Fiscal Year 2025 Continuous Quality Improvement Plan

Submission Date: June 27, 2025; Aug. 18, 2025

State/Territory/Jurisdiction Awardee: Minnesota

Part 1: Updates on prior continuous quality improvement (CQI) activities since the last update

1. **What was your CQI topic(s)?**

   From October 2023 through September 2024, the area of focus for CQI was identified as family engagement and retention. This continued from the prior year, during which two local implementing agencies (LIAs) participated in the CQI practicum from January 2023 through August 2023.

   From October 2024 through September 2025, the focus identified for CQI was on Maternal, Infant, and Early Childhood Home Visiting (MIECHV) performance measure 10, parent-child interaction and decreasing missing data for MIECHV performance measure five (5), postpartum care.

   From January 2024 through April 2025, Minnesota and three LIAs did participate in the Home Visiting Collaboration, Improvement, and Innovation Network (HV-CoIIN) collaborative focused on child-caregiver interaction.

2. **What was your SMART aim(s)?**

   The following aim statements were drafted in June 2023:

   - By September 2024, families still enrolled in family home visiting at 9 months will increase by 10%.
   - By September 2024, the percent of primary caregivers enrolled prenatally will increase by 15%.
   - By September 2025, there will be a 10% increase in the percentage of primary caregivers enrolled in family home visiting that receive an observation of caregiver-child interaction using a validated tool.
   - By September 2025, missing data for the postpartum care measure will decrease from 38% to 25%.

   During the HV-CoIIN collaborative, participating LIAs focused on additional aims developed by HV-CoIIN staff related to parent-child interaction including the following:

   - By March 2025, 75% of caregiver-child pairs have strong, positive and nurturing relationships with each other.
   - By March 2025, 75% of caregiver-child pairs identified for additional support in caregiver-child interactions see improvement within three months.

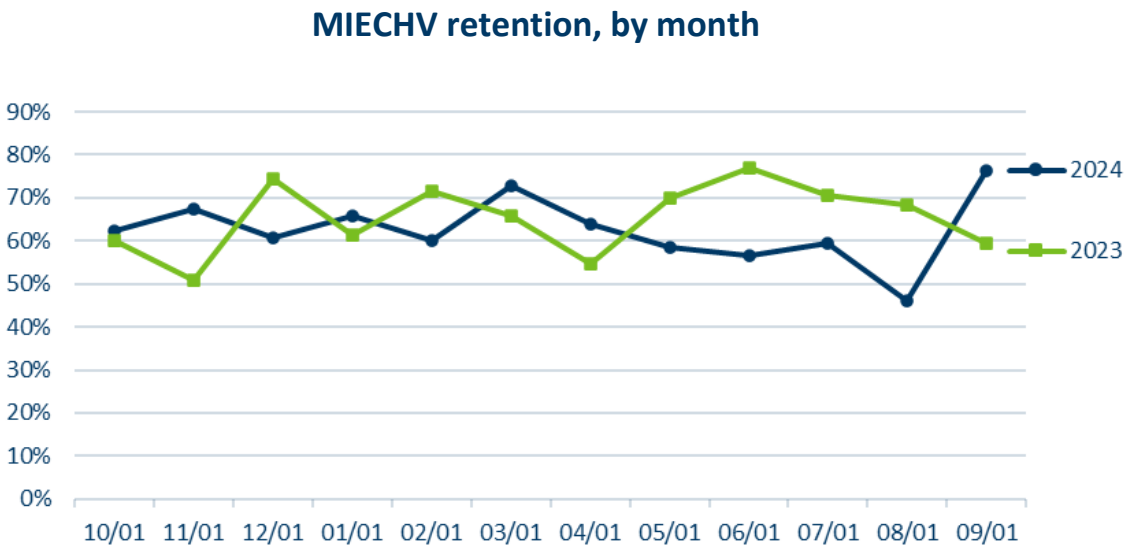
3. Did you meet your SMART aim(s)?

☒ Yes ☒ No

a. If no, explain why.

9-month retention aim

In fiscal year 2023, the average retention at 9-months was calculated to be 65% and in fiscal year 2024, it was calculated as 62%. The chart below displays the changes in retention over time, by month.



Source: MDH

Over the course of this project, there were months where families still enrolled after 9-months was higher in 2024 (blue), and others that dropped below the previous year (green). While working on this project, we identified challenges related to how to best calculate retention. MDH is currently utilizing our contract with the University of Minnesota to identify effective ways to measure retention.

LIAs noted that the measure was difficult to interpret, and some struggled with understanding what the results meant each month they received data. This may have impacted LIA focus on family retention. It may have helped to break this goal down into smaller pieces, for example focusing on a few reasons why families left family home visiting and creating smaller measures around these.

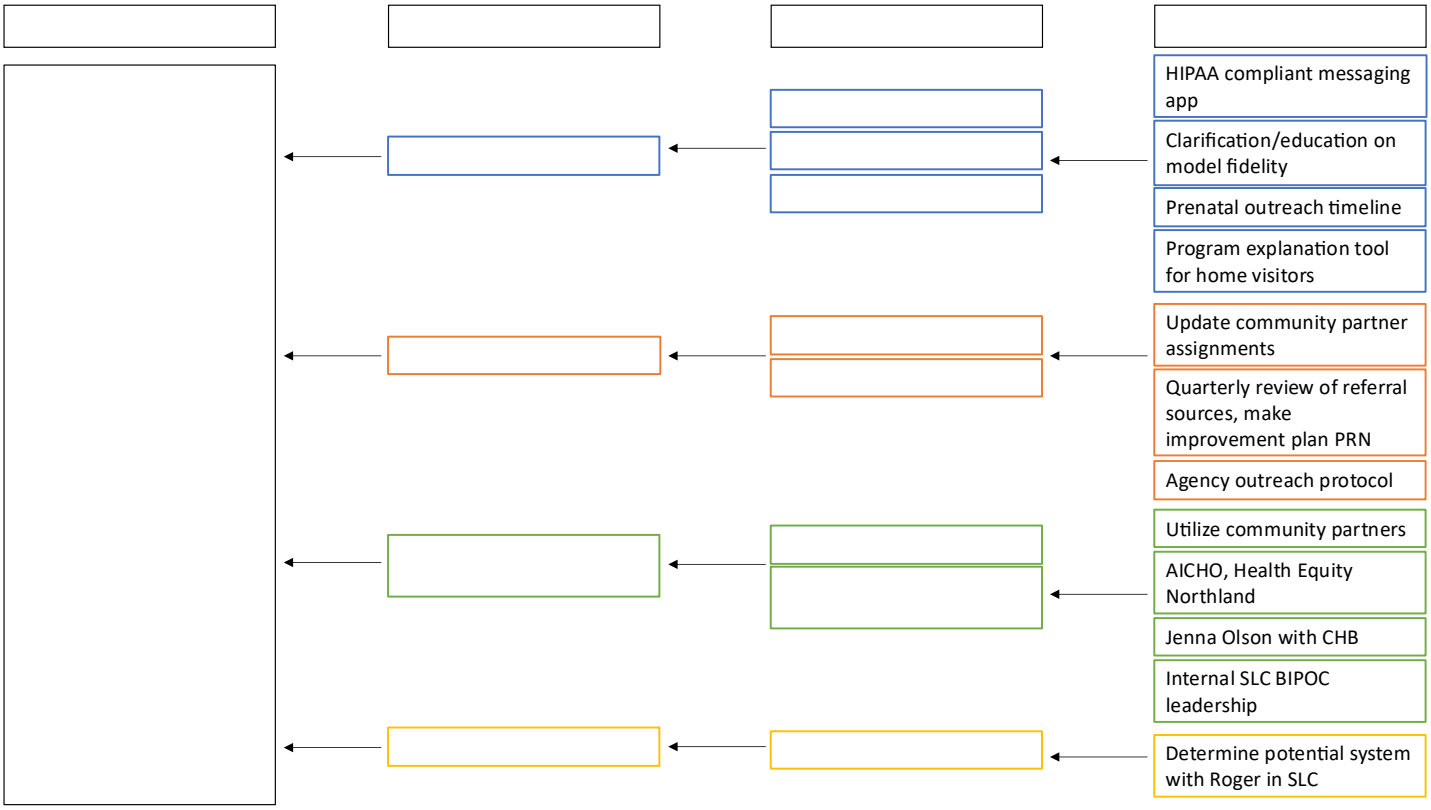
Prenatal enrollment aim

The prenatal enrollment percentage for MIECHV-funded grantees was 60% in fiscal year 2023 and dropped slightly to 56% in fiscal year 2024. Note: Fiscal year 2023 includes the first three quarters of calendar year 2023. Fiscal year 2024 was calculated with the fourth quarter of 2023 and the first three quarters of calendar year 2024.

LIAs worked on increasing their number of community partners, focused outreach efforts on clinics and agencies serving pregnant people and implemented efforts to improve their 'elevator speech' about the benefits of home visiting for pregnant families. Although these efforts did result in agencies receiving more referrals, it was more challenging for families to agree to enroll in family home visiting.

The two LIAs participating in the CQI practicum (January-August 2023), Washington and Carlton-Cook-Lake-St. Louis, focused on these aims as well. Carlton and St. Louis counties specifically tested changes to increase prenatal enrollment with an aim of: By September of 2023, at least 75% of families will be recruited into home visiting services during the prenatal period. Find their key driver diagram with change ideas tried below.

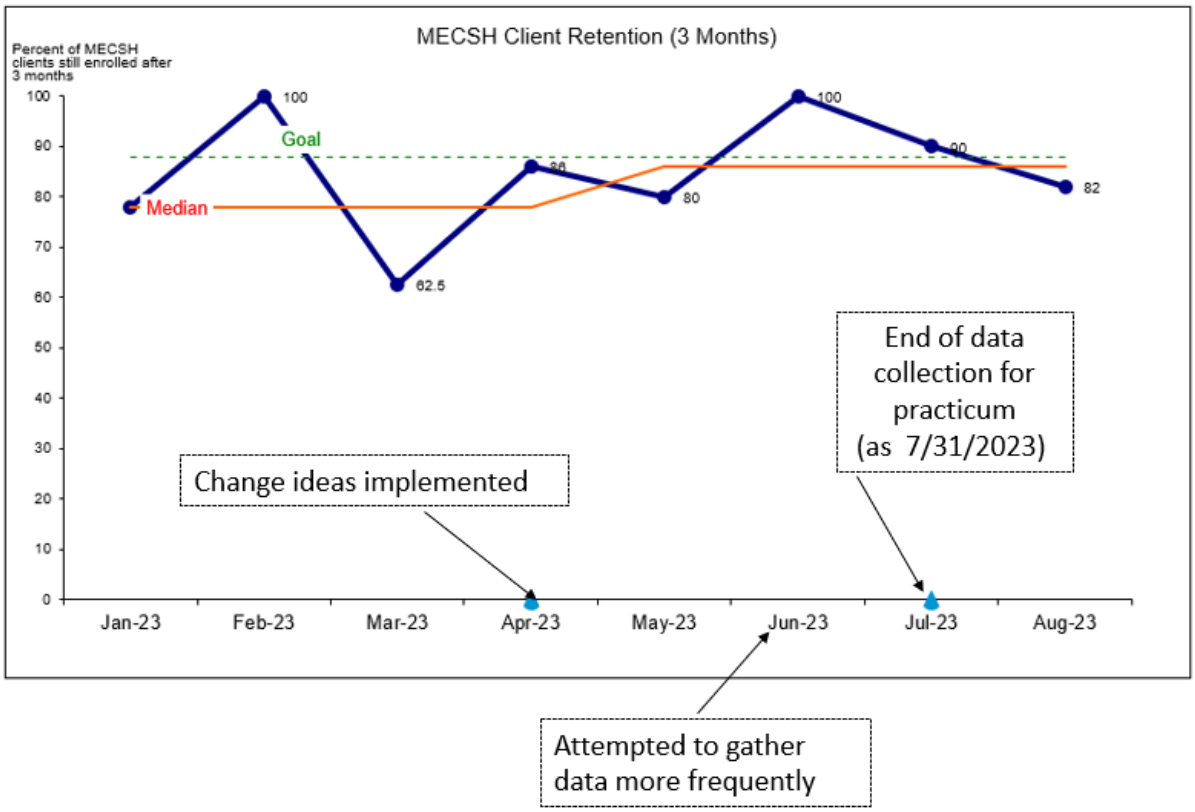
Key driver diagram



Source: CCLS

Washington county focused on retention at three months, with an identified aim of: By Aug. 31, 2023, the number of families still enrolled in family home visiting at three months will increase by 10%. The below run chart outlines their progress over time.

MECSH client retention at three months into the program



Source: HV-CoIIN database

Watch the 2023 CQI Practicum Showcase video on YouTube to learn more.

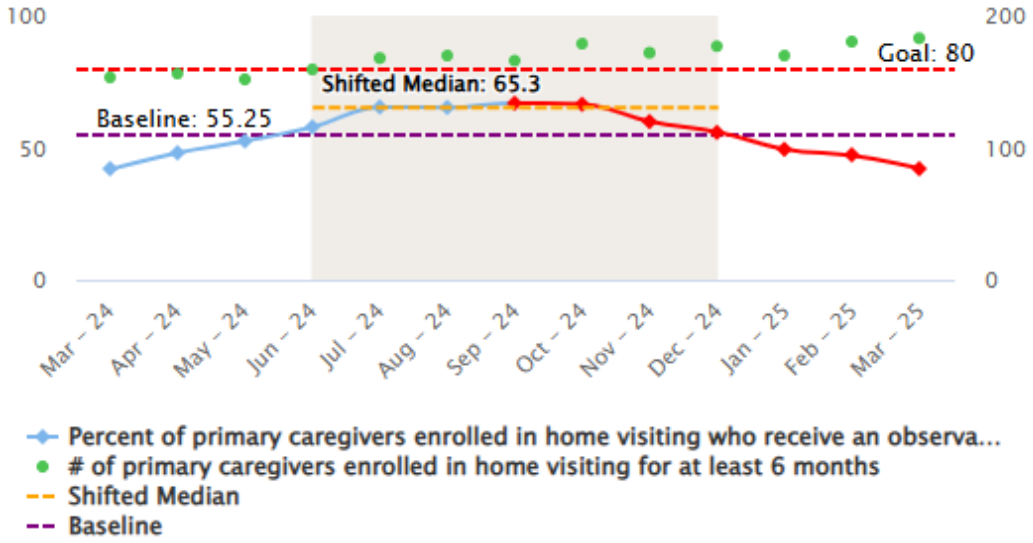
Measure 10: Parent-child interaction tool completion

There has been much focus on the calculation of this measure over the past year. Initially, this MIECHV measure was calculated at 19% for fiscal year 2024. As we moved through fiscal year 2025, updated guidance was learned and provided to grantees for the use of the parent-child interaction observation tool, Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO). PICCOLO had been identified as a validated tool beginning with children at age 10 months, and after discussions with the PICCOLO developer, this changed to a much lower age (3 months) in early fiscal year 2025. Therefore, in March 2025, MDH provided guidance to MIECHV grantees recommending that the PICCOLO be completed every six months (at child ages 6 months, 12 months, and 18 months). This new guidance therefore changed how this measure is calculated, prompted questions from grantees, and provided complications for data comparison from year-to-year in our CQI discussions. MDH consults with the University of Minnesota research staff to aid in effectively calculating this measure.

Throughout the HV-CoIIN collaborative, one measure focused specifically on the percent of primary caregivers who receive an observation of a caregiver-child interaction by the home visitor using a validated tool within the last six months.

The data from the three participating LIAs from Minnesota (St. Paul/Ramsey, Washington, and Dakota) throughout the collaborative are depicted in the figure below.

Percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool within the last six months



Source: HV-CoIIN database

This chart displays baseline data for this measure starting at just over 55% for these three LIAs. The first data point in March 2024 came in around 42% and then there was some positive movement upward which shifted the median to 65%. However, after about halfway through the collaborative, there is a downward slope in the data, to 42% in March 2025. MDH is using this data to reflect on factors that may have influenced the downward shift (i.e. if canceled visits for sickness or holiday months equate to lack of opportunity to complete a PCI tool, are we calculating the measure the same, etc.) with hopes of implementing strategies in the future as we continue focus on this topic.

Measure 5: post-partum care missing data

Missing data for this measure was calculated at 38% for fiscal year 2024. As of the end of April 2025, missing data decreased to 30%. Monthly reports have been sent to grantees identifying specific caregivers with this missing information. MDH is hopeful that this will continue to decrease throughout the remainder of this year. While focusing on this, the following learnings have been identified:

- Due to the visit schedule within the Maternal, Early Childhood Sustained Home visiting (MECSH) model, there are families who do not have a scheduled home visit during the time period when this information is collected (2-4 months of age). These families are included in the denominator for this measure although there was not an opportunity for the home visitor to complete the form that includes the question about a postpartum visit (3 month age interval form).

- Families were originally included in the missing category even if they never had a visit after the child was 2 months of age. We have since updated our calculation to ensure there was a data collection opportunity (must have had a visit between 2-4 months of age).
- If a home visitor completes this question (three-month interval form) outside of a home visit and does not connect it to a home visit within the electronic health record, the information will not be sent to the MDH database and will continue to appear as missing.
- There appears to be a need for continued guidance about home visitors being able to complete the 3-month age interval form between the child's age of 2 months and 3 months, 29 days.

4. What progress can you report from the CQI project?

MDH identifies several areas of progress and learning as a result of our CQI projects. First, as briefly mentioned above, focusing on these measures and reviewing monthly and quarterly data reports with LIAs has led to discussions and efforts to clarify and ensure accurate calculation of the measures. We've been able to identify where more guidance is needed, where calculations might prove to be more complicated than anticipated, and where challenges with electronic health records and our data system exist. These conversations have also aided in improving data literacy for internal staff as well as LIAs.

Additionally, participation in the HV-CoIIN collaborative provided opportunities for relationship building and collaboration between the three LIAs participating, as well as these LIAs being willing to share to other home visiting programs. This has opened more peer-to-peer learning conversations that we anticipate will be on-going as we spread and scale our project outcomes.

5. Did you encounter challenges in the implementation of your CQI project?

☒ Yes ☐ No

a. If yes, please explain.

Challenges related to measure calculation and lack of comparison baseline data have been highlighted throughout the last two years. This has led to discoveries for MDH as we learn more about our data, measure calculations, and how to best support grantees with their data. We have been able to provide LIAs with data reports, learn from what is useful with these reports, and make changes to these reports as needed.

The support and technical assistance received as part of the CQI practicum and the HV-CoIIN collaborative have been assets to being successful at moving this project along, improving LIA knowledge and experience with CQI, and keeping LIAs engaged in our CQI projects the last two years.

6. What are you doing to sustain the gains from your CQI project?

As described below in our future planning, to sustain the gains from the project focused on parent-child interaction this past year, MDH will continue to keep this topic as the focus for

the period of this CQI plan. Building in parent-child interaction throughout family home visiting (every home visit and not simply while completing a required PCI observation tool), will keep this concept at the forefront of all conversations. We will continue to highlight and share change ideas tried during the time in the HV-CoIIN collaborative, by MN LIAs and by other states, at monthly CQI meetings and regular practice connections.

7. **Please explain the method(s) or strategies that you used to spread successful CQI activities to other LIAs or communities.**

   Throughout the last two years, MDH has held regular monthly CQI office hours, which have been relatively well attended by LIA staff. In early 2025, these "office hours" were rebranded as *CQI Connect and Learn* to promote a more inviting peer-learning space. During these monthly CQI focused meetings, along with scheduled MIECHV specific project webinars, LIAs hear successes of peers, brainstorm together change ideas being tried or hoping to try, and share Plan-Do-Study-Act (PDSA) cycles.

   In May 2025, MDH and the three LIAs who participated in the HV-CoIIN collaborative held a webinar to share learnings from the time in the collaborative. Additional LIAs requested PDSAs and other documents created from the collaborative to implement in their home visiting programs (i.e. scripts to introduce parent-child interaction and video observation).

   In addition to regular group sharing, during individual grantee meetings, CQI is always on the agenda and discussed. When appropriate, MDH staff have been able to share ideas learned from other LIAs to support spreading successful activities.

8. **What successful innovations, tested during the course of your project, could be shared with other awardees?**

   As a result of participation in the HV-CoIIN collaborative, MDH and one LIA, Dakota County, recorded a Podcast with the EDC about the importance of parent-child interaction in family home visiting. We are looking forward to the publishing of this podcast to share this with other awardees. Further, we have been able to share scripts and talking points related to the introduction of parent-child interaction observation tools with additional LIAs.

9. **Based on what your team has learned from the last two years of CQI plan implementation, what goals do you have for growing your awardee level CQI capacity in the next two years?**

   MDH has interest in focusing continued efforts on improving internal knowledge and capacity to support CQI. Beginning in 2024, MDH implemented a project using a CQI framework to work internally and identify ways to better support grantees. As part of this project, CQI lead staff participated in and led more conversations using CQI principles and tools. Through informal scaling in December 2024, MDH staff identified that participating in regular conversations using CQI principles improved their confidence of talking about CQI with grantees. The CQI team would like to see efforts like this continue as this promotes a more 'parallel process' of implementing CQI, being just as important at the awardee level as promoted at the local level.

Part 2: CQI plan for Sept. 30, 2025-Sept. 29, 2027

Organizational system and support

Awardee level:

1. Staff members on CQI team

Staff members on MDH CQI team and professional development needs

Staff roles assigned to CQI teams	Experience with CQI (years in role and specific skills)	Professional development needs to be successful in this role (e.g., training, written resources)	LIAs supported (List)
Charlotte McDonald, CQI lead	Five years training and experience with CQI in child welfare; Trained in Collaborative Safety Model; In current position, lead CQI coordinator since July 2022.	Continued relationship building with MIECHV awardees; Knowledge and training related to MECSH and other home visiting models.	All LIAs (see table below)
Rebecca Paulson, MECSH practice consultant	Over 14 years of experience in working with continuous quality improvement- both at the local level and with the state of Minnesota. Experience with using PDSA, run charts, and data to inform decision making. Trainer in PICCOLO and MECSH model.	Collaborative meetings with LIAs to gain knowledge of CQI efforts across the state; Intermediate/advanced training with the Model for Improvement and PDSA Cycles.	All LIAs (see table below)
Amy Goodhue, MECSH practice consultant	Relatively new to MDH. Experience with CQI at the local level working with PDSA cycles with MDH support.	Collaborative meetings with LIAs to gain knowledge of CQI efforts across the state; Intermediate/advanced training with the Model for Improvement and PDSA Cycles.	All LIAs (see table below)
Kristie Sundquist, Family Spirit nurse practice consultant	Knowledge of Tribal practices and experience with implementing CQI at local level and Tribal Public Health. Participated in planning for 2024 project.	Collaborative meetings with LIAs to gain knowledge of CQI efforts across the state; Intermediate/advanced training with the Model for Improvement and PDSA Cycles.	All LIAs indirectly (see table below)
Sue Ewy, Nurse Family Partnership nurse practice consultant	Has participated in several CQI projects with 8 years of experience leading family home visiting LIAs in CQI efforts.	Collaborative meetings with LIAs to gain knowledge of CQI efforts across the state; Intermediate/advanced training with the Model for Improvement and PDSA Cycles.	All LIAs indirectly (see table below)
Cora Vavra, Parents as Teachers nurse practice consultant	Participated in 2022 and 2023 CQI project and bringing knowledge and experience with implanting CQI at the local level.	Collaborative meetings with LIAs to gain knowledge of CQI efforts across the state; Intermediate/advanced training with the Model for Improvement and PDSA Cycles.	All LIAs indirectly (see table below)
Chandra Bittmann, community and state initiatives supervisor	Participated in planning CQI projects for 2021-2023.	Collaborative meetings with LIAs to gain knowledge of CQI efforts across the state.	All LIAs (see table below)

Staff roles assigned to CQI teams	Experience with CQI (years in role and specific skills)	Professional development needs to be successful in this role (e.g., training, written resources)	LIAs supported (List)
Jennie Lippert, family home visiting section manager	Bringing knowledge and experience with implanting CQI at the local level.	Collaborative meetings with LIAs to gain knowledge of CQI efforts across the state.	All LIAs (see table below)
Jennifer Hains, senior data scientist	Participated in data analysis and interpretation for CQI project in 2019, 2021, 2022, and 2023.	Training on interpreting disaggregated data to better inform CQI practices.	All LIAs (see table below)
Luke Huber, senior data scientist	Previous work focusing on CQI efforts and work at the local level in Iowa from 2020-2022. Participated in CQI data analyses and interpretation in 2023 and HV-CoIIN in 2024.	Collaborative meetings with LIAs to gain knowledge of CQI efforts across the state.	All LIAs (see table below)
Sonja Ausen, grant manager	New member of the team, will bring fresh ideas and grant manager perspective.	Collaborative meetings with LIAs to gain knowledge of CQI efforts across the state; Intermediate/advanced training with the Model for Improvement and PDSA Cycles.	All LIAs (see table below)

Participating LIAs fiscal year 2026-2027

Community Health Board (CHB)	Counties Served
Anoka County CHB	Anoka
CCLS CHB	Carlton, Cook, Lake, and St. Louis
Cass County CHB	Cass
City of Bloomington CHB	Hennepin
Dakota County CHB	Dakota
First Steps CHB	Benton, Sherburne, Stearns, and Wright
Olmsted County CHB	Olmsted
St. Paul-Ramsey County CHB	Ramsey
Washington County CHB	Washington

2. How will you ensure awardee staff and LIA teams are trained in CQI? Describe the methods or strategies you plan to use to support awardee and LIA teams' implementation of CQI. How often will training occur?

MDH CQI Coordinator provides training, coaching, and technical assistance to MIECHV LIAs on a regular basis throughout each year. The following consistently occurs:

- MIECHV CQI Change Package drafted (each year with new aims) and posted on the MDH CQI website. Driver diagram, change ideas, and sample PDSA cycles included.
- Webinar(s) to announce, discuss, and review the MIECHV identified CQI project and progress (approximately three per year).
- Quarterly individual MIECHV grantee check-ins (three practice connections and one site visit each year). These occur primarily virtually, although are in person potentially once per year.

- Data reports provided to grantees monthly or quarterly, depending on need. Evaluation staff assist grantees in the interpretation of these data reports.
- Monthly CQI Connect and Learn meetings scheduled the second Wednesday of every month. Topics are brought as a start to the conversation and the space allows for peer-to-peer learning opportunities.
- Tips and Tricks published in Tuesday Topics (listserv) approximately twice a year.
- Additional individual coaching as needed/requested by grantees. The frequency and content of coaching and training is individualized based upon grantee needs.
- Progress reports from grantees twice per year provide opportunity to request additional training or technical assistance on specific CQI processes and projects.

In the fall of 2025, MDH is collecting information from grantees about their identified CQI process and efforts at the local level. We are hoping to learn from grantees what is most useful for them to engage in CQI and then be able to tailor our technical assistance to what is most beneficial to grantees.

3. **How will you engage technical assistance providers for the purposes of improving CQI practices and methods (e.g., TARC, CQI practicum, HV-CoIIN, etc.)?**

☒ **TARC**
☐ **CQI Practicum**
☒ **HV CoIIN**
☒ **Other:** Peer CQI Leads

MN spent the last year actively participating in the HV-CoIIN collaborative focused on parent-child interaction. This was a valuable experience that allowed for positive relationships to be developed with CoIIN staff. MDH will access CoIIN staff for further support and resources if needed as we continue to spread the gains of what was learned in the collaborative. Further, MN assigned TARC staff will be accessed as needed, including at quarterly calls held with HRSA.

The MN CQI coordinator will continue to participate in monthly peer-led community of practice sessions with other CQI leads across the nation. This has been a beneficial space historically to gain support, gather ideas, and share knowledge among peers.

4. **In what CQI areas would you be interested in receiving additional support (e.g., family engagement in CQI, capacity building, etc.)?**

☐ Family Engagement in CQI
☒ CQI Capacity Building
☒ Sustaining the Gains from your CQI project
☒ Spread and Scale
☐ Other

5. **Describe the resources and strategies in place to involve home visiting families on awardee and/or LIA CQI teams.**

a. To what extent are home visiting families partnering in CQI activities? (e.g., families are involved in ad hoc ways through surveys or focus groups; families are trained in CQI methods; families lead or co-lead CQI activities).

Several LIAs survey families yearly to obtain feedback on the program and gather participant input on their experience. LIAs utilize this feedback to improve, shift, change programming, as well as highlight the positive impact of family home visiting. MDH has encouraged LIAs to add a parent leader(s) to their CQI team. Often there are barriers identified to this at the county level; however, LIAs continue to make efforts for this and at a minimum have been able to access community advisory groups to obtain feedback on programming.

b. What steps will you take to grow your partnership with home visiting families in CQI activities over the next two years?

MDH will collect information at least quarterly from LIAs about how they engaged parents/families in CQI. Including this question at quarterly practice connections with LIAs will prompt discussion about the importance of including parents in CQI. MDH will have at least one CQI Connect and Learn focus on this topic within the next two years.

CQI Priority(s)

6. Describe the topic(s) of focus at the awardee level and/or for each LIA. If topics are not known, describe how topics will be identified. Teams may continue to consider their Demonstration of Improvement data when identifying priorities for fiscal year 2025.

Use the optional table format or describe the topics below. Be sure to include how topics were identified and how they meet the needs of the communities served by home visiting.

Awardee/ LIA Participating in CQI (List name)	Topics selected for CQI	How were these topic(s) chosen?	How do the topic(s) meet the needs of the communities served?
All MIECHV funded grantees	Parent-Child Interaction (PCI)	This topic was chosen as a continuation of this current year's topic. So far this year, we have learned much about our data calculation, provided improved guidance about our PCI tool, and made intentional efforts to center PCI as a crucial component to home visiting. LIAs have been engaged in this project as being important to them.	Focusing on parent-child interactions supports communities by: - Enhancing early development - Building secure relationships - Promoting community well-being and overall health - Reducing stress and toxic stress - Encouraging family engagement
All MIECHV funded grantees	Missing data (decreasing). If identified as an appropriate need for focus.	MDH prioritizes data quality. During previous projects on missing data, we have learned more about our data system and the challenges that our LIAs experience. We have also learned that LIAs have a preference and get more buy-in when focusing on projects that are practice oriented and not focused solely on data.	At LIA request, MDH would like to focus the majority of this year for CQI on PCI and related more to practice and implementation. Should there be an identification of significant missing data that appears necessary and appropriate, we will then reach out to LIAs and work together on a plan for improvement.

Goals and objectives

7. Describe SMART aim(s) for the topic(s) listed above. You can use the optional table format or describe the SMART aims for each LIA. Include CQI practicum and HV CoIIN aim(s) for participating LIAs.

The following aims have been drafted for fiscal year 2026:

- By Sept. 30, 2026, 85% of MIECHV home visitors will have completed training in the PICCOLO.
- By Sept. 30, 2026, post-training survey average scores of home visitor confidence about using the PICCOLO tool in practice will show improvement from pre-training surveys.
- By Sept. 30, 2026, there will be a 10% increase in percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool.

The following aims, with identified considerations, have been drafted for fiscal year 2027:

- By Sept. 30, 2027, 50% of home visits where a child is present will include a dialogue and reflection on parent-child interaction.
  - This aim is modeled after an aim from the HV-CoIIN collaborative this past year and distinguishes the importance of parent-child interaction in home visiting beyond simply the completion of a parent-child interaction tool. MDH recognizes that an aim of this nature is important to LIAs, yet the data for this aim is not collected easily in LIAs documentation systems. Over the first year of this plan (fiscal year 2026), MDH will engage in conversations with LIAs to obtain feedback and may therefore need to adjust as necessary.
- By Sept. 30, 2027, 20% of families will see an increase in scores in their highest domain on the PICCOLO from a previously scored PICCOLO.
  - The PICCOLO is grounded in the belief that concentrating on strengthening a caregiver's higher domains may likely result in a natural increase in other domains. Prior to finalizing this aim statement, MDH envisions further internal discussions as well as discussions with LIAs to determine what is the most appropriate domain(s) for emphasis.
- By Sept. 30, 2027, there will be a 5% (another) increase in percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool.
  - While CQI does embrace aiming high, MDH is aware that LIAs are often more engaged in the project when they are encouraged by 'wins' and noticeable accomplishments. Because this aim is a continuation from the year prior, we will review the official identified percentage aim as we get closer to the close of fiscal year 2026.

Missing data

As noted in the above table, MDH values data accuracy and appreciates the importance of this as a CQI focus when data is significantly missing. MDH also has learned from LIAs during the last two CQI projects that there is more desire and interest at the local level to spend more time on goals related to improving their practice and the implementation of family home visiting. Therefore, this plan is more concentrated on practice rather than data. MDH remains committed to monitoring data and if deemed appropriate, will work with LIAs to set appropriate aims when necessary.

Changes to be test

8. Describe your process for identifying changes that teams will test out to achieve the goals and objectives of your CQI projects. If known, please include changes that teams will test.

MDH will develop a change package that will outline the CQI aims, primary and secondary drivers, and change ideas. Teams will review the change package to brainstorm change ideas at the local level. MDH will support LIAs in identifying changes to test with one-on-one coaching and monthly CQI Connect and Learn meetings. Change ideas will be related to the following primary drivers:

- Culturally responsive and supported workforce with capacity to assess, address, and promote parent-child interaction.
- Comprehensive data-tracking system.
- Standardized and reliable process for documentation of measures.
- Equipped and attuned caregivers.
- MECSH model support.

Methods and tools

9. Identify the CQI tools that will be used by your LIA teams during the implementation period (Sept. 30, 2025-Sept. 29, 2027) below:

☐ Charter that outlines the scope of the CQI project

☒ Key driver diagram that displays the theory of change underlying the improvement efforts

☒ Fishbone diagrams

☒ Root-cause analysis

☒ Process mapping or flow charts

☒ Data graphs such as frequency plots, run charts, and Pareto charts

☒ Other, please describe: MDH provided change package

Teams will be supported with an MDH provided change package including an outline of the scope of the project, a primary driver diagram and potential change ideas. Teams will

prioritize primary drivers and change ideas that are relevant to their local agency by completing root-cause analysis, process mapping, and fishbone diagrams.

Teams will use PDSA cycles to test changes using ideas from the change package or ones they develop themselves. Teams will also be encouraged and supported in the use of run charts to visualize changes.

10. **Identify the CQI methods that will be used by your LIA teams during the implementation period (Sept. 30, 2025-Sept. 29, 2027) below:**

    ☒ Plan-Do-Study-Act cycles

    ☐ Six Sigma

    ☐ FADE

    ☒ Model for Improvement

    ☐ Other, please describe:

    We utilize the Model for Improvement for our CQI methods, asking 1) What are we trying to accomplish? 2) How will we know that a change is an improvement? and 3) What change can we make that will result in improvement? Teams complete regular PDSA cycles. We also recognize that some Teams are not as familiar with the Model for Improvement, so we support them also by recognizing their informal CQI methods and demonstrating how their work fits into the Model for Improvement.

Measurement and data collection

11. **Describe the type of data that will be collected for your CQI project(s), how often, and how data will be reviewed and utilized below or in the optional table format.**

    Data Type: We will collect quantitative data for these aims (i.e. PCI tool completion, number of home visitors trained in PICCOLO, pre and post training survey results). MDH and LIAs will work together to identify data available to track home visits with dialogue and reflection about parent-child interaction. We also will encourage local agencies to collect qualitative data relative to home visitor experience and parent stories to capture bigger picture outcomes related to parent-child interaction in family home visiting.

    Data Collection and Timeline: Local teams will enter data into their EHR system, or a REDCap form, and this data will be sent directly to MDH with monthly updates. MDH evaluation staff will calculate measures for each team and create an excel report showing how the measure changes over time. These reports will be at least quarterly although can be monthly based upon usability. Local LIAs will compare their local data to the data shared from MDH to ensure accuracy and address any discrepancies.

    MDH will provide support and technical assistance to LIAs for this project. We will be able to answer questions about data, help LIAs use tools such as run charts to map their data, and encourage LIAs to collect general data about things such as barriers to completing a PCI tool to be able to think more about potential change ideas.

Data Review and Utilization: MDH will provide data information though a webinar at the start of each year. We will generate reports for teams on at least a quarterly basis (potentially monthly depending on measure and usability). MDH will review these reports with teams in one-on-one meetings quarterly and as needed. We will also review any local real-time data with teams in one-on-one meetings quarterly and as needed. Strengths and challenges will be discussed as well as PDSA cycles and change ideas tested. MDH will hold CQI Connect and Learn meetings to allow for teams to ask questions and share progress on goals and challenges. MDH will hold a year end webinar where teams will highlight wins and lessons learned.

Sustaining the gains

12. **Describe how you will sustain the progress you make at the awardee and LIA levels after the CQI project ends (e.g., integrating new processes into staff training, updating agency protocols, ongoing monitoring of data, etc.). You may want to set aside time immediately following your CQI project to support LIAs to develop a sustainability plan that determines what measures will be monitored on an ongoing basis, how frequently, by whom, and a plan for action if data regress beyond a certain point.**

    MDH will continue to calculate performance measurements on a regular basis. This will be completed at least quarterly, although can be monthly depending on measure and usability.

    Effective virtual trainings will be offered during the CQI project period and can be repeated in the future beyond this project to keep parent-child interaction a central topic of conversation.

    MDH will summarize change ideas and outcomes in a story board or narrative format and post on our website for future reference and will support LIAs in creating a sustainability plan.

    Further because MDH has two PICCOLO trainers on staff, ongoing training adaptions will occur as a result of learnings from this project and an improved curriculum (i.e. additional focus on practice and local barriers) can be developed for use for home visitors in the future.

Spread and scale

13. **Describe the methods and strategies you will use to spread and scale successful interventions and lessons learned to additional LIAs or communities. Consider when these activities will occur given the two-year period.**

    MDH will host monthly CQI Connect and Learn meetings that will allow teams to share success stories and lessons. These will be held virtually, and grantees will be asked to share to facilitate peer-to-peer learning. These meetings will be targeted for MIECHV funded LIAs, however, other FHV grantees will be able to attend and therefore spread the CQI work beyond MIECHV funded LIAs.

Teams will be encouraged to share their best practices with colleagues and spread the improvements beyond clients who are being served by an evidence-based model to include traditional and general home visiting services as well. Further, MDH is hopeful that change ideas tried in fiscal year 2026 will be able to expand to additional LIAs, including non-MIECHV funded LIAs, in fiscal year 2027.

Family home visiting nurse consultants will share successful change ideas that have been tried and implemented by LIA's from across the state at their regular check-ins with grantees. These check-ins occur quarterly. The CQI coordinator will highlight successes in Tuesday Topics newsletters to encourage application of similar change ideas among LIAs. Tuesday Topics is a weekly e-newsletter communication distributed to over 5000 subscribers.

Addressing community health factors in CQI work

14. What steps will you take to identify community health factors in your available data within your CQI topic (e.g., disaggregated data by certain variables of interest)?

Throughout the last year, MDH worked with the University of Minnesota to explore family home visiting data across different variables. Two findings from focus groups included the need to adapt screenings (i.e. depression, IPV) with certain groups, such as non-English speaking, and that when families were identified to have higher, more complex needs, it was reportedly more challenging to focus on things such as screenings. In learning more about this, MDH is interested in continuing this work and consider how these findings might translate to parent-child interaction within home visiting.

15. Describe strategies that you will use to address community health factors in your CQI topic over the next two years. What is the next step you will take?

MDH has become aware that some LIAs are interested in assessing and improving practice around completion of parent-child interaction tools with non-English speaking caregivers. As we explore our PCI data, we anticipate asking about barriers to this and, more importantly, leveraging learnings from agencies having more success with this to pass on their knowledge and experience. We are committed to supporting agencies in implementing best practices and appropriate adaptations to the PICCOLO.

In addition, we are continuing to increase our collaborations throughout MDH and across state agencies. Members of our CQI team represent MDH-FHV on several intra-agency and inter-agency workgroups, including the Help Me Connect Planning Team, the Family First Prevention Services Act (FFPSA) workgroup, the Minnesota Interagency Developmental Screening Task Force, and the MN Association of Children's Mental Health - Infant Early Childhood Collaborative. These workgroups provide opportunities for our team to learn about initiatives and projects occurring throughout the state, share and gather feedback about family home visiting, and allow for collaboration as we work together to support children and families across all communities.