MIECHV FOCUS

Second Quarter of 2013/2014 Cycle
Continuous Quality Improvement (CQI) Newsletter

Winter is a subtle nudge to remind us to reflect on our lives. Though we are surrounded by the chill in the air, it is also an exercise in cleansing. With each snowfall, we are given a clean slate with the innocence and beauty the white power brings. - Mark A. Leon

January 2014

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February 2014

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March 2014

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1st Level CQI
All Level 1 Teams meet
Between January 13-24

2nd Level CQI
February 5, 2014
1:00-2:30
Toll free 866-630-9348

3rd Level CQI
March 10, 2014
1:00-2:30
DHSS
Wild Pine A
Toll free 866-630-9348

Year Two Data Submission – Successes and Challenges

On October 30, the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program submitted required data collected from October 1, 2012 through September 30, 2013 to the United States Department of Health Resources and Services Administration (HRSA). The first attachment to the newsletter contains feedback and questions from HRSA. In the attachment, several areas of success in meeting the definition of improvement listed in the Missouri Benchmarks and Constructs Data Elements plan are listed. Following these successes, are areas we need your input on regarding plans for improvement; therefore, each benchmark/construct has an "Action Alert" for you to discuss at Level One and Level Two.

We Have Data – Now What?

State MIECHV staff attended the Region VII and VIII MIECHV Regional Forum held in early December in Kansas City. States in Region VII are Missouri, Kansas, Iowa and Nebraska. States in Region VIII are North Dakota, South Dakota, Wyoming, Montana, Colorado and Utah. During the forum, one session focused on this question: We have data - now what? The MIECHV program has been created to provide voluntary, intensive home visiting services to families identified most in need. That is the most important purpose of the program. However, to document the differences early childhood home visiting makes in families lives and to support sustainability of these services, data is a necessary component. Each state has been required by the grant to develop a Benchmark Plan to address areas which will impact maternal and child health indicators. HRSA requires states to report progress on benchmarks and constructs in aggregate form. This is being requested to support the belief that home visiting (not model specific, but home visiting services as a whole) makes a difference in the lives of children and families. However, individual program data should be used to drive agencies toward a continuous process of evaluation to realize where data assists in proving successes and identifying areas where improvements can be made.

There were two purposes to the discussion which occurred during this session at the Regional Forum:

1. Outline broad ideas about the use of data and its capacity to strengthen Early Childhood and Home Visiting Systems at both the state and local level; and
2. Provide examples of how data can be applied to strengthen home visiting.

The following ideas/examples help in strengthening state and local level Early Childhood and Home Visiting Systems as well as strengthening home visiting programs in general:

Program Implementation:

1. Increases accountability at all levels;
2. Monitors and evaluates outcome standards (e.g. Benchmarks);
3. Monitors fidelity and model standards;
4. Evaluates program processes such as referral, enrollment and retention;

5. Evaluates the service delivery process;
6. Enhances up to date (real time) knowledge about the service population;
7. Improves competency development;
8. Draws attention to the need for continuous quality improvement;
9. Helps identify or modify policies and practices; and
10. Assists with the recruitment and retention of a highly qualified workforce.

Internal examples for leveraging data include the following:

1. Recruiting and retaining a qualified workforce;
2. Use of family risk factor data to determine current gaps in your workforce;
3. Regular communication of aggregate data about individual and organizational accomplishments;
4. Incorporating enrollment and retention data as a part of case supervision to enhance core competencies of home visiting services;
5. Incorporating data variables in job announcements to attract a larger and more qualified pool of applicants when needed;
6. Training and Staff Development:
   a. Using family risk factor data and competency assessment data to inform the annual training plan or strategic planning process (each agency has a different name for this same process);
   b. Using competency assessment data of individual employees to identify gaps and assist with the selection of targeted training activities to address the areas data indicates there is a need for improvement.
7. Service Delivery:
   a. Using data centered on barriers to family goal accomplishment for example, substance abuse and mental health screening data to inform service delivery processes;
   b. Using referral data to understand or map the current network of services and identify where additional connections need to be formed; and
   c. Connecting referral data and family assessment data to assess the relationship between family needs and referrals made by the program.

External examples for leveraging data include the following:

1. Keeping community partners informed about the program and system activities; Bringing a small set of program data to each community level meeting to hand out as a supplemental source of information when giving an agency update;
2. Using data sets that are easy to digest in newsletters;
3. Using quotes, videos and success stories to combine with other data sets to connect with broader audiences; and
4. Strengthening communication goals and messaging through the use of powerful data variables in all publications or program materials.

Connecting with and engaging community partners:

1. Connecting your data with community partner priorities to develop shared resources, goals and a shared agenda (for example, to increase referrals to a program you can bring data showing a high rate of prenatal visits once a family enrolls in services to physicians a the prenatal clinic or hospital);
2. Connecting your data with other systems – beginning a process of developing shared outcomes; and
3. Leveraging your home visiting data to advocate for other services in the community – making your data meaningful to a larger process.

In summary, without analyzing and discussing data, home visitors are far less likely to identify and solve the problems that need attention, apply appropriate interventions to the concerns that need to be addressed the most, or know how they are progressing toward achievement of goals (Killion and Bellamy, Journal of Staff Development, Winter 2000).

Action Alert: **Does your agency use data in any of the above listed ways? What are additional ways your**

agency might consider using data? Does your agency need technical assistance to maximize your understanding and use of data? If so, please prepare a list of specific examples of technical assistance your agency would like to learn more about and submit to Beth Stieferman at Beth.Stieferman@health.mo.gov by January 30, 2014.

Resources

1. **The Prevalence of Bed Bugs**
   The Department of Health and Senior Services (DHSS) has provided information regarding the common bed bug including steps that can be taken if bed bugs are discovered along with possible resources. The memo number is PM-14-07 and can be found at this link: http://health.mo.gov/seniors/hcbs/ihsmemos.php. Any questions should be directed to the Bureau of Program Integrity at programintegrity@health.mo.gov or by calling 573-526-8557.

Success Stories

The following success stories came from Delta Area Economic Opportunity Corporation (DAEOC) in Pemiscot and Dunklin counties:

1. Families expressed to the DAEOC Supervisor that they were really impressed with the new home visitors (teachers) because they keep the children's attention and they look as if they are very comfortable with the families. One mother's exact words were "it was like the home visitor was one of the family".

2. A home visitor (teacher) has consistently encouraged one of her parents to attend college and helped get her enrolled. The parent starts school in January 2014 and plans to be an Early Childhood Education teacher. The parent is very excited about it!

3. One mother is in her second semester of college getting her degree in Criminal Justice to be a police officer. The home visitor (teacher) had concerns about the mother's son because he had no facial expressions and would hardly speak to anyone. The home visitor referred this family to Conscious Discipline Trainings. The trainer from Conscious Discipline Trainings went out and did a home visit with this family and showed the mother a few things she could do with her children. Since that intervention, the mother picked up on the techniques taught to her and has used Conscious Discipline in her home on a daily basis and the little boy's behavior and communication with people has completely turned around. The home visitor states, "it is like he is a totally different child".

Thank you for sharing your great success stories DAEOC!

List of Attachments

1. HRSA's feedback and questions regarding Year Two MIECHV Data (includes ***Action Alerts***)

2. Taking Care of Yourself

3. New Journal Supplement Highlights Emerging Science in Home Visiting, Calls for Close Coordination of Home Visiting and Family-Centered Medical Homes

4. Revised template for Level One Activity Log

5. Revised template for Level Two Activity Log

Final Notes and Reminders

The call-in number for the Level Two CQI meeting on February 5, 2014 from 1:00 p.m. to 2:30 p.m. is toll-free (866) 630-9348. The Level Three CQI meeting on March 10, 2014 will be held at the Department of Health & Senior Services, 930 Wildwood, Wild Pine A, Jefferson City, MO from 1:00 p.m. to 2:30 p.m. the toll-free number is (866) 630 -9348.

For Level One Teams, remember to submit your detailed activity log and meeting minutes to Kayla Turner at k.turnerehshv@hotmail.com and Beth Stieferman at Beth.Stieferman@health.mo.gov by January 27.

For the Level Two team, please submit your detailed activity log and meeting minutes to Beth Stieferman at Beth.Stieferman@health.mo.gov by February 17.

Action Alert: **Beginning with the second quarter (January-March 2014), Level One and Level Two teams should complete the attached revised templates electronically along with any additional meeting minutes you wish to submit. Because there are external partners participating at Level Three, such as State Steering Committee members, please remember to reference your Level One teams as "Level One" not "Program Level" and Level Two minutes should be referenced as "Level Two" not "Local Level." Consistent labeling of CQI levels and program names makes it easier for all members of the Level Three team to have a better understanding of Level One and Level Two teams. All activity logs and supplemental meeting minutes are to be submitted electronically via e-mail only.**

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