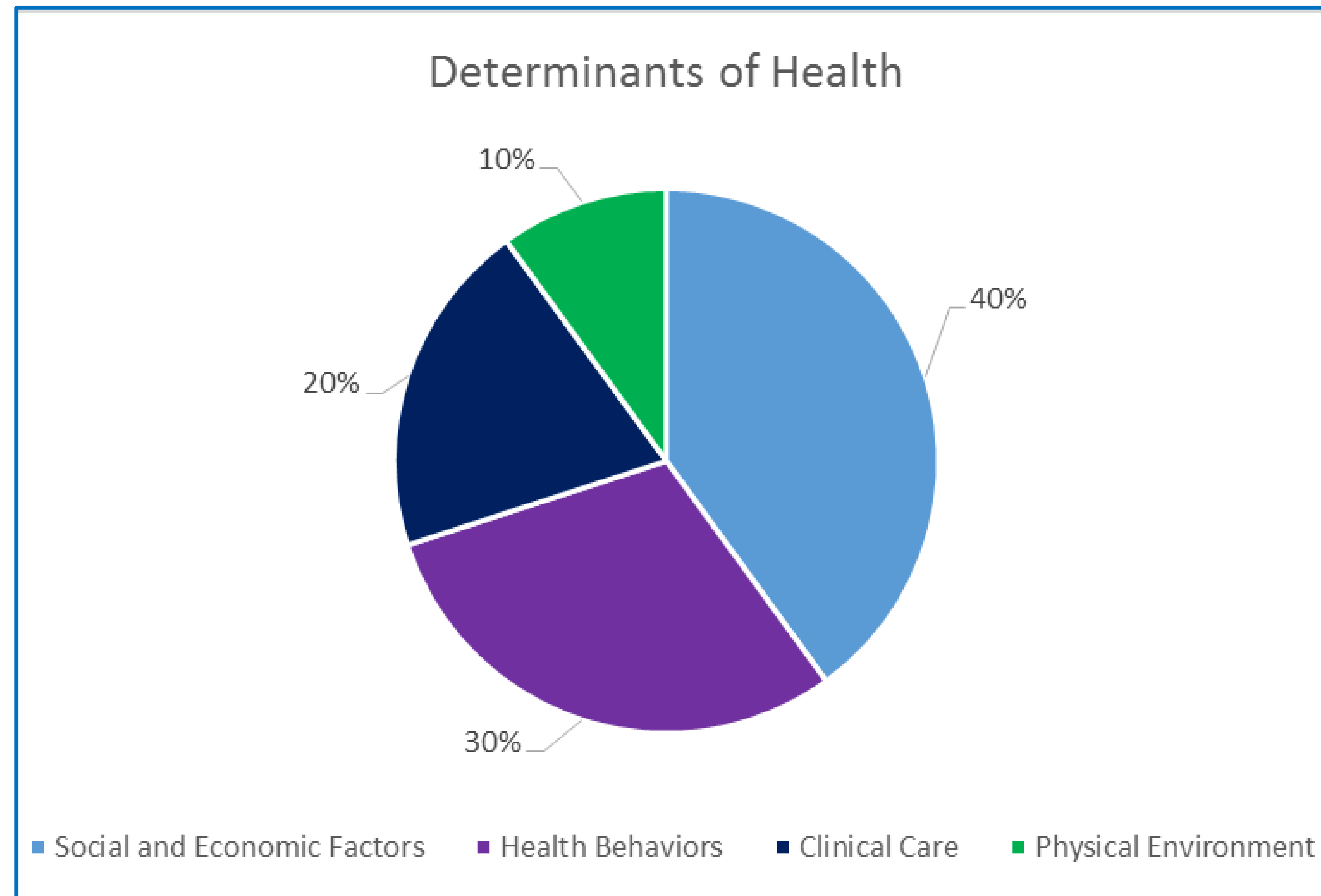
Improving Pediatric Primary Care Well Child Check (WCC) Completion in the First Months of Life

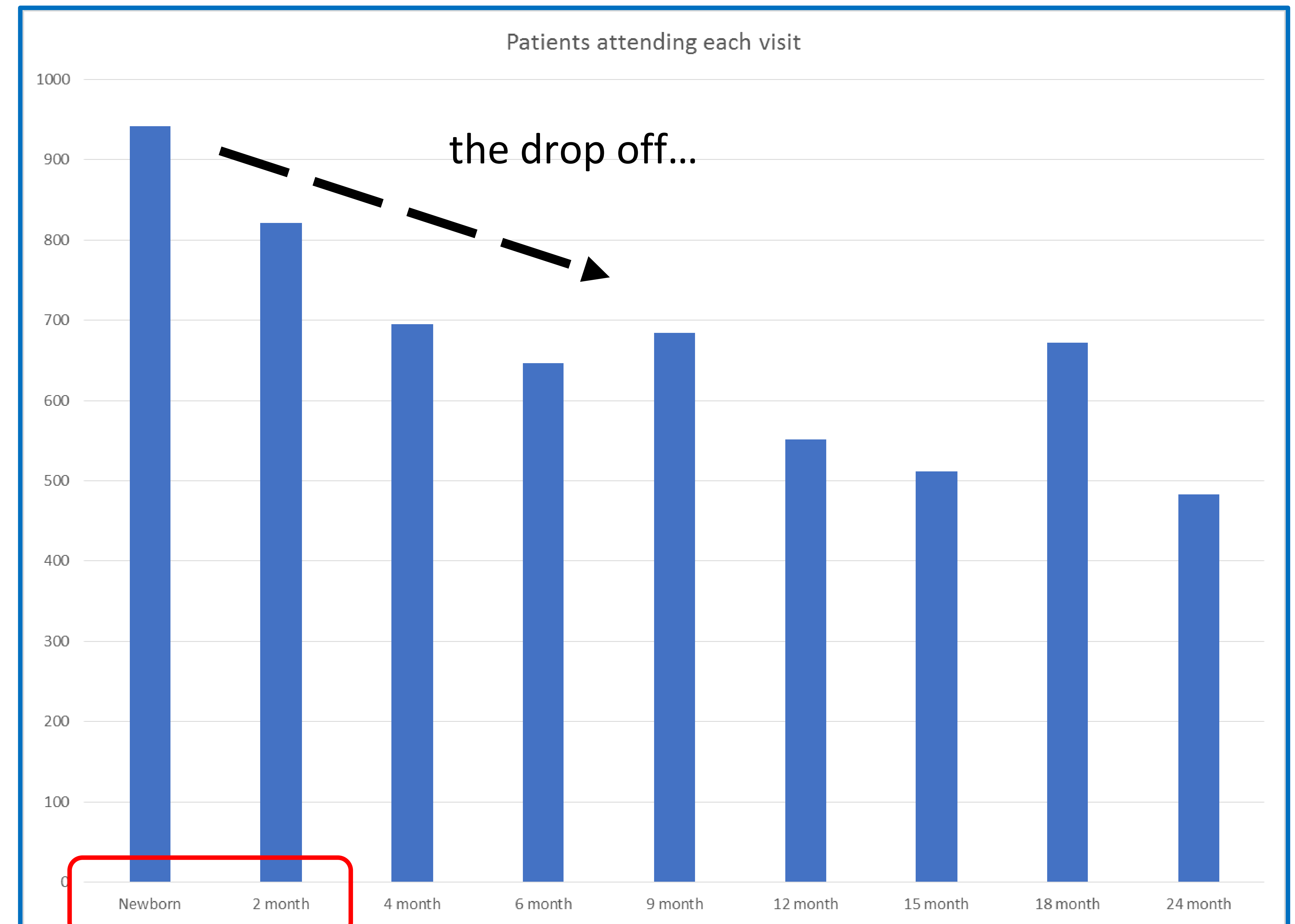
Sue Stiles, LISW-S

Cincinnati Children's
changing the outcome together

BACKGROUND



Source: Robert Wood Johnson Foundation



Source: CCHMC Gen Peds registry 12/2018

80% of what drives morbidity and mortality is outside of the healthcare system

A significant number of children do not return after their newborn visit.

Improving 2 month WCC completion in the PPC-Key Driver Diagram (KDD)

Project Leader(s):Sue Stiles

Revision Date: *5/9/2019 v#3*

Global Aim

To improve the health and well-being of all newborns

SMART Aim

To increase the percentage of patients who attend their 2 month WCC from 73% to 90% by May 16th, 2019.

Population

Babies who complete a Newborn appointment at the Pediatric Primary Care Clinic.

Key Drivers

- Patient centered newborn care
- Effective downstream community support via CHW's and/or CM's
- Proactive SW involvement with an identification of at-risk newborns
- Ease of scheduling follow up appointments at the PPC
- Educated and informed parents regarding WCC schedule
- Educated and informed staff on recognizing priority of newborn follow up care
- Available and visible NB tracker
- Preoccupation with Failure

Interventions (LOR #)

- Huddle with Staff twice per month regarding priority of newborn follow up (LOR# 1)
- CHW's will get list of scheduled at-risk patients and text appointment reminders to families (LOR#1)
- SW will see all at-risk newborns and assess for needs.(LOR#2)
- Adopted: Created Data Management Tracker for Newborns (LOR#2)
- Create tighter connectivity between CHW and NB visit
- MA/RN to schedule follow up appointments prior to end of NB visit (LOR#2)
- Redesign the newborn visit
- Real time identification of failures (LOR#2)

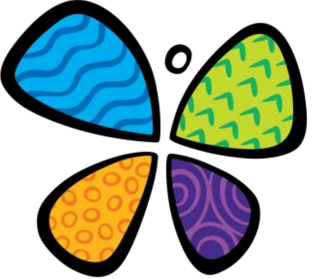
Legend

- Potential intervention
- Active intervention
- Adopted/Abandoned intervention

Note: LOR # = Level of Reliability Number, e.g., LOR 1

All Children Thrive Cincinnati

LEARNING CYCLES



a sample of my PDSA's!

PDSA Ramp Name: Appointment Scheduling at End of Visit

		Test Cycle 1	Test Cycle 2
PLAN	Test Description:	MA to schedule all required f/up appointments prior to the end of the visit	Increase to 2 Ma's and NB nurses doing the appt scheduling for newborns
	Objective:	Assess feasibility of MA's scheduling	Spread the scheduling

PDSA Worksheet – Improving PPC WCC Adherence of At-Risk newborns

Project SMART Aim: To increase the percentage of patients who attend their 2 month WCC from 74% to 90% by May 2019

PDSA Ramp Name: Newborn High Risk Indicator Assessment

		Test Cycle 1	Test Cycle 2
PLAN	Test Description:	SW Chart Review to see if identified at-risk newborns are coming back for 1 and/or 2 month visit	Newborn CHW's will do chart reviews on 31 patients who did not return and look at family no show

PDSA Worksheet – Improving PPC WCC Adherence of At-Risk newborns

PLAN: VALIDATION OF HIGH RISK INDICATORS

A. Briefly describe the test: SW Chart Review to see if identified at-risk newborns are coming back for 1 and/or 2 month visit (efforts geared to developing an Newborn EWS)

B. How will you measure the success of this test? Ability to track which newborns are identified as high risk and then whether SW saw the patient while in clinic and if patient returned for 1 and/or 2 month visit

C. What would success look like? High risk indicators are accurate in predicting which children may need more support

D. What do you predict will happen? We think that many of the identified at-risk patients are the same ones who are missing follow up appointments

DO: Test the changes. Was the cycle carried out as planned? ☒ Yes or ☐ No

Record data and observations. We haven't looked at the data yet, but it appears to be working

STUDY: Did the results match your predictions? ☐ Yes or ☐ No

ACT: Decide to Adapt, Adopt or Abandon (shade one box).

RESULTS

% Patients Completing 2 Month Well Child Check
November 2018 to Present

Desired Direction of Change

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

PDSA Scheduling
PDSA High RIsk Indicators
PDSA No Shows
PDSA CHW Assigned
PDSA: Texting
PDSA: Converting Ill to WCC
PDSA: Embedded CHW in PPC

11/18/2018 (n=21)
11/25/2018 (n=18)
12/02/2018 (n=35)
12/09/2018 (n=31)
12/16/2018 (n=19)
12/23/2018 (n=21)
12/30/2018 (n=18)
01/06/2019 (n=25)
01/13/2019 (n=37)
01/20/2019 (n=17)
01/27/2019 (n=21)
02/03/2019 (n=17)
02/10/2019 (n=17)
02/17/2019 (n=20)
02/24/2019 (n=15)
03/03/2019 (n=16)
03/10/2019 (n=18)
03/17/2019 (n=20)
03/24/2019 (n=17)
03/31/2019 (n=14)
04/07/2019 (n=18)
04/14/2019 (n=22)
04/21/2019 (n=16)
04/28/2019 (n=20)
05/05/2019 (n=20)

% Completed
Median
Goal

MOST PROUD OF

- Number of other staff who have become involved and engaged in the process.
- Getting the staff to schedule appointments and testing a CHW embedded in clinic.
- An increase in the percentage of 2 month olds that are following up for Well Child Checks.

GREATEST CHALLENGE

- Keeping team members motivated when there were so many new initiatives and “asks” for staff.
- Keeping up with the data collection.
- Getting other people to see the benefits of making changes.

TEAM MEMBERS

Sue Stiles (Susan.Stiles@cchmc.org)

- Becky Haehnle, Kelly Vogelpohl (Newborn Coordinators)
- Alicia Reynolds, Allison White, Nikki Acosta, La'Voya Behanan (Community Health Workers)
- Theresa Popelar, Sarah Goldschmidt-Jarvis, Ashli Dees (Clinic Social Workers)
- Nick DeBlasio, MD
- Lashawn Lancaster, MA
- Julie Kleiman, RN Clinic Manager