UNDERSTANDING FAMILY TRANSITIONS

OUT OF MICHIGAN'S MATERNAL INFANT HEALTH PROGRAM

FALL 2021

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Acknowledgements

MPHI is a Michigan-based and nationally engaged, non-profit public health institute. We are a team of teams, process and content experts, dedicated to our vision of building a world where tomorrow is healthier than today! Our mission is to work with you to promote health and advance well-being for all. Our broad network of partners includes academia, government, community-based organizations, and healthcare. These connections empower all of us to develop solutions to a wide range of challenges.

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The following individuals contributed to this report:

Julie Moore, MPHI
Anna Martinez-Hume, MPHI
Anna Salomonsson, MPHI
Julia Heany, MPHI
Steph Fluegeman, MPHI
Sara McGirr, MPHI
Erin Edgerton, MPHI
Amandeep Kaur, MPHI

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Executive Summary

Evaluating MIHP Transitions Support

The Michigan Department of Health and Human Services' (MDHHS) Maternal and Infant Health Program (MIHP) serves Medicaid-eligible pregnant persons and infants. The goal of MIHP is to reduce maternal and infant morbidity and mortality by addressing a wide range of family needs. When a family departs from the program, 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 therein.

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 also completed by 109 participants for a broader sample of family experience with transitions.

Results

Professionals defined transition as a process whereby families move seamlessly from MIHP to whatever comes next: often conceptualized as another home-visiting program or to self-sufficiency outside of home visiting.

Currently, there is not a standard process for transitioning families in MIHP. Some local agencies have developed their own guidance around transition.

There was variability in the timing and content of conversations about transition with families. Most families who responded to the survey felt the number of conversations about transition was "just right" and no families reported they had too many conversations about transition.

Home visitors provided resource referrals to families in preparation for transition. Staff felt strongly that warm hand-offs to other agencies was ideal but challenging. Hallmarks of successful transitions included relationships between agency staff, trust between families and staff, availability of "next step" programs in communities, and family engagement and follow-through. Most families reported that MIHP played a role in successfully connecting them with services they successfully received.

Families who reported feeling supported by their home visitor as MIHP ended were also still in touch with their home visitor; had more conversations with their home visitor about transition; and had more MIHP visits with their baby.

Results (continued)

Based on survey results, **families who felt MIHP ended abruptly** also did not complete all MIHP visits; started transition conversations earlier in programming; identified as Black or African American; lived in an urban or suburban area; and received MIHP through a private agency or hospital system.

Strong personal connections between families and home visitors and a positive MIHP agency culture helped support successful transitions. Sometimes this meant home visitors were volunteering their time outside of MIHP visits to support a gentle transition for families since the all-inclusive Medicaid reimbursement rate for MIHP does not adequately fund all activities that would potentially support transitions.

When MIHP agency staff were connected with the broader early childhood system in their community, they were better situated to support transitions for their families. This networking, formally through collaboratives or informally, was not funded by MIHP. Navigating the complexity of the early childhood system was daunting for some home visiting staff and families. Some communities do not have many options for supports for families after MIHP and it is challenging to maintain up-to-date lists of local resources to support transitions.

Recommendations

Participants and MPHI evaluators offered the following recommendations for improving families' experiences transitioning out of MIHP:

Provide financial support for transition activities

Provide transition guidance and training

Promote awareness and use of databases of community resources

Increase community supports for families

Introduction

The Michigan Department of Health and Human Services' (MDHHS) Maternal and Infant Health Program (MIHP) serves Medicaid-eligible pregnant persons and infants through 12 months of age.[1] MIHP providers deliver services including maternal and infant assessments, individualized plans of care based on family needs, coordination of services with medical care providers and Medicaid Health Plans, and referrals for local community resources. The goal of MIHP is to reduce maternal and infant morbidity and mortality by addressing a wide range of needs.

A participating pregnant person can receive up to 9 visits through their pregnancy and post-partum period. An infant and their caregiver can receive up to 9 visits. With a physician's order, an infant and their caregiver can receive an additional 9 visits as well as an additional 18 visits specifically to address substance exposure needs. Visits are offered monthly but may occur more frequently based on the needs and goals of the family.

It is often a rewarding moment when a family completes their home visiting sessions with the MIHP and is ready to move forward. However, when a family departs from the program, the transition is not always a simple process. There are many types of transitions that may be considered successful depending on the families' needs, including transitions to other home visiting programs, other community supports and services, or simply to a post-service life. While a smooth transition is recognized as ideal, MIHP's funding structure and each community's unique array of available programs can make it challenging to offer a supportive transition process. This evaluation examined how Michigan's MIHP supports families through transitions, and how MIHP and the early childhood system can improve families' experiences therein.

[1] To learn more about MIHP, visit https://www.michigan.gov/mihp/

Evaluating Transitions Out of MIHP

As the contractor for the Michigan Department of Education's Preschool Development Grant Evaluation, the American Institutes for Research (AIR) subcontracted with the Michigan Public Health Institute (MPHI) to conduct an evaluation of the Michigan MIHP and their process for supporting families through transitions. This evaluation examined how transitions take place, how MIHP programs support families through transitions, how the needs of families are met, and how to better support families through transition. These findings may inform strategies to best transition families into follow-up programs or other supports following completion of MIHP.

The objectives of the evaluation were as follows:

OBJECTIVE 1: Identify existing statewide and local guidance and preparation intended to shape the process of successful transition of families out of MIHP.

OBJECTIVE 2: Explore existing statewide, local, and home visitor-level connections to other home visiting programs and other supports/services; and the extent to which these promote successful transition of families out of MIHP.

OBJECTIVE 3: Explore the various process(es) through which families are currently transitioned out of the MIHP program.

OBJECTIVE 4: Identify what works well and what does not work well in transitions out of the MIHP program.

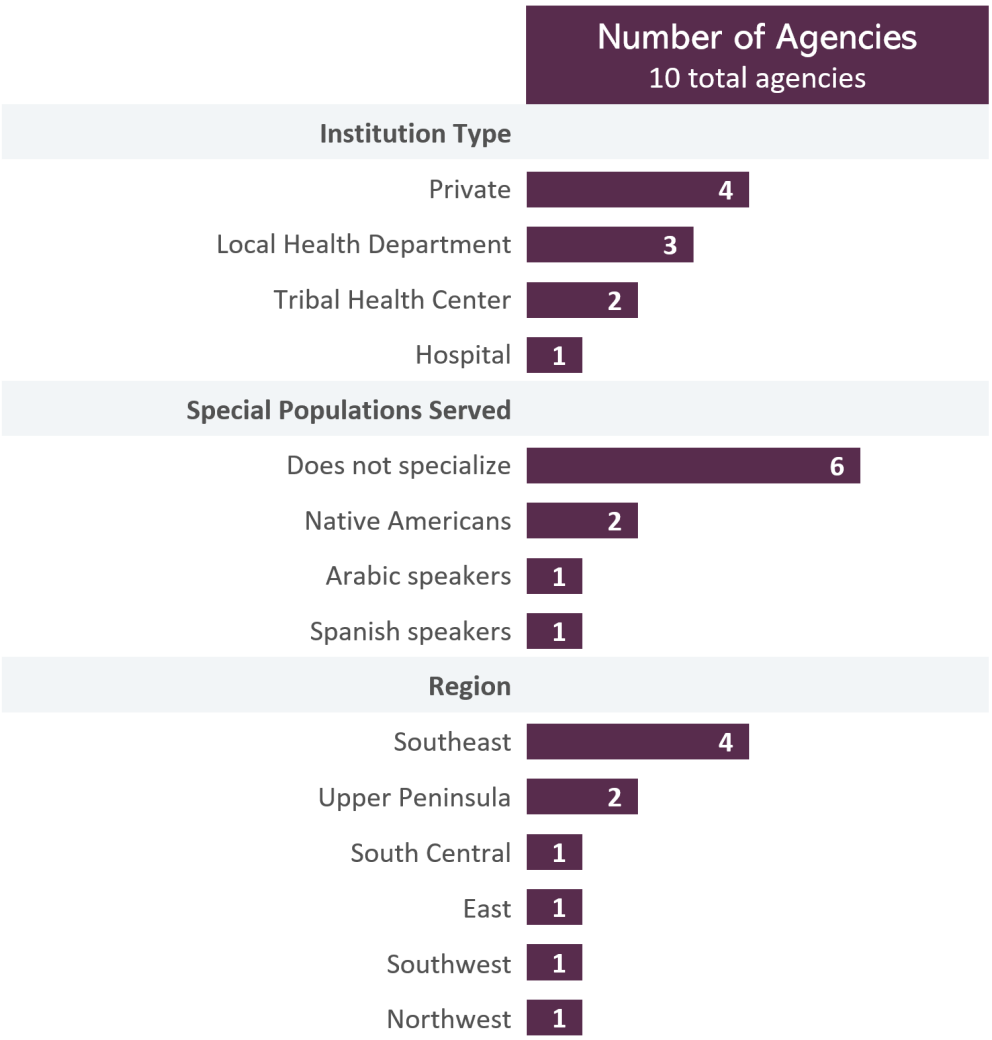
OBJECTIVE 5: Identify other state and local barriers and supports that influence transitions out of the program.

OBJECTIVE 6: Identify opportunities through which MIHP programs could better support families through transition processes.

Methods

MPHI worked closely with MIHP (in the Michigan Department of Health and Human Services) and home visiting partners at the Michigan Department of Education to develop data collection methods for the evaluation. MPHI also worked closely with ten local MIHP sites to collect data from program staff and beneficiaries. MIHP programs across the state differ substantially in size, institution type (local and district health departments, Tribal health centers, federally qualified health centers, hospital-associated programs and independent community-based agencies), populations served, and level of access to other early childhood services. These "case study" sites were purposively invited to participate as they best represent this diversity. Each site subcontracted with MPHI and agreed to participate in key informant interviews conducted with MIHP agency coordinators, recruit home visiting staff members and recently transitioned families to participate in focus groups, and distribute a survey to families who had recently transitioned out of MIHP. Each site received a stipend of $1500 for their participation.

PARTICIPATING MIHP SITES



PROCEDURES AND PARTICIPANTS

Key Informant Interviews

MPHI interviewed nine participants representing statewide leadership of several home visiting programs and related initiatives, including MIHP and its home visiting partners from the Michigan Department of Health and Human Services (MDHHS), Michigan Department of Education (MDE), and the Children's Trust Fund (CTF). Coordinators from each of the 10 MIHP sites were also interviewed. The interview questions were developed in collaboration with MIHP and MDE (see Appendix).

Focus Groups

Home Visiting Staff

MPHI facilitated four focus groups with home visitors from each MIHP site. Each focus group included between three and eight participants, with a total of 24 participants including 14 registered nurses, 9 social workers, and one registered dietician. Each pilot site was represented by between one and five staff. The focus group questions were developed with feedback from state MIHP and MDE staff (see Appendix).

MIHP Families

MPHI facilitated six focus groups with families who had recently exited MIHP programming. Five were conducted in English and one in Spanish (see Appendix for protocol). Staff from the 10 MIHP agencies recruited families for the focus groups who had transitioned out of the program in the last three to nine months. Twenty-six family members participated, with each English language focus group including between three and seven family members. One family member participated in a Spanish language session. Each site was represented by between one and seven family members. Families reported diverse experiences with MIHP, ranging from "zero" to "more than 10" visits during pregnancy and ranging between "1-3" and "10-18" visits with their baby. At the time of the focus group, families' most recent MIHP babies were between "0-6 months" and "Over 18 months" old. Families with younger babies had either left the program early or not fully completed their transition. All family participants received a $35 electronic gift card in appreciation for their time.

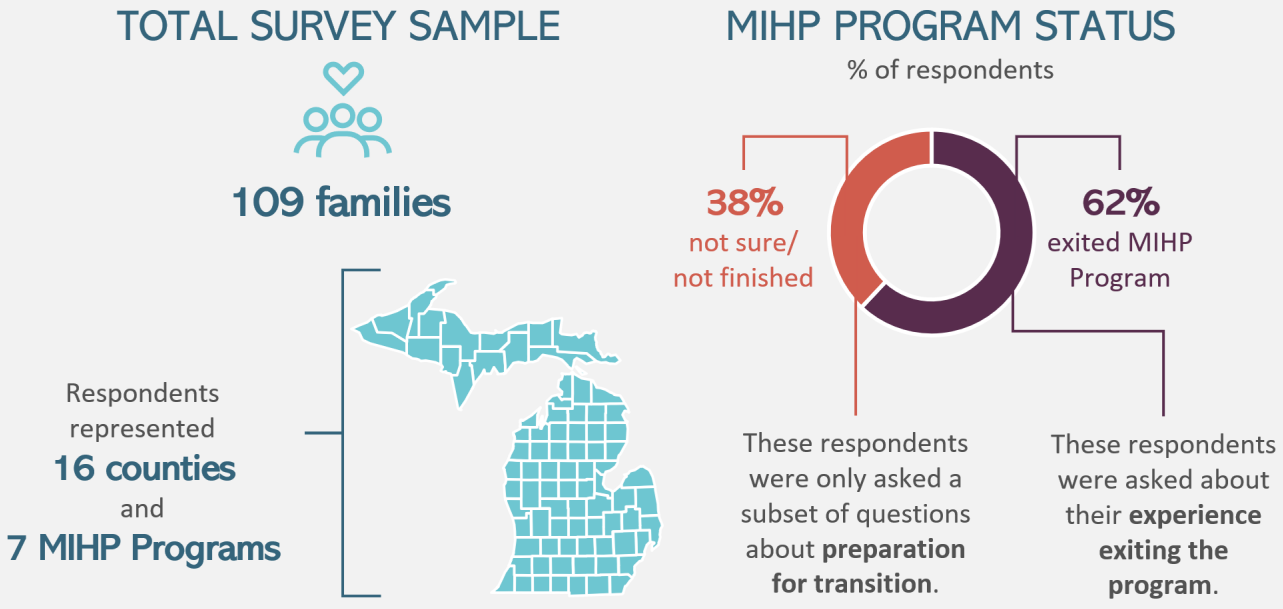
FAMILY SURVEY

Procedure

An electronic survey[2] was provided to recently transitioned families to complement the qualitative data captured in the focus groups. MPHI developed survey items with feedback from state MIHP and MDE staff (see Appendix). To encourage participation by Spanish-speaking families, the survey and invitation to participate were translated into Spanish. Both the English and Spanish invitations and survey links were shared with staff from each of the 10 participating local MIHP sites who were instructed to distribute the survey to families who had exited MIHP programming in the last year. If desired, families could enter a drawing for one of twenty $50 gift cards in appreciation for their time.

Family Demographics

A total of 109 families completed the survey. Many chose not to disclose their demographics, but those who did represented 16 different counties (ranging from 1 to 36 families per county) and 7 different MIHP agencies (ranging from 1 to 48 families per agency) across the state. Participants were asked if they were currently receiving official home visits from their MIHP home visitor to screen for study criteria that they had already exited. In response, 68 families (62%) said "Yes," 24 (22%) said "No," and 17 (16%) said "Not sure." Those who reported "No" or "Not sure" were asked a subset of questions about preparation for transition. Families included in the analyses are noted throughout the results section.



[2] PA Harris, R Taylor, R Thielke, J Payne, N Gonzalez, JG. Conde, Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support, J Biomed Inform. 2009 Apr;42(2):377-81.

DIVERSE MIHP FAMILIES RESPONDED TO THE SURVEY

Survey Demographics

	Exited MIHP 68 participants		Not Sure/Not Done with MIHP 41 participants	
Geographic Classification				
Rural/ Country	20	29%	10	24%
Suburban	4	6%	5	12%
Urban/ City	20	29%	11	27%
Not sure	12	18%	8	20%
Prefer not to say/blank	12	18%	7	17%
Race (select all that apply)				
American Indian or Alaska Native	1	2%	8	20%
Asian	3	4%	1	2%
Black or African American	15	22%	9	22%
Native Hawaiian or Pacific Islander	1	2%	0	0%
Other	2	3%	2	5%
White	35	52%	20	49%
Prefer not to say	2	3%	1	2%
Ethnicity (select all that apply)				
Neither Hispanic nor Arab	39	57%	28	68%
Hispanic or Latino	8	12%	2	5%
Arab or Middle Eastern	0	0%	2	5%
Prefer not to say	7	10%	1	2%
Language Completed Survey In				
English	66	97%	40	98%
Spanish	2	3%	1	2%

Family MIHP Experience

Families responded to several questions about their time in MIHP.

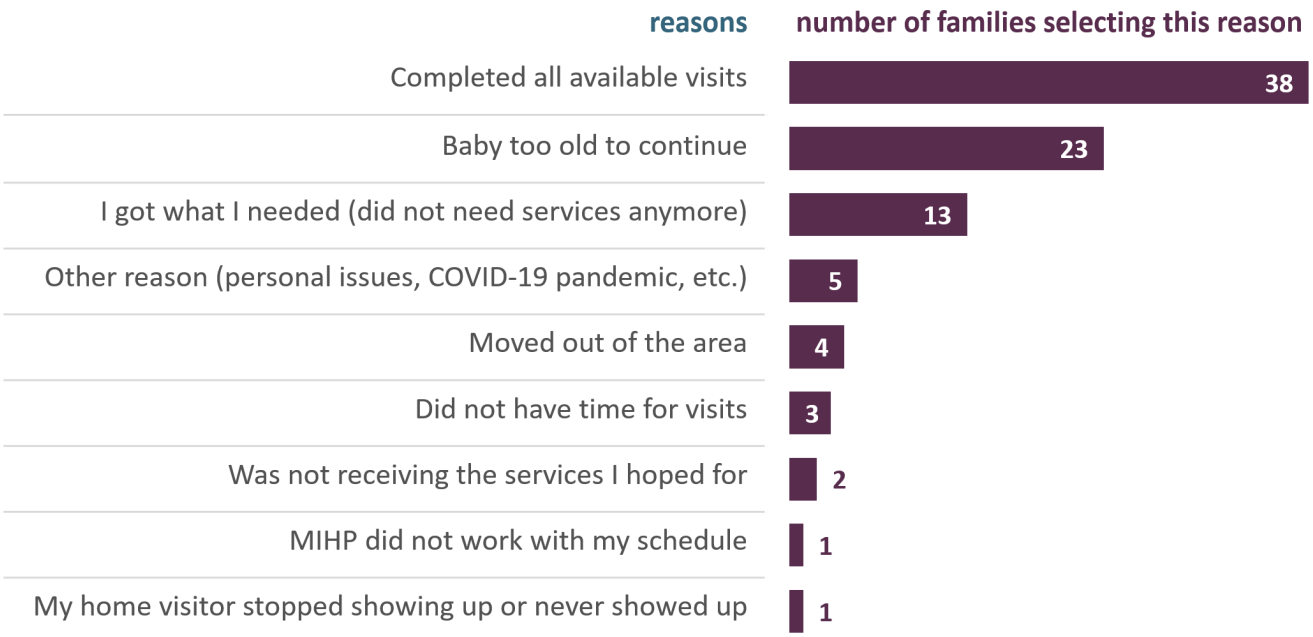
MIHP EXPERIENCES

Timing and Amount of Visits

	Exited MIHP 68 participants		Not Sure/Not Done with MIHP 41 participants	
Time since last visit				
Less than 1 month	10	15%	not reported	
1-3 months	13	19%		
More than 3 months	37	54%		
Not sure	8	12%		
Number of MIHP pregnancy visits				
0	11	16%	4	10%
1-3	11	16%	6	15%
4-10	25	37%	20	49%
More than 10	8	12%	5	12%
Not sure/ Don't remember	13	19%	6	15%
Number of MIHP baby visits				
0	5	7%	1	2%
1-3	13	19%	7	17%
4-10	14	21%	21	51%
11-18	21	31%	8	20%
19-36	6	9%	0	
More than 36	1		1	
Not sure/ Don't remember	8	12%	3	7%

Families were asked to indicate from a list of 16 reasons why they left MIHP:

TOP REASONS WHY FAMILIES LEFT MIHP



Families could check as many reasons as applied to them (range between 0 and 4 reasons across all families). Most families only chose a single reason (Average=1.3 reasons). Two groupings emerged: The "Successful Completion" group, which included those who selected the top three reasons (n=45 Families), and the "Unsuccessful Completion" group who selected any of the other reasons (n=13 Families). Three families did not provide reasons for leaving the program. The groups were not statistically significantly different relative to the number of visits they reported receiving with their baby before exiting the program indicating that reasons for leaving was not associated with length of time in MIHP.[3]

It is important to acknowledge that families who responded to the survey may have been more engaged and had a more positive experience with MIHP than all MIHP families. There is also a high correlation between race and agency type, with 95% of Black families receiving services from the hospital MIHP. As group differences are explored, it is important to understand that it is difficult to isolate the effect of agency type from other family variables in this sample.

[3] Successful Completion: Less than 4 visits: n=12 (26.7%), 4 or more visits: n=33 (73.3%); Unsuccessful Completion: Less than 4 visits: n=5 (38.5%), 4 of more visits: n=8 (61.5%). $X^2(1,58)=.68$, $p=.41$

ANALYSIS

Qualitative Coding

All interview and focus group audio recordings were professionally transcribed and reviewed for accuracy. Four MIHP evaluators developed an initial thematic codebook of both predetermined and emergent themes as they reflected project objectives. The team worked collaboratively to refine the codebook structure and definitions. All transcripts were uploaded into the qualitative data analysis software NVivo[4] and coded according to the codebook. The transcripts were coded in three phases:

> **Phase 1: Initial four transcripts and debrief**. In order to ensure agreement in coding approach, the team coded the same initial set of four transcripts from each type of qualitative data capture (State Leadership interview, MIHP Coordinator interview, Home Visitor focus group, and Family focus group). The team reviewed and resolved any inter-coder agreement discrepancies and adapted the codebook accordingly.
>
> **Phase 2: Consensus coding and debrief**. Eight transcripts were double coded by the team and reviewed for inter-coder agreement using NVivo's Coding Comparison function. Agreement across all nodes ranged from 81.0% to 100%, with an overall mean of 95.5%.
>
> **Phase 3: Single coding**. With high levels of inter-coder agreement established, the remaining transcripts were coded by just one staff member each. All coding was merged together to create a master data set. This final data set consisted of ten broad overarching codes each with numerous corresponding sub-codes. The final list of codes and definitions can be found in the Appendix.

Upon completion of coding, the team used a grounded theory approach for thematic analysis. This systematic inductive approach generated general themes, topics, and trends used to address the overarching research objectives. Two team members were each assigned half of the codes and sub-codes to analyze and generate thematic memos that captured the dominant themes, ideas, and processes emergent in the data. Due to the differing types of participants in this study, each representing different levels of knowledge and engagement with MIHP, many codes were analyzed according to the role of the speaker to delineate discrepancies and congruencies among all those involved in MIHP transitions. Both team members reviewed their thematic memos, discussing and revising the interpreted data accordingly.

Family Survey Data

Survey data was exported from the online system into Excel and SPSS[5] for cleaning, merging, and analysis. The analysis approach was a combination of **descriptive statistics, planned comparisons** (Chi-square and one-way analysis of variance) and **exploratory approaches** based on patterns in the data and new insight from findings (e.g., identifying groups of families with similar experiences, using factor analysis to create a single score from several related questions). All analyses addressed the evaluation questions (e.g., major outcomes by family demographics, MIHP agency site type; associations between transition conversation descriptions and feelings about transition experience).

[4] QSR International Pty Ltd. (2018) NVivo (Version 12), https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

[5] IBM Corp. Released 2019. IBM SPSS Statistics for Windows, Version 26.0. Armonk, NY: IBM Corp

Results

A JOURNEY MAP OF THE HOME VISITING TRANSITION PROCESS

Results are presented as a journey of the transition process. This journey begins with training and preparing home visiting professionals to support family transitions out of the program and continues through the many transition experiences reported by participants. What follows is a description of each component of this journey, concluding with reflections on both successful and unsuccessful transitions, and recommendations for change.

HOME VISITOR TRAINING, GUIDANCE, PREPARATION

Defining "Transition"

In order to have successful guidance and training for transitions out of MIHP, there should be a shared understanding of what "transition" means. Across the conversations with state leaders, MIHP coordinators and home visitors, there was a consensus that transition implies a process whereby families move seamlessly from MIHP into whatever comes next for them to achieve their goals. Many referred to filling a support gap that often occurs when MIHP services end for babies between 12 and 18 months-of-age and the beginning of preschool or kindergarten.

Two main types of transitions were described by professionals: transitions into other home visiting programs and transitions to self-sufficiency with or without other community supports. Many professionals defined "transition" as a hand-off from MIHP services to another home visiting program. The emphasis for these professionals was on continuity of home-visiting-style support for the family.

> "…when we're thinking of transitioning, we're usually thinking of **something that has a lot of overlap with what MIHP does**…usually our families that want to continue services, it's because they appreciated or liked the support, the type of support they get through MIHP, and so are wanting something that has similar benefits."
> –Home Visitor

Other professionals offered that transitions to family self-sufficiency can also be a goal. Self-sufficiency was generally defined as exiting home-visiting programs and may include other non-home visiting early childhood programming or supports, such as involvement in community Great Start Collaboratives and Great Start Parent Coalitions.

> "Ideally, families may not need anyone else in their home anymore."
> –State Administrator

Several professionals lamented the lack of intermediate early childhood programming for children between MIHP and preschool, which usually begins at age 3-4 years in their community.

> "The majority of services start when children are 3-4 years old. Families transition between 12-18 months. There are not a lot of places to transition children to other than Great Start.
> –MIHP Coordinator

Family self-sufficiency may also be supported by other community supports for basic needs, mental health, and economic growth. These referrals are a part of on-going programming and not always considered a destination for transition.

Official Training and Guidance

State Leaders, MIHP Coordinators, and Home Visitors were asked about the training, guidance, and preparation they offer and/or receive in order to successfully transition families out of the MIHP program. State Leaders and local home visiting professionals agreed that little guidance and training specific to transitioning families is offered by the state. Participants referred to general guidance stating that a transition process should happen and highlighting the timing of a family's exit from the MIHP program. Currently there is no training for transitioning families in MIHP. It is the requirements of the professional staff, RNs and Licensed Social Workers, who work as case managers to connect families with the resources needed throughout the course of care.

> "**Transitions are not a specific focus – it's an expectation** that for the good of the beneficiary, right from the beginning during enrollment, to do a forward look at where the person's going to end up once the program is completed. So transitions should be integrated into the entire plan."
> –State Leader

> "We have a MIHP handbook. I would have to refresh myself on it again but **I don't remember there being anything specific**. It mentions, "You should transition your families" but it doesn't really provide the how or the steps, or the start of the elevator conversation speech on how to approach the subject."
> –MIHP Coordinator

State leaders highlighted the difficulty in providing a single set of expectations around family transitions given the great variability among families in the MIHP program, agencies serving them, and regions of the state those agencies operate in. Consultants are available at the state level to offer individualized advice and guidance to local agencies. Some state leaders suggested the lack of specific guidance is an intentional strategy that recognizes and honors local agencies' autonomy, deep knowledge of community resources, and successful local collaborations. State leaders and local professionals referenced the many trainings and a four-day orientation offered by MIHP, but acknowledged that transition was not an explicit focus of this support. Several veteran professionals referred to the older MIHP operations guide and the more detailed support it provided around transitions. That guide was streamlined to provide a more manageable orientation document in recent years and newer MIHP professionals would not have access to it.

> "Typically, programs are very well-versed in what's available in their area and good at transitioning. If agencies run into problems…they may reach out to the state for assistance. For the most part agencies handle this themselves. **Working with people and families, needs are all over the place and there are so many unique circumstances, so it's hard to generalize**."
> –State Leader

Local Agency Learning and Preparation

Local agencies have developed their own practices and guidance to support staff as they transition families out of the MIHP program. The most frequently mentioned approach was staff communication at within-agency meetings or during informal conversations. These informal supports often rely on those with the most institutional knowledge to support others as they become more familiar with community resources and best practices. This informal approach also leaves room for variability in home visitor practice, with coordinators and home visitors acknowledging different styles and approaches to transitioning families.

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

> "I think it varies a lot by home visitor. I honestly do. **Everyone has their own way of doing things, and everyone has their own comfort level with it. I have some home visitors who are fantastic with that and others who are just trying to get the visit done**."
> –MIHP Coordinator

Two coordinators created their own training on transitions to address home visiting staff's needs for more guidance and support and make the transition process better for families. Both trainings feature guidance around timing of conversations, reflection on family progress, warm hand-offs, and acknowledging the emotions around ending the program. Several other programs referenced informational packets, steps to take when transitioning families, and resource lists that professionals use to support their transition practice.

> "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

TRANSITION CONVERSATIONS DURING MIHP VISITS

In relation to preparing families for their transition out of MIHP, a discrepancy emerged between what state leaders believe transition planning for families should entail and what actually happens in the context of MIHP home visits. Ideas about preparing families notably varied in terms of the timing and content of transition conversations.

Timing of Transition Conversations with Families

Most state leaders said that home visitors should time their conversation about transition at the very beginning of a family's home visiting journey. Most said this should begin at the first home visit and that multiple conversations about transitions to other resources, services, and home visiting programs should occur throughout the course of the family's home visits.

> "**It starts at the beginning**. Our beneficiaries often are lost to service so we talk about preparing families from the very beginning."
> –State Leader

> "We expect there to be a conversation with the family **well before they are getting discharged**. 'Have you met all your goals? Has this been helpful? What are your thoughts about the future? What can I connect you to? Let's talk about what's next for you'. And you are **developing a plan for what happens next**. 'Are you interested in another home visiting program? Childcare?' Then the home visitor will be able to provide the family with those supports to help get connected to the next system."
> –State Leader

In contrast, most MIHP coordinators and home visitors said conversations specific to transition out of MIHP happen near the end of their visits with families. However, home visitors reported they educate families about and make referrals to other local resources, programs, and services throughout their visits—not just at the point of transition.

> "**A majority of the time it is at the last visit**. I explain what [other programs] do, and what the program entails. I ask if they are interested in something like that, if so, I make a referral and have the program contact the family. If the infant is delayed when I do the ASQ or if there are any other needs that programs can better help with or address more in depth, I would make the referral earlier in the 9 visits, but **usually it's that 9th visit**."
> –MIHP Coordinator

> "[I'm] letting them know **towards the end but not at the last visit**, maybe at the sixth visit, just letting them know what's going to happen to them in advance, or the program, what's available to them. So yeah, **I'd say fifth or sixth visit**, just start talking about what they think they may need when we're out of the picture. But I think communication is definitely key so that they know what's going to happen with them, their family, and the services, and the programs."
> –Home Visitor

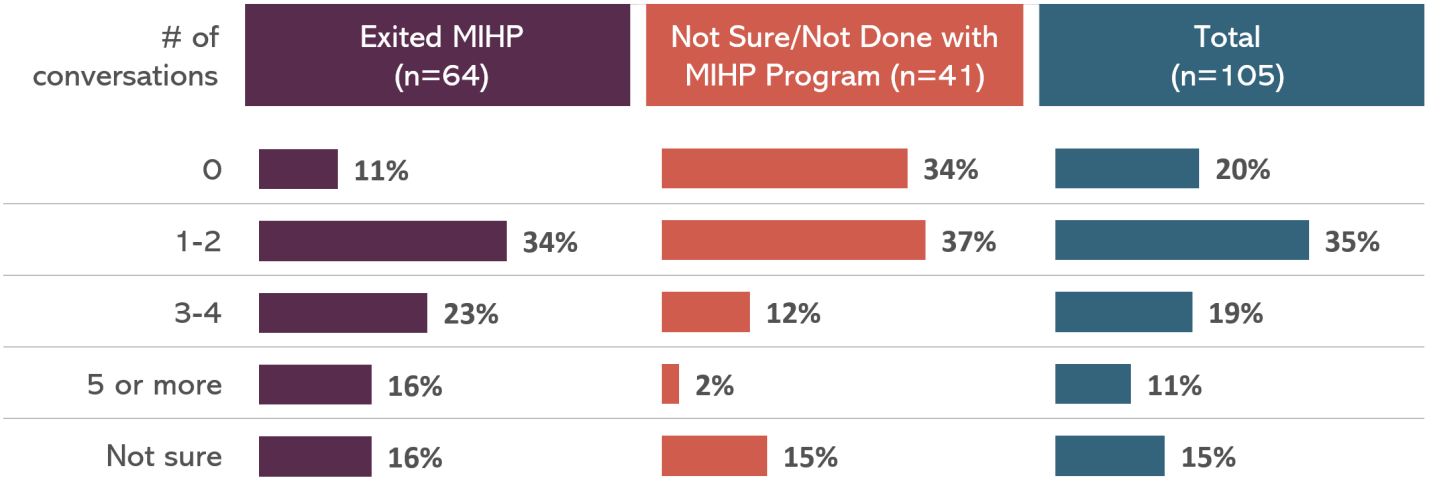
Families reported that references to other home visiting programs and to other supportive services and resources, were brought up multiple times throughout the course of their visits. For some, the topic of transition occurred at the beginning of their visits. However, many families did not resonate with the term or concept of "transition." Some families indicated that transition, for them, was about self-sufficiency. Others indicated that transition was about connecting to other supports and services, or simply that the program ended. Some mentioned that they were never told about transitioning to other programs, that their MIHP visits would eventually end, or couldn't recall if they had those conversations with their home visitor at all.

> "It was kind of like **at the beginning** where they let me know how many visits there would be. And at the end, they would help me if I needed anything to wrap up what I was doing. But then once the amount of visits were hit, that goal, then that would be done. …It was every couple of visits or so we would figure out how many were left and stuff like that."
> –MIHP Family

> "I think my worker was telling me about that. … Nothing lasts forever and that's fine. **Because you've got to be able to stand on your own two feet**. You get the support and then you've got to kind of **wing it for yourself**. … We're hitting those steps and kind of guiding us to where we're supposed to be in our **independence**."
> –MIHP Family

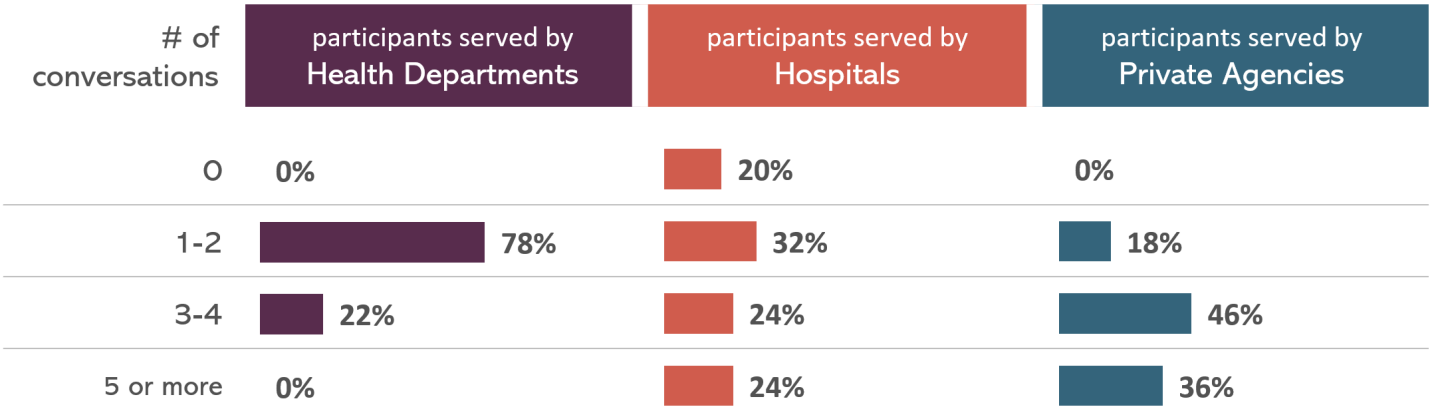
Most families who responded to the survey reported having "1-2" conversations about transition out of MIHP with their home visitor. Importantly, there was a lot of variability in the frequency of these conversations, with 21 families not reporting any and 11 families reporting "five or more." There was **not a strong relationship between number of conversations about transition and number of visits during pregnancy or with their baby**, potentially suggesting that conversations about transition are independent of service length in MIHP.

About how many conversations did you have/have you had with your home visitor about what happens after MIHP is over?



There was a significant difference across agency type, with **a greater percentage of families served by private MIHP agencies reporting more conversations than those from the health department and hospital agencies.**[6]

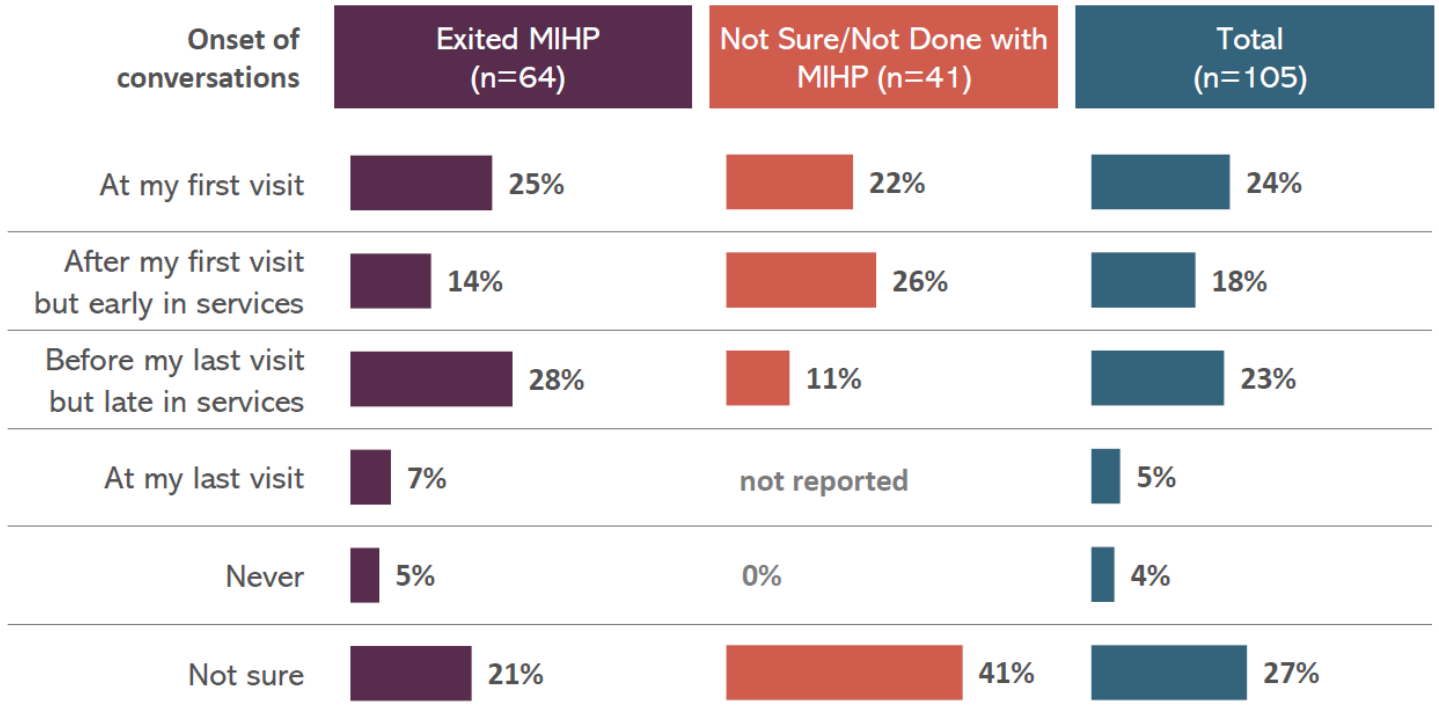
About how many conversations did you have/have you had with your home visitor about what happens after MIHP is over?



[6] $X2$ (6,45)=13.57, p=.04

Most families remember conversations about transitions starting either at their first visit or late in services, but before their last visit. There was **not a strong relationship between timing of first conversation and total number of conversations reported by families**, potentially suggesting that conversations are not evenly distributed among visits. It is also important to note that the majority who responded to this question were not sure when they had their first transition conversation. There was **no significant differences between timing of first transition conversation and agency type**, suggesting that families from different agencies were equally likely to hear about transition early.

When did you begin talking with your home visitor about what happens after MIHP is over?



Most families, **65.7%, reported they felt the number of conversations about what happens after MIHP is over was "just right."** Fifteen families (14.3%) thought there were too few conversations, and 21 families (20.0%) were not sure. Of those who felt the number of conversations were just right, 68.1% (n=47) reported having either "1-2" or "3-4" conversations with their home visitor. Most families who felt they had too few conversations reported either "0" or "1-2" conversations with their home visitor (n=13, 86.7%). While families' opinions of what the "right" number of conversations should be varies, it is important to note that **NO families reported they had too many conversations about transition**, suggesting they are open to more discussions of how their time with MIHP ends. There were no statistically significant differences in feelings about the right number of conversations and urban/ suburban/ rural location or family race.[7]

[7]Chi-square tests run for each comparison. Only Black and White vs. other families comparisons were run due to large enough sample size.

Content of Transition Conversations with Families

The majority of state leaders reported that the content of MIHP home visitors' conversations about transition involved establishing a "transition plan" with each family at the start of their entry into the MIHP program. They expected home visitors to be actively connecting families with other resources and services and ensuring there is a warm handoff upon transition out of MIHP. However, MIHP coordinators and home visitors were less likely to report establishing a formal plan or having a warm handoff to other home visiting services despite prodigiously acknowledging that this would be ideal. The majority of coordinators and home visitors expressed that they 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).

> "I typically will introduce the programs that are available and then if I have a **brochure**, provide that, or if I have a **website**, provide that, and then say, 'Unless you know right now, **I encourage you just to check them out and even call** if you have questions and call the agency or we can talk about it next visit.' And so then I'll bring it back up the next visit."
> –Home Visitor

Families' experiences in this regard varied greatly. Most families reported being provided physical information about other programs, supports, and resources. Most mentioned that there was in-person discussion about other programs, yet none cited any specific home visiting programs. Families were more likely to recall other community services such as WIC, baby item pantries, or educational resources. A few families reported being told to keep in contact with their MIHP home visitor after visits ended should they have questions or need further assistance. This was reported by family survey participants as well. Of the 68 families who had completed their visits, 24 (35.3%) reported still being in contact with their home visitor through calls or text. While a higher percentage of rural families reported calling or texting their home visitor compared to urban/ suburban families, this difference did not reach statistical significance. [8]

> "[My home visitor] said if we needed anything, **we could still get a hold of her**, but that she wouldn't be visiting anymore."
> -MIHP Family

> "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

Notably, several families expressed that they couldn't recall having a discussion about transition out of MIHP at all. Families also expressed not knowing other programs existed in their areas.

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

> "**It just ended, and that's it**… we just weren't going to see each other anymore."
> -MIHP Family

[8]Rural Families who call/text: n=10 (52.6% of Rural families); Urban/ Suburban Families who call/text: n=7 (29.2% of Urban/suburban families). $X^2(1, 43)=2.44$, p=.12.

Needs Identification and Next Steps

For most MIHP families, their needs were identified through frequent conversations with their home visitor throughout the course of their home visits, often focusing on addressing their immediate needs such as essential baby items, school supplies, counseling, housing, and food. Identifying each family's unique needs was described by state leaders as documented and procedural, but this process was more fluid from the perspective of agencies and families. State leaders described a process of regularly updating written documentation about each family's goals and needs. While most MIHP agencies documented the initial assessment in a family's plan of care, most coordinators and home visitors reported that goals and needs are typically discussed informally with families with little additional documentation.

> "**We don't have documentation** that we do other than referrals on our progress notes. **It's a pretty informal dialogue**. We can talk about Early Head Start at nine months, but it may take another three months to convince them it's a good idea ... **It's a conversation at every visit after nine months**."
> –MIHP Coordinator

Families likewise reported having many informal conversations about needs they may have, often being provided information (such as a pamphlet, website, or phone number) about how to access those resources themselves.

> "**We talked about the next steps throughout each visit**. Each visit **we made a goal plan** about what's going to prepare me for that kind of stuff. So we would make the goal plan, but then every other visit, we'd talk about what's going to happen after [MIHP ended]. **It wasn't that big of a conversation**."
> -MIHP Family

> "My home visitor always, every single time, goes, '**Oh, there's a resource for that!' Or, 'Oh, here's a phone number for this. Here, I'll send you several emails**.'"
> -MIHP Family

TRANSITIONS OUT OF MIHP

Referred Programs

There was consensus among state leaders, MIHP coordinators, and home visitors regarding which home visiting programs MIHP families are ideally referred. State leaders expected families to be transitioning primarily to Early Head Start and Healthy Families America. Coordinators and home visitors overwhelmingly said that their agencies primarily refer families to Early Head Start, Parents as Teachers and Healthy Families America, although they also commonly mentioned Early On, Healthy Start, and Head start when asked about home visiting. They also mentioned numerous other agencies or programs local to the counties in which they serve. However, referrals to these agencies varied greatly regionally depending on what is available in each county they worked in.

Many families transitioned out of MIHP but are still connected to community services that supported them in the absence of home visiting. Some home visiting staff did not consider these non-home visiting programs part of transition. Rather, they were services the family used alongside the MIHP program and can continue after exiting. Most of these types of referrals occurred during the course of MIHP programming. Home Visitors and Coordinators described using the risk screeners as a way of initiating referrals. Families also described knowing what they needed and secured referrals by asking their home visitor about their needs and concerns.

> "**Most of mine [referrals] were because I asked her questions**. Like I'm like, 'Hey, something's wrong here or I have a question here.' And she would send me emails or pamphlets on like things that I am questioning and stuff like that."
> –MIHP Family

A wide range of community referrals and supports were referenced in these conversations, including:

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

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

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

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

General Support: 211, staying in touch with MIHP home visitor

A common story that program coordinators often shared was how they must piecemeal referral resources in one county, while in other counties they experienced an abundance of resources to choose from. Not enough families mentioned specific programs by name to indicate which they were referred to most often. The exception to this pattern was in tribal communities where MIHP, Family Spirit, and Healthy Start are implemented in such an integrated way that multiple MIHP families said their transition was seamless. State leaders supported this effort and it has had a positive impact on both local MIHP staff and the families they serve.

> "Family Spirit is the one we worked really closely with because we wanted all of our tribes to be able to use that. **Family Spirit uses our MIHP documentation**… I'm not sure where this has evolved to. **The genesis of Family Spirit being developed was having it be 'MIHP beyond' for our tribal communities**."
> –State Leader

Handoff from MIHP to Other Programs

There was also a consensus that a warm handoff and follow-up upon transition was the ideal; however, these practices did not always occur due to the great variability in each program's approach, capacity, and relationships with other agencies. As previously mentioned, state leaders expected the transition process to involve a warm handoff between the MIHP home visitor and the new home visitor. Moreover, state leaders felt there could be more follow-up by MIHP programs to check on families and offer more information about other programs. They also felt that MIHP programs could benefit from expanding their referral networks. State leaders noted opportunity to strengthen handoffs between MIHP and specific programs, such as Early On and WIC.

Coordinators were likely to say they tried to establish personal relationships and connections with other home visiting programs, but were largely divided on whether or not a warm handoff happens at their agencies. Most noted that they do not routinely follow up with other agencies about referrals. Similarly, home visitors indicated that a warm handoff with other home visitors was ideal, but that this did not always happen for a variety of reasons, especially lack of time.

> "I have been thinking more lately about the term **'a warm handoff'** when you are kind of passing someone on to a new program, that you kind of meet altogether and then you're able to successfully see them on their way. **That hasn't been happening**."
> –Home Visitor

> **"When my schedule has been able to be quite flexible around theirs [other home visitor], the [family's] participation I feel is higher**… versus sometimes their schedule and my schedule will never align. And I feel like then **clients are less willing to do that transition** because when you're there and that person's there, you're affirming that this is a safe person."
> –Home Visitor

Many also reported that they expected the family to contact the referred agency at transition or that it was the family's responsibility to follow through. Multiple home visitors mentioned making referrals early in the visits due to waitlists and other issues; however, they were unlikely to report that they personally follow up with referrals at transition.

> "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

It is important to include the experience that some families had of securing additional services and supports without facilitation from MIHP. Some families experienced disruptions in MIHP visits and figured things out for themselves. Other families had life events, such as a move, that disrupted services and made efforts at transition more difficult.

> "Obviously since we were moving right after the program was over, **there wasn't really anything she could do to really help afterwards**. She tried to help us, so we could maybe find a place and whatnot to stay in Michigan, but just in the area that we were, the resources weren't there. The housing wasn't there. A full-time job…wasn't there, which is the main reason why we ended up moving."
> –MIHP Family

Families were asked a series of questions about the services they **wanted**, the services they **received**, and the degree to which **MIHP staff facilitated** those connections on the survey (see Figure on following page). The purple column shows the percent of families who said they wanted each service. The blue column shows the percent of families who successfully got the service they wanted. The orange column shows the percent of families who reported MIHP helped them access the service they got. Across all categories, 53% of families received the services they wanted. **While clearly not all family need is being met, when it is met, families report that MIHP played a role**. Looking across areas of need, MIHP facilitated between 63% and 100% of family connections to services.

Few families in the sample reported connecting with another home visiting service following MIHP. Only families who reported completing MIHP visits were asked about enrollment in other home visiting programs. The following programs were reported:

5 families
Early Head Start Home-based

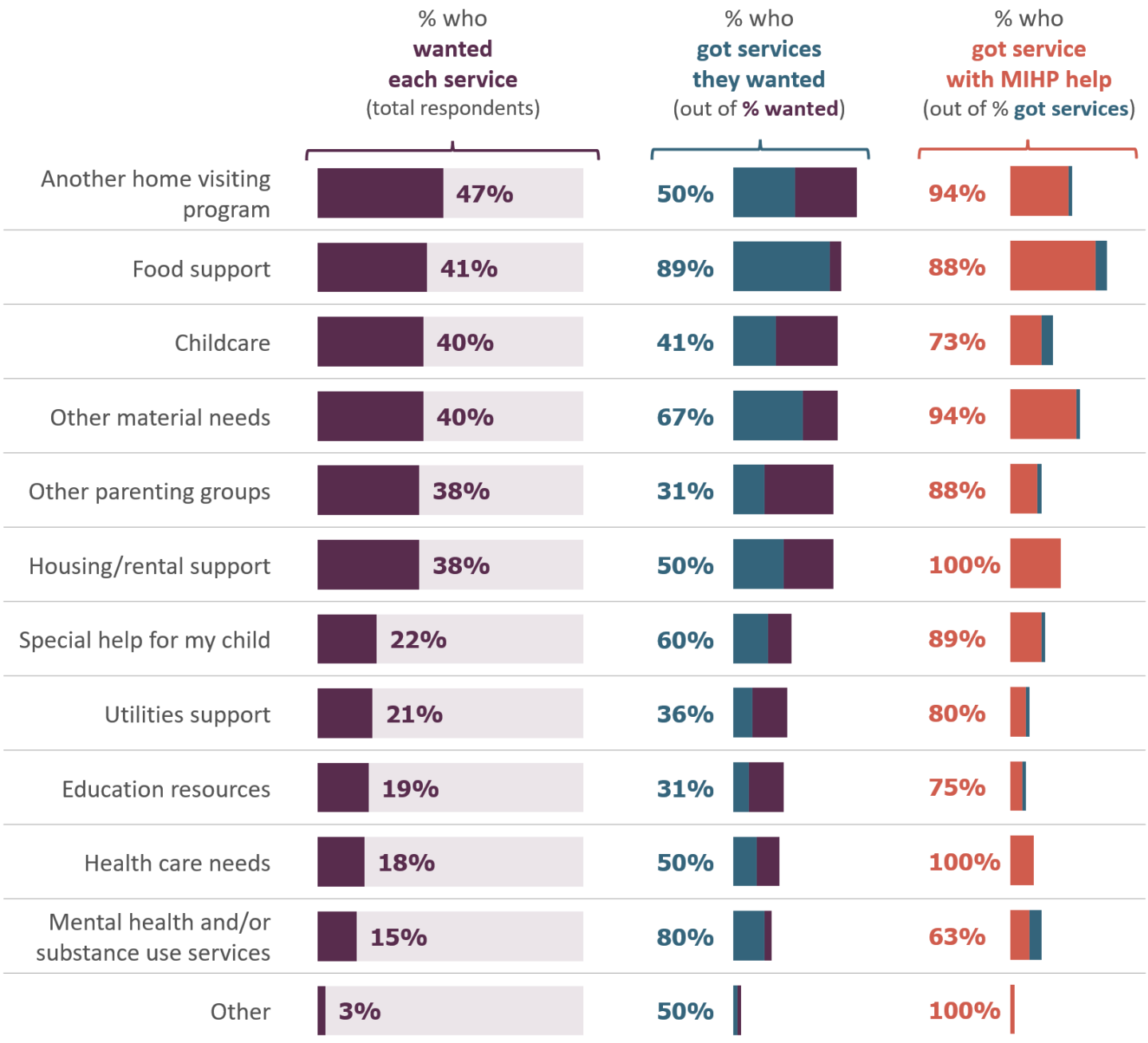
3 families
Infant Mental Health

1 family
Healthy Families America

2 families
Other Home Visiting

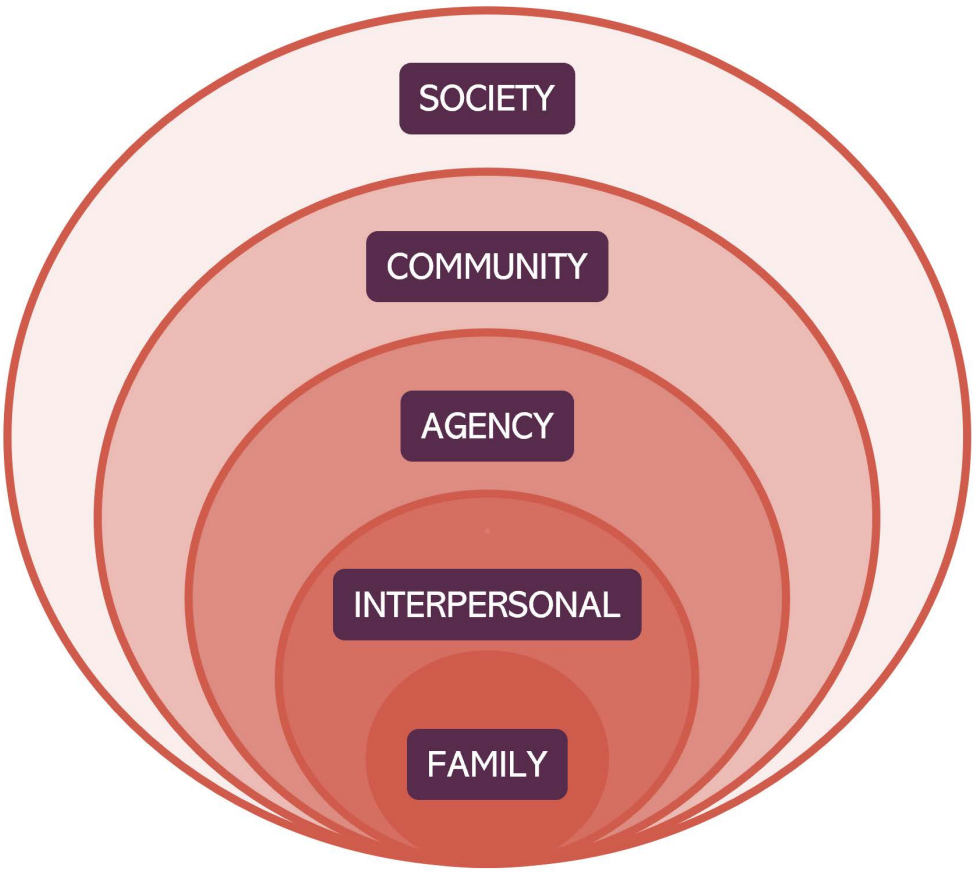
The 11 families who reported transitioning into another home visiting program were asked if they received support from their MIHP home visitor to help them into their new program. Most families reported their MIHP home visitor supported them through discussions about their transition plan, although other types of support were referenced as well such as reviewing how to contact agencies or actively contacting a new agency for the family.

Few families reported on their wait time between MIHP and other home visiting programs. For **Early Head Start-Home-based**, one family reported overlap between programs and three families reported less than one month wait. For **Infant Mental Health**, one family reported overlap between programs, one family waited less than one month and one family waited between one and six months. One family reported an overlap between programs with **special needs services** and one family did not remember their wait time for **Healthy Families America**.



REFLECTIONS ON THE JOURNEY: KEY CONTRIBUTORS TO THE SUCCESS & CHALLENGES OF TRANSITIONS

This section summarizes broad themes that contributed to successes and challenges of all types of transitions. This section is organized around a socio-ecological model, with discussion of factors at different levels that impact a family. This model is based in the understanding that individuals are embedded and deeply influenced within a system of multifaceted and interrelated personal and environmental factors.



These levels do not operate in isolation. Each level interacts with another and can compound to create highly successful transition stories or deeply flawed transitions. For example, a family with strong interpersonal relationships living in a community with a high-quality MIHP agency that operates within a high-functioning early childhood system is going to have a more positive experience than an isolated family who is struggling to connect with their home visitor and get follow-through on referrals. Identifying factors at these levels also speaks to levels of influence for creating lasting systems change. It is important to understand how these factors operate when intervening to improve transitions for everyone.

FAMILY FACTORS

FAMILY PERSONAL FACTORS AND FEELINGS ABOUT MIHP ENDING

There were many factors within the family that contributed to the success of both MIHP programming itself and the transition out of programming. Most of the family-level factors described by participants were psychological: feeling heard and understood by their home visitor, feeling safe going into a new program, feeling empowered to move forward on their own, feeling supported and not judged by professionals, and feeling connected to a larger network of support. Some participants also mentioned how positive social and situational factors helped prepare them for success after the MIHP program, including the presence of family members and other community supports.

> "I think the hardest part was having to take in all that information and be like, 'Okay, now you don't have somebody holding your hand. So it's time to be a big girl (laughs) and take care of things'…. '**You've got to take care of your kid. You're her mom. It's time for you to think about what she told you to do**.'"
> –MIHP Family

> "You'd know a successful transition when you see one when **it's the family's choice** and they haven't been guilted or pressured into it, because then they don't follow through. **When they are on board and it is their choice, and they have picked what they want next, that's when you have a successful transition**."
> –MIHP Coordinator

Contributors to unsuccessful transitions at the family level focused on families' reactions of avoidance or resistance when faced with the prospect of transitioning to other programs. Most participants stated that families who did not transition into other home visiting programs were often unresponsive and stopped answering calls upon transition. Programs expressed that they were acutely aware that a family's personal life circumstances often made it challenging to continue with home visiting during MIHP and beyond, especially in circumstances where mothers returned to work, families struggled with unstable housing, or where there was abuse in the home. In these situations, transition felt like an ambitious goal.

> "So we definitely continue to reach out. **Sometimes it's just a matter of families just having so much going on that they feel that just us coming out just would be extra or it could be a burden**."
> –Home Visitor

State leaders and MIHP coordinators cited that leaving families responsible for referral follow up was often a marker for unsuccessful transitions. However, many home visitors indicated that they expected families to follow up independently although many families did not take this responsibility.

> "Boy, **they have a heck of a lot of baggage, the clients do**. And so many things that we can work with them through. And **then it boils down to how much work do they want to put into it**. Because we can find them all kinds of referrals, **but they have to—it's hard to explain to them they have to specifically do that and follow through**."
> –Home Visitor

Some noted that families' lack of follow up may also be linked to a lack of trust for home visiting outside of MIHP. Often, this distrust was described as an unwillingness to build relationships with new home visitors.

> "Some families are not open to [transitioning]. … Families, the whole time, are building their trust and relationship with you. Sometimes families are not okay with a social worker coming in. Some will say okay, but then you can never reach them. **It's difficult for some people to build trusting relationships**."
> –MIHP Coordinator

This distrust was described by some as being rooted in the negative societal association of home visiting with being a "bad parent." The sector's presumed affiliation with Child Protective Services (CPS), the of fear of being judged by a new home visitor or stigmatized by the community, were all cited as fostering a profound sense of mistrust among families.

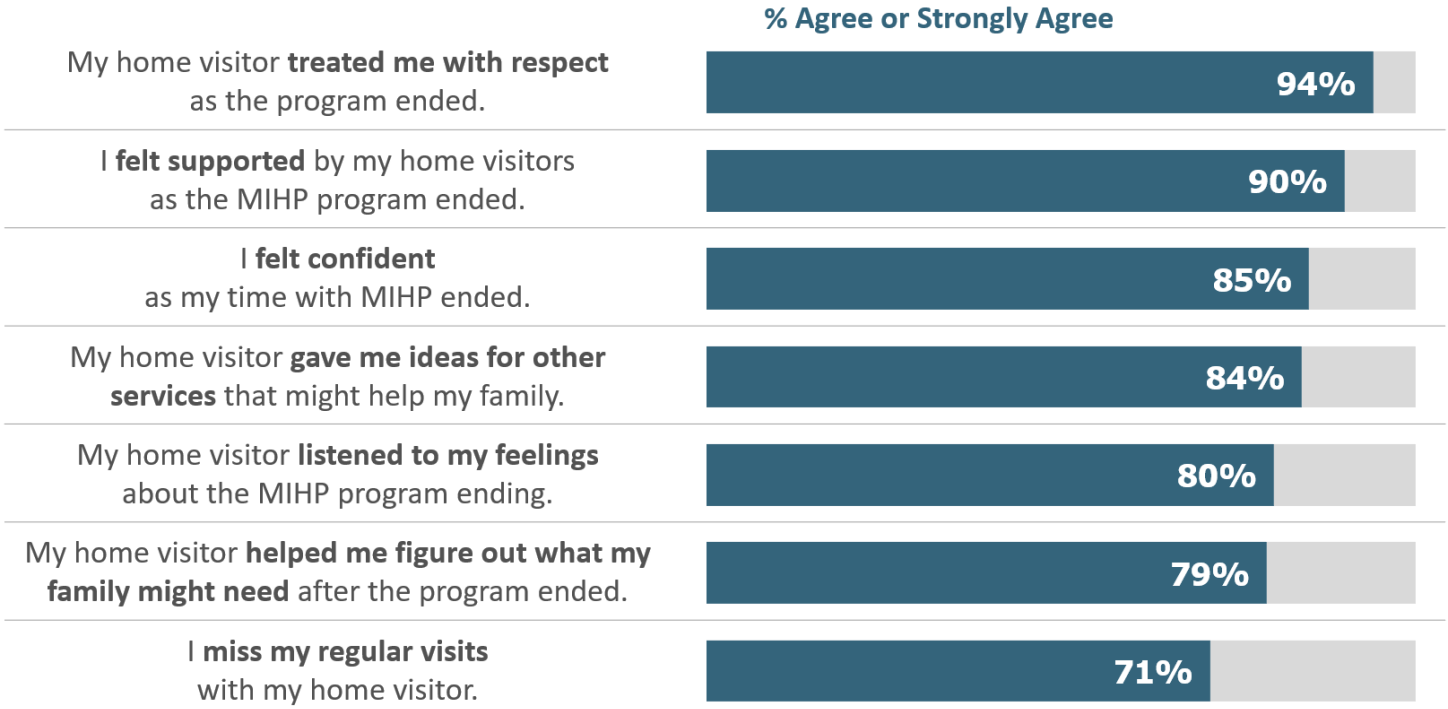
> "**Home visiting isn't a bad thing, it doesn't mean you are a bad parent**, it doesn't mean we are going to come and look and make CPS come to your house."
> –MIHP Coordinator

> "From the family perspective, they may think the agency is just in it for the money and they didn't really care about them. **I feel their distrust for home visiting when it's unsuccessful**. They may not trust another home visiting program if they feel judged."
> –MIHP Coordinator

Family survey respondents who exited MIHP programming were asked a series of questions about their feelings around the transition. Overwhelmingly, families "agreed" or "strongly agreed" that they felt supported when the program ended, miss their regular visits, and their home visitor gave them ideas for services they might need, listened to their feelings, and treated them with respect. Eighty-five percent of families "agreed" or "strongly agreed" that they felt confident as their time with MIHP ended. On the other hand, several families reported feeling that the program ended too soon (45% "agreed" or "strongly agreed"), that the program ended too suddenly (29%), or that they felt abandoned after their last visit (14%). A factor analysis was run to see if some of these items could be combined into bigger ideas. Two factors emerged and composite variables were created by taking the average of items that loaded onto each factor:

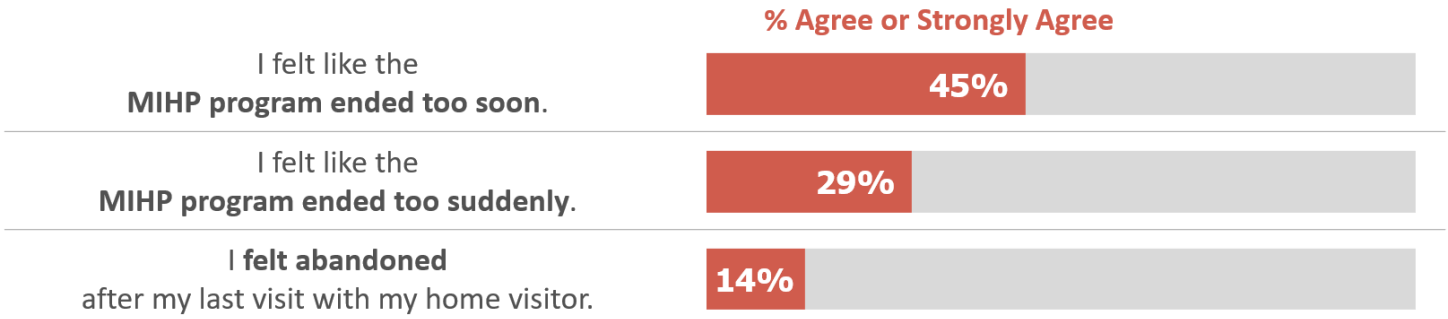
FACTOR 1: **FELT SUPPORTED BY HOME VISITOR AS MIHP ENDED**

Mean Score = 4.31, Minimum Score = 1.4, Maximum Score = 5.0



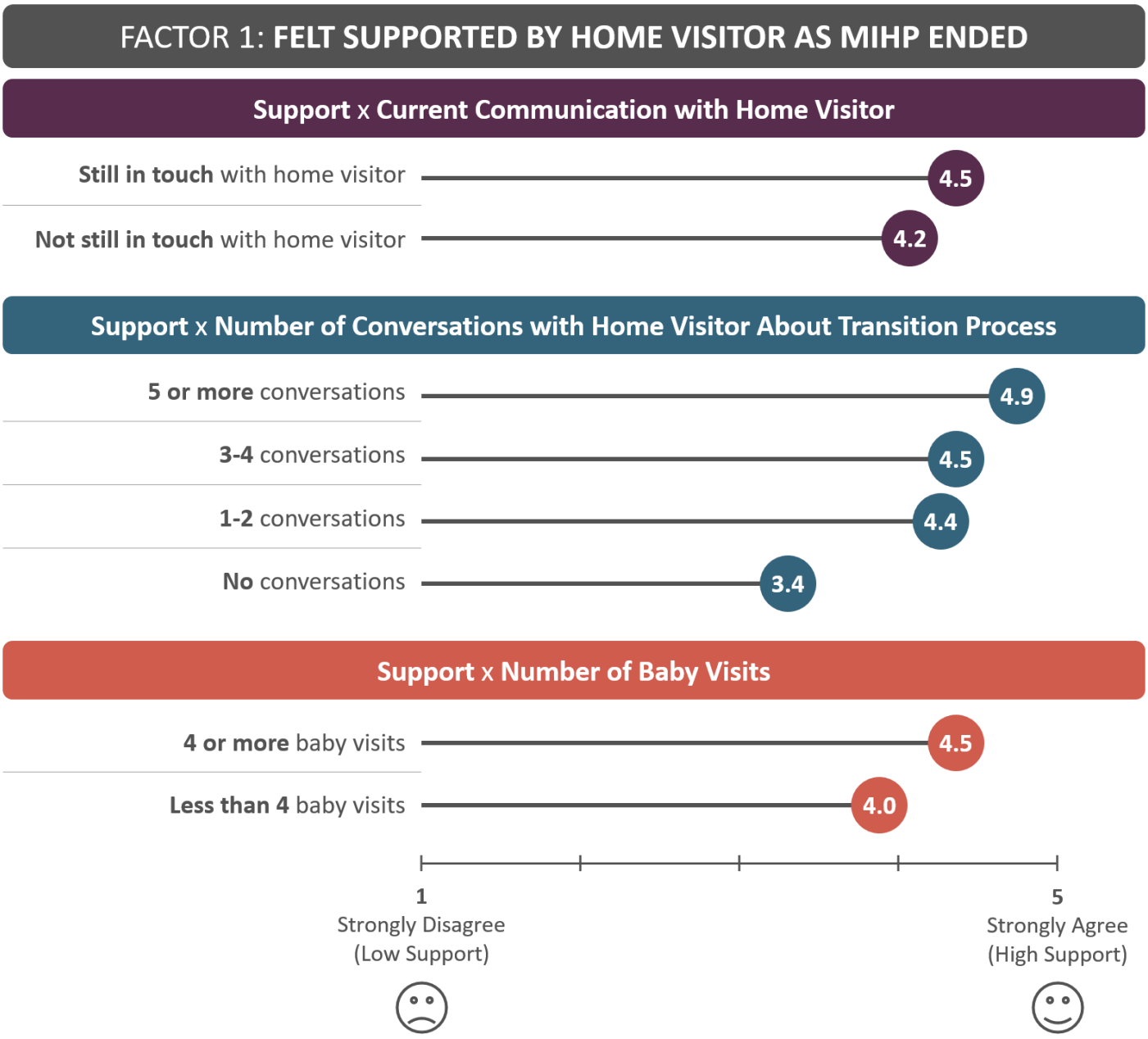
FACTOR 2: **FELT MIHP ENDED ABRUPTLY**

Mean Score = 2.77, Minimum Score = 1.0, Maximum Score = 5.0

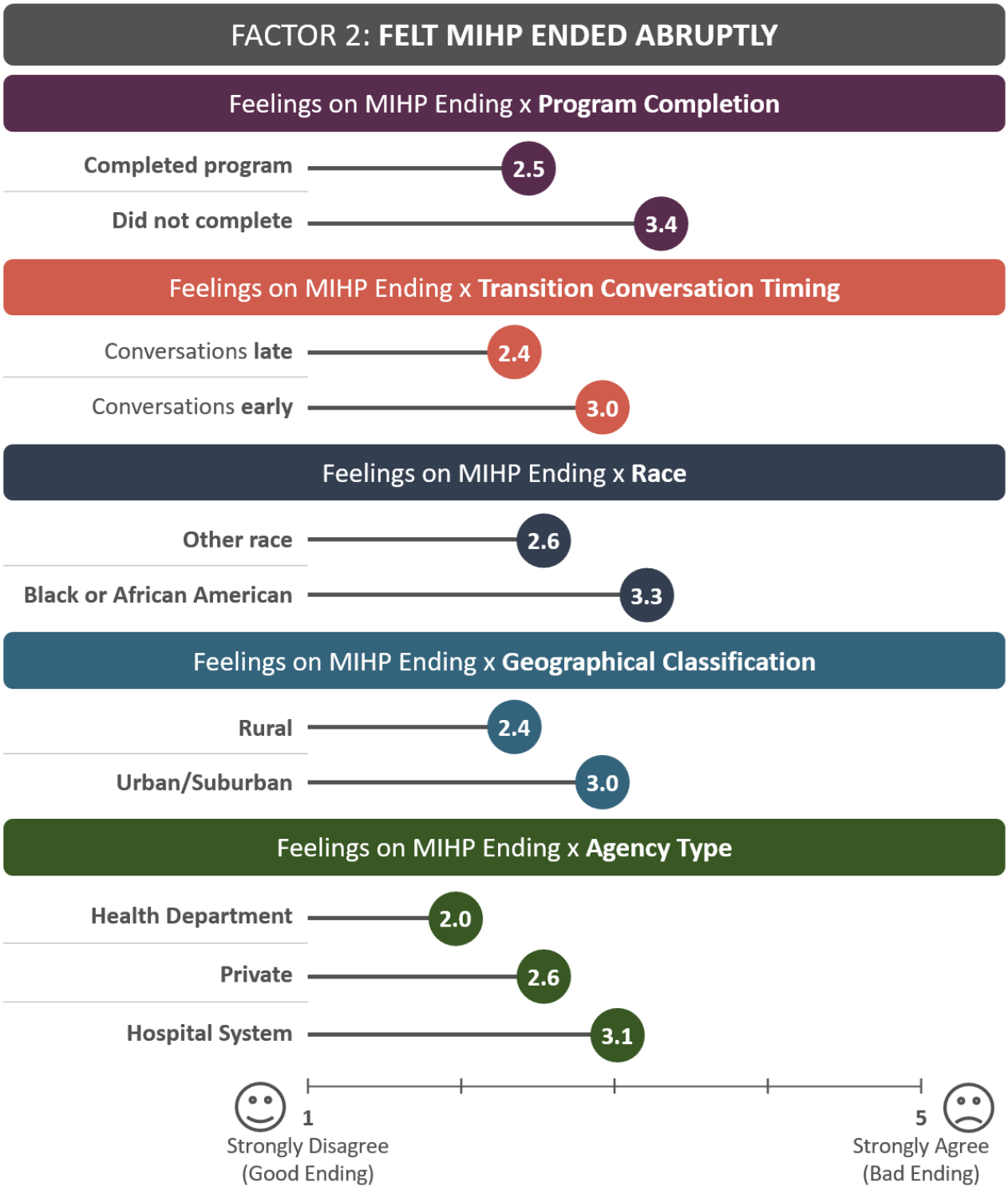


Using the two factor scores, a series of comparisons were run to see if program ratings were related to other variables. The first set explored relationships with family demographics. **Families from urban or suburban areas were more likely to feel MIHP ended abruptly compared to rural families.**[9] This effect is likely correlated with race as **Black families were also more likely than others to report feeling MIHP ended abruptly** and 94% of the Black families in the sample reported living in an urban or suburban area.[10] Unfortunately, the sample of other racial and ethnic groups was not robust enough to run other comparisons.

The next analysis looked to see if families' reports of their conversations about transition were related to their feelings as MIHP ended. **Families who reported more conversations with their home visitor about transition felt more supported by their home visitor as MIHP ended.**[11] Interestingly, **families who report their transition conversations started early in services were more likely to feel MIHP ended abruptly.**[12] This relationship did not emerge in focus group conversations and may be worth more exploration about whether there is a downside to addressing transition too soon.



We also looked to see if transition ratings varied based on whether families reported still being in touch with their home visitor, perhaps indicating a gentler transition out of the program. There was a statistical trend indicating that **families who were still in touch with their home visitor rated feeling more supported by that home visitor as MIHP ended**.[13]



[9]One-way ANOVA: $F(1,43)=5.21$, $p=.03$
[10]One-way ANOVA: $F(1,59)=6.49$, $p=.01$
[11]One-way ANOVA: $F(3,50)=8.69$, $p<.001$
[12]One-way ANOVA: $F(1,40)=5.62$, $p=.02$
[13]One-way ANOVA: $F(1,56)=3.26$, $p=.08$

Experience in the MIHP program was also related to reported feelings about ending the program. **Families who reported having four or more visits with their baby were more likely to feel supported by their home visitor** than those who reported less than four.[14] **Families who reported successful completion of the program were LESS likely to report feeling the program ended abruptly**.[15]

Finally, agency types were also significantly associated with feelings of transition with **families from a hospital system MIHP more likely to report feeling MIHP ended abruptly than those in health department MIHPs**. Private MIHP agency families were not significantly different from the other groups.[16] This finding is highly confounded with race. In this sample, 95% of Black families were served by a hospital system MIHP, so **it is impossible to say if race or agency type is the stronger driver of families feeling services ended abruptly.**

When asked to provide an overall rating of their experience ending the MIHP program, **75% of families said their experience was "Very Good"** (n=45). Another 15% (n=9) rated the transition experience as "Good," 8% (n=5) as "Neutral" and only 1 family (2%) rated it as "Bad."

[14]One-way ANOVA: $F(1,53)=6.65$, $p=.01$
[15]One-way ANOVA: $F(1,56)=11.32$, $p<.001$
[16]One-way ANOVA: $F(2,50)=6.74$, $p=.003$; Post-hoc comparisons with Bonferroni correction showed 1 significant difference between Hospital and Health Department $p=.002$

INTERPERSONAL FACTORS

Family-Home Visitor Relationship

Many participants described a positive relationship between families and home visitors as the cornerstone to a successful transition. A deep connection with a home visitor that included non-judgmental openness about needs supported transition in two ways: 1) by creating a positive and encouraging environment around new referrals and taking the next step and 2) by instilling families with a sense of mutual support and care that they can take with them into the future. In some cases, the relationships extended beyond the MIHP program, either because of community connections outside of MIHP or because of agency practices that kept an open door to enrolled families after they exited the program.

> "Families are comfortable with the workers. **The workers view them as important as a family and deal with their issues and are non-judgmental.**"
> –MIHP Coordinator

> "She was like my—I mean we are like family kind of. **She really like made herself a personal connection with me and my daughter. So I felt comfortable enough to ask her the hard-hitting questions and she was comfortable enough to answer them**."
> –MIHP Family

> "But I've got my one MIHP worker, she actually just lives down the road from me. So she's like, 'If you have any questions or anything else, don't be afraid to call or stop in and we can talk about it.'"
> –MIHP Family

Several families described the emotionality of parting with a trusted resource when the program ended. While sad, this was a true sign of the strength of the personal connection between families and home visitors.

> "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 she is the only person that I had there all the time. And so **when we finally ended, she cried and I cried (laughs). So but it's not like she doesn't have my number and it's not like I don't have hers**."
> –MIHP Family

While most families indicated they had a positive connection to their MIHP home visitor, a few mentioned frustrating aspects of their relationship with their home visitor, particularly in regard to sharing helpful information. For example, some raised issues about their home visitor's lack of transparency about the MIHP program requirements (such as the number of visits or when it would end) and lack of knowledge about other available resources and supports in their area.

> "[My home visitor] gave me the information for the car seat program, **but it expired in 2019** when she sent it to me. … I don't know if maybe she was new or **she just didn't have the information or the resources**."
> –MIHP Family

AGENCY FACTORS

MIHP Agency and Home Visitor Practice

There were many things individual MIHP agencies and home visitors did to support successful transitions for families. Coordinators bore a large responsibility for creating a positive culture and communicating expectations around transition to their staff. That included hiring staff who understand family-centered practice, supporting staff in understanding the importance of transitions, and communicating messages and guidance from the state. Home visitors reported often feeling supported by both their supervisors and colleagues. A positive team orientation was critical for sharing resources, asking for help, and solving problems.

> "A lot of home visitors have their own resources that they share with the team. **They are comfortable talking to each other and asking for help**."
> –MIHP Coordinator

Participants also discussed how agencies approached transition. Agency practice that supported successful transitions included being family-informed and family-driven, having a strengths-based approach that focused on a family's positive qualities over their needs and challenges, and going above and beyond for families. Examples shared included reaching out after program obligations are complete, sending job postings, and attending court hearings. There were also transition-specific practices that some agencies embraced, such as introducing the topics of transition from the first meeting and providing consistent and gentle follow-up on referrals.

> "We are constantly trying to encourage these women, 'Yes, you can do these things. And you need to do these things. And it's going to help your entire family grow.'"
> –Home Visitor

Several participants observed that agencies with more resources are better able to support transition work. Agencies that had grants or other resources to draw on outside of Medicaid funding had the capacity to deliver higher-quality service to their families and retained employees which meant they had more seasoned staff.

> "…**we have a foundation to get additional funds**. So if there is a need, without over-doing it, we see where we can fill those holes."
> –MIHP Coordinator

Relatedly, participants highlighted numerous intersecting and compounding factors within the broader MIHP home visiting system as underlying contributors to unsuccessful transitions. These included high caseloads within MIHP and other programs, understaffing, the inability to hire new personnel at MIHP agencies, administrative burdens around transition that often go unpaid, and competition within the MIHP home visiting sector. One state leader mentioned the potential for disconnect between MIHP coordinators and staff for prioritizing resources for transition if the coordinator does not have a background in family service and understand the importance of transition.

> "**Our documentation is detailed, and the administration requirements are broad. So sometimes just doing the bare minimum that's required gets in the way of successful case management**… [Home visitors] don't get paid for this additional work. So reimbursement for the time, effort, and energy going into this is a barrier. And lots of home visitors are contracted so they only get paid per visit. … we don't have any guidance about case load, so with that in mind, it is difficult to say what is the ideal amount of people and the ideal space because we've never provided that."
> –State Leader

> "This impacts more than just transition – there is still a lot of competition. There is a lack of knowledge of and trust in other supports available across the system. People get used to what they know, and then they don't always reach out to others. … **The way MIHP is structured may create competition because they get paid for the number of families enrolled**."
> –State Leader

COMMUNITY FACTORS

Other System Players and Coordination

Many participants described the varied dynamics of the broader early childhood and service systems in which they operate. When partnerships with other home visiting agencies, government offices, hospital systems, civic organizations, and schools are strong, families can navigate between agencies in the system seamlessly. The most tightly-coupled and efficient systems included those where multiple system players operated out of the same office or building, allowing for a nearly imperceptible transition for families—some of whom were not even aware they changed programs.

> "**I feel like everything is so close-knit there**. You have the WIC office, you have the next step up for kids after they turn 18 months. Right now, on my last phone call, my two year-old and I were referred to the [specialist], which is also right in that same office. **So it's kind of convenient and nice to have all of that kind of meshed together so closely**. I mean I can be on the phone with my worker during COVID, and she'll just hand it to somebody else that might have the resources I need."
> –MIHP Family

Agencies with more intimate, local, and personal relationships tended to have the social capital needed to support referrals and transitions, although those relationships resided with individuals, not necessarily the institution. Agency type also played a role in how connected MIHPs were to community partners.

> "Being affiliated with the health department you just have this automatic connection with the other services that the county is offering, whereas **we're like a little mom and pop shop pretty much trying to make ourselves known in the community**."
> —MIHP Coordinator

> "If I left, there would be a learning curve. I know that everybody likes to think that programs should be based on their own attributes and if somebody leaves it should be seamless but that is not how things work, especially in [rural area]. Everything in [rural area] is based on personal relationships. It's all about who you know and what you know."
> –MIHP Coordinator

Participants were emphatic about how relationships among the home visiting sector impacted referrals and transitions for families. When relationships between individual professionals is strong, the information shared about referrals is more accurate and detailed, and the likelihood of co-visits and warm handoffs with families increased compared to contexts where professional relationships were strained. Personal relationships also helped smooth over problems that might arise between agencies, such as missed referrals, so families got the services they needed. Participants suggested that coordinators were the most likely to build strong relationships with other programs, as they were more likely to have the time to attend meetings and network. This model was not always supportive of transitions. Many home visitors felt they personally lacked sufficient and up-to-date knowledge about other programs and lacked the time and financial support to establish personal connections to other program colleagues in their area like coordinators do.

> "**All of us home visiting programs come together**, we do frontline meetings once a month, to break down the barriers and use each other. **When we need each other, we reach out to each other** … We do a lot of collaborative teamwork together, **so I know I can transition families to these programs with just a phone call**."
> —MIHP Coordinator

> "**I wish I did have more of a relationship with other agencies, and … the individual workers** … My boss will go to meetings, regional meetings, and several people from agencies will be there, so she'll build relationships with the leaders of those programs. **But for us out in the field, we can't speak directly about the programs**. So yeah, I just wish there was **more time to build those relationships**."
> –Home Visitor

Participants discussed how engaging in community collaborations helped to create shared messaging around programs, services, and parenting support for families and understanding of different enrollment criteria across agencies. While most participants acknowledged collaborations weren't working on improving transitions directly, engaging with other agencies improved communication and referrals. Some common collaborative bodies participants referenced included the Perinatal Quality Collaboratives, Great Start Collaboratives and Parent Coalitions, Fetal Infant Mortality Review, and other local community collaboratives. A geographic difference emerged in conversations about collaboration. Staff in rural areas often reported stronger connections with partners but had fewer active agencies to engage with. Staff in urban areas described having more partners to refer to but challenges in developing close relationships with all of them.

> "Across all three regions, the Great Start Collabs, the [local birth equity collaborative], the Home Visiting hub meetings in [Name] county. **A lot of different programs. So many that you can't really get to all of them**. We also have the home visiting conference. At the home visiting hub I was on yesterday, we created a proclamation to have a "home visitor month" in August. We created a proclamation to take to the governor. **Those are the kinds of things we are doing to recognize home visiting in general**."
> –MIHP Coordinator

A predominant contributor to challenges with transitioning from MIHP to other early childhood programs was related to system complexity and capacity. MIHP coordinators and home visitors frequently mentioned that some programs did not consistently follow-up with families who were referred to them; did not have staff to assist families with special needs and circumstances (such as children with autism or non-English speaking families); and had challenging eligibility criteria. Program staff noted that other home visiting eligibility criteria does not always align with the stage in which MIHP typically transitions families out of the program, resulting in fewer options for families. Moreover, many raised the issue that the age of enrollment criteria for other home visiting programs would require dual enrollment with MIHP.

> "It would be nice to have **more guidance** on knowing what programs are out there and what eligibility requirements of these program are. **Even as a professional it feels very complicated** to know where can I transition people. **A lot of programs have rules like how old the kid can be to even enroll**. Even if they serve past 18 months maybe they had to have enrolled as a baby. **So no wonder it's hard for parents to figure it out too**."
> –MIHP Coordinator

Families and home visitors also cited other issues within other home visiting program practices that impacted families' decisions to transition, such as programs having inflexible schedules, unrealistic expectations, and too frequent visits.

> "**I'm a part-time worker and a single mom** myself… I had to pick up an extra job just to cover rent and certain things that my children needed. … trying to squeeze in calls [with a home visitor] here and there when you're having a **busy schedule**, it's like, '**Where on this calendar can I fit you in?**'"
> –MIHP Family

SOCIETAL FACTORS

The single largest societal factor mentioned that impacted transitions was the COVID-19 pandemic. When public health measures were put in place to control COVID spread, home visits either ended or continued through telephone calls or telehealth video visits. On the positive side, participants discussed how telehealth has allowed access to some families who had barriers or concerns about welcoming a stranger into their home.

> "I have a lot of families that are like, "Nope, you're not coming to my house." But now that we have telehealth, I would say **our sense is caseloads have really increased because so many people are willing to do a video with you or talk on the phone**. They just don't want you in their house."
> –Home Visitor

On the negative side, virtual visits limited the development of personal relationships between families and home visitors, led to feelings of lower quality interactions with home visitors, and led to reduced or early cessation of services. Some participants felt it also limited the ability of MIHP staff to support transitions to other home visiting programs.

> "I just really feel like because of the lack of services for 14 months or so, there hasn't been as many referrals to those programs because we really don't know what people are doing. And it just feels disjointed. … It's really, really hard for us as home visitors to get back into these homes and to be referring out to yet another home visiting program. … [families] are not all that comfortable with us coming in right now as it is. And then to be referring yet another program? … I feel like it's really kind of a dysfunctional situation right now."
> –Home Visitor

RECOMMENDATIONS FOR IMPROVING MIHP TRANSITIONS

Participants offered various recommendations for improving transitions out of MIHP. MPHI evaluators also offered their recommendations based on findings from this evaluation.

Provide Financial Support for Transition Activities

Participants at the state and agency levels acknowledged that one of the most significant barriers to supportive transition planning is MIHP's funding structure. They described using supplemental resources or donating their time to make the transition process more supportive, including offering continued contact with families after program completion. While the generosity of MIHP home visitors is certainly notable, it is also a sure signal of an under resourced system. MIHP could benefit greatly from being able to bill for a transition visit, referral follow ups, and warm handoffs.

The findings also pointed to a gap in MIHP agency staff's capacity to participate in the local collaborative bodies, such as Great Start Collaboratives and Local Leadership Groups, that support building strong and supportive relationships between home visiting programs and other early childhood system partners. MIHP staff recognized the value of these bodies in becoming better integrated within the local system; however, they lacked the funding support to make this work possible. Compensating staff for critical networking and other transition related professional development activities would improve the transition experience for families.

> "The first thing people say is, '**Are we going to get paid for this?**' There needs to be more funding for the transition. 40% of **staff won't do it if there is no reimbursement attached to it. Everyone's time is worth something**, it's additional paperwork. It's a necessity at this point. I always felt MIHP just drops off. Some staff follow through but there is nothing formal."
> –MIHP Coordinator

> "Those things all take time and for our agency, we get paid per visit. It's not an hourly rate. So a lot of those times we're spending our time referring people, faxing a form … **it takes time for us to do it that we don't get paid for**… I want them to be successful parents and if I can help them do that, I will. But sometimes it's a bit frustrating the time that it takes you to do those things. … **I just wish there was something that would help us follow up with [them].**"
> –Home Visitor

Provide Transition Guidance and Training

This study has indicated that there is great variation in families' transition experiences, sometimes along racial and geographic lines. MIHP may benefit from providing agencies with flexible transition guidance that creates space for local variation while acknowledging that not all communities offer the same opportunities for families at the point of transition. 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 more consistent, supportive transition process for families. Additionally, MIHP as a model could provide agencies with a framework for conceptualizing responsibility for transitions. Participants held different perspectives on the degree to which MIHP home visitors, families, and other agencies are responsible for this process, and guidance around this tricky balance would be useful.

While broad guidance should be developed at the state-level, there remains a great deal of work in adapting and supplementing that guidance to local guidance. Coordinators and home visitors would also benefit from internal accountability structures around best transition practices.

> "**I would like something very user friendly or a training** … that is practical **about transitioning well** … I feel like this is something that for us, as professionals, is something we should be able to figure out how to do well **so that the burden isn't on the client** to have to figure out where to go."
> –Home Visitor

Promote Awareness and Use of Databases of Community Resources

MIHP providers varied in their awareness of locally available programs and services. Building MIHP providers' awareness and capacity in using MI Bridges, the Home Visiting Program Finder, Michigan 211 and other statewide databases of common referrals may be helpful for identifying eligibility, location, and contact information. MIHP agencies can certainly supplement these statewide databases with local knowledge, but centralized state resources would help them avoid recreating resource bases that already exist. Agencies can also invest in processes to keep the resource directories they are required to develop up to date with specific information obtained from participation in these groups including application processes, key staff, and eligibility criteria.

> "I have dug through so many places … probably like eight different counties and it's insane trying to figure out what [and] where. **But that would be great if the state could have this all listed**. I mean as soon as we're onto something, we're always sharing it with each other, but there's a lot of things that are out there that people don't know about."
> –Home Visitor

> "It would be helpful if there was **something on their website where it says 'transitioning' and lists different places we can call** – those hidden gems out there."
> –MIHP Coordinator

Increase Community Supports for Families

A common service system change raised by programs was the need for increased community supports for families. This primarily revolved around resource supports beyond home visiting such as improving transportation, assistance with obtaining affordable housing, access to counseling, accessible childcare services, and an increase in community events to support basic needs. These observations point to a need for maternal child health and early childhood to partner with other sectors to make sure families have what they need to thrive. All dimensions of children's development are impacted by these social determinants, suggesting a need to expand partnerships and participate in efforts to address deep root causes such as poverty and structural oppression.

> "**Easier access to housing, counseling, more agencies that have ready availability for women who are experiencing domestic violence** that they can go to with their families. At times that I have referred these agencies to my clients, there is waiting lists and the **families need this now**. And again, therapy and counseling, that they're made easier for them. A lot of my beneficiaries do not have easy **transportation** access."
> –Home Visitor

Participants noted that in many communities there is a gap in services between 12 or 18 months and 3-4 years. This gap is created by multiple factors. There are home visiting programs that enroll families for longer than MIHP but require most families to enroll during the timeframe MIHP is delivering services. There are also home visiting programs that can enroll at 12 or 18 months, but these programs are not available in all communities and the programs that do exist often have waiting lists. Non-home visiting programs for this age group are also very limited. Specific suggestions in this regard included taking steps to expand the availability of other home visiting services; integrating the transition phase within Michigan's MIHP Medicaid policy; allocating funding for another Medicaid-based home visiting service to follow immediately after MIHP; and expanding eligibility criteria within other home visiting programs. It also suggests a need to ensure MIHP providers have accurate and up-to-date information about the programs in their community that do exist for this age group and how to access them. Connecting MIHP providers to community resources such as Great Start Parent Coalition parent liaisons may also help.

> "You want to make sure the baby fits within the other program's guidelines too. **If they are a place that only takes up to 6 months of age, well you aren't in that window**. Some of them might hold on to babies until 3 years, but do they have to have entered the program **at a certain point to be eligible?"**
> –MIHP Coordinator

> "**Another Medicaid funded program that fills in that gap**. Something that's similar to MIHP but is for **18 months to 3 years**. I know there's the Nurse Family Partnership. I don't know if that's Medicaid-based or how that works. But it seems like that's not in every county. MIHP is pretty unique in its comprehensiveness as far as the disciplines represented: social work, nursing, nutrition and lactation … it's pretty hard to find in any other situation—or any other program … So yeah, **funding for that gap**."
> –Home Visitor

Celebrations and Next Steps

This report highlights many of MIHP's assets and strengths, including practices that might serve as models that promote supportive transitions for families. Families who shared their transition stories were overwhelmingly positive about their service experience with MIHP and the support they received as the program ended. Many coordinators and home visitors were well connected with local resources that supported transition and facilitated family connection to new services. Finally, state leaders are clear about what successful transitions look like, were supportive of local MIHP agencies, and demonstrated openness and willingness to engage in steps to improve the system.

While many recommendations were offered in the section above, the following are suggestions for next steps that are both high-impact and attainable in a shorter timeframe:

- **Begin strategic planning around state-level transition guidance.** Assemble a team of stakeholders, including local agency staff who have formalized their own transition trainings and processes. Consider integrating all transition-related support products with other MIHP resources online for ease of access. Once established, transition supports can be added as they are developed with the goal of having an accessible repository of resources as interests and needs evolve.
- **Increase awareness among local MIHP agencies of existing resources that support transition.** This awareness could be coupled with guidelines or suggestions of how to integrate these resources into internal agency processes or conversations with families.
- **Participate in the Transitions Learning Collaboratives and the Coordinated Eligibility and Enrollment Community of Practice** to explore quality improvement efforts to improve transition experiences for families. Positive experiences with these changes to improve transition can be incorporated into state-level transition guidance.
- **Engage in a Home Visiting Cost Study and other MIHP funding conversations with funding for transition support in mind.** Dedicated funding for transition activities was one of the biggest suggestions from local MIHP agencies. By engaging with the cost study, MIHP will be able to have a model for expanding infrastructure support for this type of support that increases the quality of services for families.
- **Continue to promote and educate home visiting colleagues about the importance of transition** as part of best practice at the annual home visiting conference and other venues to ensure this important topic remains top of mind to all partners.

Appendix 1: State Leadership Key Informant Interview Script

Introduction

Thank you so much for agreeing to talk with us today! A little info before we begin:

- *This interview is expected to last no longer than 60 minutes.*
- *To ensure we do not miss anything I have Erin here taking notes, and we are planning to record this session. The recording will not be shared with anyone, and it will be stored on a secure server at MPHI and will be destroyed after all notes have been captured. All responses will be de-identified and reported in aggregate in any reports back to MIHP or other stakeholders. Are you okay with being recorded today?*
- *The following questions are meant to inform strategies that will improve families' experiences transitioning out of MIHP into other home visiting programs or community supports. The information you share today will be analyzed with data from focus groups and interviews with other state folks, local home visiting administrators, home visitors, and families. We are excited to learn all that we can, and to share it back with folks like you to inform next steps.*

Are there any questions that I can answer for you before we get started?

Participant Background

1. First and foremost, could you please describe your role and how you work or interact with the Maternal Infant Health Program?

2. Great! As you know, we are here to ask you a variety of questions about the process by which families transition out of MIHP, and the extent to which they are connected with other home visiting programs or other local supports. Is it clear what we mean when we say "transitions"?

STATE FACT FINDING: Existing Guidance & Preparation

Let's start out by talking about what is currently in place or happening at the STATE level when it comes to transitions out of MIHP to other home visiting programs or other supports—more or less fact finding about what the state is up to. Then we'll move into what we see happening LOCALLY, what makes for more or less successful transitions, as well as what we would LIKE to see happen.

So in starting out with the facts, we just want to acknowledge that you may or may not have information on the following- We just want to make sure we cover our bases.

3. To your knowledge, is there any official guidance from the state level that guides local providers on when and how to appropriately transition families out of MIHP? This might be super detailed or brief, and could include trainings, memos, procedure documents, contractual info, or other formal guidance.
    a. If YES:
        i. Could you please share what you know about this guidance?
        ii. Do you have any documentation of this guidance you could share with us? (e.g. pdfs or PowerPoints)
        iii. To what extent do you see evidence that programs or individual home visitors are actually following this guidance when transitioning families? Is any data collected around this currently?
    b. If NO:
        i. MOVE TO NEXT QUESTION

4. When questions come up from providers related to transitioning families out of MIHP, is there advice or suggestions state consultants provide? This might be the same or different from existing formal guidance.

5. In your opinion, how well prepared are local programs to transition families from MIHP to other home visiting programs? To other services?

GENERAL: Connections

6. To your knowledge, are there any state- or local-level efforts working to improve coordination between MIHP and other Home Visiting models to improve transitions out of MIHP? How about between MIHP and other Early Childhood system players?
    a. If YES:
        i. Could you please share what you know about this coordination work?
        ii. To what extent are these efforts based on personal relationships versus formal institutional relationships?
    b. If NO:
        i. MOVE TO NEXT QUESTION

GENERAL: Defining Successful v. Unsuccessful Transitions/ MIHP's Strengths and Weaknesses

Now that we've gotten the nitty gritty state activities out of the way, let's get more into what constitutes a successful v. an unsuccessful transition, and what contributes to it going one way or the other.

7. First, let's just talk generally about successful transitions out of MIHP to other home visiting programs or other services. What does a successful transition look like, from your perspective? How would we know a successful transition when we see one?
    a. [PROBE: What do families experience? What do they get? How do they feel?]
    b. Generally speaking, are there certain components of a successful transition that MIHP providers across the state tend to excel at, where they are strong?

8. I'm wondering if you could take a minute and think of specific providers, communities or regions where you've heard success stories around transitions out of MIHP?
    a. Did you think of specific providers or communities? [name providers/communities/regions]. If not, that's ok.
    b. Thinking about more successful providers or communities, what is going well in these places or programs?
    c. How do you think these providers/communities/regions achieve these results? What contributes to their success?
        a. [Probe around policies/procedures, service components, staff/agency capacity, coordination/cooperation, resources, mindsets, power dynamics, other community or system characteristics]
    d. Do you see any "promising practices" emerging from these successful providers/communities that might be worth trying out in other communities?

9. Now let's talk about less successful or downright ugly transitions out of MIHP to other home visiting programs or other services. In your opinion, what does an unsuccessful transition look like?
    a. [PROBE: What do families experience? What do they get/not get? How do they feel?]
    b. Generally speaking, are there certain components of transitions that MIHP providers seem to struggle with more often?

10. Let's take a minute and think of specific providers, communities, or regions that have struggled to help families transition out of MIHP successfully to other home visiting programs or other supports. Can you take a minute and think of examples? [Don't worry; this info won't get back to them. It's just for our reference.]
    a. Did you think of specific providers or communities? [name communities/regions]. If not, that's ok.

a. Thinking about providers or communities that have a harder time with transitions, what are these places or programs struggling with?

b. What do you think contributes to these struggles? What gets in the way of their success?

i. [Probe around policies, guidance, service components, staff/agency capacity, coordination/cooperation, resources, mindsets, power dynamics, other community or system characteristics]

STATE: Barriers & Facilitators/Promising Practices/Desired Changes

So you've identified things at the local level that support successful transitions, and get in the way of successful transitions. Now let's talk about those factors at the STATE level, and changes you'd like to see therein. Let's start with MIHP itself, and then we'll talk about other home visiting models and other partners.

11. When it comes to helping local programs have more successful transitions out of MIHP and into other programming, what do you think the state **MIHP** administration itself could think about keeping in its current practice, and what should they think about changing?

a. [Probe around Medicaid policies, state procedures, service components, staff/agency capacity, coordination/cooperation, resources, mindsets, power dynamics, other community or system characteristics]

Keep
Change

12. Now let's think about other home visiting models and other system partners. When it comes to helping local programs have more successful transitions from MIHP, what do you think other **home visiting models or other systems in the state that support families with young children** should think about keeping about the way they approach the work, and what should they think about changing?

a. [When I say "other systems that support families with young children, I'm thinking widely here—certainly Early Childhood Education and WIC, but also public safety, housing, economic development, public health, etc.]

b. [Probe around policies/procedures, service components, staff/agency capacity, coordination/cooperation, resources, mindsets, power dynamics, other community or system characteristics

Keep
Change

13. We are coming to the end of our interview--- Thank you so much for all of this great information! Before we wrap up, did you have any last thoughts or ideas you wanted to share about MIHP transitions?

CLOSING

- *Thank you for participating!*
- *If you have additional questions about the interview or the evaluation, please reach out to me at smcgirr@mphi.org*

Appendix 2: MIHP Agency Coordinators Key Informant Interview Script

Introduction

Thank you so much for agreeing to talk with us today! A little info before we begin:

- *This interview is expected to last no longer than 60 minutes.*
- *The following questions are meant to inform strategies that will improve families' experiences transitioning out of MIHP into other home visiting programs or community supports. The information you share today will be analyzed with data from focus groups and interviews with state folks, other local MIHP coordinators, home visitors, and families. We are excited to learn all that we can, and to share it back with folks like you to inform next steps.*
- *We encourage you to answer the questions as honestly as possible. We want to hear about what is working well, but also what is not really working. You can feel comfortable sharing your real experiences as a coordinator, because the information you share will not be communicated back to the state in a way that will identify you or your site. All results will be combined across sites and no individual or agency will be identifiable. Our job is to gather enough information for the state to make decisions and improve the program—and that means hearing about the good, the bad, and the ugly.*
- *To ensure we do not miss anything I have Sara/Anna here taking notes, and we are planning to record this session. The recording will not be shared with anyone, and it will be stored on a secure server at MPHI and will be destroyed after all notes have been captured. Are you okay with being recorded today?*
- *Are there any questions that I can answer for you before we get started?*

Participant Background

1. First and foremost, could you please describe your role and tell us a bit about your MIHP program and the agency you work for?
    a. [Probe briefly: location, rural vs. urban, beneficiary demographics, longevity/stability]

2. Great! As you know, we are here to ask you a variety of questions about the process by which families transition out of MIHP. When I say transitions, what does that mean to you? Where are families transitioning to?
    a. [Note for Interviewer: Think about who is going to continue the goals of MIHP with the family]

3. To the best of your ability, can you describe the process of how families are typically transitioned out of your agency's program, if everything goes according to plan?
    a. [If needed, probe:
        i. When should home visitors ideally start the transition process? What does that conversation look like with families?
        ii. How do you identify a family's ongoing needs and wishes, and determine what other programs or services to recommend
    b. How do you make the 'hand off'? Do you use a transition plan or put any of this process in writing?]Does the transition differ when families are transitioned to another home visiting program vs. when they are transitioned to other services and supports? (If so, How?)
    c. Where are families transitioned to most frequently?
        i. Which Home visiting programs [Healthy Families America (HFA), Infant Mental Health (IMH), Nurse Family Partnership (NFP), Parents Aa Teachers (PAT), Family Spirit, Play and Learning Strategies (PALS), Early Head Start Home Based (EHS)]?Which Specific services and supports [Early On, childcare, parent education programs, housing support, food assistance, mental health treatment, etc.]?

Ok, now let's talk about guidance and supports around transitions work.

4. To your knowledge, is there any official guidance or training from the state level that guides local providers, like you, on when and how to appropriately transition families out of MIHP? This might be super detailed or brief, and could include trainings, memos, procedure documents, contractual info, or other formal guidance.
    a. If YES:
        i. Could you please share what you know about this guidance?
        ii. How did you receive this guidance?
        iii. How helpful are these trainings or other resources?
        iv. How easy or hard is it to follow this guidance and advice? Do you think most home visitors follow this guidance?
    b. If NO:
        i. What types of state guidance would be helpful for your agency?
        ii. MOVE TO NEXT QUESTION

5. Does your agency have any specific guidance for your home visiting staff on how to transition families out of your agency? [Probe: formal protocols, informal conversations, ongoing trainings, etc.].
    a. If YES:
        i. How did you develop this guidance?
        ii. How do you train your staff? What are the key components of the transition process for your agency?
        iii. How consistently do your home visitors follow this guidance?
    b. If NO:
        i. MOVE TO NEXT QUESTION

Now, let's get more into what constitutes a successful v. an unsuccessful transition, and what contributes to it going one way or the other.

6. First, let's just talk generally about successful transitions out of MIHP to other home visiting programs or other services. What does a successful transition look like for families? How would we know a successful transition when we see one?
    a. [PROBE: What do families experience? What do they get? How do they feel?]

7. What is working well at your agency in terms of transitioning families to other HV programs or other services?
    a. What contributes to your success? In other words, what helps make for good transitions at your agency?
        i. [Probe around policies/procedures, service components, staff/agency capacity, coordination/cooperation, resources, mindsets, power dynamics, other community or system characteristics]

8. *[IF NOT COVERED ABOVE]* Are there other home visiting programs or services that your program has strong relationships with when it comes to transitions?
    a. IF YES: Which programs or services does your agency have strong relationships with?
    b. What contributes to the success of these relationships?
    c. Are they based on personal connections, formal partnerships, or something else?

9. Now let's talk about less successful or downright ugly transitions out of MIHP to other home visiting programs or other services. In your opinion, what does an unsuccessful transition look like?
    a. [PROBE: What do families experience? What do they get/not get? How do they feel?]

10. Every agency has struggles with certain components of their program and areas for growth. Knowing that, what is not working well at your agency in terms of transitioning families to other HV programs or other services?
    a. What contributes to these challenges? In other words, what gets in the way of successful transitions at your agency?
        [Probe around policies/procedures, service components, staff/agency capacity, coordination/cooperation, resources, mindsets, power dynamics, other community or system characteristics]
    b. Do you have any ideas of what supports would help overcome these challenges?

11. *[IF NOT COVERED ABOVE*] Are there other home visiting programs or services that your program has strained relationships or no relationship with when it comes to transitions?

a. IF STRAINED: What contributes to the challenges in these relationships?

i. [Probe around history, consistency of relationship and related challenges,]

b. IF NO RELATIONSHIP: What are some reasons that you have not been able to establish these relationships as of yet?

i. [Probe around history, consistency of relationship and related challenges,]

c. Has there ever been discussions in your community around trying to strengthen these relationships, or intentionally setting up processes around transitions from MIHP into these programs?

d. Do you have any ideas of what supports would help bridge/strengthen these relationships?

For this final part of the interview, we're going to talk about work to change the system to make it better for families--- including what is already happening and what you'd like to see happen.

12. *[IF NOT COVERED ABOVE]* To your knowledge, are there any regional or local-level collaboratives or groups working to improve coordination between Home Visiting models? How about between home visiting programs, including MIHP, and other Early Childhood system players?

a. If YES:

i. Could you please share what you know about this coordination work?

ii. To what extent are these efforts based on personal relationships versus formal institutional relationships?

iii. Have these collaboratives tackled any issues related to transitions between programs?

b. If NO:

i. MOVE TO NEXT QUESTION

13. What would you like to see changed in your **local community** to encourage more successful transitions out of MIHP and into other programming,?

a. [Probe around policy changes, agency changes, awareness, mindset changes, etc.]

14. What would you like to see changed at the **state level** to encourage more successful transitions out of MIHP and into other programming?

a. [Probe around Probe around policy changes, program changes, system level changes, etc.]

b. What do you hope comes out of this project? What do you hope does NOT come out of this project?

CLOSING

We are coming to the end of our interview--- Thank you so much for all of this great information!

Before we wrap up, did you have any last thoughts or ideas you wanted to share about MIHP transitions?

- *Thank you for participating!*
- *We will be in touch about the family survey coming up – start compiling emails of families that have recently transitioned out of your program. We will be sending the survey out to those folks.*
- *If you have additional questions about the interview or the evaluation, please reach out to me or Sara.*

Appendix 3: Home Visitor Focus Group Protocol

Introduction

*Thank you all so much for agreeing to join this conversation today. My name is **Anna Martinez-Hume** and I am with the Center for Healthy Communities at MPHI, and I am joined by my colleague **[Sara McGirr/Erin Edgerton]**, who will be assisting me in facilitating today's discussion. A little recap about the purpose of today's focus group:*

- *This focus group is expected to last no longer than 90 minutes.*
- *The purpose of today's discussion is to hear from home visitors like yourselves, to inform strategies that will improve families' experiences transitioning out of the Maternal Infant Health Program (MIHP) into other home visiting programs or community supports. The information you share today will be analyzed with data from focus groups and interviews with state folks, local MIHP coordinators, other home visitors, and families. We are excited to learn all that we can, and to share it back with folks like you to inform next steps.*

Informed Consent

- *The first thing I want to tell you is that whatever we say here is confidential. That means that the information shared by you will be summarized in a report and you will not be identified. Your name will not be attached to any of the comments you make. All results will be combined across sites and no individual or agency will be identifiable.*
- *We will be recording this conversation, as well as taking notes. The reason we are doing this is so we can make sure that we correctly describe what you tell us today. We will destroy this recording after we have written the summary report. Are you ok with being recorded today?*
    - *If someone says NO: OK. For now, I'm going to ask you to hop off this meeting, and our team will plan on contacting you for a separate conversation. Apologies for any inconvenience!*
- *We encourage you to answer the questions as honestly as possible. We want to hear about what is working well, but also what is not working well. You can feel comfortable sharing your real experiences as an MIHP home visitor, because the information you share will not be communicated back to the state in any way that will identify you or your site. Our job is to gather enough information for the state to make decisions and improve the program—and that means hearing about the good and the bad.*
- *That being said, since this is a group space, we are all responsible for protecting each other's confidentiality. After this session, if you want to discuss any of ideas that may have come up with others, you can do that. But refrain from identifying who said what, or who was participating in the group discussion, for the protection of everyone involved.*
- *You are free to choose not to answer any question that makes you feel uncomfortable and to leave the discussion at any time. Your continued participation in our conversation today will be considered your consent.*
- *We will share our project contact information in the Zoom chat should you have any questions/concerns regarding your participation in this study.*

Guidelines

Before we begin, here are a few guidelines for our discussion today:

- *We want you to do the talking.*
- *There are no right or wrong answers. We'd like to hear the many varying viewpoints and experiences you may have and would like everyone to contribute their opinions.*
- *Give everyone the chance to express their opinion during the conversation. Speak up when you agree or disagree. You can address each other if you like. However, please refrain from interrupting others. Let's have just one speaker at a time.*
- *What is said today should remain here. Please don't disparage others' remarks.*
- *Are there any questions that I can answer for you before we get started or does anything need to be explained more clearly?*

Questions

Let's first go around and each take about a moment to briefly introduce yourselves, including your name and how long you've been a MIHP home visitor.

1. Thank you! As I mentioned, we are here to learn more about the process by which families transition out of MIHP. When I say "transitions," I'm referring to the process whereby MIHP helps families identify and link to services as their time with MIHP ends if they need or want services. This might be linkages to home visiting, other early childhood programming, or self-sufficiency services. Can you give me an example of where you transition families to most frequently at your agencies?
    a. Probe around specifics:
        i. Which Home visiting programs [Healthy Families America (HFA), Infant Mental Health (IMH), Nurse Family Partnership (NFP), Parents as Teachers (PAT), Family Spirit, Play and Learning Strategies (PALS), Early Head Start Home Based (EHS)]?
        ii. Which Specific services and supports [Early On, childcare, parent education programs, housing support, food assistance, mental health treatment, etc.]?
    b. As a home visitor how did you learn about these other agencies in your region?
    c. Are you more comfortable referring or connecting families to certain programs over others? Which ones? Why do you think there is more comfort with these programs?

2. Let's talk a little bit more about your relationships with other programs in your area. Some of you might have **strong relationships** with other programs and their providers/home visitors, and some of you might have **strained relationships** with these programs (or no relationship at all). This can vary a lot community to community. We are trying to understand what contributes to relationships being strong, strained, or just non-existent.
    a. When you think about the programs or individuals you have strong relationships with, what helped build these **strong** relationships?
    b. For those of you who experience **strained** or **non-existent** relationships with other programs, what contributes to the challenges in these relationships?

Ok, now let's talk about guidance and supports around your transition work as a home visitor.

3. By a show of hands, how many of you have received any kind of official guidance or training on how to appropriately transition families out of MIHP? [This might be detailed or brief, and could include trainings, memos, procedure documents, contractual info, or other formal guidance.] **[Invite participants to use the hand raise icon in Zoom or raise hand in video]**
    a. For those of you who raised your hands, can you share what you know about this guidance?
        i. Was this guidance from the state MIHP program or from your agency?
    b. For those of you who didn't raise your hands, what guidance would be helpful for you?

4. What approach do **you** personally follow to transition families out of MIHP? This might be the same or different from the guidance your agency or the state gives.
    a. How did you learn/develop this approach?
    b. Are there times when you don't follow this approach? Why?
    c. Ideally, what do families experience when transitioning out of MIHP with you?
    d. Now that we've heard how other's approach the transition process, what components of those examples do others share? Or what is different at your agency?

Now, let's get more into what you think constitutes a successful v. an unsuccessful transition, and what contributes to it going one way or the other.

5. Think about your approach to transitioning families out of MIHP and into other HV programs or services. What do you feel works well? **Let's generate a list of best practices.**
    a. [Probe around policies/procedures, service components, staff/agency capacity, coordination/cooperation, resources, mindsets, power dynamics, other community or system characteristics]
6. Imagine a scenario where a mother chooses to end her involvement with MIHP before completing all her available visits with you. If this has happened to you, how has MIHP supported transition for mothers who ended early?

7. Think about a family who had an unsuccessful or ugly transition out of MIHP. What kind of barriers and challenges did you as a home visitor or this family face when trying to transition or seek additional services/resources? **Let's generate a list of these barriers.**

    a. Probe: How do things like race/ethnicity, geography, income, religion, or language impact what transitions look like for families?

For this final part of the session, we're going to talk about work to change the system to make it better for families.

8. What aspects of your community support successful transitions for families with infants and young children?

9. I'd like for each of you to take moment to think about what you would like to see changed in your **local** community AND at the **state** level to encourage more successful transitions out of MIHP to other programming and to overcome some of these barriers/challenges you've mentioned. What would be helpful for your work as a home visitor?

    a. What things came to mind for **community level** change?

    b. What things came to mind for **state level** change?

10. As I mentioned earlier, the purpose of this study is to inform the state's next steps at improving MIHP transitions for families. With that in mind, what do you hope comes out of this project **specifically for home visitors like yourselves**, and what do you hope does NOT come out of this project?

<u>Closing</u>

Thank you all for sharing. Those are all of our questions. Are there any last comments before we end our discussion today?

Thank you all for participating in this group discussion and sharing your personal experiences as MIHP home visitors with us today. Your input and time today will be invaluable for informing the next steps in improving families' experiences with MIHP and the transition process.

Appendix 4: Family Focus Group Protocol

Introduction

Thank you so much for agreeing to talk with us today! A little info before we begin:

My name is Julie Moore and I will be your main facilitator today. I also have ***[Sara McGirr/Erin Edgerton]*** here with me taking notes and asking questions in case I miss something. We are both from the Michigan Public Health Institute.

We invited you here today to hear about what your experience was like leaving the Maternal Infant Health Program (or MIHP). We are asking questions to improve families' experiences transitioning out of MIHP into other home visiting programs or community supports.

We encourage you to answer the questions as honestly as possible. We want to hear about what worked well, but also what didn't work well. You can feel comfortable sharing your real experiences as an MIHP family, because the information you share will not be communicated back to the agency you worked with or the state in a way that will identify you or your community. Our job is to gather enough information for the state to make decisions and improve the program—and that means hearing about the good, the bad, and the ugly.

That being said, since this is a group space, we are all responsible for protecting each other's confidentiality. After this session, if you want to connect with anyone about some of the ideas that may have come up, you can do that. But don't use names for the protection of everyone involved.

We are recording this focus group so we can type out what we say here today. Recording is also a great way to make sure we capture everything you are saying. The original recordings will be destroyed after our conversation has been typed out so no one will hear your voice connected to what you share today. We will use your name in the zoom meeting today to keep track of who's talking, but we will replace your name with an ID number after we type out the conversation. If you are not ok being recorded, let us know now so we can reach out to you individually to talk. Is anyone NOT ok being recorded today?

You are free to choose not to answer any question that makes you feel uncomfortable and to leave the discussion at any time. Your continued participation in our conversation today will be considered your agreement to participate.

This focus group is expected to last no longer than 90 minutes. Each of you will receive a $35 Amazon electronic gift card as a token of our thanks. You should receive an email at the address you provided during registration with the gift card information within 10 days. If you do not receive this, please reach out to Erin at eedgerto@mphi.org. We will place her email in the chat for those of you in the video conference.

Are there any questions that I can answer for you before we get started?

And be sure to ask any questions that might come up as we're talking.

Participant Background

I'm going to start the recording now.

I'd like to give everyone a chance to introduce themselves. Please share your name you registered with (first name only is fine), where you live, and tell us a bit about your experience with the Maternal Infant Health Program. For example, when you started, how long you received visits for, and when and why you ended services with MIHP.

Expectations & Conversations about Transition Out of MIHP

We are going to use the word "transition" a lot today. What we mean by transition is the process by which MIHP supports families in identifying their needs and connecting with any additional services they may want when their time with MIHP is done. In other words, what happened when you finished MIHP. If you have had more than one experience with MIHP, feel free to talk about any of them.

1. When did you learn about how your transition out of MIHP would work? *(probe for whether experiences impacted by own choice to end services or if they ran to end of all visits)*
    a. Near the beginning, during services, near the end?

2. How did you learn about it? Who told you what to expect, if anyone?
3. For those who were told what to expect with transition, who started the conversation about transitioning out of MIHP?
    a. You? Your home visitor? Someone else at MIHP?
4. About how many times did your home visitor discuss what your next steps would be once MIHP ended? In other words, was it just one conversation, did you talk about it during each visit, or something in between?
5. What do you recall your home visitor telling you would happen after MIHP services were over for your family?
6. How did your home visitor talk with you and your family about the services you might want after MIHP ended?

Transition Process

Now I'd like to hear about what it was like during your transition out of the MIHP program.

7. When it came time to transition, how prepared did you feel to move on?

Sometimes when families transition out of MIHP, MIHP has been able to help make connections to meet their needs. Other times, they felt that transition could have been smoother.

8. Did your home visitor identify or suggest what resources you might want for support after MIHP?
    a. If so, what were these based on? Observations? Paperwork or "screeners"? Something else?
9. How did you decide if you wanted to continue with some sort of supports after MIHP? *Prompt if necessary:* For example…
    a. Things you loved about home visiting that you wanted more of?
    b. Challenges that you were still experiencing?
    c. New concerns based on home visits?
    d. Your own observations and feelings?
    e. Learning about services available in your community?
10. To what extent did you feel heard and understood by your home visitor during these conversations, like they really got what you wanted to do next?
    a. To what extent did you and your home visitor agree on your ongoing needs or plans for the next step after MIHP?
    b. If not, what was that conversation like?
11. **For those of you who transitioned to another home visiting program**, what was that transition like?
    a. What new program did you transition to?
    b. Was there time between programs when you didn't see anybody?
        i. For how long?
        ii. Do you know why there was a delay in getting into the next program?
        iii. Did this cause any problems for you?
    c. What did the process of transitioning look like for you? Did your MIHP home visitor help introduce you or enroll you in your new program? Or were you given a referral that you followed up with on your own?

12. **Now I want to talk to those of you who transitioned out of home visiting completely,** In other words, after you left MIHP you didn't enroll in any other services where a person came into your home to work with your family. What was that transition like?

    a. What other services and supports were you offered or referred to? (Such as housing or food assistance, mental health, etc.)

    b. What services did you enroll in?

        i. For those of you who did not enroll in any other services after home visiting, can you tell me more about the decision to not continue with any services? (*probe for: adequate connections, all needs met, bad experience with programming*)

    c. Was there time between home visiting and your other support services?

        i. For how long?

        ii. Do you know why there was a delay in getting into other services?

        iii. Did this cause any problems for you?

    d. What did the process of transitioning look like for you? Did MIHP help introduce you or enroll you in new services? Or were you given a referral that you followed up with on your own?

Recommendations

You have just shared some of your stories about what happened when your time in MIHP ended. Now I'd like to hear about your recommendations about what should change and what should stay the same to support other families.

13. What did you like about the transition experience?

    a. What supports helped you transition to another program smoothly?

14. What do you think could have been better about the transition experience?

    a. What supports would have made your transition better?

    b. What got in the way of having a smooth transition out of MIHP services?

    c. What was hard for you about transitioning out of MIHP? (*probe for emotional impact*)

15. Does anyone have stories from another program that handled exit and service referrals in a really great way?

    a. What made it great?

    b. Which of these ideas do you think MIHP should try?

We are coming to the end of our time--- Thank you so much for all of this great information! Before we wrap up, did you have any last thoughts or ideas you wanted to share about your experience with MIHP and your transition out of the program?

CLOSING

- *Thank you for participating!*
- *If you have additional questions about the interview or the evaluation, please reach out to me at* jamoore@mphi.org

Appendix 5: Qualitative Codebook

Code	Sub-code(s)	Definition/Example
1. Background *Who did we talk to? What is their intersection/experience with MIHP?*	1.1 Agency	*References to their state agency or MIHP agency demographics; location; counties, population served; etc. [Admin, Coordinator & HV protocols].*
	1.2 Roles and Duties	*References to their specific job experience, roles and duties, training, networking, reporting, etc. [Admin, Coordinator & HV protocols].*
	1.3 Family Overview of MIHP Experience	*How families found out about MIHP, length of time in program, # of children served, general feelings about program [Family protocol].*
2. Transition Guidance *What documentation or training exists regarding what "should" happen when it comes to transition*	2.1 Meaning of "Transition"	*How "transition" is defined by admins, coordinators & HVs. What they understand transition to mean. [Admin, Coordinator & HV protocols].*
	2.2 Internal (Their MIHP agency)	*Trainings; informal conversations; where coordinators and HVs go for information/resources. [Admin, Coordinator & HV protocols].*
	2.3 External (State; Community)	*MIHP handbook; state training/orientation; websites, local community meetings; MIHP conference; other MIHPs. [Admin, Coordinator & HV protocols].*
3. Transition Preparation Conversations & Logistics *What actually happens around the conversation and preparation for the transition with families (when did it happen, what was communicated)*	3.1 Onset & Dosage of Conversations	*When Home visitors first begin preparing families for transitions; How many times/how often they discuss it*
	3.2 Content of Conversations	*Content of preparation conversations- What is being said in these conversations; How family learned what to expect; understanding of what would happen*
	3.3 Identifying Needs	*How family needs & wishes are identified and linked to services*
4. Transition Process to No Services *Transitions to no other programming*	4.1 Did not Transition to Services	*Did not transition to other services at all*
	4.2 Reasons for Transition to No Services	*e.g. Self-sufficiency; No services available; relocated or moved*

Code	Sub-code(s)	Definition/Example
5. Transition Process to Home Visiting Program *Where they transitioned and What happens around the actual transition to another HV program*	5.1 Which Home Visiting Program	*Which specific home visiting programs [Healthy Families America (HFA), Infant Mental Health (IMH), Nurse Family Partnership (NFP), Parents as Teachers (PAT), Family Spirit, Play and Learning Strategies (PALS), Early Head Start Home Based (EHS)].*
	5.2 Referral & Handoff	*References to referral actions taken on a spectrum from list giving and cold calls to warm handoffs (i.e. printed resource list, putting a referral in a system, leaving a voicemail, taking someone somewhere, navigating appointments, introducing someone, 3 way phone call, co-visiting)*
	5.3 Home Visiting without MIHP facilitation	*Family received programming without MIHP involvement*
6. Transition Process to Other Services/Supports *Where they transitioned and What happens around the Actual transition to another service or support other than Home Visiting*	6.1 Which Services & Supports	*Which specific services and supports [Early On, childcare, parent education programs, housing support, food assistance, mental health treatment, etc.].*
	6.2 Referral & Handoff	*References to referral actions taken on a spectrum from list giving and cold calls to warm handoffs (i.e. printed resource list, putting a referral in a system, leaving a voicemail, taking someone somewhere, navigating appointments, introducing someone, 3 way phone call, co-visiting)*
	6.3 Services & supports without MIHP facilitation	*Family received services & supports on own or outside MIHP experience*

Code	Sub-code(s)	Definition/Example
7. Marker or Contributors to Successful Transitions	7.1 Family Psychological Experience (Preparation; Emotional)	*References to what families ideally feel, experience, & receive (i.e. trust; resources; feeling self-sufficient); what family expected; how they feel prepared to transition; what families liked about transition.*
	7.2 Interpersonal Relationships 7.2.1 Within-Family 7.2.2 Family-HV 7.2.3 Professional-Professional	*Presence of social support or other interpersonal supports in families lives that promote more successful transitions, outside of MIHP or other organizations. dynamics with partner, extended family, child.*
	7.3 MIHP Agency and Home Visitor Practice (Organizational)	*References to ideal or preferable internal MIHP agency and staff policies/procedures, service components, staff/agency capacity, resources, mindsets, and practices that promote better transitions; successful approaches that lead towards successful transitions; promising practices and understandings at the provider or MIHP agency level; Positive relationships with home visitors.*
	7.4 Other System Players and Coordination (System)	*Presence of promising or successful Coordination/cooperation among early childhood and family support programs, services, and systems; strong relationships with other HV services and resources; Other system players that have practices that promote successful transitions.*
	7.5 Positive Social Determinants of Transition (Societal)	*Positive structural social determinants of transitions; factors facilitating family transitions (having adequate financial resources; close knit or supportive communities; positive economic circumstances; job opportunities/ flexibility; transportation); Other descriptions of family examples and scenarios that facilitate transition.*
	7.6 Other Facilitators	*Any other contributor/marker/facilitator that promotes successful transition or marker of better transitions that does not fit above.*

Code	Sub-code(s)	Definition/Example
8. Contributors or Markers to Unsuccessful Transitions	8.1 Family Psychological Experience (Preparation; Emotional)	*References to what families should not experience, feel & receive; what family didn't expect; fears; how unprepared they are for transition; References to falling off/loss to follow-up; health, mental health and substance use concerns; what got in the way or was hard for families about transition.*
	8.2 Interpersonal Relationships 8.2.1 Within-Family 8.2.2 Family-HV 8.2.3 Professional-Professional	*Lack of social support or other interpersonal supports in families lives that get in the way of transitions (i.e. having no family or friends); Negative relationships with partners, family, friends that get in the way of successful transitions, not including relationships with home visitors or other service providers.*
	8.3 MIHP Agency and Home Visitor Practice (Organizational)	*References to inadequate internal MIHP agency and staff policies/procedures, service components, staff/agency capacity, resources, mindsets, and practices that impede transitions; unsuccessful or problematic approaches that lead towards unsuccessful transitions at the individual provider or MIHP agency level; areas where HVs and MIHPs struggle; negative relationships w/HVs; Family descriptions of inadequate HV support.*
	8.4 Other System Players & Coordination (System)	*Lack of/or poor coordination/cooperation among early childhood and family support programs, services, and systems; Competition or poor relationships with other HV services and resources; eligibility misalignment; Other system players that have practices, policies, or other limits that impede successful transitions (i.e. waitlists, delays, limited caseloads, poor follow up).*
	8.5 Negative Social Determinants of Transition (Societal)	*Negative social determinants of transitions; factors impacting transition that fall at the societal level (i.e. language barriers; racism; lack of employment; housing situation; rurality (no other services to go to); COVID); descriptions of challenging family examples or scenarios*
	8.6 Other Barriers	*Any other contributor/marker/ barrier that impedes successful transition, or marker of unsuccessful transition that does not fit above.*

Code	Sub-code(s)	Definition/Example
9. Change, Improvement & Suggestions	9.1 Agency-specific improvements	*Areas for growth within their MIHP; What MIHP practices to keep/change; what to adapt from other home visiting models; Recommendations for HVs from families.*
	9.2 Community/ inter-system changes	*Community level changes (i.e. more networking/coordination);*
	9.3 State-specific improvements	*State level changes (I.e. funding; training/guidance); suggestions for state improvement of MIHP*
10. Good Quotes		*Code any good/powerful quotes here.*

Appendix 6: Family Survey

About your time with MIHP

1. Have you finished your MIHP home visits? In other words, are you done getting official home visits (in person or virtual) from a MIHP home visitor?
    - Yes
    - No *[Skip to Question 28]*
    - Not sure

2. About how long ago was your last visit or call from your MIHP home visitor?
    - Less than 1 month
    - 1-3 months
    - More than 3 months
    - Not sure

3. Do you still call or text your home visitor even though your MIHP visits are done?
    - Yes
    - No
    - Prefer not to say

4. During your most recent MIHP enrollment, about how many MIHP visits did you have when pregnant? (at your house, in the office, or on a virtual visit)
    - 0
    - 1-3
    - 4-10
    - More than 10
    - Not sure/Don’t remember

5. During your most recent MIHP enrollment, about how many MIHP visits did you have with your baby after they were born? (at your house, in the office, or on a virtual visit)
    - 0
    - 1-3
    - 4-10
    - 11-18
    - 19-36
    - More than 36
    - Not sure/Don’t remember

6. About how old was your baby at the last MIHP visit?
    - 0-6 months
    - 7-12 months
    - 13-18 months
    - Over 18 months
    - Not sure/Don’t remember

7. Why did you leave the MIHP program? Please select all that apply.
   - ☐ Completed all available visits
   - ☐ I got what I needed (did not need services anymore)
   - ☐ Baby too old to continue
   - ☐ Getting services somewhere else
   - ☐ It wasn't for me
   - ☐ Was not receiving the services I hoped for
   - ☐ Did not like my home visitor
   - ☐ Did not trust my home visitor
   - ☐ Did not like the things my home visitor wanted to talk about
   - ☐ MIHP did not work with my schedule
   - ☐ Did not have time for visits
   - ☐ Moved out of the area
   - ☐ My home visitor stopped showing up or never showed up
   - ☐ Loss of pregnancy or infant death
   - ☐ Loss of child custody
   - ☐ Other, please specify: _____

Leaving MIHP

Transition is the process where MIHP supports families in finding their needs and connecting with any more services they may want when their time with MIHP is done. In other words, it's what happens when you've finished MIHP. Activities during transition may be finding new services, deciding what needs you still have, and saying goodbye to your home visitor.

8. About how many conversations did you have with your home visitor about what happens after MIHP is over?
   - ○ None
   - ○ 1-2
   - ○ 3-4
   - ○ 5 or more
   - ○ Not sure

9. How did you feel about the number of conversations you had with your home visitor about what happens after MIHP is over?
   - ○ Too few
   - ○ Just right
   - ○ Too many
   - ○ Not sure

10. When did you begin talking with your home visitor about what happens after MIHP is over? [skip if Q8= "none"]
   - ○ At my first visit
   - ○ After my first visit but early in services
   - ○ Before my last visit but late in services
   - ○ At my last visit
   - ○ Never
   - ○ Not sure

11. Please indicate your agreement level with the following statements:

	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
I felt supported by my home visitors as the MIHP program ended.	○	○	○	○	○
I miss my regular visits with my home visitor.	○	○	○	○	○
I felt like the MIHP program ended too soon.	○	○	○	○	○
I felt like the MIHP program ended too suddenly.	○	○	○	○	○
I felt abandoned after my last visit with my home visitor.	○	○	○	○	○
My home visitor gave me ideas for other services that might help my family.	○	○	○	○	○
My home visitor helped me figure out what my family might need after the program ended.	○	○	○	○	○
My home visitor listened to my feelings about the MIHP program ending.	○	○	○	○	○
My home visitor treated me with respect as the program ended.	○	○	○	○	○
I felt confident as my time with MIHP ended.	○	○	○	○	○

11. Overall, how would you rate your experience **ending** the MIHP program?
- ○ Very Good
- ○ Good
- ○ Neutral
- ○ Bad
- ○ Very Bad

Good…

13. Please share what was good about your experience **ending** MIHP:

Bad…

14. Please share what was bad about your experience **ending** MIHP:

Other Supports

15. What types of supports or services did you want or need as your time with MIHP ended? Select all that apply.
- ☐ Another home visiting program (like Parents as Teachers, Head Start, etc.)
- ☐ Special help for my child (like screening for developmental delays, Early On, etc.)
- ☐ Childcare (center or home based, after-school programs, paying for childcare)
- ☐ Other parenting groups (parent coalition, play learn groups, MomPower, Fatherhood Connection, etc.)
- ☐ Health care needs (navigating insurance options/issues, scheduling appointments, medical costs, etc.)
- ☐ Education resources (GED, college, or vocational/training programs, etc.)
- ☐ Mental health and/or substance use services (Community Mental Health, etc.)
- ☐ Housing/rental support (like government rental assistance programs, eviction diversion help, etc.)
- ☐ Food support (like WIC, government food assistance programs, food pantries, etc.)
- ☐ Utilities support (like help with electric or water bills, etc.)
- ☐ Other material needs (diapers, wipes, etc.)
- ☐ Other, please specify: _____
- ☐ I did not want or need any services **answer choice mutually exclusive*

If they wanted or needed any services…list narrowed down to what they selected in Q15

16. What types of supports or services did you receive as your time with MIHP ended? Please select all that apply.
    - ☐ Another home visiting program (like Parents as Teachers, Head Start, etc.)
    - ☐ Special help for my child (like screening for developmental delays, Early On, etc.)
    - ☐ Childcare (center or home based, after-school programs, paying for childcare)
    - ☐ Other parenting groups (parent coalition, play learn groups, MomPower, Fatherhood Connection, etc.)
    - ☐ Health care needs (navigating insurance options/issues, scheduling appointments, medical costs, etc.)
    - ☐ Education resources (GED, college, or vocational/training programs, etc.)
    - ☐ Mental health and/or substance use services (Community Mental Health, etc.)
    - ☐ Housing/rental support (like government rental assistance programs, eviction diversion help, etc.)
    - ☐ Food support (like WIC, government food assistance programs, food pantries, etc.)
    - ☐ Utilities support (like help with electric or water bills, etc.)
    - ☐ Other material needs (diapers, wipes, etc.)
    - ☐ Other ([text entered in Q15 'Other, please specify'])
    - ☐ I did not receive any of the services I wanted or needed **answer choice mutually exclusive*

If they received any services…list narrowed down to what they selected in Q16

17. Did MIHP help you make connections with these supports or services as MIHP ended?

	Yes	Somewhat	No
Another home visiting program (like Parents as Teachers, Early Head Start-Home Based, etc.)	○	○	○
Special help for my child (like screening for developmental delays, Early On, etc.)	○	○	○
Childcare (center or home based, after-school programs, paying for childcare)	○	○	○
Other parenting groups (parent coalition, play learn groups, MomPower, Fatherhood Connection, etc.)	○	○	○
Health care needs (navigating insurance options/issues, scheduling appointments, medical costs, etc.)	○	○	○
Education resources (GED, college, or vocational/training programs, etc.)	○	○	○
Mental health and/or substance use services (Community Mental Health, etc.)	○	○	○
Housing/rental support (like government rental assistance programs, eviction diversion help, etc.)	○	○	○
Food support (like WIC, government food assistance programs, food pantries, etc.)	○	○	○
Utilities support (like help with electric or water bills, etc.)	○	○	○
Other material needs (diapers, wipes, etc.)	○	○	○
Other ([text entered in Q15 'Other, please specify'])	○	○	○

If they received HV program (Q16)…

18. Which Home Visiting Program(s) did you connect with as you ended your time with MIHP? (Check all that apply.)
    - ☐ Early Head Start Home Based (EHS-HB)
    - ☐ Family Spirit (FS)
    - ☐ Healthy Families America (HFA)
    - ☐ Infant Mental Health (IMH)
    - ☐ Nurse Family Partnership (NFP)
    - ☐ Parents as Teachers (PAT)
    - ☐ PALS (Play and Learning Strategies)
    - ☐ Other, please specify: _____
    - ☐ Not sure/Don't remember **answer choice mutually exclusive*

Loop for each HV program selected…

19. Which of the following did your home visitor do to help you connect with [new home visiting program]? Please select all that apply.
    - ☐ Discussed my thoughts and ideas regarding my transition plan
    - ☐ Reviewed how best to contact the transition agency(ies) that I have been referred to
    - ☐ Contacted the new agency(ies) on my behalf to help in my transition
    - ☐ Contacted me in follow up to determine if I made the connection
    - ☐ None of the above **answer choice mutually exclusive*

20. How long did you have to wait before you enrolled in [new HV program]?
    - ○ 0 days (there was overlap between my last MIHP visit and my first visit with the new program)
    - ○ Less than 1 month
    - ○ Between 1 and 6 months
    - ○ Longer than 6 months
    - ○ Not sure/Don't remember

21. Is there anything else you want to share about getting into new services during or after MIHP?

Opportunities to improve transition

22. Is there anything else you want to share about your experience leaving the MIHP program, and how leaving MIHP could be better for families?

About you

23. Which county do you live in?
    - ○ [Drop-down list of MI counties]
    - ○ Prefer not to say

24. What is the name of the MIHP program you participated in?
    - ○ American Indian Health and Family Services
    - ○ Caring and Sharing
    - ○ Cradle Me Care
    - ○ Health Department Northwest MI
    - ○ Keweenaw Bay Indian Community
    - ○ LMAS Health Department
    - ○ Michigan Medicine
    - ○ Sanilac County Health Department
    - ○ Silverspoon
    - ○ Twenty Hands

25. How would you describe the area you live in?
    - ○ Rural/Country
    - ○ Suburban
    - ○ Urban/City
    - ○ Not sure
    - ○ Prefer not to say

26. Please select the race(s) with which you identify:
    - ☐ American Indian or Alaska Native
    - ☐ Asian
    - ☐ Black or African American
    - ☐ Native Hawaiian or Other Pacific Islander
    - ☐ White
    - ☐ Some other race, please specify: _____
    - ☐ Prefer not to say **answer choice mutually exclusive*

27. Which of the following best describes your ethnicity? Please select all that apply.
    - ☐ Hispanic or Latino
    - ☐ Arab or Middle Eastern
    - ☐ Not Hispanic/Latino or Arab/Middle Eastern **answer choice mutually exclusive*
    - ☐ Prefer not to say **answer choice mutually exclusive*

Questions for those still enrolled in MIHP

28. During your most recent MIHP enrollment, about how many MIHP visits did you have when pregnant? (at your house, in the office, or on a virtual visit)
    - ○ 0
    - ○ 1-3
    - ○ 4-10
    - ○ More than 10
    - ○ Not sure/Don't remember

29. During your most recent MIHP enrollment, about how many MIHP visits did you have with your baby after they were born? (at your house, in the office, or on a virtual visit)
    - ○ 0
    - ○ 1-3
    - ○ 4-10
    - ○ 11-18
    - ○ 19-36
    - ○ More than 36
    - ○ Not sure/Don't remember

30. How old is your baby?
    - ○ 0-6 months
    - ○ 7-12 months
    - ○ 13-18 months
    - ○ Over 18 months

Transition is the process where MIHP supports families in finding their needs and connecting with any more services they may want when their time with MIHP is done. In other words, it's what happens when you've finished MIHP. Activities during transition may be finding new services, deciding what needs you still have, and saying goodbye to your home visitor.

31. About how many conversations have you had with your home visitor about what happens after MIHP is over?
    - ○ None
    - ○ 1-2
    - ○ 3-4
    - ○ 5 or more
    - ○ Not sure

32. How do you feel about the number of conversations you have had with your home visitor about what happens after MIHP is over?
    - ○ Too few
    - ○ Just right
    - ○ Too many
    - ○ Not sure

33. When did you begin talking with your home visitor about what happens after MIHP is over? [skip if Q31= "None"]
    - ○ At my first visit
    - ○ After my first visit but early in services
    - ○ Before my last visit but late in services
    - ○ Never
    - ○ Not sure

Other Supports

34. What types of supports or services do you <u>want or need</u> as your time with MIHP ends? Please select all that apply.
    - ☐ Another home visiting program (like Parents as Teachers, Head Start, etc.)
    - ☐ Special help for my child (like screening for developmental delays, Early On, etc.)
    - ☐ Childcare (center or home based, after-school programs, paying for childcare)
    - ☐ Other parenting groups (parent coalition, play learn groups, MomPower, Fatherhood Connection, etc.)
    - ☐ Health care needs (navigating insurance options/issues, scheduling appointments, medical costs, etc.)
    - ☐ Education resources (GED, college, or vocational/training programs, etc.)
    - ☐ Mental health and/or substance use services (Community Mental Health, etc.)
    - ☐ Housing/rental support (like government rental assistance programs, eviction diversion help, etc.)
    - ☐ Food support (like WIC, government food assistance programs, food pantries, etc.)
    - ☐ Utilities support (like help with electric or water bills, etc.)
    - ☐ Other material needs (diapers, wipes, etc.)
    - ☐ Other, please specify: _____
    - ☐ I do not want or need any services **answer choice mutually exclusive*

If they want or need any services…list narrowed down to what they selected in Q34

35. What types of supports or services have you <u>received</u> so far? Please select all that apply.
    - ☐ Another home visiting program (like Parents as Teachers, Head Start, etc.)
    - ☐ Special help for my child (like screening for developmental delays, Early On, etc.)
    - ☐ Childcare (center or home based, after-school programs, paying for childcare)
    - ☐ Other parenting groups (parent coalition, play learn groups, MomPower, Fatherhood Connection, etc.)
    - ☐ Health care needs (navigating insurance options/issues, scheduling appointments, medical costs, etc.)
    - ☐ Education resources (GED, college, or vocational/training programs, etc.)
    - ☐ Mental health and/or substance use services (Community Mental Health, etc.)
    - ☐ Housing/rental support (like government rental assistance programs, eviction diversion help, etc.)
    - ☐ Food support (like WIC, government food assistance programs, food pantries, etc.)
    - ☐ Utilities support (like help with electric or water bills, etc.)
    - ☐ Other material needs (diapers, wipes, etc.)
    - ☐ Other ([text entered in Q34 'Other, please specify'])
    - ☐ I have not received any of the services I want or need **answer choice mutually exclusive*

If they have received any services…list narrowed down to what they selected in Q35

36. Has MIHP helped you make connections with these supports or services so far?

	Yes	Somewhat	No
Another home visiting program (like Parents as Teachers, Early Head Start-Home Based, etc.)	o	o	o
Special help for my child (like screening for developmental delays, Early On, etc.)	o	o	o
Childcare (center or home based, after-school programs, paying for childcare)	o	o	o
Other parenting groups (parent coalition, play learn groups, MomPower, Fatherhood Connection, etc.)	o	o	o
Health care needs (navigating insurance options/issues, scheduling appointments, medical costs, etc.)	o	o	o
Education resources (GED, college, or vocational/training programs, etc.)	o	o	o
Mental health and/or substance use services (Community Mental Health, etc.)	o	o	o
Housing/rental support (like government rental assistance programs, eviction diversion help, etc.)	o	o	o
Food support (like WIC, government food assistance programs, food pantries, etc.)	o	o	o
Utilities support (like help with electric or water bills, etc.)	o	o	o
Other material needs (diapers, wipes, etc.)	o	o	o
Other ([text entered in Q34 'Other, please specify'])	o	o	o

37. Is there anything else you want to share about getting into new services during MIHP?

About You

38. Which county do you live in?
    - o [Drop-down list of MI counties]
    - o Prefer not to say

39. What is the name of the MIHP program you participated in?
    - o American Indian Health and Family Services
    - o Caring and Sharing
    - o Cradle Me Care
    - o Health Department Northwest MI
    - o Keweenaw Bay Indian Community
    - o LMAS Health Department
    - o Michigan Medicine
    - o Sanilac County Health Department
    - o Silverspoon
    - o Twenty Hands

40. How would you describe the area you live in?
    - o Rural/Country
    - o Suburban
    - o Urban/City
    - o Not sure
    - o Prefer not to say

41. Please select the race(s) with which you identify:
    - ☐ American Indian or Alaska Native
    - ☐ Asian
    - ☐ Black or African American
    - ☐ Native Hawaiian or Other Pacific Islander
    - ☐ White
    - ☐ Some other race, please specify: _____
    - ☐ Prefer not to say **answer choice mutually exclusive*

42. Which of the following best describes your ethnicity? Please select all that apply.
    - ☐ Hispanic or Latino
    - ☐ Arab or Middle Eastern
    - ☐ Not Hispanic/Latino or Arab/Middle Eastern **answer choice mutually exclusive*
    - ☐ Prefer not to say **answer choice mutually exclusive*