

MIECHV Continuous Quality Improvement Process Webinar transcript
Sept. 30, 2013

Hello and welcome to the recording of the webinar that was originally held on September 30, of 2013 regarding the Maternal, Infant and Early Childhood Home Visiting program continuous quality improvement process. I am Benjamin Hazelton. I am the project coordinator for the Maternal, Infant and Early Childhood Home Visiting project and with me today is –

Next Speaker: Kathleen Anger, the CQI and Valuation Lead.

Next Speaker: So today we would like to welcome folks who were unable to join us on the 30th and talk to you about how happy we are to have this opportunity to share this information with you and get all of us growing in the same direction when it comes to continuous quality improvement. It is a very exciting time and a real opportunity for us. We're excited to welcome new grantees to this process. Through our expansion grant we will be adding new counties to the MIECHV for Maternal, Infant and Early Childhood Home Visiting. I will probably end up shortening it to MIECHV frequently. But we will be adding new communities to our efforts, um, to expand evidence-based home visiting and those counties include Clatsop, Jackson, Klamath, Marion and Yamhill. Other information can be provided in terms of the which efforts will be happening in which counties. In the original webinar we did introduce the new State Systems Coordinator. Her name is Laura Gestout and folks will be meeting her as she comes around and introduces opportunities for system development, and Kathleen and I have already introduced ourselves. We're going to start by talking a little bit about, um, the importance of continuous quality improvement and, um, we'll just clear the first one out of the way and that is that our grant requires us to do continuous quality improvement. And so we figured we'd put that right at the top because it just is. That said, I think that those of us on the team here at the State level are very excited about this opportunity as well because this opportunity to engage in a continuous quality improvement process is, uh, going to be a major contributor to demonstrating a need for continued funding for the Home Visiting grant and other Early Childhood opportunities. Um, our renewed funding depends on us being, uh, making improvements. And so we do need to demonstrate improvements in at least 50 percent of the, uh, measures and four of the six benchmark areas. We'll be talking a little bit more about benchmarks later so, um, I'll hold on that. But we do need to show a 50 percent, I'm sorry, we do need to show improvement in at least 50 percent of four of six benchmark areas. Um, and of course, most importantly, we need to, uh, keep in mind that continuous quality improvement can help us to improve the services to our families and ultimately the outcomes that they experience. Currently, and we've been working to develop a plan and an action, and, um, there has been some **** pretty much consistent with every other effort on this branch. So, um, it's not inconsistent. Um, uh, and it does provide us an opportunity to engage the folks who are coming on this **** grant, um, as we really get things rolling out. So, our current status is that we know that our local implementing agencies, and those are the programs, um, that are providing the service of **** home visiting. Those are the, the Early Head Start sites, the Healthy Family Oregon sites, and the Nurse/Family Partnership sites or programs. Those are our local implementing agencies and we know that a part of those program models works, but there are processes for continuous, uh, quality improvement as well as, um, quality assurance. There is, I'll just make a quick plug, a separate, uh, webinar available from our Federal partners that goes

into greater detail about the differences between continuous quality improvement and quality assurance. Um, so we note that, that folks are doing continuous quality improvement as part of their practices and guidelines. Um, in communities where we have more than one model, and more than one implementing agency, there is a designated county lead, and we know that in some of the communities these leads have done some initial work with their local implementing agencies to, um, to, uh, initiate, um, continuous quality improvement activity. Um, at the State level we've convened a work group and we have a plan, um, that I alluded to earlier, uh, but many of those details, um, weren't quite fleshed out. And so this is an opportunity to, to flesh those out a little bit further. So, looking ahead, um, today we want to provide you a foundation, um, and clarify processes, um, set the stage for moving our work forward at a, at a more, uh, quick pace, um, than we have been at so that we can get everybody on board and moving ahead, and in the same direction, and, uh, we hope to provide an opportunity for better coordination and communication among all of the agencies and programs involved with Maternal, Infant and Early Childhood Home Visiting program. So, again, those would include the local implementing agencies shortened here as LIAs and our counties grantees which are our lead agencies and our State **** program staff. So, today, um, first of all, we want to acknowledge and recognize that the State of Oregon and many of the **** actually would argue that all of the home visiting programs were going to take pride in the, um, culture of quality. And actually, we believe that continuous quality improvement can help us advance that pride. We want to be able to – we do plan today to review the charge of the State work group, um, and provide some highlights of the plan, um, as well as Federal expectations. Um, we have a proposed process for the plan, as well as, um, a model. So we do plan to use the model of Plan, Do, Check, Act. Um, others may – some of you may be familiar with that as the Plan, Do, Study Act. Um, they are very similar; the, um, the, the, that the, uh, the nuances will be described later as we go into detail about that cycle. Um, we are going to initiate the opportunity for folks to become familiar with the benchmarks and the constructs, um, so all the, the, the six benchmarks and the 36 constructs that are associated with them, um, how to be able to recognize what you're looking at when you receive data, um, but, and how it, it has been analyzed so that, uh, when you read it, you're reading it correctly and not misinterpreting it. Um, this, this will be continued with subsequent webinars scheduled in December and potentially January depending on our pace, um, to make sure we make it all the way through all 36 of them, of the constructs, um, and today we'll just be doing a few. Um, I know that Kathleen has also, uh, looked at and has identified that there are groups of benchmarks, um, for which, uh, she believes that the workflow process will be similar and provide us an opportunity to combine some, some of the 36 constructs and some of the benchmarks so that, um, by doing one continuous improvement activity, we might be able to effect some outcomes and measures.

So, continuing with our culture of quality, we also want to acknowledge that we, um, understand and appreciate that our programs providing home visiting services try to do excellent work at all times. We also acknowledge that the work that you do on a day-to-day basis and the families with whom you interact regularly, um, that it's difficult work. Um, we at the State level and in the MIECHV program, we want to be able to provide you support for your work, and support for demonstrating your cultural quality and the excellence that you put forward every day for the children and families that you are providing services for. Um, among our three evident State models, again, Early Head Start, Healthy Families America, and Nurse/Family Partnership, um, and through the extension grant, we will now be working in the 13

communities, that were determined, um, as having the highest risk populations through our home visiting needs assessment in 2011. Those, um, 13 communities include, let's see if I can remember this: Clatsop, Lane, Lincoln, Marion, Malheur, Multnomah, oh gee, Tillamook. Oh, Jefferson and Jackson, I forgot the Js. Uh, Umatilla, Morrow, and Klamath, I believed are all 13 or pretty close. Um they should be available on our website as well. Um, but we will be working now in 13 communities, um, with the MIECHV Program and we also have, um, a unique opportunity to use these individual programs and these models to look at strengths and strengthen our entire effort, um, under this Maternal, Infant and Early Childhood Home Visiting Program, and home visiting as a system or network in general in our state.

Later in this webinar we will be looking at some of the benchmark data as I mentioned. Um, but before we do, I do want to highlight, um, for folks a little bit about what continuous quality improvement is and what it isn't. Um, so I'm going to start with what it isn't. It is not being collected or used, or we are not engaging in this process in any way, um, to compare programs against one another, um, to compare models against one another. It is not a comparison process. The data is not being used for, um, punishment or identifying where we are going to prioritize funding, or anything like that. It is, – this is not a, a, a, any kind of an evaluation to determine, um, where we put our resources or our efforts in the State. Um, because what this is, is an opportunity to build on strengths and look for opportunities to overcome challenges that we identify through the continuous improvement process. Um, it is also an opportunity for helping us learn more about our work, um, and what processes might be modified, amended or improved so that we can make overall improvements to the program, to the service delivery and to the services for children and families.

So, we do have a State work group. It is comprised of folks from the State MIECHV Program as well as at a minimum, our county leads. And then we'll talk a little bit more about some additions that we plan to make to this process. Um, the State work group, the charge of the group is to, um, guide for the State program, the ongoing development and implementation of our plan. To provide input on revision and, uh, future plans as we need them. To implement at the local level a continuous quality improvement process. To help the State team identify priorities for focus. To help us identify gaps in services, structural gaps, and help us to brainstorm and propose changes that will promote improvement in processes and, uh, outcomes, as well as guide the development of the format and content of data reports that will be circulated to folks engaged in the MIECHV work. Our plan that has been submitted to our Federal partners, um, emphasizes our desire to build on existing infrastructure. So, um, what we mean by that is that we want to identify areas where this work is already happening, capture it, um, and use whatever opportunities we can for existing continuous quality improvements efforts to be folded into this rather than create a whole new structure. Um, some of these activities include, uh, the model from Fulton that we have, um, **** order. Um, and that speaker with Early Head Start. We have a vacancy in Health Families currently and Cynthia Icada for Nurse/Family Partnership. We know that in the Fulton **** that there is an opportunity for doing some of this continuous quality improvement for example. Um, I alluded to this, but we do plan to add new members to the quality assurance work group at the State level. Um, we're trying to be careful not to make the, the work group so large as to make it difficult to do our work. But we do want to assure that we have the three home visiting models that are **** working with under MIECHV; um, that we have a good representation; that we have good representation from

different positions within the home visiting network as well as geographic areas, um, the workforce. And in addition to that we want to start including family, recruiting family members to be participants, or clients, in our continuous quality improvement efforts. Um, we will also, um, eventually replace our, our temporary data system that we referred to as the MIECHV bridge with our home visiting data system, um, an interoperable data system, uh, with other early childhood programs so that we can better look at and, um, daresay track, um, family outcomes across different programs. Um, so the State, uh, the, the plan in the State work group also will periodically be reviewing data reports, um, to see what trends these are identifying and, and help guide next steps. So, um, a little history: We did submit a, the project as committed data plan. Um, we received a friendly note back saying we, we would like a few more things from our Federal partners, and, um, just to help us **** just an overview, a little bit of an overview to, to, uh, what additional items they, they wanted from us. Um, they want to – our Federal partners have an expectation for this project to strengthen our CQI work at all levels; that's at the State level, the local level, um, and, um, and to assure that it's across the system and, and isn't just specific to the home visiting models that are being supported under the MIECHV grant. Um, they want assurance that we have greater in, uh, involvement of our local implementing agencies. Those are the programs doing services at the local level. Um, they want an assurance that we had identified a formal model for continuous quality improvement efforts and as identified earlier, it's, we have identified the Plan, Do, Check Act model for to follow. Um, systematic inquiry so that we have a deep understanding of processes and outcomes that are related to those processes and how processes affect those outcomes. Um, they want us to assure that there is systematic testing of, and evaluation of new strategies and approaches to see if we, if there are opportunities for improvement. Or if that change has not made improvement, um, that we have the willingness and flexibility to try other things. And they want us to be sure that this work is, is being collected in some way and that there are opportunities to spread that information among, among the folks participating in the MIECHV grant, as well as others, um, who provide home visiting services, um, when we plan promising, uh, processes that can help improve outcomes.

So, this is the flowchart. Um, I might invite folks to come back and take a look at it later. There's a lot of information here. It's just an overall, um, flow of the work as we see it happening. So at a minimum, we anticipate that – and this is at the top center, that there will be quarterly, um, continuous quality improvement meetings at the State level. On the left-hand side of your flowchart are the activities, um, that folks should expect from the State MIECHV team. On the left – I'm sorry, on the right side of your flowchart, are the activities that we anticipate and that we have expectations that the county leads will take the lead on. You will see that there is a correlation between the activities in terms of the State team, uh, assuring that there are – that there is dissemination of data reports, etc., and that there is a, uh, uh, a feedback loop from the county team in terms of what they've done with that information and/or what else it may have made them think of, um, and a reporting process, uh, from the County teams back to the State level so that we can identify the, I guess, I guess overall identify continuous quality improvement activities, um, that we, that, that may be, uh, community-specific. They may be more model-specific. They may be something that we want to take on as a State team. Um, but through these processes and this continuous communication about the processes we'll be able to identify and tease out those activities.

Okay. So, at a minimum, we do expect that our county leads will participate in the, in the State, uh, quarterly meetings. Um, we do have them in there, as a placeholder as quarterly. We're, again, doing everything that, you know, we, we hope to try to make this as, um, non-intrusive as possible. Um, that said, I, I do – my experience has been that when folks fully engage in continuous quality improvement it doesn't feel like an additional, um burden, but rather an opportunity. So, um, and, I, I just wanted to highlight right now, we're anticipating quarterly, but as folks are aware, we are meeting with some greater regularity right now to assure that folks, um, are interpreting the, the benchmark analysis correctly. Um, between State meetings, and this is sort of fleshing out their, the, um, the flowchart from the previous page, um, but between State meetings, uh, county, county leads will be expected to convene community continuous quality improvement workgroups. Again, if such a meeting already exists, then perhaps there's an opportunity to have that discussion there, um, rather than create a new one. We do, uh, have the expectation, as I said, that, um, every community has each, uh, each of the MIECHV model and implementing agencies represented in that workgroup so that it is a, uh, a representative workgroup of that community as related to the MIECHV grants. Um, we anticipate that at these community meetings, um, the CQI meetings, that the group will look at data, whether those are benchmarks, um, enrollment numbers, other data that may be collected by the local implementing agencies. As I said earlier, we have had some leads, um, initiate a process, and I know there have been some data collected that are not specifically related to the MIECHV benchmarks or constructs. We will ask the workgroups to choose one or more topic areas to focus on, um, and make improvements. It would be something like screening that are based on the MIECHV timing and schedule; it could be other activities such as breast feeding or client retention. We anticipate the group will review the, uh, processes that are used as related to ****, you have, let's say, um, treatings related to the MIECHV schedule. We would ask that the county level supervisor would do some level of investigation, um, and assessment of what the process is for each of the local implementing agencies. So if there are multiple local implementing agencies, what is their process for assuring that they're doing their screenings on that schedule, and then everybody knows that you need to go through that process for each, so that we can really identify where the opportunities are. After doing that, we anticipate that folks will be able to identify one or more root cause of the current issue, and then we would anticipate that the local level continuous quality improvement workgroup would select and assign um, each of the, would assign local implementing agencies um, a part of the process to make an improvement um, that they expect will change or ameliorate the root cause. Um, so uh, just to take that a step further, I guess, um, you may have one local implementing agency trying um, one process improvement, and another local implementing agency trying a different process improvement and then coming back together to determine whether one was more successful in terms of improving outcomes in the other, or if they were both successful, so they both might be auctioned, so it isn't, um, I just wanted to clarify it isn't to say that everybody walks away necessarily with the same assignment. It could be, we're gonna try different things at the same time and come back together and see which ones might be the best alternative.

So as I indicated in the last slide, we talked about, um, having each of the local implementing agencies represented, so um, it is our hope that that will be a regular person from the local implementing agency and that it isn't just a rotating assignment. The reason is that we hope that each local implementing agency will uh, have a representative who is in effect a continuous quality improvement champion at that very, we've got the county or the community level, and at

that very, very local program level, but that there's a benefit to having a famous quality improvement champion onsite. And that champion will be the person to work with others at their program site to do the planning and the implementation and the process change testing. Um, really refine what is the change that they plan to initiate. Um, they will help facilitate the collection of baseline data and review of the existing data. They will be the person to champion the implementation of the process change, collect data during and after the change um, and review the data onsite so that they're prepared for the community meeting to report back, because we do hope, especially in the circumstance where there's again, more than one local implementing agency and especially in a case where you may have had more than one process change tested, that's reporting back to that community level is a real opportunity to identify opportunities as a whole as a more, a home visiting hole to make process improvements that ultimately result in service improvements and family outcome improvements.

Next Speaker: Hi, everybody. This is Kathleen and we're going to step through now the plan-do-check-act process, uh, so that you get an overview of it. Some of you may be very familiar with it, others, um, may not be as familiar with it but, uh, as Benjamin pointed out, this is the process that we're going to use, uh, in our CQI work and, uh, we're, we're also going to step through an example so that you can see, um, perhaps a little bit more clearly what a concrete example might look like. So the plan-do-check-act process is often, uh, displayed as what you see there on a, in a circular manner and it's start at 12 o'clock with plan, goes down, uh, to do, over to check and then up to act. And on this slide you're seeing, uh, what is involved, uh, in a brief way, uh, for each of those steps. And so in the plan you're going to figure out exactly what is, uh, the problem or the improvement, what, what is that thing that you're wanting to improve and work on. And then you're gonna describe the current process, and this is an important part, uh, it can look a little tedious but if you don't exactly what you're doing now, you're not going to be able to figure out, um, where the best place is to make the changes. And then after you look at that process in some detail, uh, you're going to identify a root cause or some root causes, uh, of the problem, where in the process make seem to be breaking down or where could you do things a little bit better, uh, to help, uh, lead to the end, uh, improvement that you would like. Uh, so then you're gonna develop a solution that you think, uh, might work and you'll develop a testing plan. Uh, after that, you'll carry out that testing, so implement the test solution and probably before and during, uh, you're going to wanna take some data as to ex, exactly what you did. Did you make the changes that you had intended to and then what are, uh, the results of those changes and, and, like I said, we'll do an example in a debt so you'll see better. Uh, uh, the final step is the act, uh, and that means that you look at the results of what you did, uh, reflect on those and then if you still wanna improve further, uh, you know, you would wanna plan some further changes.

Uh, if it turned out really great and, uh, then you may wanna communicate those results, uh, more broadly, uh, so that others can benefit from that improvement. Okay, so just a little bit more detail here, uh, in starting the example. Uh, so, uh, on that first step, uh, we're gonna use the example of you have too many screenings that are not being conducted on time. So for the screenings, of course, what on time means is that they're conducted according to the data collection schedule that's indicated in your copy of the benchmarks and actually it gets a little bit more complex than that because, uh, you know, obviously a lot of the data collection schedules are related to the child's birthday. And so say you're supposed to do a screening, uh, for a mom

on her child's, uh, 6-month birthday. Well, you know, it's obviously too much to ask for that screening to occur exactly on that child's birthday and so you have to have a window of time in which you can conduct the screening and for a lot of the screenings, uh, that window of time is 30 days before and after, uh, the child's birthday and on the child's birthday as well, of course. So, um, you're, you're gonna go through all the steps that I already said. I don't wanna run through them some more but, uh, in that whole thing you're going to develop your process map and so the next slide shows an example of what a process map may look like and, um, I'm the one who developed this and I'm not a home visitor.

Uh, so, and I'm, I'm sure that your processes vary in your different local agencies. So, uh, I just tried to stab at here, you know, what might be a process and I made it a little bit, uh, complex, which yours may not be that complex or it may be require more stuff than this. So, so just very quickly the home visitor enrolls in new client, completes the enrollment form. Um, **** enrollment electronically and emails that, uh, enrollment form to the state. Uh, the home visitor creates a folder on the agency's computer, uh, for that client. Uh, and then the home visitor's going to receive from the state, from our data manager here, uh, a, um, file that's going to tell the home visitor exactly what the schedule is for that particular client because it's going to be related to her stage in pregnancy or her child's age, for the most part, if you, uh, are related to the time of an enrollment and some other times. Uh, so let's say, uh, the home visitor then saves that, uh, in the, uh, client's electronic file and maybe she prints a copy 'cause she's gonna carry, uh, some papers to the client's home when she visits. Um, so then when she's getting ready to go to the client's home she looks that over again and she sees that it's time for the PHQ9 screening, uh, sometime within 30 days, un, for this client. So she, knowing the other things that she wants to do with that client, she's gonna plan out, uh, say a target date that will fit all the different activities into, uh, the schedule and she'll choose that date, uh, maybe discuss it with the supervisor. Um, and then go, uh, when it gets to be one day or a little bit more, um, before the time to actually make the home visit, then she's gonna, uh, look at that again, take it, uh, with her to the home visit and then after she completes the home visit, she's gonna have to just check in her mind okay, that thing's done, uh, and she had done it within the target date time, so if she has, uh, yes. Uh, she goes down and she, um, takes the form and puts it in a locked file cabinet and later she's going to scan it and email it to the state. And, of course, if she's missed her target date, she's gotta select a new one and that's where the no line is above there. So there's an example process and then on the next slide we're seeing, uh, that same process and we're looking at well, what, uh, what things are happening here that may make that process less than optimal.

And so one thing may be that, uh, sometimes the home visitor forgets to review the client's calendar. She's got other clients to take care of, referrals to make, so many different things to do, uh, that, you know, the time creeps up and she then doesn't take the, um, required screening instrument with her to the client's home. So that's just an example of something that could go wrong. There's plenty of other examples. Um, another example might be, uh, down there in the far right bottom corner that, uh, she's done everything she needs to do. She kinda crossed that off, off her list but she did still have to scan it and email it to the state. So maybe that step gets done for a while and I wanna make sure you understand, these two examples are like the home visitor forgetting something, but that's not to say that any, you know, that all examples are gonna be of home visitors forgetting something. There's lots of other structural

barriers that, uh, can happen that's nothing to do with the home visitor's job performance or anything like that. It's just, um, look, it's, you have to see where all those, um, weaknesses are. So now the next part, uh, you're going to develop a solution to test and, um, and then an action plan to actually test that. So, um, so say you're focusing on the forgetting to review the calendar and time. So you come up with a plan to put a link to the electronic version of the client's MIECHV schedule, uh, on the home visitor's Outlook calendar and then two days before, uh, it's time for the home visit, the Outlook calendar reminds her of that, um, screening that's due. So, um, then once you, that's what you're going to test. Whether that helps, uh, get the screening done on time better and, uh, so you then have to, to set up a method that you're going to, um, collect some data so that you know whether that's working or not. You will get data from the state on at least a quarterly basis if not more frequently about this but the data from the state is not gonna tell you anything about did the home visitor do this step at this, uh, time that she had in her plan-to-do. It's just going to tell you the final results. So for your local program, how many of the, uh, required screenings in the whole program, uh, were carried out on time and you'll get a percentage. So you probably are going to need to take some data on your own and do a tally of some sort as to, um, whether a screening, uh, was conducted on time or not and keep us, like I said, a tally of those, uh, so that you know, uh, if that, uh, particular action is working then. So then after you set up that plan, uh, you put it in place and you begin the Outlook reminders and you continue, continue to do your tallying. I would suggest you start your tallying be, before you actually start, uh, the reminder system because then you'll make sure that you actually have that part of your system going, uh, and not have, oh, errors in tallying or whatever, um, contributing to the process.

So, uh, the next slide then, um, you're gonna reflect on the results and for this one – yeah, I put okay, it's a success, uh, and a percent of on-time screenings is higher than the last quarter, uh, based on your, uh, the state data that you get and, you know, your tally will have told you well before that state data, uh, whether you were getting an improvement or not. And so then, uh, we would like you to write the report that Benjamin referred to and submit it to the county lead so that, um, the county lead can then gather the various agencies' reports together, send them to the state and then you can discuss in your, um, community meetings, uh, just like Benjamin described, uh, what's working, what's not working, what further, um, types of supports might you need from the state, that type of thing.

All right, now we're gonna move into the benchmark data and the interpretation of the data and for this time we're going to look at three different benchmarks and, uh, we'll look at some actual data and we'll look at the thing we have to keep in mind when we're, um, interpreting the data. So the first one's breastfeeding and, by the way, just a little terminology thing, uh, Benjamin very correctly referred to the six benchmark areas and then the 36 constructs, uh, fall into the benchmark areas. And, uh, but often I'm going to just, um, call a measure of a construct a benchmark. It's just easier language than – the construct is really what the federal government gave us as kind of a topic area that we have to measure. And then our measure that our state and local team came up with when we developed the benchmarks, um, is that measure is defined, uh, very precisely and that's what you see when you look at a copy of the benchmarks. And, again, I'm likely to just refer to the, those as a benchmark. So for breastfeeding the improvement definition is among index children whoever received breast milk during enrollment in the program, an increase from baseline to comparison period in the average

length of time up to 24 weeks that they received any breast milk. Well, lotta different parts to that right there. So first of all, if, for this benchmark we're only looking at kids, uh, who received breast milk or who were breastfed during enrollment in the program. And your program obviously can't do anything to influence, uh, people, or very little, uh, to influence moms, uh, outside of the program. So, um, that's a part of it we have to keep in mind and then the baseline to comparison period, uh, not all of our benchmarks have a baseline to comparison period but most of them do and for the ones that do, the baseline is, uh, from the very start up of the MIECHV program, uh, to, through July 31 of this year, 2013 and, um, then the comparison period to check for our improvement, is our comparison period result, uh, better than the baseline period result? The comparison period is August 1 this year through September 30th of next year, 2014. So we, as you can tell, we're already in the comparison period, so this is our time for really focusing on that improvement. So and that's also why we're eager to really push ahead, uh, with our CQI processes, so we can help you make that happen. Uh, also for this benchmark we're only counting time up to 24 weeks, so approximately 6 months, um, because, uh, for one, we, our time in the program is limited. Uh, so some children, you know, may not go to 24 weeks or may not go much after, you know, others, of course, we're hoping to keep quite a bit longer than that. Uh, and then the other thing is just to, that I think, uh, experts in the field agree that that, uh, first six months is the most important time. We are continuing to collect data on the, the rest of the time period of, uh, breastfeeding but we're not using it for MIECHV but we might wanna use that data later for another purpose.

Okay, so now here's some real data and this is for all 11 program sites that are currently operating and we broke this down into quarterly periods and I'll continue to do that so you can see, you know, how things are changing over the quarters, see if you're going in the right direction or not. So then the next column after the reporting period is the number of children weaned or still receiving breast milk at age 6 months and, um, that's a really important statement there because if a child was still breastfeeding, uh, and had not reached 6 months of age, uh, let's say in the first reporting period, 6/1 through 9/30/2012, uh, we're not gonna count that child at all there, no matter how many months they have been breastfeeding or how many weeks or days, uh, because it would show an inaccurate picture that those, the kids that are still breastfeeding, we don't know how long they're going to go on and we don't wanna have a lower number in there of time of breastfeeding, uh, than they actually might get at a later time. So we wait until they're weaned or until they've reached 6 months of age, which is the endpoint we're comin' up to for MIECHV. So then we look in the next column, we have the total number of weeks children received breast milk. So across all the kids who were in that category, um, for all 11 program sites, uh, we're counting up the number of weeks and, uh, you know, who had been weaned, etc., like I said. And then we're gonna divide by the number of kids, uh, who were in, um, in that group and we come up with their average number of weeks that children received breast milk. And you can see here the number of children weaned. It's very low at, uh, our first quarter and it gradually gets higher. We had a little drop off, um, in April through June of this year. But, um, that's probably just kind of a fluke of timing as to when women and children came into the program. Um, so you can see that over those four quarters, uh, the, uh, number of weeks of breast milk, uh, increased really nicely and so congratulations down at the bottom there that this one we're doing well on so far. Um, one of the things also to keep in mind on that is that as children get older then, uh, you know, the more months of breast milk they're going to receive. So just by the fact that they're getting older and receiving breast milk is going to

contribute to that increase. But at some point that'll come to kind of an equilibrium and, uh, you know, then it'll be entirely how long we're, um, able to, uh, see that the breastfeeding continues.

All right, so the next slide we're looking at an individual site and just wanting to look at some kind of anomalies or unusual things that you'll, you know, that the eye gets drawn to right away. But, uh, and so you want an explanation for those, um, and one of 'em pointed out here is that we had no children indicated in that second quarter for this particular site and, uh, one of the issue, of course, here is that you can see the number of children in this particular site is much lower than, uh, the number for the state as a whole. So, um, we have to be real careful of that. When we have small numbers things can fluctuate a lot and it's not due to any trend or anything. It's just due to chance fluctuation. So we don't wanna put very much, uh, weight on small numbers. So then that zero, does that indicate that there were no children breastfeeding? Yet in the next quarter we've got children receiving, you know, 63 weeks of breast milk. So I think the most likely thing that happened there, I don't really know about looking into it more, but it's, I think it's pretty clear that yes, children were breastfeeding because some got weaned in the very next quarter or reached 6 months of age but during this particular quarter, um, it just was that nobody got weaned or reached, reached their 6-month birthday. So that's accounting for that zero.

All right, then we'll go to the next one and it's a different site that we're looking at here. Again, very small numbers. Uh, so small that, you know, there, there just weren't any children, uh, receiving breast milk, uh, in the first two quarters and, you know, that's probably due to the fact that everybody who was enrolled in that program was a pregnant mom, uh, rather than a woman with a child who was being breastfed. So we, we do, of course, wait for those children to be born and start breastfeeding. And then, uh, we see in the last two quarters that that's happening and the amount of time they're receiving breast milk on average is increasing.

All right, the next, uh, benchmark then is, uh, Construct 5, PHQ9, depression screening and the improvement definition there, as it is for many, um, of our screening definitions, uh, increase or maintain, though it's an increase or maintenance from baseline to comparison period and the percent of recommended or required screenings or which a screening was actually conducted. And, again, those recommended or required screenings, uh, that number comes from the schedule, the data collection schedule that is shown in general on the benchmark, um, copies the document and then it's shown, uh, in the schedule that you get from our data manager, uh, for each individual client. So we're gonna look at all 11 program sites here and, uh, you know, over the course of the quarters, uh, there were a lot of screenings required. Um, and that's partially due to the fact that for pregnant moms, we really wanna make sure we're getting those screenings in, uh, right around the time of just before birth and just after birth, so they're pretty, the schedule calls for, uh, pretty closely, um, timed screenings. So when we look at this one then of all the screenings required for all the moms in all of the programs, those are the numbers shown in that screens required column, and then you see of all the screenings the ones that were conducted on time and, um, you see that the percentages do climb a bit there from 62 up to about 67 percent. So it's going in the right direction. And then we're gonna look at some others, uh, at two individual sites and, by the way, the Site 1 and Site 2 are not the same individual sites in each of these examples. It's just pulled an example, um, for each of these different measures, um, and then keep track of which, um, particular local agency was which. So then we see in this,

um, this local agency the number of screenings required across all the moms and then the number conducted on time. And here we see something we might wanna pay a little bit of attention to in our CQI work and that's that, um, you know, from the first quarter of, uh, it was zero. Well, you know, you're, the program's just getting started, no big deal. Uh, and we're only looking at three clients again. And, um, then it goes up to 50 percent. Well, that's great. And then 66.7 and the numbers of clients are increasing, uh, in this site, which we would expect. Uh, but then we have a bit of a drop off in the quarter from April through June of 2013. Now it's not a huge drop off at all, so, and we're still don't have a huge number of screenings required here. So we don't wanna get, you know, probably too concerned about this at this point. But just, it probably is something to keep in the back of the mind if you're, uh, working at this Site 1, uh, so that, um, you know, you know that your performance had that drop off and, uh, you know, you just might wanna keep in mind that that maybe something you wanna work on later but you may wanna give another, another quarter to see how you're doing.

So the next one that we call Site 2, um, now this, again, is, looks like a pretty small site because we've got a small number of screens required. Uh, in this case, however, uh, the percent, uh, done on time went down. So from 100 percent down to 57 percent and it went down each quarter so that is showing a definite trend and so if, you know, I were working at that site, if I were the CQI champion, um, this is something I would probably wanna point out to my team members and, uh, see if it might be something they'd wanna work on.

All right, then we're gonna look at a Construct 9 and these are the visits for children to the emergency department from all causes and our improvement definition is to decrease from the baseline to the comparison period in the wait of emergency department or urgent care visits. So we're counting both in this for any cause, so it doesn't matter if it's an injury, an illness, whatever, uh, per child year in the program. And then in parentheses there you're seen by age group and when the, uh, team was working on developing these benchmark measures, uh, they, you know, very actively, I think, pointed out that, um, causes of emergency department visits, um, may vary by age group. It probably does vary by age group. And there are different kinds of risk factors, uh, in the different age groups. So they urged us to, um, analyze these data broken down by age group. Well, we can't do that for the federal benchmark. The federal benchmark only allows us to provide, um, for each branch one numerator and one denominator, uh, so we can't, we can't do it for a federal grant but we can do it for ourselves. And that, uh, may be something that we'll wanna look into later.

So now example, um, of that data, we're looking at all 11 programs again and now this is a little bit tricky calculation, uh, and it may really be kinda hard to keep all these different things in mind but, um, you know, I think, um, once you work with it a little bit, um, it'll get easier. So, um, in the far left, left, not, well, the far left column is the reporting period and then the next column the number of children that there, the measure was based on and so that would be, um, the number of children en, enrolled in any of the programs at any point in time, uh, during that reporting period of June through September 2012.

So then in the next column we do, um, a little bit unusual things. It's common in some, um, kinds of measures but it's, it's a little unusual. Um, where we're figuring up the total number of child years in the program, so what we wanna do here is figure out, uh, how many

emergency department or urgent care visits are these children having while they're in the program. So we, because, again, we can't control anything or even measure anything outside the program, so that, that's all we wanna look at and that's all we wanna count. So if a child left the program before the end of the reporting period, we don't wanna keep counting time for that child because the child wasn't there and, um, we would be artificially making our rate go, go lower because we're counting, um, more time altogether than, uh, the children actually had in the program. So we're adding up and actually we added it up in days, um, all the, the total time period that these children were in the program and that, what you see in the second column. Now it actually gets more complex than that, um, in the fact that the way we're measuring that is, uh, home visitors will recognize right away that, uh, we're asking the mom at certain measurement points, uh, based on the child's age, uh, did your child go to the emergency department or urgent care at all during the last six months? So when mom is thinking back about that, she's thinking about the last six months and some of that six months may have been in the program and some not. So we have to make sure that we're looking at the six months that we're referring to of were there any visits during that time and make sure that, uh, we're counting that time and the time in the program, not anything that falls outside of the six months referred to and anything that falls outside of the enrollment period. And not anything that falls outside of the reporting period. So it is a rather tricky thing for analysts to deal with and for people in general, everybody to wrap their head around. Um, but like I said, I think once you work with it a bit, um, it'll get more familiar to you.

So then we come up with the visits per child year in the program and we're counting child years because often, um, rates of things like emergency department visits are calculated on a yearly basis, so these numbers then will more closely reflect something that we can kind of compare to. Um, so we can see in that first quarter then that there were only 2 ½ years, um, that children spent in the program and one child had one emergency department visit in that time and that comes out to a rate of .4 emergency department visits per child year. And so that's what you see in all those columns.

So now we'll look at Site 1 and, uh, what this slide is showing an example of what we're gonna have a lot of times at the local-level sites. Uh, there were hardly any there, didn't even reach one child year in any of the individual quarters and it only, uh, reached 1.2 child years for the total period, uh, of a little bit over a year. So these are very small numbers, uh, and when we see everything zero, which is great, uh, but where one emergency department visit occurred, it comes out to 2.7, uh, per child year but, you know, really we just have to ignore that because it's based on very small numbers and there's fluctuation, uh, like I said, when you're dealing with very small numbers. So really we can't tell much about this site on emergency department visits.

Uh, then the next site we're looking at here, uh, there's a few more children in this and we did at least reach a year or two in each of their quarters except the first one. But they're still quite small numbers, uh, so I don't feel very comfortable about 'em. But, um, the fact that, uh, they are going up, um, you might just wanna check, uh, on okay, who were the kids that were having these visits? And what were, what was going on, um, you know, are they being taken there for illness? Are they getting injured? You know, is there, are there two special health needs children in this program and, you know, it would be expected for them to have to visit the

emergency department more than usual. So look at those kinds of things to, uh, see if you have an issue or not.

Okay. Now, uh, the next slide, I think, is it two? Yes. The next two slides show groups of benchmarks that Benjamin alluded to earlier. And that's just tryin' to demonstrate to you that, uh, there are really, uh, according to what I used as, um, as my categories and I think they're probably pretty okay. Uh, that there're really only three groups, um, of benchmarks for families. Moms and kids and families and children. So, um, as Benjamin said, by improving one of the benchmarks in a particular group, you know, you may be then finding, uh, that if you change, that if you change the process and that process change help you improve, well, if you change that process in the same way for all the benchmarks in that group, uh, that may work. And so, um, you might wanna spread out your, um, improvement efforts, uh, over time across the three different categories, uh, so that you're addressing in a way all of the different benchmarks. So, um, I'm, I'm not gonna read through this at this time. You can just see that the first 12, uh, that there are 12 benchmarks in total that are related to the goal of detecting needed services, uh, by screening, um, or provision of services on time as required by the benchmark schedule. Then there are nine that are related to the goal of increasing the receipt of needed services by making referrals or tracking whether or not services were received or assisting with home **** barriers to receipt of services. And then finally, uh, there are 13 benchmarks in the category where the goal, overall goal is improving the likelihood of positive outcome by assisting with parenting, uh, parenting skills, education and financial improvements, uh, as well as by checking for progress in intervening between time points for each family. So then those are listed below. But is aid there were only three categories. There's actually a fourth but those don't refer directly to children and families. Uh, it's improving, uh, on a community level, um, your, um, contact with other service providers, uh, to improve the communication and ease with which clients can get services.

All right. And finally we just wanna look at the next steps here. Actually I'm sorry that this, um, in the interviewing times since September 30th of when we first gave this webinar, uh, we made a few changes in the schedule, but I can at least tell you roughly about those changes. So, uh, we had our, uh, September 30th webinar, which right at this moment is being repeated for your use, uh, and then in mid-October we did have our, um, a training webinar that was put on by our federal partners. And, uh, now our next date is December 3rd, uh, for another webinar and, uh, like Benjamin mentioned, we're going to go through some more data and just be able to make sure that we're feeling comfortable with what the data means, uh, what kind of interpretation we can actually make from it, what we have to be cautious about and so forth. Um, and we're gonna start sending out this data, uh, to the counties and, uh, local sites, uh, really as soon as you've listened to and gone through, uh, this webinar. So, uh, as soon as people go through it they can get their first set of data which are just those first three benchmarks that we covered. Um, so then, uh, we'll continue with benchmarks as long as we need and then we'll have an in-person meeting, uh, in which then, as a state-level group, we can discuss the results of all the benchmarks and all issues related to CQI and, you know, really get firm about our next, next step forward and get the process, um, moving faster.

All right, Benjamin, do you have anything you'd like to add?

Next Speaker: The only thing that I will add is that I have received permission from our federal partners to put a link for the webinar they conducted in October on our web site. So I would direct you to the home visiting web site for MIECHV under the public health division. And that will be the same site where **** will be posted as well. So you should be able to find that link for that webinar in the events **** in the same location. And with that, I thank you all for your time and we look forward to engaging on this journey together as we go forward and make these improvements to the home visiting **** network and to the services we provide children. Thank you so much.

Next Speaker: Bye, everybody.

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