DEPARTMENT OF HEALTH

2025 Continuous Quality Improvement Goals

FEBRUARY 2025

2025 Continuous Quality Improvement Goals

Minnesota Department of Health
Child and Family Health Division
Family Home Visiting Section
625 Robert St N
PO Box 64975
St. Paul, MN 55416-0975
health.homevisiting@state.mn.us
https://www.health.state.mn.us/communities/fhv/index.html

To obtain this information in a different format, call: 651-201-5000.

Contents

Introduction

This document summarizes goals of the Minnesota continuous quality improvement (CQI) plan for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grantees for Federal Fiscal Year (FFY) 2025, October 2024 through September 2025. The areas of focus chosen this year are increasing the number of parent-child interaction (PCI) tools completed and 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 specific, measurable, achievable, relevant, and time-bound (SMART) aims, primary drivers, secondary drivers, and change ideas associated with these aims.

For questions, contact the family home visiting CQI team at health.FHVcqi@state.mn.us.

FFY 2025 CQI timeline of activities

FFY 2025 is Sept. 30, 2024, through Sept. 29, 2025.

- December 2024:
    - Introduction and planning of 2025 CQI project webinar
    - Grantees receive baseline data
- Monthly January – October 2025:
    - CQI office hours hosted by MDH
    - Grantees implement tests of change and CQI activities
    - MIECHV grantees submit CQI activities to health.fhvcqi@state.mn.us
- Quarterly January – November 2025:
    - Practice connections check-in with grantees
    - Grantees receive PCI and missing postpartum care data from MDH
- Ongoing January – October 2025:
    - CQI tips and tricks/resources via Tuesday Topics
    - Individual agency support as needed
- November 2025:
    - Review of 2025 CQI outcomes
    - Introduction and planning for 2026 CQI project

Goal 1: Parent-child interaction

Improve the number of caregivers enrolled in family home visiting who receive an observation of parent-child interaction.

Throughout most of 2024, the Minnesota Department of Health (MDH) and three MIECHV funded grantees have been participating in a Home Visiting Collaborative Improvement and Innovation Network (HV-CoIIN) project related to parent-child interaction (PCI). To continue our learnings and growth in this area, this year's CQI project will focus on MIECHV performance measure 10, the percent of caregivers enrolled in home visiting who receive an observation of PCI by the home visitor using a validated tool.

This measure requires screening within the window of the target age range(s) of the selected validated tool(s). For example, if implementing the Maternal, Early Childhood Sustained Home-visiting (MECSH) model, the PICCOLO is the validated tool that is used.

Baseline data

Across all MIECHV grantees, the completion rate of PCI tools has increased over time; however, this performance measure continues to have a low completion rate across grantees (Table 1).

Table 1: MIECHV PCI completion average

	2023	2024
PCI completion rate (percent)	19%	35%

SMART aim

By Sept. 30, 2025, there will be a 10% increase in the percentage of primary caregivers enrolled in family home visiting who receive an observation of PCI using a validated tool.

Data to support this aim

In December 2024, MDH provided baseline data to MIECHV funded grantees on the PCI performance measure. Ongoing, MDH will provide quarterly data which will include:

- Numerator: Number of primary caregivers enrolled in home visiting who receive an observation of parent-child interaction by the home visitor using a validated tool.
- Denominator: Number of primary caregivers enrolled in home visiting with children reaching the target age range.
- Percent of primary caregivers enrolled in home visiting who receive an observation of PCI by the home visitor using a validated tool for the quarter and cumulatively.
- Person level data will also be included (should consents be in place).

Local agencies will be able to use this data to identify challenges and barriers to those missing a PCI and then brainstorm and implement change ideas to make improvements.

How will we get there?

Reaching an aim can be influenced by a variety of factors, including primary drivers, secondary drivers, and change ideas. Primary drivers are the factors that directly impact the goal. Secondary drivers are smaller factors that impact the primary drivers. Change ideas are tangible ideas to try out to see if they impact the secondary drivers. A sample Plan-Do-Study-Act (PDSA) cycle is included as Appendix A.

Primary drivers

Culturally responsive, supported workforce with capacity to assess, address, and promote parent-child interaction.

Secondary drivers and change ideas

Table 2 lays out several examples of secondary drivers that assist in reaching the aim for parent-child interaction, as well as examples of change ideas that agencies may choose to try as it is applicable and appropriate to each agency.

Table 2: Secondary Drivers and Change Ideas for Goal 1

Secondary Drivers	Potential Change Ideas
Professional development to increase knowledge and strengthen ability to support parent-child interaction.	• Provide education and training to home visitors on early relational health, supportive strategies that caregivers and children can engage in at different ages, and different periods of child development to support nurturing interactions. • Train all staff in understanding implicit bias and the importance of cultural responsiveness when observing and supporting parent–child interactions. • Provide follow-up opportunities (e.g., peer-to-peer role-play, post-training practice) for home visitors to improve their skills and capacity to promote parent–child interaction. • Use reflective supervision to explore and increase home visitor's confidence in conducting caregiver-child assessments.

Secondary Drivers	Potential Change Ideas
Observation and reflection on parent–child interaction during home visits with a validated PCI tool	• Design and use tracking tools that include parent-child observation and feedback within ongoing visits (i.e., standardize visits). • Engage in regular, objective observation of parent–child interaction. Use reflective questions to discuss parent–child interaction during home visits (not only at targeted age groups). • Develop and use scripts to introduce parent-child interaction. • Develop and use scripts to introduce video observation. • Support home visitors in a follow-up process to provide positive feedback and reflection after the home visit. • Schedule a separate visit for just the completion of a PCI tool. • Use reflective supervision to share results of parent-child interaction observations.
Active engagement of caregiver with child during home visits.	• Invite caregivers to give their own observations of their interactions and relationship with their child. • Give caregivers an opportunity to observe their own parent–child interactions by having them review video observations. • Engage with caregivers to help keep focus on interacting with the child and guiding the focus back to the child during the visit. • Develop an orientation for families focused on their role as their child's most important teacher.

Note: Some drivers and change ideas listed above were created by the HV-CoIIN team of the Educational Development Center and adapted from the HV-CoIIN project related to caregiver-child interaction.

Goal 2: Data for postpartum care

Decrease missing data for postpartum care.

FFY 2024 data showed a high amount of missing data in some performance measures. Having quality data is important to celebrate the impact of home visiting and to ensure continued funding. The Health Resources and Services Administration 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. This performance measure includes the percent of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within eight weeks (56 days) of delivery.

Baseline data

In FFY 2024, postpartum care performance measure showed 33% missing data. By focusing on this measure, MDH hopes to decrease this to 20%.

Data will be counted as missing if:

- The answer to "Did the child's biological mother have a postpartum visit with a healthcare provider after childbirth?" is yes, but the postpartum visit date is not noted.
- "Unknown/unsure" is answered for the first question (from the client perspective).
- "Not answered at this visit" is charted.
- "Client declines to answer" is charted.

SMART aim

By Sept. 30, 2025, missing data for MIECHV performance measure five, postpartum care, will decrease from 33% to 20%.

Data to support this aim

Postpartum care is MIECHV performance measure five, the percent of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within eight weeks (56 days) of delivery.

The numerator for this measure includes: the number of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within eight weeks (56 days) of delivery.

The denominator for this measure includes: the number of mothers who enrolled in home visiting prenatally or within 30 days after delivery and remained enrolled for at least 8 weeks (56 days) after delivery.

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." The MIECHV IHVE Data Crosswalk document is available to clarify where this data is coming from in IHVE.

Baseline data shows that missing data for this performance measure for FFY 2024 was 33%. MDH will provide agencies with quarterly data of their missing percentage. Person level data will also be included (should consents be in place). Local agencies will be able to use this data to identify reasons for missing data and then brainstorm and implement change ideas to make improvements.

How will we get there?

Reaching an aim can be influenced by a variety of factors, including primary drivers, secondary drivers, and change ideas. Primary drivers are the factors that directly impact the goal. Secondary drivers are smaller factors that impact the primary drivers. Change ideas are tangible ideas to try out to see if they impact the secondary drivers. A sample Plan-Do-Study-Act (PDSA) cycle is included as Appendix B.

Primary drivers

Complete and accurate performance measure data.

Secondary drivers and change ideas

Table 3 lays out several examples of secondary drivers that assist in reaching the aim for missing postpartum data, as well as examples of change ideas that agencies may choose to try as it is applicable and appropriate to each agency.

Table 3: Secondary Drivers and Change Ideas for Goal 2

Secondary Drivers	Potential Change Ideas
Standardized policies and procedures for data entry	• Schedule weekly time for data entry. • Identify Data Steward who is the agency expert. • Conduct regular data quality checks.
Competent and skilled workforce	• Review of MIECHV IHVE Data Crosswalk at team meetings. • Training for FHV staff in data entry. • Following up with caregiver while charting, if necessary, data did not get asked at a home visit. • Enter *estimated* date of the postpartum visit. **Accept that it is okay to not be the exact date.** • During home visits, support caregivers to look at their medical records to locate the date of their postpartum visit.

Appendix A: Plan-Do-Study-Act (PDSA) Form for Goal 1

Change Being Tested: Develop and Use Script to Introduce Video Observation

Month: February 2025	**Local Implementing Agency**: Small Town USA **Home Visiting Model**: BEST Model
Cycle #: 1	**Primary Driver**: Culturally responsive, supported workforce with capacity to assess, address, and promote caregiver-child interaction. **Secondary Driver**: Observation, description of and reflection on caregiver–child interaction during home visits with a validated PCI tool.
Objective of Cycle	☐ Develop a change ☒ Test a change ☐ Implement a change
Questions we want to answer with this PDSA cycle	**If we**….develop and use a script to introduce the PICCOLO observation tool with a family…. **Will it result in….** ▪ Caregivers feeling more comfortable to agree to the video observation, and ▪ Family home visiting staff feeling more confident at introducing the PICCOLO tool.
Predictions	By creating a script for home visitors to use, home visitors will experience more confidence in introducing the PICCOLO tool so that they will be able to keep this a priority when needed, scoring a 4 on a scale of 1-4. By feeling more confident in the delivery of the introduction of the tool, caregivers will better understand and agree to using the tool at an increased percentage, three out of five times.
Plan 1. **Who** 2. **What** 3. **Where** 4. **When** 5. **Tasks/Tools Needed** **Data Collection**	**Plan for this Test:** 1. **Who**: Team and one family home visitor 2. **What**: Team will create the script in reflective supervision on Feb. 3. Char will use script during her visit on Feb. 5. 3. **How**: In-person during the home visit 4. **When**: Feb. 5 5. **Tasks/Tools Needed**: Script to introduce PICCOLO. 5-point scaling question on confidence of introducing based upon use of the script.

	Plan the Collection of Data: After the visit, Char will document yes or no in the family's chart of whether the PICCOLO was completed in the home visit. After the visit, Char will answer the following question here: On a scale of 1-5, with 5 being high, did using the script support you in experiencing more confidence in introducing the PICCOLO tool?
Do	**What happened? Was the test carried out as planned? What did you observe?** Char was able to introduce PICCOLO using the script on Feb. 5. The family did not want to use a video observation tool. **Data**: Char identified a 3 on the scale of confidence and noted that using the script for the first time was a bit more challenging than anticipating, likely because of needing more practice.
Study	**How did the data compare to your predictions? What did you learn? What surprised you?** The script did not help in getting this one family to say yes to completing the PICCOLO; however, it could be that the family home visitor Char wasn't comfortable with the script.
Act ▪ ☒ Adapt ▪ ☐ Adopt ▪ ☐ Abandon	**What changes are to be made to the process (decisions made/action to take/next steps)?** Char will practice in supervision and then try the script again with two more families to run this PDSA again.

Appendix B: Plan-Do-Study-Act (PDSA) Form for Goal 2

Change Being Tested: Following Up with Caregiver While Charting When Noticing Necessary Data Did Not Get Asked at a Home Visit

Month: Quarter 1, 2025	**Local Implementing Agency**: Small Town USA **Home Visiting Model**: BEST Model
Cycle #: 1	**Primary Driver**: Complete and accurate performance measure data in family home visiting. **Secondary Driver**: Competent and skilled workforce
Objective of Cycle	☐ Develop a change ☒ Test a change ☐ Implement a change
Questions we want to answer with this PDSA cycle	**If we**…. Follow up with the caregiver while charting when we notice that necessary data did not get asked at a home visit **Will it result in**…. enabling the family home visitor to have the required information to enter about postpartum care.
Predictions	Following up with the caregiver after the home visit to answer the postpartum care questions will decrease our missing data for the first quarter of 2025 by 10%.
Plan	**Plan for this Test:** 1. **Who**: All family home visitors 2. **What**: When a family home visitor realizes they do not have the answer and date for the postpartum care question, the home visitor will call/text the caregiver and ask for the information. 3. **Where**: EHR 4. **When**: Home visits that occur in quarter one 2025 when target child is between 2 months to 3 months, 30 days old. 5. **Tasks/Tools Needed**: EHR, Target-Child 3-month Age Interval form, telephone. **Plan for Collection of Data:** 1. **Who/What**: Data analyst will review updated data from MDH. Staff will provide updates at if they need to make a follow up call/text. 2. **When**: April 2025

Do	**What happened? Was the test carried out as planned? What did you observe?** There were 15 home visits that occurred in the first quarter for target children aged 2 months to 3 months, 30 days. During 11 of these visits, the family home visitor completed the 3-month age interval form in entirety, leaving four times needing a follow up call/text. Three of the caregivers provided the information over the phone while one did not reply. **Data:** 2024 data showed that we had 36% missing data for the postpartum care performance measure. For Q1 2025, data from MDH showed that for Q1, we had 33% missing data for the postpartum care measure.
Study	**How did the data compare to your predictions? What did you learn? What surprised you?** We didn't meet our goal of reducing by 10%, but we did decrease by 3%. 75% (three out of the four) caregivers responded to the follow up phone/text. Staff reported that the call/text was an easy thing to remember and did not take too much time.
Act ▪ ☐ Adapt ▪ ☒ Adopt ▪ ☐ Abandon	**What changes are to be made to the process (decisions made/action to take/next steps)?** We will adopt this change idea and continue implementation. We will plan a new PDSA cycle with a change idea to decrease the 3-month age interval forms that are missed being completed at all.