Healthy Babies Healthy Children   **Continuous Quality Improvement Plan**

Public Health Unit Name: __Choose an item._____   Based on data from Calendar Year: __Choose an item.

Program Component, Targets and Indicators	PHU Performance to Targets and Indicators (previous year)	Current year plan						
		Change – **What change can be made that will result in an improvement?** (see PDSA cycle)	**Opportunities that will be addressed to reach in-year target**	**Identify tools used to support analysis and/or decision making**	*Measure* – **What measure(s) will be used to demonstrate improvement?** (see PDSA cycle)	**Identified mid-year target (if any)**	*Aim* - **Identified in-year target**	*Benchmarks* Values are based on provincial performance and/or best practice
Screening - Targets								
☐ Prenatal - 25% of provincial births screened	Report from planning worksheet	Based on findings from the sub-structures of the HBHC CQI Framework (See planning worksheet)	(e.g. Partnership Development, education/training, data sharing)	(e.g. Root Cause Analysis, Decision Matrix)				9% of provincial births are screened
☐ Postpartum – 100% of provincial births screened								A minimum of 80% establishes universal screening
☐ Early Childhood – 25% of the population of children 6 weeks to 6 years old screened								5% of the early childhood population is screened.
Screening – Outcome Indicators								
☐ Number of screens completed at: (a) prenatal, (b) postpartum, (c) early childhood								
☐ Number of screens received as: o (a) inconclusive because no responses, o (b) inconclusive because of less than 36 responses, o (c) conclusive because only								Minimizing inconclusive screens reduces rework and false positive identification. Benchmarks will be individually determined by health units.

question #36 completed ○ (d) conclusive because 2 risk factors identified but less than 36 responses and ○ (e) conclusive because all 36 responses were completed.							
☐ 10-25% of total HBHC Screens received are confirmed with risk during assessment.							10% of families screened should be confirmed with risk.
☐ Number of HBHC Screens completed from community resource during the (a) prenatal, (b) postpartum and (c) early childhood							
Assessment – Target							
☐ 100% of families, who received IDA Contact, and consenting to service, have a completed In-Depth Assessment.							The predicted false positive rate is between 10% and 33%. IDA completed rate should reflect this with a minimum of 70%
Assessment – Outcome Indicator							
☐ 10-25% of total HBHC Screens received are confirmed with risk during assessment.							10% of families screened should be confirmed with risk.
Support Services – Target							
☐ 100% of families identified with risk,							Universal contact is achieved

and consenting to service, receive a postpartum IDA Contact within 48 hours of being discharged from birth admission.								with a minimum of 80% contact.
Blended Home Visiting Services - Targets								
☐ 100% of families confirmed with risk using the In-Depth Assessment, and consenting to service receive Blended Home Visiting Services								To limit loss of service to families confirmed with risk, benchmark is set for 80%
☐ 100% of families who receive Blended Home Visiting have a Family Service Plan initiated								To support effective support to families confirmed with risk, benchmark is set for 90%
Blended Home Visiting Services – Outcome Indicators								
☐ The Family Service Plan goals reflect the Family Assessment Instrument results.								
☐ Average frequency, duration and length of home visits as well as completion rate of scheduled home visits.								
☐ Number of families that receive long term services equal to or less than 18 months, compared to number of families that discharge at equal to or less than 6 months								
☐ As a population health indicator, increased number of prenatal HBHC clients with children born at >2500gm								

and >37 weeks gestation.							
☐ Improvement in pre-service and post-service scores of NCAST Parent-Child Interaction Feeding and Teaching scales.							
☐ Consistent NDDS completion demonstrating children receiving Home Visiting services are meeting milestones.							
Referral and Recommendations – Outcome Indicators							
☐ Increased "referred to and accessed" response rate to community referrals.							
Service Integration – Outcome Indicators							
☐ Public health units involved in an increasing number of community planning boards and tables.							