HRSA's HV-PM/CQI

Webinar: Demonstrating Improvement in Benchmark Areas

October 10, 2019

>> Hi again. Thanks, everyone, for joining. I want to kick us off here this afternoon on our second PM/CQI Webinar of the year. We are going to be discussing how to demonstrate improvement in the benchmark area. I am Kassandra Miller. I work as the PM/CQI Universal TA Coordinator. And I'm also on [indiscernible] so I know I have met many of you across the project.

Just a couple quick reminders this afternoon, please join audio by your computer or by your phone. It's preferred via computer. But please do mute your computer speakers, if you have joined by phone so that you don't hear an echo. There is a technical support chat box. So just send out a message, if you need our support team. And everyone is -- their audio is live. So please mute yourselves until you have a question. You're welcome -- we'll have two sections for questions this afternoon. And please just unmute yourself for time for questions or you're welcome to add a question in the chat box as you hear or as you think of it. And we will address it when we get to those questions' sections. Just like another quick reminder, we are recording this session. And it will be made available as soon as it is cleared. And there are few handouts in the File Share Pod, including these slides, as well as the most recent improvement guidance and a thank you that were [indiscernible] distributed.

I would like to introduce our crew of presenters this afternoon. First, we're going to hear from Kyle Peplinski, who is HRSA's Acting Chief Branch -- Acting Chief of the PDTAC Branch. We have Matt Poes on who is PM/CQI Region 9 TA specialist. Sara Voelker is the PM/CQI Associate Project Director. And Rachael Glisson Griffin will also be sharing. She is the PM/CQI Region 4, 6, 10 Region TA Specialists. So you may know many or all of us this afternoon.

So first, we are going to turn it over to Kyle to review the final improvement guidance that was recently released. And then the TA Specialists are going to discuss some strategies to help you

all assess and plan for improvement. These will include identifying patterns and getting into the context of your data, learning how to calculate an interim baseline, and make a plan to address areas ripe from improvement with CQi prior to your CQI plan [indiscernible]. And then we'll talk about a couple of available resources that support awardees. And like I mentioned, we'll have two sections for questions, but feel free as things come up to please enter them in the chat box. And we'll make sure that we get to those and [indiscernible]. So with that, I'd like to turn it over to Kyle.

>> Great. Thank you so much Kassandra. And welcome, everybody. Thank you for joining us today. The portion of my presentation today is not intended to go in depth into the guidance itself, but just to highlight the key statutory requirements related to the assessment of improvement, talk a little bit about how we will be measuring improvement, and then to highlight some of the key changes that we in clarifications that HRSA made in response to the public comments that we received from all of you. Okay.

So just as background, the bipartisan Budget Act of 2018 provided additional funding for the MIECHV Program through fiscal year 2022 and made several changes to the authorizing statute. One of those changes was the continuation of the requirement that MIECHV awardees provide information to HRSA demonstrating that their programs result in improvement for eligible families in at least four of six benchmark areas, following fiscal year 2020 and every three years thereafter. The language also clarified that improvements must be demonstrated in the benchmark areas that the model or models implemented by the awardee were intended to improve. Awardees who do not demonstrate improvement must develop a corrective action plan and be provided technical assistance by HRSA. HRSA we'll use the 19 performance indicators and systems outcome measures currently reported on Form 2 for this purpose. However, awardees also have the opportunity to provide additional information as necessary.

I'll now describe the proposed methods for conducting the assessment of improvement as described in the [indiscernible]. So as we've discussed, awardees must demonstrate improvement in four of six benchmark areas. To demonstrate improvement in a benchmark area an awardee must demonstrate improvement in at least one-third of the measures within that benchmark using HRSA's current organization of measures within the benchmark areas.

This means that for all benchmark areas except benchmark one, an awardee needs to demonstrate improvement in one measure. For benchmark area one, which is maternal and newborn health, an awardee needs to demonstrate improvement in at least two measures. We have defined improvement at the measure level by meeting one or both of these criteria. The first is demonstrating any change in the intended direction of the measure as compared to your baseline value.

The second is by meeting or exceeding an established threshold for a measure while not simultaneously decreasing performance from baseline by 10% or more. Again, you only need to meet one of these criteria in order to demonstrate improvement for that measure. For the baseline value we will calculate each awardees' mean value for that measure as reported to HRSA for fiscal years 2018 and 2019. For the threshold we will calculate national means for each measure for fiscal years 2018 and 2019. More information about these calculations is provided in Appendix B of the guidance document that was released on Tuesday.

We are using two-year averages to calculate baselines and thresholds in order to minimize the impact of outliers or random variation for these comparisons. We will provide awardees specific baseline values and national thresholds to you on or before March 1st, 2020, so you know exactly what is required to demonstrate improvement for each measure in advance. And here's a short description of the calculations for improvement. Again, more information is provided in Appendix B of the guidance. In the guidance we also described opportunities to look at your form to performance data differently or have you provide additional information in order for you to demonstrate improvement. We outline several strategies for this for awardees who do not demonstrate improvement using the measure-level criteria I just described. The first includes assessing the impact of including systems outcome measures on your overall assessment of improvement.

As a reminder, systems outcome measures are measures that are more distal to the home-visiting intervention and/or are less sensitive to change due to home visiting alone. We will assess whether systems level measures directly contributed to not demonstrating improvement and may determine that these measures be excluded from the final determination. Awardees do not need to provide additional information for this step. HRSA will

undertake this step automatically after going through the measure and benchmark level improvement criteria. If necessary, we will also determine if certain measures should be excluded because they do not align with the outcomes that the model or models implemented by the awardee were intended to improve. Again, HRSA will undertake this process automatically without asking awardees for additional information. After this process, we may invite awardees who have not demonstrated improvement to provide additional information. And specific examples of the types of information that may be provided are included in the guidance. Statute requires awardees who do not meet the criteria for improvement I just described to develop and implement a corrective action plan. For the purposes of this requirement we are calling the plan an outcome improvement plan.

The goals of the outcome improvement plan are to meet statutory requirements to improve outcomes and benchmark areas to serve as a mutually agreed-upon quality management tool and to promote continuous quality improvement in target technical assistance as needed. For awardees required to develop an outcome improvement plan, we encourage you to align those activities with other required CQI activities. More details about all the processes and methodologies I just described are available in the full guidance in the accompanying frequently asked questions document that was released on Tuesday. Now I'm going to highlight a few key changes and clarifications that we made in response to comments from all of you. Several questions arose around the calculation for the statement that an awardee may not meet the threshold, if they simultaneously reduce performance from baseline by more than 10%.

We want to clarify, that this is a percent-change calculation and not a percentage-point change. Again, this has been clarified in the guidance and the accompanying frequently asked questions. There were a number of requests for clarification around the actual formulas used to calculate the national threshold and the baseline. As I've stated, we added an Appendix B to the guidance, which includes formula calculations for all of the formulas that will be included as part of the calculations. A number of questions arose around the opportunity to provide additional information. We want to clarify that HRSA will take steps prior to requesting additional information to assess the impact of systems outcome measures and model alignment on the overall assessment of improvement prior to asking for additional information

from the awardee. We also added additional examples of the types of information that may be considered during the process for providing additional information. And those examples are included in the updated guidance. And I'm happy to take questions now related to the guidance.

>> Great. Thank you, Kyle. We have a large group on the phone today. As Kassandra said, your lines are open. We are going to ask you to use the raise-your-hand feature, which is up in your upper-left-hand part of your screen. You can raise your hand, if you have a question. And we will call on you to ask it over the line. You can also feel free to type it into the chat box at this point. And I see a question from Michelle that says: Do you have a process to determine how or when awardees are selected? Michelle, if you could unmute your line. I wonder if you could say a little bit more about that question.

I see a number of people typing in the chat box. If anyone would like to talk over the phone line, please do that. From Hannah: Do you anticipate that state awardees would work with LIAs to complete their own improvement plan if struggling in a certain benchmark?

>> That's a great question. Thanks for that, Hannah. We're in the process of developing the template that will be used for the outcome improvement plan, should an awardee need to complete one. And so I don't have details about what exactly will be included in that template at this point, but do know that there will be a template that will include information instructions on things like that. That being said -- and the guidance does speak to this -- that we do hope that you use the process and methods that have been outlined in the guidance to work with your own local programs and state-level infrastructure to bring the spirit of CQI and demonstration of improvement to your own program.

>> All right. And we have a comment from Drewallyn: I appreciate that HRSA will review the systems outcomes measures and model considerations before asking a state for additional information. Thank you for that. A question about when is the guidance available. You can actually find a copy of the final guidance and the FAQs in the File Share Pod at the bottom of your screen today. And it went out over email two days ago, I believe. I see we have more

people typing. Okay. Do you have a better sense of when FY 2020 baseline and threshold data will be available? The earlier, the better, so LIAs can look at their work and plan for CQI.

>> Yeah, thank you for your question. Our goal is certainly to provide that information to you as soon as we're able to do so. Obviously, it's based on data that you're currently submitting through your annual performance reports for FY '19. And it's just to get through our internal process, to clean and analyze that information, as soon as we're able to get through that, we will try to get it out as soon as possible. We do commit to a date of March 1st, and no later than that. But if we're able to get it out earlier, we will certainly try to do that.

>> All right. And it looks like we don't have any additional questions coming in at this point. If you didn't get a chance to ask your questions, please feel free to put it in the chat box. We will have some time at the end of the webinar to come back to those. But now I'm going to turn things over to Rachael and Matt to talk some more about strategies that you can use to plan for improvement, so Rachel.

>> Thanks, Sara. Hi, everyone. My name is Rachael Glisson. And I'm a TA Specialist with Regions 4, 6, and 10. And I'm very glad to be here with you this afternoon. We just talked a little bit about the finalized guidance for demonstrating improvement, but now what? Throughout the rest of the presentation we will be talking about different ways to think about your data and strategies that you can take now to help you to be able to demonstrate improvement in FY 2020. So even though baseline for demonstrating improvement is only using FY 18' and FY 19' data, you can still look at all of your data to identify patterns for each of the performance measures. You have data available from FY 17' and FY 18', and you're currently working on analyzing your data for FY 19'.

So once finished, use three years of the data to visualize each measure. Be sure to ask yourself these questions: What patterns are evident? Where does your state have room for improvement? You should use the patterns from your past data to inform expectations and goal setting for future performance. So to use the three years of data for each performance measure to look at the number of dates -- to look at the numbers -- excuse me -- you can set up tables.

While it's great to look at tables and numbers, some people need to be able to see the data on a line chart to really understand patterns within the data. Our first example is three years of data for measure three: The percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within three months of enrollment for those not enrolled prenatally or within three months of delivery for those enrolled prenatally. And you can see in the table that FY 17' data is at 30%. FY 18' is at 45%. And FY 19' is at 60%. But what does that look like? You can use your data and set up line charts to see how the data looks.

How much have you changed from each year? Are the numbers going up? Are they going down? Being able to visualize what the data looks like will help you identify which performance measures you should focus on. In this example, the numbers are steadily rising from year to year. Our next example of performance measure 11: The percent of children enrolled in home visiting with a family member who reported that during a typical week she or he read, told stories, and/or sang songs with their child daily every day.

You can see in the table that FY 17' data is at 80%. FY 18' is at 70%. And FY 19' data is at 85%. But once again, what does that look like on a line chart? The pattern is not as clear here. We see a decrease from FY 17' to FY 18', but than an increase from FY 18' to FY 19'. Something to keep in mind if you decide to focus on this performance measure, what might be a realistic goal to set for improvement? If you've already had a goal set up for each measure, you could include it in your line chart. And you'll see more about this in a few slides.

So then even though we just visualized our data using all three years of data available, for the baseline calculation for demonstrating improvement you should only be using data from FY 18' and FY 19'. The baseline calculation is completed by finding the mean value for FY 18' and FY 19' for each performance measure. The mean value we've computed by adding the two annual performance values for that measure together and dividing by two.

Like Kyle said, baselines for each awardee for the FY 2020 assessment of improvement will be made available on or before March 1st, 2020. Even though you don't have a final number, keep in mind that you can calculate your own baseline before your finalized baseline is sent to you. It's great to have an understanding of where your baseline is so you can start to prioritize ways

to improve in areas you want to focus on. So sticking with our performance measure 11 example. In this line chart we added in the baseline shown at the green, dotted line.

Adding the baseline to our chart allows us to visualize the pattern of data in the context of the state-level baseline for improvement. In addition to charting your baseline, you can also plot your goal on the chart. When you set up a goal line, we can easily see how much room for improvement there is from year to year. This is just another way to visualize your data. It's not required, but might be a good tool to help identify topics that are ready for improvement.

So once we have visualized each of our 19 performance measures, we can then start to target which measures we want to focus our improvement efforts on. To ensure the program continues to perform at or above the baseline for FY 2020, we can incorporate each of these measures into our CQI processes. So an example smart aim for this measure may be: By September 30th, 2020, the percent of families who read, sing, or tell stories with their child every day will increase from 80 to 95%. And now I'll pass it over to my colleague Matt to talk more about context.

>> Hi, everybody. My name is Matthew Poes. And I'm going to tell you things you already know, but I think it's actually really important to talk about these. And I think anyone who's worked with me as a TA provider knows that often when you're running into issues with the data year to year, that one of the first things I do is talk to you about context. So as we know, context can be really important in looking at improvement. As the slide says, context is king or queen. So context matters. We should use our contextual understanding of the data to help us make decisions on how and what to improve.

So the first point to make here is that we need to spend time understanding context. Many of the previous slides discussed contextual factors. More contextual factors may exist, and so we need to be sure we spend time talking to our home visitors and other LIA staff to understand what is going on. And I know all of you do this already. So for example, we may see that a particular site has a very low IPV screening rate. And it's easy to conclude that the site is simply failing to follow protocol. You may decide that the site should be put on a corrective action plan, if they are unable to improve their IPV screening rates by a specified timeframe. But what

if the reason the IPV rates are so low are that something happened at the site which caused this drop. And for which a simple solution, like requesting they get in compliance, will not work.

What if one of the home visitors was threatened or injured while trying to administer the IPV, and this scared the home visitors? For their safety, the program temporarily suspended IPV screenings. In this case, it would make more sense to provide the site with special training in how to administer IPV screenings in a safe manner, to recognize when they should be avoided, and to even reconsider which IPV screening tools to use. I know some of my -- excuse me -- some of my past Illinois team had been on the call -- oh, it says, people are having trouble hearing me. I don't have a way to turn my mic up, I don't think.

>> Matt, I think if you could just speak a little bit louder. >> Okay. I will try moving the mic -- >> That's better.

>> People are saying they can hear me fine. Okay. I'm going to keep going. So I was saying some of the folks from my Illinois team probably remember that when we first implemented the IPV screening, we actually had some issues with how it was being administered. And the right solution there turned out to be to try a different IPV screening and a lot of training to help support the home visitors. This was sort of new for them.

Now, another one where context was huge, was that I worked with the program, this was years ago in New York, so it'll kind of give away the rest of the story, where the State had recently passed a public smoking ban. It was the second state in the nation to do so. Smoking rates were significantly higher at that time than they are today. And we had put in place a new smoking cessation program within the context of NFP and HFA. So it was added on to that program.

I was asked to conduct a study on the effects of curriculum sequencing, so the particular order in which the curriculum was administered on retention and engagement. And we very unexpectedly found that a particular model -- module, sorry -- which started by focusing on the parents' health factors from smoking was actually predictive of moms disengaging and leaving early. Further, we found that home visitors skip this in favor of the child health effects focus section of the curriculum had parents that stayed engaged longer. We learned two important things here. First, that the smoking cessation curriculum that we had developed was actually

driving families out of the program. And second, the main problem with the focus on parent health. So we talked to the home visitors. And what we found was this is exactly what they were being told. That context is actually really important for us.

So why do we need to know our data? When we know what the data says, we know what we need to improve. We need to keep our ear to the ground in order to be sure we know what is happening in our programs. By regularly reviewing our data, we get a good sense of what is going on and how to make improvements. We can also see what data-quality issues arise, which may prevent us from tracking progress we make as we seek to improve our performance measures. And this goes back to the context idea as well.

If we are more regularly tracking our data and talking to home visitors and families about the context associated with the data, it can be really, really helpful in understanding what's going on so that we can address it before it's a real problem. So why did my data do that? You need to consider the contextual factors or events that could impact the data. So you're seeing this data going up and down. And what's going on here? It's very, very hard to understand, you know, what's causing this. And a change in the data system, the data collection tools, or high staff turnover can actually be associated with sudden changes in the data.

So when you see the data just not following the trends you expected, these are one of the first things I always look for. And again, like I was saying earlier, for those of you that work with me as a TA provider, you'll know whenever you guys tell me something like this, the first thing I ask is, was there any change that preceded this? Tell me about the new data system. Tell me about the forms; any recent trainings.

So even a change in the LIAs can actually have an impact, which should be tracked and monitored. That's another thing we commonly see is folks will say, oh, we actually had to get rid of one of the LIAs we were using. And we brought a new one on. And we dove in, and it turned out that they did not realize they were supposed to be collecting this data. And it was driving down the statewide numbers.

So it's not uncommon to see a single LIA drive changes in statewide data. And understanding this can help the state to work with those LIAs to address any problems they may be

encountering. Review your performance measurement plan to identify changes that matter. You see all the blocks are knocking over. That guy's going to get hurt. I didn't notice that, when I put that picture there. So you want to review your performance measure plan to identify changes to how measures were captured, calculated, or other changes to your data system or process. Often changes must be made to the PM plan in response to changes made by the models, a change in how HRSA would like the PM reported. You know, we've all had to deal with all of this.

And these changes can impact the data values themselves. So this can make comparisons over time difficult and should be well understood. Note that not all changes to the performance measurement plan would be expected to have an impact on a performance measurement value. And so if such a change is seen, it may reflect fixable problems. So here's an example of that. Switching from one maternal depression scale to another should not negatively impact the depression-screening rate. If we were to see a sudden drop in maternal screening, this is a good sign that something has gone wrong in the transition. So sometimes as simple as the data system not capturing the screening properly or other times due to a misunderstanding in the training.

The one thing I've seen with this is that occasionally when new tools are introduced, the tool is essentially independently added to the data system. And home visitors were maybe entering it correctly, but the report itself was never updated to include the new tool. Okay. Now, I'm going to hand it over to Sara.

>> Great. Thank you, Matt. So now that Rachael and Matt have taken us through this process of considering your baseline and exploring factors that are impacting your data, we want to take a step back and look at the big picture and talk about how you can think strategically about where to focus your efforts for improvement. So as Kyle went over at the start of the call, the guidance states that awardees must demonstrate improvement in at least four of the six benchmark areas. An improvement in a benchmark area is defined as meeting the measure level improvement criteria and at least one-third of the measures under that benchmark area. And so that means that in order to demonstrate improvement in benchmark area one, maternal and newborn health, you will need to show improvement in a minimum of two

measures. And then in order to demonstrate improvement in each of the other benchmark areas, you will need to meet the improvement criteria for at least one measure.

So there are a number of different pathways that you can take to meet these criteria. And I'm going to talk through a few examples and strategies that you can use, as you're thinking this through. So in this first example, the team decides that given what they know about their baseline numbers and their program strengths, they're going to target four benchmark areas for improvement. And those four benchmark areas that have been selected in this example are: Maternal and newborn health, school readiness and achievement, crime or domestic violence, and coordination and referral. And then within each of the four benchmark areas, they decide to target measures that they feel confident about their ability to either move in the intended direction as compared to their baseline, or meet or exceed the established threshold while not decreasing their performance by more than 10% from their baseline.

So this, the yellow boxes, is just one pathway that would lead you to meeting the improvement criteria. The important thing to note here is that you'll need to spread your focus across multiple benchmark areas and measures in order to achieve improvement in at least four of the six. So one possible strategy to help with this is to look for areas where there's alignment and where you might have the opportunity for multiple wins. So for example, if you design a CQI project that would encompass both improvements in developmental screening and follow up, you could potentially meet the improvement criteria for two benchmark areas by showing improvement in both your developmental screening measure and your completed developmental referrals measure.

Similar logic would apply to the IPV screening measure. And so you could show by focusing on IPV screening and IPV referral, you could show improvement in both crime or domestic violence measure -- or benchmark area, and the coordination and referrals benchmark area. So other pathways that you could take to meet the criteria could be targeting measures where your program has the greatest control over the process and potential improvement ideas, or thinking about which benchmark areas and measures that align with the models you're implementing.

So above what you see in the yellow is just another example of how you could demonstrate improvement in four out of the six benchmark areas by targeting safe sleep, behavioral concern, IPV screening, and IPV referral. Measures that are more removed from the home visitors' role, for example, primary caregiver education or child maltreatment, may be more difficult to improve in a short period of time. So while it is still important to consider your performance on these measures, when you think about long-term improvements and CQI planning, you may not want to target them for [indiscernible] purpose.

You might also consider targeting measures where there are well-tested improvement ideas already available. So the home visiting coin has playbooks for maternal depression screening and referrals and developmental screening, behavioral concerns, and linkage to services. These playbooks author change ideas, PDSA cycles, and key insights and learnings from other home visiting teams who have worked to improve outcomes in these areas. And then the HV CoIIN is also currently accepting applications for teens that are interested in working on areas related to breastfeeding, well-child visits, depression screening and referrals, and developmental screening and referrals.

So all these areas in green that you see are areas where there are HV CoIIN resources to help you with improvement. And another consideration that you could make when planning for improvement, is thinking about time. So given the relatively short time between now and the end of FY 2020, you might consider prioritizing measures where data are collected more frequently, because that will give you more opportunity to see improvement. So what you see here, well-child visits, safe sleep, child injury, early language and literacy skills and behavioral concerns, are all measures that home visiting programs may be capturing at multiple time points during the year. So you may want to consider these when thinking about which measures to target for improvement in those first three benchmark areas.

Again, the really important piece to remember here as you're planning is to think about how you're spreading your attention and efforts in a strategic way, to make sure that you can achieve improvement in four out of the six benchmark areas. So we encourage you to start thinking about and planning for that now, realizing that you may need to revisit and adjust your strategy when the threshold data and the national averages are made available in March of

2020. And then just please keep in mind, that there are supports available to you to help with demonstrating improvement in the benchmark area.

So as we talked about earlier, HRSA has released the final guidance and an FAQ document. And both of those are available in the File Share Pod on your screen today. Your HV-PM/CQI Specialists are always available to answer questions, support you with your planning, and are there to provide additional technical assistance around examining your data and planning an improvement project. And then finally, HRSA will be adding a feature to the HVIS in the future. This will be a dashboard that awardees can use to access analyses of their performance data. And so that will include comparisons to national averages and being able to see your own prior year's data.

So now we have time for some more questions. And I see we've had a few come in so far. So I will start with a question from Amy: Can non-CoIIN participants have access to playbook? Yes, they can. If you go to the CoIIN website, which I can put into the chat box here in just a second, you can -- there's a brief form for you to fill out. And then the change package will be emailed to you. So I'll put that website in the chat box today.

We also received a question about who needs to demonstrate improvement. And if this is a process that needs to happen every year? So Kyle, I wonder if you could just go over again the process of when the improvement assessment will take place.

>> Sure, happy to. So statute identifies that awardees are required to provide information to HRSA within 30 days following the end of fiscal year 2020, so that's October 30th of 2020, that demonstrate improvement in four of six benchmark areas. And then that process gets repeated every three years thereafter. So the next assessment will occur using data submitted in October of 2020 and then will occur every three after that.

>> Great. Thank you. And then we have a question from Hannah: To confirm, awardees should plan to demonstrate improvement in four benchmark areas within seven months, March 1st through September 30th of 2020, understanding that we should get started now as much as possible by reviewing data currently available within our program. And so Hannah the way that – and Kyle, please jump in, if I don't explain this appropriately -- but Hannah, your baseline

will be calculated based on this year's reporting and last year's reporting. And then you will be comparing them for improvement to the data that you collect in FY 2020. And so that would be October 1st of 2019 through September 30th of 2020.

And Lesley is asking: Will our HRSA-approved CQI plan need to be updated to reflect this new process? Kyle, I wonder if you have –

>> Sure. I'm happy to just jump in there. Yeah, sure. And, Lesley, the answer to your question is not necessarily. The guidance does describe that you may want to review your performance measurement plan, your CQI plan, for any potential updates or changes that you would like to make based on this process. It's not a requirement. And really where we talk about aligning this process with the CQI plan is through the outcome improvement plan process. So if after we do our assessment of improvement, and you're -- a state is determined to not have demonstrated improvement, then we do suggest, but do not require the alignment of that outcome improvement plan with your CQI activities.

>> Thanks, Kyle. That's helpful. This is Lesley.

>> Also, I'll just jump in here too, I see Lesley's question about are there schedules easily accessible that you can view? We did add Appendix C to the final guidance, which is a table that outlines all of the key dates for the process that will occur before and after fiscal year 2020 related to the FY 2020 assessment of improvement. So there's a table with key dates in the final guidance.

>> Great. Thank You, Kyle. And another clarifying question about the timeline to engage in improvement effort. And so through our recommendation is that while you won't have the national -- or you won't have the threshold, the national threshold, until March 2020, you could use some of the strategies we talked about today, as far as looking at your baseline, considering which measures you think you may be able to improve over your baseline. So you should be able to calculate your baseline here within the next few weeks as you're finalizing your report. And then think about if there are areas that you want to target for improvement, just based off of your baseline data. We do realize that strategy might change for states once they see the national threshold, but you could start to implement some of these strategies and ideas now.

>> I also would like to jump in quickly and note that as you're creating your charts and looking at your calculated baseline, you're welcome to reach out to your PM/CQI TA specialist. And they can meet with you to look over your data and help you strategize some of your CQI efforts for the upcoming -- your upcoming plan and once you receive the final data in march.

>> And I'm seeing a few questions about the HV CoIIN website. Once you get to the website, there's a news and resources tab and under that is HV CoIIN 2.0 key documents. If you go to that page and scroll down, there's a link that says, access available playbooks here, in large letters. If you have any issues with that, please follow up with us over email, and we can get you connected to those resources. Any other questions at this time? All right. As Kassandra said, you can always feel free to reach out with additional question. Oh, I see we have one from Hannah. An OIP would be needed after September 30th, 2020, then for areas not meeting criteria. Correct; not prior to. Kyle, would you want to share a little bit more about the timeline.

>> Sure. So after awardees submit data by October 30th of 2020, HRSA will conduct the assessment and provide notification. If an awardee after that process is determined not to have demonstrated improvement, then the outcome improvement plan will be required to be developed. The guidance outlines, sort of the general timeline, instates that all outcome improvement plans would have to be finalized by October 1st of 2021, and that the activities in the outcome improvement plan would not extend beyond the end of fiscal year 2022.

>> Great. Thank you. And I see a question from Gina: When do states have to inform HRSA of the selected measures? And Gina, awardees do not have to select measures. HRSA will assess your performance across all of the measure to see if you've met the improvement criteria. We are just suggesting that you -- to plan ahead for that process. You may want to select some measures that you're going to focus your efforts on. But that is not -- you do not have to sort of formally select those measures and inform HRSA of that. All right. I'm not seeing any other questions at this point. You can feel free to send them to us, as I said, over email or reach out to your TA specialists, but I'm going to pass things over to Kassandra.

>> Thanks, Sara. And I just see one more question coming through in our presenter chat. After FY 2020 you will have to demonstrate performance every three years. So 2023 is the next time;

correct? Will FYI 23' be compared to a new baseline? Will FYI 23' be compared to FY 20' or an average of FY 21' and FY 22'? Those are a lot of FYs. And I'm going to post that into the full chat. And then Kyle, you can read it, if you could give us your thoughts on that.

>> Absolutely. So related to the first part of the question, yes. The next assessment will occur following fiscal year 2023, that would be three years after the 2020. In our guidance we describe that we may in consultation with awardees and other stakeholders assess how this process went and may make updates to the methodology or the process for future assessments, after we are able to reflect together about what we've learned through this initial process so that we can do it better. So we're not in a position right now to describe what the baseline will be for a future assessment or what the particular comparisons will be, but we hope to reflect on how this process goes and learn from it for future assessments.

>> Thank You, Kyle. And thanks to whomever asked that question. We will move on now to our closing reflections. I do want to remind you that you're welcome to send any remaining questions to your TA specialist, and we'll make sure that we get those answered. So for right now April [phonetic] has just opened up a poll box. So if you could take just a second here and let us know if you plan to take an action that's based on this webinar. And if yes, if you could let us know briefly what you plan to do. And if not, if you could just tell us what we can do to help you be able to be more prepared to take action step in the future. And I'm grateful to see those that have responded are all excited about taking an action step. So we'll give another few moments to answer the poll.

>> While everyone is answering the poll question, I see we have another question come in about who qualifies as an evidence-based home visiting home model developer.

>> And I'm happy to take that one as well.

>> Great.

>> The list of model developers that are eligible for to receive funding and meet HHS criteria for evidence of effectiveness are included in each notice of funding opportunity or, in the case of this year, in the NCC update. So in that guidance document outlines the list of home-visiting model developers that are eligible for implementation through MIECHV.

>> And I just added the HomVee website, so that can give you a little bit more detail if you want to look into any specific model. [Indiscernible] [cross talk]

>> Oh, go ahead, Kyle.

>> Sorry. I just wanted to thank you for adding to HomVee website. I just wanted to note that not all the models that have been reviewed by HomVee or all the models that are deemed evidence-based through Homvee are eligible for implementation through MIECHV. So just want to make that clear.

>> Thank you. And thanks to everyone who answered the poll. Moving on, I want to thank you for attending and to ask you all to please complete a quick five-minute survey following this presentation. We just really like your feedback on how we can make sure that we're keeping these webinars focused and helpful to you all as awardees. So there is a link you can click directly on the slide in the presentation, or you can also click the link in the in the pod underneath the presentation. And again, that takes just a couple minutes. And it is different than the question you just answered in the poll. So with that, I'd like to thank you all for attending, and have a great afternoon.