

CONTINUOUS QUALITY IMPROVEMENT GUIDANCE MANUAL

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PREFACE

PRESENTING THE CONTINUOUS QUALITY IMPROVEMENT GUIDANCE MANUAL!

The purpose of the Continuous Quality Improvement (CQI) Guidance Manual is to provide a standardized approach to, and tools for, developing capacity to better address the needs of designated Unserved/Underserved (U/U) Populations who are victims/survivors of domestic violence. The populations targeted for the CQI include the following:

- Individuals who have Disabilities and Developmental Disabilities (DDD)
- Individuals identifying as Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ)
- Individuals with Mental Health and Substance Abuse (MH/SA) Issues.

This manual has been designed to complement Training and Technical Assistance (TAT) provided by three contractors¹ to the California Department of Public Health (CDPH) through June 2009. In support of the regional U/U TAT Initiative, the CQI Guidance Manual provides processes for putting training and technical assistance (TA) into practice to effect systems change among 94 providers of domestic violence services throughout California. The contents of this manual have been drafted to help providers determine which practices to change, how to plan for and implement change, and how to document and describe your accomplishments.

Similar to the Continuous Quality Improvement (CQI) presentation provided through the U/U Access Project regional training, this CQI Guidance Manual has three core sections, as well as other resources and materials to guide the way through the process of change. These sections include:

Section 1: Introduction to the CQI Curriculum is an overview of Continuous Quality Improvement (CQI), what it is and how to benefit from it.

Section 2: The CQI Process Overview presents the CQI process in a flowchart, followed by a general description of each major step of the curriculum. The process uses the “Plan-Do-Study-Act” approach to systems change and concludes with a CQI Data Report Form that will be integrated into the DVP

¹ California Partnership to End Domestic Violence (CPEVDV), Marin Abused Women’s Services (MAWS), and ONTRACK Program Resources, Inc.

Shelter Agencies semi-annual reporting to CDPH. It also includes a list of the recommended practices for each MPOI, and a worksheet to help you select your agency's MPOIs.

Section 3: Sample PDSA Vignettes to provide a few examples of ways this process can work. These were designed to help make the connection between a "recommended practice" within each Measurable Performance Outcome Indicator (MPOI), the CQI and PDSA processes, and the reporting to CDPH.

Section 4: U/U Access Project Technical Assistance and Training (TAT) Providers presents information about each of the TriProject Contractors associated with the U/U Access Project, the providers of training and technical assistance. For each TriProject Contractor, there is also a list of subject areas and topics that they anticipate will be helpful to domestic violence providers as they address the MPOIs.

Frequently Asked Questions are included as well, and would be a good place to look if you have any unanswered questions.

All **Appendices** are *optional*. The Sample Worksheets for PDSA and CQI can be helpful while working through the Plan-Do-Study-Act (PDSA) Cycle.

- Appendix A – Sample Worksheets for PDSA and CQI
 - Blank PDSA Worksheet
 - Blank Logic Model Worksheet
 - Sample PDSA and CQI Timeline

GLOSSARY OF TERMS USED IN THE MANUAL

Sometimes we *think* we all know what we mean when we use a term, or sometimes we are not sure but it is hard to ask for clarification. These are some terms and abbreviations used throughout the manual, and a few that are definitions used for reporting to CDPH.

- Activity:** A specific program service, like training, counseling, shelter, or referrals to other services (in context of logic model).
- CDPH:** California Department of Public Health.
- CQI:** Continuous Quality Improvement (CQI), which is an ongoing process for using data to gauge progress, reflect on accomplishments, and apply data to inform decisions.
- Client:** A client is an individual for whom the domestic violence provider has completed an intake form and is providing services.
- Contractor:** For the Unserved/Underserved Training and Technical Assistance Project there are three contractors who are providing Technical Assistance and Training (TAT) to improve access to the designated populations in need. These are the "TriProject Contractors" referenced throughout the Manual.
- DDD:** Disabled and Developmentally Disabled. One of the three Unserved/Underserved populations.
- LGBTQ:** Lesbian, Gay, Bisexual, Transgender, and Questioning gender identity. One of the three Unserved/Underserved populations.
- Logic Model:** A Logic Model is a framework for illustrating the relationship between program implementation and evaluation, and it can be used to reinforce CQI. The logic model integrates into a single flow diagram the outputs and incremental stages of outcomes as they relate to program resources and activities. As a process, developing a logic model can be a powerful tool for galvanizing staff or stakeholders with a common set of expectations for program service delivery and data collection and measurement of performance.
- MH/SA:** Mental Health and/or Substance Abuse. One of the three Unserved/Underserved populations.
- MPOI:** Measurable Performance Outcome Indicator. These are areas where CDPH would like to see improvements in access.
- Outcomes:** The short-term, intermediate, and long-term results from activities and outputs (in context of logic model).

- Output:** The number of services provided, usually in terms of attendance for, participation in, dissemination of, or similar units (in context of logic model).
- PDSA:** “Plan-Do-Study-Act” cycle, a systematic process for identifying an area for change, outlining a planned approach for small-scale pilot testing, collecting and analyzing data to reflect on the pilot effort, and then taking a proven practice to scale. This is a manageable way to try new practices with staff buy-in and prior to making system-wide changes.
- Partnership:** Inter-agency partnerships and linkages take a variety of forms. At the most formal level is a relationship between the domestic violence provider and another agency that is contractual (i.e., one is a contractor to the other). Having a Memorandum of Understanding is another form of a partnership this is relatively formal and structured, though not as much so as a contract. At the opposite extreme are partnerships that are more informal, where partners to the domestic violence provider may sit on the same advisory group or collaborative entity for a shared purpose or advocacy. Somewhere in between are relationships that acknowledge two-way or one-way referrals for shared clients.
- Referral:** A referral may be incoming or outgoing. An incoming referral is an individual referred to the domestic violence agency to receive services there. An outgoing referral is a referral that the domestic violence provider is making to another resource in the community. An outgoing referral is more substantive than simply providing a client with a name and phone number; to be counted as a referral, an outgoing referral must engage the client with the referral actively, and requires a “soft hand-off” to the community resource (e.g., a phone call in advance, a named contact person, an escorted introduction).
- Resources:** The funding, human resources (staff and volunteer), and partnerships with other organizations that make it possible to provide services to domestic violence victims (in context of logic model).
- U/U TAT:** Unserved/Underserved Training and Technical Assistance. It’s the “technical” name for this project. The U/U TAT project began with the Needs Assessment, which led to trainings and technical assistance, which are now being augmented by Continuous Quality Improvement (CQI).



Ready? Let's move on to Section 1: Introduction to CQI Curriculum...

SECTION 1: INTRODUCTION TO CQI CURRICULUM

From the CQI presentation at the Unserved/Underserved Trainings, we learned that CQI is a process to create change, to evaluate the results, and to help us focus our energies on those changes that really create improvements. The philosophy of CQI is about empowerment –

WHAT IS CONTINUOUS QUALITY IMPROVEMENT?

- CQI is an organizational process in which staff identify, plan, and implement ongoing improvements in service delivery.
- CQI provides a participatory method to assess and monitor the delivery of services to ensure that they are consistent with an organization's best practice standards.
- CQI focuses energy and resources on the improvement of systems and processes in order to support an organization's mission.
- The focus is on a team approach to improvement which celebrates progress and successes.
- Bottom line: CQI is about challenging ourselves to be accountable to delivering the highest quality services to survivors.

CQI PHILOSOPHY

- No matter how good we are, there is always room for improvement
- Focus is on systems and processes
- CQI is driven by data collection and analyses
- The emphasis is on organizational learning and on-going improvement
- CQI values diverse and representative participation
- Emphasizes small, incremental changes
- Ultimately, CQI is empowering

Remember to start your agency's CQI process **as soon as possible**. This process will take time; it will serve you and your agency well if you use the steps outlined, take full advantage of the TA available through the UU/TAT initiative.

In the Unserved/Underserved Project, there are several “givens” associated with CQI:

1. There are four Measurable Performance Outcome Indicators (MPOIs) as follows:
 - Number of DDD, LGBTQ, MH/SA clients served;
 - Types and numbers of referrals for related services/providers;
 - Types and numbers of agency partnerships/linkages established; and,
 - Types and numbers of physical plant/equipment modifications.
2. Each MPOI has a list of “recommended practices” from which to select for your CQI. There is a list of recommended practices at the end of Section 2, with a worksheet to help you through the selection process. Think of this as the “menu” of ideas you might want to consider as you plan for the CQI. Although these are recommended, they should in no way be perceived as limiting your TA options!
3. Domestic violence providers will be required to submit data pertaining to these MPOIs using a standardized reporting format provided in this manual (this will be discussed in Section 2). The MPOI data will be integrated with semi-annual reporting to CDPH.
4. Domestic violence providers may access information provided in the U/U Access Project Needs Assessment (completed 2/28/07) to revisit or modify “baseline data” on selected MPOIs. Baseline data relevancy will vary across populations, MPOIs, and among providers. If the surveys did not yield relevant baseline data for you, you will need to provide some estimates for your baselines. Work with your staff to make these estimates, based on their experience. You may also seek technical assistance from one of the TriProject Contractors for guidance in determining your baseline measures.
5. Plan-Do-Study-Act (PDSA) is an approach to systems change that can support domestic violence providers through the CQI process.
6. The CQI curriculum complements the training and technical assistance provided by the contractors.
7. The CQI curriculum will likely stimulate additional interest in individualized technical assistance, as domestic violence providers begin to identify the MPOIs they want to pursue. The three TriProject Contractors to CDPH will respond to requests for TA through June 2009.
8. The processes and tools associated with CQI, PDSA, and the MPOIs will all facilitate capacity building among domestic violence providers, enhancing not only your agency’s services for the populations targeted, but also for organizational changes unrelated to this initiative. These are processes that have application well beyond the U/U Access Project.

The remainder of the COI Guidance Manual will present the process to address these questions:

- **What change(s) will our domestic violence agency seek during the U/U Access Project?** Which recommended practices pursuant to each MPOI will we pursue? Where do we start and how do we decide what to change? Think “goals and objectives.” Select only one MPOI for each population! You will work on these through June 30, 2009. Once you’ve used this process and worked through one MPOI for each population, you may want to address others beyond the scope of this initiative, at your option.
- **How will we begin to address each new area of change for our agency?** Remember to take into account training you have received from the U/U Access TriProject Contractors, the needs assessment study that was completed in March 2007, and other resources you may bring to bear.
- **How will we chart our progress?** How will we know if we achieved the change we were seeking? Where did we start, what milestones did we reach, and what were the final results? Remember, you may need to implement a succession of changes to reach the point when you can actually report a number to CDPH related to each MPOI. Those incremental changes will be important for you to acknowledge along the way, as internal markers for you and your agency.



How do we begin? Go to Section 2, where we've outlined the steps for you . . .

SECTION 2: THE CQI PROCESS OVERVIEW

The Unserved/Underserved Training and Technical Assistance Project is about change. It is also about improving access to domestic violence services, to improve services for selected U/U populations. For all 94 providers who participated in the needs assessment² component of this project (completed in March 2007), there are opportunities to improve capacity for serving these populations. In addition, this project provides opportunity for training and technical assistance to inform and facilitate the changes your agency elects to pursue. Use this manual and all three contractors to plan for, implement, and document your own systems change.

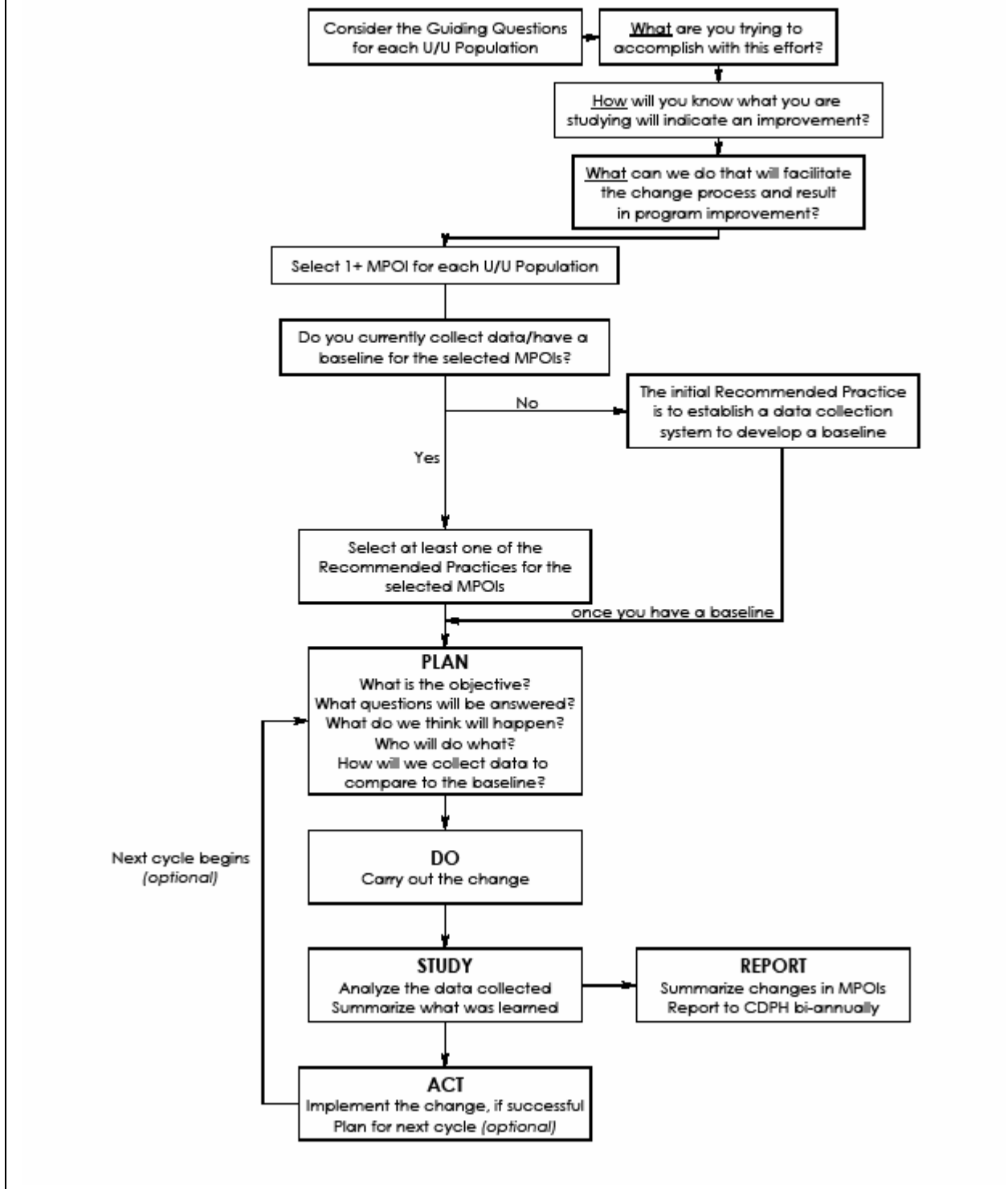
The CQI process will require you and your agency to:

1. Select at least one Measurable Performance Outcome Indicator (MPOI) associated with each of the three U/U populations);
2. Implement changes or improvements to increase access for the identified U/U populations (see recommended practices in MPOI Selection at the end of this section).
3. Create a work plan or steps to take to implement the change(s) you've selected, and including assignments of roles and responsibilities;
4. Consider applying the PDSA approach to change to pilot test your change(s); and
5. Document changes and measures of change, including but not limited to the reporting to CDPH on each MPOI.

Figure 1 illustrates this process (see following page).

² If the data from your agency's needs assessment does not yield the baseline data you are looking for, you will need to estimate a baseline. You may develop this baseline estimate from existing documentation, anecdotal staff input, or through consultation with one of the TriProject Contractors to help determine a baseline for your agency.

FIGURE 1 – CQI PROCESS FLOWCHART



PDSA STEP-BY-STEP GUIDE

This section presents a PDSA Step-by-Step Guide to walk you through the CQI process. We've proposed using the "Plan-Do-Study-Act" (PDSA) cycle for implementing systems change. PDSA is a great tool for bringing about change with deliberation, inclusion, and reflection. This 4-step process provides a systematic way to test a new idea on a modest scale, before applying the new idea on a larger scale, or agency-wide. We suggest you use the PDSA to test new practices, as illustrated in the steps outlined in the following PDSA Step-by-Step Guide.

<p>PURPOSE</p>	<p>In the context of the U/U TAT Initiative, the focus is on improving access to DV services for victims with disabilities, mental health and/or substance abuse needs, and/or who identify as LGBTQ.</p> <p>There are four Measurable Performance Outcome Indicators (MPOs) related to the U/U TAT:</p> <ol style="list-style-type: none"> 1. Number of U/U clients being served 2. Types and numbers of referrals for related services/providers 3. Types and numbers of agency partnerships/linkages made 4. Types and number of physical plant/equipment modifications made
<p>STEPS TO FOLLOW</p>	<p>To complete the CQI Process you will need to:</p> <ol style="list-style-type: none"> 1. Select Your MPOs 2. PLAN: Decide Who, How, and What 3. DO: Carry Out the Change 4. STUDY: Summarize the Findings 5. ACT: Implement or Reject 6. Report to CDPH semi-annually <p>Note: If you elect not to use the PDSA model, you are still required to complete steps 1 and 6.</p>

STEP 1 - SELECT YOUR MEASURABLE PERFORMANCE OUTCOME INDICATORS (MPOIS)

This section provides an at-a-glance overview of the CDPH Unserved/Underserved Measurable Performance Outcome Indicators (MPOI's) and how these relate to the technical assistance and training components (TAT) offered by each of the three Unserved/Underserved (U/U) TriProject Contractors (i.e., DDD, LGBTQ and MH/SA).

DECIDE WHICH MPOIS YOU WANT TO ADDRESS

Each agency will be asked to select one MPOI per U/U population. You will address these from now until the TriProject contract period ends, June 30, 2009. You will not be required to select additional MPOIs.

1. Increasing the number of clients served
2. Increasing the number and type of referrals
3. Increasing agency partnerships and linkages
4. Increasing physical modifications at shelter

Take the time to review the proposed MPOIs. You are required to select and report on at least one MPOI for each of the U/U Populations. Refer to the MPOI Selection at the end of this section to see the list of recommended practices.

You have quite a bit of freedom in selecting your MPOIs. You may select the same MPOI for all three populations, or you may select different MPOIs for each population. You may change your MPOIs from one reporting period to the next, or you may decide to focus on one MPOI across several reporting periods.

Technical assistance (TA) is available to assist your agency in meeting its MPOI goal. Some TA will be better suited to different MPOIs. This section gives examples of the types of TA that can be made available to your agency, sorted by MPOI (starting on page 14). Of course, your agency may receive TA on any topic, regardless of the MPOI you select. Consider this a way of organizing and focusing TA efforts by MPOI.

Depending on your agency's needs, you may find it easiest to:

1. Begin by selecting which of the four MPOIs

you will report to CDPH for each of the three U/U populations (i.e., DDD, LGBTQ, and MH/SA). Then:

- a. Review the corresponding list of Technical Assistance Components offered by each TriProject Contractor (see page 14);
- b. Request specific technical assistance and training from the appropriate TriProject Contractor;
- c. Use CQI processes to implement program changes/recommended practices;
- d. Record your progress on the corresponding MPOI using some of the optional Sample Forms; and
- e. Report your progress on the selected MPOI to CDPH using the Data Report Form³ on page 28.

~ *Alternatively* ~

2. Start by reviewing the Technical Assistance Components suggested by each TriProject Contractor and selecting those component(s) which make the most sense for your program (see page 14). Then:

- a. Request specific technical assistance and training from the appropriate TriProject Contractor;
- b. Use CQI processes to implement program changes/recommended practices;
- c. Record your progress on the corresponding MPOI using some of the optional Sample Forms; and
- d. Report your progress on the selected MPOI to CDPH using the Data Report Form³ on page 28.

³ The Data Report Form will also be made available on www.SafeNetwork.net

QUESTIONS TO ASK YOURSELF

Here are some factors to think about to help you decide which MPOI to address first:

- *What are you trying to accomplish with this effort? Where do you want to end up? What would make the kind of difference you and your agency are seeking to make?*
- *Which recommended practice do you want to address for this MPOI? Do you want to address your biggest gap or barrier? Do you want to work on improving something you already started? Consult with staff and clients to determine what you want to do first.*
- *How will you know if the change will indicate an improvement? Figure out what you want to document and how you can measure and evaluate your successes. Do you need to make some modest changes before you can tackle the bigger ones?*
- *What can you do that will facilitate the change process and result in program improvement? What have you learned from the regional trainings? What can you apply now? How might you access additional technical assistance to help out?*
- *Do you have baseline data? If not, the first step is to collect baseline data. Consider the 2006/07 U/U Needs Assessment as a place to start looking for baseline information. You may need to establish a baseline using your best "guesstimate" in the absence of other guidelines.*

SUMMARY

After completing this step, you should know which MPOI you will address first.

Ask yourself: *Why did we pick this MPOI and related Recommended Practice first?*

Technical Assistance Components and MPOIs

Here are a few examples of the types of technical assistance that can be made available to your agency, sorted by MPOI and associated “recommended practices.”

MPOI #1: Number of <DDD/LGBTQ/MHSA> clients being served

Note: these are both recommended practices and *suggested* technical assistance components for this MPOI. You will not be limited to any particular technical assistance topics.

DDD Technical Assistance Components

- Safety counseling
- Screening and intake practices
- Reasonable accommodations policy
- Outreach and collaboration
- Emergency planning
- Staff training
- CQI

LGBTQ Technical Assistance Components

- Intake interviewing
- Physical plant/equipment accessibility (fostering a welcoming environment)
- DVP shelter agency policies and procedures affecting individual / family life at the shelter
- Outreach in the community and within the existing client base
- Case management
- Establishing effective partnerships with local, State, and Federal providers, especially with those agencies serving the LGBTQ population
- CQI

MH/SA Technical Assistance Components

- Screening more clients into shelter:
 - Screening tools
 - Training staff for uniform screening
- Working more effectively with women with MH/SA issues:
 - Policies and procedures
 - Staff training
- Adding support services for MH/SA women
- Looking at rules, enforcement and exiting

MPOI #2: Types and numbers of referrals for related services/providers

Note: these are both recommended practices and *suggested* technical assistance components for this MPOI. You will not be limited to any particular technical assistance topics.

DDD Technical Assistance Components

- Screening practices
- Outreach & collaboration
- Alternative communications
- Staff training
- CQI

LGBTQ Technical Assistance Components

- Case management
- Establishing effective partnerships with local, State, and Federal providers, especially with those agencies serving the LGBTQ population
- CQI

MH/SA Technical Assistance Components

- Verify referral contact information is current
- Follow-up to ensure referrals happened
- Re-assure client that s/he can return for more information or non-shelter services

MPOI #3: Types and numbers of agency partnerships/linkages established

Note: these are both recommended practices and *suggested* technical assistance components for this MPOI. You will not be limited to any particular technical assistance topics.

DDD Technical Assistance Components

- Outreach to people with disabilities
- Collaboration with disability organizations and service providers
- Linkages to resources in your area
- Staff training
- CQI

LGBTQ Technical Assistance Components

- Outreach in the community and within the existing client base

- Case management
- Establishing effective partnerships with local, State, and Federal providers, especially with those agencies serving the LGBTQ population

MH/SA Technical Assistance Components

- Increase knowledge about services in community
- Advocate for needed services

MPOI #4: Types and numbers of physical plant/equipment modifications made

Note: these are both recommended practices and *suggested* technical assistance components for this MPOI. You will not be limited to any particular technical assistance topics.

DDD Technical Assistance Components

- Reasonable accommodations policy
- Emergency planning
- Physical accessibility
- Alternative communications
- CQI

LGBTQ Technical Assistance Components

- LGBTQ-inclusive posters, magazines, symbols and other visual cues and representations displayed in the office, shelter and other environments
- LGBTQ-inclusive brochures and other written materials displayed in the office, shelter and other environments

MH/SA Technical Assistance Components

- Any physical plant/equipment modifications made to physical space to increase access for MH/SA populations will vary greatly based on the needs of your agency. For specific guidance, please contact ONTRACK Program Resources, Inc. for technical assistance.



If you've selected an MPOI for each U/U Population, you're ready to move on to Step 2.

STEP 2 - PLAN: DECIDE WHO, HOW, AND WHAT

DECIDE WHO WILL BE INVOLVED IN THE PDSA PROCESS	<p>The Plan-Do-Study-Act (PDSA) model is one way of approaching Continuous Quality Improvement (CQI). The first step, selecting MPOI, is followed by step two, planning for change. Step two is designed to be completed by project staff. Here are some points to consider in deciding who should be involved:</p> <ul style="list-style-type: none">• <i>Who takes a lead role in developing/modifying policies and procedures or activities at your site?</i> It is important to include staff members who have a role in shaping and executing practice you use at your site, as their involvement could help strengthen future activities.• <i>Who knows your site and clients the best?</i> Including individuals who know the clients, goals, objectives, and activities of your site could help make the process more informative.• <i>Who might be interested in being part of this process?</i> It is always beneficial to include individuals who have a personal interest in the process (e.g., board members, current clients, past clients, staff, key stakeholders or potential partner organizations).
DECIDE HOW YOU WANT TO COMPLETE THE PDSA PROCESS	<p>Next, you need to think about the best way to approach the task at your site. Here are some ideas to consider:</p> <ul style="list-style-type: none">• You could form a "CQI Team" – a small task group to work together on the PDSA. (This is ideal.)• You could select a small task group and divide up the tasks so that each person has different parts of the process. You could then come back together as a team to discuss the outcomes.• You could assign one person to complete the PDSA process and report back to the group. (This is the most difficult approach.)

DECIDE WHAT YOU WANT TO DO – GUIDING QUESTIONS

There are **three guiding questions** that you should ask yourself during the **Plan** phase. The following questions can help to focus your work throughout the PDSA Cycle.

1. What are we trying to accomplish? (Increased access for U/U populations).
2. How will we know that what we are studying will indicate an improvement? (See MPOIs).
3. What can we do that will facilitate the change process and result in program improvement? (These are the change(s) your agency will make).

You might also ask yourself:

What do you want to do to address your selected MPOI? Review the MPOI vignettes in Section 3 for guidance.

What changes do you want to make?

What is feasible to do in a short time and on a small scale?

Ensure the changes are on a small scale. The plan you're developing now is meant to be a *test* or a *pilot*. Change practices on a small enough scale to not disrupt services, but large enough to see an impact.

SUMMARY

After completing this step, you should be ready to **Do**, or begin to carry out the change. Ask yourself:

Have I left anybody out of the process?

Does everyone on the CQI Team know what their role is in the PDSA?

How long will the test/pilot last?

Refer to Appendix A for optional tools to facilitate the PDSA process; there is a PDSA worksheet to help you complete this part of the process.

STEP 3 - DO: CARRY OUT THE CHANGE

<p>CHANGE YOUR PRACTICES</p>	<p>Do it. Test it out. Implement the change.</p> <p>This may be the scariest part of the process, but remember that this is a short-term and small change. You may find new champions or saboteurs in the process. Work with staff to see that this is a test or a pilot.</p> <p>Prerequisites: Create ways to document your progress with milestones, the steps toward achieving the goal or objectives.</p> <p>Resources: Refer to Appendices A and B for <i>optional</i> forms and worksheets to document outreach and engagement activities, referrals, partnerships and linkages, client feedback, stakeholder/partner input, sample COI and PDSA timelines, a logic model framework, and action planning template.</p> <p>Call on the TriProject Contractors. That is what they are there for!! See Section 4 to review who they are and what they are ready to provide.</p>
<p>SUMMARY</p>	<p>After completing this step, you should have implemented the change on a small scale in a test or pilot setting.</p> <p>Note: this step can run concurrently with Step 4.</p>

STEP 4 - STUDY: SUMMARIZE THE FINDINGS

WHAT HAPPENED?	<p>Now that you have implemented the change, you should see an impact (positive, negative, or neutral).</p> <p>The CQI Team should take the time to analyze any data collected and discuss what happened during the change. Talk about it – assess what worked well, what did not work so well, and consider modifications that might improve fit between the recommended practice and your agency/client needs. Some questions to ask might include:</p> <p><i>How did staff react?</i></p> <p><i>How did clients react?</i></p> <p><i>Did the change have its intended impact?</i></p> <p><i>Is this something the agency can implement on a larger scale for a longer term?</i></p> <p>The CQI Team should summarize the finding and make a recommendation for implementation.</p>
SUMMARY	After completing this step, the CQI Team should know what has happened and be ready to make a recommendation.

STEP 5 - ACT: IMPLEMENT OR REJECT

<p>WHAT HAPPENED? Now WHAT?</p>	<p>Now that you have analyzed the data from the change, the COI Team should make a recommendation. Questions to consider include:</p> <p><i>Was the initiative successful?</i></p> <p><i>Should you implement this change on a broader scale or over a longer time?</i></p> <p><i>Were some aspects of the new initiative successful, while others were not? Why might that be?</i></p> <p><i>Should you reject this change altogether? Why or why not? How did you arrive at this conclusion?</i></p> <p><i>Should you try something different to implement this change? If so, what are some alternatives based on what you learned in the process?</i></p> <p><i>Do you want to implement another change to address a different MPOI?</i></p>
<p>SUMMARY</p>	<p>After completing this step, the PDSA is over. The agency should decide whether to make the change permanent and widespread or not. Assess the following:</p> <p><i>How extensive are the changes?</i></p> <p><i>When should the changes occur?</i></p> <p><i>Do you have a set time of year in which staff members review and update implementation?</i></p> <p><i>Do you have standard program cycles (e.g., fall and spring)?</i></p>

PAUSE!

QUICK REVIEW OF THE PDSA CYCLE

We've just given you a lot of information. If this is all new to you, then maybe you're experiencing "information overload." Let's recap...

The Plan-Do-Study-Act (PDSA) Cycle is just one of many approaches to Continuous Quality Improvement. We've used this approach here to illustrate how change can be made and results evaluated in a relatively quick and straight-forward manner.

PDSA SUMMARY

The key to PDSA is to try out your change on a small scale and to rely on using many consecutive cycles to build up information about how effective your change is.

- This makes it easier to get started, gives results rapidly, and reduces the risk of something going wrong and having a major impact.
- Think of a "small" PDSA model in terms of the scope of your test:
 - For example, run your cycle over one day, with one person, or in one program.
 - Or look at the last ten crisis calls, the last ten referrals made, or the next ten survivors sheltered.
- When you plan your PDSA model, make sure you are clear about who is doing what, where and when:
 - Your results are dependent on how good your plan is.
- Record your CQI efforts as you go: the plan, the results, what you learned, and what you are going to do next:
 - Not only is it motivating to see the results of your efforts, it is also a great way to accumulate information about your systems, and a good way of sharing your learning with others.
- Discuss what you think will happen when you try out your improvements - What are your hunches?
 - Then, once you've implemented some improvements, compare your expectations with what actually happened. You may learn something interesting about how things work.
- The "Study" part of PDSA cycles give you the opportunity to reflect on what happened, think about what you have learned, and to build your knowledge for further improvement.

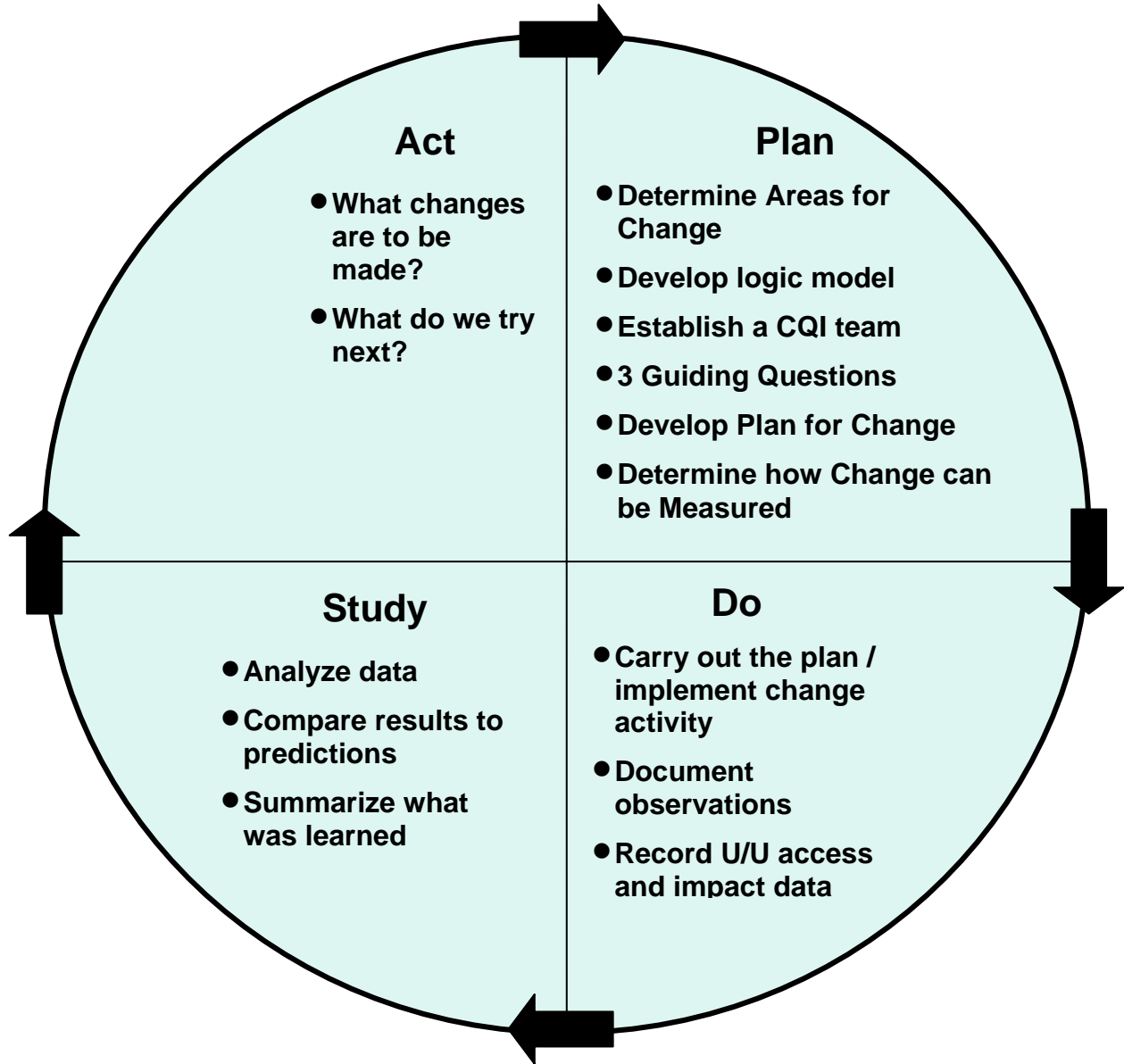
When you have built up enough information to feel confident about your change, you can then implement it as part of your system.

OR . . .

If what you try doesn't work as well as you hoped, you can try again.

Figure 2 gives a visual representation of the PDSA Cycle and some of these key concepts to keep in mind.

FIGURE 2 – PDSA CYCLE



Did the review help? There's still one more step! On to Step 6...

STEP 6 - REPORT TO CDPH

On a semi-annual basis, you will be required to report on implemented changes and impacts on your selected Measurable Performance Outcome Indicators (MPOIs). The reporting will be integrated with existing semi-annual reporting to CDPH, Maternal, Child, and Adolescent Health, Office of Family Planning (MCAH/OFP) Branch, to simplify the process for providers. The most basic measures link directly to the MPOIs:

- _____ The number of U/U population clients served
- _____ The number and types of referrals by U/U population
- _____ The number and types of agency partnerships/linkages made
- _____ The number and types of physical modifications made to improve access to the U/U population

Each of the four MPOIs ask for **numbers**. Three of them, however, also ask for specific **types** - for example, the types of referrals, the types of partnerships, and the types of physical modifications. Your TriProject Contractors can provide technical assistance to facilitate you in your data collection process, including helping you to tailor reporting documentation to suit your MPOI needs.

On the following pages, you will be instructed on how to use the Data Report Form. All forms and instructions will be available from SafeNetwork or your Program Consultant.

Use this experience to develop ways to document and track other elements of your programs and services, to spread the lessons you will be learning by using the COI, PDSA, and all related processes described herein.

REPORTING INSTRUCTIONS

<p>TERMINOLOGY USED IN THE NEW TOOL</p>	<p><u>Unserved/Underserved (U/U)</u></p> <p>This project encompasses three (3) U/U populations:</p> <ul style="list-style-type: none"> • Disability and Developmental Disabilities (DDD) • Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) • Mental Health / Substance Abuse (MH/SA) <p><u>CQI</u> Continuous Quality Improvement</p> <p><u>MPOIs</u> The four Measurable Performance Outcome Indicators (MPOIs) for this Unserved/Underserved project are:</p> <ul style="list-style-type: none"> • Number of U/U clients served • Types and numbers of referrals for related services/providers • Types and numbers of agency partnerships/linkages made • Types and number of physical plant/equipment modifications made
<p>CDPH REPORTING REQUIREMENT</p>	<p>CDPH-funded DVP shelter agencies are required to report on <u>one</u> measurable performance outcome (MPOI) for <u>each</u> of the three U/U populations. You may choose to report the same MPOI for each U/U population, or you may vary them.</p> <p>Your selected MPOIs will remain the same through June 30, 2009.</p>
<p>REPORTING PERIOD</p>	<p>You will report to CDPH on a semi-annual basis. The reporting periods and due dates are as follows:</p> <ul style="list-style-type: none"> • Period from July to December – Report due January 31 • Period from January to June – Report due July 31

<p>INSTRUCTIONS FOR MPOI 1: NUMBER OF U/U CLIENTS SERVED</p>	<ul style="list-style-type: none"> • Provide an unduplicated count of clients served during the six-month reporting period. • U/U clients refer to those who self-identify as being from the DDD, LGBTQ and/or MH/SA populations. • “Clients” include adults and children who receive any domestic violence services from your agency (e.g., emergency shelter, community-based support groups, transitional housing assistance, restraining order advocacy, children’s activities, etc.).
<p>INSTRUCTIONS FOR MPOI 2: TYPES AND NUMBERS OF REFERRALS</p>	<ul style="list-style-type: none"> • Provide an unduplicated count of referrals made for U/U-specific services or providers. • Referrals should be counted for both clients and for crisis/hotline calls. • Referrals may be given by paid or volunteer staff. • A reportable referral means the client or hotline call was given an individual or organizational name, valid contact information, and an overview of potential assistance available. • Suggestions about websites, brochures, educational materials, etc. may only be counted if there is also a reasonable expectation a client may receive some supportive service(s) from the provider. • In some cases, appropriate referrals may be outside the DVP shelter agency’s immediate service area. • Report U/U referrals provided regardless of whether or not clients follow-through with the referral or subsequent contact is actually made with the service/provider. • U/U services and providers may be stand-alone, population-specific organizations. They may be population-specific programs within larger, mainstream organizations. Or they may be individual, expert providers operating independently or within programs. All of these are considered reportable services/providers.

<p>INSTRUCTIONS FOR MPOI 3: TYPES AND NUMBERS OF AGENCY PARTNERSHIPS/LINKAGES MADE</p>	<ul style="list-style-type: none"> • Provide an unduplicated count of new partnership and/or linkages made <i>or</i> growth in existing partnerships and/or linkages, which specifically pertain to the identified U/U populations. • Reportable partnerships and linkages may be formal, written agreements between the DVP shelter agency and another organization (e.g., a Memorandum Of Understanding). • They may also be less formal partnerships/linkages between agencies so long as representatives from both organizations have discussed the partnership and agreed upon a mutual linkage on behalf of U/U clients. • These formal and less formal partnerships/linkages should be periodically revisited and updated to ensure communication, appropriateness and agreement. • Report newly-established U/U-related partnerships, as well as modifications to in-operation linkages functioning during the reporting period.
<p>INSTRUCTIONS FOR MPOI 4: TYPES AND NUMBER OF PHYSICAL PLANT/EQUIPMENT MODIFICATIONS MADE</p>	<ul style="list-style-type: none"> • Provide an unduplicated count of physical plant/equipment modifications completed during the reporting period. • Only those new modifications which are fully functional during the reporting period should be counted. • Physical plant/equipment modifications mean any physical changes at shelter or agency. • Modifications may include structural improvements, communication devices, signage, accessible or representative materials.

NOTES	<ul style="list-style-type: none"> • Figure 3 shows what the U/U Section of the Data Report Form will look like. • MPOI 1 requires your agency to track <i>numbers</i>. • MPOI 2 requires your agency to track <i>numbers and types</i> for clients and from crisis calls. • MPOI 3 requires your agency to track <i>numbers and types</i>. • MPOI 4 requires your agency to track <i>numbers and types</i>.
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FIGURE 3 – U/U SECTION OF DATA REPORT FORM

Unservd/Underserved

DVP Grantees are required to report on one Measurable Performance Outcome Indicator (MPOI) for each of the U/U Populations			U/U Populations		
			DDD	LGBTQ	MH/SA
MPOI 1	Numbers of U/U Clients Served	Number of U/U Clients Served			
MPOI 2	Types and Numbers of Referrals for Related Services/Providers	Number of Referrals for Clients			
		Number of Referrals from Crisis Calls			
		Types of Referrals (Client and Call)			
MPOI 3	Types and Numbers of Agency Partnerships/Linkages	Numbers of New Partnerships			
		Types of New Partnerships			
MPOI 4	Types and Numbers of Physical Plant/Equipment Modifications	Numbers of New Modifications			
		Types of New Modifications			

EXAMPLES OF WHAT TO COUNT

Still confused as to what goes where? Below are some examples of what you might report in Table 3. This list is not exhaustive, but provides a starting point. Each TriProject Contractor has information about defining each U/U population. Refer to population definitions you've received in training sessions with the TriProject Contractors.

MPOI 1: Number of U/U Clients Served

- Track disability in one of three ways:
 - Clients may self-identify as having a disability. It is not necessary to ascertain specific diagnoses or "types" of disability.
 - Client may request a "reasonable accommodation," such as sleeping on the first floor, large print materials, or any number of other potential accommodations to disability.
 - Staff could identify disability while working with clients. This approach should be used with caution. Contact TriProject Contractor for guidance if necessary.
- **LGBTQ** clients include those who self-identify as Lesbian, Gay, Bisexual, Transgender (Female-to-Male and Male-to-Female), and/or Questioning.
- Count clients who self-disclose **mental health** and/or **substance abuse** issues.

MPOI 2: Types and Numbers of Referrals

DDD-specific referrals may include, but are not limited to:

- Deaf and hard of hearing services
- Blind and low vision services
- Technological accessibility
- Mental health providers
- Regional centers
- Independent living resources
- In-home supportive services
- Vocational rehabilitation
- Local universities/colleges
- Hospitals or health care providers
- Adult protective services
- Other DDD services/providers

LGBTQ-specific referrals may include, but are not limited to:

- LGBTQ-specific domestic/sexual violence providers/programs
- LGBTQ-specific mental health providers/programs (including therapists who work independently or within providers/programs)
- LGBTQ-specific substance abuse providers/programs
- LGBTQ community/social/recreational groups
- LGBTQ-specific legal services
- Other LGBTQ services/providers

MH/SA-specific referrals may include, but are not limited to:

- Mental health providers
- Mental health consumer groups
- Drug/alcohol treatment programs
- Self-help sobriety support groups
- Other MHSA services/providers

MPOI 3: Types and Numbers of Partnerships and Linkages

DDD-specific partnerships/linkages may include, but are not limited to:

- Deaf and hard of hearing services
- Blind and low vision services
- Technological accessibility
- Mental health providers
- Regional centers
- Independent living resources
- In-home supportive services
- Vocational rehabilitation
- Local universities/colleges
- Hospitals or health care providers
- Adult protective services

LGBTQ-specific partnerships/linkages may include, but are not limited to:

- LGBTQ-specific domestic/sexual violence providers/programs
- LGBTQ-specific mental health providers/programs
- LGBTQ-specific substance abuse providers/programs
- LGBTQ community/social support groups
- LGBTQ-specific legal services

- LGBTQ businesses

MH/SA-specific partnerships/linkages may include, but are not limited to:

- Mental health providers
- Mental health consumer groups
- Drug/alcohol treatment programs
- Self-help sobriety support groups

MPOI 4: Types and Numbers of Physical Plant/Equipment Modifications

DDD-related modifications may include, but are not limited to:

- Accessible communications (moving signs/notices/information to an accessible height, posting emergency maps in accessible formats, TTY/TDD machines, emergency notification mechanism, etc.)
- Non-structural space modifications (rearranging furniture layout to increase accessibility, including a 36" wide pathway to all essential rooms and 18" of clearance space by all door handles; removal of throw-rugs and area rugs or securing rugs to floor; designation of accessible parking space)
- Structural space modifications (raised toilet seat, grab bars behind and to the side of toilet, modification of interior doorways for compliance, faucets operable with closed fists, creation or designation of at least one accessible bedroom, at least one accessible entrance, ADA-compliant door handles, shower seat or roll-in shower, ADA-compliant sinks, creation or designation of accessible bathrooms)

LGBTQ-related modifications may include, but are not limited to:

- LGBTQ-inclusive posters, magazines, symbols and other visual cues and representations displayed in the office, shelter and other environments
- LGBTQ-inclusive brochures and other written materials displayed in the office, shelter and other environments

MH/SA-related modifications may vary based on your agency and your population's needs. Please contact ONTRACK Program Resources, Inc. for guidance on potential physical modifications to your shelter or agency.



Now that you've worked through the PDSA Step-by-Step Guide, from selecting your MPOI through Reporting, you probably have a pretty good grasp on CQI and PDSA concepts. Section 3 helps to illustrate these concepts through vignettes...

SECTION 3: SAMPLE PDSA VIGNETTES

This manual includes some “vignettes” or samples of ways to put the PDSA and COI into practice. These illustrations are for the purpose of stimulating your own imagination, trying to take what you’re learning, and putting it into practical use. These are not intended to direct all providers to select the same MPOIs, but you may find ways to adapt from these vignettes to plan, implement, and measure the MPOIs your agency selects.

The following vignettes are examples of practice applications for agencies.

Vignettes:

1. How to select an MPOI (*Step 1*)
2. MPOI #1 – Clients Served (*Steps 2-5*)
3. MPOI #2 – Referrals Made (*Steps 2-5*)
4. MPOI #3 – Partnerships and Linkages (*Steps 2-5*)
5. MPOI #4 – Physical Changes (*Steps 2-5*)
6. Using the Data Report Form (*Step 6*)

VIGNETTE 1 – HOW TO SELECT AN MPOI

ACME DV Shelter came back from the Opening Doors training, motivated and prepared to increase accessibility at their shelter. Three people attended the training and immediately wanted to start a CQI Cycle for improving access for people with disabilities. The three knew the first step was to select a Measurable Performance Outcome Indicator (MPOI). Unfortunately, all three had a different goal in mind.

Maria, the Executive Director, wanted to focus on improving physical accessibility at shelter. She knew that the shelter must be made compliant with state and federal laws. Maria wanted to make a list of all the changes that could be done now and create a plan for more extensive changes in the next fiscal year.

Jill, the Shelter Manager, felt that their energies would be better spent by improving referrals. She knew that the shelter was currently serving women with cognitive disabilities, but she thought her staff could do a much better job at improving access by increasing referrals.

Toni, a Case Manager, agreed that referrals would be a good area to focus on, but she also wanted to make sure that clients had an accessible shelter to come home to. And Toni knew that they needed to take another look at their screening procedures, because she suspected that ACME DV was not identifying all the people with disabilities who came through their doors. She knew from the training that they could focus on and report on all MPOIs. Maybe this would be the best approach for ACME DV?

The three set a goal for their first CQI meeting to decide which MPOI to focus on. First step? To decide whether they should choose one or more MPOIs. Selecting one MPOI would give focus to staff efforts and resources, as all energies could be focused on that one area. Selecting more than one MPOI would be more resource-intensive, but it might also see greater increases in access by addressing multiple areas of access.

The CQI Team decided that choosing just one MPOI would be best for their agency. They wanted to be able to focus limited staff time and agency resources on improving one area. And so they moved onto the second step – deciding which MPOI to focus on.

Measurable Performance Outcome Indicators – Disability and Developmental Disability

1. Increasing the number of clients identified as having a disability
2. Increasing the number and type of referrals for disability related services
3. Increasing outreach within the disability community
4. Increasing physical accessibility at shelter

Each MPOI had its merits, but after a long discussion the three felt confident that they could best increase access by increasing the number and type of referrals. Why?

- They were already serving many women with cognitive disabilities and some women with physical disabilities.
- Case Managers only worked with three organizations in their area that served people with disabilities. Toni, and the rest of the CQI Team, felt they could likely increase these numbers.
- Physical changes, while necessary, really required a long-term plan for ACME DV Agency.

The CQI Team selected the Referrals MPOI and made note that next year, they would address the Physical Accessibility MPOI. Having finally decided on an MPOI, they scheduled a second meeting to discuss which recommended practices they wanted to implement at their shelter.

VIGNETTE 2 – CLIENTS SERVED

ACME DV Shelter wanted to improve its access for survivors who identify as LGBTQ. To begin, they formed a CQI Team made up of a Board member who is a lesbian, the Associate Director and the Outreach Coordinator.

The CQI Team first addressed the PDSA Guiding Questions:

1. What are we trying to accomplish with this effort?
→ Their overall goal was to increase access for LGBTQ survivors.
2. How will we know that what we are studying will indicate an improvement, and therefore, should result in a change in practice?
→ They chose to track and report on the following MPOI: The number of LGBTQ survivors being served.
3. What can we do that will facilitate the change process and result in program improvement?
→ Given that they were not regularly asking, recording, nor tracking LGBTQ survivors served, they felt the best place to start would be to determine a baseline figure representing their current status (recommended practice, found within the CQI Guidance Manual).

The CQI Team then mapped out the following PDSA Cycle:

Plan:

Initially, the CQI Team turned to the LGBTQ needs assessment completed in 2006. Apparently they had estimated that approximately 5% of survivors served identified as LGBTQ, however this raised several questions:

- Where did that estimate come from? Were there some old client forms or statistics used? Was this based on anecdotal information?
- Did this estimate represent survivors served in all their programs? Shelter only?
- What was the likely break-down between the L, G, B, T and Q populations?

Unfortunately, they didn't feel very comfortable with the 5% estimate and decided they needed to establish a more thoughtful and realistic figure.

The Team was curious about the LGBTQ-appropriate intake questions recommended in the Unserved/Underserved training and wondered if they would provide decent baseline data? At the same time, they were somewhat concerned about safety, confidentiality and reactions for LGBTQ-identified survivors in the communal shelter setting. Since the Outreach Coordinator had attended the U/U Train-the-Trainer sessions and participated in the CQI Team, they opted to begin with their Outreach Program.

Thus, their plan was as follows:

- The Outreach Coordinator would revise the intake forms for the Outreach Program to include the LGBTQ-sensitive questions as recommended in the U/U Train-the-Trainer session.
- She would train the Outreach Advocates providing restraining order, support group, hospital accompaniment, and outreach advocacy services on the new form and LGBTQ-sensitive interviewing.
- *Data Collection:* The Outreach Coordinator would compile the LGBTQ data and the CQI Team would reconvene at 3-month intervals to review their progress.

Predictions: The Team didn't have consensus about possible reactions. Some thought the Outreach staff would struggle and resist the new form, others thought they would be willing to try it out.

Although they had the preliminary 5% estimate, they really couldn't guess what the "real" baseline figure would be. They thought it would be important to meet at 3-month intervals to check-in about staff training and how the actual questions were received (i.e., the process), but assumed they wouldn't see significant numbers of LGBTQ survivors being identified very quickly.

They did agree, however, that they would be open to trying out and modifying the questions over time based on their experiences.

Do:

The Outreach Coordinator implemented the above steps according to plan. Revising the intake form was simple enough, but training the Outreach Advocates on the new form was a bit more difficult due to an unexpected absence which resulted in staff turn-over. So only one of the two Outreach Advocates was trained on the form during the first 3-month period. This Advocate initially voiced concerns about asking such personal questions, but after the training on LGBTQ-competent interviewing, was willing to give it a try.

The data from the first 3 months are as follows:

	Month 1	Month 2	Month 3	Average
Sexual Orientation				
# heterosexual	14	11	12	12
# lesbian	0	0	1	0
# gay	0	0	0	0
# bisexual	0	1	1	1
# questioning	0	0	0	0
# declined to answer sexual orientation	0	1	1	1
<i>LGBQ Orientation Subtotal</i>	<i>0</i>	<i>1</i>	<i>2</i>	<i>1</i>
Gender Identity				
# female	13	11	14	14
# male	0	2	0	0
# transgender (M→ F)	0	0	0	0
# transgender (F→ M)	0	0	0	0
# declined to answer gender identity	1	0	1	1
<i>T Identity Subtotal</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>
TOTAL LGBTQ	0	1	3	1
<i>% of Outreach Clients Served</i>	<i>0%</i>	<i>8%</i>	<i>20%</i>	<i>2%</i>

Study:

When the COI Team reconvened for their 3-month check-in meeting, they reviewed the data provided by the Outreach Coordinator and immediately noticed the 2% average being different from the original 5% figure from the 1996 needs assessment. And even though there was very little data, they appreciated L, G, B, T and Q specificity provided. They made two other observations about the data, which in turn, raised further questions:

- On 4 occasions, survivors declined to answer about either sexual orientation or gender identity
 - Was this due to the survivors' own comfort level, or was it due to the way they were being asked, or both?
- The LGBTQ responses increased slightly from Month 1 to Month 2, and then from Month 2 to Month 3
 - Was this because they actually served more LGBTQ survivors over those months, or was it because the Outreach Advocate became better at asking the questions, or both?

As they discussed at the beginning with their possible predictions, they didn't expect valid baseline data right away, and thus their 3-month check-in was

most concerned with how the process was going and the way it was all being implemented. By that time the replacement Outreach Advocate had been hired, but not yet trained on the intake form nor LGBTQ-competent interviewing, so they decided to ask the current Outreach Advocate for more feedback about her experiences:

- As initially expressed, she remained concerned about asking such personal questions;
- As a result, she felt she stumbled over the questions quite a bit during the first month, but got more comfortable with them over time;
- She confessed that she still wasn't really sure what was meant by the term "questioning;" and
- She also wasn't clear about the agency's policies serving people who were transgender since their primary population was female DV survivors.

The Outreach Coordinator thanked her for her candid feedback and shared this with the CQI Team. Upon review, the Team felt these concerns were best addressed as a training issue and did not yet point toward revising the actual language in the intake form.

Act

Because they were encouraged by the initial data, they decided to continue with the intake form as written for another 3-month period of time. Thus, they asked the current Outreach Advocate to participate in the mini-training session with the new Outreach Advocate again reviewing the intake form and LGBTQ-appropriate interviewing.

The Outreach Coordinator would again compile and report similar data and qualitative feedback to the CQI Team at the end of another 3-month interval. At that time, the Team would consider making minor adjustments to the language of the intake form.

After that, they planned to initiate a similar PDSA cycle with their Shelter Program using the same intake questions. At the end of the first year, they would have 12 months of Outreach Program data and 6 months of Shelter Program data which would provide more a realistic baseline figure from which they could implement further improvements.

VIGNETTE 3 – REFERRALS MADE

ACME DV Shelter wanted to improve its access for survivors with mental health and substance abuse issues (MH/SA). To begin, they formed a CQI Team made up of the Shelter Manager, Women’s Advocate, and a Volunteer who is active in the AA recovery movement.

The CQI Team first addressed the PDSA Guiding Questions:

1. What are we trying to accomplish with this effort?
 - Their overall goal was to increase access for survivors with MH/SA issues.
2. How will we know that what we are studying will indicate an improvement, and therefore, should result in a change in practice?
 - Anecdotally, they had observed that survivors with MH/SA issues tended to have a lot of conflicts, leave shelter earlier, and usually didn’t connect with other community services. So the CQI Team believed that improvement would be demonstrated by an increase in the types and numbers of referrals for MH/SA-related services/providers (CDPH’s Measurable Performance Outcome Indicator or MPOI).
3. What can we do that will facilitate the change process and result in program improvement?
 - The CQI committee decided to start with two things:
 - First, they set a goal of having up-to-date information about substance abuse recovery meetings easily accessible for Staff, Volunteers and residents in shelter (Recommended Practice).
 - And second, they decided to reach out and build relationships with Counselors at the County Mental Health agency (Recommended Practice).

The CQI Team then mapped out the following PDSA Cycle:

Plan:

The Volunteer offered to collate all the different recovery meeting announcements into one comprehensive schedule (including AA, NA, Alcoholics Victorious, Rational Recovery, etc.). She would review the meeting schedule with Staff and Volunteers so they were more familiar with these sources of support. Recovery meeting schedules would be posted on two different

bulletin boards in the shelter, would be placed in every welcome packet, and be available in the Intake office and Advocates' office. She planned to update this schedule every three months.

The Women's Advocate knew of a particular County Mental Health Counselor who had previously referred a couple of DV survivors for shelter, so she (the Women's Advocate) offered to approach this Mental Health Counselor directly to talk about the challenges and see if they could try out some quicker, simpler yet informal referral methods.

Data Collection: They already had a form they kept in each shelter resident's file which was a checklist of services the survivor desired/needed, so they easily revised the form to include a similar checklist to track the actual referrals Advocates made (including a list of specific referrals for MH/SA services, providers and recovery self-help groups). The Woman's Advocate agreed to collate this referral information and provide it to the Shelter Manager on a monthly basis. The CQI Team planned to meet again after 6 months to review this data and assess their overall progress.

Predictions: Because the County Mental Health system was a bit onerous, the Team felt they would probably see a greater increase in referrals for substance abuse groups vs. mental health services.

Do:

The CQI Team implemented the improvements according to their plan. The Volunteer collected recovery meeting schedules and the Women's Advocate worked with the cooperative Counselor she had identified.

Study:

The CQI Team reconvened at the end of 6 months to review their progress. As planned, the Woman's Advocate had tracked the numbers of referrals made using their enhanced case management forms:

	# MH referrals	# SA referrals
Month 1	0	1
Month 2	1	2
Month 3	1	1
Month 4	2	3
Month 5	0	1
Month 6	3	2
TOTAL	7	10

Together they discussed their experiences and agreed the effort had been successful:

- The Volunteer found that collecting and updating the meeting schedules had been relatively easy. The only challenge was making sure staff recycled the out-of-date schedules when the new ones were available.
- The Woman's Advocate made great progress with the Mental Health Counselor. She contacted this Counselor 5 times over the 6-month period:
 - On three occasions the Counselor was able to expedite the County's intake process so Shelter residents in crisis were able to see Therapists quicker;
 - The Counselor tried to arrange for an in-patient detox and treatment program for two Shelter residents, but was only successful once; and
 - She was willing to come to the Shelter during an especially scary crisis when a 6 year-old had climbed up onto the roof.

Act

Given their initial success, the Team talked about how to build upon these efforts:

- The Volunteer agreed to continue collecting and updating the recovery meeting schedules. She also offered to talk with a couple leaders about the possibility of starting another group at a church meeting hall which is closer to the Shelter. ACME DV Agency already had a good relationship with this church, who regularly gave them donations, and the Volunteer thought she could convince others to start a group there without revealing anything about the DV shelter location nor their residents' needs.
- The Woman's Advocate would speak with the Mental Health Counselor to see if she were still amenable to these informal referrals. If so, they would invite her to present a training on crisis management at their next all-staff meeting, and inform other Shelter Staff of her availability.

Lastly, the COI Team agreed to continue with their referral data collection efforts, and to meet again six months later. If their results were still positive, they would wrap up this Team and call it a success!

VIGNETTE 4 – PARTNERSHIPS AND LINKAGES

The Executive Director at ACME Shelter returned from the Unserved/Underserved (U/U) train-the-trainer session and quickly organized a series of trainings for Staff and Volunteers utilizing the LGBTQ materials. Staff and Volunteers welcomed the new information and were eager to put into practice their new skills.

Over time, they sheltered a few LGBTQ survivors, but worried about the lack of support available in their rural community once those survivors moved on. Wanting to make improvements, the Executive Director agreed to work with the Shelter Manager to conduct a CQI process.

They began by looking at the PDSA Guiding Questions:

1. What are we trying to accomplish with this effort?
→ Their overall goal was to increase access for LGBTQ survivors.
2. How will we know that what we are studying will indicate an improvement, and therefore, should result in a change in practice?
→ They accessed technical assistance from the LGBTQ technical assistance providers who listened to their concerns and advised them to look at the four Measurable Performance Outcome Indicators (MPOIs). They decided to focus on increasing the types and numbers of agency partnerships/linkages established with LGBTQ providers.
3. What can we do that will facilitate the change process and result in program improvement?
→ In this case, the MPOI is the same as the recommended practice, so they began working out a plan to increase the types and numbers of agency partnerships/linkages established with LGBTQ providers.

Plan:

They would gather a meeting with all Staff and Volunteer to spend time brainstorming:

- All the LGBTQ providers they knew in the area;
- “Types” of organizations which might have LGBTQ-sensitive providers/services as suggested by the technical assistance provider (e.g., women’s health clinics, family law attorneys, LGBTQ-friendly businesses, LGBTQ-specific media, etc.); and

- Individuals, programs and agencies outside their immediate area identified by the technical assistance provider.

Once the brainstorming was completed, the Executive Director and Shelter Manager would strategize about their likely contacts and prioritize the top 4 to approach within the next 6 months.

Data Collection: In terms of measuring and reporting on their progress, they agreed that they would count formal, written partnerships as well as informal linkages made. The LGBTQ technical assistance providers recommended a Partnerships and Linkages tracking tool to help them collect this data.

Predictions: They knew it would be difficult, but hoped that out of 4 prioritized contacts, they could establish at least one partnership during the 6-month period of time.

Do:

They held the brainstorming session with Staff and Volunteers and were able to identify 6 possible individuals, programs and/or organizations which might provide LGBTQ-specific support to survivors exiting their shelter. Of those, they prioritized 4 whom they committed to contacting in the next six months:

- The Executive Director already attended a meeting of local Department Heads which included the Director of Public Health, so she (the Executive Director) met with this individual to talk about the possibility of LGBTQ-sensitive services available through their community health clinics.
- The Executive Director also knew the local Family Court Judge and met with him to ask about LGBTQ-specific proceedings, resources, potential attorneys, etc. However, the Judge was not very cooperative.
- The Shelter Manager followed-up on a suggestion from the technical assistance provider that they partner with an LGBTQ-specific domestic violence agency across the border in a neighboring state.
- And the Shelter Manager also worked with a Volunteer who attended the local AA and NA recover groups to ask about LGBTQ-specific support (with no luck).

Study:

At the end of six months, the Executive Director and Shelter Manager met to review their progress with these prioritized contacts. Of the four, the only lead was the LGBTQ organization in the neighboring state. Because they were three-and-a-half hours away in another state, it didn't make sense to develop a formal Memorandum Of Understanding between the two organizations. But both felt it was encouraging to know of the other's interest in serving the LGBTQ population and agreed to include their organizations in their referral lists.

So the Executive Director and Shelter Manager reviewed their progress with the Staff, Volunteers, and Board and were able to report they had met their goal of establishing at least one informal linkage during the 6-month period of time. In so doing, two members of the Board took some interest in the project and thought that as representatives from the community, perhaps the Board would have some additional ideas and contacts?

- One Board member, who was a lawyer, knew of two family law attorneys in the broader geographic region who he thought had done recent work on domestic partnerships, same-sex adoptions, etc.
- Another Board member who was a businesswoman looked at ads in the LGBTQ newspaper from a neighboring county. She suggested that she could cross-reference this list with businesses that were members of the Chamber of Commerce and might be willing to offer support to LGBTQ survivors leaving shelter.

Act:

The Executive Director and Shelter Director realized they had unintentionally narrowed their scope of possible contacts and agreed to hold a similar brainstorming session with the Board to generate additional leads for the next 6-month period.

VIGNETTE 5 – PHYSICAL CHANGES

ACME DV Shelter was proud of the renovations they had recently completed which made their shelter ADA-accessible. As word got out to the community about their accessibility, they began to experience an increase in shelter residents with disabilities. While the facility was now accessible, the Shelter Director became concerned about how well they were actually serving survivors with disabilities coming through their doors. She had been to the Unserved/Underserved (U/U) Train-the-Trainers session and decided to implement some of the changes she had learned there.

The Shelter Director first addressed the PDSA Guiding Questions:

1. What are we trying to accomplish with this effort?

→ Her overall goal was to increase access for survivors with disabilities. Upon closer review, they had been serving more people with physical and sensory disabilities so she decided to focus her efforts on those sub-populations.

2. How will we know that what we are studying will indicate an improvement, and therefore, should result in a change in practice?

→ With everything else going on, she felt it would be simplest to report on their continued progress with the types and numbers of physical plant / equipment modifications made (CDPH's Measurable Performance Outcome Indicator or MPOI).

3. What can we do that will facilitate the change process and result in program improvement?

→ The Shelter Director decided to start with the Emergency Planning recommendations outlined in the training materials she received at the U/U Training.

She then mapped out the following PDSA cycle:

Plan:

She would follow the recommendations from the U/U Training-of-Trainers and seek technical assistance in drafting their own emergency plan for people with physical and sensory disabilities (Draft #1).

Once she had a good draft plan prepared, she would invite disability advocates from the nearby Independent Living Center to visit the shelter in order to get a feel for the layout of the facility. Afterward, she would talk them through her draft emergency plan and seek their input. Based on the feedback she received from the ILC advocates, she would revise the emergency plan (Draft #2).

Because ACME Shelter already had a strong emergency plan in place and their shelter met all of the ADA requirements, she predicted that it would be fairly simple to amend their existing plan to meet the needs of people with disabilities.

Do:

The Shelter Director was able to follow the above process for amending their emergency plan pretty easily. She worked hard on the first draft of the emergency plan and incorporated suggestions from the technical assistance she received. Two staff from the Independent Living Center came to the shelter and gave her good feedback which she incorporated into Draft #2.

As she prepared to roll out the new emergency plan to the rest of the agency, she contacted the ILC advocates to thank them for their assistance. They suggested that it might be a good idea to test out the new emergency plan before training everyone else so they would be sure it would be effective in case an emergency arose.

So while the Staff and Shelter residents conducted the weekly emergency drill, the Shelter Director assigned herself as the designated staff to attend to the needs of residents with disabilities. One of the ILC advocates acted as the resident with a disability, and the other ILC advocate acted as an observer. Once the drill was completed, they debriefed their experiences and made further revisions to the emergency plan before it was finalized and disseminated to all Shelter Staff and Volunteers for subsequent training.

Study:

When the Shelter Director reflected on what she had learned in the process of developing this accessible emergency plan, she noted that the input from the ILC advocates and the “trial-run” experiences had been invaluable for herself and the end product. Thus, she also amended the agency’s policies and procedures for conducting emergency drill so that they regularly included scenarios with residents with disabilities. With that, she felt confident in reporting on the selected MPOI reflecting an increase in the types and numbers of physical plant / equipment modifications made.

Act:

Once all the Shelter Staff and Volunteers felt comfortable conducting the emergency drills with a variety of physical and sensory disabilities, the Shelter Director would then proceed to further develop emergency plans which took into account the needs of people with cognitive disabilities. She planned to utilize a similar process in the development of that new emergency plan as well and hoped to be able to include that in her next 6-month MPOI report.

VIGNETTE 6 – USING THE DATA REPORT FORM

ACME DV Shelter wanted to improve its access for survivors with mental health and substance abuse issues (MH/SA) so they formed a CQI Team made up of the Shelter Manager, Women’s Advocate, and a Volunteer who was active in the AA recovery movement.

The Team selected the following MPOI to assess their progress toward meeting the overall access goal:

MPOI: Types and numbers of referrals for related services/providers

Based on the recommended practices from the technical assistance provider, the Team devised and implemented two strategies for increasing MH/SA-specific referrals:

- First, they set a goal of having up-to-date information about substance abuse recovery meetings easily accessible for Staff, Volunteers and residents in shelter. During their first 6-month PDSA cycle, the Volunteer successfully collected and disseminated updated meeting schedules.
- Second, the Women’s Advocate made great progress working with a cooperative Counselor from the County Mental Health agency.

In addition to anecdotal feedback about their progress, the Team revised their Shelter forms and collected 6 months of data on referrals made for specific MH/SA services, providers, and recovery self-help groups. The data showed 7 mental health and 10 substance abuse referrals made.

The Shelter Manager knew that this information needed to be included in the data report form. She wasn’t very clear on how she should fill out the new tables, though. So she went to SafeNetwork, where she found the new form and instructions.

Unserved/Underserved

DVP Grantees are required to report on one Measurable Performance Outcome Indicator (MPOI) for each of the U/U Populations			U/U Populations		
			DDD	LGBTQ	MH/SA
MPOI 1	Numbers of U/U Clients Served	Number of U/U Clients Served			
MPOI 2	Types and Numbers of Referrals for Related Services/Providers	Number of Referrals for Clients			10
		Number of Referrals from Crisis Calls			7
		Types of Referrals (Client and Call)			-MH Providers -MH Consumer Groups -SA Providers
MPOI 3	Types and Numbers of Agency Partnerships/Linkages	Numbers of New Partnerships			
		Types of New Partnerships			
MPOI 4	Types and Numbers of Physical Plant/Equipment Modifications	Numbers of New Modifications			
		Types of New Modifications			

The Shelter Manager took one look at the form and realized there was not enough information there! Although her team had done their part in working toward the mental health substance abuse MPOI, the shelter manager realized that she did not know the progress her coworkers were making on the other two MPOIs.

Before they could report to CDPH on their progress, the Team first needed to figure out what numbers to include for the other two Unserved/Underserved populations. At the next staff meeting, the shelter manager asked everyone involved in CQI to submit their information to her.

Within a week, all information had been collected and Acme DV shelter was able to submit a complete report by January 31st.

Unserved/Underserved

DVP Grantees are required to report on one Measurable Performance Outcome Indicator (MPOI) for each of the U/U Populations			U/U Populations		
			DDD	LGBTQ	MH/SA
MPOI 1	Numbers of U/U Clients Served	Number of U/U Clients Served			
MPOI 2	Types and Numbers of Referrals for Related Services/Providers	Number of Referrals for Clients			10
		Number of Referrals from Crisis Calls			7
		Types of Referrals (Client and Call)			-MH Providers -MH Consumer Groups -SA Providers
MPOI 3	Types and Numbers of Agency Partnerships/Linkages	Numbers of New Partnerships		3	
		Types of New Partnerships		Legal; Social	
MPOI 4	Types and Numbers of Physical Plant/Equipment Modifications	Numbers of New Modifications	3		
		Types of New Modifications	Structural; Communication		

The Data Report Form was a mixed success. The Team were encouraged by their initial success and made plans to build upon these efforts. The Team decided to **Act** on their new Mental Health and Substance Abuse referral data collection process, and agreed to meet again six months later to review, report and finalize this improvement. On the other hand, the Shelter Manager realized that she would need to communicate more regularly with any other CQI Teams working on different Unserved/Underserved populations.

The Shelter Manager recognized how easy the tool was to complete – but only because they had been collecting and tracking the information as a part of their CQI Process. She was grateful for having planned in advance to collect the information her agency would need to report on.



"That's great, and I'd love to use CQI at my agency, but I don't even know where we'd begin! We're too busy, don't have the resources, and to be honest – I don't even know where we'd begin."

Well – the three TriProject Contractors can give you some help here. If you want help selecting an MPOI, working through the PDSA process, or guidance for the Data Report Form, they're there to help! Section 4 gives you all the information you need about the three TriProject Contractors and how to contact them.

SECTION 4: U/U ACCESS PROJECT TECHNICAL ASSISTANCE AND TRAINING (TAT) PROVIDERS

California Department of Public Health (CDPH) contracted with three organizations to provide technical assistance and training via the Unserved/Underserved (U/U) Access Project. These organizations work in close collaboration to identify and develop resources to facilitate your agency's change process. They bring content expertise to the U/U Access Project, provide regional training on topics specific to each U/U population, and provide ongoing technical assistance upon request.

This section provides you general information about each TriProject Contractor, their contact information, and suggestions for technical assistance that may facilitate your CQI and PDSA cycles.

Technical assistance is designed to provide you with additional training, guidance, and information on better serving the Unserved/Underserved populations. TA may be individual or grouped with other agencies. Contact any of the TriProject Contractors for more information on this process.

Summary of steps for requesting and completing technical assistance:

1. Call or email the TriProject Contractor that is addressing the population that will be the focus of your MPOI. There are individual contacts listed for each TriProject Contractor.
2. Discuss your goals and objectives for the MPOI.
3. Respond to their questions, so they can best determine how to address your needs.
4. Complete any necessary TA application process.
5. Schedule the TA.
6. Following the TA, complete evaluation feedback form or survey (distributed by contractors).
7. Let them know how the TA did or did not help you achieve the goal and objectives you set for this MPOI.

U/U TAT - DISABILITY & DEVELOPMENTAL DISABILITY (DDD)

WHO WE ARE

Transforming Communities – Technical Assistance, Training, and Resource Center (TC-TAT) is a national leader in the creation of contemporary, community-based approaches to preventing violence. By developing and implementing prevention campaigns and by disseminating best practices through trainings and publications, TC-TAT advances the prevention agenda within the domestic violence field. Drawing from the experience of effective social movements and the public health model of prevention, TC-TAT fosters sustainable change by building community ownership, promoting individual transformation, and fundamentally shifting the social norms that condone or support violence.

As a learning center for the development and application of interlocking strategies, TC-TAT seeks to change the prevailing knowledge, attitudes, beliefs, and behaviors that support violence and other forms of abuse as a social and individual norm. The interventions, campaigns, training programs, and publications of Transforming Communities specifically pilot, assess, and promote strategies for domestic violence prevention as related to broader community issues.

TC-TAT serves as a technical assistance, training, and resource center for the advancement of new practices, learning, and skill development in domestic violence prevention. TC-TAT's vision is to strengthen the collective efforts of domestic violence and allied organizations to ameliorate the effects of domestic violence and to prevent such violence.

HOW TO CONTACT US

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WHAT WE CAN DO FOR YOUR AGENCY

TC-TAT has significant experience as a statewide training, technical assistance, and resource center on domestic violence prevention. TC-TAT has provided statewide training and technical assistance on domestic violence prevention and media advocacy. TA requests have spanned the continuum of assistance from requests for resources and materials, to on-site TA including the facilitation of prevention-focused meetings and strategic planning sessions, as well as a variety of trainings for shelter-based staff, advocates and volunteers.

Technical assistance may be accessed via email, phone, or onsite at your agency. Technical assistance may be grouped, to help facilitate intra-agency collaboration, or may be individualized for your agency's specific needs.

Based on the needs assessment results, TC-TAT recommends a building-block training and technical assistance approach starting with regional trainings. Five prioritized areas were identified for capacity-building and will be tailored to the needs at both the regional and agency levels.

1. Increased Training on Disability Awareness

Assistance with implementing disability awareness trainings at your agency.

2. Policy and Procedure Development

- a. Developing reasonable accommodations policy.
- b. Assistance in safety planning for people with disabilities.
- c. Developing emergency planning procedures for people with disabilities.
- d. Creating sensitive and effective screening protocols.

3. Outreach and Collaboration

- a. Building partnerships with disability communities.
- b. Developing outreach programs for people with disabilities.
- c. Locating and accessing resources in your community.

4. Communication

- a. Assistance in creating and distributing materials in alternate formats.
- b. Training in communication technologies for working with people with disabilities.

5. Physical Access Issues

- a. Identification of areas for modification.
- b. Developing a plan of action for addressing short, intermediate, and long-term changes.

U/U TAT - LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUESTIONING (LGBTQ)

WHO WE ARE

The LGBTQ Domestic Violence Technical Assistance and Training Project (LGBTQ DV TAT Project) is administered by the California Partnership to End Domestic Violence (CPEDV) in collaboration with project partners Community United Against Violence (CUAV) and the Los Angeles Gay and Lesbian Center (LAGLC). The purpose of the LGBTQ DV TAT Project is to support each of the 94 CDPH-grant funded domestic violence program shelter (DVPS) agencies to increase access to services by Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) DV victims/survivors. The project promotes the adoption of a consistent set of competencies and recommended practices for culturally effective and accessible services for the LGBTQ population. The project team consists of experienced TAT providers from CPEDV, CUAV and LAGLC. The project team provides high-quality learning opportunities in accessible settings and formats, reinforced through follow-up support and assistance in the application of recommended practices. In addition to providing specialized direct assistance to individual agencies, the project will encourage ongoing cross-program learning in the 5 CDPH-defined regions of California.

The California Partnership to End Domestic Violence is a catalyst and advocate for social change through innovative solutions to ensure safety and justice for victims and survivors of domestic violence and their children.

Community United Against Violence is a multicultural organization working to end violence against and within our lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities. CUAV offers a 24-hour confidential, multilingual crisis line, free counseling, legal advocacy, and emergency assistance (hotel, food, and transportation) to survivors of hate and domestic violence, as well as technical assistance and training to a wide range of service providers and community agencies.

The Los Angeles Gay and Lesbian Center provides a broad array of services for the gay, lesbian, bisexual, and transgender community. Health services include free or low cost HIV/AIDS medical care, individual and group counseling, HIV/STD testing and prevention, and alternative insemination. The Center also offers legal, social, cultural, and educational services, with unique programs for seniors, families and youth, including a 24-bed transitional living program for homeless youth, as well as technical assistance and training to a wide range of service providers and community agencies.

HOW TO CONTACT US

The California Partnership to End Domestic Violence
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TTY: 866-484-4913
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Central Region: Lisa Fujie Parks, lisa@cpedv.org, 916-444-7163
Southern and Los Angeles Regions: Mary Case, mcase@lagaycenter.org, 323-993-7503

WHAT WE CAN DO FOR YOUR AGENCY

The LGBTQ DV TAT Project Curriculum provides for some level of standardization with flexibility for customization per individual grantee needs and includes 8 specific areas:

1. How to write and get organizational buy-in for **organizational policies** to ensure a safe and welcoming environment for LGBTQ DV survivors.
2. How to conduct in-house LGBTQ sensitivity and DV **training for staff members and volunteers**.
3. How to set up **mechanisms to track** the number of LGBTQ clients served.
4. How to conduct an **effective intake interview** with LGBTQ clients and screen to differentiate between victim/survivor and batterer in same-sex DV situations.
5. How to do effective **case management** with LG BTQ victim/survivors, including how to make appropriate referrals and advocate effectively on behalf of a client who may face discrimination.
6. How to create **an LGBTQ-welcoming environment** through use of sensitive agency materials and LGBTQ-welcoming materials in the office and shelter environments.
7. How staff and volunteers can be more effective in **dealing with situations of homo/bi/transphobia** coming from clients and community members.
8. How to find, establish and maintain **partnerships and linkages** with local, state & national LGBTQ-specific agencies, groups and businesses.
9. How to conduct effective and creative **outreach** to LGBTQ communities.
10. How to design, implement and sustain **programs and services specifically and primarily for LGBTQ individuals**.

U/U TAT - MENTAL HEALTH/SUBSTANCE ABUSE (MH/SA)

WHO WE ARE

ONTRACK Program Resources, Inc. serves as a resource to increase knowledge and strengthen strategies of organizations that provide services and programs for individuals and population groups that are traditionally underserved. ONTRACK targets community-based organizations, neighborhood groups and public agencies that provide services to improve the health and well being of communities with economic and social disadvantages.

Since its founding in 1997, ONTRACK has focused on assisting organizations to advance their charitable missions by developing program structure, content and management tools that increase the effectiveness of their efforts. ONTRACK manages a pool of consultants with expertise and experience in broad areas of program development. Technical assistance and training services are customized to meet the needs of the specific organization or agency. Primary technical assistance and training services support organizational goals to:

- Effectively implement planned services
- Strengthen leadership and decision-making skills
- Sustain community health and development initiatives
- Increase funding opportunities and program assets
- Professionally manage and administer public and charitable resources

In addition to providing technical assistance and training services, ONTRACK engages in a range of dynamic services designed to eliminate policy and systemic causes of social, political and economic disparities for African Americans and other disadvantaged population groups. ONTRACK engages in advocacy, education and outreach within multiple sectors of the community, in government, the courts and justice system, the workplace, schools, neighborhoods and families.

HOW TO CONTACT US

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WHAT WE CAN DO FOR YOUR AGENCY

Technical assistance delivery strategies are based on an assessment of the best approach for meeting your agency's needs. Examples of U/U TAT include:

1. MH/SA/DV Integrated trauma-informed services and treatment

Learning more about integrated trauma curricula, services, and theory.

- a. Principles and philosophies of a trauma-informed system
- b. Specific evidence-based and emerging best practice treatment curricula
- c. Working successfully with the MH/SA consumer/survivor
- d. Universal screening for trauma
- e. Hiring and staff training programs
- f. Trauma-informed review of policies & procedures
- g. Integrated MH/SA/DV case management

2. Mental Health Signs and Symptoms

Introducing and customizing the statewide mental health and domestic violence curricula.

- h. Basic training
 - i. Signs, symptoms, and strategies
 - ii. Specific types of mental illness
 - iii. Screening for mental illness (including tools)
- i. Referring to local mental health agencies
- j. Cultural competency
 - i. Culturally-appropriate strategies for ethnic populations
 - ii. Counseling and mental illness: what DV counselors need to know

3. Substance Abuse Signs and Symptoms

Providing customized training and technical assistance based on regional variations regarding substance abuse, including alcohol and drug of choice.

- k. Basic training
 - i. Signs, symptoms, and strategies
 - ii. Specific types of drugs
 - iii. Screening for drug addiction (including tools)
- l. Referrals
- m. Cultural competency
 - i. Culturally-appropriate strategies for ethnic populations
 - ii. Counseling and mental illness: what DV counselors need to know
 - iii. Relapse prevention

4. Development of Model Policies & Procedures

Reviewing current and developing new policies and procedures specific to the agency's need.

- n. MH/SA screening and entry criteria (including tracking)
- o. Referral protocols (including follow-up)
- p. Drug testing policies (including exiting policies)
- q. Relapse prevention procedures (including support group)

5. Inventories of MH/SA resources available for women with or without children

Developing a comprehensive referral source for MH/SA services in the agency's community.

6. Cross-training with County Mental/Behavioral Health Departments

Facilitating meetings and/or cross-trainings to build and/or strengthen relationships.

- r. Reaching out to MH/SA providers
- s. Coalition building strategies
- t. Creating workable MOUs
- u. Understanding legal and institutional cultures
- v. Contracting specialized services
- w. Creating community change

7. Crisis Hotline and/or Intake Interviewing Techniques

Providing specialized training to ask sensitive MH/SA screening questions and/or engage in motivational interviewing.

- x. Motivational interviewing

8. Cultural Competency

Acknowledging and distinguishing cultural interpretations of and cultural issues around mental health issues and treatment and substance abuse and treatment.

9. Organizational Capacity Building Related to MH/SA Service Expansion

Increasing service capacity both agency-wide and in targeted areas.

- y. Strategic planning for increasing organizational capacity
- z. Fund development
- aa. Grants management
- bb. Program management techniques
- cc. Policy and procedure development
- dd. Web-based computer training
- ee. Staffing and training
- ff. Marketing and outreach

FREQUENTLY ASKED QUESTIONS

How should I select which component to measure with each U/U population?

Great first question!!! You and your agency will need to figure this one out. Start by asking yourselves, “which of the U/U populations would we like to address to make our services more accessible?” Have a discussion about selecting the population with your staff, to get their input. Your selection may depend on a combination of factors; you may want to address your agency’s “biggest blind spot” in terms of who you want to better serve. Alternatively, you may want to improve on something you’ve already started, and just want to continue improving. See the sample MPOI Vignette (in Section 3) about selecting your MPOI, if you need help getting started or imagining how this could work.

Can I request TA to specifically address the CQI component?

Sure, you can request TA for anything related to the U/U Access Project. Each of the three TriProject Contractors has a designated “evaluation consultant” or “evaluation staff.” They may refer you to this individual to help you better understand the CQI, PDSA, or even the development of a logic model to help you as you plan and implement changes.

Who do I call if I have a CQI question that is unrelated to a specific U/U population? Can I request a general CQI session?

Call any of the three TriProject Contractors. All have evaluation expertise either on staff or consultants.

Once I’ve completed the PDSA process, “then what?” If I see no change, what is my incentive to repeat the cycle?

Use the PDSA process to dissect what did and what did not work. Pull together the team of folks who worked on the PDSA; find out what they think about the process and the outcomes. Discussion will help you all figure out what worked, why or why not, and will likely help elicit ideas for modifying what you did on the PDSA. You may want to address the same MPOI again, but differently. Consult with one of your TA contractors to talk through your options too.

Do I have to use all these forms in the appendices?

Not unless you think that would be useful to you. Everything in the appendices is optional. Some agencies may find that some forms are helpful to them in tracking information for specific MPOIs.

APPENDICES

Appendix A: Sample Worksheets for PDSA and CQI

Blank Logic Model Worksheet

Blank PDSA Worksheet

Sample PDSA and CQI Timeline