2014

Michigan's MIECHV CQI Plan

Continuous Quality Improvement Plan for the Michigan Maternal, Infant, and Early Childhood Home Visiting Program – Version 1.5

Michigan Department of Community Health

& Michigan Public Health Institute

Michigan's CQI Plan Overview

Michigan is required to implement a Continuous Quality Improvement (CQI) Plan as a part of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. Quality improvement (QI) is a systematic approach to specifying the processes and outcomes of a program or set of practices through regular data collection and the application of changes that may lead to improvements in performance. QI is a method that has been proven effective at improving performance and outcomes in a variety of settings. Through Michigan's MIECHV Program, CQI methods and tools will be used by State, local, and provider site[1] teams to improve the home visiting system within the State to ensure that programs are delivered with model fidelity and are meeting legislatively mandated Benchmarks over time.

Research suggests that CQI is most effective when it takes place in a culture of quality. A culture of quality is characterized by:

- Embracing an attitude that values learning and improvement;
- Using data to set targets and track changes over time;
- Working as a team to review data, understand root causes, and test improvements;
- Analyzing work processes to find opportunities to make progress toward targets;
- Looking to best practices to find opportunities to make progress toward targets; and
- Possessing the necessary training and leadership support to engage in CQI.

Michigan's MIECHV Program will work to create a culture of quality throughout the home visiting system by working with each MIECHV funded home visiting program in the State on using CQI methods and tools and building a culture of quality. Michigan's goal is to bring the State home visiting system as a whole, as well as individual local programs, to the point where they use CQI on a regular, ongoing basis in a culture of quality.

Several specific strategies will be employed to build a culture of quality throughout the home visiting system in the State. Specifically, the following strategies will be used:

- Two-day, in-person, hands on Kick Off Training on CQI methodology and tools for all sites involved in Michigan's MIECHV Program as well as the State and local Teams;
- Quarterly teleconferences/webinars bringing all sites (Provider Site and State Teams) together to provide just in time training on CQI methodology and tools as well as engage in peer learning;
- Annual Learning Collaboratives composed of Provider Site teams working toward a common improvement goal in order to address areas in the legislatively mandated Benchmarks where the State as a whole needs to make an improvement;
- Ongoing technical assistance on CQI methodology and tools;
- Regular CQI data reports designed to support CQI around common Benchmarks with all sites;
- Sharing of projects and results across sites via story boards as well as the program SharePoint site;
- Annual in-person CQI Learning Meeting with all sites; and

[1] The term 'provider site' refers to local agencies implementing a home visiting model.

- Sharing State averages on Benchmarks with all sites, moving toward greater transparency across agencies and with the State while empowering agencies to drive their own improvement efforts and celebrating their work.

Michigan's Plan for CQI involves four components:

1. Establishing state, local, and provider site-level CQI teams
2. Developing the capacity to ensure data availability and access
3. Monitoring progress toward objectives
4. Sustaining CQI as the way of doing business

Quality Improvement

QI is a systematic approach to specifying the processes and outcomes of a program or set of practices through regular data collection and the application of changes that may lead to improvements in performance. In other words, QI is:

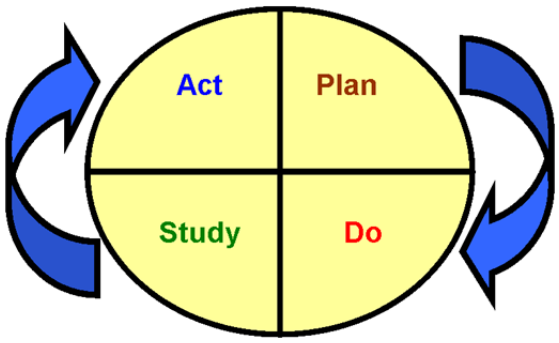
- A deliberate and defined process,
- Continuous and ongoing, and
- Reliant on measureable indicators of service or process quality.

Michigan's MIECHV Program will utilize the Plan-Do-Study-Act (PDSA) method to implement CQI activities at both the State and local levels. PDSA was made popular by Dr. W. Edwards Deming as a method for improving quality. Notable features of PDSA include:

- It involves four stages (Plan, Do, Study, and Act) and nine steps that are designed to be repeated over time.
- It can be used on a small or large scale, by an individual or a team, within or across departments, agencies, or organizations.
- It is designed to improve existing processes and to help find more efficient and effective ways of getting work done. It is not used for program planning or implementing new programs, it is used to improve what you already do.
- It is rooted in data, so that you can determine where you're starting from (baseline), whether you've made a change, whether you've made the right change, and whether the change you've made is an improvement.

During a PDSA Cycle, teams will identify a problem they currently have by examining baseline data, constructing a problem statement, and developing an initial Aim Statement. Teams will then spend time examining the current approach using CQI tools, including process mapping and fishbone diagrams. Upon identifying the root cause of the problem, teams will use an affinity diagram to determine possible solutions to the problem and then construct an improvement theory (If…Then Statement) to test. During the 'DO' stage, teams will test their improvement theory. Following the 'DO' stage teams will 'STUDY' their results determining whether the change they made resulted in an improvement or not. At this point teams may decide they need to test the change with additional home visitors, under different circumstances, or over a longer timeframe. Finally, teams will 'ACT' on their improvement by deciding to adopt the change or start a new PDSA Cycle in order to further explore the root cause of the problem and determine a new test. Most importantly teams will communicate the results of their project through a CQI Story Board using the template provided, celebrate their successes, and identify their next QI project. Examples of some of the tools used by teams can be found in Appendix A.

Michigan's MIECHV Program will utilize legislatively mandated Benchmark data as a key data source for all CQI efforts at both the State and provider site levels. Benchmark data will be provided to CQI teams on a quarterly basis for review in order to inform timely CQI efforts. Specific QI projects will be selected by State and provider site staff based on Benchmark data.


Act
Plan
Study
Do

State, Local, and Provider Site CQI Teams: Team Descriptions

Quality improvement activities will be carried out by teams focused on three levels of the home visiting system. A state CQI team will focus on state level system improvements, local CQI teams will focus on local level system improvements, and provider site CQI teams will focus on improving home visiting programming within a provider site. Each team will be responsible for selecting and implementing QI projects that are designed to drive improvement on Michigan's Benchmarks. A description of each team follows.

State CQI Team

The State CQI Team will be responsible for reviewing MIECHV data on a quarterly basis to track fidelity and progress against legislatively mandated Benchmarks. Based on the team's findings, the team will identify strategies for supporting local home visiting agencies in implementing improvements. In particular, the State CQI Team will identify opportunities for system improvements that will improve quality across local agencies. In addition to reviewing MIECHV data, the State CQI Team will review CQI projects completed at the local level on a quarterly basis.

Membership

The State CQI Team will consist of State Home Visiting Workgroup (HVWG) members and additional partners. The HVWG includes Home Visiting Program staff from the Michigan Department of Community Health (MDCH), MDCH Maternal and Child Health leadership, representatives from the Department of Human Services, representatives from the Department of Education, a representative from the Early Childhood Investment Corporation, and other state-level partners with a stake in early childhood. State CQI Team Members will include:

- State Home Visiting Workgroup Members
- 1-2 evaluation team members from the Michigan Public Health Institute (MPHI)

Meeting Schedule

Biweekly CQI Team meetings will be held at the onset of each CQI project in order to ensure enough time is devoted to the Plan stage. The meeting frequency will be adjusted based on the team's needs during the latter stages of the PDSA cycle.

Deliverables

- Data report (produced by MPHI)
- Begin three CQI projects per fiscal year and complete:
    - CQI Team Charter
    - Story Board (upon completion of full PDSA Cycle)
- Share CQI project materials:
    - With Local and Provider Site Level CQI Teams via the program's SharePoint site

Local Level CQI Teams

The Local Leadership Group in each community receiving MIECHV funds will serve as Local CQI Teams. These teams will identify lessons learned through state and provider site MIECHV CQI activities that can

be used to improve the local home visiting system. The teams will discuss state and provider site level CQI project findings, provide State and Provider Site-level CQI Teams recommendations and/or feedback, and identify processes that can be improved in the local system.

Membership

Local CQI Teams will consist of the Local Leadership Group in each community receiving MIECHV funds. These teams include leadership from each home visiting program operating in the county. As such, these teams will include leaders of other home visiting programs not currently engaged in the MIECHV Program.

Meeting Schedule

Meetings will be scheduled and held monthly.

Deliverables

- Begin one CQI project per fiscal year and complete:
    - CQI Team Charter
    - Story Board (upon completion of full PDSA Cycle)
- Share CQI project materials:
    - With State and Provider Site Level CQI Teams via the program's SharePoint site

Provider Site Level CQI Teams

Provider Site CQI Teams will use CQI methods and tools to improve the performance of local home visiting agencies. They will make improvements that increase model fidelity and improve performance against federally mandated Benchmarks. Provider Site CQI Teams will review data provided by MPHI each quarter in order to identify opportunities for improvement. Teams will begin at least two PDSA Cycles per fiscal year focused on making improvements on the federally mandated Benchmarks. These cycles may involve participation in a broader CQI effort, such as HRSA's Home Visiting Collaborative Improvement and Innovation Network. CQI project results will be reported as they become available.

In addition to the two PDSA Cycles the teams will complete at the program level, each Provider Site CQI Team will also be required to participate in one Learning Collaborative per fiscal year. At least two Learning Collaboratives will be convened per fiscal year focused on areas in which the State needs to show improvement on the federally mandated Benchmarks. Provider Site CQI Teams will be provided with the opportunity to indicate the top two Learning Collaborative topics they have interest in participating in, based on four to six pre-identified areas, prior to on the onset of the Collaboratives. Learning Collaboratives will be formed based on the teams' interest and current performance on the measures of focus. The Learning Collaboratives will be convened in person three times over the course of the fiscal year to work together on components of the projects, share what worked well and did not, share lessons learned, and celebrate successes.

Membership

The Provider Site CQI Teams will be composed of approximately 4-6 Provider Site staff. Members should include:

- Home Visiting Supervisor
- Home Visitors
- Data Entry Staff Member
- Support Staff

Meeting Schedule

- Internal Provider Site CQI Team meetings will be scheduled and held on a regular basis (biweekly meetings are recommended). These meetings can be incorporated into standing meetings, if possible.
- Learning Meetings, for all Provider Site CQI Teams, will be scheduled and held on a quarterly basis via teleconference/webinar.

Deliverables

- Begin two CQI projects at the program level and participate in one CQI Learning Collaborative per fiscal year and submit:
    - CQI Team Charter
    - Story Board (upon completion of full PDSA Cycle)
- Share CQI project materials:
    - With other MIECHV grantees via the program's SharePoint site and through quarterly Learning Meetings conducted via teleconference/webinar;
    - With the Local CQI Team; and
    - With the State CQI Team and HVWG.

Relationship between Teams

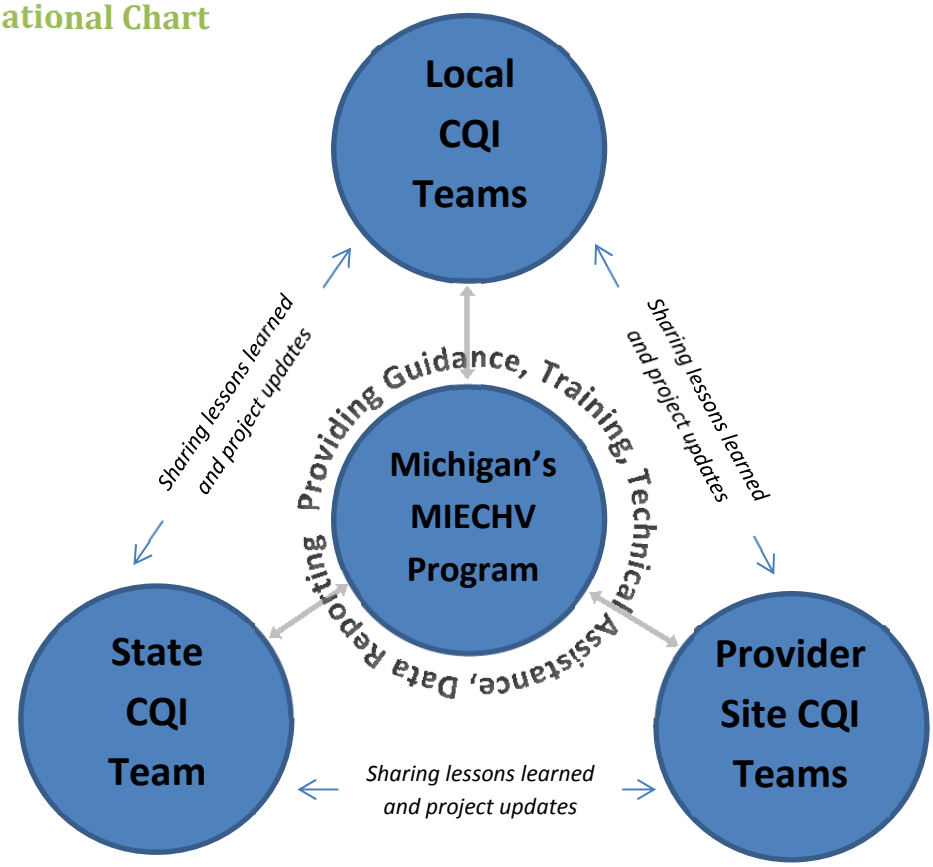
The State CQI Team, Local CQI Teams, and Provider Site CQI Teams will each engage in QI activities designed to improve processes and outcomes that are within the team's unique sphere of influence. The State Team will focus on improvements in the home visiting system at the state level, the Local Teams will focus on improvements in local home visiting systems, and Provider Site Teams will focus on improvements within their agencies.

However, Teams will interact with one another in two ways. First, Teams will share what they've learned with their partners. State and Provider Site Teams will regularly communicate with one another through quarterly CQI teleconferences/webinars during which each Team's QI project activities will be shared and discussed. Additionally, Provider Site Teams will share their QI project activities with their Local Team during Local Leadership Group meetings. Each Team's deliverables will also be posted on SharePoint such that they can be accessed by other programs in the state. Further, State, Local, and Provider Site teams will have the opportunity to share their QI work at the annual statewide home visiting conference through a CQI Showcase. Other opportunities for sharing will be explored throughout the implementation of MIECHV.

Second, beginning in fiscal year fourteen Provider Site Teams will engage in collaborative QI projects using the IHI Breakthrough Series Collaborative Model to tackle common challenges across home visiting agencies. Michigan's baseline value for each construct in the state's Benchmark Plan will be used to

identify opportunities to work across the system toward improving specific constructs. Four to six areas for improvement will be identified and Provider Site Teams will be asked to indicate the top two areas they would like to improve. Collaboratives will be formed based on teams' preferences as well as each Provider Site's baseline data. A minimum of two learning collaboratives will be formed each fiscal year. The learning collaboratives will be convened in person three times over the course of the fiscal year to work together on components of the projects, share what worked well and did not, share lessons learned, and celebrate successes.

Organizational Chart



State, Local, and Provider Site CQI Team Roles

Team Roles

In order for the CQI Teams at each level to operate efficiently and effectively, each team member must agree to take on a role. Roles include, but are not limited to: Leader, Facilitator, Meeting Scribe, Data/Information Liaison, Document Management, Meeting Scheduler, and Subject Matter Resource. These roles should generally rotate on a yearly or cycle-to-cycle basis. If there is sufficient membership on the team, it is recommended that a second person be selected for the roles of Leader and Facilitator to serve as alternates. If alternates are selected, they may assume the role at the beginning of the next year or project. Additional team roles may be assigned based on the team's needs. For additional information on organizing a CQI Team and assigning team roles please see Chapter 3 of *Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook*.

Leader

The Leader's role is to support the work of the team and to represent the team when needed.

Tasks:

- Provide opening remarks and introductions to the meeting
- Support and reinforce the team for productivity and idea generation
- Ensure that issues are well understood
- Communicate team efforts and accomplishments to outside parties
- Ensure successes are noted and celebrated
- Orients the next Leader at the end of the year/project

Facilitator

The Facilitator must be able to participate in the meeting while also providing focus and direction for the conversation, ensuring meeting objectives are met, and engaging all team members in the conversation.

Tasks:

- Prepares the meeting agenda with the Meeting Scribe/meeting notes
- Introduces the meeting agenda to the group with the time parameters
- Pays close attention to the time limits on the meeting
- Draws out opinions of quiet team members
- Keeps team members focused on the task
- Ensures meeting objectives are met
- Summarizes the next steps with the Meeting Scribe agreed upon by the team
- Trains the next Facilitator at the end of the year/project

Meeting Scribe

The Meeting Scribe must be able to participate in team meetings while also recording the wisdom and comments of the team members.

Tasks:

- Takes legible notes at each meeting and shares notes will all team members

- Updates the Team Charter on regular basis and shares with all team members
- Orients the next Meeting Scribe at the end of the project

Data/Information Liaison

The Data/Information Liaison must be able to collect and organize data/information pertaining to the project.

Tasks:

- Gathers data/information for the project through a variety of mediums (emails, surveys, interviews, focus groups, etc.)
- Works with team to construct data/information gathering instruments
- Provides already existing data for the project (from databases)
- Ensures data are compiled and provided to the team on a regular basis

Document Manager

The Document Manager must be able to capture and document the team's project from start to finish.

Tasks:

- Maintains team documents and records in an organized and accessible fashion
- Ensures all team documents are kept up-to-date
- Ensures the story of the team's project is captured and documented

Meeting Scheduler

The Meeting Scheduler must be able to schedule meetings, reserve meeting space, and ensure the team meets on a regular basis to work on the project.

Tasks:

- Sends out meeting schedule and reminders to team members
- Ensures the team has a space that is appropriate to meet
- Works with Facilitator and copies any materials that team members need for the meeting

Subject Matter Resource

The Subject Matter Resource must be able to gather subject matter resources related to the process the team is working on in order to inform the project.

Tasks:

- Provides needed subject matter resources to the team (latest research and practices, instruments, etc.)

Other Roles

During the Plan stage of each PDSA Cycle, QI teams will discuss the other roles that may be required. Teams may need to consider adding a parent to the team in order to ensure the needs and concerns of customers are appropriately addressed. For example, if a team wishes to improve screening processes, a parent may be able to provide important insights. Additional team roles should be identified at the team's discretion.

A Data Driven Approach

Common Data Collection

Michigan has not yet invested in a common electronic data system for home visiting. The current system for data collection, management, and reporting is paper based and coordinated by the Michigan Public Health Institute (MPHI). MPHI shares responsibility for data collection with all MIECHV funded home visiting programs. MPHI is responsible for developing all data collection forms and procedures, training and providing technical assistance for individual programs collecting data at the site level, and sending all relevant materials for data collection through the MPHI Institutional Review Board (IRB).

Based on common benchmark indicators, identical data are collected from each individual MIECHV site implementing Early Head Start and Healthy Families America through the use of a common data collection form. Additionally, MPHI has aligned its common data collection form with items captured through Nurse Family Partnership's *Efforts to Outcomes (ETO)* data collection system. As such, each home visiting program funded through Michigan's MIECHV Program collects a common set of data that aligns with Michigan's Benchmarks. These data will be used to inform the selection of QI projects at the Provider Site and state level, and they will be used to measure improvement over time.

In addition to the data collected and managed by MPHI and through ETO, individual home visiting agencies may determine that they need to collect additional data based on their specific CQI projects. MPHI will be available to provide technical assistance when additional data collection is necessary, but with appropriate training and support, the collection, analysis, and reporting of such project-specific data will be coordinated at the individual site level.

Centralized Data Analysis

MPHI serves as the primary coordinator of data collection, management, analysis, and reporting for Michigan's MIECHV Program. MPHI receives batches of data from individual sites each quarter (January 1, April 1, July 1, and October 1). MPHI ensures the necessary forms are completed and submitted, edits and enters forms in SPSS, and cleans the data for analysis. In addition to using these data for evaluation and benchmark reporting, MPHI will produce aggregate and site-specific reports to support data-driven CQI projects and processes.

Additionally, MPHI receives quarterly data files from the NFP ETO system, which are cleaned and used for MIECHV benchmark reporting. NFP's National Service Office provides a quarterly NFP-specific CQI report to NFP sites (including MIECHV NFP sites in Michigan); however, the way in which the constructs are defined in the report does not align exactly with how Michigan has defined the constructs. As such, MPHI will produce aggregate and site-specific reports to support data-driven CQI projects and processes for the constructs not covered via the NFP-specific CQI report.

Benchmark Driven Reporting

CQI Teams will receive a standard data report on a quarterly basis from MPHI. The report aligns with Michigan's MIECHV Benchmarks and constructs, and it is designed to support identifying improvements in these areas at the state and Provider Site level. The report specifies measures of quality and QI

targets related to each construct. Targets were selected based on Provider Site level baseline data. The State CQI Team will receive mean scores on each measure, as well as the range. Provider Site CQI Teams will receive these data, as well as data on the performance of their own site. Local CQI teams will not receive a separate data report; however, Provider Site CQI Teams will be encouraged to share their data with their Local CQI Teams. The report template is included in Appendix B.

State, Local, and Provider Site CQI Team Deliverables

CQI Team Charter

CQI Teams will be required to develop a CQI Team Charter for each CQI project. The charter will serve as the team's roadmap by describing the team's purpose and the targeted improvement. A good charter sets team direction and helps the team come to agreement regarding communication, accountability, and delivery of products. Most CQI Team Charters capture the following information:

- Team sponsor
- Team members and roles
- Problem, issues, or opportunity statement
- Description of the process improvement
- Aim statement
- Customers and their needs
- Timeline for completing each stage of the PDSA Cycle
- Timeline and frequency of team meetings
- Internal and external stakeholders
- Improvement theories (If…Then)

For more information on CQI team charters, please see Chapter 3 of *Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook*. The CQI Team Charter template in located in Appendix C of this plan.

CQI Story Board

An important part of conducting a CQI project is communicating the work of the project. CQI Teams will be required to complete a CQI Story Board for each CQI project. Story boards are organized around the steps in the PDSA Cycle and tell the projects' stories from start to finish. Story boards are graphic-heavy, not text-heavy. The more charts and pictures the better! The text included on the story board should be as concise as possible; use bullets when you can. The following types of graphics are great to use on a story board:

- Process map
- Logic model
- Fishbone diagram
- Check sheet
- Pareto chart
- Run chart
- Bar chart
- Data table

For more information on CQI story boards, please see Chapter 4 of *Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook*. The CQI Story Board template in located in Appendix D of this plan.

State, Local, and Provider Site CQI Team Training and Technical Assistance

The Michigan Public Health Institute (MPHI) will support Michigan's MIECHV Program CQI activities. MPHI has engaged in QI work for over the last eight years with public health agencies at the State and local level providing QI training and ongoing technical assistance in PDSA methodology and tools. Over the years, MPHI has developed several QI resources to assist agencies in implementing QI work. Such QI resources include:

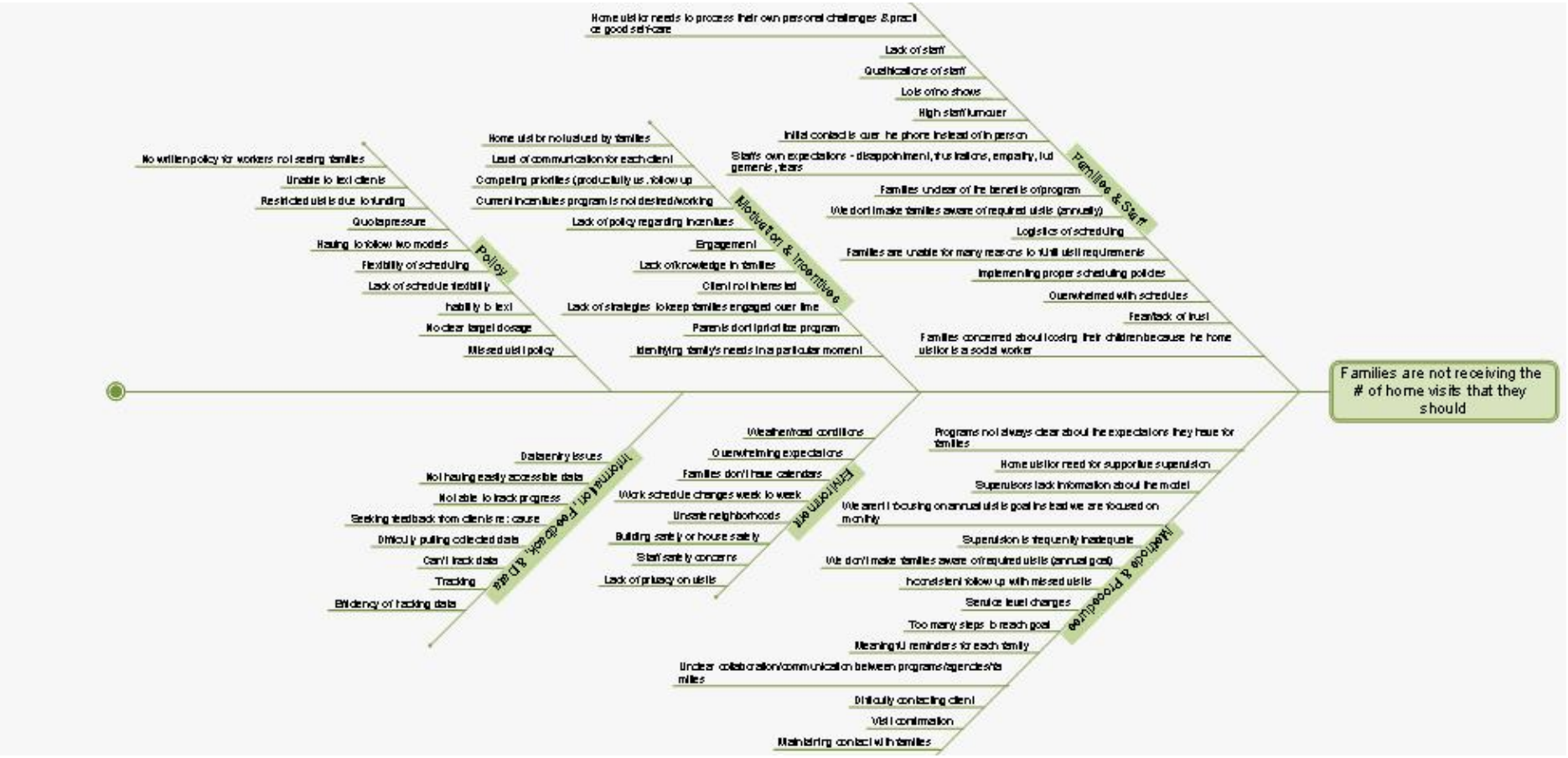
- *Embracing Quality in Local Public Health: Michigan's Quality Improvement Guidebook*
- *Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook*
- QI Team Charter Template and Guidelines
- Aim Statement Worksheet
- QI Story Board Template and Guidelines
- Step-by-step QI Tool Tutorials
- In-person and Web-based QI Trainings

Moreover, MPHI staff are trained and well versed in QI methodologies and tools. Staff work closely with agencies to guide them through their QI projects from start to finish.

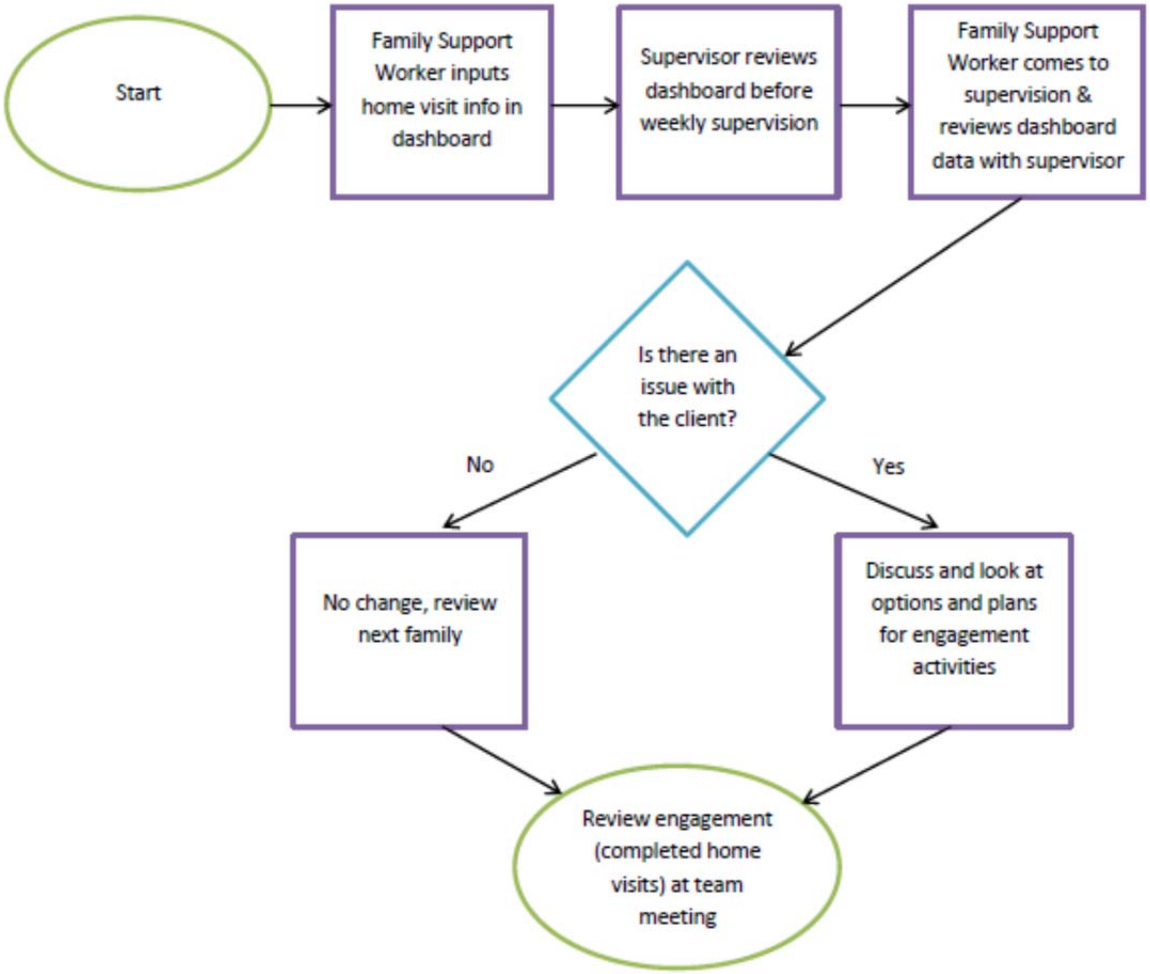
MPHI will support Michigan's MIECHV Program CQI activities by providing ongoing training and technical assistance, including: a two-day Kick Off Training, quarterly teleconferences/webinars, three Learning Collaborative meetings held each fiscal year, annual in-person Learning Meeting, and ongoing individual site technical assistance. Staff will check in with each CQI team on a regular basis to help facilitate progress with their CQI work and ensure needs are met in a timely manner. Also, MPHI will create regular CQI data reports for agencies to use in order to identify opportunities for improvement within their home visiting program and to track change over time. Moreover, MPHI will help facilitate peer sharing across sites through dissemination of CQI story boards and ensuring that the program SharePoint site is kept up-to-date with the latest CQI work shared by teams.

Appendix A: Example CQI Tools

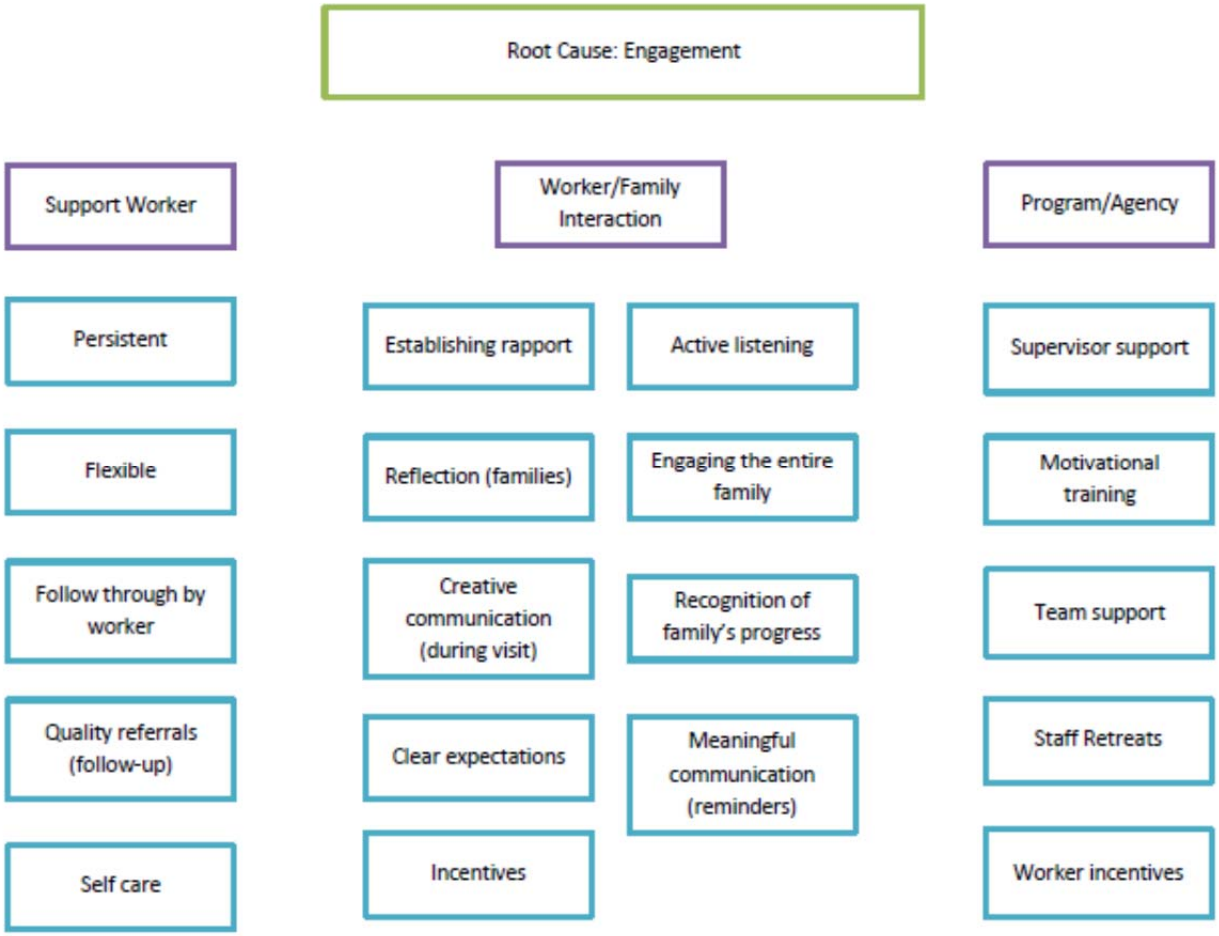
Fishbone Diagram



Process Map


Start
Family Support Worker inputs home visit info in dashboard
Supervisor reviews dashboard before weekly supervision
Family Support Worker comes to supervision & reviews dashboard data with supervisor
Is there an issue with the client?
No
Yes
No change, review next family
Discuss and look at options and plans for engagement activities
Review engagement (completed home visits) at team meeting

Affinity Diagram



Appendix B: CQI Data Report Template

January 2014 MIECHV QI Data Report						
Name of MIECHV Program: Ingham EHS *** = This measure is reported similarly to the measure in the Michigan MIECHV Benchmark Table**						
Demographic Information						
Construct	**Program Level Cohort 1**	**Program Level Cohort 2**	**All MIECHV funded HFA & EHS Programs - Cohort 1**	**All MIECHV funded HFA & EHS Programs - Cohort 2**		
Number of Families Reported	At Enrollment: At 6 months: At 12 months:	At Enrollment: At 6 months: At 12 months:	At Enrollment: At 6 months: At 12 months:	At Enrollment: At 6 months: At 12 months:		
Number of Caregivers Reported	Women pregnant at enrollment: Female caregivers enrolled: Male caregivers enrolled:	Women pregnant at enrollment: Female caregivers enrolled: Male caregivers enrolled:	Women pregnant at enrollment: Female caregivers enrolled: Male caregivers enrolled:	Women pregnant at enrollment: Female caregivers enrolled: Male caregivers enrolled:		
Female Caregivers Age at enrollment:	**n =** 10-<15: 15-<18: 18-<20: 20-<22: 22-<25: 25-<30: 30-<35: 35-<45: 45+: Unknown/Did not report:	**n =** 10-<15: 15-<18: 18-<20: 20-<22: 22-<25: 25-<30: 30-<35: 35-<45: 45+: 0% Unknown/Did not report:	**n =** 10-<15: 15-<18: 18-<20: 20-<22: 22-<25: 25-<30: 30-<35: 35-<45: 45+ : Unknown/Did not report (not included in 'n' or %):	**n =** 10-<15: 15-<18: 18-<20: 20-<22: 22-<25: 25-<30: 30-<35: 35-<45: 45+ : Unknown/Did not report (not included in 'n' or %):		

Female Caregiver's Race at Enrollment	**n =** Black: White: AI/AN: Asian: Multiracial: Unknown/Did not report:	**n =** Black: White: AI/AN: Asian: Multiracial: Unknown/Did not report: .	**n =** Black: White: AI/AN: Asian: Multiracial: Unknown/Did not report (not included in 'n' or %):	**n =** Black: White: AI/AN: Asian: Multiracial: Unknown/Did not report (not included in 'n' or %):		
Female Caregiver's Ethnicity at Enrollment	**n =** Hispanic/Latino: Not Hispanic/Latino: Unknown/Did not report (not included in 'n' or %):	**n =** Hispanic/Latino: Not Hispanic/Latino: Unknown/Did not report (not included in 'n' or %):	**n =** Hispanic/Latino: Not Hispanic/Latino: Unknown/Did not report (not included in 'n' or %):	**n =** Hispanic/Latino: Not Hispanic/Latino: Unknown/Did not report (not included in 'n' or %):		
Target Child's Age at Enrollment	**n =** Prenatal: Under 1 year: 1-2 years: 3-5 years: Unknown/Did not report (not included in 'n' or %):	**n =** Prenatal: Under 1 year: 1-2 years: 3-5 years: Unknown/Did not report (not included in 'n' or %):	**n =** Prenatal: Under 1 year: 1-2 years: 3-5 years: Unknown/Did not report (not included in 'n' or %):	**n =** Prenatal: Under 1 year: 1-2 years: 3-5 years: Unknown/Did not report (not included in 'n' or %):		
Target Child's Race at Enrollment	**n =** Black: White: AI/AN: Asian: Multiracial: Unknown/Did not report (not included in 'n' or %):	**n =** Black: White: AI/AN: Asian: Multiracial: Unknown/Did not report (not included in 'n' or %):	**n =** Black: White: AI/AN: Asian: Multiracial: Unknown/Did not report (not included in 'n' or %):	**n =** Black: White: AI/AN: Asian: Multiracial: Unknown/Did not report (not included in 'n' or %):		

Target Child's Ethnicity at Enrollment		**n =** Hispanic/Latino: Not Hispanic/Latino: Unknown/Did not report (not included in 'n' or %):	**n =** Hispanic/Latino: Not Hispanic/Latino: Unknown/Did not report (not included in 'n' or %):	**n =** Hispanic/Latino: Not Hispanic/Latino: Unknown/Did not report (not included in 'n' or %):	**n =** Hispanic/Latino: Not Hispanic/Latino: Unknown/Did not report (not included in 'n' or %):		
Zip codes Families Reside In				NA	NA		
I. Improved Maternal and Child Health							
Construct	**Measure**	**Numerator**	**Denominator**	**Quality Improvement Target**	**Program Result**	**All MIECHV Programs**	**# of Programs Reporting**
1. Prenatal Care	Prenatal care visits received by women enrolled prenatally who have given birth	NA	NA	Mean number of prenatal care visits received by women enrolled prenatally who have given birth increases	**Cohort 1** n = Mean visits = **Cohort 2** n = Mean visits =	**Cohort 1** n = Mean = Highest mean = Lowest mean = **Cohort 2** n = Mean = Highest mean = Lowest mean =	Cohort 1: Cohort 2:
	Number of months pregnant when women enrolled prenatally received their first prenatal care visit	NA	NA	Mean number of months pregnant when women enrolled prenatally received their first prenatal care visit decreases	**Cohort 1** n = Mean months = **Cohort 2** n = Mean months =	**Cohort 1** n= Mean = Highest mean = Lowest mean = **Cohort 2** n= Mean = Highest mean = Lowest mean =	Cohort 1: Cohort 2:

2. Prenatal Use of Alcohol, Tobacco, or Illicit Drugs	Female caregivers use of alcohol, tobacco, or illicit drugs is assessed	# of female caregivers screened for use of alcohol, tobacco, or illicit drugs by 6 months of enrollment	# of female caregivers enrolled for 6 months	90% of female caregivers are screened for alcohol/drug use within the first 6 months of enrollment	**Cohort 1** By 6 months # screened: # of female caregivers: % screened: **Cohort 2** By 6 months # screened: # of female caregivers: % screened:	**Cohort 1** By 6 months # screened: # of female caregivers: % screened: **Cohort 2** By 6 months # screened: # of female caregivers: % screened:	Cohort 1: Cohort 2:
	Female caregivers who screen positive for use of alcohol, tobacco, or illicit drugs are referred for services	# of female caregivers who screen positive who are referred for services by 6 months of enrollment	# of female caregivers who screen positive for alcohol, tobacco, or illicit drugs by 6 months of enrollment	90% of female caregivers who screen positive for use alcohol or drugs are referred for services by 6 months of enrollment	**Cohort 1** By 6 months # screened positive who were referred: # screened positive: % screened positive and referred: **Cohort 2** By 6 months # screened positive who were referred: # screened positive: % screened positive and referred:	**Cohort 1** By 6 months # screened positive who were referred: # screened positive: % screened positive and referred: **Cohort 2** By 6 months # screened positive who were referred: # screened positive: % screened positive and referred:	Cohort 1: Cohort 2:

3. Pre-conception Care	Biological mothers have access to family planning services that provide education regarding planning for pregnancy, medical services to monitor reproductive health, and access to birth control *	# of biological mothers who have access to family planning services by 12 months of enrollment	# of biological mothers enrolled for 12 months	90% of biological mothers have access to family planning services that provide education regarding planning for pregnancy, medical services to monitor reproductive health, and access to birth control by 12 months of enrollment	**Cohort 1** <u>At Enrollment</u> n = % = Unknown/Did not report (not included in 'n' or %): <u>At 6 months</u> n = % = Unknown/Did not report (not included in 'n' or %): <u>At 12 months</u> n = % = Unknown/Did not report (not included in 'n' or %): **Cohort 2** <u>At Enrollment</u> n = % = Unknown/Did not report (not included in 'n' or %): <u>At 6 months</u> n = % = Unknown/Did not report (not included in 'n' or %): <u>At 12 months</u> n = % = Unknown/Did not report (not included in 'n' or %):	**Cohort 1** <u>At Enrollment</u> **n =** Overall % = Highest % = Lowest % = <u>At 6 months</u> n = Overall % = Highest % = Lowest % = <u>At 12 months</u> n = Overall % = Highest % = Lowest % = **Cohort 2** <u>At Enrollment</u> n = Overall % = Highest % = Lowest % = <u>At 6 months</u> n = Overall % = Highest % = Lowest % = <u>At 12 months</u> n = Overall % = Highest % = Lowest % =	Cohort 1: Cohort 2:

4. Inter-birth Intervals	Biological mothers report they use a form of birth control that is at least 75% effective at preventing pregnancy *	# of biological mothers who report they use a form of birth control that is at least 75% effective at preventing pregnancy	# of biological mothers enrolled, excluding pregnant women	90% of biological mothers use a form of birth control that is at least 75% effective at preventing pregnancy	**Cohort 1** <u>At Enrollment</u> n= % = Missing (not included in 'n' or '%') = <u>At 6 months</u> n = % = Missing (not included in 'n' or '%') = <u>At 12 months*</u> n = % = Missing (not included in 'n' or '%') = **Cohort 2** <u>At Enrollment</u> n= % = Missing (not included in 'n' or '%') = <u>At 6 months</u> n = % = Missing (not included in 'n' or '%') = <u>At 12 months*</u> n = % = Missing (not included in 'n' or '%') =	**Cohort 1** <u>At Enrollment</u> n= Overall % = Highest %= Lowest %= <u>At 6 months</u> n= Overall % = Highest %= Lowest %= <u>At 12 months*</u> **n=** Overall % = Highest %= Lowest % = **Cohort 2** <u>At Enrollment</u> n= Overall % = Highest %= Lowest % = <u>At 6 months</u> n = Overall % = Highest % = Lowest % = <u>At 12 months</u> **n =** Overall % =	Cohort 1: Cohort 2:

5. Screening for Maternal Depressive Symptoms	Female caregivers are screened for maternal depression	# of female caregivers screened for maternal depression by 6 months of enrollment	# of female caregivers enrolled, excluding pregnant women, enrolled 6 months	90% of female caregivers are screened for maternal depression by 6 months of enrollment	**Cohort 1** By 6 months # screened: # of female caregivers not pregnant: % screened: **Cohort 2** By 6 months # screened: # of female caregivers not pregnant: % screened:	**Cohort 1** By 6 months # screened: # of female caregivers not pregnant: % screened: **Cohort 2** By 6 months # screened: # of female caregivers not pregnant: % screened:	Cohort 1: Cohort 2:
	Female caregivers who screen positive for maternal depression are referred for services	# of female caregivers who screen positive for maternal depression and are referred for services by 6 months of enrollment	# of female caregivers who screen positive for maternal depression by 6 months of enrollment	90% of female caregivers who screen positive for depression are referred for services by 6 months of enrollment	**Cohort 1** By 6 months # screened positive who were referred: # screened positive: % screened positive and referred **Cohort 2** By 6 months # screened positive who were referred: # screened positive: % screened positive and referred:	**Cohort 1** By 6 months # screened positive who were referred: # screened positive: % screened positive and referred: **Cohort 2** By 6 months # screened positive who were referred: # screened positive: % screened positive and referred:	Cohort 1: Cohort 2:
6. Breastfeeding	Women enrolled prenatally initiate breastfeeding at birth of target child	# of women enrolled prenatally who initiate breastfeeding at birth by 12 months enrollment	# of women enrolled prenatally who have given birth and are enrolled 12 months	75% of women enrolled prenatally initiate breastfeeding at birth	**Cohort 1** By 12 months # who initiated: # enrolled prenatally who have given birth: % who initiated:	**Cohort 1** By 12 months # who initiated: # enrolled prenatally who have given birth: % who initiated:	Cohort 1:

	Women enrolled prenatally continue breastfeeding through 6 months *	# of women enrolled prenatally who breastfeed through 6 months	# of women enrolled prenatally who initiate breastfeeding who have a 6 month old child	50% of women enrolled prenatally breastfeed through 6 months	**Cohort 1** # who breastfeed through 6 months: # who initiated breastfeeding and have a child 6 months or older: % breastfeeding through 6 months:	**Cohort 1** # who breastfeed through 6 months: # who initiated breastfeeding and have a child 6 months or older: % breastfeeding through 6 months:	Cohort 1:
7. Well Child Visits	Target children enrolled in the program complete their last scheduled well-child visit	# of target children who completed their last scheduled well-child visit	# of target children enrolled	90% of target children enrolled in the program complete their last scheduled well-child visit	**Cohort 1** <u>At 6 months</u> n= % = Unknown/Did not report (not included in 'n' or %): <u>At 12 months</u> n= % = Unknown/Did not report (not included in 'n' or %): **Cohort 2** <u>At 6 months</u> n= % = Unknown/Did not report (not included in 'n' or %): <u>At 12 months</u> n= % = Unknown/Did not report (not included in 'n' or %):	**Cohort 1** <u>At 6 months</u> n= Overall % = <u>At 12 months</u> n= Overall % = **Cohort 2** <u>At 6 months</u> n= Overall % = <u>At 12 months</u> n= Overall % =	Cohort 1: Cohort 2:

8. Maternal and Infant Health Insurance Status	Female caregivers have health insurance	# of female caregivers with health insurance	# of female caregivers enrolled	90% of female caregivers have health insurance	**Cohort 1** <u>At Enrollment</u> n= % = Unknown/Did not report (not included in 'n' or %): <u>At 6 months</u> n = % = Unknown/Did not report (not included in 'n' or %): <u>At 12 months</u> n = % = Unknown/Did not report (not included in 'n' or %) = **Cohort 2** <u>At Enrollment</u> n= % = Unknown/Did not report (not included in 'n' or %): <u>At 6 months</u> n = % = Unknown/Did not report (not included in 'n' or %):	**Cohort 1** <u>At Enrollment</u> n = Overall % = <u>At 6 months</u> n = Mean = <u>At 12 months</u> n = Mean = **Cohort 2** <u>At Enrollment</u> n = Mean = <u>At 6 months</u> n = Mean =	Cohort 1: Cohort 2:

	Target children have health insurance	# of target children with health insurance	# of target children enrolled	90% of target children have health insurance	**Cohort 1** At Enrollment n= % = Unknown/Did not report (not included in 'n' or %): At 6 months n = % = Unknown/Did not report (not included in 'n' or %): At 12 months n= %= **Cohort 2** At Enrollment n= % = Unknown/Did not report (not included in 'n' or %): At 6 months n = % = Unknown/Did not report (not included in 'n' or %):	**Cohort 1** At Enrollment n = Overall % = At 6 months n = Overall % = At 12 months n = Overall % = **Cohort 2** At Enrollment n = Overall % = At 6 months n = Overall % =	Cohort 1: Cohort 2:
II. Child Injuries, Child Abuse, Neglect, or Maltreatment and the Reduction of Emergency Department Visits							
Construct	**Measure**	**Numerator**	**Denominator**	**Quality Improvement Target**	**Program Result**	**All MIECHV Programs**	**# of Programs Reporting**

9. Visits for Children to the Emergency Department from all Causes	Visits by target children to the hospital or emergency department for any reason*	Number of target children who have visited the emergency room in the 6 months prior to the home visit	Number of target children	The percent of target children using the hospital or emergency department decreases	**Cohort 1** <u>At 6 Months</u> # of children visiting ER: # of children: %: <u>At 12 Months*</u> # of children visiting ER: # of children: %: **Cohort 2** <u>At 6 Months</u> # of children visiting ER: # of children: %: <u>At 12 Months*</u> # of children visiting ER: # of children: %:	**Cohort 1** <u>At 6 Months</u> n= Overall %: <u>At 12 Months*</u> n= Overall %: **Cohort 2** <u>At 6 Months</u> n= Overall %: <u>At 12 Months*</u> n= Overall %:	Cohort 1: Cohort 2:

10. Visits for Mothers to the Emergency Department from all Causes	Visits by female caregivers to the hospital or emergency department for any reason*	Number of female caregivers who have visited the emergency room in the 6 months prior to the home visit	Number of female caregivers	The percent of female caregivers using the hospital or emergency department decreases	**Cohort 1** <u>At 6 Months</u> # of female caregivers visiting ER: # of female caregivers: %: <u>At 12 Months*</u> # of female caregivers visiting ER: # of female caregivers: %: **Cohort 2** <u>At 6 Months</u> # of female caregivers visiting ER: #of female caregivers: %: <u>At 12 Months</u> # of female caregivers visiting ER: #of female caregivers: %:	**Cohort 1** <u>At 6 Months</u> **n=** Overall %: <u>At 12 Months*</u> **n=** Overall %: **Cohort 2** <u>At 6 Months</u> **n=** Overall %: <u>At 12 Months*</u> **n=** Overall %:	Cohort 1: Cohort 2:
11. Information Provided or Training on Prevention of Child Injuries	Number of child injury prevention topics covered with families who were enrolled 12 months and have data reported at both 6 and 12 months.	Total number of child injury topics covered at both 6 months and 12 months	Number of families who reached 12 months post enrollment and reported number of injury prevention topics at both 6 months and 12 months	Mean # of child injury prevention topics covered increases	<u>By 12 months</u> n= Mean at 6 months = Mean at 12 months =	<u>By 12 months</u> n = Mean at 6 months = Mean at 12 months =	

12. Incidence of Child Injuries Requiring Medical Treatment	Target children requiring medical care for an injury or ingestion*	# of target children requiring medical care for an injury or ingestion as of 12 months post enrollment	# of target children enrolled at 12 months	0% of target children require medical care for an injury or ingestion at 12 months	**Cohort 1** At 12 months n = % = Missing (not included in 'n' or '%') = **Cohort** At 12 months n = % = Missing (not included in 'n' or '%') =	**Cohort 1** At 12 months n = Overall % = **Cohort 2** At 12 months n = Overall % =	
III. Improvements in School Readiness and Achievement							
Construct	**Measure**	**Numerator**	**Denominator**	**Quality Improvement Target**	**Program Result**	**All MIECHV Programs**	**#of Programs Reporting**
16. Parent Support for Children's Learning and Development	HOME Inventory assessments are completed	# of HOME Inventory assessments completed	# of HOME Inventory assessments due	90% of HOME Inventory assessments are completed	At 6 months # completed: # of children over 6 months: At 12 months # completed: # of children over 6 months:	At 6 months # completed: # of children over 6 months: At 12 months # completed: # of children over 6 months:	
	Presence of learning materials in the home	NA	NA	Statistically significant improvement in mean scores on HOME Inventory Learning Materials subscale from 6 months to 12 months	**n =** (with matched HOME scores) Mean time 1 = Mean time 2 = Significance =	**n =** (with matched HOME scores) Mean time 1 = Mean time 2 = Significance =	

17. Parent Knowledge of Child Development and of their Child's Developmental Progress	Caregivers review target child's ASQ-3 & ASQ-SE results*	# of caregivers who reviewed both ASQ-3 & ASQ-SE results	# of caregivers who had both ASQ-3 and ASQ-SE results available for review	90% of caregivers have reviewed both ASQ-3 and ASQ-SE results by 12 months	**Cohort 1** <u>By 12 months</u> # reviewed both: # had both available for review: % reviewed both: **Cohort 2** <u>By 12 months</u> # reviewed both: # had both available for review: % reviewed both:	**Cohort 1** <u>By 12 months</u> # reviewed both: # had both available for review: % reviewed both: **Cohort 2** <u>By 12 months</u> # reviewed both: # had both available for review: % reviewed both:	Cohort 1: Cohort 2:
18. Parenting Behaviors and Parent-child Relationship (e.g., discipline strategies, play interactions)	Caregivers are responsive to their children's needs	NA	NA	Statistically significant improvement in mean scores on HOME Inventory Responsivity subscale from 6 months to 12 months	**n =** (with matched HOME scores) Mean time 1 = Mean time 2 = Significance =	**n =** (with matched HOME scores) Mean time 1 = Mean time 2 = Significance =	
19. Parent Emotional Well-being or Parenting Stress	PFS are completed	# of PFS completed	# of PFS due	90% of PFS completed when they are due	<u>At 6 months</u> # completed: # due: % completed = <u>At 12 months</u> # completed: # due: % completed =	<u>At 6 months</u> # completed: # due: % completed = <u>At 12 months</u> # completed: # due: % completed =	
	Parents have the social and concrete support they need	NA	NA	Statistically significant improvement in mean scores on PFS Social Support and Concrete Support subscale	**n =** (with matched PFS) Mean time 1 = Mean time 2 = Significance =	**n =** (with matched PFS) Mean time 1 = Mean time 2 = Significance =	

20. Children's developmental well-being is assessed	Target children are screened for developmental delays using the ASQ-3 by 12 months	# of eligible target children who were screened with the ASQ-3 by 12 months	# of eligible target children who reached 12 months post enrollment	90% target children who are eligible are screened for developmental delays by 12 months	**Cohort 1** At 6 months # eligible children: # screened: % screened: By 12 months # eligible children: # screened: % screened: **Cohort 2** At 6 months # eligible children: # screened: % screened:	**Cohort 1** At 6 months # eligible children: # screened: % screened: By 12 months # eligible children: # screened: % screened: **Cohort 2** At 6 months # eligible children: # screened: % screened:	Cohort 1: Cohort 2:
21. Children with developmental delays are identified	Target children with developmental delays are identified using the ASQ-3	# of target children with delay on the ASQ-3 in any area	# of target children screened with the ASQ-3		**Cohort 1** At 6 months # screened: # positive: % positive: By 12 months # screened: # positive: % positive: **Cohort 2** At 6 months # screened: # positive: % positive:	**Cohort 1** At 6 months # screened: # positive: % positive: By 12 months # screened: # positive: % positive: **Cohort 2** At 6 months # screened: # positive: % positive:	Cohort 1: Cohort 2:

22. Children with identified developmental delays receive services	Target children with identified developmental delays are referred to services	# of target children with a delay on the ASQ-3 in any area who are referred to services	# of target children with delay on the ASQ-3 in any area	90% target children who are experiencing delays are referred to services	**Cohort 1** At 6 months # with delay: # referred: % referred: By 12 months # with delay: # referred: % referred: **Cohort 2** At 6 months # with delay: # referred: % referred:	**Cohort 1** At 6 months # with delay: # referred: % referred: By 12 months # with delay: # referred: % referred: **Cohort 2** At 6 months # with delay: # referred: % referred:	Cohort 1: Cohort 2:
23. Child's Social Behavior, Emotion Regulation, and Emotional Well-being	Target children are screened for social emotional developmental delays using the ASQ-SE by 12 months	# of eligible target children who were screened with the ASQ-SE by 12 months	# of eligible target children who reached 12 months post enrollment	90% target children who are eligible are screened for social-emotional developmental delays by 12 months	**Cohort 1** At 6 months # eligible children: # screened: % screened: By 12 months # eligible children: # screened: % screened: **Cohort 2** At 6 months # eligible children: # screened: % screened:	**Cohort 1** At 6 months # eligible children: # screened: % screened: By 12 months # eligible children: # screened: % screened: **Cohort 2** At 6 months # eligible children: # screened: % screened:	Cohort 1: Cohort 2:

	Target children with delays in social emotional development are identified	# of target children with delay on the ASQ-SE	# of target children screened with the ASQ-SE		**Cohort 1** <u>At 6 months</u> # screened: # positive: % positive: <u>By 12 months</u> # screened: # positive: % positive: **Cohort 2** <u>At 6 months</u> # screened: # positive: % positive:	**Cohort 1** <u>At 6 months</u> # screened: # positive: % positive: <u>By 12 months</u> # screened: # positive: % positive: **Cohort 2** <u>At 6 months</u> # screened: # positive: % positive:	Cohort 1: Cohort 2:
	Target children identified with developmental delays in social emotional development receive a referral *	# of target children with delay on the ASQ-SE who receive a referral	# of target children with delay on the ASQ-SE	90% of target children with developmental delays in social emotional development receive a referral	**Cohort 1** <u>At 6 months</u> # with delay who were referred: # with delay: % with delay who were referred: <u>By 12 months*</u> # with delay who were referred: # with delay: % with delay who were referred: **Cohort 2** <u>At 6 months</u> # with delay who were referred: # with delay: % with delay who were referred:	**Cohort 1** <u>At 6 months</u> # with delay who were referred: # with delay: % with delay who were referred: <u>By 12 months*</u> **Cohort 2** <u>At 6 months</u>	Cohort 1:

24. Child's Physical Health and Development	Target children are up-to-date with immunizations while enrolled in the program	# of target children who are up-to-date with immunizations	# of target children	90% of target children are up-to-date with immunizations	**Cohort 1** At 6 months n = % = Unknown/Did not report (not included in 'n' or %): At 12 months n = % = Unknown/Did not report (not included in 'n' or %): At 18 months n = % = Unknown/Did not report (not included in 'n' or %): **Cohort 2** At 6 months n = % = Unknown/Did not report (not included in 'n' or %): At 12 months n = % = Unknown/Did not report (not included in 'n' or %):	**Cohort 1** At 6 months n = Overall %= At 12 months n = Overall %= At 18 months n = Overall %= **Cohort 2** At 6 months n = Overall %= At 12 months n = Mean %= At 18 months n = Mean %=	Cohort 1: Cohort 2:
IV. Domestic Violence							
Construct	**Measure**	**Numerator**	**Denominator**	**Quality Improvement Target**	**Program Result**	**All MIECHV Programs**	**# of Programs Reporting**

25. Screening for Domestic Violence	Female caregivers are screened for domestic violence	# of female caregivers screened for domestic violence by 6 months enrollment	# of female caregivers enrolled 6 months	90% of female caregivers are screened for domestic violence by 6 months of enrollment	**Cohort 1** By 6 months # screened: # of female caregivers: % screened: **Cohort 2** By6 months # screened: # of female caregivers: % screened:	**Cohort 1** By 6 months # screened: # of female caregivers: % screened: **Cohort 2** By 6 months # screened: # of female caregivers: % screened:	Cohort 1: Cohort 2:
26. Number of Families Identified for the Presence of Domestic Violence, Number of Referrals Made to Relevant Domestic Violence Services	Female caregivers who screen positive for domestic violence are referred to services	# of female caregivers who screen positive for domestic violence who are referred for services	# of female caregivers who screen positive for domestic violence	90% of female caregivers who screen positive for domestic violence are referred for services by 6 months of enrollment	**Cohort 1** By 6 months # screened positive who were referred: # screened positive: % referred: **Cohort 2** By 6 months # screened positive who were referred: # screened positive: % referred:	**Cohort 1** By 6 months # screened positive who were referred: # screened positive: % referred: **Cohort 2** By 6 months # screened positive who were referred: # screened positive: % referred:	
27. Number of Families Identified for the Presence of Domestic Violence, number of Families for which a Safety Plan was Completed	Female Caregivers who screen positive for domestic violence have a safety plan	# of female caregivers who screen positive for domestic violence and have a safety plan	# of female caregivers who screen positive for domestic violence	90% of female caregivers who are experiencing domestic violence have a safety plan by 6 months of enrollment	**Cohort 1** By 6 months # screened positive who have safety plan: # screened positive: % with safety plan: **Cohort 2** By 6 months # screened positive who have safety plan: # screened positive: % with safety plan:	**Cohort 1** By 6 months # screened positive who have safety plan: # screened positive: % with safety plan: **Cohort 2** By 6 months # screened positive who have safety plan: # screened positive: % with safety plan:	

V. Family Economic Self-sufficiency							
Construct	**Measure**	**Numerator**	**Denominator**	**Quality Improvement Target**	**Program Result**	**All MIECHV Programs**	**# of Programs Reporting**
28. Household Income and Benefits	Benefits received by all families that have reached 12 months enrollment and have data reported at both 6 and 12 months	Number of benefits received by families who have been enrolled 12 months	Number of families that have been enrolled 12 months and have reported benefit data at both enrollment and 12 months	Mean number of benefits received by families increases	**n=** At Enrollment Mean = Missing (not included in 'n' or 'mean') = At 12 months Mean = Missing (not included in 'n' or 'mean') =	**n =** At Enrollment Mean= At 12 months Mean=	
	Combined estimated dollar value of income and benefits	Combined estimated dollar value of income and benefits	Number of families who reached 12 months post enrollment and reported income and benefits at both 6 months and 12 months	Combined estimated dollar value of income and benefits by famlies increases	**n=** At Enrollment Mean combined dollar value: At 12 months Mean combined dollar value:	**n=** At Enrollment Mean combined dollar value: At 12 months Mean combined dollar value:	
29. Employment or Education of Adult Member of the Household	Caregivers' hours of employment for families which have reached 12 months enrollment and have data reported at both 6 and 12 months	Combined hours of employment (total paid work and care of child) for participating caregivers from 6 and 12 months enrollment	Number of caregivers who reached 12 months post enrollment and reported hours of employment at both 6 months and 12 months	Mean number of hours of employment (total paid work and care of child) for participating caregivers increases	At Enrollment n= Mean = At 12 months n = Mean =	At Enrollment n = Mean = Highest Mean = Lowest Mean = At 12 months n = Mean = Highest Mean = Lowest Mean =	
VI. Coordination of Referrals and Other Community Resources							
Construct	**Measure**	**Numerator**	**Denominator**	**Quality Improvement Target**	**Program Result**	**All MIECHV Programs**	**# of Programs Reporting**

31. Number of Families Identified for Necessary Services	Families receive a comprehensive assessment of their service needs*	# of families who received a comprehensive assessment of their service needs at 6 months	# of families that have reached 6 months enrollment	90% of families receive a comprehensive assessment of their service needs by 6 months of enrollment	**Cohort 1** <u>At 6 months</u> # assessed: # of families: % assessed: **Cohort 2** <u>At 6 months</u> # assessed: # of families: % assessed:	**Cohort 1** <u>At 6 months</u> n = Mean = **Cohort 2** <u>At 6 months</u> n = Mean =	Cohort 1: Cohort 2:
32. Number of Families that Required Services and Received a Referral to Available Community Resources	Service needs are met with referrals	# of specific service needs with a matching referral	# of service needs reported at enrollment and 6 months	90% of specific service needs receive a matching referral by 6 months of enrollment	**Cohort 1** <u>By 6 months</u> # of needs that received a matching referral: # of specific needs identified: % of needs that received a matching referral: **Cohort 2** <u>By 6 months</u> # of needs that received a matching referral: # of specific needs identified: % of needs that received a matching referral:	**Cohort 1** <u>By 6 months</u> n = Mean % = **Cohort 2** <u>By 6 months</u> n = Mean % =	Cohort 1: Cohort 2:
	Families with any service need receive at least one referral*	# of families that had at least one service need who received at least one referral at 6 months	# of families with at least one service need	Number of families with service needs that receive a referral at 6 months increases	**Cohort 1** <u>At 6 months</u> # of families with at least one service need: # of families with a need(s) and at least one referral: % of families with referrals: **Cohort 2** <u>At 6 months</u> # of families with at least one service need: # of families with a need(s) and at least one referral: % of families with referrals:	**Cohort 1** <u>At 6 months</u> n = Mean % = **Cohort 2** <u>At 6 months</u> n = Mean % =	Cohort 1: Cohort 2:

33. MOUs: Number of Memoranda of Understanding or other Formal Agreements with other Social Service Agencies in the Community	MOUs or other formal agreements each HV funded agency has with other social service agencies in the community*	NA	NA	# of formal relationships with other social service agencies increases annually	**Year 1/Baseline (10/2011-9/2012):** #: **Year 2 (10/2012-9/2013):** #:	**Year 1/Baseline (10/2011-9/2012):** n = Mean = Highest # = Lowest # = **Year 2 (10/2012-9/2013):** n = Mean = 7 Highest # = Lowest # =	Year 1: Year 2:
34. Information Sharing: Number of Agencies with which Home Visiting Provider has a Clear Point of Contact	Agencies have a clear point of contact with members of their local Great Start Collaborative*	# of Great Start Collaborative members home visiting agency reports clear point of contact	# of Great Start Collaborative members in the community	Home visiting programs have a clear point of contact with 90% of Great Start Collaborative members	**Year 1/Baseline (10/2011-9/2012):** %: **Year 2 (10/2012-9/2013):** %:	**Year 1/Baseline (10/2011-9/2012):** **n =** Mean %= Highest % = Lowest % = **Year 2 (10/2012-9/2013):** **n =** Mean %= Highest % = Lowest % =	Year 1: Year 2:
35. Number of Completed Referrals	Specific referrals result in contact between a family and the targeted referral agency	# of specific referrals that result in contact between a family and the targeted referral agency by 6 months	# of referrals provided at both enrollment and 6 months	75% of referrals result in contact between families and referral agency by 6 months of enrollment	**Cohort 1** <u>By 6 months</u> # specific referrals that result in contact: # referrals: % completed referrals: **Cohort 2** <u>By 6 months</u> # specific referrals that result in contact: # referrals: % completed referrals:	**Cohort 1** <u>By 6 months</u> **n =** Mean % = **Cohort 2** <u>By 6 months</u> n = Mean % =	Cohort 1: Cohort 2:

	Families with any referral make contact with a referral agency*	# of families that contact a referral agency once a referral has been provided	# of families that received a referral for any service at 6 months	# of families that make contact with referral agencies at 6 months increases	**Cohort 1** At 6 months # families that made contact: # families receiving referrals: % completed referrals at 6 months: **Cohort 2** At 6 months # families that made contact: # families receiving referrals: % completed referrals at 6 months:	**Cohort 1** At 6 months **n =** Mean % = **Cohort 2** At 6 months n = Mean % =	Cohort 1: Cohort 2:
Program Level Indicators							
Measure	**Quality Improvement Target**		**Cohort 1**	**Cohort 2**	**All MIECHV funded HV Programs - Cohort 1**	**All MIECHV funded HV Programs - Cohort 2**	**# of programs reporting**
Length of time families are enrolled in program	Mean length of time families are enrolled in the program increases		Exited **n =** Mean: Still Enrolled: n = Mean =	Exited **n =** Mean: Still Enrolled: n = Mean =	Exited **n =** Mean = Still Enrolled **n =** Mean =	Exited n = Mean = Still Enrolled n = Mean =	Exited: cohort 1: cohort 2: Still Enrolled: cohort 1: cohort 2:
Home visits are completed by families	Mean percent of home visits completed by families increases		At 6 months **n =** % = At 12 months n = % =	At 6 months **n =** % = At 12 months n = % =	At 6 months **n =** Mean % = At 12 months **n =** Mean =	At 6 months n = Mean % = At 12 months n = Mean % =	Exited: cohort 1: cohort 2: Still Enrolled: cohort 1: cohort 2:

Appendix C: CQI Team Charter Template

CQI TEAM CHARTER

1. Team Name:	2. Version:	3. Subject (Target Area):

4. Problem / Opportunity Statement:

5. Team Sponsor (Program Manager/Coordinator/Supervisor):

6. Team Members:	Role:
	Leader
	Facilitator
	Scribe

7. Process Improvement Area:

8. Initial Aim Statement:

9. Revised Aim Statement (s) (include date revised):

10. Scope (Boundaries)/Team Authority:

11. Customers (Internal and External):	12. Customer Needs Addressed:

13. Success Measures (What does success look like?):	

14. Considerations (Assumptions / Constraints / Obstacles):

15. PDSA Timeline:	Date:
Plan	
Do	
Study	
Act	
16. Meeting Frequency:	
17. Communication Plan (Who, How, and When):	
18. Stakeholders (Internal and External):	
19. Improvement Theories (If…Then):	
If	Then
If	Then

Appendix D: CQI Story Board Template

MIECHV Program CQI Story Board

Home Visiting Program Name Home Visiting Program Model: Counties Served: Population Served:	**CQI Team Members:**	**Quality Improvement Story Board** CQI Project Title

PLAN
Identify an Opportunity and Plan for Improvement

1. Getting Started

Problem Statement

2. Assemble the Team

Aim Statement

3. Examine the Current Approach

Process Map

Fishbone Diagram

4. Identify Potential Solutions

Affinity Diagram

5. Develop an Improvement Theory

Improvement Theory

DO
Test the Theory for Improvement

6. Test the Theory

STUDY
Use Data to Study Results of the Test

7. Study the Results

ACT
Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop New Theory

9. Establish Future Plans