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

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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

Enroll Participants

Select Topic
Recruit Faculty

Develop Framework and Changes

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

Summative Congresses and Publications

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

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Development Results: Met All Aims Set

% HVs this month where parents were asked if they have concerns re: child’s development, behavior or learning

Goal=95%

% of children with identified developmental or behavioral concern appropriate for referral to Part B/C referred w/in 7 days of concern being identified

Goal=75%

% children screened for developmental risk/delay within last 6 months

Goal=75%

% of children with identified developmental or behavioral concerns that receive appropriate combination of promotion and services in a timely manner

Goal=80%
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%

Maternal Depression
All Process Aims met, SMART AIM- making reliable progress

Seeing a reliable rate of mom’s with improved symptoms!
HV CoIIN 2.0: 2018-2022

Scale Tested Topics with 25 awardees and 250 local teams

Engage in (3) New Topic CoIINs
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

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

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[https://public.mphi.org/sites/mihomevisiting.org/Pages/default.aspx](https://public.mphi.org/sites/mihomevisiting.org/Pages/default.aspx)
Our Lessons Learned

- Developing a Culture of Learning for CQI
- Maintaining this Culture of Learning
- Scaling What Works
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.
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: Topics That Matter
Developing a Culture: Engage Passionate Experts
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Project Charter

Project Charter

HVCoIN Maternal Depressive Disorder

A short slide on the "HVCoIN" Plan.

Key Driver Diagram

Key Driver Diagram

HVCoIN Maternal Depressive Disorder

Change Package

Change Package

Measurement System

Measurement System

The HVCoIN 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 of 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 postnatally.
- 85% of women with a positive screen for MD who do not access EB services will be re-screened within 10 days, (or sooner in cases of acute or worsening symptoms).
- 75% of all enrolled women who screen positive and are ultimately in evidence-based services will be referred to evidence-based services. (Patient or involved within 1 month.
- 85% of women referred to an evidence-based service will have one service contact.

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

Measure 1 (Primary Driver): % of women screened for MD within 3 months of enrollment and within 3 months of giving birth.
- Numerator: [Women enrolled 90-120 days ago screened for MD + (Women enrolled > 120 days ago who gave birth 90-120 days ago & were screened for MD)]
- Denominator: [Women enrolled 90-120 days ago + (Women enrolled > 120 days ago who gave birth 90-120 days ago)]
Developing a Culture:
Starting with Volunteer Early Adopters
Developing a Culture: “All Teach, All Learn”
Developing a Culture: Provide High-Level Support for Learning

Baseline Survey

Follow-up Survey
Developing a Culture: Internal Accountability

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

Notes/Todo
- Need set days every month for K2 and MCA for coaching sessions, 45 minute blocks for MC/K2 to send rob open dates 2-3 months out
- Should we track coaching sessions?
- Really need to integrate state QI leaders 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

Due date tickler sent to list serves- Mary to send 5 days prior to due date

Data Submissions
- Team Data Submitted – second Friday each month
- Data reports tracked by Rob and reported to data team by Monday following due date (% of teams reporting by topic, list of who is not reporting by team name)

Send email to all collaborators with reporting rates- Mary to send (Monday after due date COI)

Copy reports from website to monthly google drive file- Rob

MC/K2 sends Monthly report to Mary w/in 8 days of due date

Mary creates data reporting error letters (should this be rob? & infusion run charts into monthly reports w/xx xx days of due date

Mary sends out all reports to teams/data leads/model developers- w/10 days from due date

Rob sends data reporting error letters to teams (send summary to MM- w/10 days of due date

Birmingham runs reports w/ 1-2 working days of rob email

Rob creates PP slides- collaborative and small multiples

Rob sends slides to MM for Topic call PP

Individual emails sent to teams missing reports- Tuesday after due date- Rob (copy leads/MM/PP)

Rob sets up coaching session w/ AC and state QI leaders- set w/in 72 hrs?

Coaching needed?

Coaching calls held

Q&A to benefit other teams? If yes:

Type up Q&A and send across list serve

Change to reporting guidance? If yes:

Change guidance and disseminate to all

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Supportive Infrastructure

PD

QI Model

Guidance

Structure

Resources
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
Documentation
Data
Turnover
Multiple demands
Lack of process
Getting stuck

Practice
Streamline
Innovate
Routine PD
Shift in focus
Quality planning
Keep it fresh
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

<table>
<thead>
<tr>
<th>SMART AIM</th>
<th>DRIVERS</th>
<th>Scalable Interventions</th>
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<tbody>
<tr>
<td>85% of women who screen positive for depression &amp; access services will report a 25% reduction in symptoms 12 weeks (from 1st service contact).</td>
<td>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).</td>
<td>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</td>
</tr>
<tr>
<td>PD2. Competent and skilled workforce to address maternal depression</td>
<td>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</td>
<td></td>
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<tr>
<td>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.</td>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>PD4. Comprehensive data-tracking system for developmental promotion, identification, and linkage 80% of home visitors using data in practice each month.</td>
<td>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</td>
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## Alignment with Federal Policy

<table>
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<th>Numerator</th>
<th>Denominator</th>
<th>HV CoLin Measure</th>
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<td>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)</td>
<td>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</td>
<td>For those not enrolled prenatally, the N primary caregivers enrolled in HV for at least three months post delivery</td>
<td>% of women screened for maternal depression within 3 months of enrollment and within 3 months of giving birth</td>
</tr>
<tr>
<td>17. % of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts</td>
<td>N primary caregivers enrolled in HV who received recommended services for depression (and met the conditions specified in the denominator)</td>
<td>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</td>
<td>% 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</td>
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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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