Developing, Maintaining and Spreading a Culture of Rapid Cycle Learning Within Home Visiting: Lessons Learned

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HVCoIN 2.0
Home Visiting Collaboration Improvement and Innovation Network

EDC Education Development Center

MPHI®

Home Visiting Collaborative Improvement and Innovation Network

2013-2017

Set-Up: 2013

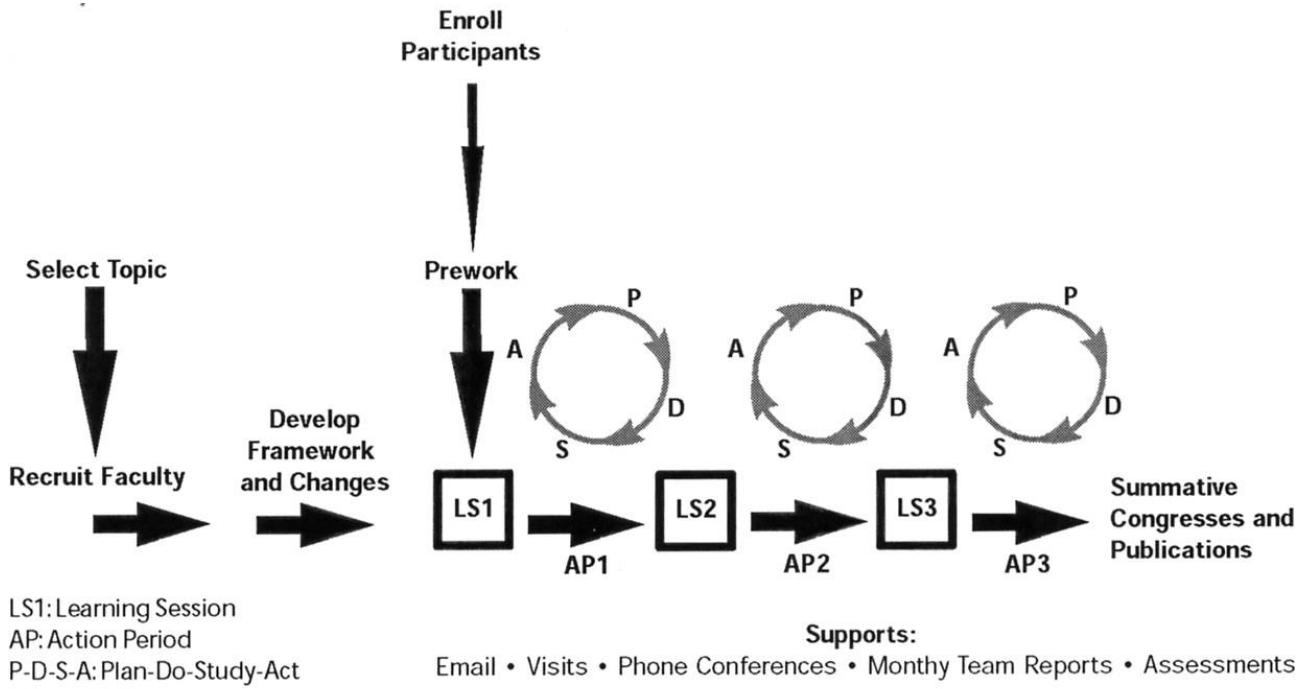
Identify topics ripe for change, assembled experts and developed the theory and measurement system

Pilot: 2013-2016

Tested the changes in a small group of intentionally varied settings 12 states, 37 teams

Spread: 2017

Spread successful changes to a larger group of settings within 6 original pilot states and 47 local teams



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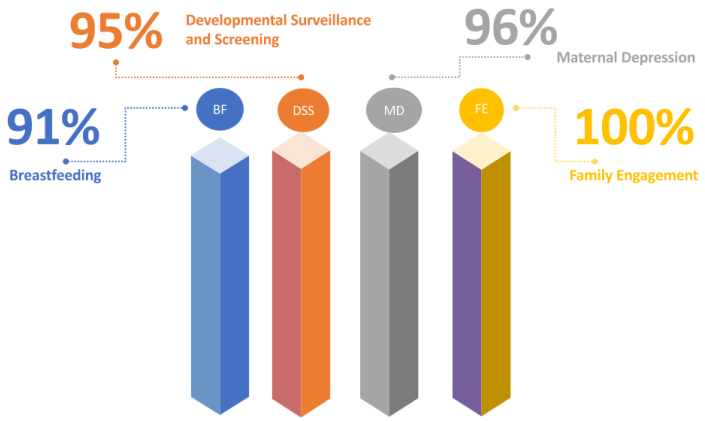
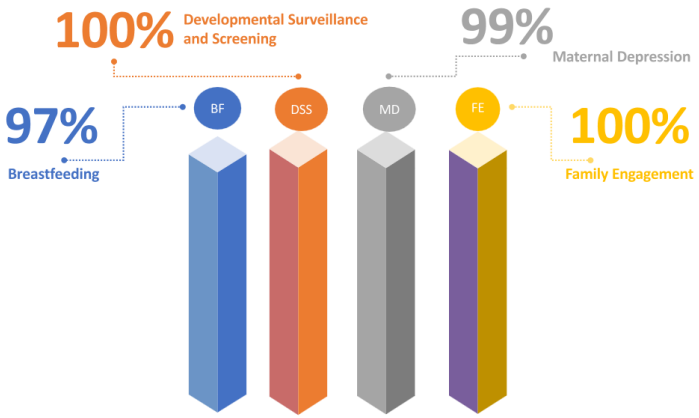


Data Reports Submitted



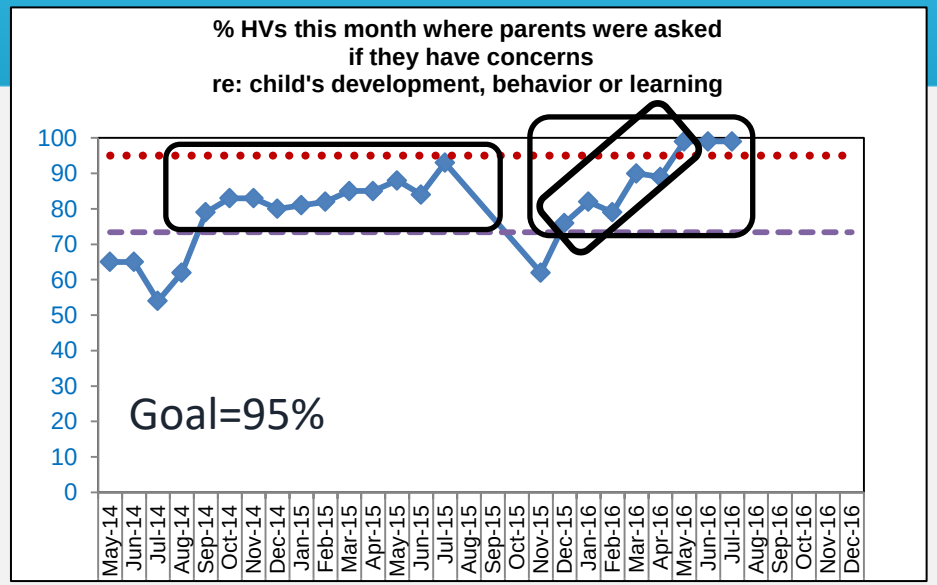
Regular Support to Teams to Teach QI and Theory

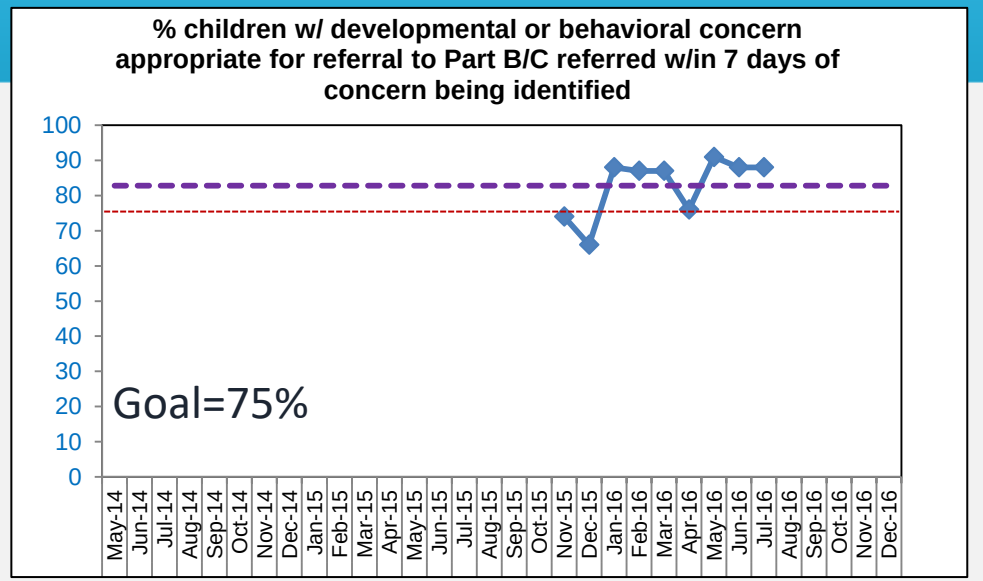
Learning Sessions
- Get ideas
- Learn QI Methods
- Get started> Get a stride> Sustain

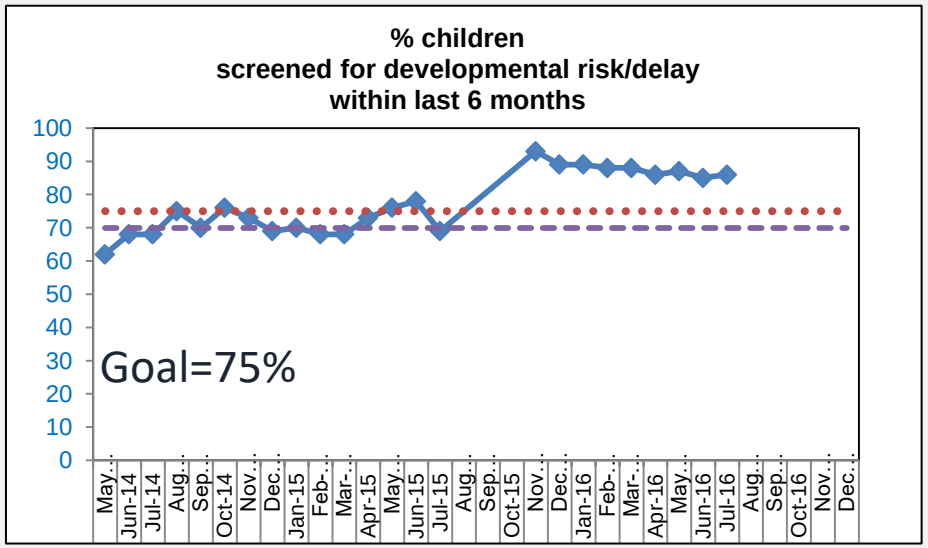
Action Periods (time between Learning Sessions)
- Test changes
- Collect and monitor data

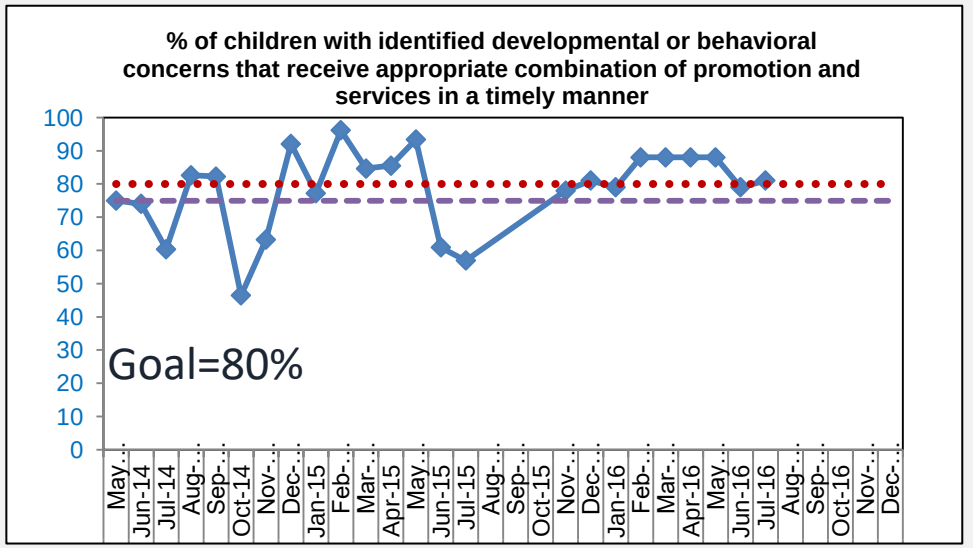
Coaching
- Monthly collaborative calls
- 1:1 and small group coaching
- QI training to enhance skills

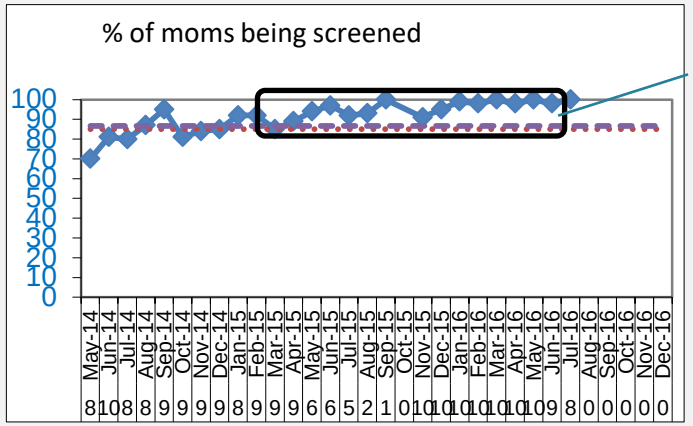
Development Results: Met All Aims Set



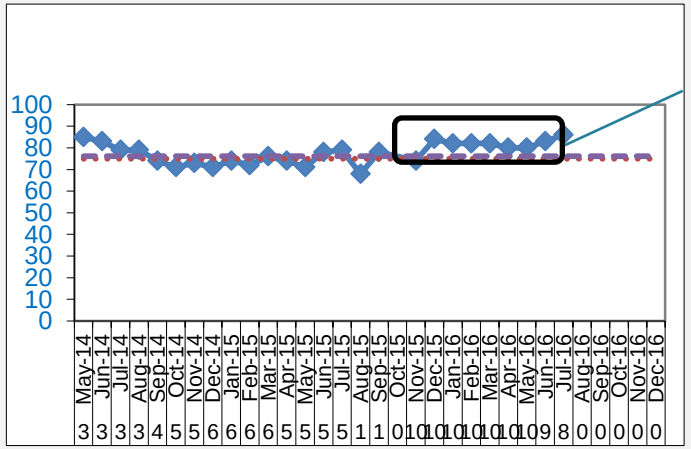




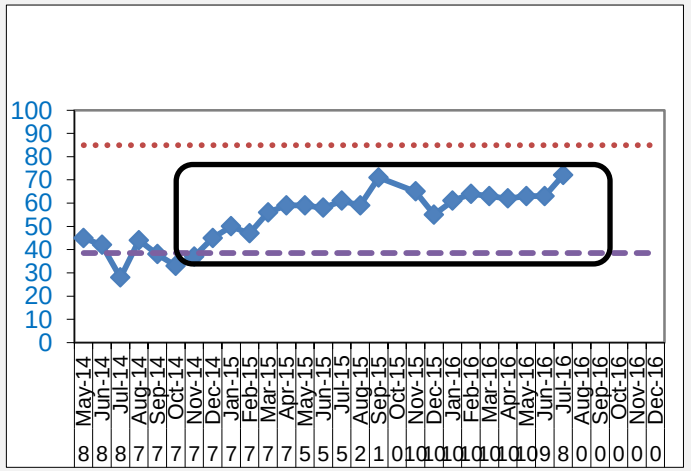




1. Over 90% of moms are screened, exceeded aim of 85%

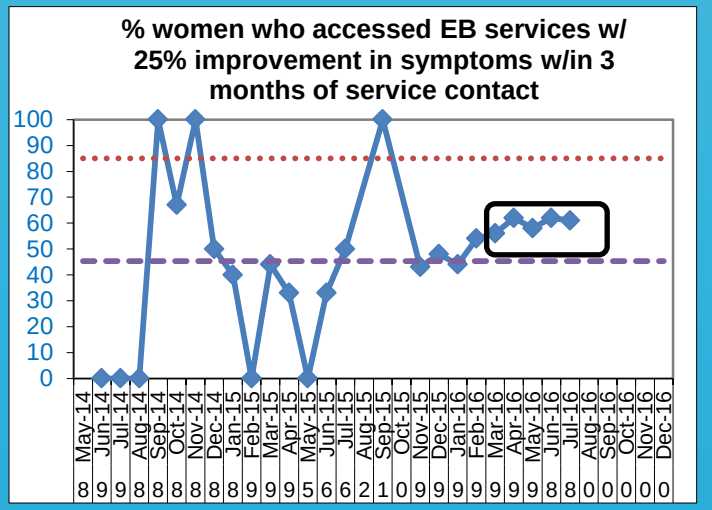


2. Over 80% of moms at risk accept a referral to services, exceeded aim of 75%



3. Over 70% of moms accepting referral get an evidence-based service contact, moving toward aim of 85%

Seeing a reliable rate of mom's with improved symptoms!



Maternal Depression

All Process Aims met, SMART AIM- making reliable progress

HV CoIIN 2.0: 2018-2022

Scale Tested Topics with 25 awardees and 250 local teams

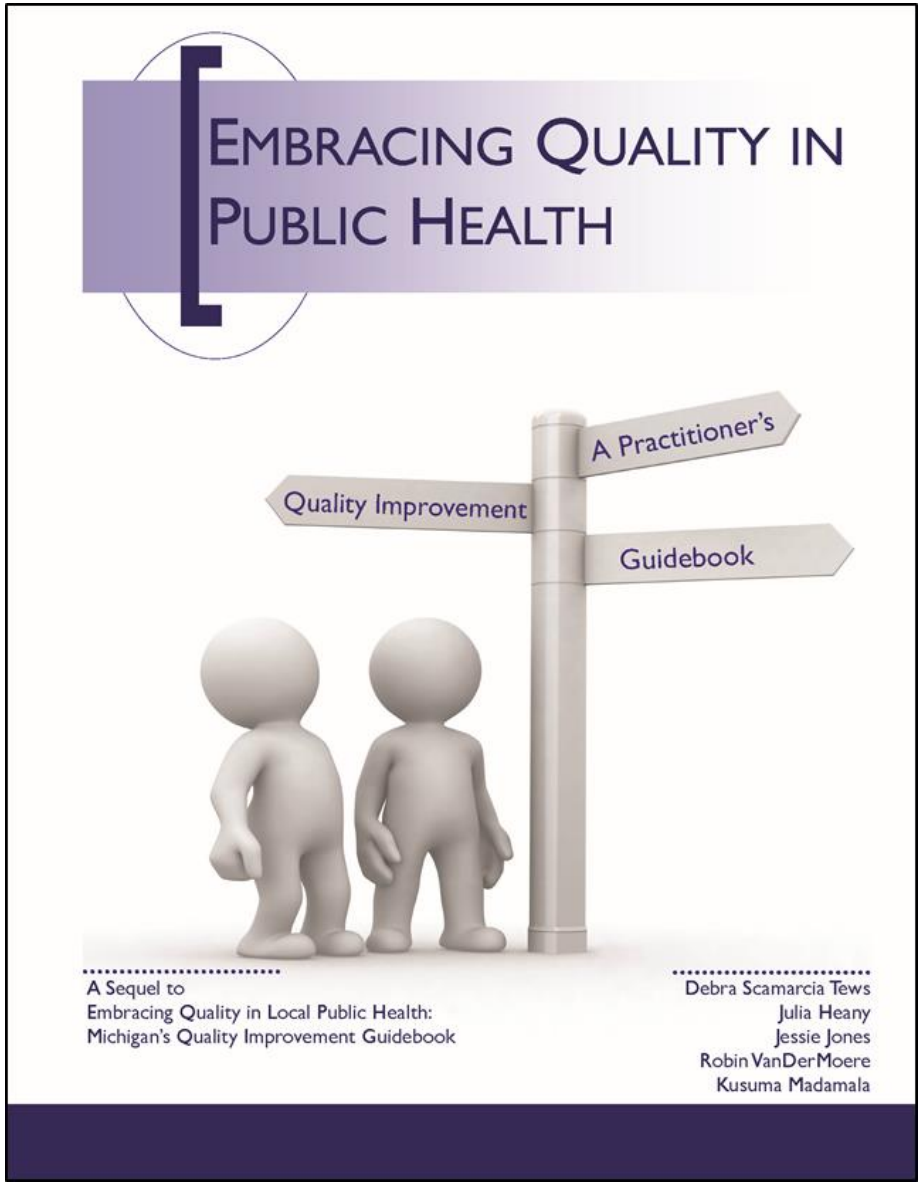
Engage in (3) New Topic CoIINs

Our Partners

MPHI Center for Healthy Communities

- Building a culture of quality such that QI is used on an every day basis to solve every day problems
- Achieving breakthrough improvements in areas where we find common challenges

MPHI



https://www.mphiaccredandqi.org/qi-guidebook/

CQI in Home Visiting Michigan's Approach

Monitoring Performance

- Implementation Data
- Performance Measures
- Monthly, Quarterly and Annual Reporting

Continuous Improvement

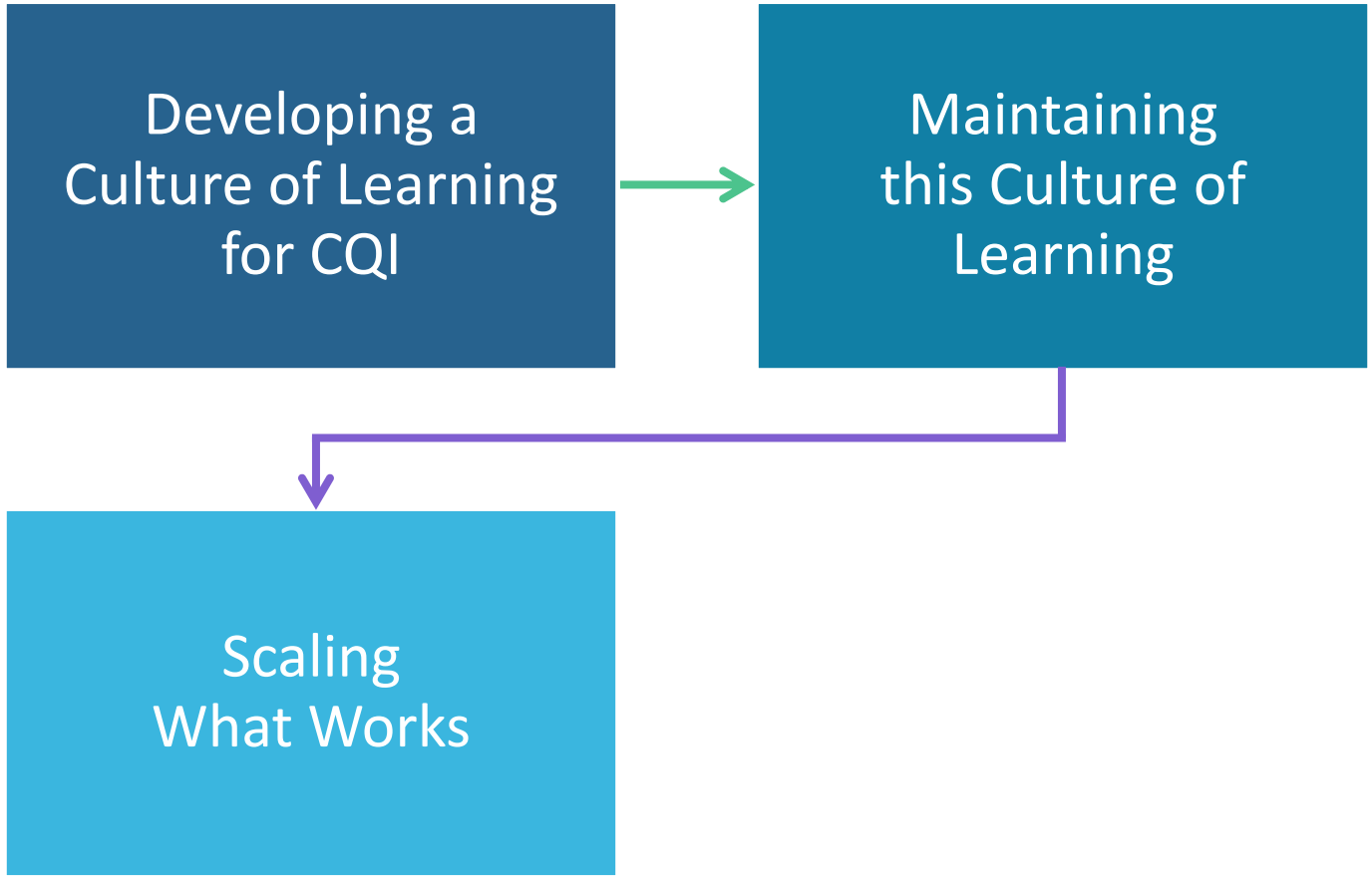
- State & Local CQI Projects
- QI Training and Advising
- Team Charters and Storyboards

Collaborative Learning

- Learning Collaboratives
- Community of Learning Webinars
- SharePoint Site

https://public.mphi.org/sites/mihomevisiting.org/Pages/default.aspx

Our Lessons Learned



Developing the Culture
Reducing Fear and Building Leaders

Developing a Culture: Executive Sponsor

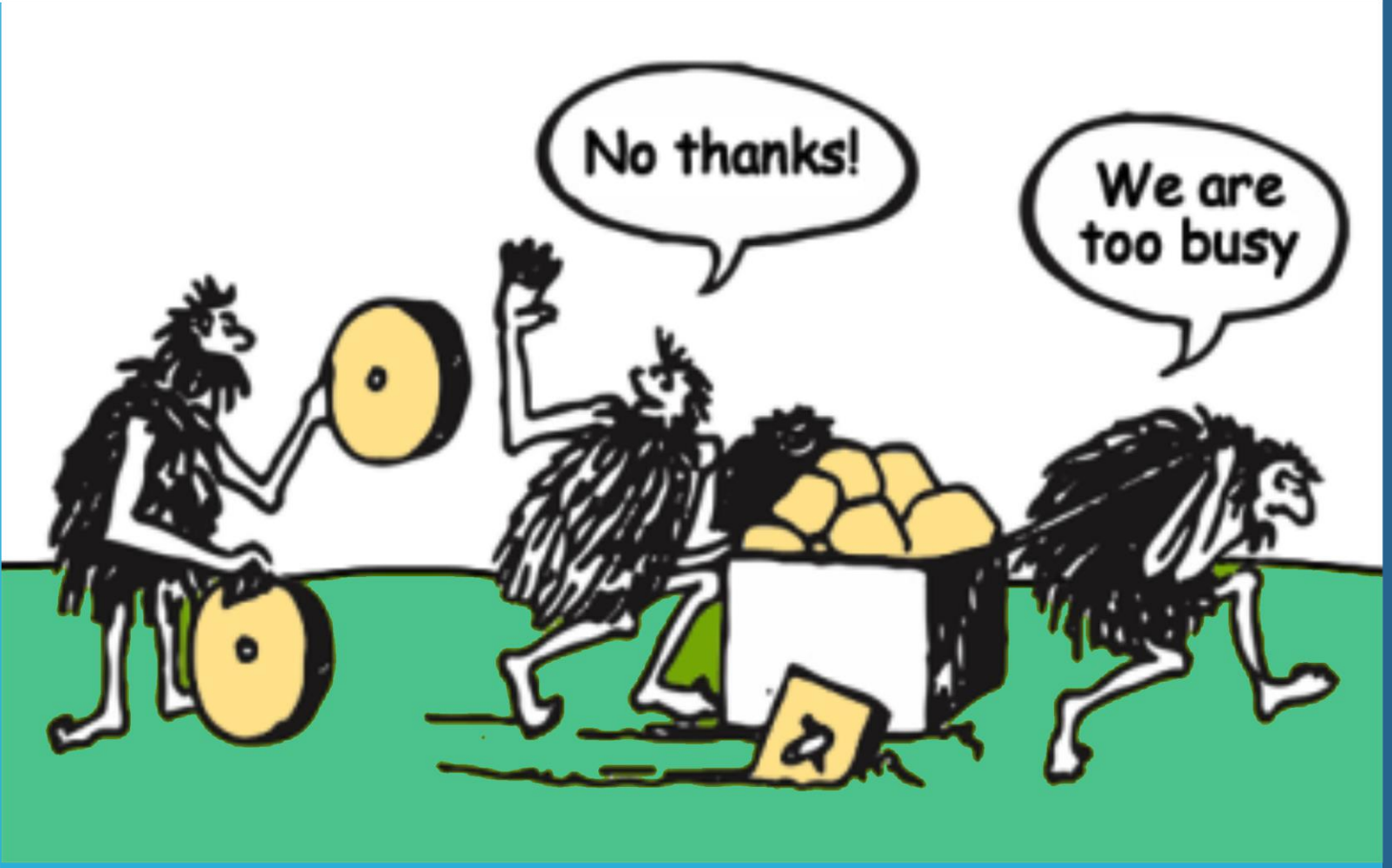
The Executive sponsor is the leader who is responsible and accountable to their organization for the performance and results of the CQI work.

Typically, this person is not a member of the day-to-day team, but is responsible for championing CQI efforts—securing the resources for the team to accomplish their aim and communicating their progress to other leaders in the organization.

Home Visiting CoIIN and HV CoIIN 2.0

Dr. David Willis

Dr. Monique Fountain Hanna



Developing a Culture:
Topics That Matter

Identify a particular area or issue that is ripe for improvement based on three criteria:

- existing knowledge is sound but not widely used;
- better results have been demonstrated in real-world settings; and
- current defect rates affect many clients somewhat, or at least a few clients profoundly.

Developing a Culture:
Engage Passionate Experts

Project Charter

HV CoIIN Maternal Depression Charter

A. WHAT ARE WE TRYING TO ACCOMPLISH?

Call to Action: Studies show that 40-60% of families with young children enrolled in home visiting programs experience elevated depressive symptoms, and 10-15% have major depression.[i,ii] Left undetected and untreated, maternal depression can have long-lasting negative effects on the growth and development of infants and young children. Studies have shown that mothers with depression present as less positive, spontaneous, and responsive with infants, [iii] compromising the critical relationships a young child needs to develop. Young children with compromised responsive caregiving are at an increased risk of exhibiting challenging behavior, developmental difficulties, poor social relationships, and cognitive impairment.[iv v]

Identification and linkage of women with depressive symptoms to effective, evidence-based interventions can make a difference, [vi vii viii] reducing by half the percent of women exhibiting major depression or developing depression. [ix, x] However, families challenged with maternal depression often struggle to access and engage with treatment: they have less frequent use of preventive health services and greater use of emergency departments and in-patient services for illness and injury.

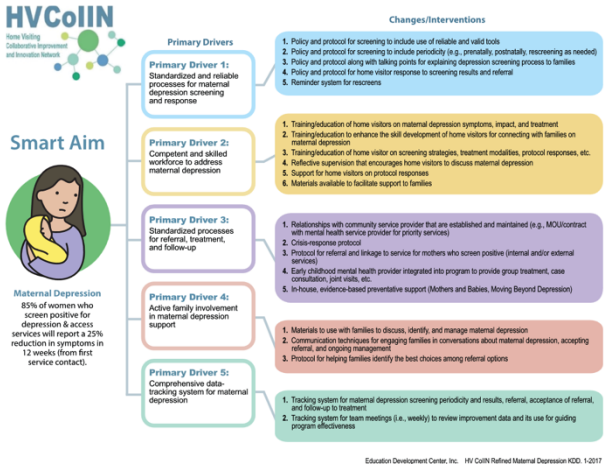
HV CoIIN teams have made great strides in developing and refining policy and practices to improvement identification of mothers with maternal depression symptoms. Screening rates of all enrolled mothers in Phase I is at a mean of 88%. Furthermore, once identified, referral of mothers to treatment is high, averaging 88%. In the next steps of alleviating symptoms, parental acceptance of referrals and getting to treatment must be strengthened. For example, approximately 30% of mothers being referred to treatment in the HV CoIIN are receiving a minimum of one evidence-based contact. Overall, 50% of women screening positive for maternal depression, with receipt of evidence-based services are reporting an improvement of 25% > in symptoms.

Mission: Together, in Year 4 Scale-Up, we will dramatically reduce depressive symptoms among mothers of young children receiving home visiting services over five months by developing and refining policy and practices that lead to: 1) standardized and reliable processed for maternal depression screening and response, 2) competent and skilled workforce to address maternal depression, 3) standardized processes for referral, treatment, and follow-up, 4) active family involvement in maternal depression support, and 5) comprehensive data-tracking system for maternal depression.

This is important to home visiting because:

- Consistent delivery of evidence-based models and services improves maternal and infant well-being.
- Data tracking will lead to Continuous Quality Improvement (CQI).
- Communities will prosper with more focus on promotion of mental health, prevention of issues when feasible, and identification and treatment when necessary

Key Driver Diagram



Change Package

Change concepts (Primary Drivers)	Key Changes (Secondary Drivers)	Specific Changes (Change ideas)	Citations/Resources
Standardize process for maternal depression screening and response	• Identify and correctly use appropriate screening instrument • Develop periodicity schedule for maternal depression screening • Develop protocol for sharing results of screening with family • Develop response protocol for urgent and non-urgent care	• The *home visiting agency* establishes systematic standards of culturally and linguistically sensitive screening for maternal depression to include identification and appropriate use of reliable and valid tools (EPDS, PHQ-2 & 9, CES-D, PDSS) • The *home visiting agency* establishes a standardized periodicity schedule for regular maternal depression screening (Within 3 months of enrollment (pre- or postnatal) and within 3 months postnatal) • The *home visiting agency* establishes a protocol for home visitors to use when sharing results of maternal depression screening and educating mothers on maternal depression (providing support, assisting to de-stigmatize the condition by normalizing it (providing prevalence figures and role models who have experienced it), and providing a scientific explanation of the condition. The purpose is to help client understand the condition and feel more comfortable seeking or accepting services. Also encourages mother to obtain support from others, provides information of evidence-based options (medication, psychotherapy, exercise), offers direct links to treatment resources and assists with navigation). • The *home visiting agency* establishes a protocol for response, referral and intervention for urgent and non-urgent care • The *home visiting agency* trains all home visitors in o Depression screening to raise confidence and skills with tools (e.g., concerns about discussing depression or screening results, etc.) o Standardized protocols for screening, sharing results, provision of supportive services, referral and linkage to treatment, follow-up, etc. • The *home visiting agency* develops and delivers ongoing refresher training on systematic standards of screening and response(i.e. screening tool use and interpretation) • The *home visiting agency* develops and regularly assesses client's satisfaction with screening and referral.	Ammerman, Robert T., Frank W. Putnam, Nicole B. Bosse, Angelique R. Teeters, and Judith B. Van Ginkel. 2010. "Maternal Depression in Home Visitation: A Systematic Review. Aggression and Violent Behavior 15:191–200 Golden, O., Hawkins, A., & Beardslee, W. 2011. Home visiting and maternal depression: Seizing Opportunities to help mothers and young children. The Urban Institute. Chaudron, L. H., Szilagyi, P. G., Tang, W., Anson, E., Talbot, N. L., Wadkins, H. I. M., Wisner, K. L. (2010). Accuracy of depression screening tools for identifying postpartum depression among urban mothers. *Pediatrics*, *125*(3), e609–17. Leung, S. S. L., Leung, C., Lam, T. H., Hung, S. F., Chan, R., Yeung, T., Lee, D. T. S. (2011). Outcome of a postnatal depression screening program using the Edinburgh Postnatal Depression Scale: a randomized controlled trial. *Journal of Public Health (Oxford, England)*, *33*(2), 292–301. Breedlove, G., & Fryzelka, D. (2011). Depression screening during pregnancy. *Journal of Midwifery & Women's Health*, *56*(1), 18–25. National Research Council. Depression in parents, parenting and children: Opportunities to improve identification, treatment and prevention. Washington, DC: The National Academies Press, 2009. Design Options for Home Visiting Evaluation. (2011). *DOHVE compendium of measurement Tools*. New York, New York: Author.

Measurement System

The HV CoIIN for Maternal Depression aims to achieve that 85% of women who screen positive for depression and access services will report a 25% reduction in symptoms in 12 weeks (from first service contact).

Process AIMS:

- 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.
- 85% of women with a positive screen for MD who do not access EB services will be rescreened within 30 days, (or sooner in cases of crises or worsening symptoms).
- 75% of all enrolled women who screen positive (and are not already in evidence based services) will be referred to evidence based services[xiii] (offsite or in-house) within 1 month.
- 85% percent of women referred to an evidence based service will have one service contact.

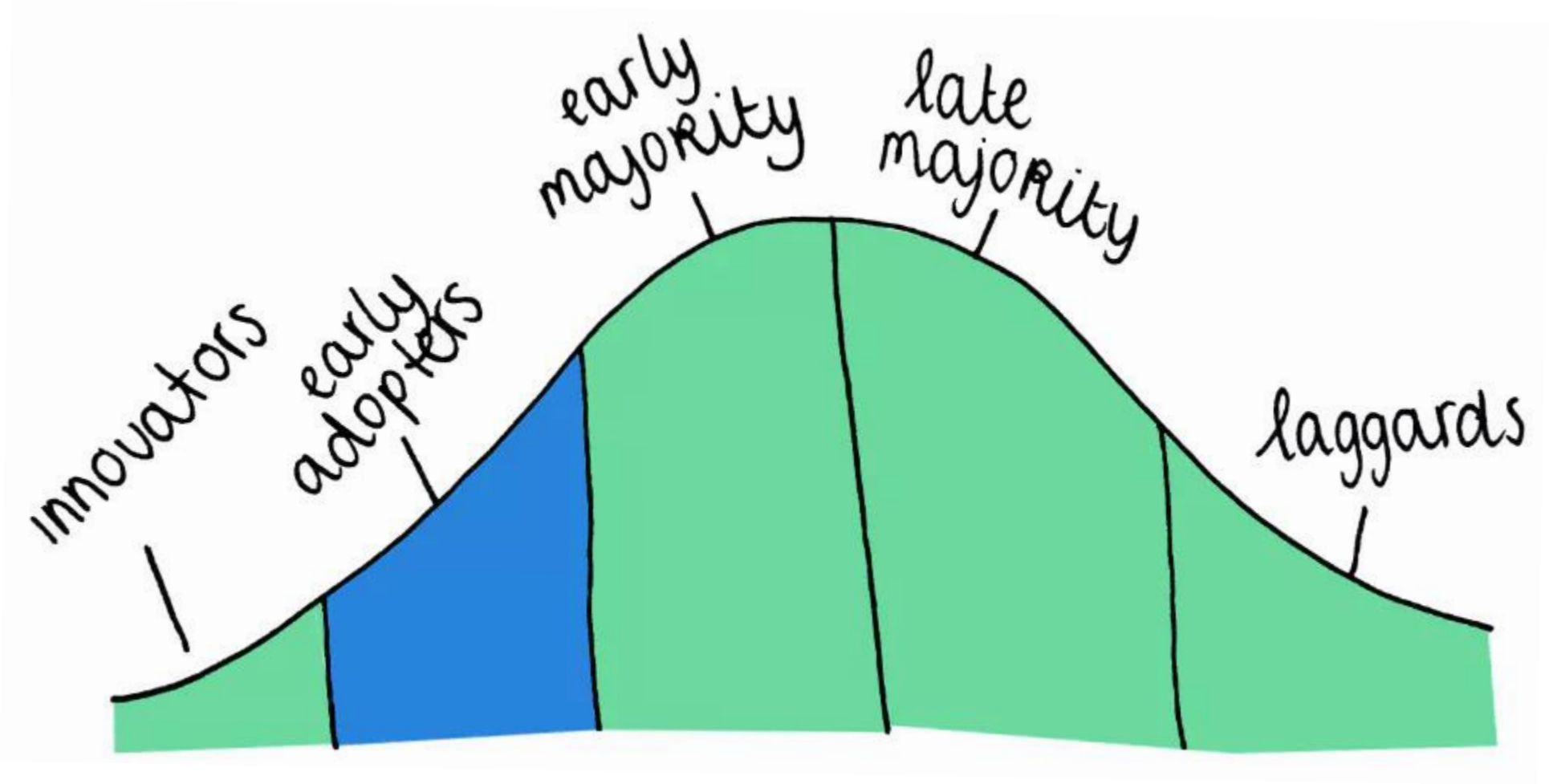
The following measures were selected to reflect the processes necessary to achieve the SMART aim. They are listed in the order in which these processes occur in many sites, and are labeled with the Primary Driver they reflect.

Measure #1 (Primary Driver 1): % of women screened for MD within 3 months of enrollment and within 3 months of giving birth.

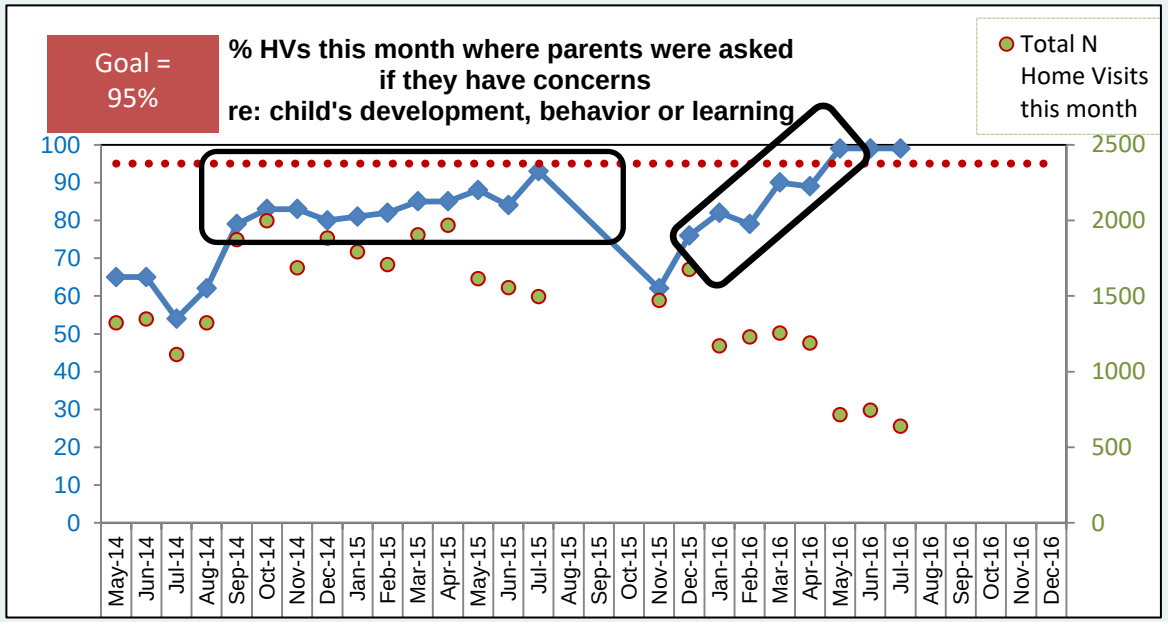
- Numerator: (N women enrolled 90-120 days ago screened for MD) + (N women enrolled > 120 days ago who gave birth 90-120 days ago & were screened for MD)
- Denominator: (N of women enrolled 90-120 days ago) + (N of women enrolled > 120 days ago who gave birth 90-120 days ago)

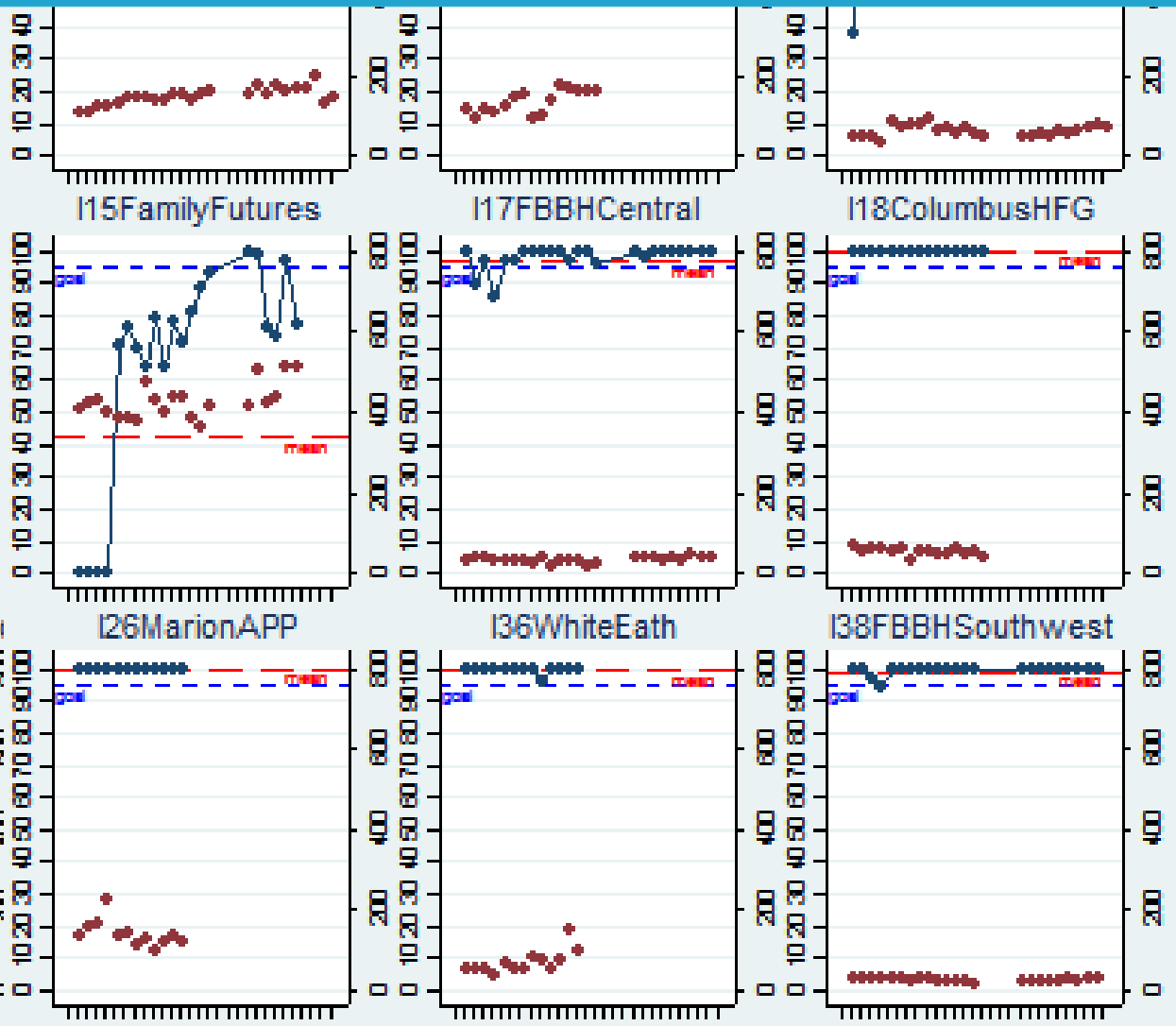
Developing a Culture: Assembling a Roadmap

Developing a Culture:
Starting with Volunteer Early Adopters

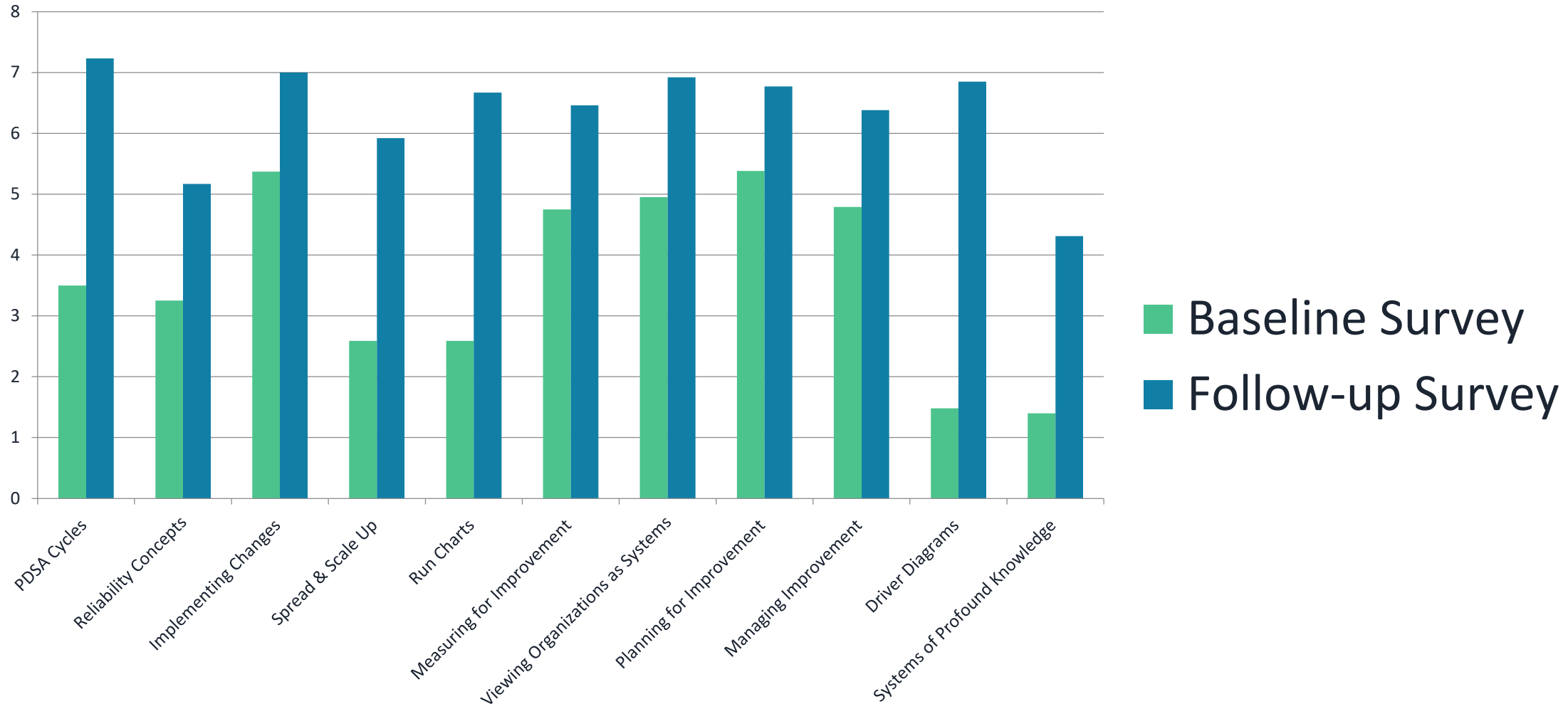


Developing a Culture:
"All Teach, All Learn"





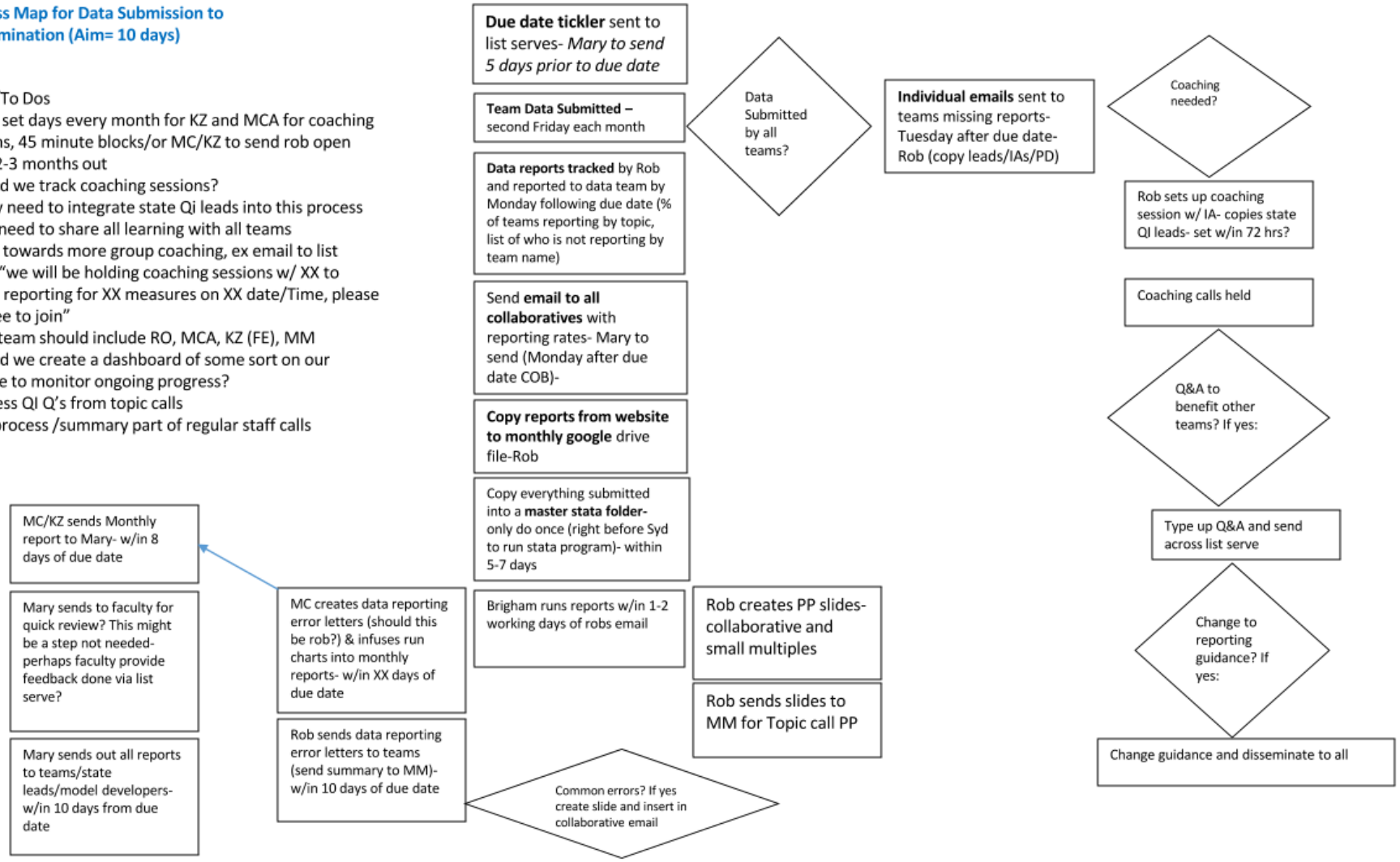
Developing a Culture:
Provide High-Level Support for Learning



Developing a Culture: Internal Accountability

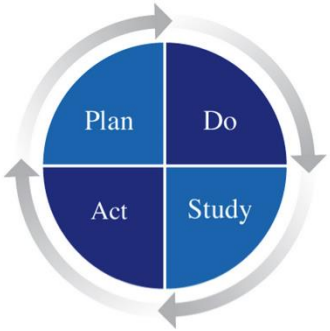
Process Map for Data Submission to Dissemination (Aim= 10 days)

Notes/To Dos
- Need set days every month for KZ and MCA for coaching sessions, 45 minute blocks/or MC/KZ to send rob open dates 2-3 months out
- Should we track coaching sessions?
- Really need to integrate state Qi leads into this process Really need to share all learning with all teams
- Work towards more group coaching, ex email to list serve: "we will be holding coaching sessions w/ XX to review reporting for XX measures on XX date/Time, please feel free to join"
- Data team should include RO, MCA, KZ (FE), MM
- Should we create a dashboard of some sort on our website to monitor ongoing progress?
- Address QI Q's from topic calls
- This process /summary part of regular staff calls



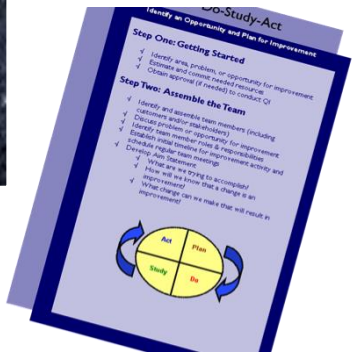
Supportive Infrastructure

PD



QI Model

Guidance



Resources

Structure

Strong Customer Focus

Quality is defined by the customer

- Internal: those impacted by your work process
- External: those you want to value your services

Strategies for understanding the customer

- QI team composition
- Training customers in QI
- Structures that put customers in positions of leadership
- Learning from the customer surveys, focus groups, check-ins
- Questioning measures

Developing a Culture:
Executive Sponsor

Engaged and supportive leadership is essential to QI

Leaders with thriving QI teams:

- Engage the whole staff
- Are transparent
- Have clear goals & drive
- Care deeply about doing things the right way

Leaders set the stage for success:

- Training & support
- Quality in conversation
- Data & team knowledge
- Space to fail

Empowered Teams

Work on teamwork

Build confidence

Value learning over perfection

Have information and authority

"The HV CoIIN experience has helped us grow a culture of change in our site. Our staff is creatively thinking outside the box and testing ideas outside the CoIIN topics now. CQI has been embedded in our day-to-day operations and used any time we see the need for improvement or adjustments in our practice, policies and procedures."

Maintaining a Culture of Learning: Build Superstars!

Maintaining a Culture of Learning: Teams as Leaders

01

Presenting at Learning Sessions

02

Sharing on Topic Calls

03

Participating as part of a Steering Committee

04

Participating as faculty

Maintaining a Culture:
Strengthening Parent Leadership

We aim to increase the percent of family partners that are actively engaged and self-report that they are making a meaningful contribution to their team's improvement work

Bryn Fortune,
HV CoIIN 2.0 Parent Coach-Michigan's Early Childhood Investment Corporation

Erin Moore,
HV CoIIN 2.0 Family Coach-Shift-Results

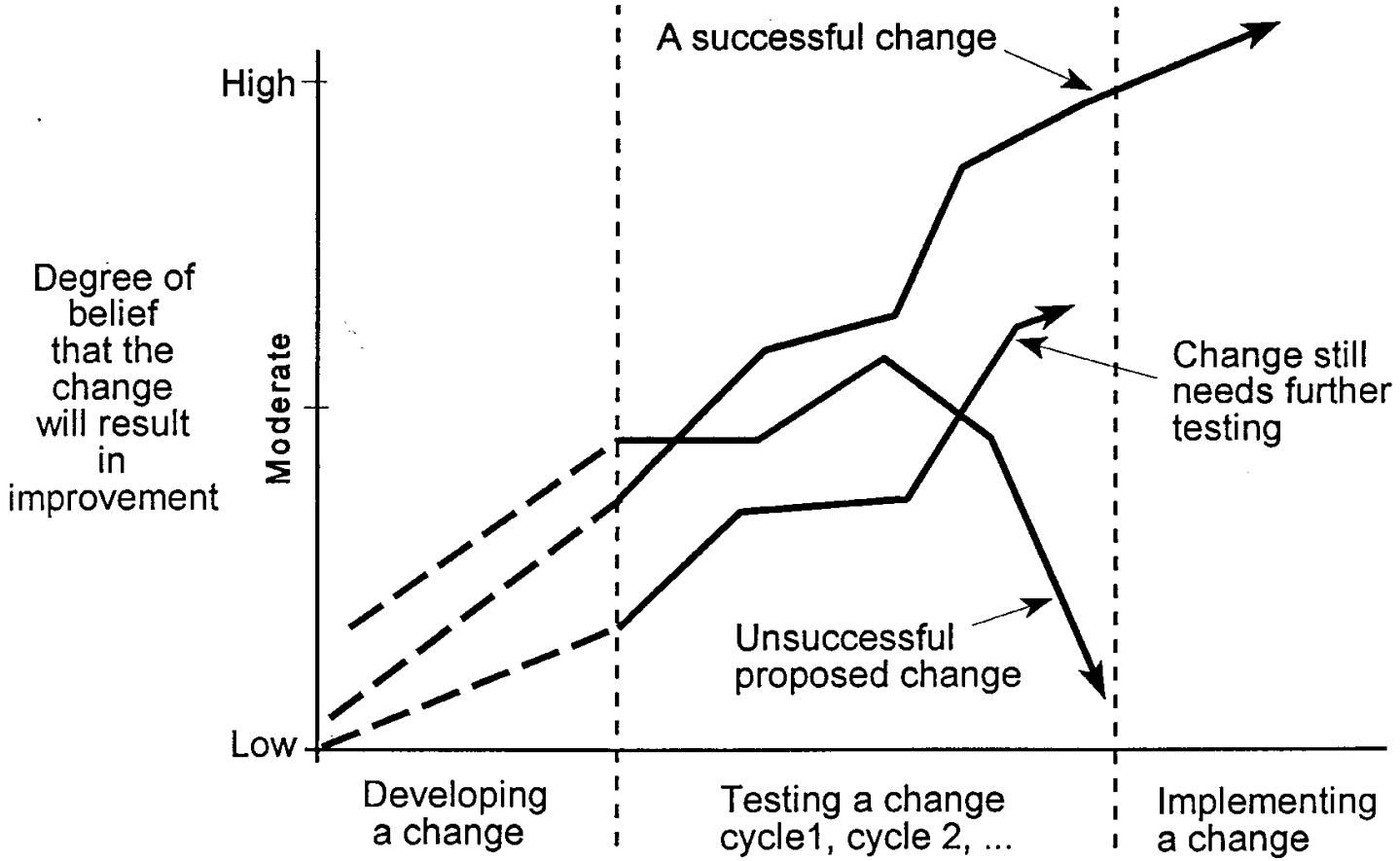
Maintaining a Culture: Foundational Supports for All Participants

- IHI delivered virtual Breakthrough Series College
  - 12 modules delivered over 6-months
- Model for Improvement
  - Six virtual, self-paced modules
- CQI Conferences
- Improved Database and
- Parent Leadership coaching

Maintaining a Culture: Addressing the Challenges

Time	Practice
Documentation	Streamline
Data	Innovate
Turnover	Routine PD
Multiple demands	Shift in focus
Lack of process	Quality planning
Getting stuck	Keep it fresh

Scaling What Works



Scaling What Works: HVCoIIN 2.0 Scale Theory

AIM

To build a movement and capability for ongoing learning that improves maternal and child health outcomes for families in home visiting by engaging 25 MIECHV awardees and 250 LIAs to scale improvements and meet aims in identified topics by 2022 including:

- 85% of women who screen positive for depression and access services will report a 25% reduction in symptoms in 12 weeks from 1st service contact
- 80% of children with an identified developmental or behavioral concern will receive targeted developmental promotion and support in a timely manner, including an appropriate combination of home visitor-delivered developmental promotion, community services and/or Part B/C services.

Primary Drivers:

1. Learning System to accelerate scale and change
   - For awardees
   - LIAs
   - National team
   - HRSA
2. Tested, proven, refined intervention to spread
3. Awardees and family members with high will and leadership capability as change agents
4. Data system and feedback loop to make adjustments in real time
5. Competent team
6. Federal partner that authorizes, aligns, funds and gives credibility to the work
7. Awareness and will building strategy

Scaling What Works: Turnkey Resources

SMART AIM	DRIVERS	Scalable Interventions
85% of women who screen positive for depression & access services will report a 25% reduction in symptoms 12 weeks (from 1st. service contact).	PD1. Standardized and reliable processes for maternal depression screening and response *85% of women will be screened, using appropriate instruments at appropriate intervals: Within three months of enrollment (pre- or postnatal) and within three months postnatal.* *85% of women with a positive screen for maternal depression who do not access evidence-based services will be rescreened within 30 days, (or sooner in cases of crises or worsening symptoms).*	1. Policy and protocol for screening to include use of reliable and valid tools 2. Policy and protocol for screening to include periodicity (e.g., prenatally, postnatally, rescreening as needed) 3. Policy and protocol along with talking points for explaining depression screening process to families 4. Policy and protocol for home visitor response to screening results and referral 5. Reminder system for rescreens
	PD2. Competent and skilled workforce to address maternal depression	6. Training/education of home visitors on maternal depression symptoms, impact, and treatment 7. Training/education to enhance the skill development of home visitors for connecting with families on maternal depression 8. Reflective supervision that encourages home visitors to discuss maternal depression 9. Support for home visitors on protocol responses
	PD3. Standardized processes for referral, treatment and follow-up *75% of all enrolled women who screen positive (and are not already in evidence-based (offsite or in-house) within one services) will be referred to evidence-based services month.* *85% percent of women referred to an evidence-based service will have one service contact.*	10. Crisis-response protocol 11. Protocol for referral and linkage to service for mothers who screen positive (internal and/or external services 12. In-house, evidence-based preventative support (e.g., Mothers and Babies)
	PD4. Comprehensive data-tracking system for developmental promotion, identification, and linkage *80% of home visitors using data in practice each month.*	13. Tracking system for maternal depression screening periodicity and results, referral, acceptance of referral, and follow-up to treatment 14. Tracking system for team meetings (i.e., weekly) to review improvement data and its use for guiding program effectiveness

Alignment with Federal Policy

Federal Measure	Numerator	Denominator	HV CoIIN Measure
3. % of primary caregivers enrolled in HV who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally)	For those not enrolled prenatally, N primary caregivers enrolled in HV who are screened for depression within the first 3 months since enrollment; for those enrolled prenatally, the N primary caregivers screened for depression within 3 months of delivery	For those not enrolled prenatally, the N primary caregivers enrolled in HV for at least 3 months; for those enrolled prenatally, the N primary caregivers enrolled in HV for at least three months post delivery	% of women screened for maternal depression within 3 months of enrollment and within 3 months of giving birth
17. % of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts	N primary caregivers enrolled in HV who received recommended services for depression (and met the conditions specified in the denominator)	N primary caregivers enrolled in HV who had a positive screen for depression within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally) and were referred for services	% of women who verbally accepted a referral to services after a positive screen for maternal depression, and who have had one or more evidence-based service contacts

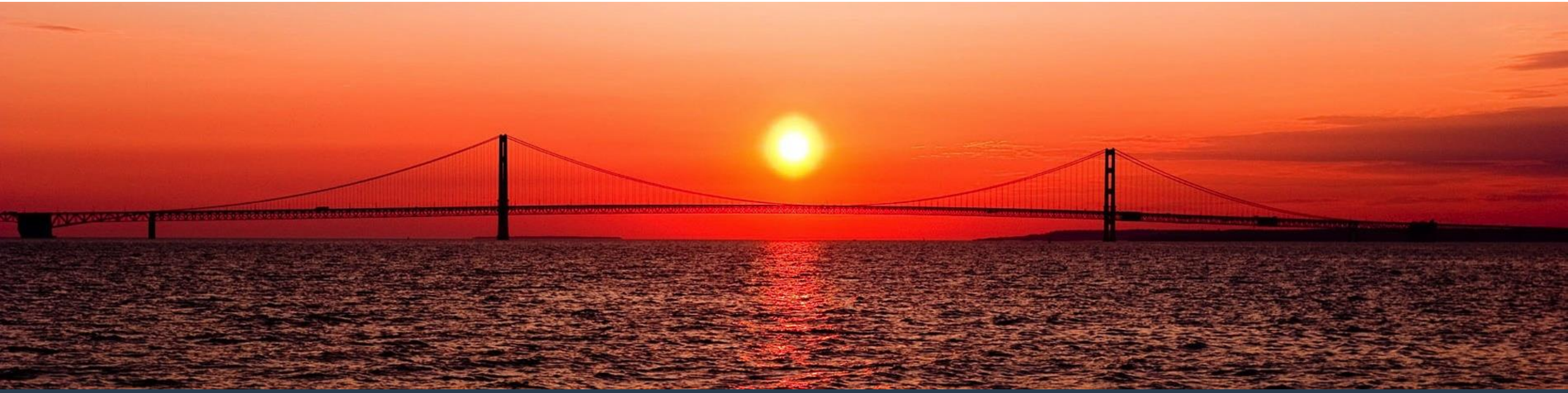
Taking CQI as a Method to Scale

Spread:

- Across Systems
- Multiple Funding Streams
- Agencies, both State and Local
- Beyond MI

Scale:

- Training to Train-the-Trainer
- Single 6 month LC to many multi-year LCs
- QI as a practice to QI as a culture



What Questions or Reflections Do You Have?

Your Next Steps

Thank You

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