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MIECHV

N-MIECHV QUALITY
MANAGEMENT 2014-
2015

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N-MIECHV Quality Management 2014-2015

Nebraska Department of Health and Human Services Division of Public Health



An effective Evidence-Based home visiting system responds with a data and quality driven methodology to the diverse needs of children and families in your community and provides a unique opportunity for collaboration and partnerships to improve health and development outcomes.

An effective Continuous Quality Improvement (CQI) system is one that involves all levels of invested and motivated home visiting stakeholders in a process of evaluating system processes that were designed to achieve a number of predetermined federal benchmark and other outcomes.

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PURPOSE

The purpose of this manual is to provide a technical overview of the Nebraska Maternal, Infant and Early Childhood Home Visiting (N-MIECHV) Quality Improvement (CQI) processes. The manual is divided into three purpose areas or chapters.

1. Infrastructure
 - a. Background
 - b. Philosophical framework
 - c. Operational procedures
 - d. Data system for collection of CQI data
 - e. Reporting structure and formats
2. N-MIECHV CQI Model
3. CQI annual plan

- I. Chapter one describes the specific infrastructure and processes designed to support the work of the CQI teams,
- II. Chapter two describes the specific operational procedures and processes members of the CQI teams use to get the work done, and
- III. Chapter three provides an annual overview of the planned CQI work. This chapter is updated annually (or more often as needed) to outline the major steps and actions for each community and the state team in maintaining and elevating the CQI work.

This manual describes a number of current procedures that are already in operation, and also describes a number of planned steps and procedures scheduled for implementation during the current grant year. As this year's process continues our team will re-evaluate the feasibility of the proposed model and provide sufficient opportunity to make modifications along the way.

Chapter I

Infrastructure

INTRODUCTION

MIECHV

Nebraska Maternal, Infant and Early Childhood Home Visiting (N-MIECHV) is part of a national initiative centered on home visiting as a primary service delivery strategy, targeting specific participant outcomes including improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, reduction of emergency department visits, improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports.

An Opportunity for Building System Quality

The MIECHV initiative provides an unprecedented opportunity for collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for children through evidence-based home visiting. The program is one of several strategies embedded in a comprehensive early childhood system that promotes maternal, infant, and early childhood health and development, relying on the best available research evidence to inform and guide practice. An integral part of this is the application of a strategic and continuous method of assessing processes and program quality.

A Need for CQI

To achieve this purpose it is essential to implement a procedure that systematically reviews performance measures and outcomes, and creates plans for improvement within programs and the broader system. This will help determine whether services and activities meet program expectations of quality and progress as well as other outcomes.

This CQI process will involve all staff and a number of community stakeholders in the evaluation of the effectiveness of home visiting services, the support system, and N-MIECHV as a whole. To achieve maximum impact, staff and stakeholders will practice a system of self-directed improvement.

What is CQI?

CQI is an approach that builds upon traditional quality assurance methods. It focuses on "process" rather than the individual or a program. CQI is a philosophy which accepts that most things can be improved. At the core are on-going efforts to monitor and a process of experimentation applied to everyday work to meet the needs of families and improve services. Collectively CQI provides:

- An approach that promotes the objective analysis of data to improve processes and outcomes.
- A process that focuses on system improvements rather than individual deficiencies.
- A means for the adaptation of standardized processes and frameworks for programs.
- An analytical decision-making process that allows for testing a solution, evaluation of the results to predict the likelihood of achieving target outcomes.
- An emphasis on a process of constant improvement in service delivery, requiring long-term organizational commitment and teamwork.¹

¹ Adapted from information from the Institute for Healthcare Improvement, NC Center for Public Health Quality, NC Charlotte Area Health Education Center, and NC State University Industrial Extension Service.

PHILOSOPHICAL GUIDELINES

Philosophical Framework

The N-MIECHV CQI process strives to achieve a level of service and system quality that meets federal MIECHV and Healthy Families America (HFA) accreditation standards, and that promotes quality outcomes for children and families. The overall goals of the N-MIECHV CQI process are to:

1. Promote the achievement of the federal benchmark outcome goals.
2. Assure the implementation of quality Evidence-Based home visiting services that meet applicable fidelity measures.
3. Achieve local and statewide efficiencies and effectiveness around home visiting.
4. Increase the availability of resources and quality tools for the state's Home Visiting programs.

The N-MIECHV CQI system works within the framework of the vision and mission of the Nebraska Home Visiting Partnership.

Mission: To ensure coordination and collaboration between public and private partners in the planning and implementation of high quality home visiting strategies in Nebraska.

Vision: Children are healthy, families thrive, and communities grow stronger.

N-MIECHV CQI Guiding Principles

Fundamental to the development of Nebraska's CQI is remembering that the system is designed to improve the lives of young children and their families, thereby strengthening communities. We have a commitment to providing credible and transparent processes that are aimed at achieving the best possible outcomes. Guided by this core commitment, the N-MIECHV CQI process also includes the following fundamental principles:

1. CQI team members are adequately trained in CQI modalities and home visiting best practice.
2. CQI and data inform policy and procedure development.
3. The team supports various perspectives and views with a collaborative spirit, and encourages creative yet efficient and effective solutions to problems.
4. CQI is seen as an investment.
5. The focus is on learning and process improvement rather than blaming people or programs.

N-MIECHV Data System Core Value

Every data component represents a child, a parent, a family and a N-MIECHV Community.

We are committed to this responsibility.

Department of Health & Human Services
DHHS
NEBRASKA

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The graphic features a dark blue header with the title 'N-MIECHV Data System Core Value' and a glowing blue globe icon. Below the header, the text is centered on a white background. To the right of the text is a collage of three photos: a man and woman, a group of people, and a baby. At the bottom left is the DHHS Nebraska logo, and at the bottom right is the number '6'.

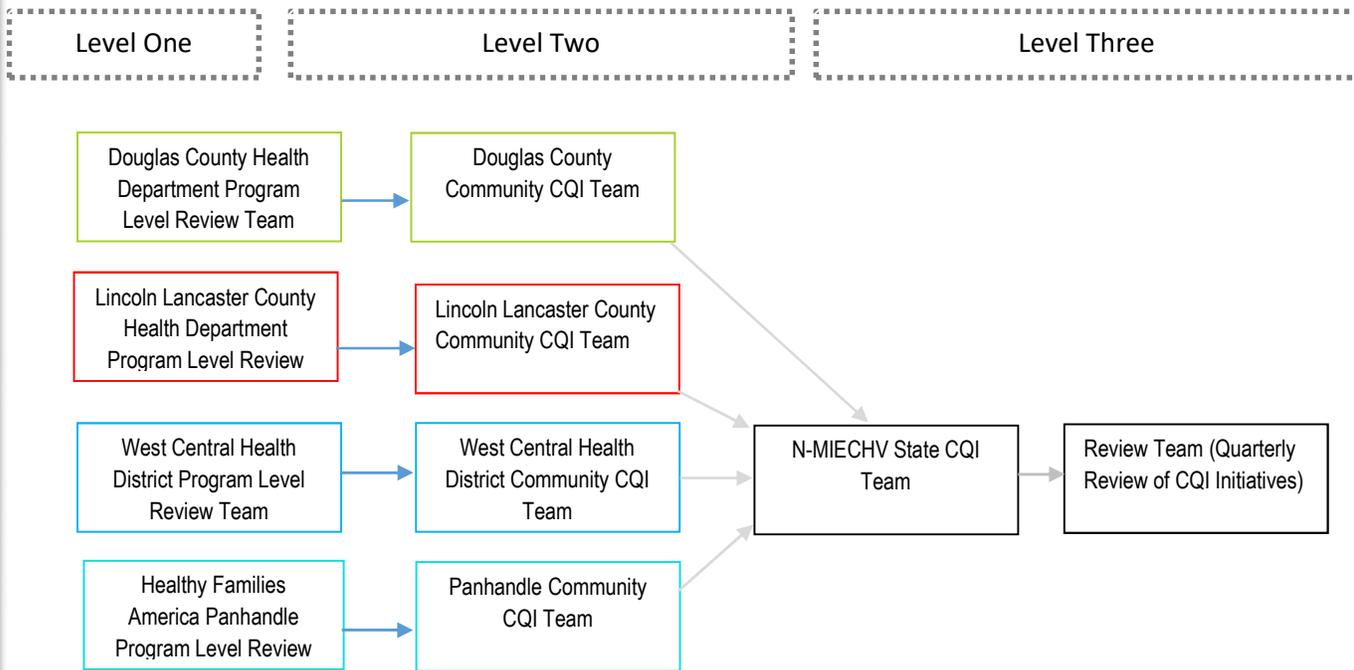
OPERATING PROCEDURES

The N-MIECHV CQI organizational structure contains three processes (please reference the CQI model chart on page 19 for a more comprehensive view of the process).

- a.) The first level process is facilitated continuously at the program level and is completed by a program level review team.
- b.) The second level process is facilitated as a formal CQI process at a site or community level.
- c.) The third level process is facilitated as a formal CQI process at the state level.

Organizational Chart

N-MIECHV currently includes home visiting services provided in the four communities of Douglas County, Lincoln/Lancaster County, West Central Health District, and the Panhandle. Each of these communities will facilitate program- and community-level CQI processes for local problem-solving, while passing the information to the state-level CQI team if it is a problem that is also experienced by other communities. A final annual review of all completed CQI cycles and possible recommendations will be provided by a state review team². A more comprehensive description of the proposed CQI process is provided in chapter two.



Membership

The N-MIECHV CQI teams are comprised of stakeholders from participating Home Visiting programs and other disciplines from around the state to identify key processes that contribute to positive outcomes in home visiting. Both, the involvement of all staff and the array of community stakeholders are vital to the success of the N-MIECHV CQI process. The teams review program data and findings, evaluate and test recommendations, and suggest and implement changes to improve practice.

CQI team members are individuals who are willing to challenge each other to make key decisions, and to be creative and forthcoming with recommendations. Teams typically have 8-12 members. The following chart provides suggested team configurations.

Level	Recommended Membership
<u>Program Level Quality Review</u>	<u>Review Team Members</u> <ul style="list-style-type: none"> ➤ 2-5 Home Visitors ➤ A data specialist ➤ A program manager or supervisor ➤ The site administrator
<u>Community Level CQI</u>	<u>CQI Stakeholders</u> <ul style="list-style-type: none"> ➤ Site administrator (or designee) ➤ Site supervisor ➤ One consumer ➤ One Home Visitor ➤ Referral network representative ➤ Early childhood system representative ➤ Other community stakeholders as desired
<u>State Level CQI</u>	<ol style="list-style-type: none"> 1. <u>State Stakeholders</u> <ul style="list-style-type: none"> ➤ Statistical Analyst ➤ Home Visiting Program Coordinator ➤ MCH Surveillance Coordinator and Epidemiologist 2. <u>Home Visiting Stakeholders</u> <ul style="list-style-type: none"> ➤ Directors or supervisors of each local N-MIECHV implementation site ➤ Other Home Visiting program representatives (should have decision making responsibility – or be able to strongly advocate for implementation of strategies) ➤ One Home Visitor

Meeting Schedule

CQI teams meet at least quarterly - a best practice standard. New teams might find it appropriate to meet more frequently during the initial implementation period (for up to one year) to more closely monitor process efficiencies and the effectiveness of the early childhood and community support systems. Program-level monitoring should be a continuous process with frequent monitoring by supervisory and Home Visiting staff. The site and the state-level CQI teams meet minimally, on a quarterly basis; more often as needed or as requested by the program-level review team. The CQI cycle for each project goal will take approximately 6-10 months to complete, beginning with the analysis, continuing with the planned implementation, and concluding with a permanent implementation of the agreed-upon strategy.

Record Keeping

A good communication plan is a key ingredient of a successful CQI process. Stakeholders and team members impacted by the process will be kept informed of the changes, timing, and status of the quality improvement projects.

Each CQI team will keep a file of all documents related to activities and accomplishments. This includes at a minimum meeting agendas, data reports, meeting notes, attendance records, research material and a description of each completed CQI cycle. The description will contain narrative and graphical information about each step of the CQI cycle and a formal plan for each goal (a plan outline is provided in appendix 3). The CQI manual will be updated annually and, in addition to the items described in this section, should also include all CQI procedures and a description of the annual CQI plan.

Decision Making

All decisions are made by consensus. Consensus does not mean everyone agrees with the decision, nor does it mean taking a vote and majority rule. Rather, consensus means that everyone agrees to actively support the group decision.

Confidentiality

Confidentiality can become a concern during the CQI process as sensitive information will be shared. In order to assure confidentiality of families, staff and programs, there is to be no reference during meetings to specific identifiable information such as names, protected information or titles. Data will be provided only as community-level aggregate data and may be shared only with permission from applicable program administrators.

A second level of confidentiality also needs to be observed. The majority of concerns discussed by the team can be shared. However, team members need to be sensitive to the fact that some discussions should remain confidential. Problem solving is a creative process during which teams discuss ideas and concerns that might be misinterpreted by someone unfamiliar with the context of the discussion. Information discussed during team meetings should not be shared with persons outside of the meeting.

Training and Support

The CQI process needs to be well organized and adequately supported with sufficient resources. The N-MIECHV state team plays a vital role in the support and development of the CQI process. After core training, ongoing support and development of the CQI teams is provided as follows:

- 1.) Each site receives technical assistance in the development of a CQI manual and procedures.
- 2.) As needed, the N-MIECHV state team will provide training and orientation for new CQI team members. The specific purpose of the training is to gain a deeper understanding of home visiting, fidelity, and the purpose and strategies of effective CQI.
- 3.) In addition to the N-MIECHV state Maternal Child Health Epidemiology team, other levels of expertise are available to the team as needed through:
 - a. The University of Nebraska Medical Center (UNMC) N-MIECHV evaluation team. The team can provide professional guidance relating to data analysis and practical application. (Note: This evaluation ends 9/30/2015)
 - b. The University of Kansas (KU) data team. The team can provide expertise relating to data collection, data analysis and visual presentation of data.
 - c. The Nebraska Public Health Improvement Initiative. This team is able to provide national expert technical assistance related to CQI.
 - d. The MIECHV Technical Assistance and Coordinating Center (TACC). The TACC is a national provider and provides support to state and territory grantees in implementing MIECHV-funded Home Visitation programs. The TACC brings extensive experience and a wealth of expertise in achieving high quality program implementation, creating integrated service systems and improving program outcomes.
 - e. Design Options for Home Visiting Evaluation (DOHVE). DOHVE provides guidance and assistance to grantees funded under the MIECHV Program on issues related to strengthening their evaluations of promising programs, developing and adapting data systems to facilitate tracking and reporting on federal benchmarks, and implementing quality improvement systems.

CQI Process Procedure

The N-MIECHV initiative will use the CQI model of data-driven decision-making to promote the use of evidence-based practices, in which programmatic decisions are guided by data and the best evidence from scientifically sound research. While there are several formal models of CQI, N-MIECHV has chosen *the Plan, Do, Study and Act (PDSA)* cycle.

The cycle involves a well-researched and logical approach to team problem-solving. The steps include the use of quality tools. The advantage of a common model is that everyone can begin to speak the same quality improvement language, and each stakeholder can understand what step of the process they are working in. The PDSA cycle is a series of activities designed to improve efficiencies in order to achieve better outcomes. It breaks the CQI process into manageable pieces, using a series of individual cycles that build on successes and lessons learned.³

³ Adapted from information from the Institute for Healthcare Improvement, NC Center for Public Health Quality, NC Charlotte Area Health Education Center, and NC State University Industrial Extension Service.

1. Identify the need

Identify needs and develop a problem statement.

2. Define the current situation

Break problem down into component parts, identify major problem areas, and develop a target improvement goal.

3. Analyze the problem

Identify the root causes of the problem, using charts and diagrams as needed.

4. Develop an action plan

Outline ways to correct the root causes of the problem, specific actions to be taken, identify who, what, when and where.

5. Engage in Plan , Do, Study, Act

Plan

Plan a pilot test of the action. Include in the plan a measure of performance and means of data collection. This will enable the QI team to know whether the intervention is working.

Do

Implement the intervention. Make sure necessary data are generated.

Study

Collect and analyze data to see whether the intervention works before making it part of ongoing daily operations.

Act

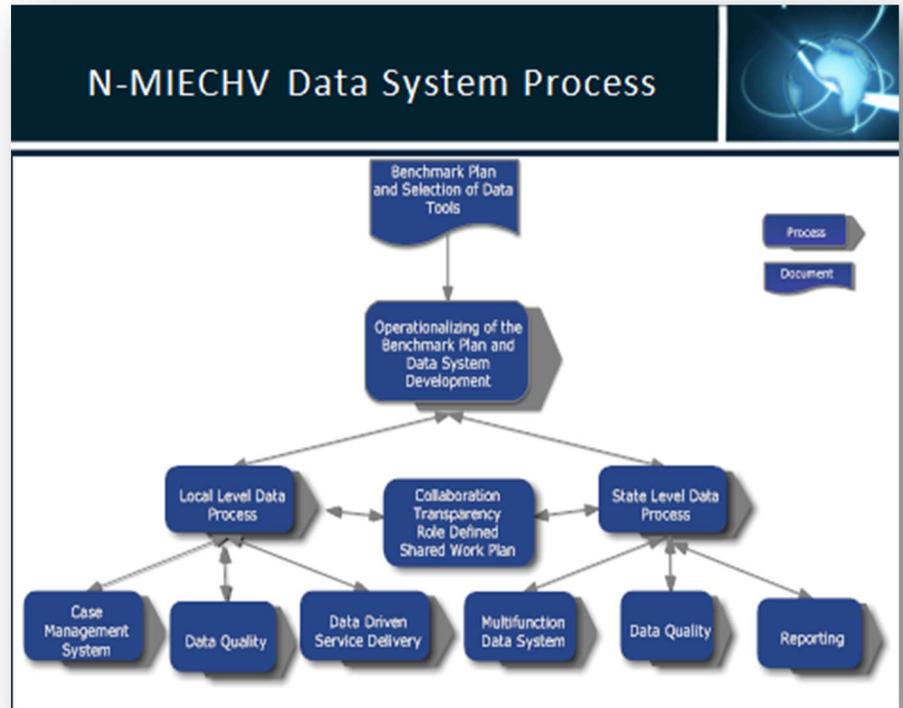
If the new process is effective, make it part of ongoing operations. If the change is an incremental step, continue on to the next step in the subsequent PDSA cycle. If the new process is not effective, use what was learned to design another intervention that will be tested in the next PDSA cycle. The "Act" of one cycle informs, or sometimes becomes, the "Plan" of the next cycle, creating a continuous process of improvement.

DATA COLLECTION

Collection, management and utilization of data are vital concepts in CQI. To assist this process, N-MIECHV has developed a comprehensive information system that collects data to monitor key implementation processes and outcomes. These data are used to measure the MIECHV Benchmarks, perform the N-MIECHV Evaluation and assess CQI efforts. This section describes the data collection and data management process.

The foundation for all data-related activities is the team's commitment to quality data collection. A programmatic culture where data are valued and used for process improvement and optimal outcomes needs is a shared vision of all N-MIECHV team members.

The N-MIECHV data system includes both local level case management databases and a state-level data collection and integration system. The state system merges local level data with other relevant data collected by outside agencies. The process for data collection is one that is shared and parallel across sites, and characterized by a highly collaborative and transparent procedure. A shared work plan with specific activities defines roles and responsibilities of the state and the site teams.



Sources of Information

Most of the information collected concerns the participant/family and the target child. On occasion, information may also concern other members of the household. Some information may not readily be available to the Home Visitor. For this reason the system is designed to collect data from other sources to complement the data collected during service initiation and home visits. For example, quarterly reports will be obtained at the state level from Nebraska Child Protection Services to identify substantiated cases of child abuse and neglect. The following tables describe the data sources, the data collection tools and the data collection timeframes.

Data Collection Sources

- Family self-reports
- Questionnaires
- Assessment tools
- Screening Tools
- Field observation HV
- Field observation Supervisor
- External data bases

Data Collection Tools

Data Bases	Data/Assessment Tools
<ul style="list-style-type: none"> ○ Local Case Management Systems ○ N-Focus ○ NESIIS ○ REDCap ○ Vital Records 	<ul style="list-style-type: none"> ○ ASQ 3 and ASQ SE ○ UNCOPE ○ HFPI ○ CES-D ○ DV Screening Tools

(Psychometric properties of the tools can be found in Appendix (5) Tool Description and Psychometric Properties)

Data Collection Time Table

<ul style="list-style-type: none"> ○ Before enrollment ○ At referral ○ At assessment ○ At intake ○ Prenatal ○ Post-partum 	<ul style="list-style-type: none"> ○ At 3 or 6 months ○ When the child reaches a certain age ○ During home visits ○ When an event occurs ○ Annually ○ Upon discharge
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(Additional information about timeframes can be found in Appendix (1) Data Collection Schedule)

Local HV Data Bases

Each program collects individual-level data through electronic case management systems. An implementation process is utilized to assure that each data system is designed to collect specific data related to the MIECHV Benchmarks, CQI, demographic and service utilization and other local needs. The data systems are either purchased from vendors or are locally developed. Each system meets specific requirements, is comprehensive, and serves to inform the local CQI process as well as provide data for benchmark reporting. Careful planning during implementation phases assures that all necessary data fields are collected and that data quality checks are implemented. Characteristics of the local data systems include:

- a.) Owned and operated locally
- b.) Use of technology such as electronic tables (e.g., iPads®) to collect data in “real time”
- c.) Flexibility in custom design
- d.) Data quality and reporting functions

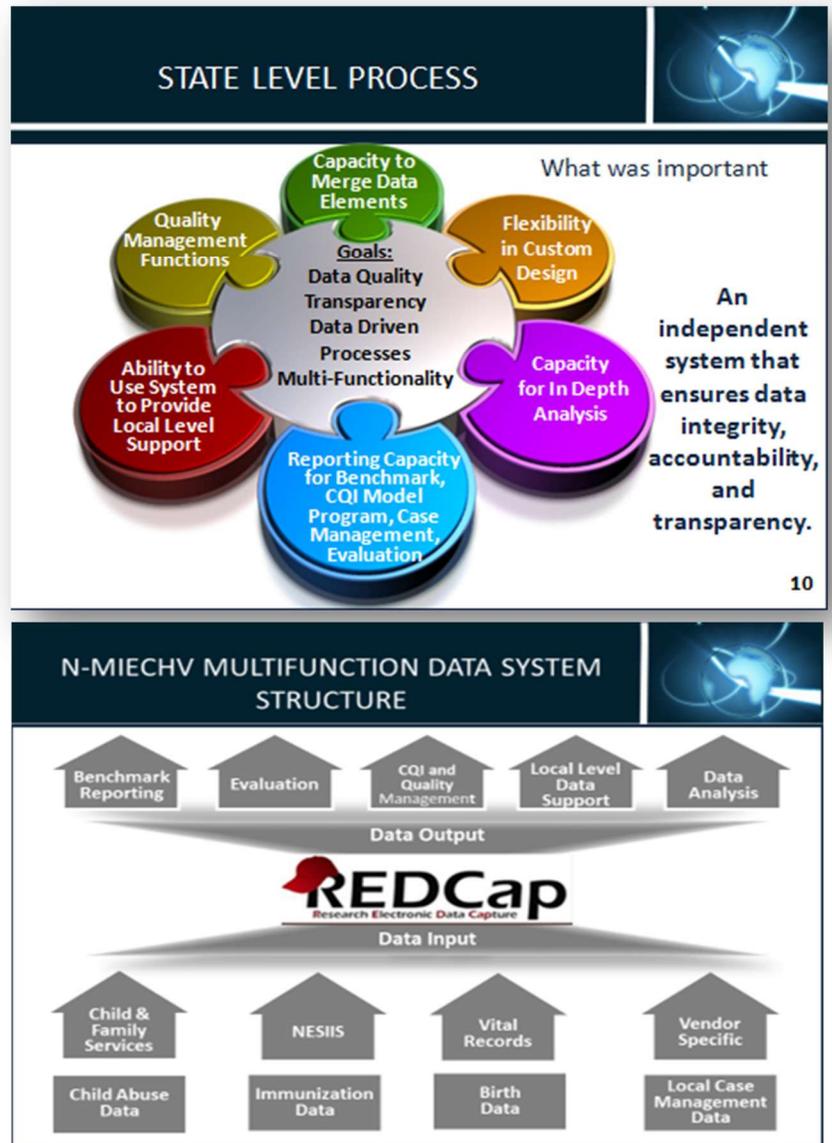


N-MIECHV Data System

At a minimum, program level data are transferred quarterly to the secure NDHHS FTP site. Datasets are then processed and transferred to the REDCap (Research Electronic Data Capture) system which is housed on a secure DHHS server. REDCap is a data repository or warehouse that manages longitudinal linked data, and is the platform for statewide data collection. The REDCap system was specifically tailored for N-MIECHV and is currently supported through a contract with the University of Kansas. Key characteristics of the state data system include:

- a.) Quality management functions
- b.) Capacity for merging data elements
- c.) Flexibility in custom design
- d.) Capacity for in depth analysis
- e.) Benchmark, CQI, and evaluation reporting capacity
- f.) Capacity of provide local data support

In addition to local-level home visiting program data, N-MIECHV obtains additional data from the DHHS Child and Family Services (CFS), Vital Records, Immunization (NESIIS), and Health Statistics programs. These files are integrated into the reporting and evaluation file, using a unique Family ID. Once the data are successfully merged in REDCap and data quality standards are met, a data package is exported for CQI reporting.



Data Quality Management

To meet data quality CQI standards, local systems need basic elements such as usability and accessibility, real-time access, training and support of users, and ongoing maintenance and upgrades (Ammerman 2011). Vendors for local case management systems provide the overall maintenance of the system. The databases are web-based systems, and Home Visitors utilize data entry “tablets” for real time/field data entry. Training and support, and efficiency capacities include the following:

- Data entry, data quality trainings and on-going training support as needed are addressed by the N-MIECHV state team.
- Case management vendors are available to assist with immediate data entry needs.
- Webinars centering on connecting the data to practice and addressing data entry concerns are provided by Vendors.
- Technical assistance and training is provided for special topics as needed through the University of Kansas.
- Tickler/alert systems provide Home Visitors with the due dates of the various assessments, fidelity activities and data entry schedules.
- Reporting capability allows supervisors to provide regular data quality checks and also serves as a real time supervision tool.
- Web-based real time data entry.
- Fidelity reports match each Model Program standard and provide enrollment and retention reports.
- Table export utilities provide automated export procedures for seamless data downloads to Excel and common statistical packages (SPSS, SAS, Stata, R).

REPORTING

Extensive data reporting formats have been developed for the CQI process. This section describes the reporting capacity and structure that will be utilized for N-MIECHV CQI, and includes local and state-level capacities and structures.

Local Level Reporting Capacity

The local level data bases have advanced features that can produce reports for CQI, staff support and fidelity assessment. This increases ownership and independence, allows program level access to reports and data in “real time,” and reduces the reliance on state-level reporting. The following reporting capacities are available at the local level:

- a.) Credentialing reports addressing critical fidelity elements.
- b.) CQI reports addressing primary processes.
- c.) Quarterly reports addressing service utilization and outcomes.
- d.) An export utility allowing the transfer of data into statistical analysis programs.
- e.) “Tickler” reports providing alerts of due dates.

Vendors for the local case management systems offer considerable flexibility so that communities can design and add additional reports to the system as needed.

State-Level Reporting Capacity

On a state level, the N-MIECHV data system has the capacity to produce a considerable amount of client, family, and community-level data. An attractive feature of the REDCap data management system is its ability to merge multiple sources of data – whether generated by the program or received from external partners, and produce reports on these multiple levels.

As needed, additional reports will be developed for relevant processes to enhance operation and decision-making and to optimize services. The statewide REDCap data system links local data with child abuse data and well-child data. Linking databases in this manner provides a firm cornerstone for effective use of data reporting for QI purposes.

What are the Benchmarks?

The legislation establishing MIECHV requires quantifiable, measurable improvements for the populations participating in the program. Grantees must demonstrate improvement in the following benchmark areas:

1. Improved maternal and newborn health
2. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits
3. Improvement in school readiness and achievement;
4. Reduction in crime or domestic violence
5. Improvements in family economic self-sufficiency; and
6. Improvements in the coordination and referrals for other community resources and supports. "

Alignment and Integration with Benchmarks

Reports also include aggregate outcome data, which will be submitted to the federal funders in the MIECHV-approved reporting forms for demographic and benchmark data. The benchmark data will also be utilized for the evaluation plan and CQI as well as for reporting to local communities. For example, local programs will receive CQI, benchmark and evaluation reports quarterly. These reports will assist local communities with assessing their success in addressing their community's unique risks and priorities.

Reporting Formats and Schedule

The proposed reporting formats and schedule include numerous reports, formatted to fit the needs and expertise level of the target audience, designed to assist teams in tracking progress and identifying problem areas. Reports are generated on a monthly, quarterly, semi-annual and annual basis. The frequency of the reports is specific to five target areas (discussed later in this document).

For more specific information about the proposed frequency and review structure of the reports, please reference the reporting schedule below. The schedule describes the team responsible for reviewing and as applicable analyzing the data, the frequency of the reports, those responsible for producing the report and the source of the data.

Report	Review Team (P=Program Team, CCQI= Community CQI Team, CQI= State Team, ET=Evaluation Team, ST=State Leadership Team)					Reporting Schedule													Responsible Person	Source							
	Schedule					Monthly					Quarterly				6 & 12 Month		As Needed										
	P	CCQI	CQI	ET	ST	J	F	M	A	M	J	J	A	S	O	N	D	Q1	Q2	Q3	Q4	6 M	12M				
Benchmark and Outcome Report																											
All Constructs by site and by state	√	√	√	√	√													√	√	√	√					Univ. of Kansas	REDCap
Site or Model Program outcomes	√	√																√	√	√	√					Site Manager	Site DB
Consumer Satisfaction Reports																											
Cultural Competency	√	√	√		√																		√		Business Analyst	REDCap	
Satisfaction Program Process	√	√	√		√																		√		Business Analyst	REDCap	
Satisfaction with Outcomes	√	√	√		√																		√		Business Analyst	REDCap	
Home Visitor Support Reports																											
Training and Development	√	√	√																				√		Site Manager	Site DB	
Case supervision	√	√	√		√													√	√	√	√					Site Manager	Site DB
Competency related to target need	√	√	√																				√		Site Manager	Site DB	
Annual Specific CQI Reports (2012-2013 Plan)																											
Referred by county, site and state			√															√	√	√	√					Univ. of Kansas	REDCap
Retention by site and state			√															√	√	√	√					Site Manager	Site DB
Birth rate by county and state			√															√	√	√	√					Epidemiology	Birth record
Local CQI needs beyond CM system		√																						√		Univ. of Kansas	REDCap
Outlier data		√	√																			√	√			Univ. of Kansas	REDCap
Evaluation Reports																											
TBD	√			√																						Univ. of Kansas	REDCap
TBD	√			√																						Univ. of Kansas	REDCap
Data Quality Reports (monthly schedule for new programs only for the 1st six months)																											
Missing data (all reports) by site	√				√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√					Business Analyst	Server
Date accuracy by site	√				√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√					Site Manager	Server
Timeliness/Time schedule by site	√				√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√					Univ. of Kansas	REDCap
Data transfer quality					√	√	√	√	√	√	√	√	√	√	√	√	√									Business Analyst	
Service Delivery Fidelity and Model Fidelity Reports																											
Referral and Enrollment	√	√			√													√	√	√	√					Site Manager	Site Database
Retention	√	√			√													√	√	√	√					Site Manager	Site Database
Discharge	√	√			√													√	√	√	√					Site Manager	Site Database
Critical Elements	√	√			√																		√			Site Manager	Site Database
Home Visit and goal planning	√	√				√	√	√	√	√	√	√	√	√	√	√	√										
Federal Reports																											
Benchmarks				√	√																		√			Univ. of Kansas	REDCap
Demographics					√																		√			Univ. of Kansas	REDCap
Nebraska Risk Factors																											
Level 1Risk factors by county				√	√																				5 years	Epidemiology	Community

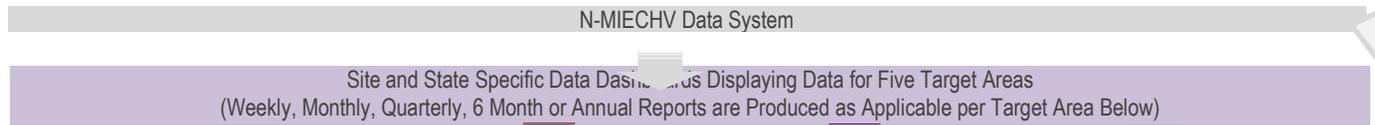
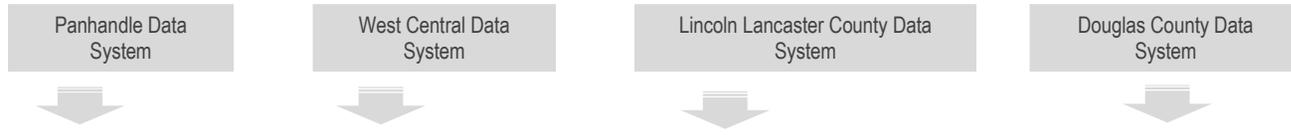
Chapter II

N-MIECHV CQI Model

N-MIECHV Continuous Quality Improvement/Management Model

Support System

- N-MIECHV State Team
- University of Kansas Data Team
- UNMC Evaluation Team
- Technical Assistance Coordinating Center
- Early childhood system
- N-MIECHV Home Visiting Partnership
- Public Health Improvement Initiative TA



Goal: Competent well trained and supported HV provide quality service delivery to fidelity, achieving intended outcomes and great customer satisfaction.



Level One: Program

Performance Management System

Program Specific Home Visiting Quality Monitoring and Improvement

Program teams review data in the 5 target areas with the assistance of a service delivery effectiveness analysis criteria check list. The effectiveness analysis examines process efficiencies and anticipated outcomes. The analysis may determine technical or adaptive challenges. If they are technical, program management will problem solve and implement strategies accordingly, and if they are adaptive and/or in need of further analysis the concern will be passed on to the community specific CQI team.

As needed a process is utilized to prioritize the number of problems to be passed on to the site CQI team (this will assure a strategic approach and avoid overburdening the system).

Level Two: Community

Community-Level CQI

The CQI Community Teams will review the 4 target areas of Support, Service Delivery, Benchmarks and Customer Satisfaction and will receive adaptive challenges passed on by the program. Community teams will complete a root cause analysis and apply the Plan, Do, Check, Study (PDSA) cycle to address the challenges in collaboration with the program. The concern, data and root cause analysis will be passed on to the state CQI team if it can be identified as a concern experienced by other sites, or if it calls for additional adaptive problems solving.

Panhandle Health District CQI Team	West Central Health District CQI Team	Lincoln Lancaster County Health Department CQI Team	Douglas County Health Department CQI Team
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As needed a process is utilized to prioritize the number of problems to be passed on to the site CQI team (this will assure a strategic approach and avoid overburdening the system).

Level
Three:
State

State-Level CQI

The CQI Community Teams will review state level data in the 4 target areas of Support, Service Delivery, Benchmarks and Customer Satisfaction and will receive adaptive challenges passed on by the Community Teams. The state CQI team will complete a secondary root cause analysis and apply the PDSA cycle. Annually, the team will submit all findings to a state review team. The review team will study the results and outcomes of the state CQI cycles and recommend and disseminate suggested changes or adaptations in home visiting to N-MIECHV and other home visiting stakeholders as applicable.

As described in the chart above, N-MIECHV uses a comprehensive CQI model that incorporates program-, community-and state-level systems. Five main target areas have been selected for CQI processes. This section describes the three-step process and actions the CQI teams use to review and address the target areas.

Quality Management Target Areas

Systematic analysis and incorporation of data is the foundation for the processes depicted in the above chart. Data analysis is an integral part of this work, and will be conducted within five main targets. These proposed target areas include:

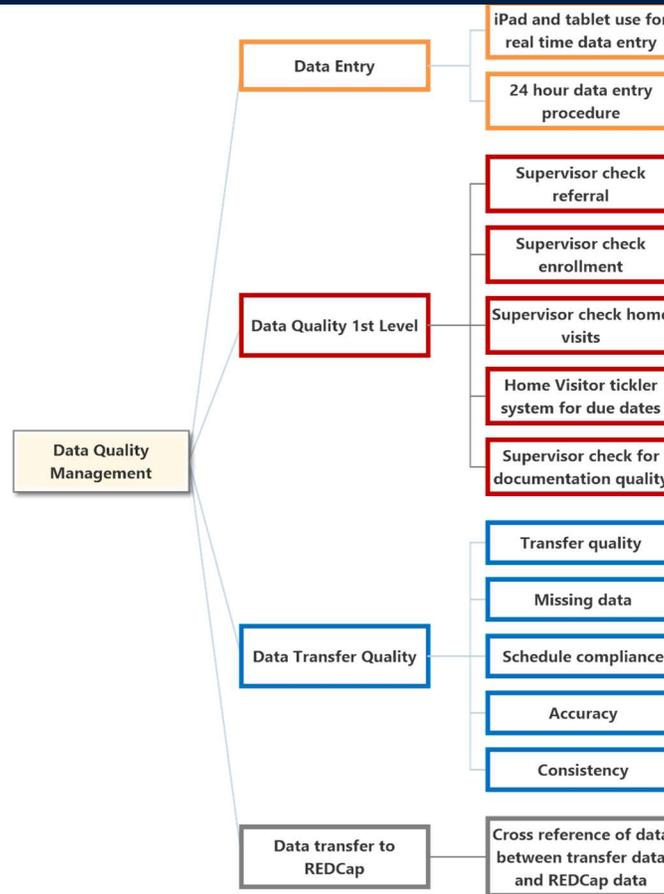
1. Data quality,
2. Service delivery mechanisms and adherence to fidelity measures,
3. Benchmark, outcome and demographic reports,
4. Support systems provided to Home Visitors, and
5. Customer Satisfaction measures.

Current practice stresses the implementation of training procedures, as needed, to strengthen these target areas. The training process includes specific training modules that address data entry, data utilization in practice, and data-informed decision making. A data collection and data quality manual has been developed for N-MIECHV programs and is disseminated to all implementation sites. This process serves as the first step in the CQI model, and helps shape a shared vision among all project staff. A number of additional tools, tables, and procedures further strengthen and enhance this process.

Target Area 1: Data Quality Management

Data-driven processes depend on quality data, which in turn depend on staff commitment to quality in data collection. Data quality is thus a collaborative process between local program sites and the state team. A number of process charts, reports and tools have been developed to check data. The process begins with training of site staff, as well as 3-6 month coaching support of program supervisors, to achieve a level of data quality from the very beginning. Four levels of quality checks occur at major junctions, producing reports that provide program- and state-level teams a summary of any data entry problems (see appendix 1 for further information about data collection timing).

Data quality management will be reviewed monthly by a Performance Management Team.



Target Area 2: Service Delivery Mechanisms and Fidelity

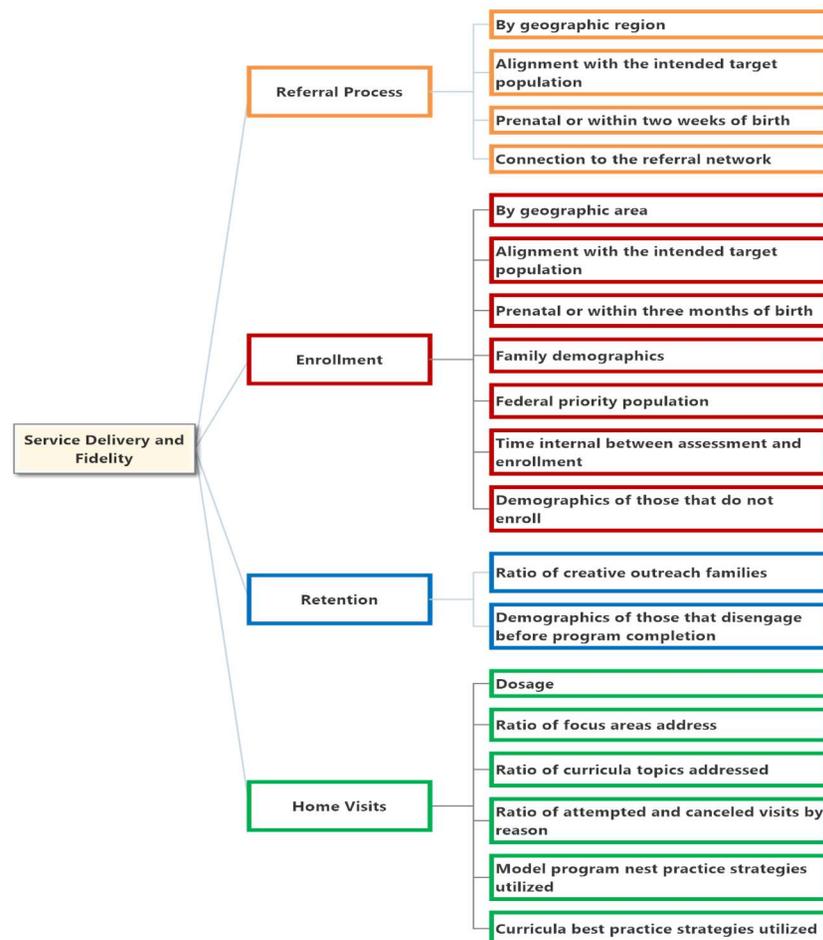
“Fidelity” refers to how well the program adheres to the structure required by the specific model. This target area addresses the specific fidelity measures, and the quantity and quality of required tasks.

Once the data are received from the local programs, the state system performs fidelity and quality analysis to measure adherence to required strategies. This important part of this work determines:

- a.) How well the program is meeting its home visit goals for dosage,
- b.) How well focus areas are addressed with families,
- c.) How often best practice strategies are applied by Home Visitors,
- d.) How well the program is meeting its goals
- e.) for developing and executing Individualized Family Supports Plans
- f.) (IFSP),
- g.) How well families are being connected with a wider support and service team,
- h.) How well the specific fidelity requirements are met as described by the applicable Home Visiting Model Program and
- i.) How the curricula is implemented.

Descriptive client demographic and service utilization data are an important part of the process described above to determine how well the program is meeting its recruitment, enrollment and retention goals. Data analysis includes linking program outcome, fidelity, implementation and process data (as described in the map to the right) to demographic variables based on program targets (e.g., by race/ethnicity, geographic location, parental age, child age), establish points of references to identify gaps and monitor change.

Service delivery data will be reviewed continuously at the program level and quarterly by the CQI teams.

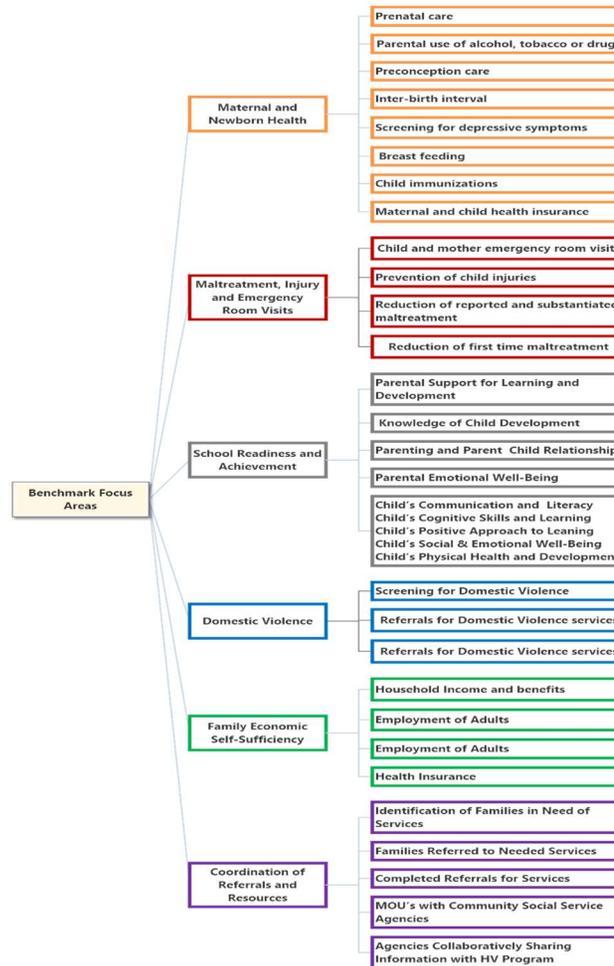


Target Area 3: Benchmarks and Outcomes

State-level staff have developed a benchmark plan, and established reports to monitor change in those benchmarks. This information is critical to the CQI work and although generated at the state, will be interpreted and used by both local- and state-level staff. Continuous measurement of benchmark outcomes indicates which performance areas are lagging and need further attention.

Each community will receive a quarterly benchmark and outcome status report for discussion at CQI meetings. Communities will be able to look at their benchmark data holistically as they relate to their other community priorities and identified needs.

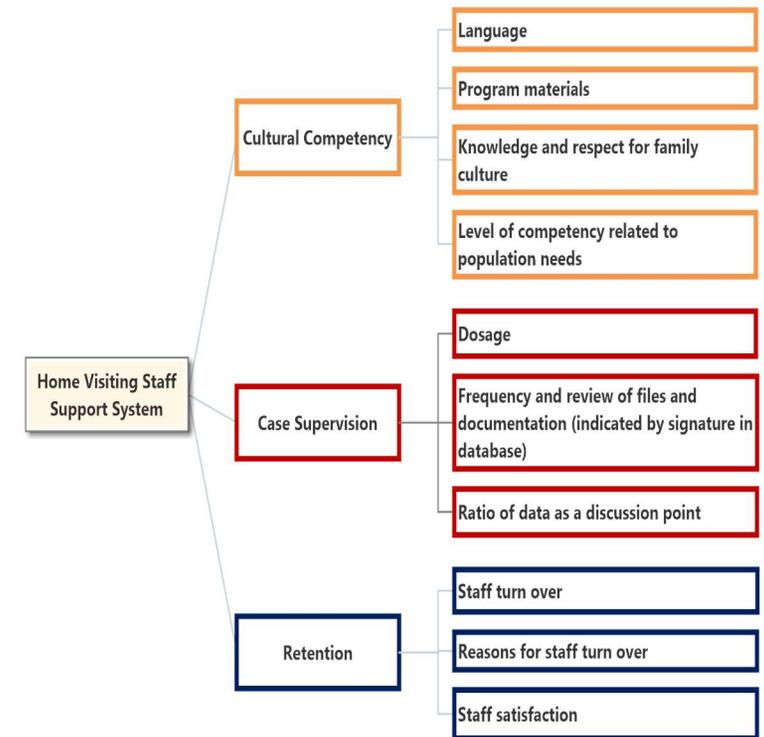
Descriptive client demographic and service utilization data are an important part of the process described above to determine how well the program is meeting Benchmark and other outcomes. As needed and determined by the CQI process data analysis includes linking program outcomes and process data (as described in the map to the right) to demographic variables based on program targets (e.g., by race/ethnicity, geographic location, parental age, child age), establish points of references to identify gaps and monitor change. Benchmark and other outcomes will be reviewed quarterly by all teams.



Target Area 4: Home Visitor Support System

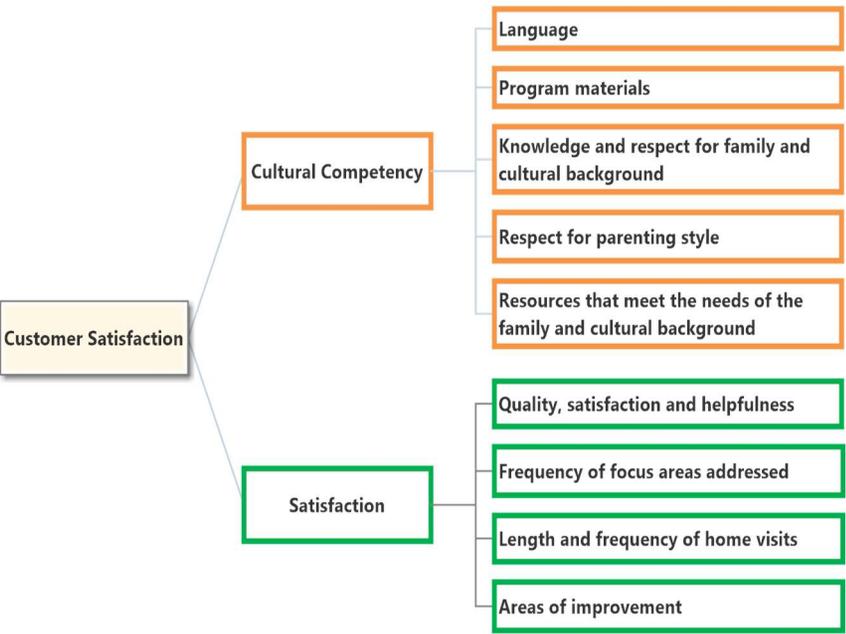
Key to effective home visiting are the knowledge, skills, and competency levels of program staff. On-going efforts are needed to assist staff in maintaining and maturing their skills. The model developer, local programs and the state N-MIECHV team work to help staff build those skills. The purpose of monitoring core competencies is to measure the demonstrated abilities of staff, and the level of support supplied to staff to obtain those skills. Teams review training reports; reconcile these with requirements; and measure competency levels of Home Visitors. Team members also compare the current knowledge and skill level of the staff to the unique needs of the population served.

Home Visitor support data will be reviewed quarterly by all teams



Target Area 5: Customer Satisfaction

The N-MIECHV customer satisfaction survey is used to gather information from the participants regarding their experiences and satisfaction with staff and with the program. Satisfaction surveys will be completed on an annual schedule by participants. The survey measures a combination of domains, including satisfaction with services, satisfaction with program dosage, and satisfaction with the level of improvement or knowledge gained by the family. A secondary measure includes satisfaction with the level of cultural competence and the staff.



displayed by the program

Customer satisfaction data will be reviewed annually by all teams.

Data Dashboards (i.e. Quarterly Benchmark Reports Attachment 3)

An effective and efficient review system requires meaningful display of the data in each of the five target areas. N-MIECHV has chosen to use data dashboards as a method of evaluating and displaying quality measures. N-MIECHV collects a large amount of data, and its evaluation and analysis can become overly burdensome to the teams if it is excessive or excessively complicated. While the state-level evaluation needs to be in depth and scientific, local- and CQI-level analyses needs most of all to be efficient, easy and well-organized. Data dashboards are a logical choice for home visiting to present the amount of data that needs to be evaluated to visually show different views of information, creating a powerful way to display data.

The five dashboards will provide data at the intervals described above for each of the five target areas. The figure (Figure 1) below illustrates a visual sample of a data dashboard and the second example (Figure 2) illustrates how a portion of the home visiting data (construct 1 and 5, Benchmark 1) might be displayed on a dashboard.

What is a Data Dashboard?

"An easy to read, often single page, showing a graphical presentation of the current status and historical trends of home visiting key performance indicators to enable immediate and informed decisions to be made at a glance."

Figure 1

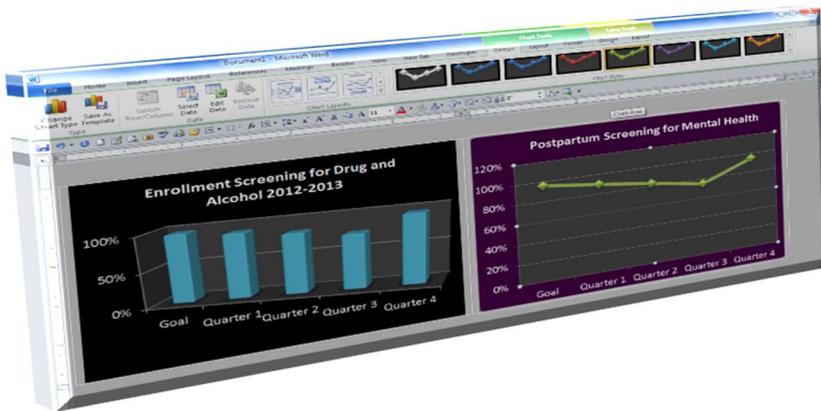


Figure 2

N-MIECHV CQI Process

This next section describes the three levels of CQI processes applied at the local and the state level. (It might be helpful to refer back to the CQI Model Chart on page 19).

Level One: Continuously Analyzing and Evaluating on a Program Level to Improve the Service Delivery Model

This process is designed to be completed as an internal practice where a team of program (site) staff and state-level staff (as needed) engage in an on-going process of effectiveness analysis. Reports are reviewed by program staff as described in the previous section.

Each Home Visiting program is required to evaluate its systems and procedures and use the findings to improve performance. The programs regularly examine internal processes through management meetings. At these meetings, information is shared regarding the five target areas discussed earlier in this document. When needed improvements are identified, and program improvement plans are developed. The process utilizes staff from all levels of the program, provides a viable method for evaluating and improving service delivery, and coordinates with the state team as needed.

To assist with this level of analysis, N-MIECHV staff and programs have developed a number of tools and processes that incorporate specific data sets into every day practice (see appendix 3 for a sample tool). Specific tools and data collection indicators (as described in the target areas above) provide information about the families' current needs, their children's developmental challenges, their needs for services, and goals for their individual family plans. With these data Home Visitors are able to determine how well they are teaching new skills, providing valuable information and setting a solid foundation for parents to develop a positive parent child relationship and learning environment. They are able to determine which aspects of service delivery and the program are succeeding and which may need adjustment. The supervisor plays an integral role and assists with helping program staff with the analysis. This is considered an essential activity for N-MIECHV programs. Research reports that the best Home Visitors and programs are those who analyze information about their work and make continuous efforts to improve.

To further assist with this process, the program teams apply an Effectiveness Analysis Criteria (specifically developed for this application) to determine if the problem is technical - solvable with routine methods, or adaptive - calling for an advanced level of analysis and problem solving. If it is technical, program management will problem-solve within the administrative structure of the program. If a problem is found to be adaptive, or otherwise in need for further analysis, the problem will be passed on to the Community CQI team.

(As needed, in the future a process to assist with prioritization and capacity management of specific CQI initiatives on the community level will be implemented. The purpose of this step is to align initiatives with the overall vision of the project and to prevent an overburdened system.)

Level Two: Problem Solving Through Community-Level CQI Teams

The Community CQI teams receive the specific proposed initiatives from the program team and will complete a root cause analysis and engage in a formal Plan, Do, Study, Act (PDSA) cycle for each problem.

This local community process provides a powerful roadmap for adapting home visiting programs to the cultural characteristics and needs of the communities while retaining the essential features of fidelity. It supports the adoption of methods and approaches to improve accountability, efficiency, and effectiveness of their community home visiting system; and its integration into local early childhood services.

Once a root cause analysis is applied, the team may determine that the initiative calls for additional adaptive problem solving or that the problem is system-wide in nature and should not be solved on a community level. In those instances the team will forward the proposed initiative to the N-MIECHV state-level CQI team.

(As needed, in the future a process to assist with prioritization and capacity management of specific CQI initiatives on the community level will be implemented. The purpose of this step is to align initiatives with the overall vision of the project and to prevent an overburdened system.)

Level Three: Problem Solving Through the State-Level CQI Team

The main focus of the state CQI team is to find areas needing improvement within the benchmark constructs. The team will meet yearly with the LIA supervisors and managers to discuss the upcoming years state CQI focus.

The state CQI team receives proposed initiatives from the community-level CQI teams and engages in a secondary root cause analysis, continuing to use the PDSA cycle to guide the work. State-level initiatives are expected to show improved efficiency and effectiveness for the entire state-wide initiative.

The final step in the process involves an annual review. Annually, a state level review team will evaluate the outcomes of each of these cycles to make recommendations for statewide change to N-MIECHV or other home visiting stakeholders.

(As needed, in the future a process to assist with prioritization and capacity management of specific CQI initiatives on the community level will be implemented. The purpose of this step is to align initiatives with the overall vision of the project and to prevent an overburdened system.)

Chapter III

CQI Plan

ANNUAL CQI PLAN 2014-2015

Each CQI team will develop an annual CQI plan that outlines specific initiatives as well as major development and training activities. The plan is a working document, and is to be updated continuously throughout the year. Specific detailed protocols for the annual plan and a standardized planning process will be developed once CQI teams are fully formed. At a minimum these plans will include:

1. Major CQI team development and process action steps for the target year (e.g. trainings planned, new member recruitment)
2. A short outline of the data reviewed and the major root causes of problems identified during the CQI analysis.
3. A completed Plan Worksheet for each formal initiative facilitated (appendix 4).

N-MIECHV Annual Activity Plan 2014-2015

N-MIECHV CQI program activities for the 2014-2015 grant year center on two main objectives: training and development.

Training

Training and competency development activities will center on revising and expanding current training models. Likely products are improved facilitation of training activities for new communities joining the N-MIECHV initiative, and formal preparation for community- and state-level CQI process.

Development

Development activities will primarily center on expanding the existing CQI system with the goal of achieving the CQI model described in this document.

A detailed description of these activities is outlined in the work plans below and is organized by the specific community or team.

	Task	Start	End	2014-2015			
				Q1	Q2	Q3	Q4
	2014-2015 State Level CQI Plan Activity Table	10/1/2014	09/30/2015				
	State Level CQI Meeting	10/29/2014	10/29/2014				
1	Panhandle Public Health District CQI Activities						
	Decided on referral project and filled out the Plan and Do portion of PDSA Form and submitted to data team.	10/1/2014	03/30/2015				
	Turned in final PDSA form on referrals and received feedback from data team during quarterly benchmark call.	04/01/2015	06/30/2015				
2	West Central Health District CQI Activities						
	Decided on referral project and filled out the Plan and Do portion of PDSA Form and submitted to data team.	10/1/2014	03/30/2015				
3	Lincoln-Lancaster Health Department CQI Activities						
	Decided on referral project and filled out the Plan and Do portion of PDSA Form and submitted to data team.	10/1/2014	03/30/2015				
	Turned in final PDSA form on referrals and received feedback from data team during quarterly benchmark call.	04/01/2015	06/30/2015				
4	Douglas County Health Department CQI Activities a. Lutheran Family Services b. Nebraska Children Home Society						
a.	Decided on referral project and filled out the Plan and Do portion of PDSA Form and submitted to data team.	10/1/2014	03/30/2015				
a.	Turned in final PDSA form on referrals and received feedback from data team during quarterly benchmark call.	04/01/2015	06/30/2015				
b.	Decided on referral project and filled out the Plan and Do portion of PDSA Form and submitted to data team.	10/1/2014	03/30/2015				
b.	Turned in final PDSA form on referrals and received feedback from data team during quarterly benchmark call.	04/01/2015	06/30/2015				

	Task	Start	End	2014-2015			
				Q1	Q2	Q3	Q4
	2014-2015 Program Level CQI Plan Activity Table	10/1/2014	09/30/2015				
1	Panhandle Public Health District CQI Activities						
	Finished a CQI project on recruitment into Box Butte and Morill County. This project took two years to complete.	10/31/2012	10/31/2014				
	Concluded a project on retention rates of clients in the program. This project also took two years to complete.	10/31/2012	10/31/2014				
2	West Central Health District CQI Activities						
	No longer receiving MIECHV funds						
3	Lincoln-Lancaster Health Department CQI Activities						
	A project was completed on increasing the number of Medicaid eligible pregnancies receiving a referral to complete the KEMPE to see if they are eligible for Home Visiting Services.	04/20/2014	04/20/2015				
4	Douglas County Health Department CQI Activities a. Lutheran Family Services b. Nebraska Children's Home Society						
b.	Completed a project on increasing child safety information given to clients. Also assembled first aid kits and distributed them to families.	1/24/2014	1/15/2015				

Appendix (1) Data Collection Schedule

Tool Administration Schedule and Data Location in Relation to the 5 Benchmark Areas and 37 Constructs	R=Referral AS=Assessment I=Intake AN=Annual HV=Home Visit DS=Discharge SE=Special Event PP=3 months Post Partum 6= Every 6 months										Administration of Tools Target Childs Age in Months										Data Source(s) & Locations		
	R	AS	I	PP	6	AN	HV	DS	SE	2	3	4	6	8	12	18	24	30	36	48		60	
Screening and Assessment																							
15 item Screen	√																					FW (Screen Data)	
Family Stress Check List (FSCL)/KEMPE		√																				FW (Family Assessment Record)	
Intake and Service Delivery																							
HFPI (SR) ● 3.1 Support of learning/development ● 3.3 Parent behaviors/child relationship ● 3.4 Parental emotional wellbeing			√			√		√			√			√		√		√	√	√		FW (G & P by Family)	
CES-D (SR) ● 1.5 Maternal depression screening			√	√		√		√														FW (G & P by Family)	
UNCOPE (SR) ● 1.2 Parental use of ATOD			√			√																FW (G & P by Family)	
ASQ 3 (WA and SR) ● 3.5 Child communication level ● 3.6 Child cognitive skills ● 3.9 Child physical development ● 3.2 Knowledge of CD and progress											√		√		√	√	√	√	√	√	√	FW (G & P by Child) FW (Home Visit Record Tab # IV- Other Information provided)	
ASQ SE (WA) ● 3.7 Child positive approach to leaning ● 3.8 Child social/ emotional wellbeing													√		√	√	√	√	√	√	√	FW (G & P by Child)	
Intake and Service Delivery																							
Family Wise	R	AS	I	PP	6	AN	HV	DS	SE	0	2	4	6	8	12	18	24	30	36	48	60	Data Source(s) & Locations	
● 1.1 prenatal care							√																FW (G & P by Child Kotelchuck)
● 1.6 breastfeeding							√																FW (Home Visit)
● 1.3 preconception care							√																FW (G& P by Family-Medical)
● 1.4 pregnancy interval									√														FW (Referral Data)
● 1.7 well baby visits							√																FW (G7P Child) + NESIIS
● 1.8a maternal insurance					√																		FW (Demographics- Adult I, II)
● 1.8b infant insurance													√										FW (Demographics-Child Data)
● 5.3 household insurance					√																		FW (Demographics -Target Adult -HMM)
● 2.1 child emergency visits							√																FW (Incident Report Data)+ER Data
● 2.2 maternal emergency visits							√																FW (Incident Report Data)+PY Data
● 2.4 injuries needed medical attention							√																FW (G&P by Child - Medical)
● 2.3 prevention information							√																FW (HV-Curricula-Other Information)
● 2.5 screened in maltreatment report									√														FW (Incident Report) + NFOCUS
● 2.6 substantiated child maltreatment									√														FW (Incident Report) + NFOCUS
● 2.7 first time maltreatment									√														FW (Incident Report) + NFOCUS
● 4.1 DV screening (4 validated questions)			√			√																	FW (Assessment-KEMPE#6 extra items)
● 4.2 referrals for domestic violence									√														FW (Referral Data)
● 4.3 DV safety plan									√														FW (Home Visit Record III)
● 5.1 household income			√			√																	FW (Household Data-One HH Rating)
● 5.2a employment of adults			√			√																	FW (Demographics - Adult I, II - HMM)
● 5.2b education of adults			√			√																	FW (Demographics - Adult I, II - HMM)
● 6.1 families that need services						√																	Needs map w/criteria - separate doc.
● 6.2 families receiving referrals						√																	FW (Referral Data)
● 6.5 families with completed referrals						√																	FW (Referral Data)
● 6.3 agencies with MOU's																							
● 6.4 communication with agencies																							

Appendix (2) Referral and Enrollment Process



Appendix (3) HFPI Data Reflection

<p>1. <u>Critical Priority Components</u></p> <ul style="list-style-type: none"> • Severity of concern/problem (#:12, 15, 16, 18, 33, 34, 37) • Critical needs (examine individual items) • Targets for treatment (scores: social support 17, problem solving 19, depression 33, personal care 16, resources 18, role 21, parent child interaction 40, home environment 33, parenting efficacy 22) • Identify strengths 	
<p>2. Are you surprised by the results? Why?</p> <ul style="list-style-type: none"> • Score(s) _____ 	
<p>3. Overall impression</p>	
<p>4. Discussion with supervisor</p>	
<p>5. Discussion with the parent</p>	
<p>6. Service plan priorities</p> <ul style="list-style-type: none"> • Red flag/severity of concern • Critical needs • Target for treatment • Strengths 	
<p>7. How do the results compare to previous HFPI data?</p> <ul style="list-style-type: none"> • Improvement? • Increased concern? • Celebration? • Compared to case load? • Compared to program? • Compared to national data? <p style="font-size: small; margin-top: 10px;">You may want to consider doing a graph to show the improvement/progress (only do this with several weeks/months' worth of data)</p>	
<p>8. Other</p>	

Appendix (4) PDSA Worksheet

Plan:

1. Aim Statement: (Example: By December 31st 2015 we would like our CES-D Screening rate to be 94% it is currently 78%)
2. Please document the work flow for this project; attach if possible (Process Map).
3. Brainstorm Ideas (Please provide a short list of potential changes/improvements that were brainstormed by your team).
4. List potential barriers.

Do: Try change.

1. The project chosen is _____
2. Who will try to do the change/improvement?
3. How will the project be carried out?

4. When will it happen?

Start Date:

Finish Date:

Study: Results: What happened?

1. Did the project turn out the way you thought? Please explain briefly.
2. What change did you see?
3. How can you tell if a change happened (measurement)?

Act:

Implement Plan

Modify Plan & Start Again

Create and Start New Project

1. If you choose to implement this plan. How will you implement program wide?
2. If you do not implement the plan what are your next steps?

Appendix (5) Tool Description and Psychometric Properties

Healthy Families Parenting Inventory (HFPI):

Developed as a tool appropriately sensitive to measure change within home-visit programs, specifically MIECHV programs (Krysiak & Lecroy, 2012), the HFPI measures aspects of behavior, attitudes, and perceptions important to high quality parenting. The inventory consists of 63 items organized into 9 categories (Social support, Problem-solving, Depression, Personal care, Mobilizing resources, Role satisfaction, Parent/child interaction, Home environment, and Parenting efficacy).

Krysiak and Lecroy (2012) describe scale development, which included interviews with experts and literature/measure reviews to generate items, preliminary testing, and exploratory factor analyses (EFAs) to determine the factor structure. Validity, then, is evidenced by high face content validity and factorial validity (appropriate correlations among items and subscale totals). Chronbach's alphas on the nine categories range from .76 to .92, indicating excellent internal reliability.

Center for Epidemiological Studies Depression scale (CES-D)

The CES-D is a 20-item self-administered instrument designed to screen for depression in adults. Respondents rate the frequency or duration of time in which they have experienced various emotions on a 1 to 3 Likert-type scale, resulting in a total (summed) score between 0 and 60 where higher numbers indicate greater psychological distress.

Reliability has been evidenced by both internal consistency, with Chronbach's alphas ranging from .84 to .90 in field studies, and test-retest reliability, with correlations ranging from .41 to .67. Validity is evidenced by moderate to high correlations to other rating scales for depression, although the CES-D does show poor discriminant validity in that it is unable to distinguish depression from other emotional responses (Mathematica Policy Research, Inc.).

Mean Life Skills Progression (LSP)(breastfeeding score only)

The LSP is a 43-item measurement to assess family functioning in 7 areas (Relationships with family and friends, Relationships with child(ren), Relationships with supportive resources, Education and employment, Health and medical care, Mental health and substance abuse, and Basic essentials) as well as child development measures.

The scale was reviewed by experts in early childhood development who determined the LSP has good content validity. Additionally, the authors note that with training, the inter-rater reliability runs at 78% to 90% indicating adequate reliability of the scale (Life Skills Progression, 2011). Only item 43, related to breastfeeding, will be used in the proposed study.

Ages and Staeges Questionarire, Social and Emotioal

The Ages & Stages SE series is a set of eight parent-completed questionnaires with 22 to 36 items in each questionnaire helps determine children's progress in their social-emotional behavior. Each questionnaire can be used within 3 months of the target age (for the 6- through 30-month questionnaires) or 6 months of the target age (for the 36- through 60-month questionnaires). The questionnaires focus on seven behavioral areas: (1) self-regulation, (2) compliance, (3) communication, (4) adaptive functioning, (5) autonomy, (6) affect, and (7) interaction with people. The ASQ-SE was developed to complement the ASQ by providing information specifically addressing the social and emotional behavior of children ranging in age from 3 to 66 months.

Validity, reliability, and utility studies were conducted on ASQ:SE between 1996 and 2001 in order to determine the psychometric properties of the screening instrument. Normative studies included 3,014 preschool-age children and their families, distributed across eight age intervals from 6 months through 60 months.

To measure the utility of ASQ:SE, 731 parents completed utility questionnaires. More than 97% rated ASQ:SE items easy to understand and appropriate. Parents indicated that ASQ:SE took little time to complete and helped them to think about social and emotional development in their children.

The results support the overall usefulness of ASQ:SE to discriminate between children with social-emotional delays and those who appear to be developing typically in social-emotional areas.

- **Internal consistency**, measured by Cronbach's coefficient alpha, ranged from **67%–91%**, indicating strong relationships between questionnaire total scores and individual items.
- **Test-retest reliability**, measured as the agreement between two ASQ:SE questionnaires completed by parents at 1- to 3-week intervals, was **94%**. These results suggest that ASQ:SE scores were stable across time intervals.
- **Concurrent validity**, as reported in percentage agreement between ASQ:SE and concurrent measures, ranged from 81% to 95%, with an overall agreement of **93%**.
- **Sensitivity**, or the ability of the screening tool to identify those children with social-emotional disabilities, ranged from 71% to 85%, with **78%** overall sensitivity.
- **Specificity**, or the ability of the screening tool to correctly identify those children without social-emotional delays, ranged from 90% to 98%, with **95%** overall specificity.

Ages and Staeges Questionarire, Social and Emotioal

The Ages & Stages Questionnaire (ASQ-3) is a series of 21 parent-completed questionnaires to help screen for developmental delays during the first 5 ½ years. It is completed by parents or the children's caregivers. Each questionnaire includes 30 developmental items and focuses on

assessment of five key developmental areas: Communication, Gross Motor, Fine Motor, Problem Solving, and Personal-Social. Communication addresses babbling, vocalizing, listening, and understanding; Gross Motor focuses on body movements, including arm, body, and leg; Fine Motor addresses finger movements; Problem Solving focuses on learning and playing with toys; and Personal-Social addresses social play and play with toys and other children. Parents rate each item as “Yes” if the child does the behavior, “Sometimes,” and “Not Yet.” Items about behaviors that are challenging to describe (for example, putting beads on a string) include illustrations to help parents guide their responses.

ASQ-3’s high validity and reliability have been proven by extensive research to determine the psychometric properties of the screener. These results support the overall usefulness of ASQ-3 to discriminate between children with developmental delays and those who appear to be developing typically.

- The **validity** of ASQ-3 has been evaluated extensively. The NEW, unparalleled research sample includes 15,138 children that mirror the U.S. population in terms of race, ethnicity, and socio-economic groups.
- The **concurrent validity** (measured by comparing the percentage of agreement between the results of the parent-completed ASQ-3 questionnaires with the results of professionally administered standardized assessments) ranged from 74% for the 42-month ASQ-3 questionnaire to 100% for the 2-month and 54-month questionnaires, with 86% overall agreement. Concurrent Validity for ASQ-3 questionnaire Intervals.
- The **sensitivity*** of ASQ-3, or the ability of ASQ-3 to correctly identify those children with delays, ranged from 75% for the 6-month questionnaire to 100% for the 4-month, 14-month, 54-month, and 60-month questionnaires, with 86% overall agreement.
- The **specificity*** of ASQ-3, or the ability of ASQ-3 to correctly identify typically developing children, ranged from 70% for the 14-month questionnaire to 100% for the 2-month, 16-month, and 54-month questionnaires, with 85% overall agreement.

*Given the complexity of measuring child development, the American Academy of Pediatrics considers high quality developmental screening tests to have sensitivities and specificities of 70% to 80%.

The Family Stress Checklist (FSC) (also known as the “Kempe”)

The KEMPE identifies psychological and social risk factors associated with child maltreatment to determine eligibility for your home visiting services. It is used as a second-level screening tool for mothers and fathers who are considered at risk based on the 15-item initial risk screen. The FSC was developed by B. D. Schmitt and C. A. Carroll (with the assistance of J. Gray) of the University of Colorado Health Services Center, Child Protection Team, in the early 1970s and at the Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect. The FSC is a 10-item scale that predicts a parent’s future risk of maltreating his or her children. The FSC covers ten domains, including psychiatric history, criminal and substance abuse history, childhood history of care, emotional functioning, attitudes towards and perception of child, discipline of child, and level

of stress in the parent's life. Each domain has three questions. Completing this assessment requires careful review of the parents' history and current emotional/behavioral functioning, and the use of clinical judgment in applying the ratings. Scores can be given for both mother and father. Families are typically labeled as being at risk if at least one of the parents is scored as high risk

The original validation study conducted by Murphy et al. (1985) tested for predictive validity by interviewing and scoring 587 primiparous or multi-parous low-income women between 3 and 6 months gestation. Sensitivity was calculated at 80 percent (percent of maltreating mothers who were scored at high risk) and specificity was 89.4 percent (percent of mothers who were scored at low risk). The percentage of mothers scoring high who were later found to maltreat their children (the positive predictive value) was 52.5 percent, and the percentage of mothers scoring low with no future evidence of maltreatment (negative predictive value) was 96.8 percent. Previous validation research on the FSC suggests caution in making decisions regarding the abuse potential for mothers who score high, positing a number of high scoring mothers, for numerous reasons, will likely not end up abusing their children. Still, even if these mothers do not abuse their children, they could (from the nature of endorsed items) likely benefit from services or treatment. Thus, the FSC should not be used in isolation; when assessing risk for future child maltreatment, multiple measures covering multiple dimensions should be used.

Appendix [6]
CQI and Data Systems Progress Report 2014-2015

CQI

The purpose of this document is to give a progress update on CQI implementation for FY 2015. The main focus of CQI for FY 2015 was Data Quality Management, Benchmarks and Outcomes. Also, during FY 2015 there was preliminary study of the Home Visitor Support System. The N-MIECHV team hired a community health educator in June 2014 to concentrate efforts on professional development of the Home Visitor Support System. This work included creating a conceptual framework for this topic.

Focus for FY 2016 will be placed on implementing Community Level CQI and Service Delivery Mechanisms and Fidelity. These are both areas in the past that were not able to be fully implemented. Full implementation of this manual is expected to occur in FY 2017.

Background on State CQI Project. NDHHS data staff and KU (University of Kansas) data staff hold an annual on-site planning meeting. The meeting on August 14, 2014 focused on state-level CQI and quarterly data reporting processes. The N-MIECHV data team brainstormed ideas for a statewide CQI project and decided on the topic of referrals to outside partners (Benchmark 6) specifically in the areas of Developmental Delay, Domestic Violence, Maternal Depression, and Substance Abuse. This focus was chosen because of its complexity in nature and connection to several other benchmarks/constructs. Within this area there are the elements of screening, making and documenting a referral, and completion of the referral. In addition, screening and referral processes are fundamental to the home visiting. It was concluded that the KU data team and the N-MIECHV data team would jointly conduct a statewide CQI meeting the day before the Nebraska Home Visiting Conference on October 29, 2014.

State CQI Project Information: Program managers and supervisors of the LIA's (Local Implementing Agencies) were invited and strongly encouraged to attend this meeting. Only one LIA was not represented at this meeting. They were debriefed at a later time about the meeting and expectations.

A packet of detailed referral data for the state (pg.) was presented at this meeting. This packet identified areas of possible improvement within the screenings, giving/receiving referrals and completing referrals. There was a great discussion between the program staff at each of the agencies and the N-MIECHV data team. This conversation centered on the processes screenings, referrals, what is considered a complete referral across the LIA's and many other topics.

Data Quality Meetings: Following the state CQI meeting the N-MIECHV data team conducted meetings with each of the LIA's. The main goal of these meetings was to provide and discuss site specific data in a format that is conducive to improving outcomes for families. During these meetings the LIA's were presented a detailed referral data packet specific to their program. Areas of possible CQI projects were discussed.

Post CQI Meeting: After this meeting each of the sites were asked to implement a CQI project in their LIA identified from the referral data and process map. The LIA was allowed to decide on what they wanted to concentrate on within referrals. The majority of the LIA's chose to concentrate on increasing their actual screening rates. Other LIA's selected to concentrate on the actual referral and completion of them. See Figure 1 below for breakdown of actual projects. They were given a PDSA (Plan Do Study Act) form to track their progress (See Appendix 4). Starting in Quarter 2 (Jan 2015-Mar 2015) each LIA received a site specific comprehensive packet of referrals. This packet was then updated quarterly by KU and discussed in detail on their quarterly call with the data team. During this ongoing quarterly discussion the program supervisors/managers gave an update of their current status on CQI project and feedback and next steps were given to each of the sites.

Current Status of State CQI project: All of the sites have finished their state CQI project on referrals and sent in their completed PDSA form. All forms have been reviewed and feedback was given.

State CQI Projects on Referrals		
LIA		Project Detail
1	Panhandle Public Health District	This project concentrated on the CES-D screening according to construct and subsequently giving a referral for a positive result.
2	West Central Health District	This project focus was on giving a relevant referral within two weeks for a positive screen for the CES-D, IPV, and UNCOPE.
3	Lincoln-Lancaster Health Department	This project was on increasing the number of referrals made and completed in the areas of intimate partner violence, mental health, substance abuse, and developmental delays.
4	Douglas County Health Department	
a.	Lutheran Family Services	The project focus was on giving clients with a positive assessment screening for Domestic Violence an appropriate referral within three months.
b.	Nebraska Children's Home Society	The CES-D completion rate according to construct was the focus of this project.

Figure 1

Future State CQI Project: For the FY 2016 we will be conducting another statewide CQI project. This upcoming project will focus on Benchmark 1 specifically in the areas of Prenatal care, Preconception Care, Inter-pregnancy interval, and Well-child visits.

Customer Satisfaction: Target Area 5 discussed on page 23 of this manual is customer satisfaction. The customer satisfaction survey (Attachment 2) is centered on client satisfaction with the services they are receiving and cultural competency of the home visitor. Please see Figure 2 for LIA completion dates of the customer satisfaction survey for FY 2015.

Figure 2

Customer Satisfaction Survey	
LIA	Completion Date
Douglas County Health Department	April 2015
Lincoln Lancaster Health Department	February 2015
Panhandle Public Health District	October 2014

Data Systems

Future: For FY2016 we will be transitioning to the (Data Application Integration Solution for the Early Years) DAISEY system for data analysis and reporting. This transition will be gradual and begin January 2016. Currently it takes KU approximately four weeks to get us the quarterly benchmark reports that we review with each of the LIA's. (Appendix). With the transition to DAISEY the reports will be more readily available monthly. The N-MIECHV data team will have access to DAISEY to be able to provide the sites with updated reports monthly. This also will help to tailor the reports to each site specifically especially during the upcoming CQI projects that will be beginning.

Changes to Manual:

Pg. 8- This diagram has been updated to reflect current CQI process.

Pg. 19- This diagram has been updated to reflect addition of Douglas County Health Department

Agenda

1. Introductions
2. Objectives
3. CQI Framework
4. Benchmark Plan Overview
5. Supporting Constructs and Impacted Work
6. Stepping through the Referral Process using Statewide Data
7. Next Steps

Objectives

1. Attendees will understand focus and effort of MIECHV state level CQI initiative.
2. Attendees will understand how their work impacts MIECHV outcomes.
3. Attendees will leave prepared to hold site-specific CQI conversations and discuss next steps at CQI data support visits.

CQI Framework

There are two valuable MIECHV perspectives-practitioner knowledge and experience, and data from data managers and CPPR. The purpose of CQI is to combine the resources each perspective has to make a larger impact than either could individually.

This dual perspective framework will show up throughout the CQI process

Benchmark Plan Overview

Benchmarks are an efficient way for HRSA to measure the impact that MIECHV money has on moms and kids.

Constructs are the specific goals of the benchmarks which demonstrate how the state of Nebraska is meeting each benchmark requirement.

N-MIECHV Benchmarks

1. Improve maternal and newborn health
Constructs include UNCOPE, CES-D, LSP, and others
2. Prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits
3. Improvement in school readiness and achievement
Constructs include HFPI, ASQ-3, and ASQ-SE
4. Reduction in domestic violence
5. Improvements in family economic self-sufficiency
Constructs include MCAFSS subscales

6. Improvements in coordination and referral for other community resources and supports

The State MIECHV Data Team has selected three constructs under benchmark six for the state level continuous quality improvement (CQI) initiative.

6.1 Families identified as requiring services

- Practice perspective: Completing the appropriate screener and identifying a positive screen.
- Data perspective: Percent of families that screen positively for mental health, violence, alcohol use, and child developmental delays.

6.2 Families receiving referrals

- Practice perspective: Giving a referral for a positive screen.
- Data perspective: Of the families who screened positive in 6.1, what percentage were given one or more appropriate referrals?

6.3 Completed referrals

- Practice perspective: Tracking if a given referral has been completed
- Data perspective: Of the referrals given in 6.2, what percentage were completed?

Supporting Constructs and Impacted Work

Referrals are complicated. They require a demonstration of need, they cover a variety of services, may overlap families' existing resources, and there is no guarantee that a family will follow through with the referral.

The **data perspective** on referrals considers all the related constructs in the benchmark plan:

- 1.2 Parental use of ATOD
- 1.5 Maternal Depression Screening
- 3.5 Communication Level
- 3.6 Cognitive Skills
- 3.9 Gross Motor
- 4.1 Domestic Violence Screen

The **practice perspective** on referrals considers all of the screeners that identify needs for referrals-this includes UNCOPE, CES-D, ASQ-3 and IPV.

Regardless of the perspective, it's important to consider the criteria for screeners.

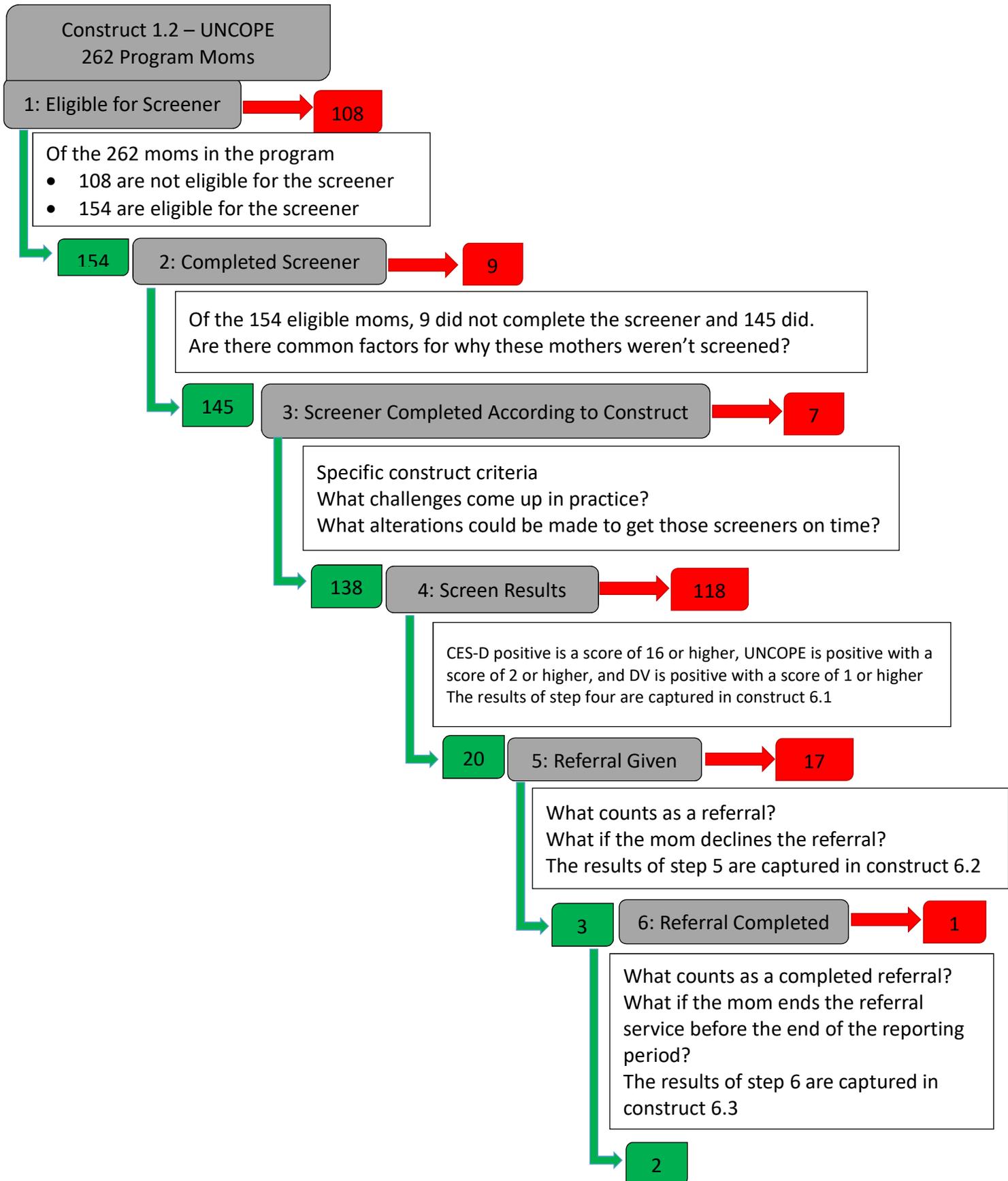
- Moms should receive the UNCOPE and IPV screeners within 90 days of program enrollment
- Moms should receive the CES-D screener within 3 months postpartum
- Kids should receive ASQ-3 screeners between 3 months and 12 months of age

How your work impacts the CQI goal

Screener	Supporting Construct	CQI Goal
UNCOPE	1.2 Alcohol Use	Improvements in coordination and referral for other community resources and supports
CES-D	1.5 Mental Health	
ASQ-3	3.5 Communication Level	
	3.6 Cognitive Skills	
	3.9 Gross Motor Skills	
IPV	4.1 Domestic Violence Screen	
	4.2 Domestic Violence Referral	

In order to give appropriate referrals, families’ needs must be established through screeners. Administering screeners and identifying positive screens finds families who should receive referrals. Following this process ensures an impact will be made on CQI goals.

Referral Process with State Data



All Screeners

	UNCOPE	CES-D	ASQ (kids)	IPV Screen
1) Eligible	154	100	38	154
2) Completed	94% (145)	71% (71)	89% (34)	95% (147)
3) Completed According to Construct	95% (138)	82% (58)	100% (34)	100% (147)
4) Positive Screen Results	14% (20)	43% (25)	3% (1)	7% (10)
5) Referral Given	15% (3)	76% (19)	100% (1)	30% (3)
6) Referral Completed	66% (2)	89% (17)	0% (0)	66% (2)

Discussion Questions

1. What alterations could be made to get screeners completed on time?
2. What is the anticipated number of positive screens?
3. What counts as a referral?
4. What counts as a completed referral?

Next Steps

Remember that state level CQI is collective and collaborative. Each site/program will identify the most critical part of the referral process at upcoming CQI Data Support Visits.

During those visits, our goal is to provide data in a format that is conducive to improving outcomes for families. Those visits will expand on today's information by discussing site specific referral data and related practice topics with program professionals, data managers, and KU-CPPR staff. The goal of those visits is for program leaders to make data informed decisions about the site focus of CQI.

Appendix (7) Data Security and Access Management Appendix

Data Storage and Security (Source: REDCap Security Policy)

This policy applies to NDHHS personnel and designated contract staff implementing the N-MIECHV Data Collection System using REDCap. Standards and procedures associated with this policy define how staff may use NDHHS, IS&T resources and the REDCap data system.

The N-MIECHV Data System resides on a secure server within NDHHS. The N-MIECHV Data System integrates required reporting data elements from the N-MIECHV program. The data system is constructed and operated utilizing REDCap (Research Electronic Data Capture) software, of which NDHHS is a consortium member. REDCap is a data repository or warehouse that manages longitudinal, linked data that can be exported to common statistical packages, including SAS.

REDCap is stored on two secure servers within NDHHS. The location for Citrix access is: <https://nfuse-dhhs.ne.gov>. Two REDCap servers are accessible. The first is the Test Server for testing software updates and other changes to the REDCap environment, and the other is the Production Server which houses the REDCap live data. The servers cannot be accessed by anyone other than those individuals that have been assigned a NDHHS USER ID and security access, password and specific access to N-MIECHV REDCap.

REDCap Security and Data Storage: REDCap, the application and all data is and is maintained on a secure, HIPAA/FERPA-compliant server housed within NDHHS. This server is certified HIPAA compliant to fulfill the REDCap install requirements. As such, REDCap is maintained on a server that meets HIPAA Security Standards. The REDCap server has the necessary safeguards in place for administrative, technical, and physical security of data to ensure the proper handling, access, storage, and recovery of Personal Health Information. Data is de-identified prior to any subsequent data exports for analysis or report generation so that no identifying information is ever allowed outside the controlled data processes. Thus, all data stored on the N-MIECHV database has the necessary security and privacy safeguards in place.

Data Transfer Protocols (Source: REDCap Security Policy)

Data Transfer from the Secure Site of local databases to the secure site at DHHS: On a monthly schedule local MIECHV case management systems will transfer data in the format of a Microsoft Access database to the secure NDHHS FTP site. For each transfer vendors utilize the secure FTP software (WS_FTP) to send the data using a FIPS140 compliant FTP. The N-MIECHV Business Analyst oversees this process for timeliness of data transfers, notification of needed partners once the transfer occurred and data quality control of the transferred data.

Data Release to and from Other NDHHS Entities: Once per quarter, NDHHS securely (via encryption or secure server transfer protocol) provide CFS, Vital Records, NESIIS, or Health Statistics an encrypted N-MIECHV Demographic Identifier File which contains necessary identifying information on all Index Children served. Each individual is assigned a unique non-identifiable number in the N-MIECHV Identifier File. This identifiable information consists of name(s), addresses, birth dates,

social security numbers and other unique IDs. In this file, NDHHS will also provide the Program Enrollment Date of each participant enrolled in services as well as a Report End Date (e.g., date of data request). This will provide the timeframes with which to search records and match data on individuals. Formal agreements have been created with these internal partners and data sharing procedures have been developed and signed by the applicable entities.

In return, those agencies will match any N-MIECHV clients with the appropriate records. For all matched records, agencies will securely provide a file with data elements linked to the unique non-identifiable number. All identifying information previously provided in the Identifier File will not be included in the matched file and will be deleted prior to returning the requested data.

These files will then be integrated into the NMIECHV Reporting File and N-MIECHV Evaluation File, linked by the unique Family ID. None of the other information in the Identifier File will be merged into the Reporting or Evaluation File.

These internal data transfer protocols have been documented in an internal data sharing protocol, and have been approved and signed by the appropriate administrators.

Data Security Training (Source: REDCap Security Policy)

All NDHHS staff and contractors accessing REDCap must follow the REDCap Policy and Procedures as well as, the required NDHHS IS&T Security Awareness Polices, Guidelines and Procedures. It is the responsibility of every IS&T resource user to complete the required IS&T security training (The six training sections to the DHHS Security Awareness Training and HIPPA Privacy & Security Awareness Training) know DHHS policies and guidelines and to conduct their activities accordingly.

At the end of each training section is a box containing instructions to certify that users have completed the training section. ***Users must complete this final step to be given credit for finishing the training. Contract staff must also send a verification email to the*** MCH Epidemiology Surveillance Coordinator, Jennifer Severe-Oforah at Jennifer.Severe-Oforah@nebraska.gov indicating the completion of the IT Security Awareness and HIPPA training. Access to data will not be granted until the security and HIPPA training is complete. The following links provide access to the training:

1. [Information Technology Computer User Security Awareness](#)
2. [HIPAA Privacy & Security Awareness Training](#)

System Access (Source: REDCap Security Policy)

Network Access/Access Control: Upon authorization, each individual receives a User ID and password. It is the responsibility of the User to protect the integrity of ID and password. Only NDHHS Help Desk Security Administrators may assign or make changes. This ID and the password may not be shared with anyone. This includes a supervisor. If a supervisor asks a user to share the password the user is required to report this to the specified contact person at the NDHHS. Additional information about the access control rules and password protection procedures can be

found in Chapter 4 of the Security User’s Awareness Guide and Chapter 3 of the Computer User’s Security Handbook.

Roles, Authority and Responsibilities: Access to the N-MIECHV data system is only granted to those individuals that have an obligatory and specifically designated responsibility for N-MIECHV data collection, data processing and Quality Assurance. Level of authority and level of access may only be granted by the MCH Epidemiology Surveillance Coordinator, Jennifer Severe-Oforah. Names with specific responsibilities access and authority are documented in the REDCap Security Policy, duly authorized and signed.

DHHS Personnel Granted Access to the REDCap Data System

Name	Role	Level of Authority
Jennifer Severe-Oforah	MCH Epidemiology Surveillance Coordinator, responsible for overseeing the data collection system	● Approval of all changes, additions and adaptations in the data collection system
Mike McCormack	Information Technology Supervisor, responsible for server maintenance, receiving and transferring of data from secure site to the secure REDCap server	● IT oversight and changes to the HV-server

Contract Staff Granted Access to the REDCap Data System

Name	Role	Level of Access	Access Period
Teri Garstka	Supervisory oversight of staff completing data linking, REDCap oversight and reporting structure development	Access to REDCap Server	10/1/2015–9/30/2017
Joe Coburn	Data linking, REDCap development and reporting structure development	Access to REDCap Server	10/1/2015–9/30/2017
Ellen Chancey	Data linking, REDCap development and reporting structure development	Access to REDCap Server	
Debbi Barnes-Josiah	MCH Epidemiology, responsible for data analysis technical assistance and extraction of birth data.	Access to the N-MIECHV REDCap	10/1/2015–9/30/2017

Confidentiality (Source: REDCap Security Policy)

Confidentiality and Security of Protected Health Information: To comply with federal requirements to collect and report on outcomes associated with the MIECHV program, N-MIECHV is creating three databases to store all client-level data on participants receiving the MIECHV-funded services. Each file is maintained under the same level of data security safeguards in place established by NDHHS for its secure server with the N-MIECHV Identifier Database protected with additional security measures.

The purpose of multiple N-MIECHV databases is to increase security of individual-level data by separating the federal reporting requirements from the client identifiers. The N-MIECHV Identifiers Database is needed to match the evaluation data and is needed to request and link further data from Child Protective Services (CPS), immunization records, and hospital records to match records of those receiving N-MIECHV services with data from these sources.

Access to the N-MIECHV protected health information level data is only granted to those individuals that have an obligatory and specifically designated responsibility for matching identifiable protected information with other databases for the collection of additional information from CFS, Vital Records, NESIIS, or Health Statistics. Level of authority and level of access to the Identifier Database may only be granted by the MCH Epidemiology Surveillance Coordinator, Jennifer Severe-Oforah. Names with specific responsibilities access and authority are documented in the REDCap Security Policy, duly authorized and signed.

DHHS Personnel and Contract Staff Granted Access to the Identifier Database

Name	Role	Level of Authority
Jennifer Severe-Oforah	MCH Epidemiology Surveillance Coordinator, responsible for overseeing the data collection system	Access to REDCap Server And approval of all changes, additions and adaptations in the data collection system
Mike McCormack	Information Technology Supervisor, responsible for server maintenance, receiving and transferring of data from secure site to the secure REDCap server	Access to REDCap Server
Teri Garstka	Supervisory oversight of staff completing data linking, REDCap oversight and reporting structure development	Access to REDCap Server
Joe Coburn	Data linking, REDCap development and reporting structure development	Access to REDCap Server
Ellen Chancey	Data linking, REDCap development and reporting structure development	Access to REDCap Server
Shannon Twist	N-MIECHV Statistical Analyst, responsible for data analysis/management and extraction of birth data.	Access to REDCap Server

Debbi Barnes-Josiah	MCH Epidemiology, responsible for data analysis technical assistance and extraction of birth data.	Access to REDCap Server
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All other (non-protected information) client data stored in the Reporting Database will be identified only by a unique non-identifiable alphanumeric ID.. When client identifying information is required to match records to CFS, Vital Records, NESIS, or Health Statistics an encrypted MIECHV Identifier Data File will be stored on the REDCap server. This encrypted file will also contain the unique non-identifiable ID (N-MIECHV Number).