MIECHV Coordinated Intake & Referral Pilot
Continuous Quality Improvement
Best PDSA Tests!

Alachua

Aim: By 8/31/17, the Family Partner will engage more caregivers in CI&R.

The most useful PDSA occurred in February, 2017 when the Family Partner shadowed the birth certificate clerk at UF-Health Shands in the Mom/Baby Unit. During this test, the goal was to ensure that the Family Partner could meet with each new Alachua County mother after she completed the infant screen with the birth certificate clerk. The birth certificate clerk was often asked to take on other job duties throughout the day, so when the Family Partner had to wait for her to finish other tasks it was not a good use of the Family Partner's time. Shadowing the birth certificate clerk was not an effective way of meeting with the new mothers. After this PDSA was completed, they determined that the Family Partner would get a list of all the Alachua County residents who had delivered and meet with them on her own to determine if they wanted or needed home visiting services or additional supports that were available through our CI&R project.

Bay

Aim: By May 31, 2017, ten families will be enrolled who match the new enrollment criteria (substance abusing or teen with child less than 3 years).

The most useful PDSA was the original diagram that determined who they would provide CI&R referrals to and how they would be integrated into the system of care. The initial target population was teens and substance using pregnant moms. The diagram was used to refer clients to Mothers and Babies and the Parents as Teachers program. In their testing, this site focused on adding additional target populations and found that incorporating infants for Early Steps was not useful as no referrals were made. They used their learning process to ensure that each program was represented to the moms in a non-overwhelming fashion and in a non-duplicative process.

Duval

Aim: By September 30, 2017, 75% of families referred and determined to need services will have been enrolled in Home Visiting or another appropriate program.
In their most useful cycle, they tested the accuracy of their decision tree and zip code directory. If these tools were accurate, then the tracking log would indicate that clients were offered the correct program. To complete this test, the potential clients' names were sent to the Coordinated Intake/Data specialist, then it was added to the CI&R tracking log. Once the potential clients were offered programs by RPC (Regional Processing Center) staff, through the CI&R process which utilized the decision tree and the zip code directory, their referral forms were sent to the Intake/ Data specialist to review and verify if they were offered the correct program. The results were higher than our predication, showing 98% of the clients were offered the correct program. They learned that the RPC staff was knowledgeable of the programs to offer. This information demonstrated transparency and assured all programs that their perspective program would be offered as a choice when warranted. The CQI work helped them think collectively of things that could be done to ensure that CI&R was operating smoothly for the families and partners. It also sparked ideas of what each program could institute within their organizations to monitor and improve engagement and retention.

Flagler-Volusia

Aim: By September 30, 2017, 75% of families referred and determined to need and desire services are enrolled in home visiting or another appropriate program.

In June, this site continued to test a revised referral form for all program services in the coordinated system of referrals. Community program descriptions were added. As predicted, they continued to increase the number of referrals and assignments to programs. Community understanding of program descriptions aided in the increase in coordinated intake & referral (CI&R). In August, this site reported that 83% of CI& R clients were successfully contacted within 14 days and 70% were enrolled in a program.

JMT

Aim: By September 30, 2017 100% of local CI&R Agencies are effectively using the JMT decision matrix and MOA that aligns program capacity, program criteria, and characteristics of participants that ensures the best fit for families and optimal utilization of services in Jefferson, Madison and Taylor Counties.

This team's most useful PDSA cycle was focused on the measurement of the feedback loop. Data gathered since October 2016 was actually insufficient to measure the feedback loop and implementation of the decision tree.The local CI&R team must each actively participate in the data collection portion and measure the same outcomes across all programs. The group decided to measure engagement rates, transition to other service providers within the team, and document feedback on referrals by the originator of the referral. The JMT team expanded its data collection in order to adequately test its project aim. In August, the local team decided each agency would measure engagement rates, defined as a successful contact and at least one service. Data would be shared quarterly with the group and used to Plan-Do-Study-Act, using the Driver Diagram for CI&R to improve engagement rates across all service providers.

Hillsborough

Aim: To improve client engagement in a home visitation program after Initial Contact is completed.

In August 2017, an analysis was conducted measuring each Intake Coordinators' rate of engagement to determine how many clients continue into case management. In addition, the supervisor monitored phone calls to gather information on the communication styles of each Intake Coordinator. A meeting was held with Central Intake Staff to discuss the PDSA. A script was provided to staff to disclose that phones calls will be monitored. Phones were programmed in order for supervisors to monitor client calls. An analysis of referral patterns of each coordinator's referral patterns was completed. Results showed opportunities for improvement for both the team and individual coaching. Individual meetings were completed and group training and individual training was held in July. Variability among staff was expected. The importance of monitoring individual coordinator's communication and referral patterns was identified. Opportunities for standardizing messages provided to clients in order to increase client engagement were identified. Efforts will continue to increase engagement through an implementation plan that includes a plan for sustainability and testing the implementation. Monitoring of calls will continue. Coaching for both the team and individuals will continue. The engagement rate for August was measured and increased to 42.3%.

Manatee

Aim: By October 31st, Healthy Start triage and care coordination staff will be generating 15 referrals per month (50% of Healthy Families monthly assessment quota) to Healthy Families.

In August, this site tested offering referrals right away, instead of implementing a two-week delay for Healthy Families outreach, They predicted that more families would be offered referrals and result in a higher number of referrals for the HV programs. Program Eligibility Forms (PEF) were dispersed as screens were assigned to triage coordinators and care coordinators in the clinical setting. The P.E.Fs were distributed as cases were assigned or as soon as the CI&R Project Coordinator received them. However, extenuating health circumstances with DOH-Manatee staff caused a disruption in the timely entering of screens, thus causing a delay in the receipt of screens by the CI&R Project Coordinator. As a result, 7 families in one week were not offered a referral to HV programs as their cases were closed prior to CI&R Project Coordinator receiving screens from the CHD. In the first week of the month, an increase in referrals was noticeable. However, due to the delay caused by the CHD the remainder of the month was slower with fewer-than-expected referrals being generated. The initial increase in referrals matched our predictions. However, the disruption in screen flow through the CHD to HSC Manatee muddled results. The initial increase is indicative that distributing PEFs with case assignments can be effective. It was also

noted that the offering of HV programs was better documented in case notes, though the offering may not have resulting in an actual referral.

OOS

Aim: By 7/31/2017 the OOS CI&R Process Pilot at three birthing hospitals located in Orange, Osceola and Seminole counties will report an increase of 10% in the number of families consenting to and accepting referrals to needed HV services.

This site identified two infant PDSA tests as their best because they highlighted results that necessitated abandoning the strategy and designing different strategies to test. From February to April, this site established a coordinated intake and referral process at one hospital (Winnie Palmer) serving three counties. The test of this intake and referral process was conducted one day per week for 90 days. This process consisted of conducting intake utilizing a newly developed universal form, educating families on home visiting programs available and providing warm referral if services were requested. In April, this pilot was abandoned because 1) only 1/3 mothers were consenting to the prescreen resulting in a low number of referrals despite a large amount of resources allocated to the process; 2) time constraints due to typical 24 hour discharge from that birth hospital; and maintaining sufficient staff across all became a challenge. Some participating agencies have challenges remitting information for intake and referral tracking purposes. In May, the strategy was adapted to move the pilot to individual birthing hospitals in each county, starting with Florida Hospital Orlando, staffed by two home visiting programs. Fluctuations in the number of pilot days contributed to a lower number of program referrals but they researched other reasons for low number of infant referrals. There are fewer births at Florida Hospital than Winnie Palmer so fewer referrals are generated. Several issues were identified that make postpartum engagement of mothers in the hospital a challenge. In July, an issue was identified with the log created to capture and track CI&R referral status by the pilot staff. Due to data collection issues, the workgroup redesigned and implemented the screening form developed from the first pilot at WPH for pilot team use at FH. The team also agreed to place greater emphasis on staff adherence to the CI&R script.

Best practices identified in the CQI process:

- CI&R worker in hospital, with a list of births in the catchment area, meets with mothers to determine needs for home visiting program or additional supports.
- Decision Tree/CI&R Referral Diagram is necessary to help determine program eligibility. A decision matrix and MOA that aligns program capacity, program criteria, and characteristics of participants that ensures the best fit for families and optimal utilization of services.
- CI&R staff must be knowledgeable about the programs they will offer clients.
- Periodic review of referrals using the decision tree and zip codes helps ensure accurate referrals, transparency and community confidence.
- Community understanding of program descriptions leads to an increase in coordinated intake & referral (CI&R). Home visiting program partners need a thorough understanding of one another's home visiting programs.
- When infant screening takes place at a birth hospital outside the catchment area, it is necessary to work out a protocol that ensures timely information sharing.
- Data is needed to measure effectiveness of the decision matrix and adherence to the system and engagement rates. The local CI&R team must each actively participate in the data collection portion and measure the same outcomes across all programs Data might include timeliness of referrals, transition to other service providers within the team, feedback on referrals .
- A CI&R manual may be helpful to guide CI&R staff and standardize procedures.
- Standardizing messages provided to clients may help increase client engagement and monitoring individual coordinator's communication and referral patterns may identify opportunities for improvement.
- Training and education for the front-line staff of Healthy Start on home visiting program eligibility and program focus as well as training on family engagement.
- It may be best to start small and refine the pilot before spreading to other counties or multiple hospital systems.