Welcome!
HOME VISITING COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK (HV COIIN)

Implementing Quality Improvement to Achieve Breakthrough Change in Breastfeeding
Project Partners

A 3-Year Cooperative Agreement between The Maternal and Child Health Bureau’s (MCHB) Division of Home Visiting and Early Childhood Systems and Education Development Center, Inc.
Purpose for the HV CoIIN

• Close the Gap between what we know works and what is happening on the ground
• Achieve results faster
• Build leaders of Quality Improvement - Sustainability
3 Improvement Topics Identified

A Gap Exists and Evidence-based Practice is Known

Alleviating Maternal Depression (MD)
Increase identification, referral, and receipt of service.

Developmental Surveillance and Screening (DSS)
Strengthen the process of developmental surveillance and screening, intentional support, referral and follow-up.

Breastfeeding (BF)
Increase initiation and duration.
Innovation Topic Identified
Robust Evidence is Not Yet Available

Family Engagement (FE)
The Breakthrough Series as the HV CoLlN Framework

Select Topic
Recruit Faculty

Develop Framework and Changes

Enroll Participants

Prework

LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act

Supports:
Email • Visits • Phone Conferences • Monthly Team Reports • Assessments

LS1 → LS2 → LS3 → Summative Congresses and Publications
Participants in Breastfeeding Collaborative

6 MIECHV Grantees

Florida
Michigan (Calhoun & Detroit)
Ohio
Rhode Island
Virginia
Wisconsin

11 Local Implementing Agencies
What Are We Trying to Accomplish?

Increase by 20% from baseline the % of women exclusively breastfeeding at 3 months and 6 months.
• 3 month exclusivity current Median = 19%
• For 6 months exclusive median is at 9%.

THE GAP
Process Aims

80% BF Supports

80% Initiation

100% HV Trained in lactation & feeding
Helping Teams with “Why and “How”
SMART Aim: to increase by 20% from baseline the % of women exclusively breastfeeding at 3 months & 6 months.

Outcome measure: % of women who report exclusive BF at 3 & 6 months.

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### Breastfeeding Key Driver Diagram

#### Primary Drivers

<table>
<thead>
<tr>
<th>PD1. Standardize internal (agency) policies and practices to support breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding policy, protocol and print resources for the delivery of breastfeeding support prenatally and postnatally</td>
</tr>
<tr>
<td>Home visitors with lactation and breastfeeding knowledge &amp; competencies</td>
</tr>
<tr>
<td>Regular professional development for home visitors in breastfeeding policies and protocols</td>
</tr>
<tr>
<td>Establish cooperative relationships with key community breastfeeding partners (WIC, La Leche League, etc.)</td>
</tr>
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<table>
<thead>
<tr>
<th>PD2. Build capacity of and support for home visitors to address breastfeeding in the target population</th>
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<tbody>
<tr>
<td>Establish relationships with breastfeeding support groups</td>
</tr>
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<td>Establish relationships and linkages with medical and educational field, e.g. hospitals, primary care, obstetrical providers, schools</td>
</tr>
<tr>
<td>Close loop of communication for referral, access and engagement in breastfeeding supports and services</td>
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<td>Mothers informed of the benefits of breastfeeding (paying special attention to debunk myths)</td>
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<table>
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<tr>
<th>PD3. Create strong community linkages to breastfeeding support systems</th>
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<th>PD4. Family Engagement</th>
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<tr>
<td>Mothers empowered to meet individual BF goals</td>
</tr>
<tr>
<td>HV engages in regular client-led conversation regarding breastfeeding</td>
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<tr>
<td>Use of best practice/evidence-informed strategies to enhance mother-infant breastfeeding practices</td>
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#### Secondary Drivers (Actions)

| C1. Protocol for HV delivery of BF support (i.e. Boston Infant Feeding Toolkit) |
| C2. Protocols for documenting communication and referral of families to key community partners |
| C3. Initial and refresher training for HVs on agency polices and protocols |
| C4. Print materials align with CDC Guidelines |

<table>
<thead>
<tr>
<th>Specific Ideas to Test or Change Concepts</th>
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<tbody>
<tr>
<td>C1. Competencies for HVs to adequately address breastfeeding with families</td>
</tr>
<tr>
<td>C2. Requirement and provision of training for home visitors consistent with United States Breastfeeding Committee guidelines</td>
</tr>
<tr>
<td>C3. Data on measures provided regularly to home visitors to use in quality improvement</td>
</tr>
<tr>
<td>C4. Regular Reflective supervision</td>
</tr>
<tr>
<td>C1. Memorandum Of Understanding with Key Community Partners (i.e. WIC)</td>
</tr>
<tr>
<td>C2. Current resource list of peer support groups and Baby-Friendly hospitals</td>
</tr>
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<td>C3. Establish breastfeeding teams</td>
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<td>C4. Protocol for warm hand off and follow-up</td>
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PDSA Report

1. Local Implementing Agency:
2. Month:
3. Cycle Number:
4. Topic:
5. What are we trying to accomplish?
6. How will we know that a change is an improvement?
7. What changes can we make that will result in an improvement?
8. What question(s) do we want to answer on this PDSA cycle?
9. Plan
   a. Who
   b. When
   c. What
   d. Where
10. Tasks or tools required to set up
11. Plan for collection of data
    a. Who
    b. When
    c. What
    d. Where
12. Predictions

13. Do

14. Study

15. Act
Examples of Changes Tested across BF Primary Driver 1;
Standardize internal policies and practices to support breastfeeding

- Use of the Boston Infant Feeding Toolkit with all families
- Policy for training all new HVs in infant feeding and lactation
- Protocol for tracking HV discussion of breastfeeding with prenatal and breastfeeding moms (Aim=at least 50% of visits)
- Provide breastfeeding kits to all exclusive breastfeeding moms at 2 weeks postpartum.
Examples of changes tested across BF Primary Driver 2; Build capacity of and support for HVs to address breastfeeding in target population

- Track the number of breastfeeding moms each nurse has and address barriers through reflective supervision.

- In-house training of HVs by certified lactation consultant (IBCLC).

- Use of a HV Breastfeeding self-efficacy scale- short form (BSES-SF) and alignment of breastfeeding education curriculum w/HV identified gaps in knowledge.
Examples of changes tested across BF Primary Driver 3; Create strong community linkages to breastfeeding support systems

- Joint family visits by HV and WIC breastfeeding counselor
- Development of a peer-to-peer breastfeeding support group for new moms
- Contract with IBCLC for concentrated support to breastfeeding moms
- Protocol for intentional warm-handoffs to community breastfeeding resources.
For More Information

Mary Mackrain, Project Director, HV CoIIN- Education Development Center, Inc.
mmackrain@edc.org

HV CoIIN Article on Developmental Promotion, Early Detection and Intervention:

http://hv-coiin.edc.org/
Calhoun County Nurse Family Partnership

michigan Home Visiting initiative
Our HV CoILLN CQI Team
Why We Chose this Topic

- In January 2014 we added the new position of the Breastfeeding Support Nurse.
  - Half time home visiting
  - Half time breastfeeding support

- Built on the Lactation Specialist training that four of our team completed.
Why We Joined the HV CoILN

- Provided direction for the new role of Breastfeeding Support Nurse.
- CoILN faculty provided evidence based strategies to direct our work.
**Key Driver Diagram: HV CoLLIN Breastfeeding**

**Primary Drivers**
- Standardize internal (agency) policies and practices to support breastfeeding
- Build capacity of and support for home visitors to address breastfeeding in the target population
- Create strong community linkages to breastfeeding support systems
- Family Engagement
  - Mothers informed of the benefits of breastfeeding (paying special attention to debunk myths)
  - Mothers empowered to meet individual BF goals
  - HV engages in regular client-led conversation regarding breastfeeding
  - Use of best practice/evidence-informed strategies to enhance mother-infant breastfeeding practices

**Secondary Drivers**
- Breastfeeding policy and print resources for the delivery of breastfeeding support prenatally and postnatally
- Standardized professional development for home visitors in breastfeeding policies and protocols
- Home visitors with lactation and breastfeeding knowledge & competencies
- Regular professional development for home visitors on infant feeding practices that support a culturally sensitive, family centered, relationship-based approach
- Regular access to performance data for quality improvement
- Timely and effective supervisory support
- Establish cooperative relationships with key community breastfeeding partners (WIC, La Leche League, etc.)
- Establish relationships with breastfeeding support groups
- Establish relationships and linkages with medical and educational field, e.g. hospitals, primary care, obstetrical providers, schools
- Close loop of communication for referral, access and engagement in breastfeeding supports and services
- Mothers informed of the benefits of breastfeeding (paying special attention to debunk myths)
- Mothers empowered to meet individual BF goals
- HV engages in regular client-led conversation regarding breastfeeding
- Use of best practice/evidence-informed strategies to enhance mother-infant breastfeeding practices

**Specific Ideas to Test or Change Concepts**
- Protocol for HV delivery of BF support (i.e. *Boston Infant Feeding Toolkit*)
- Protocols for documenting communication and referral of families to key community partners
- Initial and refresher training for HVs on agency policies and protocols
- Print materials align with CDC Guidelines
- Competencies for HVs to adequately address breastfeeding with families
- Requirement and provision of training for home visitors consistent with United States Breastfeeding Committee guidelines
- Data on measures provided regularly to home visitors to use in quality improvement
- Regular Reflective supervision
- Memorandum Of Understanding with Key Community Partners (i.e. WIC)
- Current resource list of peer support groups and Baby-Friendly hospitals
- Establish breastfeeding teams
- Protocol for warm hand off and follow-up
- Use of Boston Healthy Start Infant Feeding Toolkit
- Home Visitors utilize Best Start 3-Step Counseling strategies
- Home visitors use practices/resources that help to identify and strengthen formal and informal supports (partner, other family members, etc.)
- Home Visitors utilize practices from Secrets of Baby Behavior curricula
- Breastfeeding print resources for families that align with the CDC Guide to BF Intervention

**SMART Aim**
- to increase by 20% from baseline the % of women exclusively breastfeeding at 3 months & 6 months

**Outcome measure:**
- % of women who report exclusive BF at 3 & 6 months
Critical Time Periods for Breastfeeding Intervention

- Prenatal
- During hospital stay
- First two weeks
- Two to six weeks postpartum
PDSA Cycles

- **PDSA Cycle One**
  - Standardize prenatal education, materials, referral processes, nurse training and infant feeding assessments.

- **PDSA Cycle Two**
  - Implementation of prenatal visits by the Breastfeeding Support Nurse to prepare clients for early postpartum period.

- **PDSA Cycle Three**
  - Implementation of postpartum visits during the first three days after discharge from hospital after birth.
PLAN: Model for Improvement’s Three Fundamental Questions

- **What are we trying to accomplish?**
  Women will continue breastfeeding beyond our current average of 2-3 weeks postpartum.

- **How will we know that a change is an improvement?**
  The percentage of women breastfeeding at one month will increase.

- **What changes can we make that will result in an improvement?**
  
  #1 - By May 30, 2015, 50% of women who have reached their due date and intend to breastfeed will have received a Joint Home Visit (JHV) with their assigned Nurse Home Visitor (NHV) and the Breastfeeding Support Nurse.
  #2 - By May 30, 2015 50% women who deliver and intend to breastfeed will receive a home visit by her assigned NHV or the Breastfeeding Support Nurse within three work days of client discharge from the hospital to provide breastfeeding support.
• Prenatal JHVs and postpartum visits within three days of discharge from hospital were offered to all clients who had due dates between October 1, 2014 and April 30, 2015.
Comparing Possible Prenatal Joint Home Visits with Completed Joint Home Visits
11/18 completed = 61%

Study:
We met the goal of AIM Statement #1
We met the goal of AIM statement #2. 12/18 = 67%

Post-partum Home Visits

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
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<tbody>
<tr>
<td>Potential visits</td>
<td>18</td>
</tr>
<tr>
<td>Visits within 3 days by NHV</td>
<td>12</td>
</tr>
<tr>
<td>Within 3 days by BF Support Nurse</td>
<td>8</td>
</tr>
<tr>
<td>Within 3 days by BF Support Nurse</td>
<td>4</td>
</tr>
</tbody>
</table>
We saw an increase in the number of women breastfeeding beyond 2 to 3 weeks. Four women continue to breastfeed, 22%.

Breastfeeding Duration in weeks

- <1 week: 4
- 1 to 3 weeks: 5
- 4 to 6 weeks: 6
- 12 weeks: 1
- 18 weeks: 1
- 20 weeks: 1
• Multiple changes were made to JHV format, documentation, and content.

• Prenatal education, prenatal JHVs, and early postpartum home visits were implemented as standard practice.
Successes Achieved through Our PDSA Cycles

- Increased consistency in practice between all NHVs
- Confidence as a result of trying something new
- Shift in breastfeeding duration among women involved in the PDSA cycles
- Increase in number of women exclusively breastfeeding beyond one month
Lessons Learned through Our HV CoIIIN Experience

- Helped us discover that our clients were only breastfeeding for 2-3 weeks therefore we chose the early postpartum period to intervene

- Taught us how to “steal shamelessly” i.e. learn from the experiences of other teams

- Satisfaction of being involved in the first Home Visiting CoIIIN and in producing data that will help sustain funding for home visiting

- Improved our understanding of Continuous Quality Improvement.
Plans for the Future

- Plan how to integrate the functions of the Breastfeeding Support Nurse if that position is discontinued.

- Plan interventions to address continued breastfeeding beyond the first six weeks, build informal support among family/friends, and instruct on the health benefits of breastfeeding for mothers.

- Collect detailed breastfeeding data.
Future Data Collection

Collaborate with the Center for Health Data Research, Analysis, and Mapping (HDReAM) at Western Michigan University

- Explore breastfeeding intention, initiation, and duration (in weeks) of NFP-enrolled mothers, including reason for stopping breastfeeding (when this information is available in excel spreadsheets from Calhoun NFP records). Breastfeeding initiation rates will be compared with initiation rates of all low SES mothers in the county from vital records data.

- Prepare a plan for examining long-term progress toward increasing breastfeeding rates among participants in the Calhoun County NFP program, including suggestions for additional data elements to collect from participants for future evaluation.
Questions?
Contact Information

Michelle Datema
Calhoun County NFP
mdatema@calhournountymi.gov
269-969-6392
Our HV CoIIN CQI Team

- Team Leader: Mary Lopez, RN, BSN
- Supervisor: Lynette Smith, RN, BSN, CLC
- Nurse Home Visitor:
  Janell Ball, RN, BSN, BSW
Why We Joined the HV CoILN

- Through collaboration with other national organizations, we thought we could improve upon our processes for quality improvement in breastfeeding and family engagement to better serve our clients.
Why We Chose this Topic

- According to our data, the team realized that our breastfeeding retention rates were lacking.
- Long term breastfeeding is an indicator of positive health outcomes which is a quality that the team wanted to improve upon for our community as a whole.
- We wanted to increase our community’s knowledge of the Healthy People 2020 measures and strive towards meeting those goals.
Our PDSA Cycles

- Create a map of all local WIC offices to give to clients
- Have a meeting with WIC to better understand what they provide for breastfeeding moms
- Incorporate breastfeeding discussion in weekly reflective supervision with supervisors
- Create and handout breastfeeding kits to our exclusive breastfeeding clients
- Join the Wayne County Breastfeeding Coalition
- Standardize breastfeeding documentation
Our Most Successful PDSA

- **Primary Driver 1 – Standardize internal (agency) policies and practices to support breastfeeding**
- Increase the nurse home visitor’s knowledge of breastfeeding and breastfeeding support by standardizing breastfeeding education and measuring a pre-test/post-test with a team average score increase of 15%.
  - 1\textsuperscript{st} step: Complete pre-test
  - 2\textsuperscript{nd} step: Read Wellstart International Lactation Management Self-Study Modules
  - 3\textsuperscript{rd} step: Complete post-test within one month of pre-test

www.wellstart.org/Self-Study-Module.pdf
Results of PDSA

- June 3 – Six Nurse Home Visitors took the pre-test at the weekly team meeting.
- June 4 – Pre-tests were scored and given back to the nurse home visitors.
- June 4-July 7 – Each Nurse Home Visitor read and studied the Wellstart International Lactation Management self-study modules.
- July 8 – Each Nurse Home Visitor took the post-test at the weekly team meeting.
- July 9 – Post-tests were scored and compared to pre-test scores.

<table>
<thead>
<tr>
<th>Nurse Home Visitor</th>
<th>Pre-Test</th>
<th>Post-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>AS</td>
<td>68%</td>
<td>86%</td>
</tr>
<tr>
<td>CG-M</td>
<td>71%</td>
<td>86%</td>
</tr>
<tr>
<td>KB</td>
<td>68%</td>
<td>89%</td>
</tr>
<tr>
<td>LW</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>MD</td>
<td>64%</td>
<td>96%</td>
</tr>
<tr>
<td><strong>Averages:</strong></td>
<td><strong>75%</strong></td>
<td><strong>92%</strong></td>
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# Outcome of PDSA

<table>
<thead>
<tr>
<th>STUDY</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What have you learned?</strong></td>
<td><strong>What will you do next?</strong></td>
</tr>
<tr>
<td>- Nurse Home Visitors gained confidence and knowledge in doing the breastfeeding modules.</td>
<td>- Re-test the nurse home visitors in 6 months to ensure continuity in learning and experience.</td>
</tr>
<tr>
<td>- The test was successful because there was a 17% increase in team average scores.</td>
<td>- Add the self study modules into the policies and procedures for all newly hired nurse home visitors to complete in their 3 month orientation period.</td>
</tr>
<tr>
<td></td>
<td>- Incorporate yearly breastfeeding updates and training into the nurse home visitors’ professional development curriculum.</td>
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Lessons Learned through Our HV CoIIN Experience

- We can incorporate miniature PDSA cycles with every aspect of change throughout our organization.
- Our confidence in the information that we have to offer for our clients has strengthened.
- Breastfeeding information provided to our clients in certain intervals throughout the program has improved our breastfeeding retention rates and normalized the experience for our clients.
- The team has become more comfortable & knowledgeable of quality improvement techniques.
Plans for the Future

- Continue to use the knowledge gained through the HV CoILN in our current practice.
- Use the quality improvement technique of rapid PDSA cycles in other areas of practice.
Questions?
Contact Information

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thank you!