YOUTH POLICY LAB
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An Overview of Home Visiting Referrals in Michigan

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Executive Summary

Michigan's home-visiting programs aim to support families by promoting healthy pregnancies and providing caregivers with the tools, information, and resources needed to create a safe and nurturing environment for their child's development. These programs offer various services, including parenting guidance and connections to local community resources.

The Michigan Home Visiting Initiative (MHVI) featured a 2020 Home Visiting Needs Assessment to evaluate communities with high-risk factors, assess the quality and capacity of existing home visiting services, and explore the availability of substance use treatment and counseling for pregnant individuals and caregivers of young children. This assessment was repeated in 2024 to inform further program development.

This report focuses on home visiting capacity, referral methods, and the findings from data collected through statewide surveys, focus groups, semi-structured interviews, and REDCap submissions. The data reveals that Michigan's home visiting programs can support more families and is committed to enrolling all eligible families who could benefit from these services.

Exploration into the referral sources of each home-visiting model has provided insight from individual home-visiting agencies across the state. Home visiting programs are not at full capacity and have the room to take on more families; however, there are challenges with recruitment and staffing. These include (1) agencies do not have

1. *Home Visiting Legislative Report. (2021)*. SOM - State of Michigan. https://www.michigan.gov/homevisiting/home-visiting-reports/home-visiting-legislative-report
2. *Michigan Home Visiting Initiative*. SOM - State of Michigan. https://www.michigan.gov/homevisiting
3. *Michigan Home Visiting Initiative. (2020). 2020 Home Visiting Needs Assessment - Service Delivery [Brochure]*.

enough staff for consistent family outreach and recruitment, (2) there are significant challenges reaching families at critical intervention points, and (3) agencies are interested in establishing partnerships with community organizations to refer eligible families to home visiting programs.

Agencies are eager to utilize forthcoming support and resources from the Michigan Home Visiting Initiative (MHVI) to improve engagement and enroll more families in home visiting.

Background

Home visiting aims to promote healthy pregnancies and equip caregivers with the tools and information to support their children's growth and development in a safe, positive environment. The Michigan Home Visiting Initiative offers eight evidence-based early childhood models that provide caregivers with these supports and resources: Early Head Start-Home Based (EHS), Family Spirit (FS), Healthy Families America (HFA), Infant Mental Health (IMH), Maternal Infant Health Program (MIHP), Nurse-Family Partnership (NFP), Play and Learn Strategies (PLS), and Parents as Teachers (PAT) (Home Home Visiting Programs). The number of unique home-visiting programs available varies from county to county, as illustrated in Figure 1.[1.] In Fiscal Year 2022, Michigan Home Visiting served 20,603 families and strives to continue expanding to reach all who can benefit from these services.[2]

Home Visiting has been drastically underutilized for many years, particularly during and following COVID-19. According to the *2020 Home Visiting Needs Assessment*, only 25% of families needing support received services.[3] This low utilization rate can be attributed in part to the logistical challenges of delivering services at home during the pandemic but also to skewed public perception of state and local government agencies, what home visiting entails, and lack of awareness that home visiting programs exist in their area. Michigan Home Visiting can support significantly more families and is determined to engage and enroll families who can benefit from their support.

In 2020, at least two-thirds of reporting home-visiting agencies across Michigan indicated they were nearly full, at 85% capacity or higher.[3] However, many of these

agencies could expand capacity to meet demand while other agencies are operating under capacity. The MHVI has undertaken projects to understand and enhance engagement with local communities and promote system integration across the initiative to enhance the effectiveness of these programs. Michigan is committed to strengthening and improving the quality of evidence-based home visiting services, ensuring family choice, and meeting the diverse needs of communities. The ultimate goal is to create an integrated home visiting system that allows families to select the model best aligned with their needs and priorities.

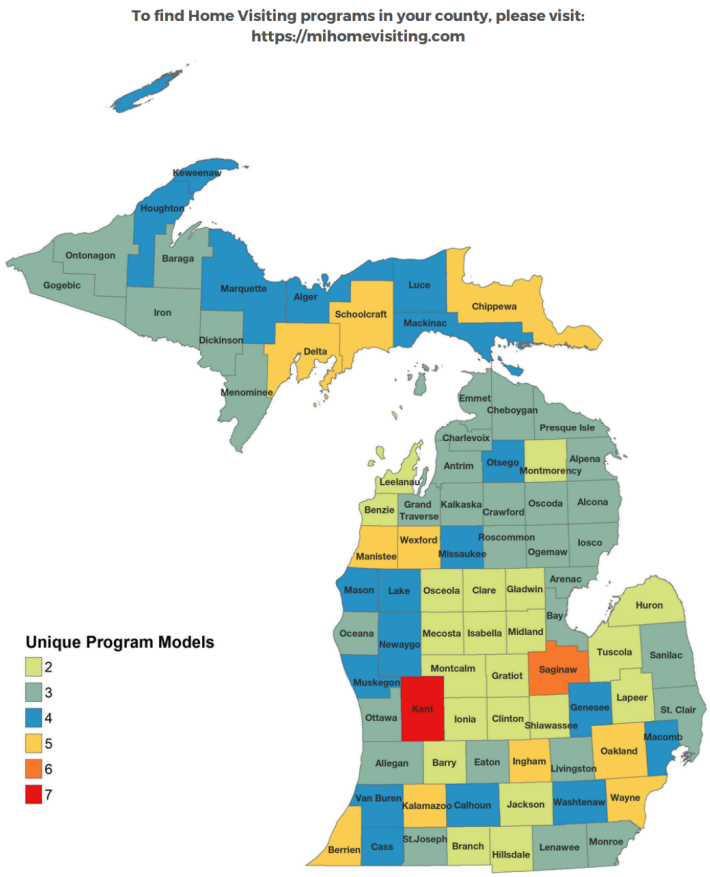


Figure 1: Map illustrating the number of unique home visiting program models in each Michigan county funded in 2023 (Home Visiting Models in MI)

Methods

This work began as an exploratory project to learn about the most frequent sources of referrals using referral network maps created as part of the 2020 Home Visiting Needs Assessment. The same survey conducted in 2020 was repeated in 2024, yielding similar data results that highlighted ongoing trends.

Figures 2 through 8 in the Appendix provide a snapshot of each model's most common referral sources across the state. For most models, local resources or family resource centers were a significant source of referrals, including agencies such as baby pantries or community health centers. Models emphasizing child development and school readiness, such as EHS and PAT, received most of their referrals from early childhood services, including *Early On*®, Great Start Collaborative, and Head Start. In contrast, programs that traditionally are implemented by nurses, such as MIHP and NFP, benefitted from connections with clinics or doctors, the Women Infants and Children Division (WIC), and Medicaid health plans. This exploration into the differences in referral sources and how that impacts enrollment from model to model catalyzed our interest in gaining insight from individual agencies across the state.

We sought to compile information and insight from all eight evidence-based models across various state regions to understand how they each engage and enroll families in home visiting. Likewise, we were interested in better understanding each model's most common referral sources and the opportunities to improve their reach. Ultimately, we wanted to underscore family choice and a no-wrong-door approach. A no-wrong-door approach is a particular priority for the State, emphasizing the importance of connecting families with home visiting services, supports, and benefits no matter the entry point where they begin. We hope this information will help the MHVI identify state and local processes that will more effectively match families with models that will meet their needs and extend resources or support to local programs that may need them.

To gather this information, we conducted semi-structured interviews with program supervisors. We paired those findings with an analysis of the different referral sources for each model type as identified in the 2020 Needs Assessment. Of the programs

recruited, six of the eight models were represented, excluding Infant Mental Health and Family Spirit, which could not participate. These agencies represented the regions of Southeastern, Western, Northern, Central, and Mid-Michigan. We discussed their approach to engaging with their communities, their challenges with outreach, relationships with community resources, and improvements they think could help engage and enroll eligible families. Our conversations yielded overarching themes and shared sentiments about the current state of the Initiative, as well as opportunities for growth and intervention.

Key Findings

The resounding sentiment from all the programs interviewed was that their main priorities are reaching families and enrolling them in home-visiting programs. Across the board, these programs expressed an excess capacity to serve more families. However, despite this, home-visiting programs face challenges in effectively engaging eligible families due to reach, recruitment, and engagement challenges.

Limited Resources for Outreach

Agencies expressed that staff are often overwhelmed with administrative work and managing caseloads, leaving little time or resources to build relationships with external partners that could support their outreach and recruitment efforts.

The current staffing structure does not account for the time it takes to sort through the volume of referrals received through platforms like MI Bridges and 2-1-1 to determine eligibility and enrollment. This underscores the need for changes in infrastructure and staffing among local agencies to encourage the utilization of referral platforms and efficiently address referrals. With additional funding, staffing support, and opportunities to connect with local partners, agencies believe they could reach and serve more families.

Most programs interviewed expressed frustration with the process of receiving self-referrals from MiBridges and 2-1-1 platforms where individuals can explore and apply for benefits, relief programs, and local resources from agencies within their community. While they see it as a great opportunity for families to find information and self-refer to their programs, program staff often need help navigating the platform and

finding someone on their staff to manage incoming referrals. They believe that keeping organizational information consistent and up-to-date takes time and effort. As a result, they have yet to succeed in engaging and enrolling families through the platform and see it as a missed opportunity.

Limited Windows of Eligibility for Signups

The home visiting programs have specific eligibility periods and lengths of enrollment. For example, the NFP is one of the models with a brief eligibility window—first-time pregnant parents at 28 weeks gestation or less—which makes it challenging to engage with and enroll eligible families before the eligibility period is closed. NFP agencies reported that most referrals come from WIC, MiBridges, and clinical partners.

NFP and MIHP see a significant gap among local OB/GYN clinics and community organizations, which interface closely with eligible families and can encourage them to look into and enroll in home visiting. They note that staff turnover within both systems is a barrier to strong relationships, impacting the ability to establish strong relationships between entities. Improved statewide knowledge of home visiting would serve as a foundation to support continuity and collaboration between agencies and local resources, increasing their presence in the community.

Limited Understanding of HV options by referral agencies

Some home-visiting models perceive that they are often disadvantaged in receiving referrals from WIC clinics. WIC clinics usually utilize historical referral practices and consistently refer families to one or two home-visiting models. The clinics are unaware of other evidence-based home-visiting models available in the community. In this respect, programs hope that WIC clinics are willing to work with the MHVI to learn how to present all eligible programs and models to clients, allowing them to make the best choice rather than pick for themselves.

Based on conversations with each model, there is a perception that MIHP is at the greatest advantage in reaching and enrolling potential clients. As the largest home visiting model in Michigan, it is one of two models implemented in every county in Michigan. Conversations with MIHP programs need clarification over the MIHP/WIC Memorandum of Understanding (MOU) that is in place. It has been interpreted to mean WIC can only refer to MIHP, but the MOU was designed to allow sharing of family

information more easily, making MIHP a primary referral for WIC rather than a secondary referral. Some WIC programs do know a change in interpretation of the MOU has been made, but not all.

Medicaid Health Plans that have contracts with MIHP agencies and hospital systems with their in-house MIHPs also tend to refer to MIHP. These entities will often send a list of eligible prenatal and postnatal people directly to MIHP programs so that MIHP staff can attempt to contact and enroll them. While this approach can be more convenient because they are usually "in-house" or "in-network," this limits family choice in deciding which program and curriculum best addresses their needs.

The 2020 Home Visiting Needs Assessment network maps information suggests that WIC is the lowest of MIHP's top 3 referral sources. A report from the University of Michigan's Youth Policy Lab, *Increasing Home Visiting Enrollment through Enhanced Outreach*, provides additional context on referrals received by three MIHP provider agencies in 2021. Their research found that WIC referrals constituted 28% of referrals received by these agencies and were the most likely to be reachable and ultimately enroll.

The majority of the HFA, EHS, PAT, and PALS programs that were interviewed are housed within Intermediate School Districts. Across the board, they expressed that the largest share of their referrals come from word of mouth from people involved in their programs. They receive few self-referrals but have a strong presence at community resource fairs and effective relationships with Great Start collaborative representatives who advertise their programs well. They also receive many referrals from community partners and even some cross-program referrals. Some programs expressed that their counterpart models referred families to their programs if they were ineligible or did not fit their model.

For example, an HFA program will refer a family to MIHP if the family has Medicaid insurance and is past the 3-month age eligibility window for HFA. Programs interviewed stated they often refer to each other and MIHP. However, these models and programs receive fewer referrals from MIHP. The MIHP programs expressed that their referrals are typically from families eligible for MIHP. As a fee-for-service model, as opposed to a program that receives a set budget to serve families, MIHP is incentivized to enroll families rather than referring the family to a different program.

Families beyond the age of enrollment for MIHP are often referred to other services in the community. However, there is no standardized way of collecting referral information at the program level to assess how a family indicates they were referred.

Challenges and Opportunities for Improvement

Most programs interviewed expressed frustration with the process of receiving self-referrals from MiBridges and 2-1-1 platforms where individuals can explore and apply for benefits, relief programs, and local resources from agencies within their community. While they see it as a great opportunity for families to find information and self-refer to their programs, program staff often need help navigating the platform and finding someone on their staff to manage incoming referrals. They believe that keeping organizational information consistent and up-to-date is difficult. As a result, they have yet to succeed in engaging and enrolling families through the platform and see it as a missed opportunity.

This prompted questions like, '*What resources or supports may programs need to get registered with MI Bridges*?' and '*How can we better support programs to handle a potential influx of referrals and caseloads?*' These needs and challenges may differ based on program size, geographic location, and client eligibility. Still, it is worth exploring further as additional changes are made to the MiBridges and 211 platforms. This insight is valuable as the MHVI strives to provide detailed, updated information across platforms like MiBridges, 211, and Program Finder while improving accessibility and user experience.

Ongoing projects with the MHVI, University of Michigan Youth Policy Lab, and Harvard Government Performance Lab will continue to coordinate opportunities working to improve the early childhood and home visiting systems. The recent 2024 Home Visiting Needs Assessment revealed that 65% of respondents, excluding MIHP and IMH, were not at full capacity. Of these, half reported operating between 75% and 90% capacity.

There is a concerted effort to approach this issue from multiple angles, including the work done by Nurse-Family Partnership and Social Finance to assess home visiting

service delivery in southeastern Michigan. The following recommendations will supplement this work:

1. **Update and maintain consistent contact information for local agencies and resources across multiple referral platforms (e.g., Program Finder, MiBridges, and 211)**
    - FY2024 Update:
      In FY 2024, a streamlined strategy was implemented to ensure accurate and consistent updates to contact information through Program Finder, the primary platform for non-MIHP home visiting providers. Program Finder is now a central hub, with monthly updates automatically transferring accurate contact details to MiBridges and 2-1-1. MiBridges and 2-1-1 currently serve as platforms where families predominantly self-refer; therefore, these platforms contribute only a small portion of the overall referrals and are underutilized as primary sources. This process significantly reduces the administrative burden on agencies, as they no longer need to manually update information across multiple platforms.

      However, a significant challenge remains. Currently, contact information displayed on these platforms often corresponds to specific individuals rather than centralized agency contacts. As a result, if an individual leaves the agency, their outdated information remains visible, leading to potential miscommunication and reduced accessibility for families seeking services.

2. **Explore options to create a centralized referral source as a one-stop resource for all home-visiting models.**
    - FY2024 Update: Help Me Grow is a centralized site that houses various resources, such as home visiting programs, healthcare or behavioral support, and basic needs, to help children grow, develop, and thrive to their full potential. It is currently focused in Southeast Michigan, Oakland, Wayne, and Macomb counties but is poised to expand in partnership with Michigan Part C, a program for children aged 0-3 who experience delays

or have a disability. MDHHS is exploring how to utilize Help Me Grow to its full advantage.

- A program in Saginaw shared its experience utilizing a community hub to serve as a 'one-stop-shop' for information about and referrals to home visiting. While it has challenges, such as limited funding and finding an objective third party to run it, the concept is meant to assist interested families in navigating the many options available. Other programs were receptive to this idea but emphasized the importance of transparency and fairness in each model. These are essential factors for MHVI, model staff, and community partners to consider when exploring ways to streamline and integrate referral processes across home-visiting models.

3. **Provide additional resources and support for agency operations and outreach.**
    - FY2024 Update: MDHHS collaborated with Harvard Kennedy School Government Performance Lab (GPL) to explore strategies for improving outreach and connections between priority families and home visiting programs. Through this collaboration, MDHHS participated in training focused on effective outreach practices to promote home-visiting models and increase enrollment rates.

      This was done by asking, "*How can Michigan connect priority families to home-visiting programs?*" Priority families were identified as those underrepresented in home-visiting models, such as Black mothers, Latine families, families impacted by substance use, Native families, and families in rural areas. A six-month pilot in Macomb and Kent counties sought to address these gaps. The pilot emphasized bridging the disconnect between outreach theory and practice by employing a three-step framework: identify, connect, and enroll.

      The identification phase focused on reflecting on agency capacity, enrollment data, and local demographics to pinpoint underserved groups and barriers to engagement. The Connect phase involved building partnerships with trusted individuals at referral organizations who could

advocate for home-visiting programs and strengthen referral pathways. The enrollment phase examines the enrollment process to ensure it meets families' needs, employs tailored communication, and maintains follow-up with referral partners.

MDHHS is working to develop materials to guide conversations with prospective families about home visiting programs and to utilize the materials with a systems lens to support better connection of families to the home visiting program that best fits their needs.
MDHHS is also piloting outreach specialists within Kalamazoo and Wayne counties to determine if direct outreach to referral sources, ideally conducted by a parent with lived experience in home visiting, can generate improved understanding of the home visiting system and what is needed to support referral partners in making referrals.

4. **Create education tools for community partners to improve understanding of home visiting and encourage referrals.**
    - FY2024 Update: Programs expressed interest in opportunities to deepen their community engagement and recruitment by better educating community partners, local clinics, community health workers, and people who assist families through 211 to share information about home visiting. Many potential enrollees can be reached through these channels. Still, it may be helpful to provide standardized educational materials or guidance to provide consistent messaging and information about home visits to eligible families.

      MDHHS is working to develop educational materials about the various home visiting programs to share with agencies and community partners.

Conclusion

This memo serves as another step in understanding and enhancing the Michigan Home Visiting Program's engagement with communities. The exploration of home-visiting referral maps served as the first step in our exploration into the differences in referral sources. It supplemented the successive interviews we completed better to understand the impacts on enrollment from model to model. Insight from individual agencies across the state unveiled three main takeaways: (1) agencies do not have enough staff to dedicate solely to community outreach and recruitment, (2) agencies are having a difficult time reaching families at critical intervention points while they are eligible, and (3) community partners need guidance or education to refer eligible families to home visiting more consistently. Agencies are ready and willing to utilize available support and resources to improve their efforts and look forward to forthcoming training and improvements from MHVI.

Appendix

The charts below illustrate seven of Michigan's eight home-visiting programs. Each chart presents the number of total referrals (n) and the number of referrals from each of four or five primary sources, as noted by the numbers along the x-axis. In addition, the percentages listed in the bars indicate the percentage of overall referrals from each source. The yellow bars highlight the most common referral source for each program.

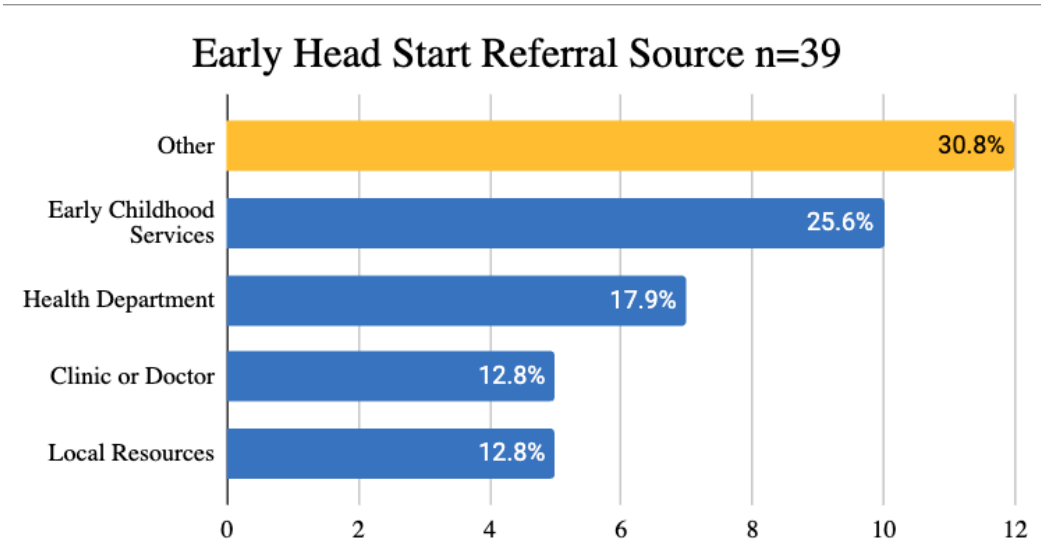


Figure 2: Early Head Start Referral Sources

Note: The other categories include child protective services, foster care, domestic violence shelters, other home-visiting models, and WIC.

Figure 3: Family Spirit Referral Sources

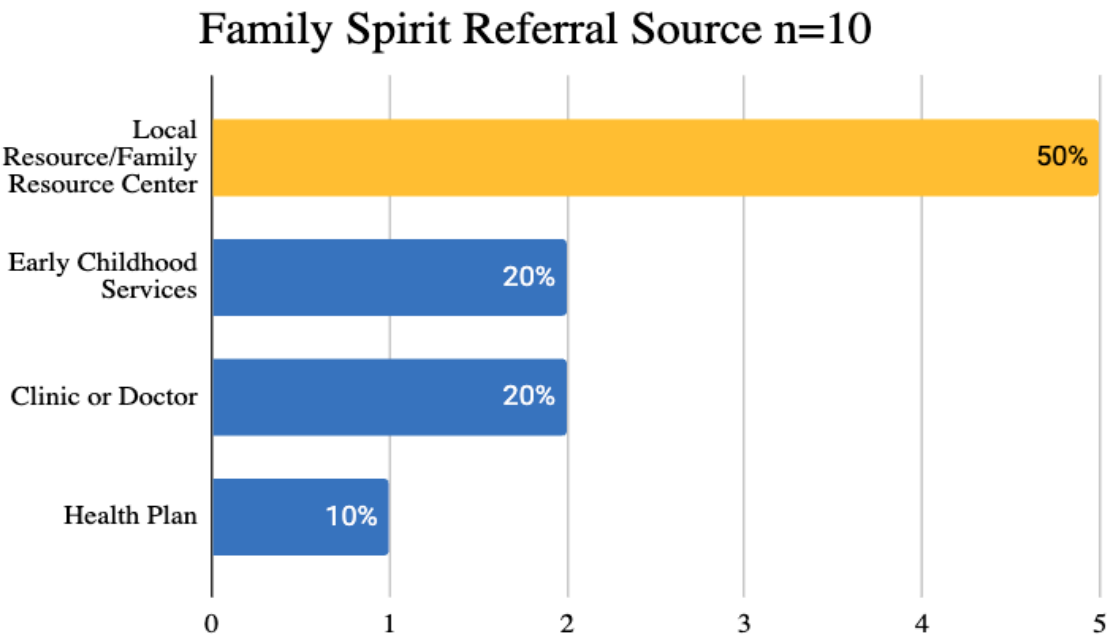
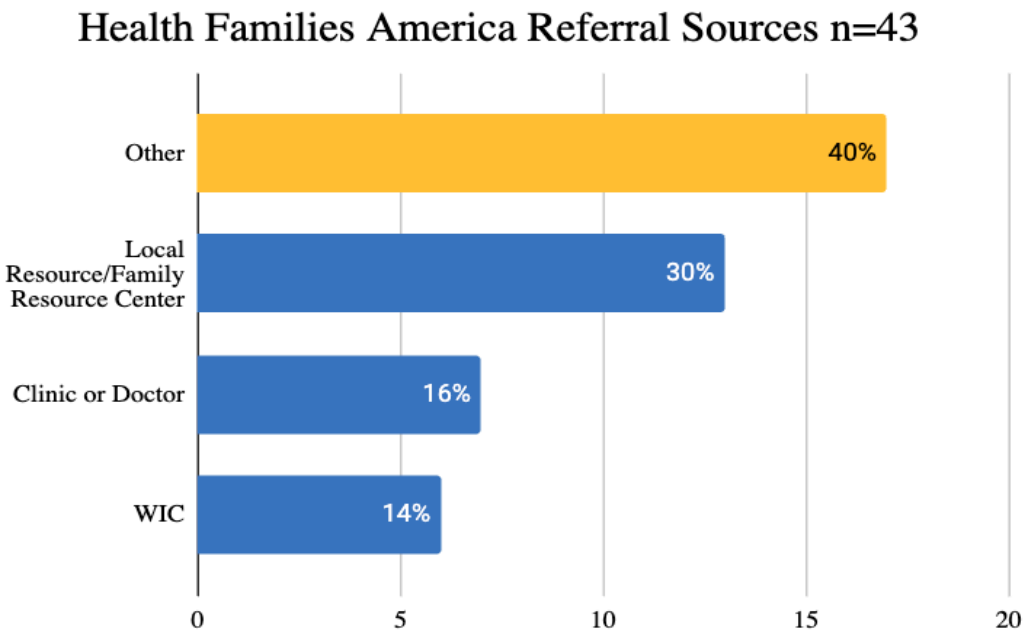
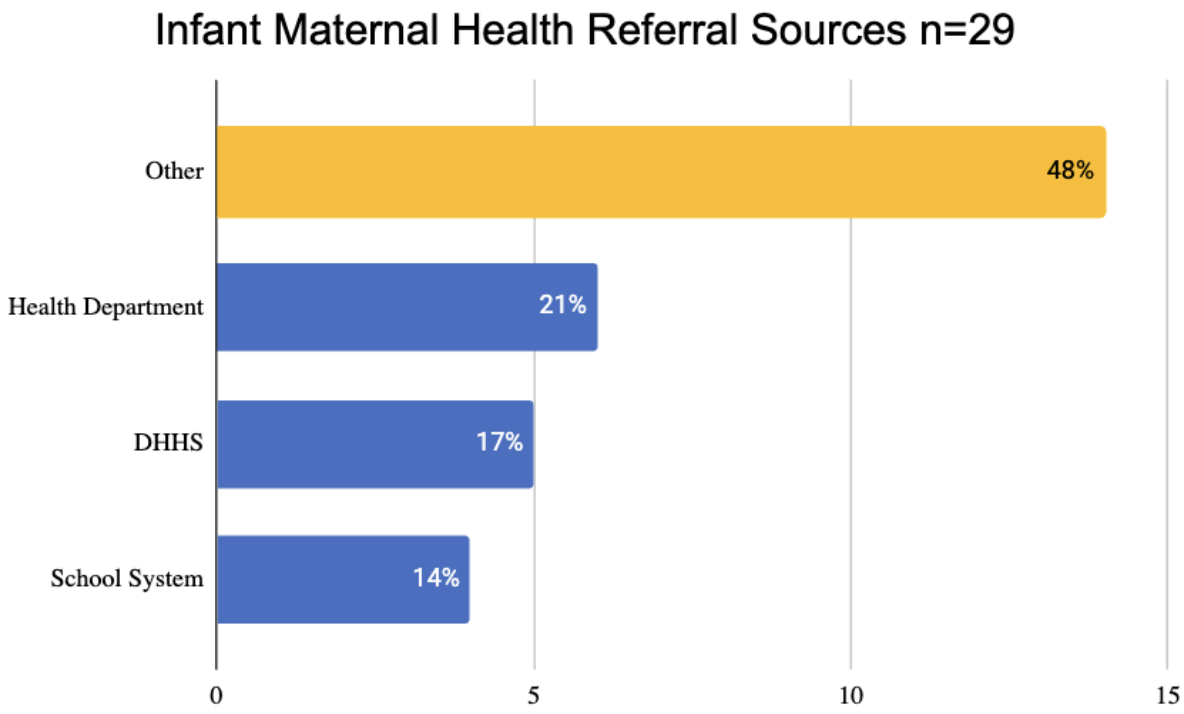


Figure 4: Healthy Families America Referral Sources



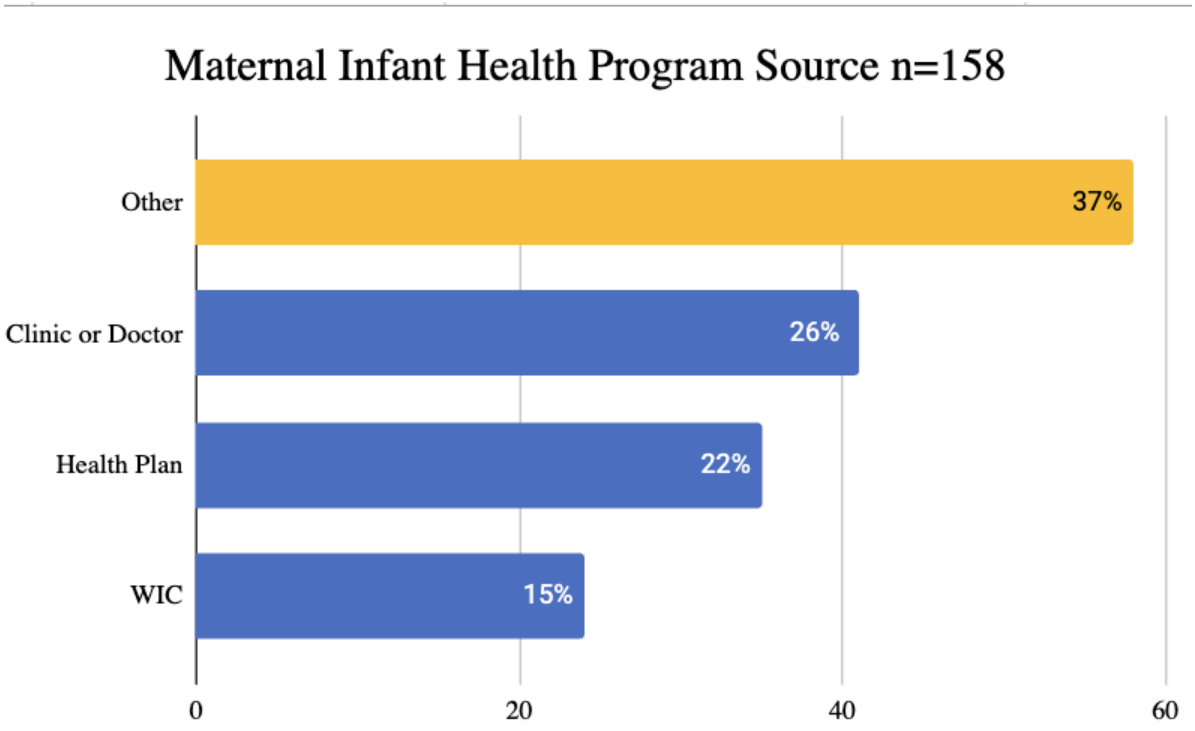
Notes: The other category includes child protective services, early childhood services, health departments, Medicaid health plans, other home visiting models, and self-referrals.

Figure 5: Infant Mental Health Referral Sources



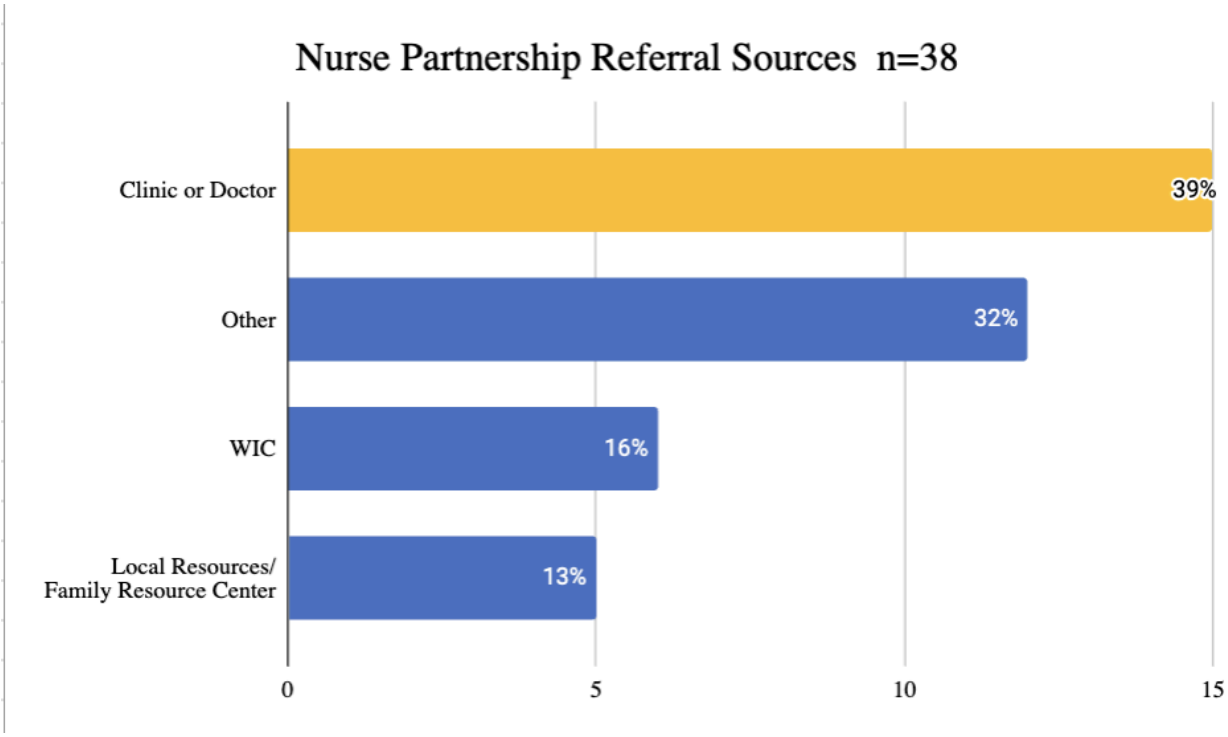
Notes: The other category includes clinics or doctors, early childhood services, health departments, school systems, and the juvenile court system.

Figure 6: Maternal Infant Health Program Referral Sources.



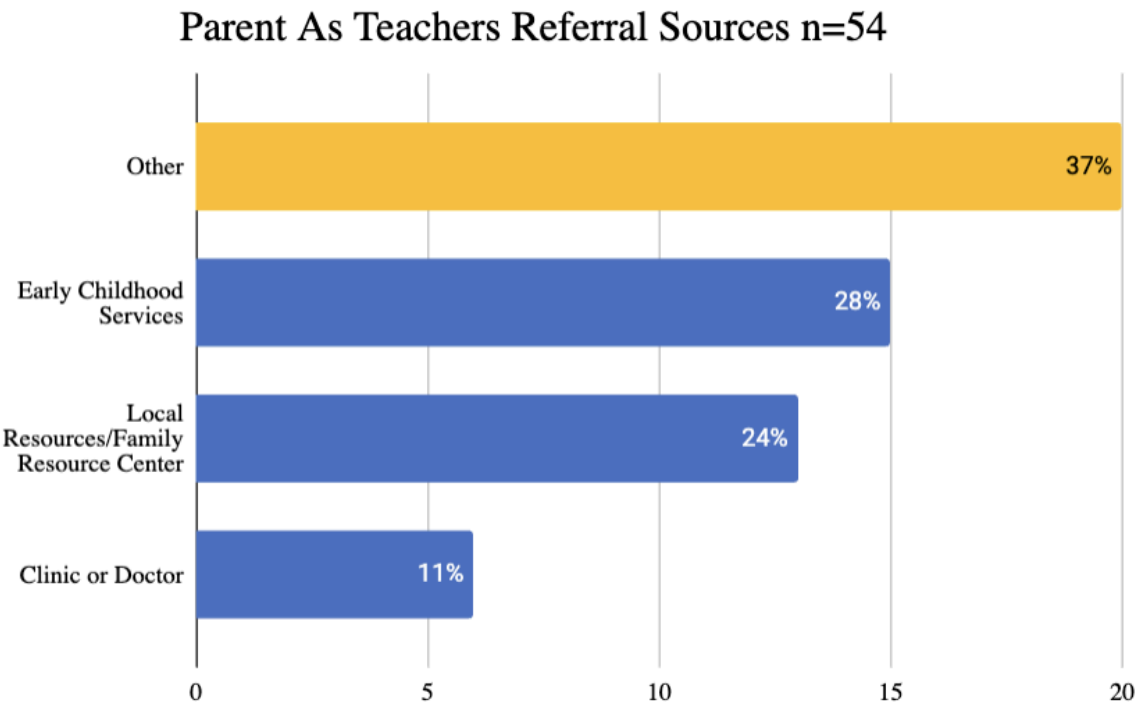
Notes: The other category includes child protective services, early childhood services, health departments, local or family resource centers, other home visiting models, and self-referrals.

Figure 7: Nurse-Family Partnership Referral Sources



Notes: The other category includes health departments, Medicaid health plans, other home visiting models, and school systems.

Figure 8: Parents as Teachers Referral Sources



Notes: The other category includes 211, child protective services, health departments, other home visiting models, and school systems.

About the Authors

Dipita Das is a Youth Policy Data and Policy Fellow collaborating with the Michigan Department of Health and Human Services (MDHHS) in the Maternal and Infant Health Program (MIHP). She contributes to MIHP by analyzing Quality Assessment Survey Data to enhance program effectiveness and services. Additionally, she authors Inclusive Insight, a monthly memo dedicated to fostering diverse discussions around maternal and infant care.

Sara Elhasan is the public health advisor for the City of Dearborn's Department of Public Health. A Dearborn native, she graduated from Fordson High School and went on to complete her BS in Public Health and BA in Sociology at Wayne State University. She later earned an MPH in Epidemiology from the University of Michigan. Prior to this role, Sara was a Data & Policy Fellow with the University of Michigan's Youth Policy Lab, where she implemented research and data-informed policies and program improvements for the Michigan Department of Health and Human Services. She has also been an ORISE Fellow with the Centers for Disease Control, served as a legislative intern at the Michigan House of Representatives, and completed research training with the National Institutes of Health. Sara is passionate about giving back to her community and working to correct how sociocultural, political, and economic circumstances influence health and well-being.

Youth Policy Lab

The University of Michigan Youth Policy Lab was launched in 2016 with a vision for reducing socio-economic disparities through improvements in education and other social policies affecting youth. By developing evidence-based, policy-relevant research in partnership with local and state agencies, practitioners, and policymakers, Dr. Robin Jacob and Dr. Brian Jacob sought to build upon their exemplary careers in social science research by taking research findings out of academic journals and putting them in the hands of decision-makers. With this aim in mind, they have spent the past seven years bringing the resources and expertise of one of the nation's leading public research universities to bear on some of Michigan's most pressing social challenges.

The Youth Policy Lab, a joint research center of the Gerald R. Ford School of Public Policy and the Institute for Social Research, envisions a world where partner-driven and policy-centered research fuels positive social change. Our mission is to inform public policy decisions that impact youth by analyzing data and evaluating programs to help society answer its most pressing questions.

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