel long distances to access even the most basic and critical services, such as urgent or emergency care or grocery stores, and indicated that many families they serve do not have adequate transportation options. Likewise, for home-based service providers, it is very challenging to deploy home-based services in rural communities. It can be challenging to provide

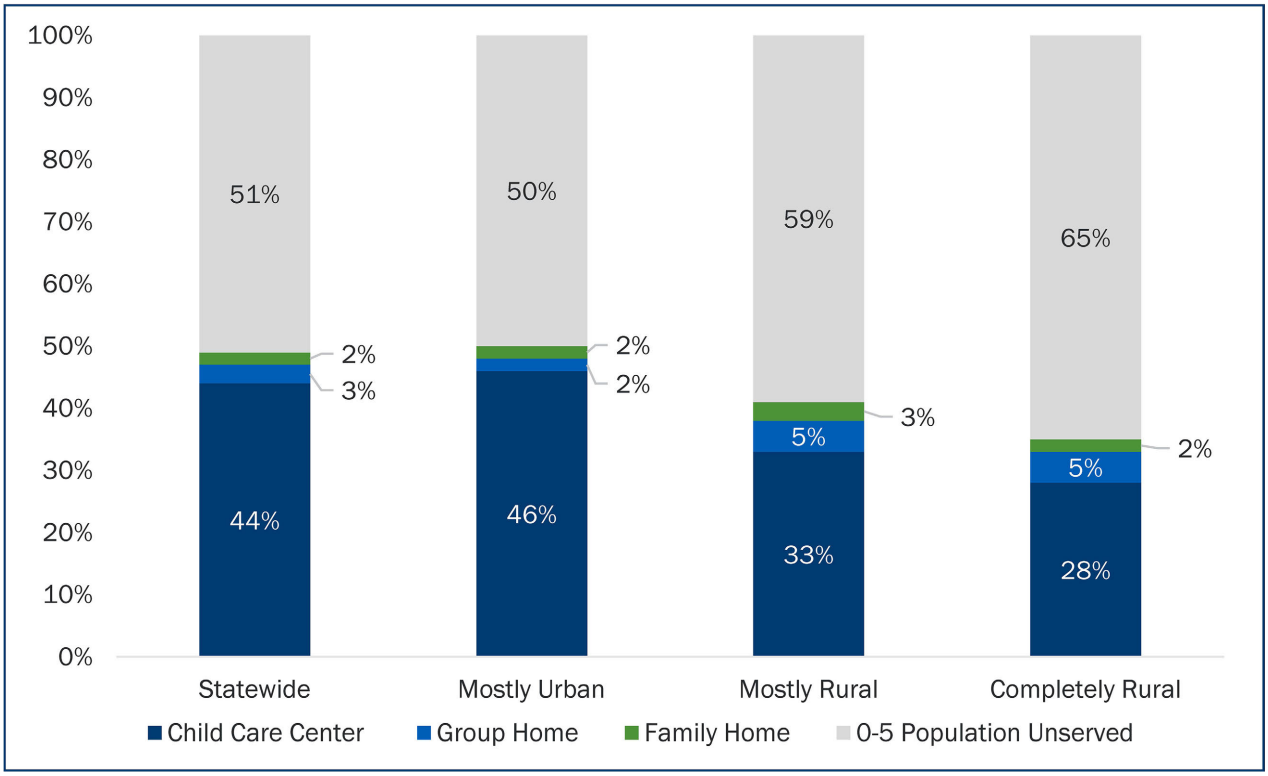
much-needed services in families' homes when providers must travel multiple hours to serve one family. This further reduces providers' ability to reach families in a cost-effective way.

> *There are some very rural and desolate areas that are very difficult to reach – especially in the winter months. Also, there are not many resources spread throughout these areas, which makes it difficult to obtain services and sometimes even access to basic needs. – Existing Needs Assessment*

Gaps in child care are even larger in rural communities.

As discussed earlier, the availability of child care is a challenge across the state, but it is especially challenging in rural communities. The gaps between the number of licensed and registered child care slots and the number of children ages 0 to 5 are even larger in rural communities (see Exhibit 9). Specifically, across the state, Michigan has the capacity to serve roughly half of children ages 0 to 5. However, that capacity is lower in completely rural communities. Even though the distribution of these slots by geographic regions aligns well with the population distribution in mostly urban, mostly rural, and rural counties, the maximum percentage of children served is significantly larger for mostly urban counties (50%) than for mostly rural counties (41%) and completely rural (35%) areas.

Exhibit 9. Percentage of Children Served in Each Type of Child Care and Those Who Are Not Served in Rural Versus Urban Counties in Michigan



Availability of primary care and specialized services within distance are particularly significant barriers within rural communities.

For rural communities, the availability of specialized services and transportation were commonly identified as co-occurring barriers for families to access the care and services they needed. For many rural communities, accessing basic medical care for their young children is a challenge. The needs assessment revealed barriers to finding pediatricians with openings for new babies as well as pediatric dentists. Rural families also have a difficult time accessing specialized services such as occupational therapy, physical therapy, speech and language services, as well as mental health services for infants and toddlers. Rural communities often do not have the population to support comprehensive medical and specialized care. The availability of specialized services in rural areas is scarce, resulting in long waitlists for families to access the care they need. Families are further limited in their access to specialized care by whether or not they have insurance, the type of insurance they hold and the types of insurance accepted by the few providers in their community. If their insurance is not accepted, it is not easy to find, for example, a second pediatric dentist that will accept their insurance.

> *Families are having to travel a long way to access health care in our rural county. We have to go to the closest city for most health care needs – pediatrics, family doctor. The doctors' offices are often not taking new patients because they are full.*
>
> *– Child Care Provider*

Theme 4: Families in Michigan struggle to find EC programs that meet the needs of children with all forms of disability.

Service equity challenges also extend to children with disabilities. Information gathered from focus groups with families, subject matter experts, and providers found that families are having trouble finding child care for children with special needs. It was also reported that the choices for preschools were limited and that the choices available did not always provide the least restrictive environment for their child.

> *Having a special needs child, you can find preschool if your child qualifies for half-day Monday through Thursday special needs preschool, but then you can't find child care for a special needs child [for the remaining hours and days], and I had to quit my job. – Parent*

It was further conveyed that providers may need increased training regarding families' beliefs surrounding disability. More specifically, not all cultures trust special education or early intervention services. An interviewee reported that providers will gain trust from families only by showing that they understand and respect families' experiences and resulting beliefs surrounding both disability and the care of their children. That interviewee further suggested that a more effective solution would be for service providers to hire more staff who represent the cultures with which they work. This is a workforce issue across the

board in Michigan's EC mixed delivery system, see a discussion in Theme 5 below. Future needs assessment should focus more on meeting the needs of families with children with disabilities in Michigan.

> *To increase access to early intervention and special needs, it's going to take getting trusted people implementing it for you to see more people of color accessing it. You may have it, they may not be showing up for sure. But because they don't feel like the person I am showing up for, I trust that person, my child is going to be marked for a long time, it's going to follow them, and all this so people and parents get scared and they don't follow through with certain things.*
>
> *– Subject Matter Expert*

Theme 5: Racial and ethnic disparities also exist in Michigan's mixed delivery system.

Racial and ethnic disparities also exist in Michigan's mixed delivery system. According to interview and focus group participants, equitable access to services for and meaningful engagement with culturally and linguistically diverse communities remains a challenge in Michigan. See Appendix C for the detailed breakdown of enrollment patterns in GSRP, HS, EHS, and home visiting by race and ethnicity.

There is a lack of meaningful and actionable engagement between service providers and culturally and linguistically diverse communities.

Focus group participants noted that more connections need to be built between organizations and the culturally and linguistically diverse families they serve. This was discussed in detail in the early child care provider focus groups. Many providers acknowledged that their staff do not spend enough time in the community learning and hearing directly from families. One participant suggested, "Once a year, twice a year, go to the community and just sit down and hear from people." Even when providers do engage with communities in meaningful conversations about reasons for racial and ethnic disparities and inequities, there is a lack of follow through. The limited engagement coupled with lack of follow through may also be related to a common theme—a general lack of cultural competence across the mixed delivery system.

> *They don't know how to interact with the families or the families are not trusting them because they don't see them being able to help them with the problem they are dealing with. – Subject Matter Expert*

Focus group participants also discussed a lack of trust specifically between Black and Latinx families and service providers when those providers were of a different racial and ethnic background. Participants noted that historical and contemporary incidences of racism make building trust between families and service providers difficult. Another challenge noted was the dependence on families to engage services. The burden is placed on families to find the services they need, rather than on providers to find the families that would most benefit from their programs.

> *I had people offended when I asked the qualifications of their staff and vaccination rates and diversity of the classes, which matters to me. It is important that you see my child as a little boy who is black, not a pipeline to prison child. You need to embrace diversity. Children need diversity…. If they [providers] were uncomfortable, we walked away. – Parent*

The needs assessment inventory also noted inequities experienced by Black non-Hispanic families and Hispanic families. Historically racialized and discriminatory systems place families of color, especially Black and Hispanic/Latinx families, into circumstances with limited opportunities to build wealth. Further, historic and current segregation across the state places families of color at higher risk of continued systemized disadvantage and oppression. These inequities require systems-level change. Several needs assessments noted a desired increase or expansion of services to better meet the needs of Black and Latinx families in Michigan. A few needs assessments also noted the importance of strategic programming to reach and serve Amish families in their communities.

There is a lack of diversity in the providers across the mixed delivery system.

Participants also shared that in their communities, there is a lack of providers who represent the culture, language, and race for children of color or dual-language learners. Focus groups with families, early childhood learning and education providers, as well as early intervention and home visit providers reported that many service providers lack interpretation services. Furthermore, it is difficult for these providers to find staff who speak the languages that are present in communities they serve. In addition, they do not have the capacity to offer informative documents in multiple languages. Moreover, families, providers, and subject matter experts reported the presence of a cultural barrier that inhibits service uptake, specifically in home visiting. It was conveyed that service providers need further education on cultural beliefs within the communities they serve and that agencies must hire more staff who represent the cultures they are working with. Furthermore, diversity of representation must also increase at all levels of leadership within Michigan's mixed delivery system.

> *It's not like people of color aren't following or running mixed delivery programs over there, but what support are they getting? Are they in the leadership? They are always at the bottom doing the work. It depends on where you are – I think that racial equity is a big deal in the whole state of Michigan, from my perspective. Someone may see it differently, but it is a big deal. There's not a whole lot going on. But if you look at the state level, we don't have people of color, in leadership and decision-making capacity in all the different sectors of early childhood in our state. I feel like the more things change, the more things stay the same. And that's what I mean by we don't have a voice at a higher table, and the people at the higher table don't look like us or don't see it as something very important.*
>
> *– Subject Matter Expert*

Equal but inequitable resources result in disparities in the mixed delivery system.

Particularly for very low-income communities, equal division of funding has resulted in inequity of service provision in areas with the highest levels of need. It was further reported that providers within underfunded locations struggle to access additional grants and funding because they commonly do not have time or access to grant-writing expertise, and they do not have valuable connections with legislators, foundations, or other funding sources.

> *It's killing our system because everybody is not equal. In general, all the minority groups are struggling, they are reaching out to ask me, "How are you getting funding?," "What are you doing differently?" And I'm telling them, I'm not getting funding from the state higher than we should have. The only thing that is helping us is that we reach out to all the foundations that support our work. You know, which means you gotta find resources, hire somebody to do that, which is very hard for small organizations to do. — Subject Matter Expert*

Service providers who work closely with lower income communities report struggling with the amount of funding they receive for both Head Start and GSRP. Participants reported that funding was not tied to the needs of communities. Therefore, communities with higher concentrations of poverty, which require more funding, received the same funding as more affluent communities. This need is true of both urban and rural areas.

Latinx Families

According to a focus group done with home visitors from across the state, Latinx families face specific barriers to accessing in-home services such as home visiting and early intervention programs. Due to recent changes in immigration policy, historical treatment of this population by ICE, and other barriers such as language, location and limited transportation, and availability of services, Latinx families, both documented and undocumented, are refraining from accepting or seeking out needed services.

Moreover, as with many other culturally and linguistically diverse families, such as Arabic and Native American families, the Latinx community often does not see themselves within Michigan's mixed delivery system as it lacks culturally and linguistically representation at all levels. This lack of representation further limits the Latinx populations' trust of the state's early childhood mixed delivery system.

Immigrant and Non-English-Speaking Families

Immigrant and non-English-speaking families face challenges to accessing services. Focus group participants, including families, foundation representatives, and service providers, reported that Michigan's mixed delivery system lacks the understanding needed to fully support families and children who have immigrated to Michigan. Families reported the existence of a cultural barrier that inhibits service uptake. That is, many families are unfamiliar with the existence, goals, and expectations of the services. It is unclear to these families the extent to which these programs and services fit with their cultural norms and traditions, which is a concern for families wishing to maintain their cultural practices. Service uptake is further limited by fear. Both providers and families reported that many families who are undocumented, and other families of color who are also often targeted by law enforcement, including ICE, do not access services for fear of being detained.

Michigan's mixed delivery system struggles to provide services to families who speak languages other than English. Focus groups with families, child care and preschool providers, and early intervention and home visiting providers widely reported that many service providers lack interpretation services, are

unable to find staff who speak the languages present in the community they serve, and do not offer informative documents in multiple languages. For families that speak languages other than Spanish, such as Arabic, services are even more difficult to access. This language barrier prevents families from accessing services for their children, which has implications for kindergarten transition.

The needs assessment inventory noted that this is not a new challenge. Several prior needs assessments noted barriers to services related to primary language spoken. Programming and resources available in languages other than English were limited, thus creating a barrier for robust engagement in early childhood services for families who do not speak English as a primary language. Importantly, none of the needs assessments directly addressed experiences of racism or other forms of bias.

Theme 6: Funding barriers: Program costs and workforce issues limit providers' ability to offer high-quality programming.

Within our five needs assessment tasks, we identified three major barriers to EC programs for providing enough high-quality slots across the state:

- High-quality care is expensive, given adult-to-child ratios, especially for infant and toddler programs.
- Child care subsidy reimbursement rates are simply not high enough to fully cover the costs of child care.
- Providers struggle to find and retain qualified and well-trained educators.

Providers reported that one of their greatest barriers to offering affordable, high-quality care is cost.

In Theme 1, we discussed that in general there are not enough EC slots across the state to serve Michigan's B-5 population. This shortage is further exacerbated for families with infants and toddlers, living below or at the federal poverty level, and living in rural communities. During focus groups, providers also discussed these concerns, noting that the cost of labor, in particular, further limits their ability to offer high-quality infant and toddler care.

> *It is hard for families to understand the added needs of infant and toddler care. It is too expensive for them, and I can't make money on infant and toddler care.*
> *– Child Care Provider*

Providers reported that infant/toddler care is not economically viable. This is because providers cannot afford to provide high-quality infant/toddler care and remain affordable to families. The increased cost to provide infant/toddler care is related to the smaller child-to-teacher ratios required by licensing. The state ratios change from 1:4 to 1:8 at 30 months of age. These smaller ratios are needed to keep infants and toddlers safe but are directly related to the cost of care.

Not surprisingly, child care, as a business, was described by several focus group participants as unfeasible in the communities that often need it most. In many locations across Michigan, the number of child care providers of all kinds is decreasing. Moreover, providers reported that prospective providers are often discouraged from opening new child care centers or home-based child care environments. They conveyed that this was because prospective providers are unaware of where to find guidance or incentives. Furthermore, prior needs assessments identified in our inventory noted that providing high-quality services also requires safe and accessible facilities and infrastructure but that facility start-up costs were a significant barrier for potential new providers.

> *In lower income neighborhoods, child care is simply not an economically viable business venture. – Child Care Provider*

Child care subsidy reimbursement rates further contribute to the barrier of providing high-quality care because they are not high enough to fully cover the costs of care.

Child care subsidies for low-income families have the greatest opportunity for addressing the cost to provider and cost to family gap. In Michigan, approximately 58% of all programs currently serve one or more child receiving a child care subsidy (Public Policy Associates, 2017). However, during focus group conversations, we heard conflicting discussions about providers' willingness to accept subsidies, and many participants noted that it is particularly difficult for low-income families to find providers willing to accept the subsidy. Child care providers reported that the subsidy reimbursement rates were too low, and the process was not efficient. From a business perspective, these challenges discourage providers from accepting a subsidy particularly in areas where child care is scarce and they can easily fill slots with unsubsidized children.

Subsidies are "nice" but not a game changer in terms of truly supporting a typical provider. Subsidized children are essentially "loss leaders" within a child care center; they need market-pay parents to offset losses. And yes, the process is far too bureaucratic. Essentially, no, subsidies do not support high-quality child care.

– Home Visitor

There are not enough providers that accept subsidies. Because I get calls from many parents who in their search for child care have called many other providers, and most do not accept the subsidy." – Child Care Provider

It is not affordable to use subsidies to get the quality where it should be. It makes it more affordable for parents but doesn't cover the cost for the center or day care. Many centers are taking infant toddler care out because the ratio requirements do not cover the staff, and the subsidy certainly does not cover the cost. If I can't pay an employee a good salary to provide quality care, then I can't afford to provide the service. The subsidy is too low to pay for that.

– Child Care Provider

Developing and sustaining a pipeline of EC educators is costly and remains a challenge in Michigan.

Providers also suggested that there are workforce challenges to finding qualified and experienced staff to teach infants and toddlers, particularly in rural areas. Even when providers do find qualified staff for their infant/toddler classrooms, turnover rates are high. Providers report that turnover is caused by underpaid and overworked infant/toddler teachers. For example, in 2018, child care workers in Michigan had an annual salary of $23,670 or about $11.38 an hour (U.S. Bureau of Labor Statistics, 2018), all of which is occurring within an economic environment where the workforce can make higher (although still very low wages) in less skilled and often less demanding jobs. This finding was also documented in the state's recent workforce study, which reported large numbers of EC providers who seek public assistance to make ends' meet (Roberts, Le, Schaak, Franko, & Morgan, 2018). The hourly wages reported by the early educators in Michigan's workforce study could support a single adult (with the exception of staff at family child cares). However, most early educators did not earn enough to support a family of one adult and one child or more (Roberts et al., 2018). The low wages of EC staff continue to be a challenge across the state and nationally.

Focus group participants also spoke to training issues within the EC workforce. For example, participants noted that EC providers need further training on subjects such as the impacts of trauma, behavioral needs, and emotional challenges to combat preschool expulsion and provide more sensitive care to children of all needs.

> *Turnover happens because the workers don't get paid! I used to work in child care, and I made $9 per hour, for 12-hour days. That's the reality. They are working you so hard, and when I can go to McDonalds and make more, it makes it not worth it. I was attached to the kids, but not paid enough and worked my butt off making barely $9. – Parent*

Likewise, home visiting and early intervention providers struggle with workforce challenges.

Workforce challenges and talent deficits are also present across the state in home visiting and early intervention programs and particularly in rural communities. Because of the need for building meaningful relationships between home visitors and the family, staff turnover is particularly challenging within these programs. Staff turnover and the loss of this relationship is therefore challenging for retention, knowledgeable transition support, and ongoing engagement in home visiting. Turnover further inhibits providers ability to make and keep connections with cautious communities who require the establishment of trust.

> *Knowing how to get in the door and stay in it is another part. There are key people that parents of infants and toddlers tend to see on a regular basis, and that is going to help us increase access if we are able to develop these strong links. If we don't have or maintain these links, we end up missing some folks. — State Staff*

Theme 7: Transition processes are inconsistent across the state.

Although some regions of the state have high-quality supports for transitions, there is not a systematic statewide approach to transitions. This is true for transitions within the EC mixed delivery system and across the EC-to-school systems.

The needs assessment focused on two transitions:

- Transitions from preschool to kindergarten (i.e., EC-to-school system)
- Transitions from early intervention to early childhood special education

It is important to note that transitions are not limited to these primary concerns. Throughout data collection, we heard from stakeholders about the causes that contributed to poor transitions. Participants discussed additional transitional challenges (e.g., home visiting to early intervention; home visiting to Head Start; private child care and preschool) as well as barriers to support successful transitions (e.g., lack of state funding for kindergarten transitions, data sharing, preschool and kindergarten pedagogical alignment, as well as early childhood and K–12 collaboration).

Information about kindergarten enrollment and expectations for children to be kindergarten ready varies greatly across the state and even within school districts.

Through interviews and focus groups, we asked stakeholders about their experiences with the kindergarten enrollment process. Stakeholders primarily discussed the following three weaknesses during these conversations:

- Limited and disparate information about kindergarten enrollment
- Limited information about what it means to be "ready for kindergarten"
- Additional challenges for children with disabilities and their families

Stakeholders did not identify any strengths in the system to support the transition to kindergarten.

Information and supports to families regarding kindergarten enrollment vary greatly by and within districts, often leaving parents responsible for identifying their child's options as well as procedures for kindergarten enrollment.

Through stakeholder engagement activities, we heard that kindergarten enrollment practices vary greatly by and even within districts in terms of the level of outreach. For the most part, the initial awareness of kindergarten enrollment activities falls on the parent. For families of children not enrolled in preschool or enrolled in many private preschools, there is limited or no information on how to begin the enrollment process. Many districts begin their enrollment process through a Kindergarten Round-Up, an event held to inform and prepare parents to enroll their children in kindergarten; however, these events have no universal date. As a result, parents often miss the event and remain uninformed regarding important enrollment processes. In addition, limited parent awareness about school of choice or young 5s/developmental kindergarten can further complicate the enrollment process.

> *About half of the children who [came] to kindergarten did not participate in any Kindergarten Round-Up-type activity.*
>
> *– Parent and Provider Collaborative Group Representative*

Focus group participants reported that many families do not have enough information about kindergarten enrollment, specifically those whose child did not attend preschool and those who utilize school of choice. This information barrier is particularly true for families with socioeconomic barriers such as a lack transportation and/or access to the Internet. In addition, for families who speak a language other than English, participants noted that the Kindergarten Round-Ups are often delivered only in English, and related information is rarely translated into other languages.

Transitions into kindergarten and kindergarten readiness vary greatly by child.

It is generally understood that the demands of young children at the start of kindergarten have increased over time. Although children are not required to attend preschool, kindergarten classrooms generally expect children to demonstrate basic skills in language and literacy, mathematics, social foundations, and physical well-being and motor development. Or, kindergarten readiness. Often, children are exposed

to these basic skills through a high-quality EC program, but children who have not attended such programs may be at a disadvantage. In focus groups, participants described a disconnect between needing to help children be kindergarten ready as opposed to kindergarten programs being ready to meet children at school entry.

> *They keep saying we need to have children be ready for kindergarten, but why can't the kindergarten be ready for the child? – Child Care Provider*

> *There is a lot of pressure put on children to be at a certain level academically. There is not a focus on each child and where that child is developmentally.*
> *– Child Care Provider*

Children who had not attended preschool may face the greatest challenges in the transition to kindergarten. According to mixed delivery system providers and leaders, limited access to preschool itself is a barrier to successful kindergarten transition. Although some parents may choose not to send their child to school until kindergarten, it is important to consider some of the needs discussed above regarding the availability and affordability of high-quality preschool and how these barriers may result in serious consequences for children's kindergarten transitions for families who otherwise would have liked to have enrolled their child in a preschool program.

> *Not a lot of kids attend a preschool, so there is the issue of a transition from a child not in preschool or formal education setting going to kindergarten. [We] cannot forget about those kids as we just assume every kid has some form of preschool experience. [We] have to make sure that transition is smooth.*
> *– State Staff*

> *I hear from elementary principals every year [that] there are so many kiddos showing up on the first day with no prior experience in preschool.*
> *– Parent and Provider Collaborative Group Representative*

During focus groups, families also reported that they "did not find out what was going to be expected in kindergarten until the end of the year before." This concern was echoed by other focus group respondents who conveyed that the parents are often surprised by the disconnect in expectations between preschool and kindergarten and that they often have "no clear messaging for what makes a child ready for kindergarten." Awareness of what constitutes school readiness and how it can be

supported also is a challenge for child care providers. Several providers reported that although they recognize that there is a difference between the two levels and that children need to be prepared, they questioned why kindergartens were so developmentally unaligned with skills of the children that were entering.

Finally, providers reported that some families struggle with the lack of support that is provided when their child transitions into kindergarten. For many families who experienced whole child or whole family supports from home visiting programs and later Head Start or GSRP, the transition to kindergarten is difficult because that level of engagement and individualized support is often lost at a time that can be very confusing and stressful. As representative of a parent and provider collaborative group said, "These families end up intimidated [and] afraid because there is no relationship or family support."

Special Education Transition Challenges

The kindergarten transition is even more challenging for children with a disability. According to families in our focus groups, transitioning from preschool to kindergarten special education services often takes too long, and during that time children may not receive services.

> *Making the transition from Head Start to school with special education with an individualized education program (IEP) was very slow. I should have kept the old IEP in place. In the meantime, my son got no services! – Michigan Family*

It was further conveyed that when children engage in school of choice, transitioning special education services can be particularly challenging—another equity challenge across the state.

> *Parents who use services who live in one county, but different school districts have problems. Services are inconsistent, not reliable, not what you would expect from the intermediate school district. – Michigan Family*

> *[There is] little coordination between preschool and [the] K–12 system. Some districts do this better than others, but generally child care and preschool operate in isolation from the K–12 system.*
> *– Parent and Provider Collaborative Group Representative*

Collaboration and supports between EC and the K–12 school system varies by the EC program type.

Focus group participants reported that collaboration between preschools and K–12 school systems was most likely to occur between publicly funded preschools directly connected to school districts, such as GSRP, and preschools located on the campus of schools. Participants were unaware of any structures of

collaboration occurring between private tuition-based preschools and K–12 school systems. Relatedly, it was reported that collaborative communication between early education and preschool teachers is rare, likely due to a lack of coordinated systems and time resources necessary to collaborate.

> *In Michigan's K–12 system, expectations of children do not align with what children are developmentally capable of. They are sitting long periods, have limited to no recess and play. [Learning] needs to be play focused.*
> *– Parent and Provider Collaborative Group Representative*

> *In kindergarten classrooms, too much pressure is put on children to be at a certain level academically. We do not focus on each child and where the child is developmentally. – Preschool Teacher*

Greater collaboration and communication is needed between EC providers and the school systems to support children's school readiness and positive transitions to kindergarten.

Many focus group and interview participants noted the lack of collaboration between EC and K–12 as a barrier to effective kindergarten transition. These participants reported that K–12 educators often disregard the work that is being done in EC and, as such, collaboration can be challenging. This disregard can include dismissiveness of EC records and assessment data and of B-5 initiatives broadly. Multiple focus group participants conveyed difficulties with engaging not only K–12 staff but also administration in their efforts to initiate school readiness and kindergarten transition committee work.

The transition to kindergarten is further hindered by pedagogical differences between EC and kindergarten settings. In focus groups with EC providers and leaders, participants noted a disconnect between pedagogical practices used in preschool and those used in kindergarten classrooms. For example, participants noted that preschool teachers typically use a play-based curriculum and felt that the developmental expectations commonly placed on kindergarteners were not developmentally appropriate for the average 5-year-old. During the initial phase, Michigan's PDG needs assessment focused on the experiences of the B-5 system providers. Future iterations of the needs assessment could benefit from including early elementary teachers and administrators to better understand the disconnect in the B-5 to K-12 transitions.

For children receiving Early On services, there is often a gap in services for children at the time the child turns 3 years old. This gap varies on whether a child qualifies for ECSE as well as additional programs and services, including Head Start.

One of the major transition gaps, discussed by key stakeholders, home visiting providers, families, child care providers, and representatives from family and provider collaborative groups, occurs when children needing EI and/or ECSE services turn 3 years old, or the "3-year-old" gap. Currently, EI/ECSE services are

funded by separate funding sources under IDEA Part C until a child's third birthday and IDEA Part B until a child enters kindergarten. Each of these funding streams vary in the services availability and needs that determine whether a child qualifies for services.

> *When it comes to supporting these children who are eligible for Part C and Part B – Part C is year round [and] Part B is school year only. Part C "gets it right" in how they work with families. The loss of learning in the summer is a challenge for all children, but it is even greater when you mix in developmental disabilities.*
>
> *– State Staff*

> *Our eligibility criteria for Early On is very broad. And [for] special education, many children will qualify, but there is not anything to capture [those children who do not] concretely at age 3 unless there are some small programs in the area.*
>
> *– State Staff*

Given these inconsistencies in eligibility criteria and funding streams, the 3-year-old gap can be broken into the following two transitional challenges:

- Children who age out of *Early On* but are not eligible to receive ECSE services
- Children who are eligible to receive ECSE services but do not successfully transition from one service to the next

Approximately 35% of children receiving services through *Early On* do not continue to receive services through ECSE.[2] Although many of these children may have made developmental gains through early intervention that no longer qualify them for services, approximately 23% of these children begin special education services but not until they enter the school system, indicating a potential gap in services. For 3-year-old children, the only state-funded program available is Head Start. Although 10% of space is held for children with disabilities, families must still meet the income eligibility requirements. All other families need to privately pay for any additional services or early childhood programming if they would like to continue building on gains their children made through early intervention. However, stakeholders reported that these programs can be costly for families, and, therefore, a number of children experience a gap in services until they are eligible for programing provided by their local school district.

[2] Data retrieved from https://www.mischooldata.org/EarlyChildhood2/EarlyChildhoodContinuityPathways.aspx.

The Early On 3-year-old cliff is a big [challenge]. Families drop off and lose the gains their children have made or families could really use continued support but have no options for them.

– Parent and Provider Collaborative Group Representative

About 65% of children who receive *Early On* services qualify for ECSE when they turn 3 years old. For these children, there is evidence that *Early On* providers support families with this transition to ECSE services. According to Michigan's State Performance Plan/Annual Performance Report, approximately 93% of children who participated in *Early On* and were eligible for ECSE had an IEP in place by their third birthday.

Despite these statistics, some focus group stakeholders noted some concerns about successful transitions from *Early On* to ECSE because of limited program collaborations—that organizations and agencies often operate in silos, collaborating on paper only, and when collaboration is present, it is often weak and ineffective. These stakeholders also reported that this lack of collaboration was largely due to competition for funds, either in the form of grant funding or through enrolling families and children. Key informants and professionals representing Michigan's mixed delivery system also noted some concerns about a reduction in services for children as children transitioned from *Early On* to ECSE such as a reduction in services during the summer months when school was not in session.

Theme 8: Systems-level collaboration remains a challenge.

Across the inventory of existing needs assessments and stakeholder engagement activities, we heard that there is a greater need for intentional and strategic recruitment and enrollment as well as interagency collaboration for improving service delivery across multiple programs and providers. Although not a conclusive list, our analysis will focus on collaborations between

- EC providers and kindergarten/K–12 programs (discussed under Theme 7: Transitions),
- programs and services in general,
- infant-toddler care and early intervention and/or home visiting services,
- medication providers and early intervention and/or home visiting services,
- different home visiting providers, and
- home visiting and early intervention providers.

> *Organizations operate in silos, and there needs to be more collaboration focused on the best needs of the child.*
>
> *– Parent and Provider Collaborative Group Representative*

Collaboration in General Among Local Programs and Services

In the inventory of existing needs assessments, collaborative relationships were frequently highlighted as a strength or gap, either in who is at the table or how agencies work together. Many needs assessments highlighted partnerships with local agencies in fulfilling their shared missions. The majority focused on referral connections rather than monetary benefits and described mutual efforts to improve communication and collaboration.

Some needs assessments commented specifically on the existing and potential opportunities for collaboration with local foundations and nonprofits. They mentioned the valued financial support received from these groups, and some discussed ongoing or potential referral and recruitment efforts. Religious groups, libraries, and support groups were among the most sought-after connections, mainly in hopes of reaching young mothers and marginalized groups.

Several needs assessments described how integrated services across sectors serve to ensure that families and children are receiving recommended screenings and relevant referrals. Within these references were frequent examples of how local (and functionally independent) agencies work together to best screen families for specific needs and triage them to the community partner best suited to support the family/child.

Collaboration Between Child Care and Preschools

Participants in our focus groups reported that collaboration between child care programs and preschools is limited. This lack of coordinated efforts impacts parental choice because child care providers are not informed of local preschool options and in turn are not informing parents of their options. This breakdown in collaboration is particularly present between private child care providers and publicly funded preschool

providers. It was suggested that in this instance, lack of collaboration is an issue of competition and that child care providers fail to provide parents with information on local preschools because they have their own preschool programs and want to retain the income.

A lack of collaboration further extends to the child care and preschool settings. Focus group participants reported that there is little to no coordination between private infant/toddler child care settings and preschools. This lack of coordination results in less information for parents and creates a barrier for transition into preschool programs that are the best fit for families. Some focus group participants suggested that tuition-based child care providers fail to collaborate with publicly funded preschools because they themselves have their own programs and want to retain tuition dollars. However, true collaboration requires efforts from all partners, and the onus for collaboration does not fall solely on either private tuition-based programs or publicly funded preschools.

Limited Collaboration Between Home Visiting and Other Mixed Delivery Providers Is Creating a Referral Barrier

Early intervention and home visiting providers deliver important interventions for young children at a significant juncture in their development. Unfortunately, collaborations between these providers and fellow providers in the mixed delivery system appear to be limited, creating a referral barrier. More specifically, focus group participants reported that there is a disconnect between child care providers, medical providers, and home visiting. Participants suggested that home visiting providers fail to reach out to child care providers and medical providers to connect families with specialized medical or educational services. Likewise, child care providers and medical providers often lack information about and connections to home visiting necessary to engage in effective referrals.

Collaboration Among Home Visiting Providers

Focus group participants further reported that many home visiting programs do not collaborate with each other. This lack of collaboration results in siloed and uninformed service provision as well as services duplication. Participants stated that competition for funding, in the form of both clients and grants, creates a hurdle to collaborative efforts. One home visitor stated, “Funding is a barrier to collaboration (in home visiting). Programs don't want to lose clients that they can bill for. Clients don't necessarily get into the (home visiting) program that is the best fit for them, they get whoever can get them enrolled first.”

> *Home visiting services are implemented without cohesion. Multiple agencies offer duplicate services (i.e., Catholic Charities, Maternal Infant Health Program, Early On). Some families receive no services, while others receive multiple.*
>
> *– Parent and Provider Collaborative Group Representative*

Theme 9: Data gaps limit the extent to which Michigan can document the quality of service provision in the EC mixed delivery system.

To understand the quality and availability of programs in Michigan, we first documented the extent to which Michigan can monitor and track quality within the mixed delivery system.

Across the state of Michigan, there is a general lack of data on the quality of services in the mixed delivery system. For home visiting programs, a single measure of quality does not exist to compare the quality of home visiting across program types; however, each program model sets its own quality and reporting standards for documenting quality. To date, statewide data capturing the quality of Michigan's early intervention/early childhood special education and child health services and providers is either unavailable or not easily accessible. The one exception is the statewide Quality Rating and Improvement System (QRIS), Great Start to Quality, which provides a singular measure of quality for all licensed and registered EC providers. However, the system is voluntary and only about half of the providers participate. Given the dearth of statewide quality data, it is difficult to quantify the quality of services across the mixed delivery system. However, in Michigan, each program typically monitors both program enrollment and quality indicators at a more local level. As such, challenges exist in understanding the quality of available programs statewide, but each program typically understands their own unique strengths and challenges.

As mentioned above, few indicators of quality are available to the state, but three exceptions could be used to track progress across time. In addition to program level enrollment data sources noted earlier, these additional indicators include the following:

- **Michigan's QRIS (GSQ)** provides a single measure of quality to apply across early learning settings; however, limited participation and recent changes to the rating system diminishes the usefulness of these data.
- **Quality indicators from the home visiting annual reports,** including prenatal care, preterm birth, breastfeeding, tobacco use, maternal depression, high school completion, postpartum visits, well-child visits, child maltreatment, and developmental screening referrals, but these data are not available for all home visiting programs across the state.
- **IDEA State Performance Plan and Annual Performance Reports,** including timely provision of services, services in natural environments, family involvement, and early childhood outcomes for IDEA Part C, as well as services in natural environments and child outcomes for IDEA Part B.

Michigan has an established Quality Rating and Improvement System, the Great Start to Quality, to measure the quality of early learning settings; however, limited voluntary participation of providers limits the usefulness of these data.

One strength within Michigan is the availability of data about the quality of EC programs. Michigan has made a concerted effort to expand families' awareness of and access to information about EC quality. Michigan's Great Start to Quality (GSQ) Quality Rating and Improvement System (QRIS) establishes a baseline measure of quality to uniformly assess the level of quality across the state's EC programs. Of all the mixed delivery components, EC is the only component with a uniform measure of quality. The ratings apply similarly, but are appropriately adjusted measures of quality for both center-based and home-based EC providers. The goal the QRIS is to rate, improve, and communicate the quality of EC programs available in Michigan. As of February 2020, 4,013 licensed and registered programs participated in the state's QRIS. Of those, 1,654 (41%) were rated as "high-quality", earning a 4- or 5-star rating. Nearly all of the high-quality programs were center-based child care settings (93%; see Exhibit 10).

Exhibit 10. Program Quality by Star Rating and Program Type, According to Michigan's Quality Rating and Improvement System, February 2020.

Program Type	1 Star	2 Star	3 Star	4 Star	5 Star
Child Care & Preschool Centers	1	43	763	1,298	231
Group Child Care Homes	28	134	540	33	38
Family Child Care Homes	49	194	607	30	24
Total Programs	**78**	**371**	**1,910**	**1,361**	**293**

Source: https://www.greatstarttoquality.org/great-start-quality-participation-data

One weakness of the GSQ is participation is voluntary and fewer than half of all licensed EC programs elect to participate in GSQ. Low participation rates limit the usefulness of these data—parents need to rely on other sources of information, such as word of mouth or program visits, to compare all options within the community, and not enough programs participate to incentivize further participation as intended. We cannot determine the quality of a programs that do not participate in GSQ. For example, programs may

opt out of the ratings because they are one of the highest quality providers within a community, be well known in the community, and therefore have no challenges recruiting families. Alternately, programs may opt out of the QRIS because they are one of the lowest quality providers within a community and worry that a low star rating could hinder their recruitment efforts. Additional exploration is needed to understand the extent to which all licensed EC programs across the state are high quality and how one program's quality compares with another.

The state is also moving forward with revisions to GSQ, with plans to roll out a revised rating system this year. Based on findings from the RTT-ELC funded validation study of Great Start to Quality, conducted by HighScope and AIR, the state is considering new classroom observational tools and changes to the self-assessments used to rate EC quality (Iruka et al., 2018). Michigan is currently convening an advisory group and stakeholder groups to inform revisions to the QRIS.

A lack of transparency about program quality as well as how to access specialized services further limits parental choice.

Because there is a lack of statewide data about the quality of EC services, parents are often forced to make decisions without good information. Parent awareness of program quality as well as how to access services may further limit family choice. Families reported that they are unaware of where to get information about the quality of early childhood programs. Families often relied on word of mouth, recommendations from family and friends, or even Google to find high-quality, affordable services. Families reported that unless they had some sort of direct contact with someone using the program or were themselves in adjacent services it was difficult for them to find programs that met their family's needs. Families need, but do not have, a singular "one stop resource" for learning about available programs, the quality of service provision, the length of waitlists, and how to enroll in services.

> *If you don't know someone that is in a program, you usually don't know about the services. If programs are available, you may not be able to know about the services because you are not utilizing similar services. — Michigan Family*

> *For programs that do exist, some parents are overwhelmed and don't know where to turn as there is not a single clear resource that they can turn to. A one stop resource that says what is available and what they could be thinking about in communities just isn't available. — State Staff*

For home visiting programs, a single measure of quality does not exist to compare the quality of home visiting across program types; however, each program model sets its own quality and reporting standards for documenting quality.

Within the home visiting components of Michigan's mixed delivery system, there is not a consistent measure of quality to apply across models such as we have within the EC component. The lack of statewide data is intentional in the home visiting field. For example, home visiting models are designed to serve specific target populations and one consistent measure of quality might not adequately capture the unique features of focus of each HV model. Instead, in each of these evidence-based HV models monitor their own fidelity and use unique quality indicators. As an example, as part of Michigan's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative, the Michigan Home Visiting Quality Assurance System (MHVQAS) was developed to monitor the implementation quality of home visiting services across various MIECHV-funded models. Efforts are now underway to use this tool more broadly to assess the quality of non-MIECHV funded home visiting models.

Other measurable indicators exist that can be used to track progress in achieving the goals of the strategic plan.

Although statewide measures of individual program and service quality do not exist for the home visiting, EI/ECSE, and health components of the mixed delivery system, the following data sources and variables could be used to help track program- and child-level outcomes over time. They include multiple quality indicators included in the Home Visiting Annual Reports that describe prenatal care, preterm birth, breastfeeding, tobacco use, maternal depression, high school completion, postpartum visits, well-child visits, child maltreatment, and developmental screening referrals. In addition, the IDEA State Performance Plan and Annual Performance Reports provide a summary of the timely provision of services, services in natural environments, family involvement, and early childhood outcomes for IDEA Part C as well as services in natural environments and child outcomes for IDEA Part B.

Theme 10: Challenges with existing data limits Michigan's ability to understand the number of children served and awaiting services.

Across the goals of Michigan's PDG B-5 grant, there is an underlying assumption that MDE can document, monitor, and track children and their families over time as they interact with Michigan's mixed delivery system. These pieces of data are critical for defining service and program provision, understanding how many children and families are served and awaiting services, and benchmarking the impact of the PDG activities on service provision and child outcomes over time. Through the quantitative needs assessment activities, we identified strengths in Michigan's existing data systems as well as areas of need for improving the state's capacity to document, monitor, and track children within the mixed delivery system. Overall, these findings can be broken down into the following themes:

- Michigan's greatest strengths for producing an unduplicated count is the existing MI School Data portal, which provides a foundation to produce an unduplicated count of program and service provision within the mixed delivery system. However, more work is needed to address existing data gaps within the portal.
- No systematic data are available that describe the number of children awaiting services in existing programs. Some administrators at the local program level report long waitlists.
- Work is currently under way to expand the capacity of the MI School Data portal to address critical data gaps in understanding program and service delivery and gaps. This work will further support Michigan's ability to track progress in achieving the goals of this grant.

Michigan's greatest strength for producing an unduplicated count is the MI School Data portal. However, more work is needed to address existing data gaps within the portal.

Michigan's MI School Data portal provides a foundation to produce an unduplicated count of program and service provision within the mixed delivery system. As part of Michigan's Race to the Top Early Learning Challenge Grant, the Center for Educational Performance and Information (CEPI) developed a statewide longitudinal data system (SLDS) to collect, store, and report the most up-to-date estimate of the unduplicated count of students across the birth through high school education life span. For the early childhood mixed delivery system, this SLDS includes data sets documenting the number of children enrolled in

- child care subsidy;
- ECSE/*Early On;*
- GSRP, Head Start, and GSRP/Head Start Blend; and
- home visiting.

Each of these records can be disaggregated by ISD or school district as well as by delivery schedule (part-time, full-time), economically disadvantaged, gender, homelessness, and race/ethnicity. Based on the work of CEPI and the MI School Data portal, as of 2017–18, the unduplicated count of children served in one or more of these programs is 128,973.

One of the biggest data gaps in Michigan's MI School Data portal is that no data are available on children not interacting with public programs. Most notably, no information is available on children participating in private child care and/or preschool as well as on children not participating in EC programming prior to kindergarten entry. Approximately half of the children ages 0 to 5 (47%) are currently accounted for in the state's unduplicated count at some time point before kindergarten entry. No data are available for the remaining 53% of children in Michigan ages 0 to 5 prior to kindergarten entry.

No systematic data are available that describe the number of children awaiting services in existing programs. Some administrators at the local program level report long waitlists for children awaiting services.

Without systematic data collection about the number of children awaiting services, it is difficult to know whether programs are reaching the state's most vulnerable families. This creates a lack of information on equity across the mixed delivery system. Enrollment data suggest that statewide programs like GSRP and Head Start serve roughly 60,000 children and families in Michigan. These data may suggest that the program adequately meets family needs. However, it is unclear if the services and programs are available in each community, if there is adequate workforce to support children's specialized needs (e.g., occupational therapy), or if there is enough funding to provide comprehensive services.

To better understand the extent to which programs are reaching all children who need services, we asked providers on the equity assessment survey whether their program had a waitlist and, if so, the number of children on the waitlist. Of the 28 program respondents, 22 indicated that their program had a waitlist ranging from zero to 842 children. Programs with the largest waitlists included the following, all within the EC component:

- Tri-County Head Start (Berrien, Cass, Van Buren Counties), 842 children
- Macomb County Intermediate School District (GSRP), 629 children
- Kalamazoo County Regional Educational Service Agency (GSRP, Head Start), 414 children
- Muskegon Area Intermediate School District (GSRP, Head Start, Early Head Start), 221 children

In addition to the equity assessment survey, in focus groups families and providers reported that waitlists are a common barrier for families seeking child care and/or preschools for their young children, regardless of income.

> *Child care has decreased by providers: family child care homes, group, and child care centers. This [has] reduced accessible child care for infants and toddlers in our county. Most providers have waitlists. A client informed me that they drive 40 minutes out of the area for child care. —Home Visiting Provider*

From a data perspective, it is important to note that there is currently no systematic process for documenting waitlist status or for coordinating waitlists across program types within a community. Likewise, from a data perspective there is not a clear understanding at the state and local levels the extent to which the supply of EC programs, including public and private programs, are meeting the demand.

Work is currently under way to expand the capacity of the MI School Data portal to address critical data gaps to better account for program and service delivery and gaps. This work will further support Michigan's ability to track progress in achieving the goals of this grant.

As part of the Michigan PDG renewal grant work, MDE is working with representatives from CEPI, MDHHS, and contractors from the PDG needs assessment, strategic planning, and evaluation teams to expand the existing MI School Data portal to address the needs of the Michigan PDG renewal activities. The goals of this partnership are to

- expand data sharing between MDE and MDHHS,
- establish data-sharing agreements with additional partners, and
- build upon the existing MI School Data portal to better understand the "whole-child" early childhood experiences of all children.

MDE is also rolling out a statewide Michigan Kindergarten Entry Observation (MKEO) to identify kindergarten-aged children's strengths and challenges and to inform classroom instruction. The MKEO data will be available for the 2020–21 school year. During the pilot years, there has been local discretion by classroom whether a sampling method of no less than 35% of children is done or 100% census is conducted and submitted. A consistent sampling method is being developed for 2020–21 with the goal to tie the results to GSRP evaluation.

Conclusions

At the completion of the initial PDG funding period, Michigan successfully documented the most pressing needs across the EC mixed delivery system. Using funds from the PDG and HHS-OCC, Michigan contracted with AIR and its partners, ECIC, HighScope, MPHI, and MLPP to complete the statewide needs assessment. AIR and its partners used a mixed-methods approach and incorporated feedback from a diverse set of stakeholders statewide to inform the needs assessment, including the following:

- Fifty-one needs assessments conducted in the last 5 years focused on all aspects of the B-5 mixed delivery system
- Ten focus groups with 118 participants ranging from Michigan families, early child care and learning providers and administrators, home visiting staff, foundation representatives, and social and emotional health care providers
- Six key informant interviews with state-level staff, agency leaders, and subject matter experts who hold unique positions in the EC system
- Five key informant interviews with innovative programs identified by MDE
- One town hall with representatives from GSC and GSPC
- Fifty different extant data files that capture enrollment patterns and the quality of services provided across the state in the mixed delivery system

Combining data from all these sources, the Michigan PDG needs assessment provides a review of the state's mixed delivery system, with a special focus on services for infants and toddlers, transitions among and between the B-5 and K–12 systems, and barriers to parental choice.

Michigan's mixed delivery system has many strengths. It is a complex system of programs, services, and supports promoting the health, development, and well-being of B-5 children and their families. The system includes EC programs, early intervention and ECSE, home visiting, health programs and providers, and family supports. It

- includes more than 8,000 EC programs serving 330,000 children from birth to age 6 across Michigan; programs, such as Head Start and GSRP, reach approximately 38,000 children across the state (50% of income-eligible children);
- serves approximately 10,000 children birth to age 3, and 22,000 children ages 3–5 receive EI/ECSE services before they enter kindergarten;
- provides more than 23,000 children with home visiting; and
- supports the public health needs of more than 270,000 children through Women, Infant, and Children as well as more than 340,000 through Medicaid, including MIChild.

The EC mixed delivery system also includes other family supports. Because the administration of these programs typically occurs at the local and regional levels, we do not have a good estimate of the number of children and families served.

The above numbers do not represent an unduplicated count of children and families served across the state, with large gaps between the number of children and families served and those eligible or waiting for services. Although Michigan's MI School Data portal provides users with the best as possible unduplicated count of children served within the state's mixed delivery system, more work is needed to move Michigan toward a comprehensive and unduplicated count of children and families served. According to analyses linking census data with program enrollment data, the needs assessment revealed the following:

- In general, the number of EC slots across the state is insufficient.
- Infant and toddler EC slots are even more scarce for families.
- These two challenges are exacerbated in rural communities and for low-income families.
- Home visiting programs do not have enough slots to serve all families who are eligible and interested in participating.
- Specialized care, including health care, pediatricians/specialists, dental health, and mental health care, is limited across the state, especially in rural communities.

However, some aspects of the mixed delivery system are doing a better job than others in meeting demand. For example, with the rapid expansion of GSRPs—the publicly funded prekindergarten program in Michigan—the state can now serve roughly half of all 4-year-olds who are income eligible for the program. However, the system as a whole is still underserving families in Michigan.

Further, affordability remains a challenge across the state. One of the most critical needs related to the availability of high-quality EC programs is the administration of affordable programs for families—the most pressing need for nearly all families across Michigan, regardless of income. Families and providers alike report that EC programs simply cost too much, and state subsidies are too low to address this need. Infant and toddler care and costs in the Southeast region of the state and Wayne-Oakland-Macomb are highest. Although child care subsidies can alleviate the high costs of child care for low-income families, the subsidy does not fully cover the costs of care for most families and programs. It is important to note that affordability is not simply a "low-income" problem. Focus group participants noted that the inability to afford child care extends beyond families whom the state defines as low income. The high cost of child care has repercussions beyond the mixed delivery system. Some families who are ineligible for the subsidy must make career and employment choices based on their inability to afford child care and, in some cases, even exit the workforce. The combined challenges in availability and affordability limit family choice in the mixed delivery system.

The needs assessment also revealed challenges for specific subgroups of children in families across the state. The needs assessment documented additional gaps in program quality and availability within rural communities. Service equity challenges also extend to children with disabilities. Racial and ethnic disparities exist in Michigan's mixed delivery system, and stakeholders repeatedly mentioned a lack of meaningful and actionable engagement between service providers and culturally and linguistically diverse communities.

The needs assessment examined transitions both within and between the B-5 and K–12 systems. Although some regions in Michigan have high-quality supports for transitions, there is no systematic statewide approach to transitions, which is true for transitions within the B-5 mixed delivery system and across K–12 school systems.

- Information about kindergarten enrollment and expectations for children to be kindergarten ready vary greatly across the state and even within school districts. This lack of information and supports oftentimes leaves parents responsible for identifying their child's options as well as the procedures for kindergarten enrollment. Kindergarten transition is even more challenging for children with a disability. Families engage in schools of choice, and the process of transitioning special education services can be particularly challenging. Michigan needs greater collaboration and communication between EC providers and school systems to support children's school readiness and positive transitions to kindergarten.
- Another key transition gap noted throughout the needs assessment is the 3-year-old gap. For children receiving *Early On* services, a gap in services often exists for children at the time the child turns 3 years old. This gap varies on whether a child qualifies for ECSE as well as additional programs and services, including Head Start.

The needs assessment revealed gaps in system-level collaboration. A great need exists for intentional and strategic recruitment and enrollment as well as interagency collaboration for improving service delivery across multiple programs and providers. Finally, the needs assessment noted gaps in the availability and quality of existing data. These data gaps limit Michigan's capacity and knowledge to understand the number of children served and awaiting services across the state.

Next Steps

The purpose of these findings is to understand the current landscape of Michigan's early learning and care mixed delivery system to inform a strategic plan to maximize the availability of high-quality services to B-5 children and their families. In the coming months, Michigan will use these findings to develop a strategic plan that outlines the key priorities, action steps, and measures of progress aligned with the findings from the needs assessment. This strategic plan will become the foundation for Michigan's PDG renewal grant activities.

In addition to the strategic plan, during the PDG renewal grant, the needs assessment team will build on these findings to examine additional components of Michigan's mixed delivery system not covered within the first iteration of this needs assessment (e.g., transportation, housing, community needs), identify and engage hard-to-reach families not yet represented in the findings, and support the expansion of the MI School Data portal to address existing data gaps.

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Appendix A. Crosswalk of Michigan's Needs Assessment Findings to the PDG B-5 Needs Assessment Requirements

To help the reader map the content of Michigan's Needs Assessment with the federal guidance provided by the U.S. Department of Health and Human Services, Office of Child Care (HHS-OCC), we prepared a crosswalk with page numbers for each question answered in the needs assessment.

Exhibit A.1 Crosswalk of Michigan's Needs Assessment Findings to the Key Domains and Questions of the PDG B-5 Federal Guidelines

Domain	Questions	Page No.
Definition of Terms	What is your definition of quality early childhood care and education (ECCE) for this grant?	4
	What is your definition of ECCE availability for this grant?	4
	What is your definition of vulnerable or underserved children for this grant?	4
	What is your definition of children in rural areas for this grant?	4
	Do you have a definition or description of your ECCE system as a whole? (If yes, what have you used that definition for? What about your broader early childhood system encompassing other services used by families with young children? Do you have a definition for that and, if so, what have you used it for?)	5
	Do these definitions differ in key ways from how you have defined any of these in the past? If so, what do you think are the advantages of your definitions for this grant?	4
	Are there any challenges you foresee in using these definitions (e.g., are they consistent with how key programs that make up the broader early childhood system define these terms)?	4
Focal Populations	Who are the vulnerable or underserved children in your state? What are their characteristics in terms of race/ethnicity, recency of immigration, language spoken at home, poverty and low-income status, and concentration in certain cities or town and/or neighborhoods? What are the strengths and weaknesses of the data you have available on this population? Are there any initiatives under way to improve these data?	8–10

Domain	Questions	Page No.
Focal Populations (continued)	Who are the children who live in rural areas in your state/territory? What are their characteristics in terms of race/ethnicity, recency of immigration, language spoken at home, and poverty and low-income status? Are they concentrated in certain regions of the state/territory? Are data available on how far they typically live from an urban area? What are the strengths and weaknesses of the data you have available on this population? Are there any initiatives under way to improve these data?	8–10
Number of Children Being Served and Awaiting Service	What data do you have describing the unduplicated number of children being served in existing programs? What are your biggest data gaps or challenges in this area?	12; 51
	What data do you have describing the unduplicated number of children awaiting service in existing programs? What are your biggest data gaps or challenges in this area?	52
	What are the strengths and weaknesses of the data you have available on children being served? Are there any initiatives under way to improve these data?	50–53
Quality and Availability	What would you describe as your ECCE current strengths in terms of quality of care across settings (e.g., accessing accurate data from rural areas, central points of data entry [+ or -], population mobility)?	48–49
	What would you describe as key gaps in quality of care across settings?	49–50
	What are the strengths and weaknesses of the data you have available on quality? Are there any initiatives under way to improve these data?	47–50
	What would you describe as key gaps in availability?	13–35
Gaps in Data or Research to Support Collaboration Between Programs/ Services and Maximize Parental Choice	What do you know about the service use of families with children (both children and family members) in the ECCE system?	10–11
	What are the most important gaps in data or research about the programs and supports available to families and children? What challenges do these gaps present? What existing initiatives are being undertaken in your state/territory to address these gaps?	49–50
Quality and Availability of Programs and Supports	What programs or supports do you have in place to make sure that children of parents who are employed, looking for work, or in training are able to access child care that is compatible with their employment or training situation? What works well about these programs or supports? What could work better? What else do you need to know about these programs and the populations they serve?	25–26

Domain	Questions	Page No.
Measurable Indicators of Progress That Align with the State's Vision and Desired Outcomes for the Project	What measurable indicators currently exist that can be used to track progress in achieving the goals of this grant and your strategic plan? What are the strengths and weaknesses of these indicators? Include the extent to which they can be used to describe the current conditions experienced by vulnerable, underserved and rural populations.	50
	What opportunities are currently under way involving developing additional measurable indicators to track progress in achieving the goals of this grant and your strategic plan?	53
Issues Involving ECCE Facilities	What issues have been identified involving ECCE facilities?	35–36
	What are the strengths and weaknesses of the data you have available on ECCE facilities? Are there any initiatives under way to improve the data?	48–49
Barriers to the Funding and Provision of High-Quality Early Childhood Care and Education Services and Supports and Opportunities for More Efficient Use of Resources	What barriers currently exist to the funding and provision of high-quality ECCE supports? Are there characteristics of the current governance or financing of the system that present barriers to funding and provision of high-quality ECCE services and supports? Are there policies that operate as barriers? Are there regulatory barriers that could be eliminated without compromising quality? For this question, you should be sure to include a discussion of supports in the broader early childhood system, not just the ECCE system.	35–38
Transition Supports and Gaps	What are the strengths and weaknesses of the transition supports for children moving from the ECCE system to school entry?	39–42
	How are parents currently provided with information about transitions? Is the information provided in a culturally and linguistically sensitive manner? What is effective about the information provided? What could be improved?	39–42
	How do the supports differ based on the type of ECCE provider (e.g., Head Start, state/territory prekindergarten, home care provider, private or religious-based provider)?	42
	How effective is the communication between ECCE providers and school systems? What could be done to improve that communication?	42–43
System Integration and Interagency Collaboration	What policies and practices are in place that either support or hinder interagency collaboration?	44–47

Appendix B. Needs Assessment Methods Supplemental Tables

Appendix B includes additional detail about the methods used for Michigan's Need Assessment. It includes

- a description of the prior needs assessments reviewed as part of the needs assessment inventory;
- a description of the stakeholder engagement plan, including a list of the interview and focus group participants by geographic area;
- a description of the approach to assessing equity within the mixed delivery system;
- a list of the extant data available for quantitative analyses by program; and
- a description of the collaborative data.

Inventory of Existing Needs Assessments

The MPHI team collected and analyzed 51 needs assessment documents focused on all aspects of the B-5 mixed delivery system, see Exhibit B.1. To guide this work, the team developed a qualitative coding structure to analyze the needs assessments documents. This coding structure reviewed needs assessment quality, geographic reach, elements of the mixed delivery system, parent or family identified needs, and system needs across each of the existing needs assessments (Appendix B, Exhibit B.2). Once the needs assessments were coded, the team conducted a thematic analysis using NVivo 12 to identify key themes across the mixed delivery system. Of the 51 needs assessments documents included in the analysis:

- Thirty-six documents assessed needs for home visiting, describing home visiting generally or mentioning one or more of the multiple models implemented in Michigan, including the Maternal Infant Health Program, Parents as Teachers, Healthy Families America, the Nurse-Family Partnership, Early Head Start-Home Based, and Infant Mental Health. Some also described home visiting Local Leadership Groups.
- Thirty-four documents assessed needs for Head Start/Early Head Start, typically making a clear distinction between these two programs but not always clearly distinguishing Early Head Start and Early Head Start-Home Based.
- Fifteen documents assessed needs for services related to child development and care, describing needs across the state for affordable quality child care options and other supports for child development such as parent groups and library programs.
- Twenty-four documents assessed needs for early intervention, describing needs related to special education, Early On, or Children's Special Health Care Services.
- Five documents assessed needs for preschool, describing needs related to the Great Start Readiness Program (GSRP) specifically or preschool more generally.

Most needs assessments also described needs related to many other services important to families with young children. The types of service providers included most frequently were community-based organizations, human services providers, independent school districts (ISDs) and individual school

districts, medical services and providers, mental or behavioral health service providers, parent or family programs and services, and public health programs or services.

Exhibit B.1 Needs Assessment Inventory Methods

Needs Assessment	Geographic Coverage	Year Completed	Elements of Mixed Delivery System Included
Capitol Area Community Services Community Assessment	Counties: Clinton, Eaton, Ingham, and Shiawassee	2019	Child development and care, early intervention and special education, Head Start/Early Head Start, home visiting, other
Kent County Head Start Community Needs Assessment	County: Kent	2015	Early intervention and special education, Head Start/Early Head Start, home visiting
Infant/Toddler Care Crisis in Northwest Michigan	Region: Northwest Michigan	2017	Child development and care
Sanilac County Home Visiting Exploration and Planning Tool	County: Sanilac	2016	Child development and care, early intervention and special education, Head Start/Early Head Start, home visiting, other
St. Clair County Home Visiting Exploration and Planning Tool	County: St. Clair	2016	Child development and care, Head Start/Early Head Start, preschool, other
Van Buren County Home Visiting Exploration and Planning Tool	County: Van Buren	2016	Early intervention and special education, Head Start/Early Head Start, home visiting, preschool
Washtenaw County Home Visiting Exploration and Planning Tool	County: Washtenaw	2016	Early intervention and special education, Head Start/Early Head Start, home visiting, other
Wexford-Missaukee-Manistee Great Start Collaborative Home Visiting Exploration and Planning Tool	Counties: Wexford, Missaukee, and Manistee	2016	home visiting, other
Northeast Michigan Community Service Agency Head Start/Early Head Start 2019	Region: Northeast Michigan	2019	Child development and care, early intervention and special education, Head Start/Early Head Start, other
St. Joseph County Intermediate School District Community Needs Assessment	County: St. Joseph	2019	Head Start/Early Head Start, other

Needs Assessment	Geographic Coverage	Year Completed	Elements of Mixed Delivery System Included
Sault Tribe Head Start/Early Head Start 2018-2019 Community Assessment	Region: Sault Ste. Marie Tribe of Chippewa Indians	2019	Head Start/Early Head Start, other
Mid Michigan Community Action Community Needs Assessment	Counties: Bay, Clare, Gladwin, Mecosta, Midland, and Osceola	2018	Child development and care, early intervention and special education, Head Start/Early Head Start, home visiting, preschool, other
Allegan County Community Commons Community Needs Assessment 2018	County: Allegan	2018	Head Start/Early Head Start
Baraga-Houghton-Keweenaw Child Development Board Community Assessment	Counties: Baraga, Houghton, and Keweenaw	2018	Child development and dare, early intervention and special education, Head Start/Early Head Start, home visiting, preschool, other
Human Development Commission Community Assessment	Counties: Huron, Lapeer, Sanilac, and Tuscola	2017	Head Start/Early Head Start, other
Young Children Mental Health Service Scan—Great Start Collaborative 2017	County: Kent	2017	Child development and care, early intervention and special education, home visiting, other
Building a Better Child Care System	State: Michigan	2016	Child development and care, other
Michigan Child Care Market Rate Study	State: Michigan	2018	Child development and care, Head Start/Early Head Start, other
IFF Early Childhood Education—Detroit	Subcounty: Detroit	2015	Child development and care, Head Start/Early Head Start
IFF Early Childhood Education—Grand Rapids	Subcounty: Grand Rapids	2018	Child development and care, Head Start/Early Head Start, home visiting
Community Based Child Abuse Prevention Grants	State: Michigan	2019	Head Start/Early Head Start, home visiting, other
Community Action Alger Marquette Community Needs Assessment-Head Start Program	Counties: Alger and Marquette	2018	Head Start/Early Head Start, home visiting, other
Kent EHSCNA	County: Kent	2018	Head Start/Early Head Start

Needs Assessment	Geographic Coverage	Year Completed	Elements of Mixed Delivery System Included
IFF Tri County Report	Counties: Macomb, Oakland, and Wayne	2015	Head Start/Early Head Start, preschool
Making Child Care a Regional Priority	Counties: Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, and Wexford	2018	Child development and care, other
Eaton County Home Visiting Exploration and Planning Tool	County: Eaton	2016	Early intervention and special education, home visiting, other
Cheboygan-Otsego-Presque Isle Educational Service District Home Visiting Exploration and Planning Tool	Counties: Cheboygan, Otsego, and Presque Isle	2016	Early intervention and special education, home visiting, other
Clare County Home Visiting Exploration and Planning Tool	Counties: Clare and Gladwin	2016	Early intervention and special education, Head Start/Early Head Start, home visiting, other
Branch County Home Visiting Exploration and Planning Tool	County: Branch	2016	Early intervention and special education, Head Start/Early Head Start, home visiting, other
Traverse Bay Area Intermediate School District Home Visiting Exploration and Planning Tool	Counties: Benzie, Grand Traverse, Kalkaska, Antrim, and Leelanau	2016	Early intervention and special education, Head Start/Early Head Start, home visiting, other
Barry County Home Visiting Exploration and Planning Tool	County: Barry	2016	Early intervention and special education, home visiting, other
Monroe County Home Visiting Exploration and Planning Tool	County: Monroe	2016	Home visiting
MLO Home Visiting Exploration and Planning Tool	Counties: Mason, Lake, and Oceana	2016	Home visiting

Needs Assessment	Geographic Coverage	Year Completed	Elements of Mixed Delivery System Included
Shiawassee County Home Visiting Exploration and Planning Tool	County: Shiawassee	2016	Early intervention and special education, Head Start/Early Head Start, home visiting, other
AMA Home Visiting Exploration and Planning Tool	Counties: Alpena, Alcona, and Montmorency	2016	Early intervention and special education, home visiting
Genesee County Home Visiting Exploration and Planning Tool	County: Genesee	2016	Early intervention and special education, home visiting
Kalamazoo Home Visiting Exploration and Planning Tool	County: Kalamazoo	2016	Early intervention and special education, home visiting
Marquette-Alger Home Visiting Exploration and Planning Tool	Counties: Marquette and Alger	2016	Early intervention and special education, Head Start/Early Head Start, home visiting
Montcalm Home Visiting Exploration and Planning Tool	County: Montcalm	2016	Early intervention and special education, Head Start/Early Head Start, home visiting
Newaygo County Home Visiting Exploration and Planning Tool	County: Newaygo	2016	Early intervention and special education, Head Start/Early Head Start, home visiting, other
Kent County Home Visiting Exploration and Planning Tool	County: Kent	2016	Head Start/Early Head Start, home visiting
Oakland Home Visiting Exploration and Planning Tool	County: Oakland	2016	Early intervention and special education, Head Start/Early Head Start, home visiting, other
Calhoun County Home Visiting Exploration and Planning Tool	County: Calhoun	2016	Home visiting, other
Delta Schoolcraft Home Visiting Exploration and Planning Tool	Counties: Delta and Schoolcraft	2016	Child development and care, early intervention and special education, Head Start/Early Head Start, home visiting, other
Eastern Upper Peninsula Home Visiting Exploration and Planning Tool	Region: Eastern Upper Peninsula	2016	Head Start/Early Head Start, home visiting, other
Saginaw County Home Visiting Exploration and Planning Tool	County: Saginaw	2016	Child development and care, home visiting, other
Bay County Exploration and Planning Tool	County: Bay	2016	Head Start/Early Head Start, preschool, other

Needs Assessment	Geographic Coverage	Year Completed	Elements of Mixed Delivery System Included
Exploration and Planning Final Muskegon	County: Muskegon	2016	Head Start/Early Head Start, home visiting, other
Ingham Great Start Collaborative Exploration and Planning Tool	County: Ingham	2016	Head Start/Early Head Start, home visiting
Livingston County Home Visiting Exploration and Planning Tool	County: Livingston	2016	Home visiting, other
Ottawa County Home Visiting Exploration and Planning Tool	County: Ottawa	2016	Home visiting, other

The needs assessment inventory used the following coding structure, presented in Exhibit B.2.

Exhibit B.2. Coding Structure for Needs Assessment Inventory

Elements of the Mixed Delivery System
Child development and care
Early intervention and special education
Head Start/Early Head Start
Home visiting
Preschool
Other
Community-based organizations
Human service providers
ISD/district providers and personnel
Medical providers and services
Mental and behavioral health programs and services
Parent/family programs and services
Public health programs and services
Services for teens
Tribal organizations
Geographic Reach
Subcounty
County
Region
Statewide

Needs Assessment Quality
Stakeholder inclusion
Focus on equity
Use of data
Use of community input
Direct involvement of families
Use of findings to identify needs and set priorities
Family Needs
Accessibility:
Affordability
Availability
Geographic accessibility
Rural
Nonrural
Accommodation
Acceptability
Choice
Engagement and connection
Experiences of racism and other forms of bias and othering
Needs related to ages birth to 3 years
Needs related to child health
Needs related to development and developmental delay
Needs related to early learning and school readiness
Needs related to mental health and trauma
Needs related to parenting and family support
Quality
Other
System Needs
Collaboration/leadership/power
Eligibility criteria and overlaps or gaps between funding requirements
Facilities and infrastructure
Funding support
Pay
Capacity to meet demand
Inequities in access to high-quality services
Ability or disability
Child age
Geography

- Immigration status or nativity
- Income
- Language
- Race/ethnicity/culture
- Religious background
- Other

Inequities in system capacity to deliver high-quality services

No wrong door

- Home visiting
- Early intervention and special education
- High-quality early learning
- Integrated systems and community hubs

Quality assurance/improvement

- Adaptation to meet the needs of a diverse population
- Data and information systems
- Quality assurance
  - Defined fidelity for the program/model, fidelity monitoring, and accountability
  - Mental health consultation and coaching
  - Regular fiscal and programmatic monitoring by the funder
- Reflective supervision
- Standards
- Supports for continuous improvement
- Training and technical assistance
- Workforce pipeline and career ladder

Recruitment and enrollment

Support from foundations and nonprofits

Support from regional/community agencies

Support from state agencies

Transitions

- Early intervention to special education
- Home to early childhood education, infant and toddler early childhood education to preschool, preschool to kindergarten
- Other

Universal developmental and behavioral screenings

Universal screening and referral

- Connecting with health care providers
- Integrated services across sectors
- Meeting basic needs

Stakeholder Engagement: Focus Groups, Interviews, and a Town Hall

Using purposive sampling and guidance from MDE-OGS, ECIC selected a diverse group of stakeholders representative of Michigan's mixed delivery system for 10 focus groups, six key informant interviews, and one town hall during the Great Start Collaborative (GSC)/Great Start Parent Coalition (GSPC) annual leadership meeting (see Exhibit B.3). Five of the key informant interviews were conducted over the phone and one was held in person. These interviews included state-level staff, agency leaders, and subject matter experts who hold unique positions in the early childhood system. The structure and content of these interviews were tailored to the roles of these individuals in the mixed delivery system and focused on assessing their high-level understanding of the strengths, weaknesses, opportunities, threats, and gaps of Michigan's mixed delivery system for the five main buckets of focus: Accessibility, Transition, Equity, Innovation, and Parent Choice. Interviews were audio recorded and transcribed. The data from these initial interviews informed the development of the focus group and town hall protocols.

Focus group and town hall data were collected via in-person note taking (eight), text collection using GoToWebinar software (three), and audio recording (10). Focus group notes and transcribed interview data were analyzed using the qualitative coding software NVivo 12. Analysis employed a nested hierarchical coding strategy. Initially, as they were collected, data were organized broadly with a set of a priori codes based on the strengths, weaknesses, opportunities, and threats analysis framework and containing subcodes based on the project's five buckets of focus. As data collection and coding continued, secondary and tertiary codes and categories were developed, and salient themes emerged within each of the subject matter buckets. Once data collection and initial coding were completed, ongoing analysis revealed prominent common themes across subject matter buckets, participant groups, and geographical areas.

Exhibit B.3. Stakeholder Engagement Interview and Focus Group Participants and Geographic Area

Collection Type	Participant Group/Professional Position	Location/Department or Agency
Focus Group	Families	South West Michigan (Kalamazoo Metro Area)
Focus Group	Families (fathers)	South East Michigan| (Detroit Metro Area)
Focus Group	Families	Eastern Upper Peninsula Michigan
Focus Group	Families	Mid Western Michigan (Grand Rapids Metro Area)
Focus Group	Early Child Care and Education Providers	South East Michigan (Detroit Metro Area)
Focus Group	Early Child Care and Education Providers	Western Upper Lower Peninsula Michigan (Ludington Area)
Focus Groups	Foundations and Funding Entities	Cross State Representation
Virtual Focus Groups	Home Visiting Providers	Cross State Representation
Virtual Focus Group	Social and Emotional Health Providers	Cross State Representation
Virtual Focus Group	Early Childhood Program Managers and Administrators	Cross State Representation

Collection Type	Participant Group/Professional Position	Location/Department or Agency
Town Hall	Great State Collaborative and Great Start to Readiness Providers	Cross State Representation
Key Informant Interview	Two State-Level Directors	Michigan Department of Education
Key Informant Interview	State-Level Staff	Michigan Department of Education
Key Informant Interview	Two State-Level Managers	Michigan Department of Health and Human Services
Key Informant Interview	State-Level Staff and Agency Director	Michigan Department Office of Great Start and a Regional Education Service Agency
Key Informant Interview	State-Level Staff	Executive Branch
Key Informant Interview	Subject Matter Expert	A Michigan University

One of the primary limitations in our methodological approach to this needs assessment was the sampling approach for the focus groups, which was limited by the amount of time we had to commit to data collection. Although the purposive sample done engaged stakeholders from large portions of the middle to lower west and east sides of the state, the sample is relatively weak in its representation of rural populations, specifically those found in the Upper Peninsula and the upper section of the Lower Peninsula. Moreover, we recognize that because of the sample size, recruitment area, and recruitment style, the information collected from the focus groups may not be fully generalizable to all regions or populations within Michigan. Participants in our focus groups were purposively selected and invited as a representation of a specific population, but, ultimately, it is likely that they self-selected into the process because they had a concern or an opinion they wanted to be heard.

Equity Assessment

To identify the elements of the mixed delivery system, HighScope created a mapping framework to conduct a formal and systematic review of programs and services provided to young children and families. Currently, no document exists that captures information about each component of Michigan's mixed delivery system in a central location; thus, HighScope created a searchable mapping framework in Excel. The mapping framework documented the following program characteristics:

- Type of program (e.g., early learning, early intervention, home visiting, family/community support, health/mental health care, human services)
- Services offered
- Program eligibility
- Age(s) served
- Geographic location
- Capacity of services/programs
- Number of children/family served

- Number of children on waitlist
- Program quality data collection requirements
- Child data collection requirements
- Funding sources and amount
- Program cost per child
- Family cost per child
- Workforce requirements
- Recruitment/access efforts

To complete the mapping framework, we first identified B-5 initiatives and providers at the **state level** in the following categories: Early Learning, Early Intervention, Home Visiting, Family/Community Support, and Health/Mental Health Care. Next, we identified B-5 initiatives and providers at the regional level in the same categories. Then we identified B-5 initiatives and providers at the local level, when possible, in the same categories. Finally, we solicited information about innovative or unique B-5 approaches through multiple sources (e.g., town hall events, surveys).

We used multiple sources, including existing needs assessment reports, B-5 inventory reports, and program websites and reports to populate the mapping framework. Most of the available data were from the 2017–18 school year. To gather the most current enrollment information for 2018–19, we collected survey data from state-level administrators of early learning, early intervention, home visiting, family/community support, and health/mental health care providers. We used Qualtrics to program and administer the survey. The survey asked respondents four questions to gather agency information and 16 questions directly from the mapping framework to gather specific information such as the latest enrollment, enrollment capacity, and waitlist capacity.

Innovative Program Interviews

HighScope interviewed key informants from five innovative programs identified by MDE. During these interviews, leaders were asked the following questions:

- What services and programs do you provide, including the number of children and families served?
- How do you determine whether all children and families in their area receive all of the needed services?
- What challenges do you face in accomplishing their mission or vision?
- What supports do you receive from state agencies?
- What supports do you provide to communities to develop stronger transitions between programs and other services?
- How do you support the No Wrong Door framework?
- How do you recruit and enroll children?

Following the interviews, we developed a brief case study for each program based on the interview notes.

Extant Data

AIR used extant data to conduct (1) an assessment of the availability and quality of existing early childhood programs and (2) an unduplicated count of children served and awaiting services at the state, regional, and local levels. To understand the coverage of services for children and families across Michigan's mixed delivery systems, we started with population estimates of the total number of B-5 children in the state. We used the American Community Survey (ACS) data from the U.S. Census Bureau to estimate Michigan's B-5 population. Using the 2017 1-Year Public Use Microdata Sample (PUMS)—the most recent release of 1-year ACS microdata—we generated statewide estimates for Michigan's B-5 population. We also generated regional- and local-level population estimates based on the 2017 5-year ACS microdata. These data generated overall population estimates as well as subcategory estimates by gender, age group, race, ethnicity, rural/urban locality, and economic well-being. Finally, we examined enrollment patterns within the mixed delivery system for children of different racial and ethnic backgrounds as well as different income levels.

Using population estimates, we calculated the number of children who are likely eligible for programs in Michigan's mixed delivery system. We then compared the ACS population estimates to the number of children actually enrolled in 2017 or during the 2017–18 school year provided by MDE to document gaps in access to services in the mixed delivery system by subcategories, with a focus on geographic locations and income levels.

Our analysis was limited to the 50+ extant data sources that were either publicly available or were made available to us by our partners. Exhibit B.4 in Appendix B provides a list of available data for each part of the mixed delivery system. Following Exhibit B.4, we also include details on the geographic level(s), demographic subgroup(s), eligibility and quality indicator(s), and waitlist information that was available to us for each program listed.

Exhibit B.4. Data Available for Analysis by Program

Mixed Delivery System Program/ Indicator	Data Availability							
	Demographic Breakdowns							
	State-Level Enrollment	*Race/ Ethnicity*	*Economic Well-Being*	*Age*	*County Level Data*	*Eligibility*	*Waitlist*	*Quality*
ECCE								
GSRP	Available	Available	Available	Available	Partially	Available	Partially*	Available
HS (MISchoolData)	Available	Available	Partially	Available	Partially	Available	Partially*	Available
HS (PIR Report)	Available	Available	Partially	Available	Partially	Available	Partially*	Available
EHS (PIR Report)	Available	Available	Partially	Available	Partially	Available	Partially*	Available
Licensed Provider (Capacity)	Available	Not Available	Not Available	Not Available	Available	Available	Not available	Partially**

Mixed Delivery System Program/ Indicator	Data Availability							
	Demographic Breakdowns							
	State-Level Enrollment	*Race/ Ethnicity*	*Economic Well-Being*	*Age*	*County Level Data*	*Eligibility*	*Waitlist*	*Quality*
Early Intervention and Early Childhood Special Education								
Early On/IDEA Part C (ED Facts)	Available	Available	Not Available	Available	Not available	Available	N/A	Available
IDEA Part B (ED Facts)	Available	Available	Not Available	Available	Not available	Available	N/A	Available
Early On/IDEA Part C (MISchoolData)	Available	Available	Not Available	Available	Partially	Available	N/A	Available
IDEA Part B (MISchoolData)	Available	Available	Not Available	Available	Partially	Available	N/A	Available
MMSE	Available	Available	Not Available	Available	Partially	Available	N/A	Available
Pathways	Available	Available	Available	Available	Not available	Available	N/A	N/A
Home Visiting	Available	Available	Partially	Available	Partially	Available	N/A	Available
By Model	Partially	Not Available	Not Available	Not Available	N/A	Available	Not Available	Available
Health								
WIC	Available	Not Available	Not Available	Not Available	Available	Available	N/A	Not available
Medicaid	Available	Not Available	Not Available	Not Available	Available	Available	N/A	Not available
Immunizations (19-35 mos.)	Available	Not Available	Not Available	Not Available	Partially	Available	N/A	Not available
Mental Health Service 0-6	Available	Not Available	Not Available	Available	N/A	Available	N/A	Not available

Note. We were unable to locate enrollment data for family support services.
*Dependent on county availability
**While there are quality indicators available, they are opt-in and not all participate.

Selection of Data Sources

We follow several guidelines to select the analytic data that deem most accurate and comparable to the ACS population estimates. First, over each program in the mixed-delivery system, if there is only one data source available, we will report statistics derived from the one data source and will report statistics by demographic breakdown only when subgroup data are available. Second, if there are multiple data sources available (for example, the Head Start enrollment number has two data sources), we report data that are more likely to provide unduplicated counts to our best knowledge. We prefer one-point-in-time snapshot data over cumulative counts of all children that have been served during the school year

because the snapshot data are more likely to be unduplicated. We acknowledge the limitation of point-in-time counts in which it may underestimate the actual enrollment counts throughout the academic year. However, as we see that the ACS population analysis is an approximate of a snapshot estimation, we believe that the point-in-time counts are most comparable with the ACS population estimates. Third, in the case of multiple data sources available, we will report data with demographic or geographic breakdowns and note the discrepancy if the data source used for the demographic or geographic breakdowns is difference from the aggregated counts.

Collaborative Data Review

Following the completion of all five research tasks, AIR and its partners met to collaboratively discuss and review major findings within each task, the alignment of findings across tasks, the strength of the evidence, and the alignment of major themes across tasks. This discussion was used to develop a crosswalk of major themes and subthemes by task. All team members were asked to review the categorization of themes and subthemes and provide any final comments and evidence to finalize the crosswalk to guide this report.

Appendix C. Supplemental Tables From the Extant Data Analysis

Appendix C provides additional detail about the quantitative analyses. It includes

- a description of the licensed and registered child care providers in Michigan and
- a description of the enrollment patterns by program and key subgroups.

Enrollment Characteristics of Licensed Child Care Providers

The licensed and registered child care providers in Michigan varied by provider type, ages served, and hours offered (see Exhibit C.1). In total, there were 8,131 providers across the state, and about two-thirds offered infant/toddler care. Just more than a quarter offered nontraditional hours.

Exhibit C.1. Number and Percentage of Licensed Child Care Providers by Type, Ages Served, and Hours

	Number of Providers	Percent
Total	**8,131**	**100%**
By Provider Type		
Child Care Center	4,114	51%
Group Home	1,609	20%
Family Home	2,408	30%
By Ages Served		
Serve Infants[a]	5,440	67%
By Hours		
Nontraditional Hours[b]	2,217	27%

Notes. These numbers reflect only those providers whose license was not expired or suspended when the data set was downloaded and that are licensed to serve some age range that includes children less than 72 months old.

[a] A provider that serves some age range that includes children less than 24 months old.

[b] Based on the variables available in the licensing dataset, we calculated providers with "non-traditional hours" as those who were open on a weekend and/or whose week-day hours included a something other than "DAY ONLY" (ex. Evening and/or Evening and Day, etc.).
Source. Licensed child care centers and homes (July 23, 2019), Michigan Department of Licensing and Regulatory Affairs.

Enrollment Patterns by Program and Key Subgroups

In Exhibit C.2, we present the numbers of children enrolled in Michigan's ECCE programs, by service area including early care and education, early intervention and special education, home visiting, and health. Within each program, we present the total enrollment numbers as well as enrollment broken down by the following four demographic groups:

- Race, as defined in six categories including White, African American, Native Hawaiian or other Pacific Islander, Asian, American Indian or Alaska Native, and Others;
- Ethnicity, as defined in two categories including Hispanic and Non-Hispanic;

- Economic well-being, as defined in two subgroups either by federal poverty line (below 100%; below 200%) or whether the child is economically disadvantaged defined by MI School Aid Act of 1979, Section 388.1631a.
- Age in years, as defined in two subgroups either by years or by age groups (0-3 and 3-5).

Exhibit C.2. Breakdown of Enrollment Patterns by Subgroup, 2017

	Early care and education			Early intervention and special education[c]		Home visiting	Health	
	GSRP[a]	Head Start[b]	Early Head Start	*Early On*®/ IDEA Part C	IDEA Part B	Michigan's Home Visiting Initiative[d]	WIC[e]	Medicaid (2017)[f]
Total	**38,257**	**28,058**	**9,355**	**10,527**	**21,624**	**23,029**	**270,784**	**345,515**
Race								
White	20,489	13,435	4,394	7,604	15,146	11,500	ND	ND
African American	10,972	9,456	4,024	1,663	3,041	8,351	ND	ND
Native Hawaiian or Other Pacific Islander	47	34	7	9	21	ND	ND	ND
Asian	762	445	140	223	541	207	ND	ND
American Indian or Alaska Native	189	505	291	86	150	257	ND	ND
Others (incl. mixed races)	1,926	4,265	1,187	272	999	6,048	ND	ND
Ethnicity								
Hispanic	3,872	4,440	983	670	1,726	ND	ND	ND
Non-Hispanic	34,385	23,618	8,372	ND	ND	ND	ND	ND
Economic well-being								
Below 100% FPL	20,367	ND	ND	ND	ND	16,677	ND	ND
Below 200% FPL	32,965	ND	ND	ND	ND	ND	ND	ND
Economically disadvantaged	29,669	21,140	7,059	ND	ND	ND	ND	ND
Not economically disadvantaged	8,419	6,918	2,296	ND	ND	ND	ND	ND

	Early care and education			Early intervention and special education[c]		Home visiting	Health	
	GSRP[a]	Head Start[b]	Early Head Start	*Early On*®/ IDEA Part C	IDEA Part B	Michigan's Home Visiting Initiative[d]	WIC[e]	Medicaid (2017)[f]
Age in years								
0	NA	161	2,754	1,539	NA	ND	ND	ND
1	NA	208	2,968	3,455	NA	ND	ND	ND
2	NA	1,225	3,281	5,533	NA	ND	ND	ND
3	NA	12,653	347	NA	5,357	ND	ND	ND
4	38,257	13,195	5	NA	6,806	ND	ND	ND
5	NA	616	0	NA	9,461	ND	ND	ND
0–3	NA	1,594	9,003	10,527	NA	23,838	ND	ND
3–5	38,257	26,464	352	NA	21,624	1,650	ND	ND

Notes. The sum of each set of race/ethnicity subcategories might not be equal to the total enrollment numbers due to how race categories are recorded in each database.

[a] Data retrieved from MISchool website: https://www.mischooldata.org/Default3.aspx?aspxerrorpath=/HelpAndSupport2/SearchForReports.aspx; total enrollment includes children in GSRP and GSRP/Head Start blended programs.

[b] Head Start and Early Head Start enrollment numbers come from the Head Start Program Information Report for the 2017–18 school year. The Early Head Start enrollment number includes both American Indian and Alaska Native (AIAN) Early Head Start and regular Early Head Start programs. The Head Start enrollment number includes both AIAN, the regular Early Head Start program, and migrant Head Start programs.

[c] Michigan also funds early intervention services through MMSE. The enrollment numbers in this table are specific to IDEA Part B and C programs and are point-in-time counts of children served at the time of data collection. EDFacts Metadata and Process System, Children and students ages 3–21 served under IDEA Part B as a percentage of population, by age and state, reporting cycle: 2017–18 school year, U.S. Department of Education, data extracted as of August 2019 (retrieved from https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html); EDFacts Metadata and Process System, Number of infants and toddlers and percentage of population receiving early intervention services under IDEA Part C by age and state, reporting cycle: 2017–18 school year, U.S. Department of Education, data extracted as of August 2019 (retrieved from https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html).

[d] Michigan Home Visiting Report, 2017, Michigan Department of Health and Human Services (MDHHS), retrieved from https://www.michigan.gov/documents/homevisiting/Home_Visiting_Initiative_Report_2017_637278_7.pdf.

[e] Number enrolled. Michigan Department of Health & Human Services, Assistance Programs, Women Infants and Children (2017).

[f] Data provided by Michigan League for Public Policy, June 2019.

In Exhibit C.3, we present the numbers of children enrolled in Michigan's ECCE programs alongside with the Census estimates of children who are potentially eligible for the program based on income criteria of the program. Within each program, we present the total enrollment numbers, the eligible population, as well as these enrollment patterns (% served) broken down by the demographic groups of race, ethnicity, economic well-being, and age group.

Exhibit C.3. State-Level Estimates of Enrollment/Service Use Versus Eligible Population Overall and by Race, Ethnicity, Income, and Age

	GSRP			Head Start			Early Head Start			Home Visiting		
	Enrolled	Eligible	% Served	Enrolled	Eligible	% Served	Enrolled	Eligible	% Served	Enrolled	Eligible	% Served
Total Enrolled	**38,257**	**64,437**	**59%**	**28,058**	**51,527**	**54%**	**9,355**	**75,448**	**12%**	**23,029**	**156,785**	**15%**
Race												
White	20,489	40,681	50%	13,435	25,233	53%	4,394	40,591	11%	11,500	78,771	15%
African American	10,972	16,823	65%	9,456	21,447	44%	4,024	24,966	16%	8,351	48,956	17%
Native Hawaiian or Other Pacific	47	NA	NA	34	NA	NA	<10	NA	NA	NA	NA	NA
Asian	762	830	92%	445	455	98%	140	621	23%	207	2,034	10%
American Indian or Alaska Native	189	802	24%	505	433	117%	291	388	75%	257	12,444	2%
Others (incl. mixed races)	1,926	5,301	36%	4,265	3,969	107%	1,187	8,882	13%	6,048	14,580	41%
Ethnicity												
Hispanic	3872	5,848	66%	4,440	5,648	66%	983	10,072	66%	NA	19,820	NA
Non-Hispanic	34,385	58,589	59%	23,618	45,879	59%	8,372	65,376	59%	NA	136,965	NA
Economic Well-being												
Below 100% FPL	20,367	26,985	75%	NA	51,527	NA	7,059	75,448	59%	16,677	128,097	13%
Below 200% FPL	32,965	52,952	62%	NA	NA	NA	NA	NA	NA	NA	148,051	NA
Age group												
0 to 3	NA	NA	NA	1,594	NA	NA	9,003	75,488	66%	23,838	94,678	25%
3 to 5	38,257	64,437	50%	26,464	51,527	50%	352	NA	NA	1,650	51,972	3%

Notes. The sum of each set of race/ethnicity subcategories might not be equal to the total enrollment numbers due to how race categories are recorded in each database.

Source. GSRP data - Enrolled: MISchoolData; Eligible: American Community Survey (ACS), One-Year Public Use Microdata Sample (PUMS), 2017, U.S. Census Bureau

Head Start data - Enrolled: PIR Report; Eligible: American Community Survey (ACS), One-Year Public Use Microdata Sample (PUMS), 2017, U.S. Census Bureau

Early Head Start data - Enrolled: PIR Report; Eligible: American Community Survey (ACS), One-Year Public Use Microdata Sample (PUMS), 2017, U.S. Census Bureau

Home Visiting data - Enrolled: Michigan Home Visiting Report, 2017, Michigan Department of Health and Human Services, retrieved from: https://www.michigan.gov/documents/homevisiting/Home_Visiting_Initiative_Report_2017_637278_7.pdf; Eligible: American Community Survey (ACS), One-Year Public Use Microdata Sample (PUMS), 2017, U.S. Census Bureau

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