Continuous Quality Improvement
Intro to **CQI**

**JULY 11TH 2019 - HOME VISITING SERVICES ACCOUNT (HVSA)**
Agenda

- Please mute your phones 😊
- What is Continuous Quality Improvement (CQI)?
- CQI Building Blocks
- CQI Tools
- SFY20 HVSA CQI Learning Collaboratives
- Q + A
What is CQI?

MODEL FOR IMPROVEMENT

CULTURE OF QUALITY
Continuous Quality Improvement (CQI)

CQI is a systematic and iterative process that connects programmatic data to practice and seeks to identify changes that result in significant improvement.

“One can describe CQI as an ongoing cycle of collecting data and using it to make decisions to gradually improve program processes.”

http://www.hhs.gov/ash/oah
What is CQI?

- Data-driven
- Understanding processes/systems
- Changing systems, not people
- Iterative/continuous adjustments as you go
- Framework to promote quality, innovation, and program reflection
The Model for Improvement

What are we trying to **accomplish**?

- Set a SMART aim or goal

How will we know if a *change* is an improvement?

- What can we measure to detect and understand improvement – *not all change is improvement*

What changes can we make that will result in improvement?

- PDSA – rapid, small-scale tests/experiments of change

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Why is **CQI** important for Home Visiting?

- Creates a feedback loop between **data** and **practice**
- Improve services/outcomes for **families**
- Draws on **expertise** across home visiting (including parents, home visitors, supervisors, etc.)
- Addresses the **unique and diverse** needs of families in different contexts
- Identify and disseminate **best practices**
## Quality Assurance vs. CQI

<table>
<thead>
<tr>
<th>Quality Assurance (QA)</th>
<th>CQI</th>
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</thead>
<tbody>
<tr>
<td>Reactive/Retrospective</td>
<td>Proactive</td>
</tr>
<tr>
<td>Meeting expected standards</td>
<td>Best possible</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Constantly working to meet or exceed standards</td>
</tr>
<tr>
<td>Focused on compliance</td>
<td>Focused on outcomes</td>
</tr>
</tbody>
</table>

_Both are necessary –_

QA is an important tool for monitoring if a system is functioning as intended, when used in conjunction with CQI our focus shifts to improving services to achieve the best possible outcomes for families.
Cultivating a Culture of **Quality**

- Impact of current culture
- Attitude
- Transparency
- Commitment
- Data use/comfort
- Outcomes
Culture of Quality

- Current Culture
- Outcomes
- Data
- Transparency
- Commitment
- Attitude
Culture of Quality

- Current Culture
- Attitude
- Transparency
- Commitment
- Data
- Outcomes
Culture of Quality

Outcomes

Current Culture

Attitude

Data

Transparency

Commitment
CQI Team

- Home Visitors
- Parents (current or graduated)
- Community Partners
- Data Support
- Supervisors
- Delegate
- Divide and concur
Questions?
CQI Building Blocks

SMART AIMS
MEASURES
PLAN-DO-STUDY-ACT (PDSA)
PDSA RAMPS
SMART Aims

Measurable
Relevant

Specific
Attainable
Time-bound

“Some is not a number, soon is not a time”

Don Berwick, Institute for Healthcare Improvement (IHI)
SMART Aims

**Specific** - Who, what, where, when, which, why?

**Measurable** - How can it be measured? Does your measurement allow you to see progress?

**Achievable** - Aim should be a stretch/challenge, but also attainable

**Relevant** - How does this goal tie to your practice? Aligned to mission/broader objectives?

**Time-Bound** - As specific as possible, realistic and attainable – provides some boundaries
SMART Aims

By ________, ________ of ________ will ________

(When) (#, %, or % Change) (Who) (What result, change, benefit?)

Examples:

By June 30, 2020, 90% of clients who screen positive for IPV will receive a referral or connection to resources.

By Dec 31, 2019, 60% of clients will receive 80% of expected visits.
SMART Aim Quiz

A. Our team will improve how we address intimate partner violence  

B. This year, we will increase the number of referrals to domestic violence services for families who have a positive IPV screening.  

C. By June 30\textsuperscript{th}, 2020, we will increase the % of families who screen positive for IPV who are provided a referral from 50\% to 75\%.  

A: X
B: X
C: ✓
Measures

Track overall progress towards our AIM
May include outcome measures and process measures

Example: **IPV** - By June 30, 2020, 90% of clients who screen positive for IPV will receive a referral or connection to resources.

- **Outcome Measure:**
  - % of caregivers experiencing IPV who have received a referral to DV resources

- **Process Measures:**
  - % of caregivers screened for IPV within 6 months of enrollment
  - % of caregivers screened for IPV who screened positive
Plan-Do-Study-Act (PDSA)

- Cyclical, iterative process for testing changes
- Structured and reflective process
- Document predictions, actions, and learnings
- Intuitive process -
  - Identify a change
  - Put it into action
  - Reflect on the results
  - Use those reflections to decide on next steps
## Plan-Do-Study-Act (PDSA)

| Plan      | • Develop a plan to test the change - (Who? What? When? Where?)  
|           | • Create a plan for data collection  
|           | • Complete *tasks* for test |
| Do        | • Carry out the test  
|           | • Document problems and unexpected observations  
|           | • Collect data |
| Study     | • Compare the data you collected to your prediction  
|           | • Summarize and reflect on what you learned from the data/process |
| Act       | • Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don’t do another test on this change idea)  
|           | • Prepare a plan for the next PDSA |
PDSA

Plan
- Objective
- Prediction
- Plan to carry out the test
- Plan for data collection

Do
- Carry out the test
- Document problems and unexpected observations
- Collect data

Study
- Compare the data you collected to your prediction
- Reflect on what you learned from the data/process

Act
- What changes need to be made
- Next PDSA Cycle?
- Adopt, Adapt, Abandon
PDSA Video

https://www.youtube.com/watch?v=szLduqP7u-k
PDSA - Guiding Principles

- Start very small
- The “Power of 1”
- Just enough data – keep it simple but clear
- Task vs. Test
Why do we “test” through PDSAs?

- Will the change lead to improvement we desire?
- Small tests allow for failure, with minimal costs
- Encourage innovation and creativity
- Builds belief in changes that work
- “Proof of concept”
- Evaluate how a change may differ between families, home visitors, communities, etc.
Project Topic: Drink More Water

<table>
<thead>
<tr>
<th>AIM:</th>
<th>By July 30th, increase water consumption from 5 cups to 8 cups of water a day.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change test:</td>
<td>Add lemon to water</td>
</tr>
<tr>
<td>Plan</td>
<td>Add sliced lemons to at least 2 glasses of water on Mon. Task: slice lemons Prediction: adding lemon will make water more exciting</td>
</tr>
<tr>
<td>Do</td>
<td>Drank 3 glasses of water with 1 lemon slice each</td>
</tr>
<tr>
<td>Study</td>
<td>Drank 6 glasses total, 3 with lemon. Lemon tasted refreshing and easy to drink</td>
</tr>
<tr>
<td>Act</td>
<td>Adapt – try adding fruit again tomorrow, test different flavor (like orange or cucumber)</td>
</tr>
</tbody>
</table>

Change Ideas:
- Carry a water bottle
- Add fruit/mint to water
- Set an alarm on phone
- Use a water tracking phone app
- Keep a full water pitcher at desk
- Start every morning with a glass of water
# PDSA – Home Visiting Example

## Project Topic: Intimate Partner Violence

| **AIM:** | 90% of caregivers with identified IPV are offered supports or services aligned with their self-identified needs and priorities |
| **Change test:** | Testing new Healthy Relationship Education tool |
| **Plan** | One home visitor (Sarah) will test introducing new Healthy Relationship Education tool at one home visit this week  
Data Collection: Ask client two questions -  
“On a scale of 1-5 (5 = very helpful), how helpful was this information”  
“Did you learn anything new?” |
| **Do** | Sarah introduced Healthy Relationship Education tool at home visit with one family, |
| **Study** | Client response: 5; learned that IPV isn’t just physical violence |
| **Act** | Adapt – Test tool with 2 additional clients, test using a script to guide the conversation |
PDSA Ramps

- Iterative process – building on each PDSA
- Building on what we’ve learned, making adjustments, testing new iterations
- Testing under different conditions
- Generating trust/buy-in that the change is working
- Example: Perfect Grilled Cheese
PDSA Ramp Example

What makes a perfect grilled cheese sandwich?

- What type of bread?
- What type of cheese?
- Technique?
- Slicing?
- Secret ingredient?
## PDSA Example

<table>
<thead>
<tr>
<th>PDSA – Cycle 1.1</th>
<th>PDSA – Cycle 1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan</strong></td>
<td>Test: make one sandwich, butter on outside, wheat bread, cheddar cheese</td>
</tr>
<tr>
<td></td>
<td>Data collection: survey taste testers: rate sandwich on scale of 1-5, “What would make this sandwich better?”</td>
</tr>
<tr>
<td><strong>Do</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Study</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Act</strong></td>
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PDSA Ramp Example – Home Visiting

PDSA Ramp 1: Healthy Relationship Education Tool

Cycle 1.1
Test: One HV Introduce new Healthy Relationship Tool with one family

Cycle 1.2
Test: HV use Healthy Relationship Tool with 2 additional families (one teen parent); test script to guide conversation

Cycle 1.3
Test: 2 HVs test with 3 additional families using script; add question to get client feedback
Questions?
CQI Tools

- Key Driver Diagram
- Process Maps
- Root Cause Analysis
- Run Charts
Key Driver Diagram

Visualize our *Theory of Change*
Three components – Primary Drivers, Secondary Drivers, and Change Ideas

**Primary Drivers**
- The key (primary) factors that are necessary to achieve improvement

**Secondary Drivers**
- Influencers/components of primary drivers

**Changes/Strategies**
- Link the activities/changes that lead to achievement of our goal
### Key Driver Diagram - Example

<table>
<thead>
<tr>
<th>Aim</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>Change Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% of caregivers with identified IPV are offered supports or services</td>
<td>1. Competent, supported, and trauma-informed workforce</td>
<td>1. Culturally responsive, universal education on healthy relationships</td>
<td>• Use a script when asking sensitive questions, providing education, or introducing educational materials</td>
</tr>
<tr>
<td></td>
<td>2. Safe and respectful conversations on healthy relationships and screening for IPV</td>
<td>2. Timely and reliable IPV screening</td>
<td>• Provide home visiting-specific safety cards or healthy relationship educational resources</td>
</tr>
<tr>
<td></td>
<td>3. Comprehensive, tailored, and collaborative “safer planning” and follow-up</td>
<td>3. Empathic response to a positive IPV screen or caregiver disclosure of IPV</td>
<td></td>
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<td></td>
<td>4. Community partnership and connection to services</td>
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Key Driver Diagrams

- Serves as a road map
- Test changes across the driver diagram (but not all at the same time)
- Breaks big goals into manageable pieces
Process Mapping

- Similar to a “flow chart” or “decision tree”
- Maps all steps and decision points in a process
- Map current or ideal processes
- Team learning – creating shared understanding
- Helpful in identifying where in the process to intervene
Process Map Examples
Root Cause Analysis - Fishbone

Fishbone Diagram (Cause and Effect Diagram)
- Visually chart the root causes of a problem
- Focus on diagnosing the problem rather than symptoms

A fishbone diagram contains 3 primary elements:

**Backbone**: connects to the problem or question being addressed

**Ribs**: Main factors/categories involved

**Bones/Branches**: Identify potential causes/contributing factors
Root Cause - Fishbone

- Low IPV screening rates
  - Partner is always present during visit
  - Fear related to CPS
  - Families with undocumented status
  - Families Comfort and Safety
  - HV Comfort, Confidence, Competence
  - Access/Availability of DV Services
  - Fear related to CPS
  - Low IPV screening rates
Run Charts

- Track data over time
- Measure/assess improvement
- Understand normal variation
- Annotation helps highlight the potential impact of PDSAs
- Statistical analysis at a glance
Run Chart Example – IPV Screening

% of caregivers enrolled in Home Visiting screened for IPV within 6 months of enrollment

- Median
- Goal

Implemented change
Questions?
Since SFY18 –

- HVSA Programs completed 2 individually-led CQI projects each year (6 mo. project cycles)
- Teams could choose from a menu of topics:
  - Family Engagement
  - Caregiver Depression Screening and Referral
  - Intimate Partner Violence Screening and Referral
  - Parent-Child Interaction (SFY18)
  - Developmental Screening (SFY19)
**HVSA CQI Examples**

<table>
<thead>
<tr>
<th>Caregiver Depression</th>
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<tbody>
<tr>
<td>• Make connections with local mental health providers to facilitate warm referrals</td>
</tr>
<tr>
<td>• Comprehensive list of mental health referral sources in the community</td>
</tr>
<tr>
<td>• Flow-chart to support home visitors with screening and referral process</td>
</tr>
<tr>
<td>• Focus on wellness and self-care as part of home visits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intimate Partner Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify and make connections with local DV Advocacy Agencies</td>
</tr>
<tr>
<td>• Plan in-person connection with local DV advocates</td>
</tr>
<tr>
<td>• Invite DV advocates to participate in team meetings or case conferencing</td>
</tr>
<tr>
<td>• Healthy relationship education</td>
</tr>
<tr>
<td>• Create a comprehensive list of domestic violence referral sources in the community</td>
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### HVSA CQI Examples

#### Family Engagement

- Creating consistent feedback loops with referral providers
- Identify one person (i.e. Supervisor) to make first contact with referred clients
- Create a script for home visitors/supervisor to use when contacting referred clients
- Contact referrals within 2 business days
- Pop-up outreach events in the community (library, parks, community events)
- Parent leadership opportunities

#### Parent-Child Interaction

- Provide parent-child interaction/learning ideas for parents
- Create a parent-child interaction log sheet (encouraging parents to post it somewhere where they see it every day)
- Shift vocabulary/language used by home visitors when talking about reading – “exploring books”
- Creating a lending library
- Incorporating a question/focus on literacy or parent child interaction during each home visit
HVSA CQI Learning Collaboratives

*Shifting our approach* >> From individually-focused projects to a *collaborative learning process*

- One year-long project
- Two topic tracks:
  - Caregiver Depression
  - Family Retention

The “Why”

- Engage more deeply with subject matter experts
- Leverage our collective learning and efforts
- Focus on **rapid cycle testing** (PDSA Reports due monthly - beginning in January)
- Common metrics to detect improvement, and understand what contributed to improvement
HVSA Learning Collaboratives

Breakthrough Series Learning Collaborative Model:

- **Topic Selection**
  - Two Topic Tracks
  - Prework: July - October
  - Learning Session 1: November
  - Learning Session 2: April
  - Action Period 2 (PDSAs): May - June
  - Learning Session 3: June/July

Wrap-up Questions

- Lingering questions?
- Anything you want to revisit?
- What do you hope to learn more about?
Thank You!

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