EARLY CHILDHOOD COMPREHENSIVE SYSTEMS

# Driver Diagram and Change Package

## Early Childhood Partnerships with Maternal-Child Health Delivery Systems, Including Medicaid

HRSA Maternal & Child Health

Early Childhood Systems
TECHNICAL ASSISTANCE & COORDINATION CENTER

# Contents



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# Introduction

The prenatal-to-three (P-3) period is a critical time of growth for families and young children, but many families encounter circumstances that make it difficult to provide a safe and nurturing environment where their children can thrive. Families need comprehensive, coordinated supports and services from family-serving organizations in early childhood and maternal-child health (MCH) delivery systems to effectively address these challenges.

Yet, long-standing system and structural barriers in coordination, equity, and reach persist which contribute to widening disparities in child health, development, and school readiness. Initiatives to align and integrate early childhood and MCH delivery systems are often disconnected from state-level planning and administrative bodies, whose individual policies, financing strategies, and practices lack alignment. These systems often have insufficient leadership, direction, and capacity to partner effectively in reaching families equitably and early.

Meaningful and effective partnerships between early childhood and MCH delivery systems, including Medicaid, are essential to improving system-level leadership, alignment, capacity, and coordination so that inequities can be reduced, and positive outcomes can be achieved in early childhood development and family health.[1]

# Purpose

This change package is intended for use by Early Childhood Comprehensive Systems (ECCS) awardees to inform continuous quality improvement (CQI) projects focused on building or strengthening partnerships between their state's early childhood system and the MCH delivery system. The MCH delivery system may encompass, but is not limited to, organizations and providers including:

- Medicaid
- Federally qualified health centers
- Health systems
- Hospitals, clinics, and private practices
- Obstetric/gynecologic, pediatric, family practice physicians and advanced practice providers
- Community health workers (CHWs)
- Doulas
- Dental providers
- Mental or behavioral health professionals
- Substance use disorder providers
- Postpartum support or recreation groups

# Definitions

| Term | Definition |
|---|---|
| CONTINUOUS QUALITY IMPROVEMENT | A systematic approach to continuously examining the processes and outcomes of a program using regular data collection and change testing to achieve measurable improvement. |
| CHANGE PACKAGE | An evidence-informed collection of actionable change ideas that are known to produce the desired result in a process or system. |
| DRIVER DIAGRAM | A visual display of an improvement theory depicting what "drives" or contributes to the achievement of a project aim; helps break down large CQI projects into smaller, more manageable steps. |
| SMART AIMS | Desired outcomes that are specific, measurable, achievable, relevant, and time-bound. |
| SMARTIE AIMS | Desired outcomes that are specific, measurable, achievable, relevant, time-bound, inclusive, and equitable. |
| PRIMARY DRIVERS | System-level components which contribute directly to achieving the aim. |
| SECONDARY DRIVERS | Lower-level components which influence primary drivers. |
| CHANGES | Ideas that are believed to result in improvement. |
| CHANGE TOOLS | Specific examples or resources to support tests of change. |
| MEASURES | Key data indicators that are used to monitor progress and assess improvement. |

# Ingredients for Improvement

To achieve system-level results, there are three "must-haves"[2] that your team should review and discuss. These include:

### ❶ WILL

The urgency and motivation to improve; "we must do what it takes!"

### ❷ IDEAS

Alternatives to the status quo; changes to the way you are currently doing things.

### ❸ EXECUTION

The ability to carry out change effectively and make improvements.

You can discuss these elements with partners to identify your strengths and opportunities for growth. The Early Childhood Systems Technical Assistance & Coordination Center (ECS TACC) team can provide technical assistance to support awardees in building the will, testing change ideas, identifying custom measures, and using CQI methods, tools, and resources. Please contact your ECS TACC Technical Assistance Specialist (TAS) if you would like more information on any part of this change package or support in applying it.

# Using the Change Package

This change package outlines a framework for building meaningful and effective partnerships between early childhood and MCH delivery systems, including Medicaid. It serves as a starting point for discussion and offers flexibility for awardees to establish unique goals and corresponding measures.

Measures are key data indicators that are used to monitor progress and assess improvement. Awardees can identify custom measures (e.g., number of interagency agreements (IAAs) / memoranda of understanding (MOUs), number of staff trained in cultural responsiveness) related to the changes they are testing from this package.

In particular, awardees are encouraged to select the change package aims and tailor them to be SMARTIE (specific, measurable, achievable, relevant, time-bound, inclusive, equitable). Examples might include specifying certain partners or adding a priority population.:

- Increase the number of decision-makers from federally qualified health centers (WW to XX) and from the state Medicaid agency (YY to ZZ) engaged in meaningful and effective partnerships with ECCS awardees.

- Increase the number of decision-makers from the MCH delivery system, including prenatal and pediatric (WW to XX) and from the state Medicaid agency (YY to ZZ), engaged in meaningful and effective partnerships with ECCS awardees to improve service delivery for tribal families.

While the change package summarizes numerous drivers and changes, choosing a subset of these can help awardees strategically focus efforts while ensuring the project feels manageable. Using the change package to guide discussions can help create a culture of collaboration by enabling each partner to identify their own strengths and opportunities. The group can determine additional actions that can be taken individually and collectively to positively impact the project aims. Awardees are encouraged to start by reviewing the drivers and corresponding changes with their partners. Discuss:

1. What items are we already doing well?

2. Where are our opportunities to improve?

3. Of those opportunities, how much time and effort might be needed to demonstrate improvement? Is the potential impact high or low?

4. How can we prioritize the drivers and changes to achieve our most urgent goals?

5. Do some changes need to happen before others can? (sequencing)

6. How will these changes be delegated?

A change package is a resource that should be referenced during CQI project planning and revisited frequently. It is intended to be a living document, one that awardees can edit and adapt as needed. Depending on progress and lessons learned, additional drivers/changes may be addressed over time, existing drivers/changes may be refined, and other drivers/changes may be added.

# Driver Diagram

A driver diagram is a visual display of an improvement theory depicting what "drives" or contributes to the achievement of a project aim. This tool helps break down large CQI projects into smaller, more manageable steps.

| Aim<br>*What are we trying to accomplish?* | Primary Drivers<br>*System-level components which contribute directly to achieving the aim.* | Secondary Drivers<br>*Lower-level components which influence primary drivers.* |
|---|---|---|
| *By June 30, 2023:*<br>*Increase the number of decision-makers from the MCH delivery system, including prenatal and pediatric (WW to XX) and from the state Medicaid agency (YY to ZZ), engaged in meaningful and effective partnerships with ECCS awardees.*<br>*Improve the level of collaboration* between ECCS awardees and key partners from the MCH delivery system (WW to XX) and the state Medicaid agency (YY to ZZ).*<br>**Using the Levels of Collaboration scale (Frey 2006)[3] or a similar partnership measurement tool.* | *Relationships* | *Outreach* |
| | | *Perceived value* |
| | | *Leadership commitment* |
| | *Equity-driven design* | *Power sharing* |
| | | *Diverse representation* |
| | | *Community-centered change* |
| | | *Family leadership* |
| | *Shared vision and SMART(IE) goals* | *Authority and oversight* |
| | | *Assessment* |
| | | *Planning* |
| | | *Shared metrics and data* |
| | | *Aligned funding* |
| | *Shared accountability* | *Communication* |
| | | *Policies and practices* |
| | | *CQI and monitoring* |

# Change Package

A change package is an evidence-informed collection of actionable change ideas that are known to produce the desired result in a process or system.

## Primary Driver: Relationships

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Outreach | • Construct a visual map of current and potential partners, including their "tables" or members, strategic agendas, system-level initiatives, and workgroups<br>• Consider where the opportunity to advance health integration is optimized by working to join and align with existing initiative(s) as opposed to developing new ones<br>• Assess which partners are currently represented at the ECCS table and which need to be; include ways that each might contribute to collective success<br>• Develop a partner engagement plan<br>• Reach out to state chapters of the American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), and other health care organizations<br>• Participate in local conferences to network with individuals who have influence and would be matches for the steering committee<br>• Determine how partners, communities, and families obtain relevant information<br>• Conduct surveys or interviews with partners to assess their awareness and perceived value of the ECCS initiative, as well as partners' organizational priorities and goals | • Practical Playbook - Building Multisector Partnerships That Work<br>• Participatory Approaches - Stakeholder Engagement in Precision Home Visiting (PDF)<br>• Template - Engagement Plan (PDF) |

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Perceived value | • Assess the political climate and its influence on each partner<br>• Identify influential champions for this work, their agendas, and how you can align the initiative with their agendas<br>• Identify the "hook" or key data and information that is most likely to motivate Medicaid and MCH delivery system partners<br>• Develop a value proposition that is tailored to the audience and aligns initiative goals to partner priorities<br>• Organize unique messages aimed to motivate differing partners into meaningful categories (e.g., internal/external partners, public health/prenatal/pediatrics, administrators/ providers/support staff)<br>• Develop promotion tools (e.g., elevator pitch, 1 page summary, social media toolkit, slide deck) summarizing the initiative's purpose, partners, and goals | • Messaging Guides – Making the Case for Infant and Toddler Policy Priorities<br>• Creating and Maintaining Coalitions and Partnerships – Community Toolbox |
| Leadership commitment | • Work with relevant partners to determine if there are opportunities for ECCS to join and align with existing initiatives that can influence decision-making, agenda-setting, and strategic pathways<br>• Assess partner leaders' availability (i.e., time, capacity, resources) to engage in the ECCS initiative<br>• Determine the level of commitment needed from each partner to be successful<br>• Make a strong and clear ask of decision-makers (e.g., document in writing, describe the need, gain commitment)<br>• Work with decision-makers at partner organizations, especially Medicaid, to ensure that participating staff have permission, clear expectations, dedicated time, and adequate resources to engage in the initiative<br>• Identify influential provider champions from each partner who will advocate for the initiative within their organization and problem solve when barriers arise<br>• Develop tangible and visible strategies for champions to advocate for the initiative (e.g., talking points, sharing progress, networking with and engaging others, social media messaging)<br>• As needed, "buy out" provider champion time or incentivize participation if possible<br>• Schedule meeting dates for providers 4-6 months in advance to avoid conflicts with clinic schedules | • Increasing Participation and Membership – Community Toolbox<br>• Levels of Collaboration Scale – Frey 2006 (PDF)<br>• Tools for Measuring Collaboration (PDF) |

# Primary Driver: Equity-Driven Design

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Power sharing | • Include systemically marginalized and underrepresented groups from the beginning and at all stages of the initiative<br>• Establish a baseline of what equity, diversity, and inclusion (ED&I) means to all partners; create a glossary of terms<br>• Identify and encourage self-exploration of implicit bias among team members; offer assessment and training<br>• Train staff in cultural responsiveness<br>• Train staff in emotional intelligence<br>• Contract with a person or organization with expertise in ED&I to inform the initiative's ongoing efforts<br>• Develop group guidelines that 1) consider the most oppressed and marginalized people first and 2) are accessible, flexible, and revisited before each meeting<br>• Assess power dynamics among partners (e.g., ECCS and health systems/payors, state/county) and among team members (administrator/provider, provider/patient)<br>• Establish a structure for decision-makers to step back and intentionally share power with marginalized people by elevating their voice and influence<br>• Identify a person or role that is well-connected to both ECCS and health systems/payors who can foster power sharing<br>• Identify a person or role that is well-connected to both providers and families who can foster power sharing (e.g., family or patient advocate, family educator, CHWs)<br>• Develop a forum (i.e., email address, discussion board) where partners can provide feedback anonymously<br>• Host meetings at flexible times to ensure providers and families can participate<br>• Engage an ombudsman to raise concerns to the initiative and assist with resolution of conflicts | • Equity Impact Review Tool - Kings County WA<br>• Implicit Association Test - Harvard<br>• Implicit Bias Training Modules - Kirwan Institute OSU<br>• Unconscious Bias in Medicine - CME Course Stanford (free)<br>• Emotional Intelligence Training - LinkedIn<br>• What Is Adaptive Leadership? - WDHB |

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Diverse representation | • Assess diversity at the state partner level; examine which organizations are invited, which populations they serve, how deep their engagement is, how their perspective is shared, how they influence decision-making<br>• Assess diversity at the individual level—who is representing partners such as decision-makers, providers, support staff, community leaders, family leaders<br>• Partner with community organizations that serve priority populations such as federally qualified health centers, CHWs, churches, local MCH coalitions, doulas, postpartum groups, lactation consultants, homeless shelters, domestic violence organizations<br>• Partner with families | • Enhancing Cultural Competence - Community Toolbox<br>• Parent Engagement and Leadership Assessment Guide and Toolkit - CSSP<br>• Program Quality Roadmap for Family & Community Engagement - Root Cause (PDF) |
| Community-centered change | • Establish a sense of inclusion and belonging for all members<br>• Elevate provider voices across an array of disciplines<br>• Amplify community stories and narratives, including where we are at and where we need to go | • Cross-Agency Partnerships for Health Equity: Understanding Opportunities Across Medicaid and Public Health Agencies - CHCS<br>• Community Engagement Assessment Tool - Wisconsin<br>• Parent Cafés — Be Strong Families |

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Family leadership | • Utilize a family leadership roadmap or toolkit to create a family leadership plan<br>• Contract with an organization that specializes in engaging families through leadership and advocacy<br>• Define the family role and commitment; make a clear ask<br>• Establish a Family Advisory Council or family-led subcommittee<br>• Provide comprehensive training to family leaders<br>• Provide skill development and mentorship to family leaders<br>• Compensate family leaders for time, childcare, travel, meals, lodging | • Roadmap to Inviting, Engaging, and Including Patient/Family Partners in Quality Improvement and Other Related Initiatives - NICHQ<br>• Family Engagement Toolkit - Family Voices<br>• Parent Engagement and Leadership Assessment Guide and Toolkit - CSSP<br>• Resources to Build Parent Leadership - Michigan<br>• Family Advisory Council Checklist (PDF)<br>• National Parent Leadership Institute<br>• Parent Leadership Training and Development - Collab4Kids<br>• List of Parent Leadership Curriculum Options (PDF)<br>• Webinar - Engaging Families in Advocacy: Strategies, Practices, and Lessons from the Field - ZTT<br>• Example - North Carolina Family Engagement and Leadership Framework (PDF) |

# Primary Driver: Shared Vision and SMART/IE Goals

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Authority and oversight | • Identify the state agency that will own, lead, coordinate, and monitor the project<br>• Establish a P-3 coalition of state agencies and organizations at the system level or identify a related initiative that exists to join and align with or build upon<br>• Establish a multi-level, diverse interagency steering committee and governance structure; include provider-level representatives such as midwives, OB/GYNs, pediatricians, family practice physicians<br>• Develop clear decision-making processes<br>• Conduct steering committee meetings at minimum quarterly<br>• Assign meeting roles in advance<br>• Train facilitators in conducting effective meetings | • Early Childhood Governance - A Toolkit of Curated Resources to Assist State Leaders - HHS (PDF)<br>• Early Care and Education Governance Infographic - ECS (PDF)<br>• Developing an Organizational Structure for the Initiative - Community Toolbox<br>• Improving Organizational Management and Development - Community Toolbox<br>• Example - Think Babies North Carolina Alliance<br>• Example - North Carolina P-3 State Policy Roadmap (PDF)<br>• Essential Components of a Statewide Home Visiting System Resource Tool - BUILD Initiative (PDF)<br>• Example - LA Best Babies Network<br>• Meeting Facilitation Best Practices and Talking Tips (PDF)<br>• Effective Coalition Meeting Checklist (PDF) |
| Assessment | • Complete a landscape analysis to assess partner programs, goals/priorities, funding, data, workforce; include evidence-informed programs as many marginalized communities are served through these<br>• Examine how cross-agency goals may or may not align<br>• Examine what has worked well in the past and what hasn't worked well; partner with community organizations to deepen understanding about root causes and opportunities for addressing | • Infants and Toddlers in the Policy Picture: A Self-Assessment Toolkit for States - ZTT<br>• Early Childhood System Performance Assessment Toolkit - CSSP<br>• Action Tools - Mapping Assets, Identifying Partners, Policy Barriers and Opportunities, Being Part of the Policy Conversation (PDF) |

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Planning | • Determine opportunities for alignment across agency goals/ priorities, programs, funding, data, workforce<br>• Identify opportunities for cross-sector collaboration that intentionally breaks down traditional silos<br>• Identify opportunities to address social or structural determinants of health<br>• Identify ways for state-level partners to model coordination for county and community-level partners<br>• Develop a logic model or theory of action<br>• Create a strategic plan that includes specific and measurable goals for: cross-sector collaboration, equity, child and family outcomes, system outcomes, trauma-informed care<br>• Establish diverse, multi-level subcommittees/workgroups to advance the objectives outlined in the strategic plan<br>• Create subcommittees/advisory groups specific to Medicaid and prenatal and pediatric health providers<br>• Direct subcommittees to develop action plans | • ZTT Policy Resource - Strengthening Connections: State Approaches to Connecting Families to Services<br>• HMA Report: Interagency, Cross-Sector Collaboration to Improve Care for Vulnerable Children: Lessons from Six State Initiatives (PDF)<br>• Prenatal to Three Outcomes Framework - NCIT (PDF)<br>• Developing Logic Models<br>• Strategic Planning - NACCHO<br>• Developing Strategic and Action Plans - Community Toolbox<br>• Example - Early Childhood Action Plan - North Carolina Dept of Health and Human Services<br>• Example - Early Childhood Action Plan – Durham Children's Initiative<br>• Logic Model templates - UW-Madison Division of Extension<br>• Example - Theory of Action Rural Home Visiting System Coordination Project - Siskiyou County, CA |

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Shared metrics and data | • Assess what relevant data each partner currently collects and how<br>• Establish aligned metrics between partners<br>• Identify baselines for selected metrics<br>• Examine differences by subgroups to identify health disparities (e.g., social and ethnic background, gender, sexual orientation, parenthood status, socioeconomic status, education, housing, employment, geographic area, first language)<br>• Apply the Cycle of Engagement principles to metrics and data<br>• Leverage, tailor as needed, and apply existing platforms that promote family-engaged, cross-system data sharing<br>• Develop a plan for who, what, when, and how data will be shared<br>• Establish a data sharing agreement / IAA / BAA that formalizes elements of the data sharing plan<br>• Develop an accessible and transparent tool (e.g., data dashboard) to monitor progress and outcomes | • NASHP: Strengthening the Title V-Medicaid Partnership: Strategies to Support the Development of Robust Interagency Agreements between Title V and Medicaid (PDF)<br>• Example - NC Early Childhood Action Plan Data Dashboards \| NCDHHS<br>• Example - Child Adversity and Well-Being Dashboard: California<br>• Cycle of Engagement<br>• Well Visit Planner |
| Aligned funding | • Create a fiscal map of relevant funding streams and payment systems<br>• Identify opportunities to align payment systems, metrics, and financial incentives with desired outcomes<br>• Assess will and capacity to coordinate funding<br>• Develop a fiscal plan that describes current funding streams, opportunities and considerations for aligning and leveraging funding, new funding that may be needed, and ways to sustain the project over time<br>• Identify options for Medicaid funding of relevant early childhood health promotion and prevention services | • Fiscal Mapping for Early Childhood Services: How-To Guide and Data Collection Tool - CHCS<br>• CSSP: Fostering Social Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change<br>• Prenatal to Five Fiscal Strategies<br>• Influencing Policy Development - Community Toolbox<br>• Finance-Related Resources to Help States Improve Maternal and Infant Health - NASHP<br>• Example - Preconception to Age 5 Blueprint for Funding and Advocacy - Fresno County, CA (PDF) |

# Primary Driver: Shared Accountability

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Communication | • Create and maintain a directory of community services<br>• Establish clear and bi-directional communication between partners<br>• Develop a communication plan that describes expectations, mechanisms, frequency, links to shared documents such as notes or progress updates; utilize tools such as RACI matrix to enhance clarity<br>• Ensure equity, diversity, and inclusion are reflected in all communications<br>• Develop plan for partners to regularly report progress, celebrate successes, and share challenges with strategies to address them | • Emergent Learning Platform<br>• Creating a Community Resource Guide and Contact List - AHRQ<br>• NowPow - Personalized Community Referral Platform<br>• Resource Referral Guide Template - Health Leads (PDF)<br>• RACI matrix template – Performance Improvement Council (PDF)<br>• Communications to Promote Interest - Community Toolbox<br>• Implementing Social Marketing - Community Toolbox |

| Secondary Drivers<br>*Lower-level components that influence primary drivers.* | Changes<br>*Ideas that will result in improvement.* | Change Tools<br>*Specific examples or resources to support tests of change.* |
|---|---|---|
| Policies and practices | • Create policies that clearly define roles and responsibilities of each partner, committee, and team member<br>• Establish IAA / MOU / BAA or other agreements that describe the expectations for each partner<br>• Clearly define which processes are standardized and describe in detail the process steps<br>• Use tools such as a process map or decision tree to ensure shared understanding of roles, expectations, and processes<br>• Standardize project activities and updates in infrastructure, such as templates for meeting agendas and regular communications<br>• Leverage time and technology to the extent possible, especially when trying to engage health providers who may need to meet outside of typical business hours<br>• Establish a commitment to flexibility and resourcefulness | • HRSA: Title V-Medicaid IAA/MOU for All States<br>• Third Sector Brief: Massachusetts Launches Cross-Agency Data Sharing Agreement to Improve Coordination Across State Agencies (PDF) |
| CQI and monitoring | • Build CQI and monitoring into the strategic plan<br>• Identify a CQI champion at each partner<br>• Provide CQI training for partners<br>• Develop mechanisms for monitoring progress including metrics, communication, method, and frequency of reviews<br>• Set regular intervals and a process to review key documents such as the strategic plan, action/work plans; identify who is responsible for updating them | • Evaluating the Initiative - Community Toolbox<br>• Quality Improvement 101 (nichq.org)<br>• Quality Improvement 102 (nichq.org)<br>• CQI Toolkit: A Resource for MIECHV Awardees - JBA<br>• Quality Improvement Essentials Toolkit - IHI |

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