HOME VISITING COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK (HV COIIN)

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First national quality improvement collaborative in home visiting
Purposes of the HV CoILN

- Disseminate practices known to work
- Innovate
- Achieve results faster
- Build leaders of QI - Sustainability
- Demonstrate effectiveness of home visiting in large scale implementation

Lessons: BTS gives us structure and clear expectations, data drives the improvement and refinement of what we do and what we measure, it is short and will is maintained!
The Breakthrough Series as the HV CoIN Framework

Select Topic
Recruit Faculty

Develop Framework and Changes

Enroll Participants

Prework

LS1

AP1

S

D

P

LS2

AP2

S

D

P

LS3

AP3

S

D

P

Summative Congresses and Publications

Supports:
Email • Visits • Phone Conferences • Monthly Team Reports • Assessments

LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act
Participants

12 states & tribes
30 implementing agencies,
using 5 evidence-based models
36 quality improvement teams
3500 families
HV CoIIN Structure
35 QI teams

- **Sponsor**, David Willis, HRSA
- **Project Officer**, Carlos Cano, HRSA
- **Project Director**, *Mary Mackrain
- **Improvement Advisor**
  - MC Arbour
- **Innovation Consultant**
  - Peter Gloor
- **Evaluator**
  - Deborah Perry

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| *Joanne Martin*  
*Elaine Fitzgerald*  
*Sally Fogerty* | *Darius Tandon*  
*Nancy Topping-Tailby*  
*Linda Beeber* | *Paul Dworkin*  
*Brenda Jones Harden* | *Jon Korfmacher*  
*Deborah Daro* |
| 11 LIA Teams | 12 LIA Teams | 12 LIA Teams | 35 LIA Teams |

*Improvement Advisor, Innovation Consultant, Evaluator, Sponsor, Project Officer, Project Director, Family Engagement*
Helping Teams with “Why and “How”
Breastfeeding
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
SMART Aim  
- to increase by 20% from baseline the % of women exclusively breastfeeding at 3 months & 6 months  

Outcome measure:  
- % of women who report exclusive BF at 3 & 6 months

Primary Drivers

PD1. Standardize internal (agency) policies and practices to support breastfeeding

PD2. Build capacity of and support for home visitors to address breastfeeding in the target population

PD3. Create strong community linkages to breastfeeding support systems

PD4. Family Engagement

Secondary Drivers

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)

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

Specific Ideas to Test or Change Concepts

C1. Protocol for HV delivery of BF support (i.e. Boston Infant Feeding Toolkit)

C2. Protocols for documenting communication and referral of families to key community partners

C3. Initial and refresher training for HVs on agency polices and protocols

C4. Print materials align with CDC Guidelines

C1. Competencies for HVs to adequately address breastfeeding with families

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

C1. Memorandum Of Understanding with Key Community Partners (i.e. WIC)

C2. Current resource list of peer support groups and Baby-Friendly hospitals

C3. Establish breastfeeding teams

C4. Protocol for warm hand off and follow-up

C1. Use of Boston Healthy Start Infant Feeding Toolkit

C2. Home Visitors utilize Best Start 3-Step Counseling strategies

C3. Home visitors use practices/resources that help to identify and strengthen formal and informal supports (partner, other family members, etc.)

C4. Home Visitors utilize practices from Secrets of Baby Behavior curricula

C5. Breastfeeding print resources for families that align with the CDC Guide to BF Intervention
Calhoun County NFP PDSA

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

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
Plan & Do

**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
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.
Developmental Surveillance and Screening
Key Driver Diagram: HV CoLLIN Developmental Screening

SMART Aim
Increase by 25% from baseline 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

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

Primary Drivers

PD1. Reliable and effective systems for surveillance & screening
- Identification of appropriate developmental and behavioral screening instruments, applied correctly
- Periodicity to capture key milestones
- Screening conducted within context of surveillance
- Screening results interpreted in context of all HV knows about family/environment
- Timely, specific and sensitive communication of results to families

PD2. Reliable and effective systems for referral & follow-up
- Strong links and care coordination community partners and resources
- Closed loop of communication for +screen: referral, access, feedback

PD3. Home visitors supported to address development in the target population
- Home visitors with knowledge of state’s comprehensive early childhood system & processes
- Use of data to improve practices

PD4. Engage Families in Promotion of Healthy Development
- 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
- Referrals & linkages HV recommends are acceptable to family (geographically, culturally appropriate)

Secondary Drivers

Specific Ideas to Test or Change Concepts

C1. Protocol for surveillance and screening standards (tools, periodicity, referral, follow-up)
C2. Tracking system for surveillance, screening & referral
C3. Regular training for HVs on policy and protocols, practices and use of tools
C4. Parent views/concerns about child’s development elicited and addressed at each home visit
C5. Program develops formal connections with community services (e.g., MRI-s)
C6. Developmental & behavioral screening passport (9-5, Watch Me Thrive)
C7. Protocols or decision tree for for process of red flag/positive screen, referral and follow up
C8. Training/education of HVs in Dev, systems & best practices
C9. Ongoing supervision on use of surveillance and screening (e.g., videos-recordings of screenings using ASQ/ASQ-SE)
C10. Home visitor has access to their own data for use in QI
C11. Support for supervisors in screening process
C12. Reflective and administrative supervision
C13. Anticipatory guidance & education to families about development based on screening process
C14. Protocols for addressing parent concern with home visiting activities
C15. HV seek feedback from parents on use of referred services
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’
**Goal**: To elicit parent concerns about development, learning and behavior at every home visit

**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.

Goal: To elicit parent concerns about development, learning and behavior at every home visit
Philadelphia NFP PDSA
Plan & Do

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

**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
Study: Cycle 2

**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

![Graph showing % HVs this month with a goal of 95% and stickers placed indicating home visits.](Image)
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
% HVs this month where parents were asked if they have concerns re: child’s development, behavior or learning

**HV CoIN DSS Report**

May 14 - Mar 15

**AXIS KEY**

*Left axis*: scale for blue diamonds & line

*Right axis*: scale for green dots
Maternal Depression
Maternal Depression Key Driver Diagram

### SMART Aim
85% of women will be screened, using appropriate instruments at appropriate intervals: Within 3 months of enrollment (pre- or postnatal) and within 3 months postnatal.

### Primary Drivers (PD)
1. **PD1. 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 (& HVs if outside assessor)
   - Response protocol for urgent and non urgent care

2. **PD2. Capacity of and support for HVs to address maternal depression in target population**
   - 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

3. **PD3. Standardize processes for referral, treatment & follow-up**
   - 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

4. **PD4. Family Engagement**
   - Training for home visitors on relationship-based practice to build increased sensitivity to families’ varying capacity to engage around MH issues

### Secondary Drivers (SD)
- PD2. C1. Training / education of HV (how to screen, coach, motivational interviewing, provide HV in-house intervention)
- PD2. C2. Reflective supervision: encourage home visitors to raise problems, emphasis on stigma, attention to home visitors mental health
- PD2. C3. Support for HV’s on protocol responses
- PD2. C5. Home visitor has access to own data
- PD2. C6. Simple and timely access to screening tools
- PD3. C1. Establish and maintain relationship with community service providers (e.g.
- PD3. C2. Early childhood mental health consultant integrated into program
- PD 3. C3. In-House EBP. Mother’s and Babies Course, IH-CBT
- PD 4. C4. Protocol for referral and linkage to service for mothers screening positive
- PD 4. C1. Developing families’ capacity to address mental health issues as demonstrated by continued enrollment in the HV program

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**Specific Changes (C)to Test**
PD1. C1. Protocol for screening standards to include (a) reliable, valid tools & (b) periodicity
PD1. C2. Protocol for sharing results of screening
PD1. C3. Protocol for response; and referral for urgent and non urgent care
PD1. C4. Initial training of assessors on tool use and protocols
PD1. C5. Periodic refresher training
PD2. C1. Training / education of HV (how to screen, coach, motivational interviewing, provide HV in-house intervention)
PD2. C2. Reflective supervision: encourage home visitors to raise problems, emphasis on stigma, attention to home visitors mental health
PD2. C3. Support for HV’s on protocol responses
PD2. C4. Ticklers / reminder system for re-screens.
PD2. C5. Home visitor has access to own data
PD2. C6. Simple and timely access to screening tools
PD3. C1. Establish and maintain relationship with community service providers (e.g.
PD3. C2. Early childhood mental health consultant integrated into program
PD 3. C3. In-House EBP. Mother’s and Babies Course, IH-CBT
PD 4. C4. Protocol for referral and linkage to service for mothers screening positive
PD 4. C1. Developing families’ capacity to address mental health issues as demonstrated by continued enrollment in the HV program
Key Driver Diagram: HV CoILN 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
By Jan 2015, all home visitors will use Motivaitonal 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 PDSA
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 who 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
% women referred to svcs for +screen for MD w 1 EB svc contact

HV CollIN MD Report
May14 - Apr15

Carolina NFP

Left axis: % women with 1 EB svc contact
Right axis: N women referred to svcs for +screen
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 CoIIN website provides real-time HV CoIIN 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.
Future Forecast

• Refine Key Driver Diagrams and measures, incorporating learnings from Cohort 1
• Expand in Fall of 2015
• Work carefully with Grantee leaders and Model Developers to build human capacity for spread
• HV CoIIN 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...

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HV CoIlN website:
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