Clark County Health Department
City: Winchester, KY
Population: 35,613

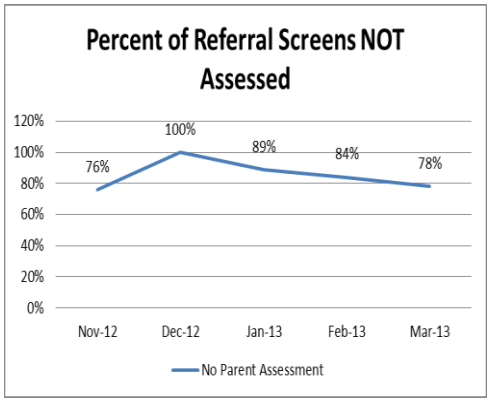
QI Team Members
Anne Hatton Rachel Gentry
Cara O'Neill Melissa Sparks
Krystal Walling Beth Willett

Improving Referral Rates For an Early Childhood Home Visitation Program

PLAN

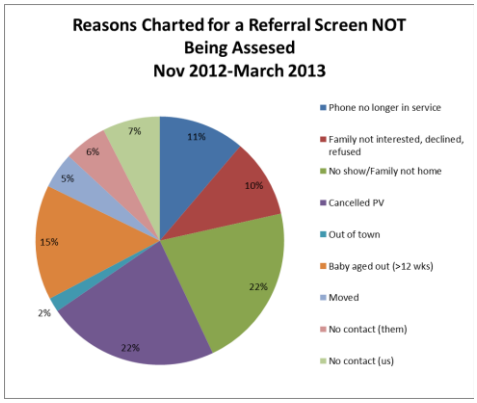
1. Background

The Clark County Health Department (CCHD) is working to improve its quality of service in the Health Access Nurturing Development Services (HANDS) program. HANDS is a voluntary home visitation program for expectant parents. HANDS aims to improve maternal and child health outcomes. To receive HANDS services, a family must complete a Parent Assessment. To be offered this service, families first receive a Referral Screen. If screen is positive, they can receive a Parent Assessment. Based on the results, some parents will receive HANDS support through home visitation. The need for improvement was demonstrated by an internal review revealing low rates of referral screens being assessed with a parent assessment. The process was studied from November 2012 through March 2013. Completion rates and reasons charted for not completing a Parent Visit were tracked as performance indicators.



2. Aim Statement

By July 31, 2013 the Clark County HANDS program will increase the percent of referral screens assessed with a parent assessment from 24% to 36%.



3. Examine the Current Situation

The team examined the current process using QI tools: flowcharting, cause-and-effect diagrams, 5 Whys
Current practices included:

- Two different forms were being used for Referral Screen
- Competing job demands for person designated as lead Parent Visitor (PV)
- Organization of referrals is by month of first contact- no way to quickly find babies aging out
- No incentive given to family for completing a parent assessment
- Babies are aging out without ever receiving contact from HANDS

4. Identify Potential Solutions

- Organize referral book by "prenatal" and "baby born" within month of first contact
- Give $10 gift card to families for completing the Parent Assessment
- Designate a new lead without a family case load or supervisory obligations
- Flag charts if phone challenges exist
- Use same form in Family Planning and WIC
- Only one person documents in referral book
- Other team members do not put referral screens into book

5. Develop an Improvement Theory

- Organizing the referral book by prenatal and baby born will help to reduce % of babies aging out
- The gift card will create incentive for parents to commit to a parent assessment visit
- Having a lead PV without competing demands on work time will increase percent of referrals assessed
- All team members will still put referrals in the book- do not want to cause a division of labor among the team
- Flagging the chart of those patients' experiencing phone challenges will increase likelihood we will make contact with them

DO

6. Test the Theory

The team implemented the process changes in April 2013. The Do phase ran through the end of June 2013, after which, the data was re-examined.

STUDY

7. Study the Results

The results from the pilot were recorded and analyzed in July 2013. The QI team facilitator and team leader counted the number of referrals for months April, May, and June 2013, and documented what percent of those referrals were assessed with a parent assessment.

CLARK COUNTY
HEALTH DEPARTMENT
AND
HOME HEALTH AGENCY

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7. Study the Results

The April 2013 referral assessment rate was 56%, May 2013 was 54%, and June 2013 was 52% (see trend chart below). This exceeds the original AIM statement goal of increasing assessment rates to 36% by July 31, 2013.

During the Plan phase of this project, the team decided to track the chart notes on the referral screens to quantify reasons why a parent assessment was not occurring. The charts notes were examined on referrals from April to June 2013 to see if process changes would impact some of these chart notes. The radar chart shows the changes in occurrences of chart notes pertaining to the referral screen receiving a parent assessment.

8. Standardize the New Theory

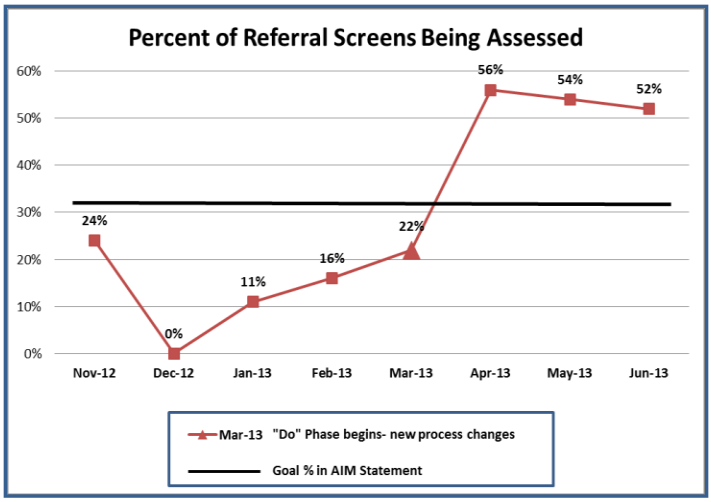
After studying the results of this pilot, the team chose to standardize the new process changes in August 2013. Significant improvements were found in the percent of families receiving parent assessments, thus increasing reach to the target population. Additionally, before this pilot, families were not benefiting from a parent assessment due to the HANDS team never contacting them or a baby aging out of services. Since the changes, the chart notes reveal all families are being contacted by HANDS, which may increase the likelihood of receiving a parent assessment. To protect the gains made during this project, the team will adopt the new changes into the standard process and continue to monitor performance.

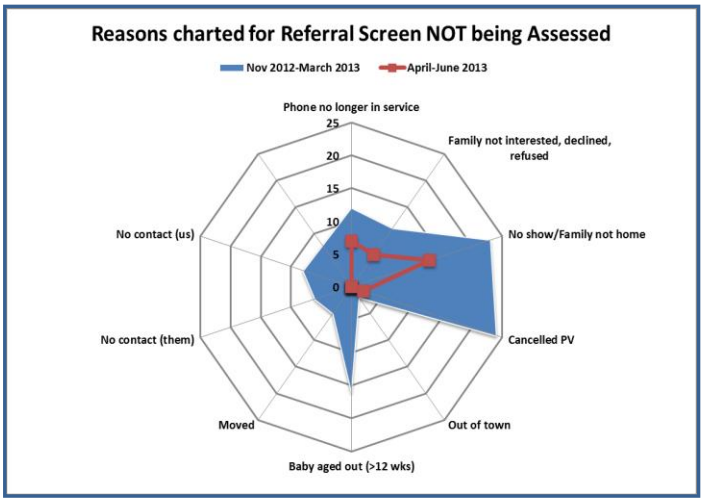
ACT

9. Future Plans

The HANDS team will continue to track the percent of referral screens assessed to defend the gains made through this QI initiative and to more rapidly detect when challenges may be occurring. The number of families engaging in home visitation services will also be tracked to determine efficiency of the parent assessment process. Two additional questions have been brought up from this initiative, which we are still exploring:

- How many contacts on average did it take to engage current HANDS families?
- How quickly are we contacting families after they cancel or no-show? How many re-contacts?





Changes Adopted into Standardized Process

- Lead team member without competing work demands will complete referral screen assessments
- Incentivize the parent assessment by giving a gift card to families after completing the assessment
- Restructure the organization of the referral book for easy identification of when a baby will age-out for services
- Flagging patient charts when we can not reach the patient due to phone issues (i.e. disconnected, voice mail not set up) to signal other health department staff to update contact information

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Starting our QI Team

- **Selection of team members**
  - Public Health Director
  - HANDS Director
  - QI Coordinator
- **Writing team charter**
  - QI Coordinator drafted
  - Team gave input at first team meeting
- **First team meeting**
  - Team building
  - Establish purpose of team
  - Explain timeline
  - Explain team roles: sponsor, coach, leader, member
  - Decide on ground rules
  - Finalize charter
  - Decide on team leader (not QI Coordinator)
    - Empowering for another staff member
    - Assists with data collection and analysis
    - Meets with coach periodically
    - Helps plan meeting, team building
- **Subsequent meetings**
  - Work through each stage of Plan-Do-Study-Act (PDSA)
- **Resources**
  - Marni Mason, BSN, MBA, PMQI Consultant
  - NACCHO Quality Improvement Resources
  - NNPHI Public Health Performance Improvement Toolkit
  - Public Health Foundation
  - TEAM Handbook 3rd Edition

Role of QI Coordinator

- Teaches PDSA, QI tools, data collection and analysis
- Encourages team to seek out root causes of problem before identifying solutions
- Facilitates discussion, moves meeting along, adheres to time, handles conflict
- Works with team leader to plan meetings
- Focused more on the process than the decisions made by team
- Mindful of including those impacted by the process for input and feedback
- Stay objective throughout cycle
- Be transparent to team and leadership on progress

Quotes from final HANDS QI team meeting

- "I liked having people on the team outside of HANDS."
- "Being an outsider to HANDS, I learned about their processes, and understand what we can do in clinic to help them."
- "Encouraging that the results were great!"

QI Team: Back row L-R- Anne Hatton, RN; Melissa Sparks, MSW; Beth Willett M.S.; Front row L -R- Rachel Gentry, Cara O'Neill R.D.; Krystal Walling