HOME VISITING COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK (HV COIIN)
Process and Progress

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Project Partners

A 3-Year Cooperative Agreement between The Maternal and Child Health Bureau’s (MCHB) Division of Home Visiting and Early Childhood Systems and Education Development Center, Inc.

Start Up: September, 2013-May, 2014
Phase I: May 2014 – August ,2015 (15 months)
Phase II: September, 2015- July, 2016 (11 months)
The Federal Home Visiting Program

Carlos Cano, MD, MPM
Senior Advisor on Quality Improvement
Health Resources and Services Administration
U.S. Department of Health and Human Services

- Section 2951 of the Affordable Care Act of 2010 (P.L. 111-148)
- Amends Title V of the Social Security Act to add Section 511: Maternal, Infant, and Early Childhood Home Visiting Programs (MIECHV)

<table>
<thead>
<tr>
<th>$1.5 billion over 5 years</th>
<th>Sustainable Growth Rate (Doc Fix)</th>
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<tbody>
<tr>
<td>$100M FY2010</td>
<td>$400M FY2015</td>
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<tr>
<td>$250M FY2011</td>
<td>$400M FY2016</td>
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<tr>
<td>$350M FY2012</td>
<td>$400M FY2017</td>
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<td>$400M FY2013</td>
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<td>$400M FY2014</td>
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The Federal Home Visiting Program

Tiered-evidence grant design

- Focuses grant dollars on approaches backed by strong evidence...evidenced-based practices
- Encourages innovation so new & effective approaches are discovered
- Examples:
  - The Home Visiting Program
  - Teen Pregnancy Prevention
  - Investing in Innovation (i3)
  - Workforce Innovation Fund
  - Social Innovation Fund

The Federal Home Visiting Program

An evidence-based, place-based strategy

- Programs in all 50 states, DC and five territories (767 counties)
- Services provided in over 700 communities - urban, rural and frontier (2014)
- Nearly 1.4M home visits over first three years of program
- 115,500 parents and children served in 2014
The Federal Home Visiting Program

• **Supports Families**
  - Evidence-based parent support services
  - Partnership between parents and home visitors
  - Ongoing visits and dialogue around family needs

• **Voluntary**
  - Families empowered w/ knowledge on health and parenting

• **Evidence-based**
  - Built on four decades of rigorous research
    - Evidence-based HV models
  - Includes a national randomized controlled evaluation
  - Launched first HV improvement collaborative: HV CoIIN

The Federal Home Visiting Program

• **Effective**
  - HV prevents child maltreatment, encourages positive parenting and promotes child development
  - Reduction of school dropout, teen pregnancy and crime
  - Every $1.00 invested, yields up to $9.50 ROI to society

• **Locally designed and run**
  - States have flexibility to tailor programs to fit needs of different communities
  - States can choose from 14 Evidence-based HV models
  - Programs run by local organizations w/ support from states and HV model developers
**Growth and Reach**

**Growth in the Number of Participants**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Participants</th>
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<tbody>
<tr>
<td>2012</td>
<td>34,180</td>
</tr>
<tr>
<td>2013</td>
<td>75,970</td>
</tr>
<tr>
<td>2014</td>
<td>115,545</td>
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**The Federal Home Visiting Program**

Who are the families we serve?

- 27% of newly enrolled households included pregnant teens
- 20% reported a history of child maltreatment
- 4/5 of participating families had household incomes at or below the 100% of federal poverty line ($23,850 for a family of four)
- Almost half were at or below 50% of FPL
- 1/3 of adult participants had less than a high school education
- 2/3 of program participants belonged to a racial/ethnic minority
Child Development Trajectories

Ready to learn

Birth 6 mo 12 mo 18 mo 24 mo 3 yrs 5 yrs

Early Infancy Early Toddler Early Preschool

"Healthy" Trajectory

"At Risk" Trajectory

Parent education

Emotional Health Literacy

Reading to child

Appropriate Discipline

Health Services

Lack of health services

Poverty

Toxic Stress

Adapted from N. Halfon, 2015

Purposes of the HV CoIIN

- Disseminate practices known to work
- Innovate
- Achieve results faster
- Build leaders of QI - Sustainability
- Demonstrate effectiveness of home visiting in large scale implementation
The Breakthrough Series as the HV CoIIN Framework

Participants

12 states & tribes
30 implementing agencies,
  using 5 evidence-based models
36 quality improvement teams
3500 families
HV CoIIN Structure: Management Team & Faculty

*Leadership Team= Project officer, Project Director, Improvement Advisor, Innovation consultant, Faculty chair(s) and External Evaluator

HV CoIIN Structure: 12 States & Tribes

State/Tribal Leaders
HV CoILN Structure: 12 States & Tribes

Starting Knowledge of QI

<table>
<thead>
<tr>
<th></th>
<th>Baseline Survey (1-10)</th>
<th>Follow-up Survey</th>
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<tbody>
<tr>
<td>PDSA Cycles</td>
<td>3.5</td>
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<tr>
<td>Reliability Concepts</td>
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</tr>
<tr>
<td>Implementing Changes</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Spread &amp; Scale Up</td>
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<td></td>
</tr>
<tr>
<td>Run Charts</td>
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<tr>
<td>Measuring for Improvement</td>
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<tr>
<td>Viewing Organization as System</td>
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<tr>
<td>Planning for Improvement</td>
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<td>Managing Improvement</td>
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</tr>
<tr>
<td>Driver Diagrams</td>
<td>1.5</td>
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Group Share

- What tools have others used to assess baseline knowledge of QI team members?

- What implications has knowledge level posed for your work?

We developed a HV CoIIN “Playbook”

Helping Teams with “Why, What and “How”
Charter

- The Problem statement
- Gap between science and practice
- Mission statement
- Specific aims
- Expectations
- CoiN
- State / grantees
- Front-line teams (LIAs)
- Team’s commitment

Key Driver Diagram - Our Best Theory

HVCoin Maternal Depression Charter SMART AIM: 85% of women who screen positive for depression & access services will report a 25% reduction in symptoms in 12 weeks (from 3rd service contact)

Primary Driver 1: Standardized procedures for mental health screening, treatment, and follow-up

1. Agency uses a standardized process for mental health screening
2. Agency has established referral and treatment processes for mental health
3. Agency has developed standardized procedures for mental health screening and treatment
4. Client feedback from screening and treatment activities

Primary Driver 2: Front-line teams (LIAs)

1. Agency provides and tracks all client / maternal depression screening periodicity and results, referral, acceptance of referral and receipt of service
2. Agency provides and tracks all client / maternal depression screening period and results
3. Agency makes referrals to local mental health services based on referral and acceptance
4. Client feedback from screening and treatment activities

Secondary Drivers

- Changes to Test
- Agency uses a standardized process for mental health screening
- Agency has established referral and treatment processes for mental health
- Agency has developed standardized procedures for mental health screening and treatment
- Client feedback from screening and treatment activities

- Changes to Test
- Agency uses a standardized process for mental health screening
- Agency has established referral and treatment processes for mental health
- Agency has developed standardized procedures for mental health screening and treatment
- Client feedback from screening and treatment activities
Changes to Test

PD3- Standardize Processes for Referral Treatment and Follow up
1. Establish and maintain relationship with community service provider (e.g., MOU/contract with mental health service provider for priority services)
2. Crisis response protocol
3. Protocol for referral and linkage to service for mothers screening positive (internal and/or external services)
4. Early childhood mental health provider integrated into program to provide group treatment, case consultation, joint visits, etc.
5. In-house evidence-based treatment (Mothers and Babies, Moving Beyond Depression) delivers by home visitors or behavioral health staff/consultants.
6. Home visitor delivered, relationship based support (prevention) to families for maternal depression (e.g., using motivational interviewing to discuss maternal depression, active listening, shorter and more frequent visits, etc.)

Shared Measures Developed
Intentional Support and Technical Assistance Provided

Ongoing and Individualized

Monthly Topic Calls
State Leaders and QI Teams come together each month with faculty & staff via webinar to:
• Learn Content from expert faculty
• Share PDSA Testing Plans & Results
• Receive QI Teaching (ex. How to scale a test, Pareto charts, etc.)

Learning Sessions
In-person Learning Sessions provide an intensive working meeting for learning, sharing of ideas and planning for the next action period.

Coaching
Regular coaching is available for QI teams and state leads from the Improvement Advisor, faculty and Project Director.

Website/Listserve
The internal portal of the HV CoIN website provides real-time HV CoIN resources, peer PDSAs, an active Q & A forum and monthly data. Additionally, each topic area has an e-mail list serve that can be used to share resources questions and ideas with faculty, peers, state leads and staff.

Group Share
- What resources have you found helpful when kicking off a collaborative?
HOME VISITING COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK (HV COIIN)
Phase I
Process and Progress

What did we aim to do?
What did teams do?
What have we achieved?
What have we learned?

Facing the Gap

Facing the Gap

Every system is designed perfectly to achieve exactly the results it gets. *Paul Batalden, MD*

What are the gaps in breastfeeding?

- Many initiate, few sustain
- Families in MIECHV programs even lower than national average
- *Varies considerably by state and by family background*
Key Driver Diagram:
HV CoiLN Breastfeeding Extension

SMART Aim
- to increase by 20% from baseline the % of women exclusively breastfeeding at 3 months & 6 months

Increase the percent of exclusive breastfeeding at 3 and 6 months

Breastfeeding Key Driver Diagram

Primary Drivers

PD1. Standardize internal (agency), policies and practices to support breastfeeding
- Breastfeeding policy, protocol and print resources for the delivery of breastfeeding support prenatally and postnatally
- Standardized/professional development for home visitors in breastfeeding policies and protocols
- Home visitors with lactation and breastfeeding knowledge & competencies
- Regular professional development for home visitors on infant feeding practices that support a culturally sensitive, family centered, relationship based approach
- Regular access to performance data for quality improvement
- Timely and effective supervisory support
- Establish cooperative relationships with key community breastfeeding partners (WIC, La Leche League, etc.)
- Establish relationships with breastfeeding support groups
- Establish relationships and linkages with medical and educational field, e.g. hospitals, primary care, obstetrical providers, schools
- Close loop of communication for referral, access and engagement in breastfeeding supports and services
- Mothers informed of the benefits of breastfeeding (paying special attention to debunk myths)

PD2. Build capacity of and support for home visitors to address breastfeeding in the target population
- Protocols for documenting communication and referral of families to key community partners
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PD3. Create strong community linkages to breastfeeding support systems
- Establish breastfeeding teams
- Home visitors use practices/resources that help to identify and strengthen formal and informal supports (partner, other family members, etc.)
- Home visitors utilize best practices from Secrets of Baby Behavior Curricula
- Home visitors utilize breastfeeding print resources from the CDC Guide to BF Intervention

PD4. Family Engagement
- Mothers empowered to meet individual BF goals
- HV engages in regular client-led conversation regarding breastfeeding
- Use of best practice/evidence-informed strategies to enhance mother-infant breastfeeding practices

Secondary Drivers

- C1. Protocol to deliver BF support (i.e., Boston Infant Feeding Toolkit)
- C2. Protocol for documenting communication and referral of families to key community partners
- C3. Initial and refresher training for HVs on agency policies and protocols
- C4. Print materials align with CDC Guidelines
- C5. Protocol for warm hand off and follow up

Specific Ideas to Test or Change Concepts

C1. Memorandum Of Understanding with Key Community Partners (i.e. WIC)
C2. Requirement and provision of training for home visitors consistent with United States Breastfeeding Committee guidelines
C3. Data on measures provided regularly to home visitors to use in quality improvement
C4. Regular Reflective supervision
C5. Home Visitors use practices from Secrets of Baby Behavior Curricula

EDC, Inc. 2014 ver 2. This resource was made possible by grant number UF4MC26525 from the Maternal and Child Health Bureau, U.S. Department of Health & Human Services.
By Jan 2015, all prenatal clients will receive a joint home visit from the home visitor and BF support nurse within 1 month of EDD and within 3 days of delivery

% of clients receiving both joint HVs

Supervisors will identify eligible clients and develop protocol and data tracking sheet. Home visitor will coordinate and complete visits

Calhoun County NFP PDSA

PDSA PD1: Standardize internal policies & practices to support breastfeeding

**Goal:** To complete 2 joint home visit with the client, home visitor & lactation specialist: 1 within 1 month of the estimated due date and another within 3 days of delivery

**Cycle 1:** Supervisor identifies clients due to deliver within 1 month. HV plans joint visit with BF support nurse

**Cycle 2:** New documentation forms make content, purpose & results of pre- & postpartum BF visits clear

**Cycle 3:** Adaptations to prenatal & postnatal forms introduced by BF support nurse, who leads the prenatal visit & planning of postpartum visit

**Cycle 4:** Clients prefer to see only their HV during post-partum visit → protocol adapted

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Calhoun County NFP PDSA

PDSA PD1: Standardize internal policies & practices to support breastfeeding

**Goal:** To complete 2 joint home visit with the client, home visitor & lactation specialist: 1 within 1 month of the estimated due date and another within 3 days of delivery

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Calhoun County NFP PDSA Study

**Goal:** To complete 2 joint home visit with the client, home visitor & lactation specialist: 1 within 1 month of the estimated due date and another within 3 days of delivery

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What are our achievements in breastfeeding?
What are our achievements in breastfeeding?

1. Improvement in home visitors prepared to provide breastfeeding support
What are our achievements in breastfeeding?

2. Improvement in initiation rates at some participating sites

What have we learned in breastfeeding?

1. Questions remain about how to identify women who need more support than a home visitor usually provides and get them that support (community linkages)
What have we learned in breastfeeding?

2. Making progress toward our overall goal requires:
• more testing and attention to the ‘critical periods’ in breastfeeding decision-making
• measure earlier in the post-partum period when most women stop breastfeeding

Developmental Surveillance and Screening
What are the gaps in developmental promotion, early detection and intervention?

- Over half of children with developmental concerns not caught until school enrollment
- Of 10-13% of children with developmental delays, only 2-3% receive appropriate services
- Varies considerably by state and by family background

Key Driver Diagram: HV CoLLN Developmental Screening

SMART Aim
Increase by 25% the % of children with developmental or behavioral concerns receiving assessment or intervention in a timely manner

Children who need it receive developmental services
Theory of Change For Developmental Promotion, Early Detection and Intervention

**Primary Drivers**

- **PD1. Reliable and effective systems for surveillance & screening**
  - Identification of appropriate developmental and behavioral screening instruments, aligned correctly
  - Periodicity to capture key milestones
  - Screening conducted within context of confidential materials
  - Screening results interpreted in context of all available knowledge about family / environment
  - Time, specific, and sensitive communication of results to families

- **PD2. Reliable and effective systems for referral & follow-up**
  - Clear lines of communication for support referral, access, feedback

- **PD3. Home visits supported to address development in the target population**
  - Home visitors with knowledge of state’s comprehensive early childhood systems & processes
  - Home visitors with knowledge and competency in developmental and behavioral surveillance, screening, tracking tools, anticipatory guidance, referral and follow-up
  - Use of data to improve practices

- **PD4. Cooperatives in Promotion of Healthy Development**
  - Families’ direct impact on development supported & maximized through coordination, strengthening of protective factors, etc.
  - HV engages family in meaningful conversation regarding development at every home visit
  - Referrals & linkages HV recommends are acceptable to family (geographically, culturally appropriate)

**Secondary Drivers**

- **SMART Aim**
  - Increase by 20% from baseline the % of children with developmental or behavioral concerns receiving assessment or intervention in a timely manner

- **Specific ideas to test or change concepts**
  - PD1. Parental concerns about developmental, behavioral, or educational
  - PD2. Tracking system for surveillance, screening, and referral
  - PD3. Regular training for home visitors on pediatrics, practices, and use of tools
  - PD4. Recent views/concerns about child's development elicited and addressed at each home visit

**Philadelphia NFP PDSA**

**PD1. Reliable & effective systems for screening & surveillance**

**Goal:** To elicit parent concerns about development, learning and behavior at every home visit

- Incorporate the best practice of eliciting at every home visit parental concerns about their child’s development, learning or behavior
- % of home visits where parental concerns elicited
- Add a label to the home visit forms that says ‘Were parent’s concerns about their child’s learning, development, or behavior elicited? Yes No’
**Cycle 1:** Add a label to the home visit forms that says “Were parent's concerns about their child's learning, development, or behavior elicited? Yes No”

Collect data on nurses' monthly summary sheets: add place to track the number of visits this question was asked

- Overall the nurses were open to this method and found it helpful to include during their visits.
- Some nurses were getting confused about the wording of the question.
  - Some used the sticker / tracking column to ask the question ONLY if the parent initiated a conversation about a concern, which was not what we were trying to accomplish
  - They said rephrasing the question would help.
Cycle 1: Add a label to the home visit forms that says “Were parent’s concerns about their child’s learning, development, or behavior elicited? Yes No”

Collect data on nurses’ monthly summary sheets: add place to track the number of visits this question was asked

Cycle 2: Rephrase the question and put a new label on the HV forms until we can have them reprinted again

Clarify that this question should be asked and answered in every home visit with every family

Philadelphia NFP PDSA

Goal: To elicit parent concerns about development, learning and behavior at every home visit

- drop on the run chart (90% to 50%) reflects nurses understanding improved after we clarifying that this should be asked in ALL visits
- all staff report understanding what they are reporting better
- we’re confident our data is correct, we can see the areas for improvement and where in the process nurses are getting stuck
What we like about PDSAs:

- It’s ok to fail!
- Becomes a learning process
- Has created a culture of quality improvement
  - “staff view challenges as an opportunity to do a PDSA cycle”
- Forces us to evaluate our processes and allows us to find areas for improvement

Challenges

- Learning curve of how quick the cycles can be
- Communication: Reminding staff when we are starting a new process
Primary Drivers

PD4. Engage Families in Promotion of Healthy Development

Secondary Drivers

Families’ direct impact on development supported & maximized (through stimulation, strengthening of protective factors, etc).

HV engages family-led conversation regarding development at every home visit.

C1. Anticipatory guidance & education to families about development based on screening process

C2. Protocols for addressing parent concern with home visiting activities

C3. HV seek feedback from parents on use of referred services

What are our achievements in developmental promotion, early detection and intervention?

We are engaging families in developmental promotion

1. In 2000 home visits each month, families are being asked if they have concerns about their child’s development, behavior or learning.

2. Home visitors provided individualized developmental promotion to 85% of children with concerns.
What have we learned in developmental promotion, early detection and intervention?

1. Challenges remain to communication and coordination with community services and Part B/C early intervention services to support children’s development (community linkages)
   - resources in community
   - criteria for referral
   - systems for knowing what happens with referrals

What are the gaps in maternal depression?

- Many affected
  - 40-60% of HV mothers experience elevated symptoms; 10-15% have major depression

- Many missed
  - Only 65% of mothers in HV are screened for depression

- Many unhelped
  - Only 57% of mothers with elevated symptoms referred for services

Key Driver Diagram:
HV CollIN Maternal Depression

SMART Aim
85% of women who screen positive for depression and access services will report improvement in symptoms

Women accessing services for depression get better

Key Driver Diagram: HV CollIN Maternal Depression Screening, 5-8-14

Primary Drivers
- Standardize processes for maternal depression screening and response
- Identification and correct use of appropriate screening instrument
- Periodicity to capture vulnerable windows
- Timely, specific & sensitive communication of results (positive and negative) to families (A HVs II outside assessor)
- Response protocol for urgent and non urgent care
- Professional Development in HV delivered interventions
- Timely and effective supervisory supports
- Administrative supports
- Identification of locally-available evidence-based Mental health services and interventions for crisis and ongoing treatment
- Development of internal services for treatment
- Establish referral and linkage process to mental health resources (internal and external)
- Standardize process for home visitor to complete a referral and follow up
- Standardized process in place for Crisis Response
- Training for home visitors on relationship-based practice to build increased sensitivity to families' varying capacity to engage around MH issues

Secondary Drivers
- Capacity of and support for HVs to address maternal depression in target population
- Protocol for screening standards to include reliable, valid tools & periodicity
- Protocol for response, and referral for urgent and non urgent care
- Initial training of assessors on tool use and protocols
- Periodic refresher training
- Protocols for assessing parent satisfaction
- Training / education of HV (how to screen, coach, motivational interviewing, provide HV in-house intervention)
- Reflective supervision: encourage home visitors to raise problems, emphasis on stigma, attention to home visitors mental health
- Home visitor has access to own data
- Support for HV's on protocol responses
- Tickers / reminder system for re-screens.
- Simple and timely access to screening tools
- Establish and maintain relationship with community service providers (e.g. MOU's)
- Early childhood mental health consultant integrated into program
- In-House EBP Mother's and Babies Course, In-CBT
- Protocol for referral and linkage to service for mothers screening positive
- Developing families' capacity to address mental health issues as demonstrated by continued enrollment in the HV program

Specific Ideas to Test or Change Concepts
- Standardized process in place for Crisis Response
- Training for home visitors on relationship-based practice to build increased sensitivity to families' varying capacity to engage around MH issues

Family Engagement
By Jan 2015, all home visitors will use Motivational Interviewing to talk with mothers about depression, and will increase referrals to services by 25%

% of visits in which MI techniques are used

Home visitors will be trained in MI, will practice 1 new MI technique per week on a topic other than maternal depression, supervisors will monitor in weekly meetings.

Stark County HFA PDSA: Capacity of and support for HVs to address maternal depression in target population

Plan & Do

Cycle 1: All home visitors will use 1 MI technique in 50% of visits & feel comfortable with it. Data tracking form introduced.

Cycle 2: Home visitors use 2 MI techniques in 60% of visits. Data tracking form revised.

Cycle 3: Home visitors use 3 MI techniques in 70% of visits.

Cycle 4: Home visitors use 4 MI techniques in 80% of visits.

Cycle 5: Home visitors use 5 MI techniques in 90% of visits.

Cycle 6-10: Home visitors apply MI techniques to depression with mothers w/ screen who refused services.

Home visitors used MI techniques more frequently than predicted
- Week 1: 93% of visits
- Week 2: 93% of visits
- Week 3: 96% of visits
- Week 4: 98% of visits
- Week 5: 100% of visits

What are our achievements in maternal depression?

1. Met goal of screening 85% of women at appropriate intervals

2. Improvement in % of women referred to services for a positive screen who had 1 or more evidence-based service contact

3. Measurement of symptoms over time established
What have we learned in maternal depression?

1. Need for capacity-building for home visitors to deliver evidence-based mental health services

2. Ongoing monitoring, rescreening and conversation using motivational interviewing and other tools can help a home visitor and client
What are the gaps in family engagement?

Enrollment

• As many as 50% of families referred to home visiting can never be reached
• 20-100% receive a 1st home visit

Retention

• 47% of families complete shorter term programs (<6 months)
• 58-73% of families in multi-year programs complete 1 year

What are our achievements in family engagement?

1. Individual LIAs showed improvement in
   • % families referred to HV program this month who received first face to face contact within 10 days
   • % of expected in-person contacts that were completed
   • 3 and 6 month retention
What have we learned in family engagement?

1. There is a lot of interest in working on family engagement that would be better served by splitting it off into its own topic area.

2. Treating families that are not on the typical visit schedule* separately will help us learn more about the typical processes.
   *i.e. creative outreach, level X, alternate visit schedule

3. Enrollment processes are complex and vary by state – additional measures are needed.

Reflecting on Phase 1

Purpose

- Close the Gap between what we know works and usual practice
- Achieve results faster
- **Build leaders of Quality Improvement – Sustainability**
- Demonstrate effectiveness of home visiting in large scale implementation
• 81% participation on monthly topic calls
• 87% PDSA submission each month
  more than 700 PDSAs
• 92% data reports submitted each month
  • Data submitted is of high quality (>90% complete)
CQI has strong component of data use that can feel burdensome to participants initially. Over time this usually changes because the data is useful
1) it’s directly linked to your processes
2) it reveals the fruits of your efforts and makes it possible to recognize and celebrate good work
3) we look at the data together and across the collaborative every month, and it directs us to learn from some sites and reach out to others

It’s important to provide a lot of experiential, hands-on practice in order to help teams get comfortable with data.

Home visiting interventions that include CQI put parents on improvement teams as equal co-creators of the intervention, with powerful results

HV CoIIN Pinellas works with substance abusing parents did a PDSA to increase family engagement by celebrating the participants who completed 8 foundational visits

  Parent: it was the only thing she’d been celebrated for since graduating from middle school

HV CoIIN NFP site: parent graduate had an idea for increasing engagement by starting a parents’ group. She ran her own PDSAs creating a parents’ group that intentionally includes fathers
CQI transforms implementation teams into protagonists

“We used to wait to have the model tell us what to do. Now we have realized: what a minute! We can do something about this. We look at our data and we ask ourselves what we want to accomplish and how we can improve.”

Jennifer Haberman-Boleyn, Marion Adolescent Parenting Program

All teach, all learn

What do participants say?

Participants have learned a lot.
“One of our biggest successes was growing our knowledge of PDSA cycles and the implementation of CQI in our program.”

Participants are achieving the outcomes they aim for.
“We standardized our evaluation and referral process, and there is so much growth in my skills to support and discuss developmental concerns with clients”

Participants anticipate the improvements they’re seeing will be sustained.
“Almost all of the testing we did has moved to implementation—so a great deal of the work will be sustained.”
What’s next?
Phase 2 HV CoIN 2015-2016

- 80% of participating LIAs chose to continue
- 13 new LIAs and 1 new state enroll
- Updated Key Driver Diagrams, Measures & Change Packages
  - Incorporated learning from Phase 1
  - Integrated sample PDSAs for new teams to ‘steal shamelessly’
- Coach in teams so everyone learns
- Enhanced support to and collaboration from Grantee leaders and Model Developers to build human capacity for spread
- HV CoIN work to assist HRSA with the redesign of a national performance measurement system for HV
- Share resources and lessons learned with others

For More Information…

Contact

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OR

Visit the HV CoIN website:
www.hv-coin.edc.org
Group Share

- What successes have you had with supporting teams in their QI work?
Group Share

- How do you work to maintain participant will?
- How have you successfully celebrated teams work?