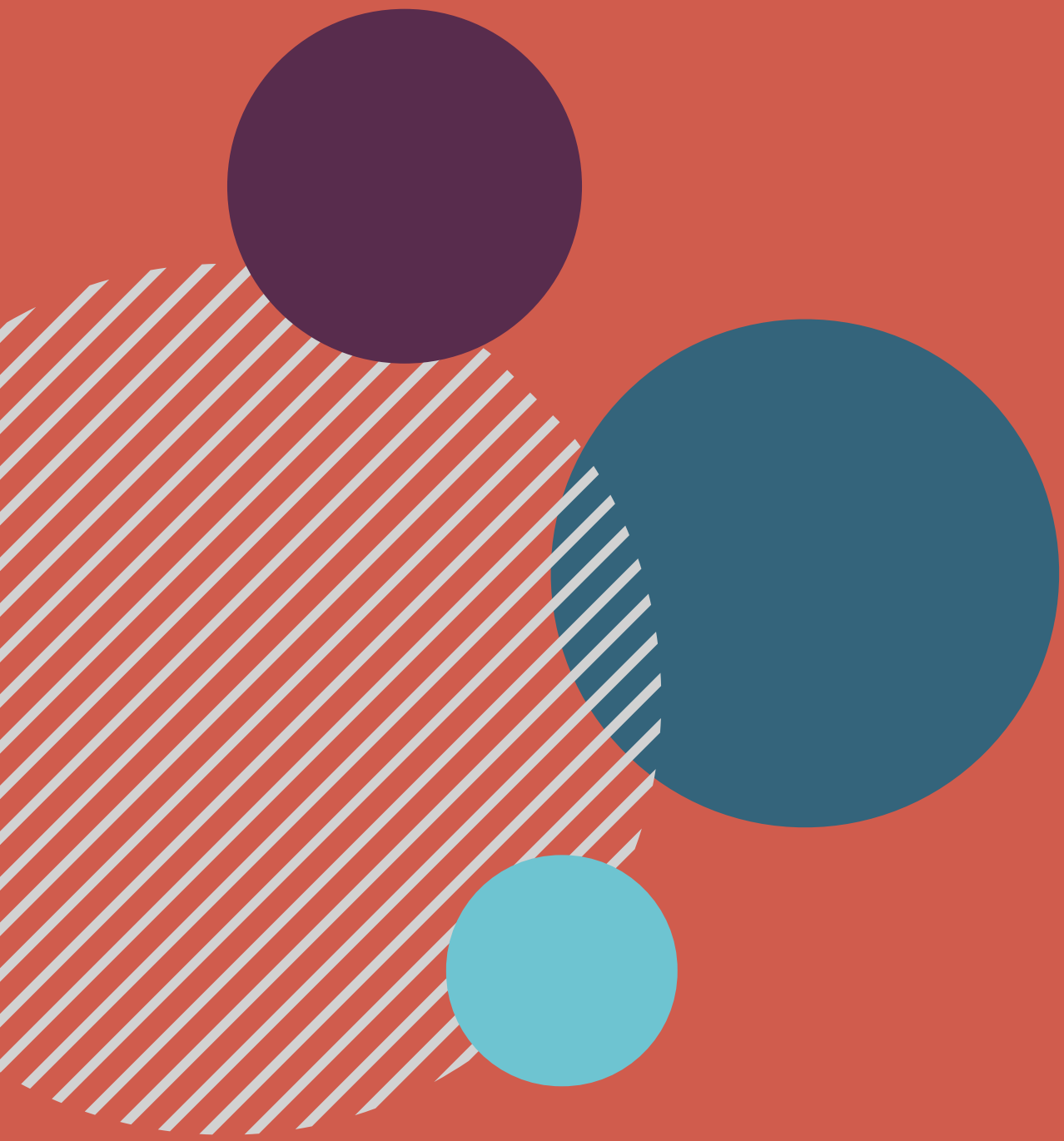

PRESCHOOL DEVELOPMENT GRANT

TRANSITIONS MINI QUALITY IMPROVEMENT LEARNING COLLABORATIVE

Authors: Brenda Dietrich, Robin VanDerMoere, Michelle Datema, and Aman Kaur

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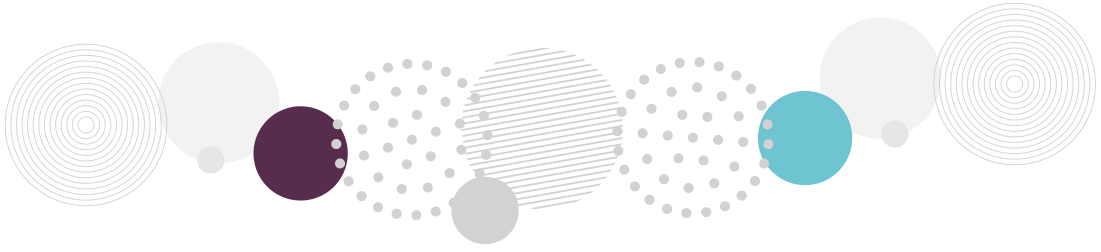
INTRODUCTION AND HISTORY

Home visiting programs are well-recognized as an effective strategy for supporting health, wellbeing, and school readiness.[1] Within Michigan there are several evidence-based home visiting models serving thousands of families each year from pregnancy to school entry. Many of these models only serve families for a portion of their journey from pregnancy to school entry. All families served by home visiting programs transition out of home visiting. They may transition to another home visiting program, other community-based programs, or school entry. Transitioning out of a home visiting program can be a time of opportunity for ensuring that families continue to grow and feel supported as children move from infancy to Preschool or Kindergarten.

Based on previous home visiting evaluations carried out in Michigan, there is wide variability in the planning, support, and successful completion of transitions between home visiting programs and other supportive programs and services. This variability in practice has also been noted in Michigan's 11 Local Leadership Groups (LLGs) who serve as community level collaboratives for home visiting programs. Some home visiting models have specific guidance on transitions while others do not. Some local home visiting providers are aware of the array of programs available in the community and share those with families while others are not as familiar. Feedback at the local level from families and from home visiting providers indicated that there was often a lack of transition planning or awareness of transition options for both families and program staff. Families exiting programs that served children through infancy were not always aware that there were other programs in the community who could continue to serve them.

In 2021, the Michigan Department of Education, through the Preschool Development Grant (PDG), sought to broaden the knowledge of what transitions in home visiting for families look like, what supports and strategies were critical for successful transitions, and what types of supports and strategies would more fully support families as they transition from one home visiting program to another or as they transition from a home visiting program to an early childhood education setting. Part of this effort involved implementing a Quality Improvement (QI) Mini Learning Collaborative focused on home visiting transitions. This effort, the PDG Home Visiting Transitions Mini QI Learning Collaborative, engaged local level teams of home visiting providers or LLGs in testing out strategies that were supportive to smooth transitions.



[1] Duffee, James; Mendelsohn, A; Kuo, Alice; Legano, Lori; et. al; Early Childhood Home Visiting. *Pediatrics* September 2017; 140 (3): e20172150. 10.1542/peds.2017-2150

METHODOLOGY

The approach consisted of implementing a Mini QI Learning Collaborative structure based on the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) model[2] utilizing Plan-Do-Study-Act (PDSA) cycles over the course of nine months alongside an implementation evaluation to inform: what strategies were successful, where local programs most need support for successful transitions, and systems level learnings. The structure is outlined below:

MINI QI LEARNING COLLABORATIVE COMPONENTS:

Change Package (Key Driver Diagram, PDSA Planning Tool)

Family Journey Mapping

Monthly Mini QI Learning Collaborative Sessions

Monthly one-on-one QI Coaching with an assigned coach

IMPLEMENTATION EVALUATION COMPONENTS:

Post Session Participant Evaluations

Post QI LC Team Interviews/Surveys

Observational notes of successes and challenges in monthly learning collaborative sessions

Observational notes of successes and challenges during individual coaching sessions

[2] *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

MINI QI LEARNING COLLABORATIVE STRUCTURE

An invitation to participate in the QI Learning Collaborative was distributed to Local Leadership Groups, Maternal Infant Health Programs (Michigan-based Model), and other home visiting program models funded through the Michigan Department of Education and the Michigan Department of Health and Human Services Home Visiting Unit. The intention was to recruit seven QI teams for a nine-month QI Learning Collaborative. Early feedback indicated that, while many teams were very interested in working on transitions, they felt the current stress programs were under and staff turnover during COVID-19 precluded them from committing to the QI Learning Collaborative at that time. Three groups did engage teams to participate in the Transitions Mini QI Learning Collaborative:

1. **HEALTHY FAMILIES DISTRICT HEALTH DEPARTMENT #10**

   A Healthy Families America Affiliate

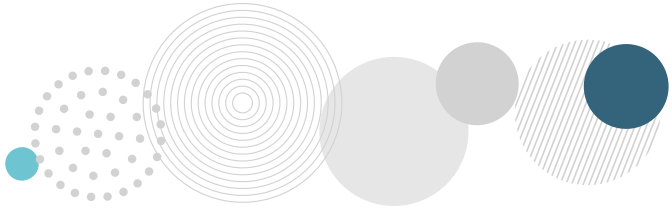
2. **OAKLAND COUNTY LOCAL LEADERSHIP GROUP (LLG)**

   A collaborative of multiple home visiting and early childhood partners

3. **OTTAWA COUNTY MATERNAL INFANT HEALTH PROGRAM (MIHP)**

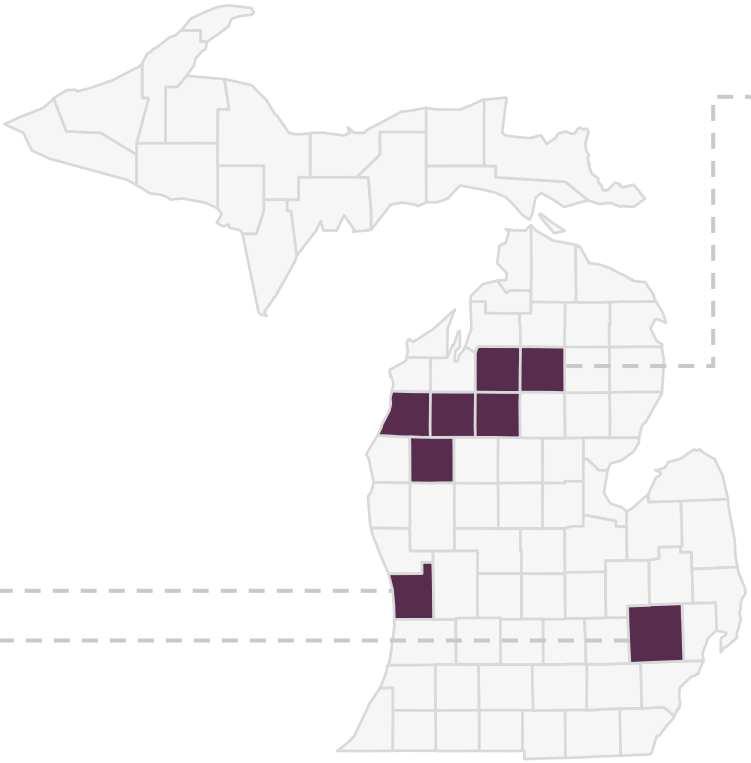
   A collaboration between the MIHP program and the Parents as Teachers local home visiting program

As only three teams were able to commit to the QI Learning Collaborative, the approach was modified to a Mini QI Collaborative wherein the teams would meet monthly together in learning sessions on a more frequent basis than a standard QI Learning Collaborative. This approach allowed for more in depth sharing between the participants throughout the collaborative, and it reduced the collaborative's reliance on quantitative data.



GEOGRAPHIC REACH

3 **OTTAWA COUNTY MATERNAL INFANT HEALTH PROGRAM** is housed in the Ottawa County Department of Public Health. Members of the Transitions Mini QI Learning Collaborative team included the Department of Public Health's Community Health Manager, the Ottawa County Great Start Collaborative Coordinator, the Assistant Director of Prevention and Community Programs at the Ottawa Area Intermediate School District representing Parents as Teachers home visiting program, a Bilingual (Spanish) Care Coordinator with Help Me Grow Ottawa, and two parents of children who currently are or recently have received home visiting services.



1 **HEALTHY FAMILIES DISTRICT HEALTH DEPARTMENT #10** provides home visiting services to Crawford, Kalkaska, Lake, Manistee, Missaukee, and Wexford counties. The Transitions Mini QI Learning Collaborative team consisted of Healthy Families America (HFA) program staff: the Coordinator, Reflective Supervisor and Data Analyst, three Family Support Specialists, and one parent representative.

2 **OAKLAND COUNTY LOCAL LEADERSHIP GROUP (LLG)** is housed within the Oakland County Intermediate School District (ISD) agency. LLG members include Oakland Schools Great Start Collaborative, Oakland County Health Division (Nurse Family Partnership, Nurturing Parent, Community Nursing), Michigan Department of Health and Human Services/ Oakland Livingston Human Service Agency (Head Start, Early Head Start), Oakland Family Services (Parents as Teachers, Fussy Baby), CARE House (Early Head Start, CAN Council), Easter Seals, American Indian Health and Family Services (Healthy Start, Maternal Infant Health Program), various Maternal Infant Health Programs, and two of families who have received home visiting services. Members most actively involved in the Transitions Mini QI Learning Collaborative were CARE House Healthy Families America, Oakland Family Services Parents as Teachers, Oakland County Health Division Nurse Family Partnership, Ascension Maternal Infant Health Program, and the two parents.

CHANGE PACKAGE

The IHI BTS model consists of a Change Package that is developed to guide the teams participating in the collaborative. The Home Visiting Transitions Mini QI Learning Collaborative Change Package consisted of:

- **KEY DRIVER DIAGRAM** (Appendix A) noting the primary drivers of successful transitions and potential strategies to support those transitions. The Key Driver Diagram was based upon previous successful tests of transitions, as well as a review of literature for successful strategies utilized in the home visiting field and other early childhood settings. Central reference documents included the Understanding Family Transitions out of Michigan's Maternal Infant Health Program report of 2021; best practice documents from Early Head Start, Early On, and Healthy Families America; and knowledge gained from previous QI Learning Collaboratives. The key drivers identified for successful transitioning were: Trusting Relationships and Family Centered Transitions, Well Established Referral Networks, and Strong Programmatic and Community Support for Transitions. The QI teams individually assessed strengths and opportunities in each of the primary drivers and came to consensus as a team around a priority transitions challenge that they would like to focus on for each PDSA cycle they carried out. Each team then selected a change strategy from the Key Driver Diagram that was most likely to be successful in impacting the challenge they identified.

- **PDSA PLANNING TOOL** (Appendix B) for each PDSA cycle completed by the individual teams. This Planning Tool outlined the reason for and overall goal of the Transitions Mini QI Learning Collaborative and gave a template for teams to use to map out and document their individual PDSA cycles.

- **FAMILY JOURNEY MAPPING** (Appendix C) occurred at both the beginning and conclusion of the Home Visiting Transitions Mini QI Learning Collaborative. Families were invited from the three teams to participate in an interview about their transitions experiences that would be used to develop individual Journey Maps. This feedback from families at the beginning of the Transitions Mini QI Learning Collaborative was shared with the participating teams to help them consider the context and experience that families have experienced recently with transitions. Journey Mapping is a qualitative data technique[3] that uses individual experiences to inform service delivery through a visual display of how a service recipient's journey unfolded. Journey Maps allow for identification of where in the journey from beginning to end of the transition the family felt supported and had sufficient information and where there were points of frustration or suboptimal experiences.

[3] Philpot LM, Khokhar BA, DeZutter MA, Loftus CG, Stehr HI, Ramar P, Madson LP, Ebbert JO. Creation of a Patient-Centered Journey Map to Improve the Patient Experience: A Mixed Methods Approach. Mayo Clin Proc Innov Qual Outcomes. 2019 Sep 24;3(4):466-475.

MONTHLY QI LEARNING SESSIONS MAY-DECEMBER 2022

In May of 2022, the Mini QI Learning Collaborative kicked-off with an initial QI Learning Session that brought all three of the teams, the QI Coach, QI Advisors, and evaluators together. The 90-minute sessions continued monthly through the end of December 2022. These QI Learning Sessions enabled the teams engaged in the Transitions Mini QI Learning Collaborative to learn from one another, sharing challenges, successful strategies, and progress on their current PDSA cycle. It was also a space for the coaches and evaluators to hear about successes and challenges overall for programs who were working to improve transitions between home visiting programs or between home visiting and early childhood education programs. Each meeting was guided by an agenda with time to discuss: where they were at in their PDSA cycle, what successes they had as a result of the strategy they were testing or as an unintended outcome of their effort they were not expecting, what challenges they had encountered in delays or learnings about what would not work, and any areas in which they would like additional resources/supports. Questions that arose from evaluations, during coaching sessions, or through email contact were discussed and workshopped.

MONTHLY ONE-ON-ONE COACHING SESSIONS

Each of the three teams also met individually with their MPHI QI coach each month from May 2022 through January 2023. This time allowed the teams to work through their PDSA cycle and receive individualized coaching and feedback. The MPHI QI coach was available on an ongoing basis as requested in addition to joining each local team monthly to provide continual coaching and sharing of resources and learnings. The one-on-one coaching sessions were critical in supporting teams in making planful improvements utilizing proven QI methods, tools, and techniques. The MPHI QI Coach also joined meetings of the whole Oakland LLG to support the Oakland LLG QI team in facilitating discussions on the current process across programs in the LLG as part of the Plan stage.

IMPLEMENTATION EVALUATION COMPONENTS AND TIMING

Evaluation components were incorporated throughout the Mini QI Learning Collaborative to learn from participants and families about their experiences with transitions and with testing new strategies locally during their PDSA cycles:

MONTHLY POST QI LEARNING COLLABORATIVE SESSION EVALUATION SURVEYS

to gain information on what was most helpful in the session and collaborative to date, where participants still had questions, and supports they would like.

JOURNEY MAPPING

with families at two time points at the beginning and at the end of the collaborative, to hear about family's personal experiences with transitions from the home visiting programs they had participated in.

POST QI LEARNING COLLABORATIVE FOCUS GROUP OR SURVEY

at the completion of the Mini QI Learning Collaborative to garner input on what worked well with the collaborative overall, where gaps still exist, and more detailed information about each team's individual experience. Participants were encouraged to join the live focus group, but if they were unable to do so because of scheduling they could complete an electronic survey to provide feedback.

OBSERVATIONAL NOTES

of successes and challenges noted by teams during monthly QI Learning Collaborative sessions, individual coaching sessions.

RESULTS AND FINDINGS

PDSA CYCLE RESULTS

Each QI team completed two PDSA cycles during the Mini QI Learning Collaborative. The first cycle was conducted May to August 2022 and the second cycle was conducted September to December 2022, see table below for overview. (Full description of PDSA cycle results for each can be found in Appendix D).

		PRIMARY DRIVER	CHANGE STRATEGY SELECTED	RESULT
DHD #10	Cycle 1	Strong Programmatic/ Community Support for Transitions	Program utilizes program level guidance based in best practices/model elements to support transitions.	Adapt and expand to all six counties.
	Cycle 2	Strong Programmatic/ Community Support for Transitions	Program develops resources such as transition plan templates, written guidance on preparing families for transition, recommendations for the timing and content of transition conversations, and transition training that support a more consistent, supportive transition process for families.	Adapt and expand to all six counties.
OAKLAND LLG	Cycle 1	Strong Programmatic/ Community Support for Transitions	Home visitors are knowledgeable on the eligibility requirements of other programs/resources.	Adapt-Decision Tree for Help Me Grow
	Cycle 2	Well Established Referral Networks	Program develops and utilizes a system to refer families to other home visiting programs to support family transitions.	Adopt-Transition Bag for families
OTTAWA MIHP	Cycle 1	Well Established Referral Networks	Program utilizes program-level guidance based in best practices/model elements to support transitions (when to start the conversation, how often to discuss, what to consider, etc.) and guidance is revisited annually with team for revisions.	Adapt the created MIHP Guidance for Best Practice document for staff.
	Cycle 2	Strong Programmatic/ Community Support for Transitions	Program utilizes co-visit strategy to increase comfort of family (other agency staff introduced during visit/home visitor accompanies caregiver to initial contact with receiving program).	Adapt the shared visit strategy.

Each team was successful in their PDSA cycles choosing to either adopt the strategy as tested or to adapt the tested strategy based upon their learnings during the cycle.

KEY LEARNINGS

1 NEED FOR ADDITIONAL PRE-COLLABORATIVE PREPARATION TIME

to gather information from families: All three of the teams noted that it took quite a bit of preparation time to gather information from families on what the current experiences were with transitions and to engaged families in their QI teams. Teams learned that most programs do not follow up with families after they leave the program, or their only contact is a program satisfaction survey that did not yield information on how the family was navigating services after they left the program. The teams wished they had preparation time prior to the Transitions Mini QI Learning Collaborative to gather this information as they felt unprepared to even rate where their program or community was in successfulness of transitions.

> We pretty much spent our whole first cycle just trying to figure out like locally how transitions look.
>
> –QI LC team member

2 NEED TO PLAN ADDITIONAL TIME FOR HARDCOPY RESOURCES

as teams testing strategies that included hardcopy resources, books, and other items for families as part of transition planning reported delays in being able to obtain those materials depending on the structure within the agency for procuring items or for printing.

3 APPRECIATION FOR COLLABORATIVE STRUCTURE WITH ONGOING SUPPORT

from teams as they met monthly with each other and one-on-one with their QI coach. Teams noted that they would not have been able to tackle or keep focus on moving forward without the structure of monthly check ins, sharing with other teams, hearing other experiences, and in accountability to a shared collaborative. Teams identified collaboration with other programs and solidifying the internal transition process as accomplishments as a result of their projects.

4 WITHIN THE LIMITED TIMEFRAME, TEAMS MADE PROGRESS ON TRANSITIONS.

All three of the QI teams updated and improved their internal transition process, focusing on making their process more supportive and structured. The teams reported home visitors became more comfortable facilitating a warm handoff thanks to redefining transitions and updating their process. While it is still too early to tell if there's an increase in the number of families experiencing supportive transitioning, teams saw an increase in understanding of the transition process and the array of program options reported by local program staff as well as positive feedback from families on how the changes felt to them.

> We have seen we have improved our warm transitions just from one home visitor to another, we've really smoothed out that process and it's been much better for the home visitors involved and for the family.
>
> –QI LC team member

RESULTS AND FINDINGS

JOURNEY MAPPING RESULTS

Four total interviews were conducted with caregivers on their experiences with transition (Journey Mapping Appendix C). Two were at the beginning of the Mini QI Learning Collaborative, and two were post Mini QI Learning Collaborative and team tests of transition strategies.

Both caregivers interviewed at the beginning of the collaborative described similar experiences:

1. **Neither transitioned from home visiting to another program.** Both caregivers reported feeling that "it was the end" when they left the program.

2. **They felt unprepared, indicating that they experienced "short notice" or were unaware of when the program was ending.** Caregivers reported not knowing when the program would end until the last or next to last visit. While both caregivers were positive and appreciative of their experience and support during the home visiting program, neither felt that they were prepared in advance or had conversations with their home visitor about what other programs or services were available. Caregivers offered suggestions on how to improve the transition process such as having a specific conversation about transitioning, having staff dedicated to follow up with families transitioning, providing a transition email with details about possible next steps, explaining to parents what to expect with new program options, and providing co-visits.

3. **They received no or minimal information on what else was available.** One caregiver reported not knowing about the other programs that were available until she engaged with a local advisory committee that contained members from other programs. The other caregiver noted being given a general flyer about the Great Start Collaborative but no information about other home visiting programs or services available in the community.

4. **Both wanted for more information or support.** Both caregivers noted the experience could have been improved if there was a centralized or one staff person focused on providing more information and managing the transition. Both shared a desire to talk more about the transition and what to expect prior to it happening.

> People don't have access to the information that programs exist, what they do, why there here, where you can get information about them.
>
> –Parent

Both caregivers interviewed post collaborative test of change noted:

1. **Their transitions were supported.**
Both had experienced either a full transition or were in the final stages of transition between two home visiting programs involved in the collaborative. Caregivers noted feeling confident going through the transition and aware of what was coming and being introduced to the staff of the program they were considering transitioning to.

> When we were getting close to agreeing we (MIHP) were going to come to an end she offered the other programs…she was very nice about sharing the information with me and getting me set up with the other program.
>
> –Parent

2. **They appreciated meeting new staff ahead of their transition.**
While both indicated appreciation for the ability to meet the new staff while still supported by their trusted home visitors, one caregiver specifically noted that it was reassuring to them when their child immediately took to the new home visitor.

> What made it easiest for me was that they did a co-visit. It was reassuring… I am confident with PAT taking over for MIHP.
>
> –Parent

3. **Co-visits were well received.**
Both caregivers expressed appreciation for the format of having a co-visit with their current home visitor and the home visitor from the program to which they would be transitioning. They reported feelings of increased comfort and confidence. Parents expressed that they were able to have questions answered, and their child was able to become comfortable with the new provider.

> The previous person from the first HV program was also with us at the first visit. She helped to introduce us to each other. Everything went very smoothly. Knowing what was coming helped me feel prepared.
>
> –Parent

4. **Their transitions were smooth.**
Both caregivers reported feeling confident and that they did not have challenges because their questions were answered.

RESULTS AND FINDINGS

FEEDBACK FROM POST SESSION EVALUATIONS

After each monthly Transitions Mini QI Learning Collaborative session participants were asked to complete a brief evaluation survey noting areas that they still had questions about, highlights for them, what they would like to see included in future sessions, and any additional comments or suggestions. Feedback was used to determine what the content of future sessions should be and where MPHI coaching support should be targeted.

Overall, Transitions Mini QI Learning Collaborative session attendees reported:

1. **No additional questions on the PDSA cycle process** beyond information on the Journey Mapping process.

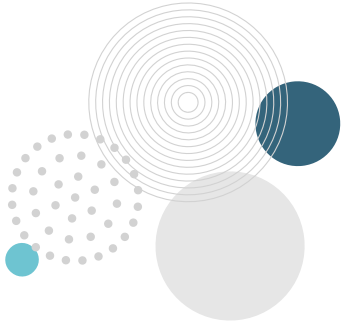
2. **Highlights of working alongside other teams in a shared goal around transitions.** Participants reflected on the benefits of sharing between teams and the ability to touch base with each other on what was working well and where there were challenges.

> I loved hearing about how other plans are going. They really helped me to clarify what we were doing.
>
> –QI LC team member

3. **Need for more information on strategies to address common challenges.** Requests from session participants centered on a desire for additional strategies for common challenges such as engaging parents on their teams and feedback from parents on how programs can support them with transitions.

> More feedback from parents and others about how we can help them with transitions.
>
> –QI LC team member

4. **Appreciation for the support of the Transitions Mini QI Learning Collaborative.** Coaching assistance, time, and support to explore with them were noted as valued resources. Teams described how the collaborative structure made it easier to focus on transitions, particularly with additional funding and technical assistance.

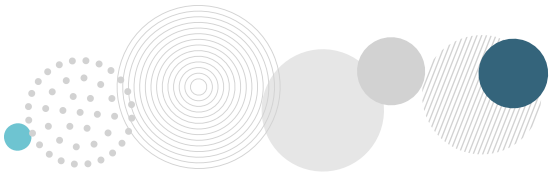


Additional questions were added to the three final meetings of the Transitions Mini QI Learning Collaborative. These additional questions included: **what was most helpful to them, what supports or resources they wish they had, and what types of support or resources the PDG funding allowed them to support:**

1. **Support from the MPHI QI Coaching team and the Collaborative Teams.** The most frequently noted helpful elements were the support from the MPHI team and being able to work with other teams and across counties in the collaborative to share experiences and tools.

2. **Financial incentives for partnering programs and internal staff** were priority remaining needs including more time, personnel, and financial assistance to continue to work to improve transitions and to sustain the gains they made during their PDSA cycles.

3. **The PDG funding through the Transitions Mini QI Learning Collaborative was noted as critical** for teams. This allowed them to seek parent feedback on their transitions after they had exited the program, engage parent participation in their QI efforts, fund the creation and printing of information and flyers for families, and support staff time from multiple programs to come together to work transitions collaboratively.



RESULTS AND FINDINGS

OBSERVATIONS OF QI TEAMS

DURING MONTHLY TRANSITIONS MINI QI LEARNING COLLABORATIVE SESSIONS

During each of the Transitions Mini QI Learning Collaborative sessions evaluation staff took note of challenges that teams were facing, successes, and strategies they had developed or adopted to keep making improvement.

AT THE BEGINNING OF THE TRANSITIONS MINI QI COLLABORATIVE

teams assessed their standing in the three Primary Drivers and identified starting points to work toward. Themes that emerged across the three teams were:

1. **A need to invest time in understanding their staff or partner's knowledge of existing transition partners and process**(es) in order to begin to identify priority areas in need of improvement. All the teams found that partners and staff had misunderstandings of other programs or lacked the knowledge of what programs were available to offer to families.

2. **A need to invest time in obtaining feedback from families who had transitioned recently to have a baseline understanding of their current experience.** Only one of the QI teams already had parents collaborating with them prior to this project to provide feedback on transitions. The other two teams needed time to recruit parents to join them and to provide feedback. One of the home visiting program teams invested time in calling families who had exited the program recently, something that was not part of their previous process. This resulted in critical learnings about support gaps for families with children who aged out of the program but were not yet able to enroll in classroom settings. Families experienced months of being unsure of how to register, how they should be supporting their child(ren) to prepare, and they felt unsupported. The team also learned that families with children who had delays especially felt adrift in not knowing who to follow up with for support.

3. **Benefits of having previous collaborations between programs and partners.** All three of the teams had some existing partnerships with early childhood providers, other home visiting programs, and other community collaborative groups that were comfortable working together prior to the Transitions Mini QI Learning Collaborative. All three expressed in monthly sessions that these existing partnerships and connections made it easier to start working together on transitions, and without those previous relationships it would have taken longer as they would need to develop the relationship first before working on challenges together.

4. **Lack of processes around transitions and knowledge of programs available.** Prior to joining the Mini QI Learning Collaborative, none of the home visiting programs had standard policies or procedures around transitions for when a family completed the program. There were no timelines about when to share that the program was ending, no readily available parent-friendly information about possible next steps, and no policy on how much support to provide to parents as they leave the program.

DURING THE LENGTH OF THE TRANSITIONS MINI QI COLLABORATIVE TESTS OF CHANGES all the QI teams met with both successes and challenges including:

1. **Challenges in not having some pre-existing templates for transition planning within programs and between programs.** The only pre-existing resource identified at the beginning of the collaborative was guidance from Early On for families as they move through services. While helpful, each of the teams was looking for guidance for their staff on how to introduce and support transitions to different partners: other home visiting programs, preschool, or other community supports for families who chose not to transitions to another specific program. The QI teams developed various tools as part of their PDSA cycles including guidance for staff and checklists for supervisors. However, they expressed that it would have been helpful to have examples of successful guidance documents to start from or to see other examples as they move forward.

2. **Challenges in how to support updating compendium resources such as Help Me Grow or individual staff knowledge of what programs are available** as programs and staff change over time. The shifting landscape requires repeated opportunities for refreshing knowledge around the array of programs available. QI teams devised plans to sustain their knowledge, such as annual revisiting, sharing this task with other early childhood workgroups, and connecting with specific county level refreshing activities.

3. **Challenges in how to engage families in their efforts** was a topic brought up for discussion across a few sessions with teams asking one another and MPHI for guidance on recruitment and strategies for engaging and keeping parents as part of their QI team. One QI team had not previously recruited parents for this type of collaborative work, and another was challenged to recruit families for this effort. The third QI team had pre-existing collaborations with parents who were already supported through other funding, which made it easier to get going at the beginning of the collaborative. QI teams also expressed that without this funding it would be difficult to financially support parents to participate, as the parents with the most feedback were those who had recently left the program and were no longer connected formally with the home visiting program.

4. **Each of the teams successfully developed new guidance for home visiting program staff** on the process for beginning to talk to families prior to transitions, what programs or other supports were available to offer families, the process for families to transition to other programs, and what home visiting models allow before during and after a family ends one program. A learning of the collaborative was that at least one model, Parents as Teachers, allows for co-visits with other programs. This ability allowed the Ottawa MIHP program to test out co-visits with the local PAT program. Home visiting programs have received mixed messaging on if they can provide visits to a family if they are enrolled in another program currently, and guidance on this topic related to transitions would be helpful.

5. **Two of the teams focused on strategies involving Help Me Grow as a local referral source families and staff can utilize. These teams updated program information in decision trees and increased staff knowledge of Help Me Grow as a resource for families** located in an area of the state with Help Me Grow available. Both noted variance in knowledge about the referral process with Help Me Grow and worked on strategies to both educate program staff on the options but also to increase staff providing families with this resource before and as they transition.

6. **One team successfully increased connection with local preschools** specifically on the relationship between their home visiting program and local preschools. Local preschools were unaware of the Healthy Families program and how they could help prepare families for preschool but were eager to work with the HFA QI team to develop guidance for families on skills to work on with their children to support them in the transition to preschool and to discuss how each could support families in transition.

RESULTS AND FINDINGS

PARTICIPANT FEEDBACK

FROM POST COLLABORATIVE FOCUS GROUP

Participant Feedback from Post Collaborative Focus Group & Survey was was gathered from all the participating individuals through either joining a focus group session or by completing a survey if they could not attend the live session. They were asked a set of questions on their experiences in the Transitions Mini QI Learning Collaborative, what was most beneficial, suggestions for improvement, where gaps remain at the local and system level, and any other feedback they wanted to share on transitions.

Participants noted at the end of the collaborative the most helpful elements were:

1. **The Change Package, especially the Key Driver Diagram, which gave teams a good starting place.** The teams reflected on various spaces that made it a challenge to immediately dive into testing transitions with families but voiced that the Key Driver Diagram and the guidance for assessing where they were in each driver was an immensely important support for them to facilitate discussions with their team that resulted in consensus around where they should begin their work. The Key Driver Diagram was the Change Package document that was specifically called out as critical to finding where to start and providing an array of strategies that could be tested.

> It (the KDD) gave us direction and some great ideas of where to start.
>
> –QI LC team member

2. **Monthly Learning Collaborative Sessions were helpful in making progress on their QI team goals.** The sessions operated as both a sharing space for all of the QI teams, but also as a space for MPHI staff to share resources in response to questions and requests of the participants. Participants noted three main areas of benefit the monthly sessions provided:

    - **Accountability in keeping on track of progress toward goals.** Knowing that they would be meeting together every few weeks drove teams to not let the projects drop in priority, which enabled them to make more continuous progress.

> I know with our team it helped us stay on track and keep focused on, you know, what's the next step, what's the next goal? … So I think it kind of helped just move things along.
>
> –QI LC team member

- **Sharing and learning with others outside their immediate team.** Being able to hear from others who were experiencing the same challenges or had developed their own tools were valued by participants. They indicated they would not otherwise have had that opportunity.

- **Sharing among the teams also provided validation of experiences.** Participants voiced that hearing from others across the state who were encountering the same challenges and were just beginning work on transitions was validating.

- **Having a one-on-one coach and support.** MPHI's technical assistance helped teams to overcome challenges, find direction, brainstorm ideas, and validate plans.

- **Pre-existing collaborations provided easy connection and the foundation for shared work on transitions.** Having a previous connection with local preschools helped DHD10 form new relationships with additional preschool partners, and engaging a newly hired home visitor who had previously worked in a local preschool offered an additional linkage to local preschools. Ottawa MIHP strengthened its previously established relationships from an early childhood grant that ended and built new relationships with organizations serving tribal communities during this project. Oakland LLG convenes a coalition of local home visiting and early childhood programs, which positioned them well to work on transitions.

- **Funding that supports multi agency collaboration, reimbursement for family involvement in improvement efforts, and providing transition resources to families was key.** Participants from all three QI teams noted that this level of work on transitions would not have been possible without the PDG funding. Funds were used to support partner staff time, resource printing costs, physical items such as transition binders, and funds to support families to be part of the team working on transitions. It was noted that individual home visiting models vary in how staff time can be supported through their existing funds and the addition of the PDG funding allowed them to not only collaborate with other community partners but also for their internal staff to spend time developing the internal guidance and resource compendiums for staff and families.

Participants also noted challenges experienced or identified during the collaborative that they felt were likely to continue including:

1. **Time commitment barriers** such as getting partners to attend meetings and heavy workloads of home visiting program staff in the current environment. Staff turnover and shortages have contributed to some of the barriers to implementing new systems and collaboration.

> The biggest challenge I had was we're trying to ask collaboration from other programs and at least with me I always get bit of like, I know they've got a lot on their plate and asking them to attend another meeting is sometimes difficult and just hoping that will be able to participate and contribute.
>
> –QI LC team member

2. **Multi program or agency collaboration challenges.** These barriers included managing different cultures of programs, being geographically spread out, and building new relationships with partners that do not know about home visiting or the array of programs in the community.

3. **Need for more local data and information on transitions.** This data would help programs to identify transition challenges, root causes, and solutions. However, the QI teams did not know where or how to get that information beforehand. An individual program, Ottawa MIHP, had that information available for their program but not for other programs in their community. The other teams noted that what happens with families after they exit a home visiting program is often not tracked, and it is not part of standard practice to follow up with a family after they have left the program.

4. **Need for collaborative cultures to work on transitions.** Teams identified continuous communication, building a collaborative culture, and funding to be key to sustaining the progress they made to improve transitions. Some of the barriers for local programs to support transitions included coordinating schedules, lack of awareness and understanding of other programs, and understanding who is qualified for what. Recommendations for improving transitions include building relationships (workgroups, affinity groups, coalitions, etc.), understanding what parents' transition needs are, and having a solid transition process with clear definitions. Teams feel it was hard for parents to transition if they had a good relationship with their home visitor, did not know if they qualify for other programs, had limited transportation access, and experienced difficulty finding the right match for the family.

> We're beginning to increase their understanding. We've had some really good conversations with our preschool partners... they had a lot of really good suggestions on how to be more collaborative about our transitions so that we can better support the families that are moving from home, visiting into preschool.
>
> –QI LC team member

> I'm really excited about the outcome... we have some really great connections. I feel like we can maybe extend those into the other home visiting work groups that we have. I feel like it was really collaborative.
>
> –QI LC team member

DISCUSSION

Common themes emerged across data collected from families and Transitions Mini QI Learning Collaborative participants:

1. **Families want to know about the options available to them and to receive support as they exit home visiting.** This is the case even if they choose to not, or cannot immediately, transition directly to another program. Families appreciated and felt more supported having activities and resources for their children in the interim between the end of their home visiting experience and entry into school.

2. **Local programs seeking more supportive transitions want and need opportunities to collaborate.** Connecting with other programs helps partners learn about one another, share data on transition outcomes, and work together to ensure supportive handoffs for families.

3. **Program staff have stretched capacity, which results in gaps in knowledge about other programs available to families.** Programs are often unaware of one another or not fully knowledgeable about programs unless they have another local entity that takes on centralizing this information or the program obtains funding to support development of a compendium.

4. **Programs benefit from sharing tools and strategies for transitions.** Home Visiting models do not consistently have guidance for programs on transitions or steps for following up post program exit with families. Programs implementing models that have adopted a standard on transitions still have gaps in lack of tools or specific guidance on working with the families.

5. **Co-visits between the family, the home visiting program, and the new program were especially successful** in easing the transition between programs for parents. Parents experiencing co-visits reported feeling supported, having their questions answered, and having time for their child to warm up to the new home visitor.

6. **Funding to specifically support multi program collaborative work on transitions is needed.** Each of the teams involved reported that they would not have been able to work on transitions across programs without the additional funding from PDG. Though programs may want to work on transitions with partners in other programs, funding to support this type of work is an essential catalyst.

RECOMMENDATIONS

The Transitions Mini QI Learning Collaborative identified gaps, both locally and system wide, in support for programs and families with transitions. These findings indicate that home visiting partners and families would benefit from:

LOCAL LEVEL STRATEGIES FOR:

- Increased collection and sharing of knowledge of family experiences after leaving a program, during transition, and after transition;
- Widely accessible compendiums and robust knowledge of what programs are available in the community;
- Additional funds to support transition related tools and resources for distribution to families as they plan for and leave the program; and
- Additional time and funds to support shared co-visits at the point of transition.

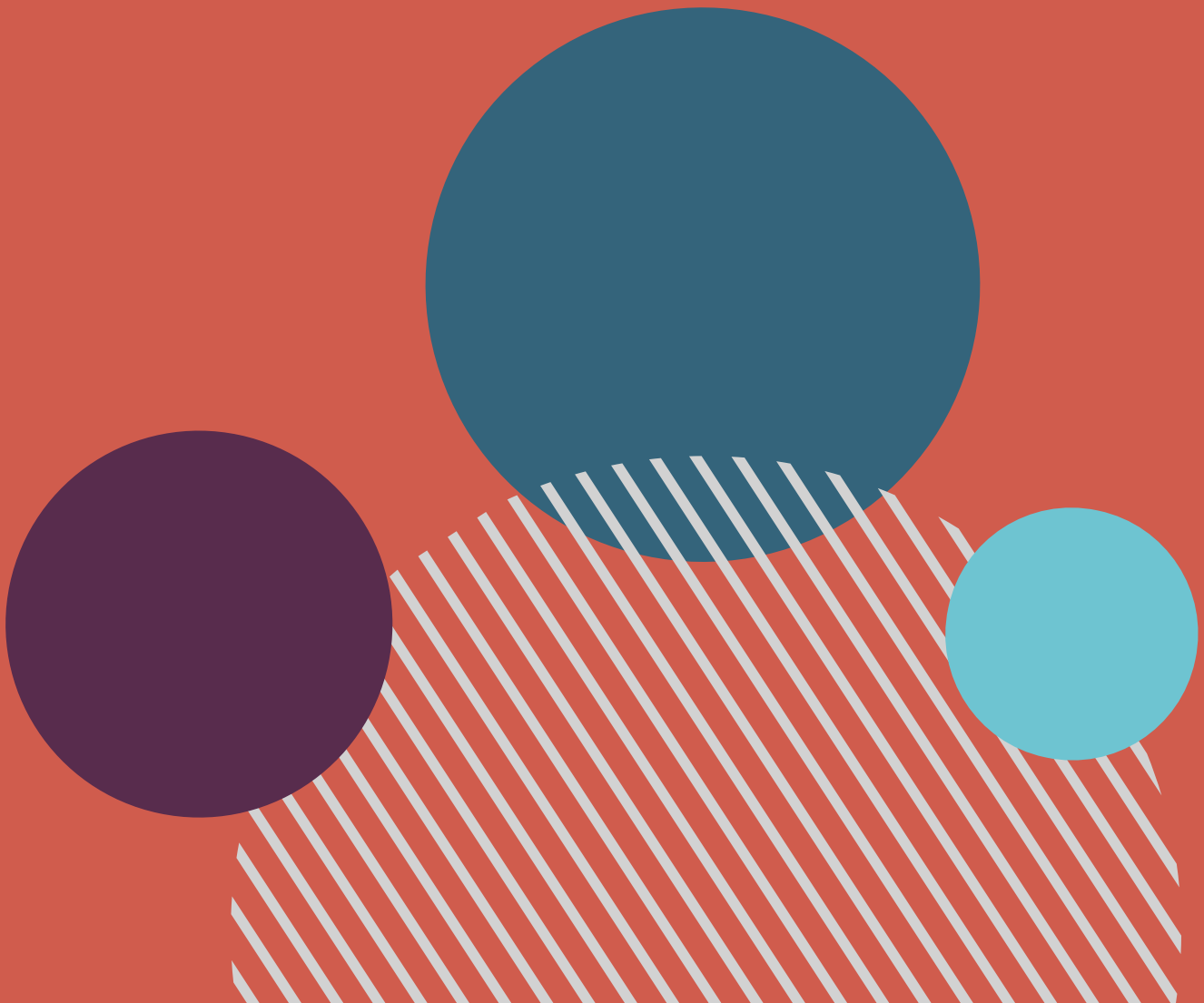
SYSTEMS LEVEL SUPPORT FOR:

- Identifying common challenges in navigating transitions;
- Developing transition processes that align with model and funder requirements;
- Building awareness of the array of early childhood programs, their availability across the state, and eligibility requirements;
- Creating stronger connections between organizations that house home visiting programs;
- Funding to support cross agency transition efforts;
- Funding for the development and distribution of community-specific resources to support transitions;
- Guidance around when to begin talking about transitions with families and strategies to support warm handoffs;
- Tools and resources for supporting transitions; and
- Conducting co-visits, such as funding this activity and clarifying if co-visits at the point of transition constitutes dual enrollment.

CONCLUSION

The Transitions Mini QI Learning Collaborative was an exploratory project for the teams and MPHI. It involved identifying where gaps existed locally and testing out small strategies to begin building local systems that can seamlessly support families as they move through the early years of infancy and childhood. Support is needed for both program staff and families to continue to build cross program transition processes, and to facilitate widespread knowledge in communities about what is available to families with young children.

APPENDICES



PDG Home Visiting Transitions QI Learning Collaborative

APPENDIX A

Learning Collaborative Goal

By December 30, 2022, participants in the PDG Home Visiting Transitions Learning Collaborative will improve transitions for families through testing small changes supported by a MPHI Quality Improvement Coach and each other.

Primary Drivers	Secondary Drivers	Specific Ideas to Test
PD1: **Trust/Trusting Relationship with Families (Family Centered Transitions)**	• Programs create a shared vision of the transition by assessing family needs, goals, and feelings about the transition. • Families are supported in transitions via warm hand off to other home visiting programs, early childhood programs or community supports. • Family readiness and need for transition process assistance is assessed well in advance. • Programs are transparent with families about options available. • Program and home visitors listen to family voice and feedback on transitions.	1. Program develops and utilizes a definition of transition that is clear to program staff and families. 2. Program has consistent communication process between families and programs i.e., family feedback on how transitions should occur. 3. Program routinely gathers feedback on transitions experiences using diverse methods (survey, holding focus groups, informal conversations, email, etc.) 4. Program utilizes a standard process for providing resources i.e., a menu of options for families to choose from. 5. Program utilizes ride along strategy to increase comfort of family (other agency staff introduced during visit/home visitor accompanies caregiver to initial contact with receiving program). 6. Home Visitor initiates discussion of transition on a standard timeframe, i.e., after enrollment, 90 days prior to program completion, etc. 7. Utilize standard process for tracking referrals from need identification through receipt including warm handoffs. 8. Program utilizes "Pal" system to connect families beginning transition to families that have transitioned and are familiar with the process and receiving program. 9. Home visitors learn about families' culture and values throughout program participation and transition plans are individualized to address children's and families' diverse backgrounds, development, strengths, and needs. 10. Program develops and utilizes guidance for determining what level of support a family might need during transition. 11. Home Visitors routinely follow up on family goals toward growth and transition checking in on what they anticipate, look forward to, and worry about. 12. Program provides families with information about resources available in the community in a format that is appropriate for the family (text, email, written brochure, website, etc.). 13. Program creates and utilizes a follow-up process with families to check-in on transition completion, gather feedback and provide warm handoff support. 14. Program ensures communication and information regarding transitions is simplified so that it addresses different literacy levels & languages.
PD2: **Well Established Referral Networks Exist**	• Consistent communication strategies exist between organizations i.e., feedback on referral process and when/if families make the connection to the referred resource. • Program/LLG has relationships with and knowledge of: ➢ Other home visiting and early childhood programs ➢ Other community resources for early childhood education and parenting support ➢ Community resources that provide support for basic needs, health, and economic growth.	1. Regular touch points are used to build relationships and a strong referral network such as: a. Attend community meetings, groups, events to increase visibility of program and build rapport with potential referral partners. b. Hosting regular lunch and learn with referral partners to put faces with names, learn what is new or changed, and build relationships for continued support. 2. Program identifies a specific contact person at each referral partner to build rapport/relationship, and contact list is updated at least annually. 3. Program utilizes a standard follow-up process with referral partners to check in on transition completion, gather feedback and provide support. 4. Program creates and maintains a resource directory for families (booklet, website, database, Facebook page, etc.) of public and private programs/agencies in the community ensuring it is current, contains reputable sources, and are listed by type of referral/family need for accessibility. 5. Program has regular referral partner touch points (i.e., physical presence, monthly email, brown bag lunches, etc.) 6. Program develops and utilize a system to refer families to other home visiting programs to support family transitions. 7. Provide regular professional development to Home Visitors to build knowledge about available community resources and can connect families to meet identified needs, i.e., bringing referral partner into team meetings to provide information and make personal connection.

Learning Collaborative Goal

By December 30, 2022, participants in the PDG Home Visiting Transitions Learning Collaborative will improve transitions for families through testing small changes supported by a MPHI Quality Improvement Coach and each other.

Primary Drivers

PD3: **Strong Programmatic and Community support for transitions**

Secondary Drivers

- Program has strong communication within the organization and structures are in place to support smooth transitions.
- Home visitors are supported in professional development for communication skills such as Motivational Interviewing, best practices for transitions, community networking.
- Program has clear guidance on best practices for transitions: timeline for conversation, process for transition, designated responsibilities, community resources, follow-up process.
- Community sees value of continuum of supports for families.
- Community agencies have strong partnership and support for transitions of families prenatal to school age.

Specific Ideas to Test

1. Program utilizes a primary contact and contents expert staff person to support communication on transitions within the organization and support home visitors.
2. Program utilizes program-level guidance based in best practices/model elements to support transitions (when to start conversation, how often, what to consider, etc.) and guidance is revisited annually with team for revisions.
3. Program maintains a standard process for tracking referrals from need identification through receipt including warm handoffs.
4. Provide regular professional development to ensure that all staff are prepared to offer children and families effective support through transitions (Motivational Interviewing, best practices, array of community resources).
5. Program supports home visitors to learn about other programs/resources in the community on an ongoing basis.
6. Program develops resources such as transition plan templates, written guidance on preparing families for transition, recommendations for the timing and content of transition conversations, and transition training that support a more consistent, supportive transition process for families.
7. Program utilizes engaging and meaningful traditions for transitioning between program, such as creating a memory book, going on an adventure to the new program/classroom, etc.
8. Home visitors are knowledgeable on the eligibility requirements of other programs/resources.
9. Program supports training and ongoing coaching of home visitors on how to best facilitate conversations about transition with families.
10. Program creates and utilizes a standard transition plan for home visitors to use in the field that includes array of community resources.
11. Program establishes a process for follow-up and accountability when transitioning clients.
12. Program encourages connection to multiple sources especially for families with complex needs to ensure supports that meet their specific needs such as special education, mental health case management, housing and/or another home visiting program are met.
13. Program supervisors regularly discuss transition planning during supervision to provide support to home visitors on an individual family basis as well as sharing knowledge and troubleshooting barriers.
14. Program and home visitors maintain a community presence to increase knowledge of and familiarity with the program for other referral partners as well as families.
15. Home Visitors stay connected with the program staff that received the referral to assist if questions arise.
16. Home visitors use a standardized process for documenting which referrals are made, follow up on referrals, the disposition of referrals and enter information into the program's database completely and accurately.
17. Home visiting staff regularly participate in local community collaborative bodies such as the Perinatal Quality Collaboratives, Great Start Collaboratives and Parent Coalitions, Fetal Infant Mortality Review, Local Leadership Groups and other local community collaboratives.

Preschool Development Grant Home Visiting Transitions Quality Improvement Learning Collaborative

Plan-Do-Study-Act (PDSA) Cycle Planning Tool

Please complete the following Planning Tool for each PDSA cycle your team charters for your Quality Improvement (QI) effort as a part of the Preschool Development Grant Home Visiting Transitions Quality Improvement Learning Collaborative. The purpose of the Learning Collaborative (LC) is that participants will improve transitions for the families in the programs/LLGs through testing small changes supported by a MPHI Quality Improvement Coach and other home visiting programs participating in the LC.

This tool is meant to be revisited and updated on a regular basis. As your team works through your PDSA cycle, you will be able to complete various portions of the tool.

For support with completing this tool, please reach out to Michelle Datema at mdatema@mphi.org

LIA/LLG Name: Choose your team.	
Date Tool Started: Click or tap to enter a date.	**Date Tool Last Updated**: Click or tap to enter a date.
PDSA Cycle #:Choose PDSA Cycle.	**Primary Driver:** Choose Primary Driver. **Change idea to test from Key Driver Diagram:** Click or tap here to enter the change idea from the KDD that your team is testing for this PDSA cycle.

Quality Improvement Team Members:

Name	Position in Program or LLG	Role on QI Team (facilitator, scribe, subject matter resource, data/information liaison, etc.)
Click or tap here to enter full name of team member.	Click or tap here to enter position in LIA/LLG.	Click or tap here to enter role member is carrying out on QI team.
Click or tap here to enter full name of team member.	Click or tap here to enter position in LIA/LLG.	Click or tap here to enter role member is carrying out on QI team.
Click or tap here to enter full name of team member.	Click or tap here to enter position in LIA/LLG	Click or tap here to enter role member is carrying out on QI team.
Click or tap here to enter full name of team member.	Click or tap here to enter position in LIA/LLG.	Click or tap here to enter role member is carrying out on QI team.
Click or tap here to enter full name of team member.	Click or tap here to enter position in LIA/LLG.	Click or tap here to enter role member is carrying out on QI team.

Plan Stage:

What is your team trying to accomplish with this PDSA cycle?

Click or tap here to enter the SMART aim/goal your team is working to accomplish through this PDSA cycle.

How will you know if the evidence-based intervention tested is an improvement to your process?

Measure(s):

Click or tap here to enter the quantitative (% or count) and/or qualitative (question(s) asked, etc.) data that will be collected.

For qualitative measures, note what specific questions will be asked, how often and of whom (such as families, home visitors, LLG members, community partners).
Click or tap here to enter a description of the qualitative data.

For quantitative measures, note the numerator and denominator or what is being counted:

If using a measure that is a proportion (%):
Numerator: Click or tap here to enter a description of the numerator.

Denominator: Click or tap here to enter a description of the denominator.

If using a measure that is a count: Click or tap here to enter what is being counted.

When will data be collected? Click or tap here to enter when data will be collected.

Who will be responsible for collecting the data? Click or tap here to enter who is responsible for collecting and entering the data.

How often will the data be analyzed? Click or tap here to enter when data will be analyzed (e.g. weekly, monthly, etc.).

Who will be responsible for analyzing the data? Click or tap here to enter who is responsible for analyzing the data.

How will your team test the change idea?

What steps will your team take to test the change idea?

- Click or tap here to enter step.
- Click or tap here to enter step.
- Click or tap here to enter step.
- Click or tap here to enter step.

Who will test the change idea? Click or tap here to enter who will test the change idea

Start and end date of when the change idea will be tested: Click or tap to enter a start date. to Click or tap here to enter an end date.

What resources are needed to test the change? Click or tap here to enter any resources needed to test the EBI.

Do Stage:

Record notes from monthly team meetings on data collected, activities completed, learnings, and challenges that occur during the Do Stage.

Month	Activity/Update
June	Click here to enter update.
July	Click here to enter update.
August	Click here to enter update.
September	Click here to enter update.

Was the test of the change idea carried out as planned?

☐ Yes
☐ No

If no, why not and what happened?

Click or tap here to enter text.

Study Stage:

Did the team meet your SMART aim/goal?

☐ Yes
☐ No

What did the team learn?

Click or tap here to enter what the team learned.

What surprised the team?

Click or tap here to enter what surprised the team.

Act Stage:

How will your team act on this PDSA cycle?

Will the team: *(Select one plan of action for this PDSA Cycle)*

☐ **Adapt:** Adjust strategy and test again in next cycle.

- In what ways will the team adapt the strategy to test again? **Click here to enter text.**

☐ **Abandon:** Try something different in next cycle.

- How does the team plan to move forward with testing a different strategy to achieve improvement in this process? **Click here to enter text.**

☐ **Expand:** Continue to test as is but with a different condition or on a wider scale.

- In what ways will the team expand the strategy to test again? **Click here to enter text.**

☐ **Adopt:** Make the tested strategy standard practice.

- How will the team sustain the gains made through the PDSA cycle? **Click here to enter text.**

THIS IS THE JOURNEY OF A PARENT **BEFORE THE START OF THE QI LC**

ENROLLMENT: Enrolled in NFP during pregnancy

EXIT: Exited NFP when child was almost 2 years old

TRANSITION: No transition

	BEFORE TRANSITION	DURING TRANSITION	AFTER TRANSITION	IMPACTS
FEELINGS	 Felt **UNAWARE** No conversation. "Before joining the LLG (after transitioning out of NFP), I did not know there were other programs. I did not know they existed."	 Was **UNAWARE** of when the program ended or that a transition was happening. "It was a big thing that happened for us, it was a bump." "Thought it (HV program) came and went."	 **SURPRISED** that there were other programs available. Felt **POSITIVE** about joining other programs if given the opportunity. "Would love to transition and see what that's like."	 Felt **SUPPORTED** by the program they did engage in. **UNAWARE** of other options despite their desire to transition
LIVED EXPERIENCE	Good engagement in home visits while pregnant, but visits became infrequent after child was born. Program did not effectively communicate when the program would end. "Exit from the home visiting program was not planned."	There were no regular home visits after the child was born. "There was no 'hey, this is it' conversation"	Family still in contact with their responsive NFP home visitor. Would have preferred having conversation about other programs. Family does not have other program or resource to rely on. "I wasn't aware, so it wasn't a big 'hey what's next' conversation."	Would have liked to know more about other programs. "Probably would have asked more questions." Would have loved to transition if had known there are other programs.
PEOPLE AND RESOURCES	Program shared community resources and services but not about other programs. NFP provided a lot of help during pregnancy. HV sent notices of community events that the family could participate in. Found the NFP baby shower very helpful for resources. "Helpful (support) outside of having a family."	Home visitor called sometimes to check in and share events.	After transition, parent gained knowledge of other programs after participating in Local Partnership Group (LLG). "Prefer to have conversation about other programs- that would be the only thing I would change."	Had multiple nurses in the beginning, and then just the home visiting nurse as the end. Got what the parent needed from NFP.
SUGGESTIONS	Need for clear communication of upcoming program end, open conversations.	Families need time to prepare for transition.	This caregiver recommended having another person besides the home visitor managing transitions.	Families benefit from knowing their options and having conversations with their HV in advance of exit as they may want to transition, they just don't know it is an option for them.

THIS IS THE JOURNEY OF A PARENT **BEFORE THE START OF THE QI LC**

ENROLLMENT: Started Oakland LLG after pregnancy

EXIT: Parent finished NFP when child was 1

TRANSITION: No transition

	BEFORE TRANSITION	DURING TRANSITION	AFTER TRANSITION	IMPACTS
FEELINGS	 Felt **SUPPORTED** by the program they were in	 Program felt **IMPERSONAL**	 Would have **BENEFITED** from a list of programs with links to websites	 Would have **PREFERRED** centralized place or one person coordinating transitions. Felt **SURPRISED** to learn there were more options.
LIVED EXPERIENCE	Felt visits were part of a routine but it was nice to have a sounding board. (Home visitor) Said we are going to have one more phone call and you know want to make sure you are all good. Was told that the next call would be the last call. Visit calls were happening every 4-6 weeks. Was in the program for over a year. Nurse answered all the questions. Don't know what else to be in.	Felt the experience could have been different if they met in person instead of phone calls only. She was really nice and she was like if you had any concerns you can reach back out to her if you had any questions but not much more than that. Was told that the program would end with next phone call (every 4-6 weeks) and that there were no other programs. Nurse home visitor informed family they could reach out if questions came up.	I don't think people have access to the information that all of these programs exist and why they are here and where you can go to get information on them. Transitions I would say, if she would have just had more of an explanation of these programs and what their purpose is so I could even understand there were more programs that existed.....	Don't know what other programs were available that they could join. I wouldn't have know that there are other programs had I not been in the Parent Leadership group. The nurse did not explain that to me.
PEOPLE AND RESOURCES	The home visiting program was a nice support to have as a first-time parent.	Nurse home visitor sent an informational flyer on the Great Start Collaborative (GSC) for the parent to contact them but did not help to connect with GSC. Parent was looking for a connection by nurse before connecting to GSC.	Wasn't aware of what is available. Parent became aware of other home visiting programs in the community when they joined the Local Leadership Group (LLG). LLG Coordinator shared information on other programs. Wouldn't have known otherwise.	Shared a flyer of resources without explaining what was on the flyer and what each program was about. People don't have access to the information that programs exist, what they do, why there here, where you can go get information about them.
SUGGESTIONS	Would have liked to know further in advance that the end of the program was coming.	Would have liked more information about why one should engage with GSC or other programs.	Would have preferred a transition email that included information of available programs.	Suggested flyers have more detail to make it clear the options are other HV programs and a centralized person who is aware of all programs.

THIS IS THE JOURNEY OF A PARENT **AFTER THE QI LC ENDED**

ENROLLMENT: Maternal Infant Health Program (MIHP) to Parents as Teachers (PAT)

CHILD: 1 child, 8 months old

TRANSITION: In progress

	BEFORE TRANSITION	DURING TRANSITION	AFTER TRANSITION	IMPACTS
FEELINGS				
	Despite not setting an end date, parent feels **PREPARED** as they have already met the PAT worker	Parent felt **CONFIDENT** going through the transition period, **EXCITED** for PAT playgroups Home visitors of both program have a great relationship with mom and baby - a little concerned about how the child would react but they warmed up to the PAT home visitor	**TRUST** PAT program built a relationship Parent felt **AT EASE** when home visitor provided advice assuring them their child is not the only child experiencing something	**VERY CONFIDENT**
LIVED EXPERIENCE	MIHP Home visitor gave information about transitions and resources. Parent asked for programs that would let her interact with other moms. Started talking about when MIHP would end at their second visit, well in advance.	PAT made contact to schedule co-visit. MIHP and PAT co-visit built trust and comfort. MIHP helped to pick the right program for the family. "Parents as teachers helps with any questions we have about raising (son)...and they give me activities to do with him to help him develop further."	Transitioned from MIHP to PAT. Has been in PAT for about 3 months. "I have a great relationship with MIHP and PAT, they are both really good people. The connection with them and (child) is very strong. Not only do they have a good relationship with me they have a good relationship with (child)."	"Did not have challenges with the transitions because they made everything super easy, I would voice my concerns and they would say "no problem, we got that". It was a super easy transition because if one person did not have the information that I needed I could find it through PAT." Co-visit made the transition experience easy. "I asked for this and they immediately said for sure...When I had the visit it was reassuring that (PAT worker) can replace MIHP. A nice transition and I could see what overlaps and what doesn't and ask questions."
PEOPLE AND RESOURCES	MIHP Caseworker emailed resources the day the parent asked for information on other programs. These included PAT and Moms Bloom. Received a flyer with information with contact information including the website.	MIHP provided information on PAT and how it would fit her needs. Home visitor initiated co-visit scheduling.	PAT provided calendar of scheduled play groups in the area.	MIHP connected them to postpartum resources that were very helpful.
SUGGESTIONS	Even though parent is nervous about transition, the support of MIHP HV in laying out options and communicating resources ahead of time helps with feeling prepared.	Parent found co-visit to be helpful in transitioning between programs.	"What made it easiest for me was that they did a co-visit. It was reassuring... I am confident with PAT taking over for MIHP."	Both programs working together on the transition enables parent to ask and have questions answered quickly.

THIS IS THE JOURNEY OF A PARENT **AFTER THE QI LC ENDED**

ENROLLMENT: Maternal Infant Health Program (MIHP) to Parents as Teachers (PAT)

EXIT: Exited MIHP when child was 15 months old

TRANSITION: Complete

	BEFORE TRANSITION	DURING TRANSITION	AFTER TRANSITION	IMPACTS
FEELINGS	 Felt **PREPARED**	 MIHP made the parent feel **SUPPORTED** when they asked questions. The co-visit was very nice. Felt very comfortable to have the extra support. PAT home visitor made the parent and child feel comfortable during the co-visit. Felt satisfied with the MIHP ending and moving to PAT	 Felt **PREPARED**	 Felt **INFORMED** and **SUPPORTED**
LIVED EXPERIENCE	MIHP home visitor shared when program was going to end Joined MIHP because they were a first time parent and were looking for child's learning knowledge and it felt good to have the home visitor to ask questions Had a planned visit. Had agreement on when the program will end. Home visitor shared information and set up them up with another program (PAT).	Parent preferred PAT as a first mom and was looking for activities focused program for their child. MIHP provided a warm handoff during the co-visit.	Knew what was coming because of the co-visit Felt **SATISFIED** with the timing She (MIHP HV) helped me along the way with signing up and getting me the information and up to the first visit (with PAT) she was still there. That was her end point. Both (MIHP) and (PAT) were very helpful and they reached out while I was in the process of filling out stuff. Everything was very smooth.	Both programs made them feel supported and comfortable Parent already had an idea of what they would experience and what was coming their way. Parent expressed that the co-visit allowed the child to meet the new home visitor and seeing the child be comfortable with the new worker was key to her as a parent feeling this was a good choice.
PEOPLE AND RESOURCES	Talking to the person visiting she (MIHP HV) kind of gave me a head's up, we can either stop it and move on to other things... she was very nice about sharing the information with me and getting me set up with the other program. MIHP home visitor shared resources (flyer) on possible programs for transition by email.	Completed PAT sign-up paperwork online. MIHP helped to connect with PAT worker. I replied to her (MIHP HV) email saying that I was interested (in PAT). She got me in contact by emails and phone calls... with the person that is now visiting our home.	MIHP followed up to answer questions and offered them a survey to complete.	It was nice to have extra guidance when it comes to learning about parenthood.
SUGGESTIONS	Parent was connected to the PAT worker through an online sign up. Nice to have that extra guidance even if you have some stuff figured out.	Phone calls were not as helpful as in-person meetings would have been. Would prefer more in person meetings if they could change their experience.		Having programs overlap with co-visits ensured that there was no gap for the family in moving to the next program as child aged out of the first.

PDG HOME VISITING TRANSITIONS MINI QI LEARNING COLLABORATIVE

PLAN-DO-STUDY-ACT (PDSA) CYCLES AND RESULTS

Each of the three participating teams (District Health Department #10 Healthy Families America Program, Oakland Local Leadership Group, and Ottawa County Maternal Infant Health Program) completed two PDSA cycles during the length of the collaborative. After assessment of where they were already strong and areas where they felt they should target improvements each team chose a Primary Driver and Change Strategy to test during each individual PDSA cycle.

Completion of the PDSA Cycle included:

PLAN

- Setting a **SMART aim statement** goal for the amount of change they were intending to achieve during the PDSA cycle.
- Mapping out their current **process** related to the improvement area they were working on to discern where there were current gaps.
- Completing a **Key Driver Assessment** and a localized **root cause analysis** to identify barriers currently experienced in relation to the area they were targeting improvements, adding to knowledge of current gaps in the current process and background information from the Key Driver Diagram.
- Based upon the discussion of goals and area the team wanted to focus improvements in light of their barriers discussion, each team selected a **Change Strategy** from the Key Driver Diagram to test during the PDSA Cycle. Materials were developed if needed to test the Change Strategy.

DO

- Teams tested the **Change Strategy** for a period of time recording data and observations.

STUDY

- Teams reflected on the **results** of the test and measure of success against their PDSA cycle SMART aim statement.

ACT

- Teams chose to either **adopt** strategies as tested, adapt, or expand what they tested.
- Teams made plans for sustaining their gains and/or making further improvements in the next PDSA Cycle based upon accomplishments and lessons learned during this cycle.

DISTRICT HEALTH DEPARTMENT #10 (DHD#10) HEALTHY FAMILIES AMERICA (HFA) PROGRAM

PDSA CYCLES

	CYCLE #1	CYCLE #2
PRIMARY DRIVER	**Strong programmatic/community support for transitions**	**Strong programmatic/community support for transitions**
CHANGE STRATEGY TESTED	**Program utilizes program level guidance** based in best practices/model elements to support transitions. This change strategy was chosen because DHD #10 did not have a standardized policy or procedure for the family transition at completion of program enrollment.	**Program develops resources** such as transition plan templates, written guidance on preparing families for transition, recommendations for the timing and content of transition conversations, and transition training that support a more consistent, supportive transition process for families.
AIM STATEMENT	By September 1, 2022, DHD#10 staff will have **increased comfort in using the HVOL transition plan tool to fidelity** from the majority of responses being "somewhat comfortable" to "mostly comfortable".	By December 30, 2022, DHD#10 HFA will see an **increase in the overall satisfaction rating score**, from an average of 8.6 to 9, on the exiting families transition surveys.
RESULTS & LEARNING	**The team tested the use of a standardized transition plan policy and procedures** (developed from HFA Best Practice Standards) for use in the last six months of a family's program enrollment. Home visitors stated that having a standardized procedure corrected wrong or incomplete information that they held about family transitions. The policy and procedures will be used across all six counties the program serves, in new staff orientation, and reviewed yearly in a full staff meeting.	**Healthy Families DHD #10 collected information from families who had recently transitioned and preschool teachers who could be receiving children upon HFA program completion.** Parents were satisfied with the transition to preschool or other services. Preschool teachers provided the HFA program a list of specific skills for the child to have for preschool and details about enrollment procedures. Using what they had learned and building on PDSA Cycle #1, DHD #10 developed Transition Bags that included a binder of materials with community resources, a transition plan to be completed by the parent and the home visitor, preschool/ kindergarten enrollment contacts and procedures, and school readiness items to use with children to improve skills needed for next steps. Important learnings were that there is a gap in knowledge and resources for children who do not qualify for free preschool and whose families cannot afford tuition-based preschool, and that the process for transitioning to preschool needs to be tailored to each of the six counties served.

OAKLAND LOCAL LEADERSHIP GROUP (LLG)

PDSA CYCLES

	CYCLE #1	CYCLE #2
PRIMARY DRIVER	**Strong programmatic/community support for transitions**	**Well established referral networks**
CHANGE STRATEGY TESTED	**Home visitors are knowledgeable on the eligibility requirements of other programs/resources.** A survey of six home visitors showed that they did not have a complete understanding of the home visiting programs in the county, eligibility criteria and how to refer families that are completing their program.	**Program develops and utilizes a system to refer families to other home visiting programs to support family transitions.** This change strategy was chosen because Oakland LLG member programs did not have a standardized system to refer families to home visiting programs and/or other community resources.
AIM STATEMENT	By August 30, 2022, the Oakland LLG home visitors will **express increased confidence in transitions** from 3 to 4 when presented with a revised decision tree.	By December 31, 2022, 80% of the home visiting staff presented Help Me Grow will have a **clearer understanding** on how it can support their clients and will **use the Help Me Grow transition bags as part of their standard transition process.**
RESULTS & LEARNING	**In collaboration with LLG members, the Oakland County Evidence-Based Home Visiting Programs Decision Tree was reviewed and updated.** The document includes a decision tree with eligibility requirements, program contact information, and how to contact Help Me Grow. Home visitors were more confident in making transitions when they had updated information about programs in the county. The LLG Coordinator will update the decision tree twice a year and when new programs are added in the county.	**LLG members stated that there are other times, in addition to the transition at the end of the program, where families need connection to resources i.e., families not ready to start or continue with home visiting, are in crisis and need additional resources or need connections when they are no longer enrolled in the program.** Many home visitors thought that Help Me Grow (HMG) was a program with eligibility criteria rather than a community resource available to everyone. They inferred that families may also be confused about the role of Help Me Grow. For this PDSA cycle, the LLG developed a Transition Bag that contained durable items (children's books, heart ice pack, journal, and feelings playing card set inside a reusable bag) that families could keep that included the Help Me Grow logo and contact information. This would support families to connect with Help Me Grow for resources at times when they are not enrolled in home visiting (after program completion, during crisis, when disengaged with home visiting).

OTTAWA COUNTY MATERNAL INFANT HEALTH PROGRAM (MIHP)

PDSA CYCLES

	CYCLE #1	CYCLE #2
PRIMARY DRIVER	**Strong programmatic/community support for transitions**	**Trusting relationships**
CHANGE STRATEGY TESTED	**Program utilizes program-level guidance** based in best practices/model elements to support transitions (when to start the conversation, how often to discuss, what to consider, etc.) and guidance is revisited annually with team for revisions. This change strategy was chosen because MIHP home visitors were inconsistent in the way they described and promoted Help Me Grow and the Parents as Teachers program to families transitioning out of MIHP.	**Program utilizes co-visit strategy** to increase comfort of family (other agency staff introduced during visit/home visitor accompanies caregiver to initial contact with receiving program). This change strategy was chosen as some families were hesitant to transition to a new home visiting program when they complete MIHP. Families are uncomfortable and/or don't trust a new home visiting program.
AIM STATEMENT	By September 15, 2022, **all Ottawa County MIHP home visitors** (six in total) **will receive a guidance document** and be able to accurately describe Help Me Grow to families.	By December 31, 2022, **three co-visits with Ottawa County Department of Public Health and Intermediate School District staff will take place** and qualitative feedback from families and home visitors will be collected in order to gauge feasibility and effectiveness of co-visits.
RESULTS & LEARNING	**The Transitions from MIHP Guidance for Best Practice document was created**. The document explains What, Who, When, Why, and How home visitors can facilitate transitions. It also includes descriptions of home visiting programs available in Ottawa County and the referral process to Help Me Grow. The team learned that a guidance document as a clear way of describing early childhood programs in Ottawa County was needed and helpful. The guidance document will be implemented as a part of MIHP onboarding and be regularly updated. The project helped strengthen the connection between MIHP and Intermediate School District (ISD) staff. The process of referring to Help Me Grow was improved as potential roadblocks were discovered.	**The Transitions Co-visit Guidance document was developed** and includes suggestions from parents on planning co-visits, the process for scheduling and holding co-visits, and a contact list of MIHP and ISD staff. The team attempted to schedule co-visits between MIHP and ISD for two months. They met several barriers: illness, holidays, home visitor part-time schedules, parent schedules, etc. They were able to complete three co-visits. The parents involved said the co-visits made them feel more comfortable with the transition, helped them trust the new home visitor, and increased their likelihood of continuing in home visiting. Home visitors also found the co-visits helpful. Additional learnings include: there is a need to clarify the purpose and content of the visit, co-visits were longer than routine home visits, it was helpful for MIHP home visitors to develop relationships with ISD home visitors, there is a need to define which families would need/benefit most from co- visits, and programs should consider if virtual co-visits would be an option. An important learning was that PAT National recommends a pre-enrollment visit (a "Courtesy Visit"). This visit gives families a better sense of what a visit is like, provides more detail about the other model components, discusses expectations for participation, and answers questions. This can help families make a genuine and well-informed commitment.

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