DEPARTMENT OF HEALTH

2024 CQI Goals for Improvement

Updated February 2024

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Introduction

This document summarizes goals of the Minnesota Continuous Quality Improvement (CQI) plan for MIECHV grantees for Federal Fiscal Year 2024, October 2023 through September 2024. The areas of focus chosen this year include family retention and prenatal enrollment as well as decreasing missing data for the Postpartum Care performance measure.

Details about the baseline data are described below as well as a timeline of activities, the SMART aims, and primary drivers and change ideas associated with these aims.

For questions, contact the Family Home Visiting CQI team at health.FHVcqi@state.mn.us.

Goal 1: Improve family retention and prenatal enrollment in family home visiting.

MDH completed a survey of MIECHV LIAs in December 2022. Family engagement and retention was identified as the most chosen topic of importance to local agencies and thus, this was our 2023 topic, with special efforts in the CQI practicum. This year we will keep focus on family engagement and retention, with intention to focus on retention rates at 9-months and prenatal enrollments.

In 2023, we learned:

- Faster face-to-face contact after referral = more likely to enroll.
- More time for rapport building at the first visit could be correlated with remaining enrolled beyond three months.
- Promoting family home visiting with internal and external community partners increases the number of referrals received.
- Incentives being offered improves family engagement.
- Creative events in the community improves family engagement.
- Improving marketing materials, including updating cultural relevance, has a positive effect on family engagement and retention.

Baseline Data

Family Retention

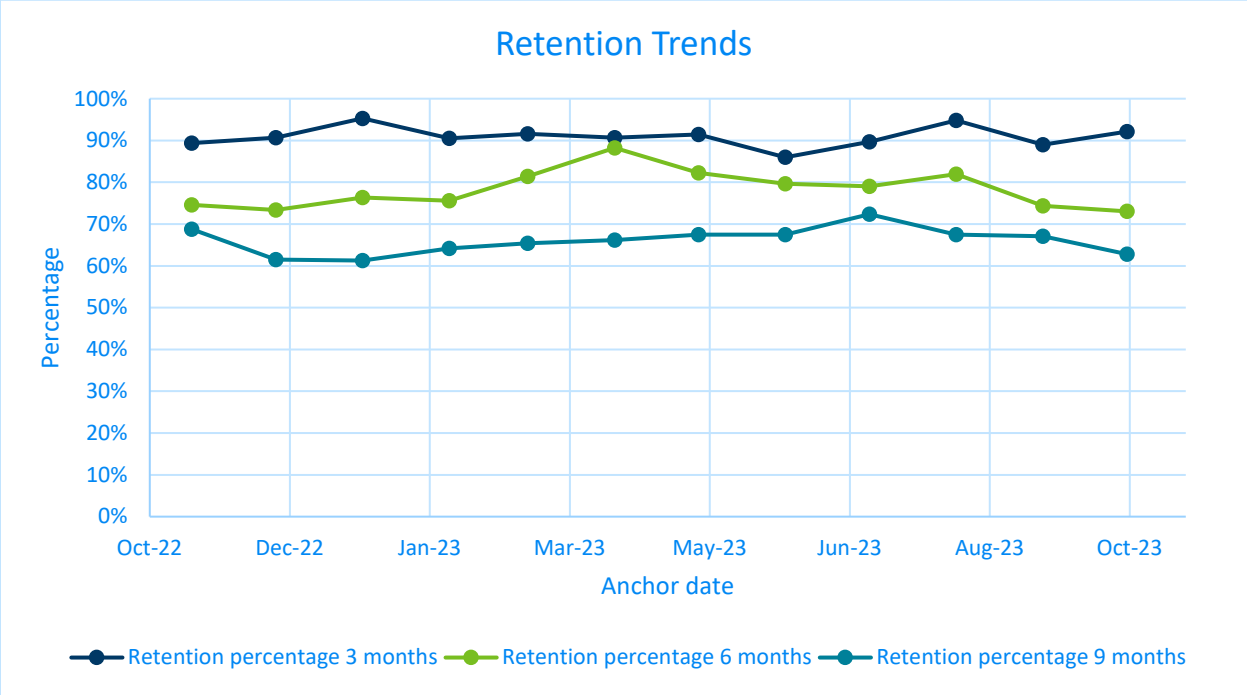
Across all Strong Foundations grantees, there is a slight increase in family retention at 3-months and slight decreases at 6- and 9- months. The percentages are depicted in table 1 below.

Table 1: Strong Foundations Retention Averages

	October 2022	October 2023
3-month retention average	89%	92%
6-month retention average	75%	73%
9-month retention average	69%	63%

The trends over time for all Strong Foundations grantees can be seen in Figure 1 below.

Figure 1: Strong Foundations Retention Trends



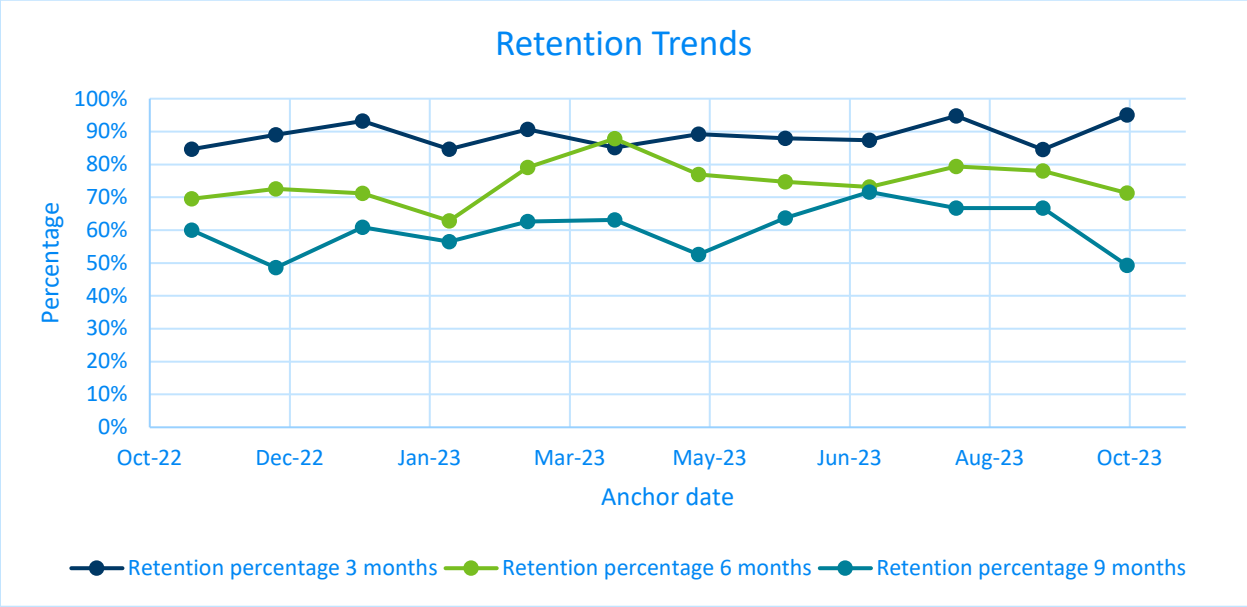
Across MIECHV funded grantees, there is an increase in family retention at 3-months, a slight increase at 6-months, and a significant decrease at 9-months. The percentages are depicted in table 2 below.

Table 2: MIECHV Funded Grantees Retention Averages

	October 2022	October 2023
3-month retention average	85%	95%
6-month retention average	70%	71%
9-month retention average	60%	49%

The trends over time for all Strong Foundations grantees can be seen in Figure 2 below.

Figure 2: MIECHV Grantees Retention Trends



Prenatal Enrollment

From January 2023 through September 2023, across all Strong Foundations grantees, the average prenatal enrollment percentage was 47%. The MIECHV funded grantees prenatal enrollment percentage was 59%.

Goal 2: Decrease missing data for Post Partum Care

FFY2023 data showed a high amount of missing data in some performance measures. HRSA requires MDH to explain any missing data that is above 10%. Of the measures, performance measure five, Postpartum Care, shows one of the highest missing data percentages. The MIECHV IHVE Data Crosswalk document supports this aim by clarifying where this data is coming from in IHVE.

Baseline Data

In FFY2023, Postpartum Care performance measure showed 36.7% missing data. By focusing on this measure, MDH hopes to decrease this by at least 10%.

FFY2024 CQI Timeline of Activities

The timeline for FFY2024 is September 30, 2023 through September 29, 2024.

November 2023:

- Introduction to 2024 CQI Project Webinar
- Review of 2023 CQI Project Outcomes
- Grantees identify interested topics and collect baseline data

Monthly December 2023 – October 2024

- CQI Office Hours hosted by MDH
- Grantees receive retention data reports from MDH
- Grantees implement tests of change and CQI activities
- MIECHV Grantees submit CQI Activities to health.fhvcqi@state.mn.us

Quarterly January 2024 – November 2024:

- Practice Connections check-in with grantees
- Grantees receive prenatal enrollment data and early language and literacy data from MDH

Ongoing December 2023 – October 2024

- CQI Tips and Tricks/Resources via Tuesday Topics
- Individual agency support as needed

November 2024

- CQI Showcase Webinar
- Review of 2024 CQI Project Outcomes
- Introduction to 2025 CQI Project

2024 SMART AIMS

Family Retention and Prenatal Enrollment

By September 30, 2024, families still enrolled in family home visiting at 9 months will increase by 10%.

By September 30, 2024, the percent of primary caregivers enrolled prenatally will increase by 15%.

Data to support this aim

MDH has provided baseline data on retention and prenatal enrollment (above). Ongoing, MDH will provide regular quantitative data related to the following:

- Length of time enrolled.
- Families closed.
- Reasons for closing (primary and secondary).
    - Is this reason intervenable?
- Demographics.
- Number of home visits.
- Percentage of families enrolled prenatally.

Local agencies will also be able to track local data that is important to family retention and prenatal enrollment. Examples of data could be:

- Number of expected visits vs. number of completed visits.
- Time between home visits.
- Time between referral to contact.
- Barriers for families.
- Prenatal referral partners.

How will we get there?

Below are some primary drivers that may assist in reaching our aim for **family retention at 9-months.** Change ideas are included as examples that agencies may choose to try as it is applicable and appropriate with the implemented FHV models.

Primary driver: Competent and skilled workforce

Potential Change Ideas:

- Reflective supervision that encourages home visitors to reflect and manage powerful emotions that often accompany the work
- Provide access to training opportunities, both in-person and virtually
- Utilize Professional Quality of Life tool (ProQol) to assess factors that affect home visiting satisfaction and retention

Primary driver: Client engagement

Potential Change Ideas:

- Program flexibility in time and location of service delivery to meet family preferences
- Utilize comprehensive Family Needs Checklist at regular intervals to continually demonstrate value of the program
- Focus group/follow-up surveys with families that are both in and leaving the program
- Implement a schedule of incentives
- Celebration at 1 year enrollment (and other time points)
- Communication strategies that enhance home visitor-family relationships
- Protocol for addressing missed visits
- Culturally and linguistically appropriate service delivery

Primary driver: Involvement of parents/caregivers

Potential Change Ideas:

- Process for family to meet other team members to increase connection with program staff
- Parents included as members of CQI teams
- Parent-led support groups (e.g., father involvement)
- Program flexibility in time and location of service delivery to meet family preferences
- HV information routinely gathered from families about their needs, personal goals, and expectations of the program; services then provided based on this input
- Update communication strategies (i.e. phone, text, email, mail)

Primary driver: Comprehensive data-tracking

Potential change ideas:

- Review agency and state data on monthly/quarterly basis provided by MDH
- Streamline data systems for data collection and entry

Below are some primary drivers that may assist in reaching our aim for prenatal enrollment. Change ideas are included as examples that agencies may choose to try as it is applicable and appropriate with the implemented FHV models.

Primary driver: Client engagement

Potential change ideas:

- Connect with families face-to-face as soon as possible after referral
- Utilize a process map for referrals
- Utilize other forms of communication to reach referrals (i.e. texting).

Primary driver: Community partnerships

Potential change ideas:

- Regularly communicate with and seek feedback from referral sources
- Seek new referral partners who serve prenatal families
- Utilize libraries and other community organizations to share family home visiting information
- Create process to ensure warm hand-offs
- Produce marketing videos to be use with parents and community partners
- Cultural and linguistically appropriate program brochures

Primary driver: Culturally and linguistically appropriate services

Potential change ideas:

- Provide access to training opportunities, both in-person and virtually
- Reflective supervision that encourages home visitors to reflect and manage powerful emotions that often accompany the work
- Recruit bi-lingual family home visiting staff

Primary driver: Comprehensive data-tracking

Potential change ideas:

- Review agency and state data on quarterly basis provided by MDH
- Streamline data systems for data collection and entry
- Implement a referral tracking tool

Missing Data: Post Partum Care

By September 30, 2024, missing data for MIECHV performance measure five, Post Partum Care, will decrease by 10%.

Data to support this aim

Post Partum Care is MIECHV performance measure five. This data comes from the question on the Child Age Interval form at 3-months of age (which can be completed between ages 2 months and 4 months). The questions that are answered are "Did the child's biological mother have a postpartum visit with a healthcare provider after childbirth?" and "Date of postpartum visit." Baseline data shows that missing data for this performance measure for FFY2023 was 36.7%. MDH will provide agencies with quarterly data of their missing percentage. Person level data will also be included (should consents be in place).

How will we get there?

Below are some primary drivers that may assist in reaching our aim for missing data. Change ideas are included as examples that agencies may choose to try as it is applicable and appropriate with the implemented FHV models.

Primary driver: Standardized policies and procedures for data entry

Potential change ideas:

- Scheduled weekly time for data entry
- Identify Data Steward who is the agency expert
- Conduct regular data quality checks

Primary driver: Competent and skilled workforce

Potential change ideas:

- Review of MIECHV IHVE Data Crosswalk at team meetings
- Training for FHV staff in data entry

Plan-Do-Study-Act (PDSA) Form

Change Being Tested: Gathering direct feedback from clients		
Local Implementing Agency: Small Town USA	**Home Visiting Model:** BEST Model	**Month:** April
Primary Driver: Client Engagement/Involvement of caregivers	**Change Idea:** Supervisor gathers direct feedback from families enrolled in the program	**Cycle #:** 1
Objective of Cycle ☐ Develop a change ☒ Test a change ☐ Implement a change		
Questions we want to answer with this PDSA cycle	**If we….** have supervisors make follow up phone calls after three months of enrollment to gain feedback from participants on their initial services, scaling their engagement level and asking what they see of benefit and what they might want to see changed. **Will it result in….** participants feeling connection to another person in FHV, participants believing that their opinion and feedback matters, and ultimately, participants remaining in home visiting past at least 4 months.	
Predictions	By April 30, supervisors will have feedback from at least 10 FHV participants that will rate level of engagement at that time and show some areas of strengths and potential growth opportunities. Engaging parents in providing feedback will improve their overall engagement to have them remain enrolled at least another month.	
Plan	**Plan for this Test** 1. Who: 2 Supervisors 2. What: Supervisors make contact with 10 FHV participants (5 each) who have been in enrolled approximately 3 months and ask feedback questions 3. How: Via telephone or text or email 4. When: By the end of April 2023 5. Tasks or Tools Needed: Questions to ask: Scaling question, What's going well question, and What could be improved question. Shared excel spreadsheet for tracking purposes.	

	Plan for Collection of Data: 1. Who/What: Supervisors will enter answers received in a shared excel spreadsheet. 2. When: Real time at completion of questions with the participant.
Do	**What happened? Was the test carried out as planned? What did you observe?** Supervisors were able to reach participants, although most were reached best via text message. Supervisors reported feeling improvement in their ability to ask the question using a quality improvement framework the more they became comfortable. **Data:** 9 participants were asked questions. The average rating on the scaling question was 8 (scale of 1-10) for if they are feeling engaged with their home visitor. Feedback was received identifying how families were benefitting from FHV as well as a contradictory theme that some participants wanted more home visits and some wanted less. In June 2023, it was identified that of the 9, 6 remained enrolled (5 months of enrollment).
Study	**How did the data compare to your predictions? What did you learn? What surprised you?** It seems plausible that getting client feedback is correlated with retention. Contacting the participants did take time that the supervisors struggled to find in their schedule so it may be better to use admin staff to support this continuing. We are not sure if caregivers felt comfortable to give honest feedback.
Act ▪ ☒ **Adapt** ▪ ☐ **Adopt** ▪ ☐ **Abandon**	**What changes are to be made to the process (decisions made/action to take/next steps)?** We will allow supervisors or support staff to continue this outreach at 3 months enrollment. We will need to make a plan for how to incorporate feedback into future change ideas. We might also want to think about a more anonymous way to gather information.

Plan-Do-Study-Act (PDSA) Form

Change Being Tested: Improve referral to enrollment by using a creative elevator speech during first contact.		
Local Implementing Agency: Small Town USA	**Home Visiting Model:** BEST Model	**Month:** July
Primary Driver: Competent and skilled workforce to engage families in services	**Change Idea:** Creative script/elevator speech to use for initial outreach call	**Cycle #:** 1
Objective of Cycle ☐ Develop a change ☒ Test a change ☐ Implement a change		
Questions we want to answer with this PDSA cycle	**If we….** If we improve our 'elevator speech' by using a created script for first contact with referrals **Will it result in….** a person meeting with us for the first time.	
Predictions	By July 31, we will see an increase in the number of referrals that enroll in the program.	
Plan	**Plan for this Test** 1. Who: All FHV staff; Intake coordinator to implement. 2. What: FHV staff will together craft a creative elevator pitch for the intake coordinator to use during first contacts with referrals. 3. Where: Unit meeting 6/15/2023 to discuss elevator pitch. Intake coordinator will use via telephone contacts with referrals. 4. When: Intake coordinator will use the elevator speech for the month of July 2023. 5. Tasks or Tools Needed: Excel sheet to track referrals and response received from potential enrollee. **Plan for Collection of Data:** 1. Who/What: Intake coordinator enters data into excel sheet. 2. When: Real time at completion of referral outreach.	

Do	**What happened? Was the test carried out as planned? What did you observe?** The team enjoyed crafting the elevator speech for the intake coordinator to try. The intake coordinator identified feeling comfortable with the elevator speech after reciting it to the referrals that she reached out to during the month of July. **Data:** There were 12 referrals received during the month of July. The intake coordinator was able to successfully reach 8 of those referrals via telephone to recite the elevator speech. Of the 8, 3 enrolled in MECSH during the month of July. This is 25% of the referrals received during that month. The previous month saw 20% referral to enrollment.
Study	**How did the data compare to your predictions? What did you learn? What surprised you?** Referral to enrollment did increase slightly during this month which is what we had hoped for. There is potential that other factors were involved in this as well. Also, the intake coordinator noted that families seemed to ask more questions after the crafted elevator speech than she had remembered from before the script was used.
Act ▪ ☐ **Adapt** ▪ ☒ **Adopt** ▪ ☐ **Abandon**	**What changes are to be made to the process (decisions made/action to take/next steps)?** We do want to continue with this for the remainder of the quarter to see if there continues to be a gain compared to last quarter. We also want to think about how we might use an 'elevator speech' via text or email.