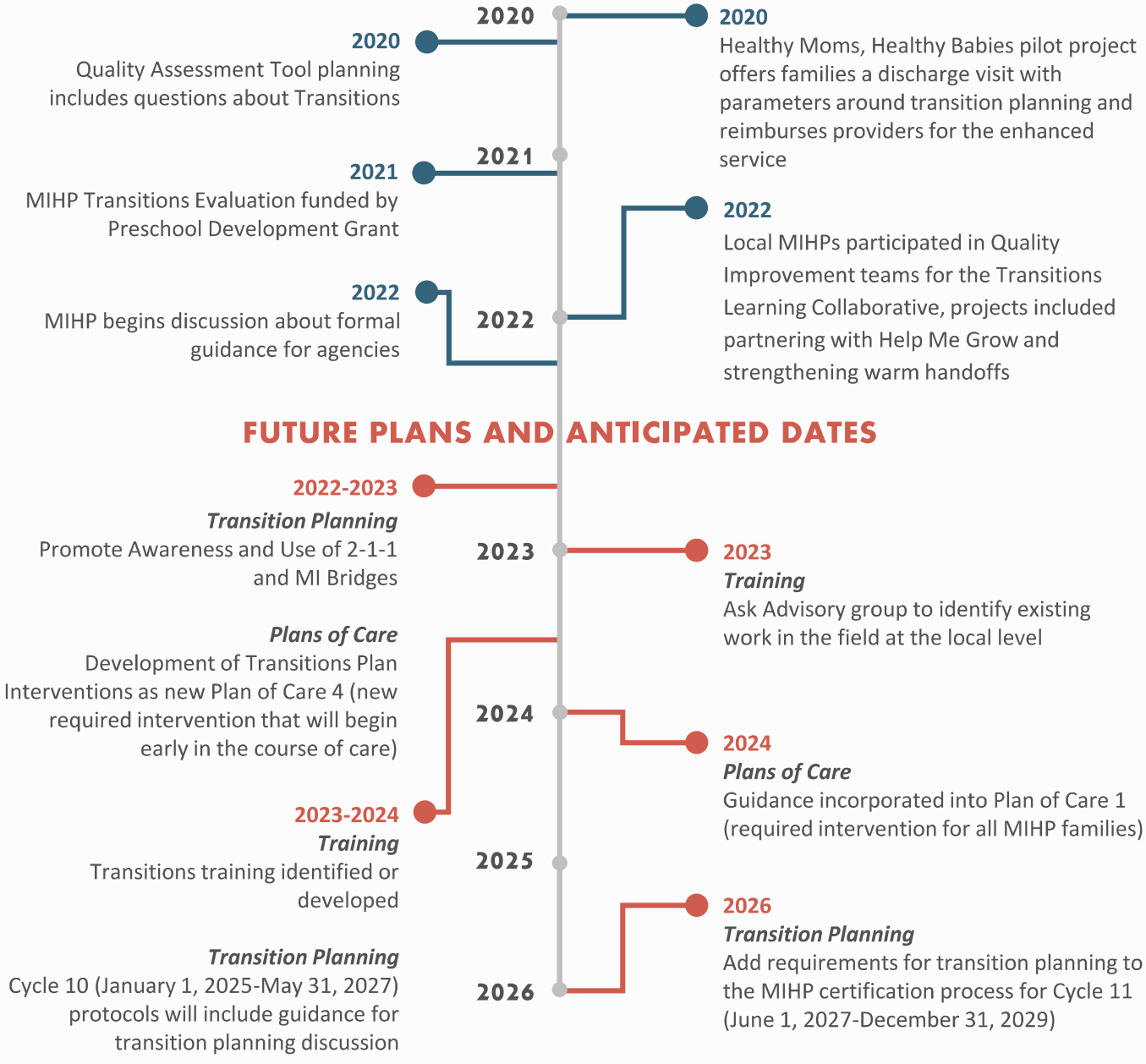
TRANSITIONING OUT OF MIHP

A Brief Summary of Evaluation Findings, Current Activities, and Future Plans

Transitioning out of home visiting services can be a critical time for ensuring a family's continued growth and wellbeing. Michigan's Maternal Infant Health Program (MIHP) has been working over the past several years to understand the experience of transitioning out of their program and how to ensure that every family has a successful transition. This brief report summarizes several recent efforts, featuring a Transitions Evaluation in 2021.

TIMELINE OF MIHP TRANSITIONS ACTIVITIES



PDG EVALUATION STUDY

When a family departs from MIHP, the transition is not always a simple process. This evaluation examined how MIHP supports families through transitions, and how MIHP and the early childhood system can improve families' experiences.

Study Methods

Key Informant Interviews with nine state home visiting leaders and 10 local MIHP agency coordinators; and **focus groups** with 24 MIHP home visitors and 26 MIHP families were conducted for detailed qualitative analysis. A family **survey** was completed by 109 participants about family experience with transitions.

What is a Transition out of MIHP?

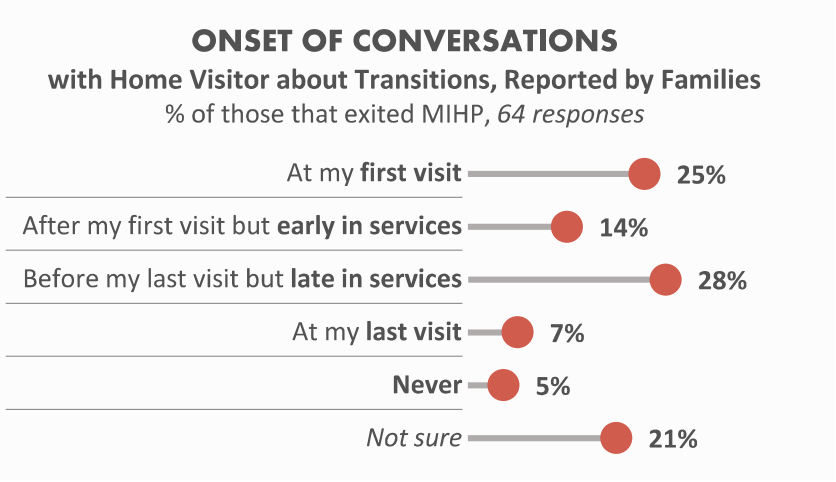
State leads and MIHP home visitors defined transition as a process whereby MIHP home visitors support families to move seamlessly to what comes next: either another home-visiting program, or community support outside of home visiting.

What Guidance do MIHP Home Visitors Have on Transition?

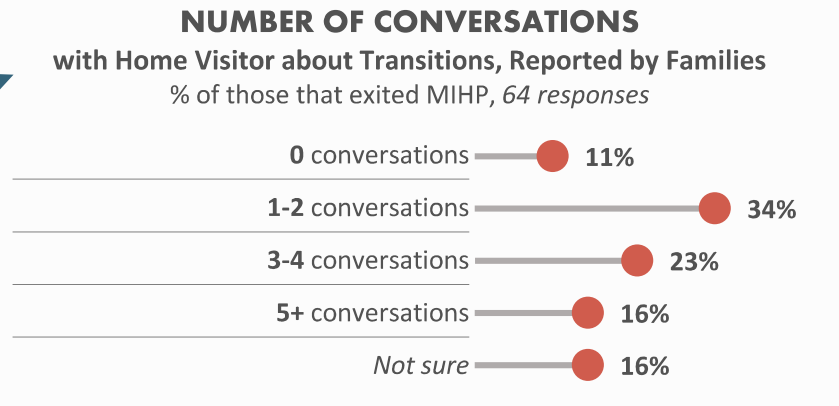
In 2021, state leaders and local home visiting professionals reported that little guidance and training specific to transitioning families was offered by the state. Case managers are required to connect families with the resources needed throughout the course of care. Local agencies have been creating their own supports, including trainings, to support staff on transitions.

When and How Often do Home Visitors Talk with Families about Transition?

There is a large range of family experience related to transition planning. At its most basic, transition planning requires conversations. State leadership encourages conversations early and often. Many home visitors in the study focus groups acknowledged that they do not start talking about transitions until the end of services. Families who were surveyed report a range of experiences around transition conversations (see graphs on the right).



While families did not agree there was a single "right" number of conversations about transitions, **NO families reported they had too many conversations about transition.**



What Happens During Transition Planning?

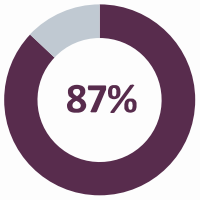
Transition planning is a broad expectation within the home visiting profession. State leaders largely agreed that ideally, MIHP home visitors would create a transition plan with each family at the start of services. Study participants reported that this standard is not often met. Most coordinators and home visitors take a family-centered approach toward transition that involved establishing the needs and goals of the family. They reported providing physical and online information about other local resources and discussing referrals to specific programs (particularly Head Start and WIC).

It is an MIHP program requirement to actively connect families with other resources and services throughout their time with MIHP. Warm handoffs have been strongly encouraged by MIHP leadership and home visitors agreed this would be ideal, even if they admit they do not often have the time or community connections to facilitate them. Some communities have an abundance of partner agencies to refer to while others have few referral options.

Families' experiences with referrals to other programs varied greatly. Most families reported getting physical information about other programs, supports, and resources and having in-person discussion about referrals. Families were most likely to recall community services such as WIC, baby item pantries, or educational resources.

Families were asked a series of questions in the survey about the services they wanted, the services they received, and the degree to which MIHP staff facilitated those connections. Across all categories, **families reported their needs were met 53% of the time.** While clearly not all family need is being met, when it is met, **families report that MIHP played a role 87% of the time.**

CONNECTING TO SERVICES



of connections to services were facilitated by MIHP staff

COMMUNITY REFERRALS AND SUPPORTS THAT HELP FAMILIES TRANSITION

mentioned by Home Visitors, MIHP coordinators, and families in the study

Home Visiting
Early Head Start Home-based, Healthy Families America, Parents as Teachers, Infant Mental Health, Family Spirit

Economic and Basic Needs Supports
Food, housing, clothing, baby items, utilities, parent's education, legal, moving costs, employment, transportation

Medical and Developmental Needs
Health insurance, medical care, immunizations, services for children with special healthcare needs, Early On, Healthy Start, mental and behavioral health, substance use counseling

General Support
2-1-1, staying in touch with MIHP home visitor

Childcare and Education
Childcare, Early Head Start Center-based, Head Start, preschool

Parenting Support Groups
Great Start Collaboratives and Parent Coalitions, playgroups, support groups, parent education programs, breastfeeding support

THE CONTINUUM OF FAMILY TRANSITION EXPERIENCES

The study of MIHP transition practices revealed the wide range of expectations held and experiences had among state leaders, home visiting professionals, and the families they serve. A continuum of family experiences and a continuum of professional practice were created to summarize that range of experiences and highlight what a Highly Supported Transition Experience can look like for both professionals and families.

PROFESSIONAL EXPERIENCE CONTINUUM

★★★ HIGHLY SUPPORTED Professionals

TRAINING: Transition-specific training and understanding of it as a unique process

DOCUMENTATION & PROCESS: Documented transition plan co-created by families and home visitor; Documentation in case file

SUPERVISOR SUPPORT: Specific discussions on transition strategies, including documented process and/or training

CONNECTION TO AND KNOWLEDGE OF COMMUNITY RESOURCES: Mix of referrals for family follow-up and warm handoffs to key supports; Home Visitors and Coordinators have personal connections to partner agencies to support follow-up

> "The thing that comes to mind, which is why I came up with the transition or end of care training, is managing the feelings around transition. If this went well, we've known these families for two years... What that goodbye is like. That part is being neglected."
>
> **-MIHP Coordinator**

★★☆ AVERAGE EXPERIENCE for Professionals

TRAINING: Awareness of transition as a unique process, no formal training

DOCUMENTATION & PROCESS: Largely verbal and informal planning that may be noted in case file

SUPERVISOR SUPPORT: Informal support from local agency

CONNECTION TO AND KNOWLEDGE OF COMMUNITY RESOURCES: Only Coordinators have personal connections to partner agencies to keep information up to date and share with home visitors

> "It's more just like verbal and on-the-job. Like we never had a checklist or anything."
>
> **-Home Visitor**

★☆☆ UNDER SUPPORTED Professionals

TRAINING: No training or limited awareness of transition as a unique process

DOCUMENTATION & PROCESS: No documentation in case file

SUPERVISOR SUPPORT: No discussion of transition process

CONNECTION TO AND KNOWLEDGE OF COMMUNITY RESOURCES: Knowledge out of date; no personal connections to partner agencies

> "I hate to say this, but honestly ... this whole discussion [about transition] is completely new to me. I was trained basically that all of the time you're spending with the family, you should be training them on how to follow through with resources and the different connections."
>
> **-Home Visitor**

FAMILY EXPERIENCE CONTINUUM

HIGHLY SUPPORTED Families

NUMBER AND TIMING OF CONVERSATIONS: Early and often

TRANSITION PLANNING: Documented transition plan co-created by families and home visitor

REFERRALS: Warm handoffs to other programs as appropriate; ideally to another home visiting program if desired

EMOTIONAL SUPPORT: Developing healthy boundaries around end of services; Acknowledgement that ending a long-term relationship may be difficult; Attending to unique needs of individual families, when appropriate, thinking of a family with referrals or support soon after program ends to provide a bridge to full independence

FAMILY READINESS: Family feels strong and capable to navigate services independently or is confident they are receiving new services that will continue to meet their needs

"Yeah, I mean the fact that like I can't just see her [Home Visitor] anytime. ...She's been there with me the entire time... And so when we finally ended, she cried and I cried... but it's not like she doesn't have my number and it's not like I don't have hers."

-MIHP Family

AVERAGE EXPERIENCE for Families

NUMBER AND TIMING OF CONVERSATIONS: Last several visits

TRANSITION PLANNING: Family-centered approach to identify needs and goals; primarily verbal and informal

REFERRALS: Online and physical referral lists largely to non-home visiting services for family to follow-up with as needed as part of ongoing service provision; Verbal reminders from home visitor to encourage follow-up which aligns with program requirements to follow up within 3 visits

EMOTIONAL SUPPORT: Relationship based in mutual support and care that families can take with them into other service settings; families miss seeing their home visitor regularly

FAMILY READINESS: Families receive referrals throughout services and it is their responsibility to follow-up to address needs; families may not want home visiting to end

"I do remember [my home visitor] explaining to me that as soon as the program ended, then someone from my local WIC office would contact me to get everything switched over and set up on that end."

-MIHP Family

UNDER SUPPORTED Families

NUMBER AND TIMING OF CONVERSATIONS: No conversations or single conversation on last visit

TRANSITION PLANNING: Little to no plan established for services ending; families left to navigate next steps on own

REFERRALS: General referral lists provided without support or coaching on how to successfully initiate new services; families have to ask for referrals

EMOTIONAL SUPPORT: Home visitor and family not emotionally connected during services; ending feels abrupt and formal

FAMILY READINESS: Family is overwhelmed or unresponsive; lack of trust with service providers in general; feeling abandoned by home visitor

"Is there something else that happens? ... I just figured, 'It's done, it's done' pretty much. Yeah. So are there services?"

-MIHP Family

RECOMMENDATIONS FROM THE EVALUATION STUDY

Provide Financial Support for Transition Activities

One of the most significant barriers to supportive transition planning is MIHP's funding structure. MIHP could benefit greatly from being able to bill for a transition visit, referral follow ups, and warm handoffs. Compensating staff for critical networking with early childhood system partners and other transition related professional development activities would improve the transition experience for families.

Provide Transition Guidance and Training

Resources like transition plan templates, written guidance on preparing families for transition, recommendations for the timing and content of transition conversations, and transition training would all support a transition process for families. MIHP as a model could provide agencies with a framework to understand family, home visitor, and agency responsibilities during transitions.

Promote Awareness and Use of Databases of Community Resources

Building MIHP providers' awareness and capacity in using MI Bridges, the Home Visiting Program Finder, Michigan 2-1-1 and other statewide databases of common referrals may help identify eligibility, location, and contact information. MIHP agencies can supplement these statewide databases with local knowledge and develop processes to keep their required resource directories up to date.

Increase Community Supports for Families

There is a need for maternal child health and early childhood to partner with other sectors to make sure families have what they need to thrive, including transportation, housing, counseling, accessible childcare services, and community events to support basic needs. In many communities there is a gap in services between 12 or 18 months and 3-4 years. Expanding home visiting services to address this gap and expanding networks so home visitors are aware of all programming can address this.

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