Prototype 3: Warm Handoffs

Cradle Cincinnati Learning Collaborative Fall 2016 Learning Session

April Griffin, CCHW, TriHealth Outreach Ministries

Karen Hills, RN, BSN, CCM, Good Samaritan Hospital

Learning Objectives

- Identify key drivers for Prototype 3
- Understand at least two best practice PDSAs for Prototype 3
- Create a customized KDD for Prototype 3 with my team
- Plan out for my team at least 2 PDSA cycles or 1 Ramp for Prototype 3

AIM:

- Increase the number of Avondale and Price Hill patients receiving a community health worker visit within 10 days of receiving the referral from 38% to 50% by December 31, 2016.

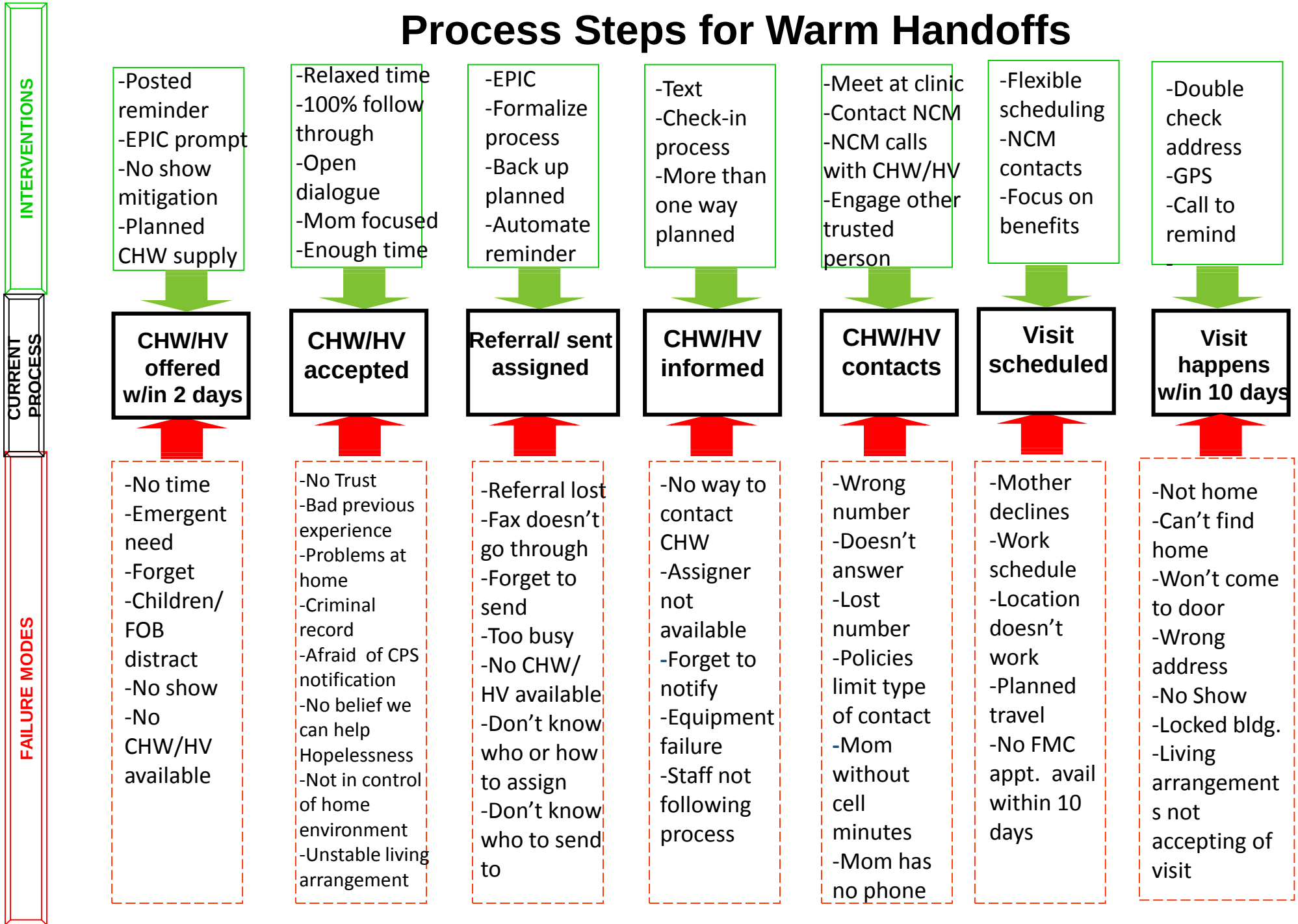
History of FMC warm handoff improvement

- StartStrong initiative to reduce prematurity
- Place based—Avondale and Price Hill
- Early lesson that clinic and home links are essential to outcomes

Our approach:

- Deep understanding of the steps of our process
- Brainstormed what could go wrong and what we could do to prevent it
- Analyzed what would need to be true for us to reach our goal.
- Used quality improvement tools to help us
- Designed interventions

Process Steps for Warm Handoffs



Cincinnati Children's
changing the outcome together

Revision Date: 11-2-16
(v4)

Cradle Cincinnati Learning Collaborative Prototype 3 Key Driver Diagram (KDD)

Karen

GLOBAL AIM

Eliminate all infant deaths in Hamilton County

SMART AIM

Increase the number of Avondale/Price Hill FMC patients receiving community health worker visit within 10 days of referral from 38% to 50% by December 31, 2016.

KEY DRIVERS "WHAT"

1. Rapid, trusted Mom, NCM, CHW relationships
2. Perceived need
3. Enough CHW/HV supply
4. Services to meet needs (ex. housing, transportation)
5. Rapid referral and contact
6. Team comfort and confidence with one another
7. Preoccupation and mitigation of system failures

INTERVENTIONS "HOW"

- Welcome contact 1st visit red carpet
- Pre-visit planning and huddle
- Reliably use Contingency Plan discussion prompts
- Develop models to project need and match supply
- Legal Aid partnership for housing, domestic violence and benefits issues
- Automated referral through EPIC
- CHW calls/texts with NCM/mother within 4 days
- Flexible scheduling of visit time and location
- Weekly huddle to discuss hard to engage mothers

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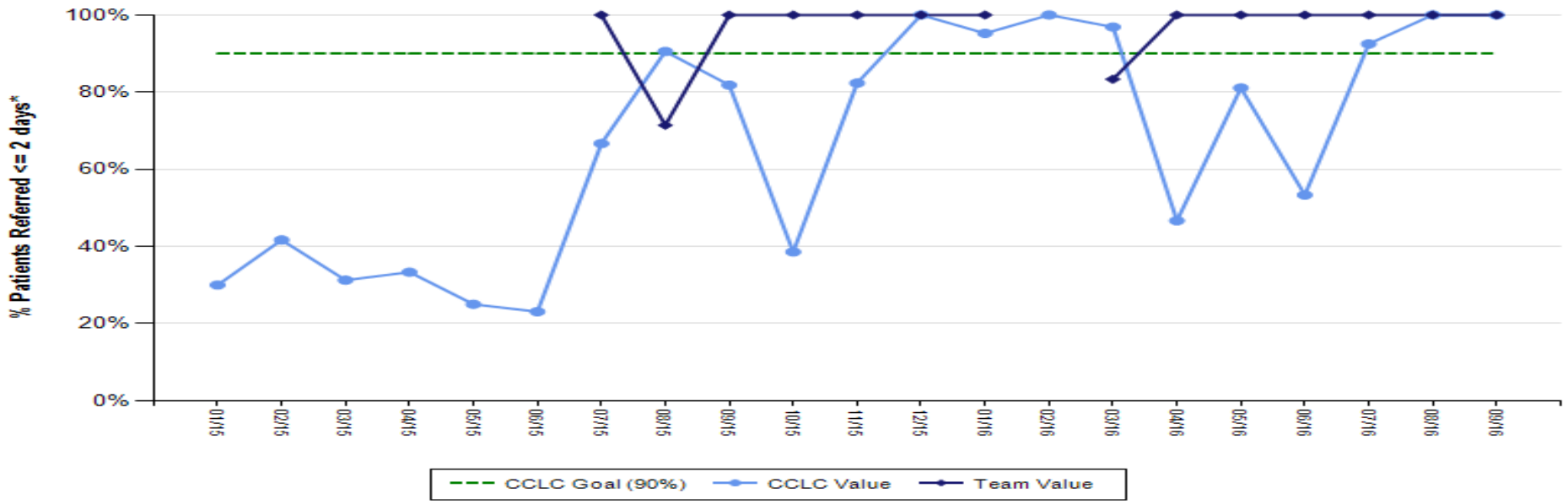
LEARNING COLLABORATIVE

Cradle Cincinnati Learning Collaborative
% New OB Patients Referred to Community Health Worker within 2 days
Good Samaritan Hospital/TriHealth Outreach Ministries

Desired Direction of Change



	01/15	02/15	03/15	04/15	05/15	06/15	07/15	08/15	09/15	10/15	11/15	12/15	01/16	02/16	03/16	04/16	05/16	06/16	07/16	08/16
# Community Health Worker (CHW), Home Visitor (HV), or Case Manager(CM) referrals sent <= 2 business days of first OB visit *business days = Monday--Friday (exclude Saturday and Sunday)	-	-	-	-	-	-	3	5	3	7	7	9	2	-	5	8	5	7	6	6
# Patients referred for first CHW, HV, or CM visit	-	-	-	-	-	-	3	7	3	7	7	9	2	-	6	8	5	7	6	6
Measure Value	-	-	-	-	-	-	100%	71.4%	100%	100%	100%	100%	100%	-	83.3%	100%	100%	100%	100%	100%
# of Sites scoring >= 90%	0	0	0	0	0	0	2	1	1	3	2	4	4	3	4	3	5	3	5	6
# of Sites Reporting	1	1	1	1	1	1	3	3	2	5	3	4	5	3	6	6	6	5	7	6

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% New OB Patients Referred to CHW, HV, CM <= 2 days* After First OB Visit

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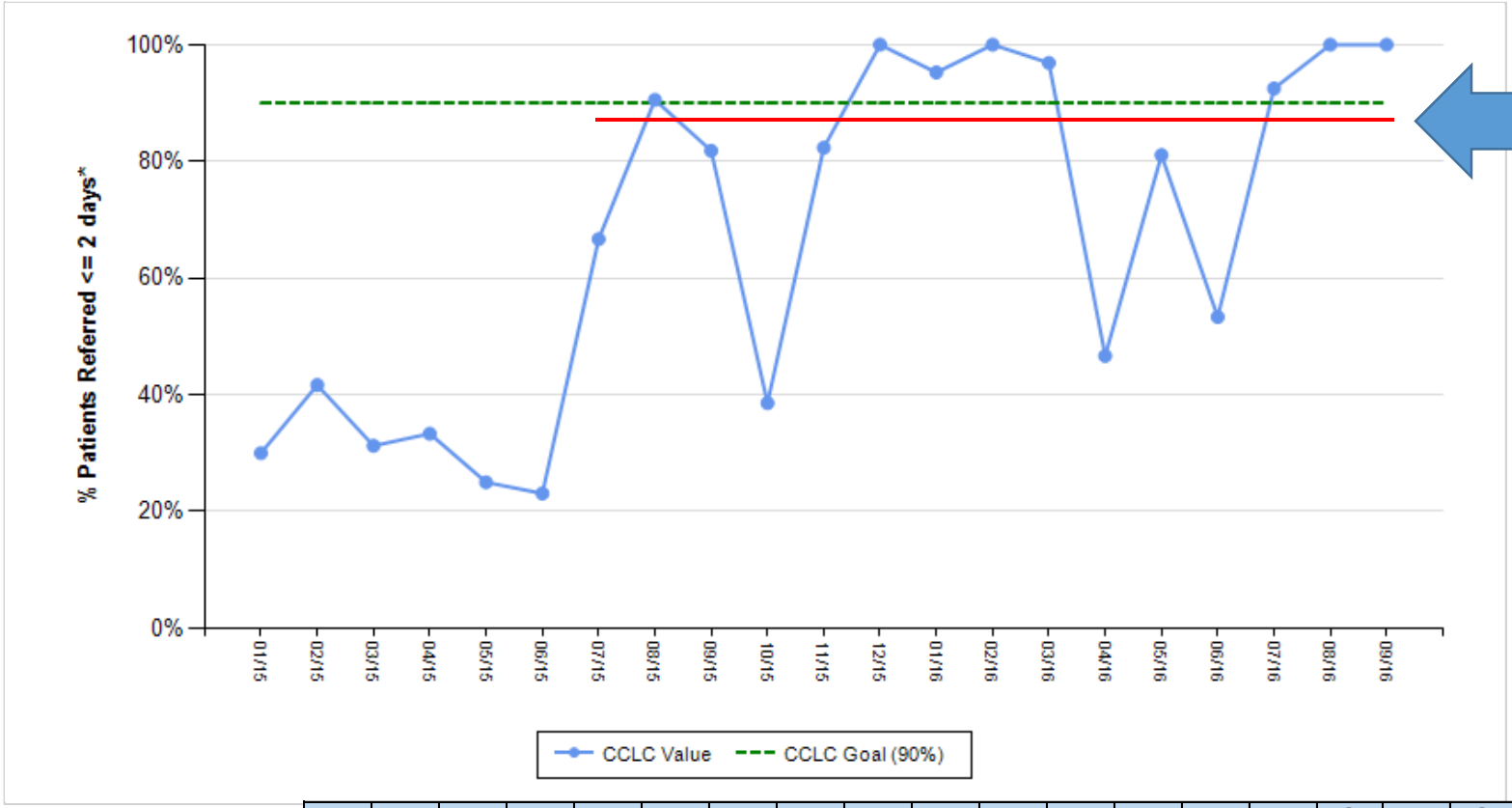
Desired Direction of Change



Baseline Median 86% (centerline)

	01/15	02/15	03/15	04/15	05/15	06/15	07/15	08/15	09/15	10/15	11/15	12/15	01/16	02/16	03/16	04/16	05/16	06/16	07/16	08/16	09/16
# Community Health Worker (CHW), Home Visitor (HV), or Case Manager(CM) referrals sent <= 2 business days of first OB visit *business days = Monday--Friday (exclude Saturday and Sunday)	3	5	5	4	3	3	10	67	9	86	14	40	20	50	93	28	60	16	37	31	18
# Patients referred for first CHW, HV, or CM visit	10	12	16	12	12	13	15	74	11	223	17	40	21	50	96	60	74	30	40	31	18
Measure Value	30.0%	41.7%	31.3%	33.3%	25.0%	23.1%	66.7%	90.5%	81.8%	38.6%	82.4%	100%	95.2%	100%	96.9%	46.7%	81.1%	53.3%	92.5%	100%	100%
# of Sites scoring >= 90%	0	0	0	0	0	0	2	1	1	3	2	4	4	4	4	3	5	3	5	6	2
# of Sites Reporting	1	1	1	1	1	1	3	3	2	5	3	4	5	4	6	6	6	5	7	6	2

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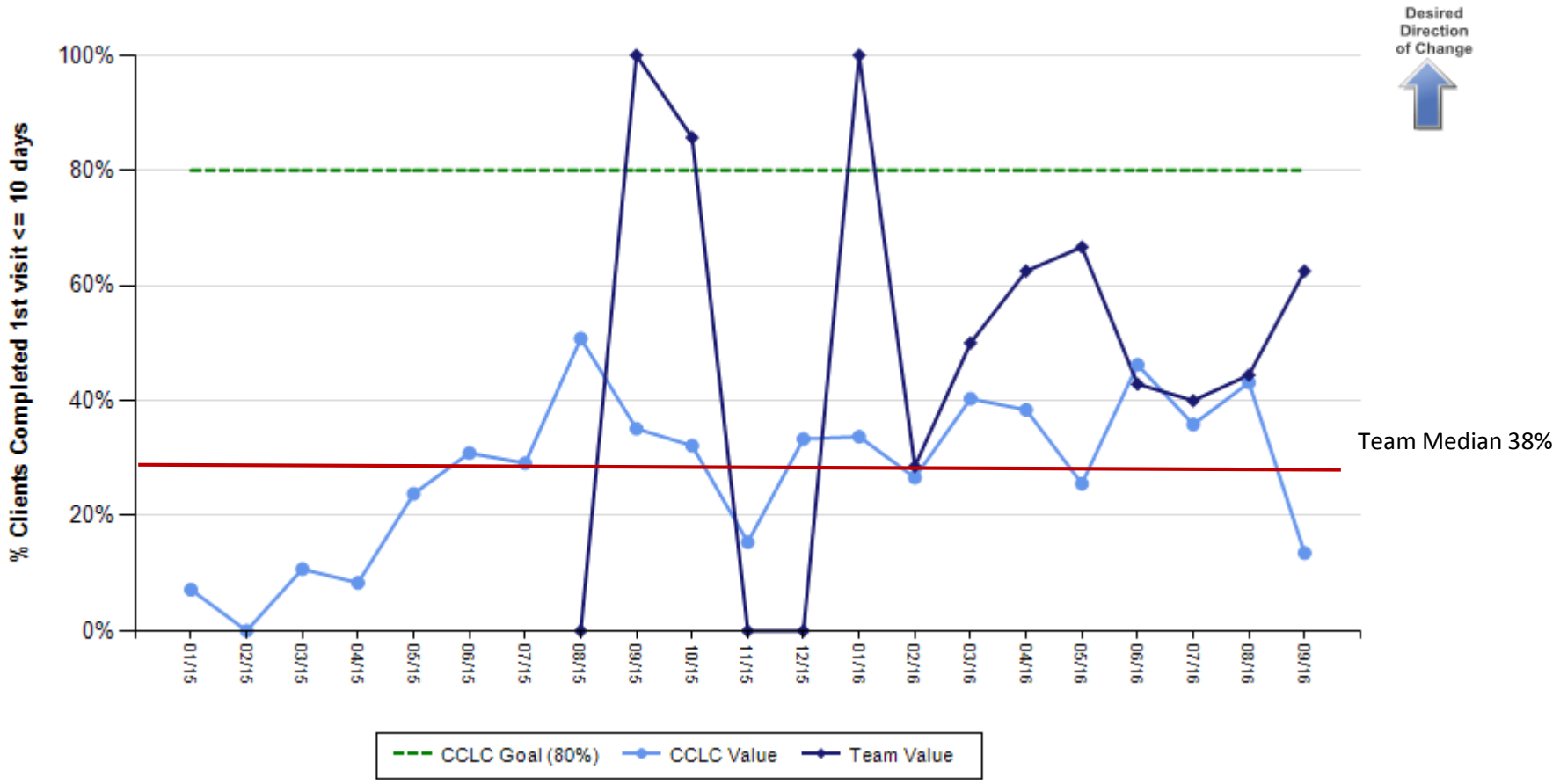
% of women receiving first home visit within 10 days of referral
Good Samaritan Hospital/TriHealth Outreach Ministries



Team Median 38%

	01/15	02/15	03/15	04/15	05/15	06/15	07/15	08/15	09/15	10/15	11/15	12/15	01/16	02/16	03/16	04/16	05/16	06/16	07/16	08/16	09/16
# Community Health Worker (CHW), Home Visitor (HV), or Case Manager(CM) first visits completed <= 10 days of receipt *receipt = date documented that referral was received by community team	-	-	-	-	-	-	-	0	3	6	0	0	1	2	3	5	2	3	2	4	5
# Clients referred for first CHW, HV, or CM visit	-	-	-	-	-	-	-	7	3	7	7	10	1	7	6	8	3	7	5	9	8
Measure Value	-	-	-	-	-	-	-	0%	100%	85.7%	0%	0%	100%	28.6%	50.0%	62.5%	66.7%	42.9%	40.0%	44.4%	62.5%
# of Sites scoring >= 80%	0	0	0	0	0	0	2	2	1	3	1	1	2	1	1	0	2	2	2	3	0
# of Sites Reporting	2	2	2	2	2	3	8	9	7	9	7	9	9	8	9	8	11	10	11	10	4

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% Clients with Completed First CHW, HV, or CM visit <= 10 days of Receipt* of Referral

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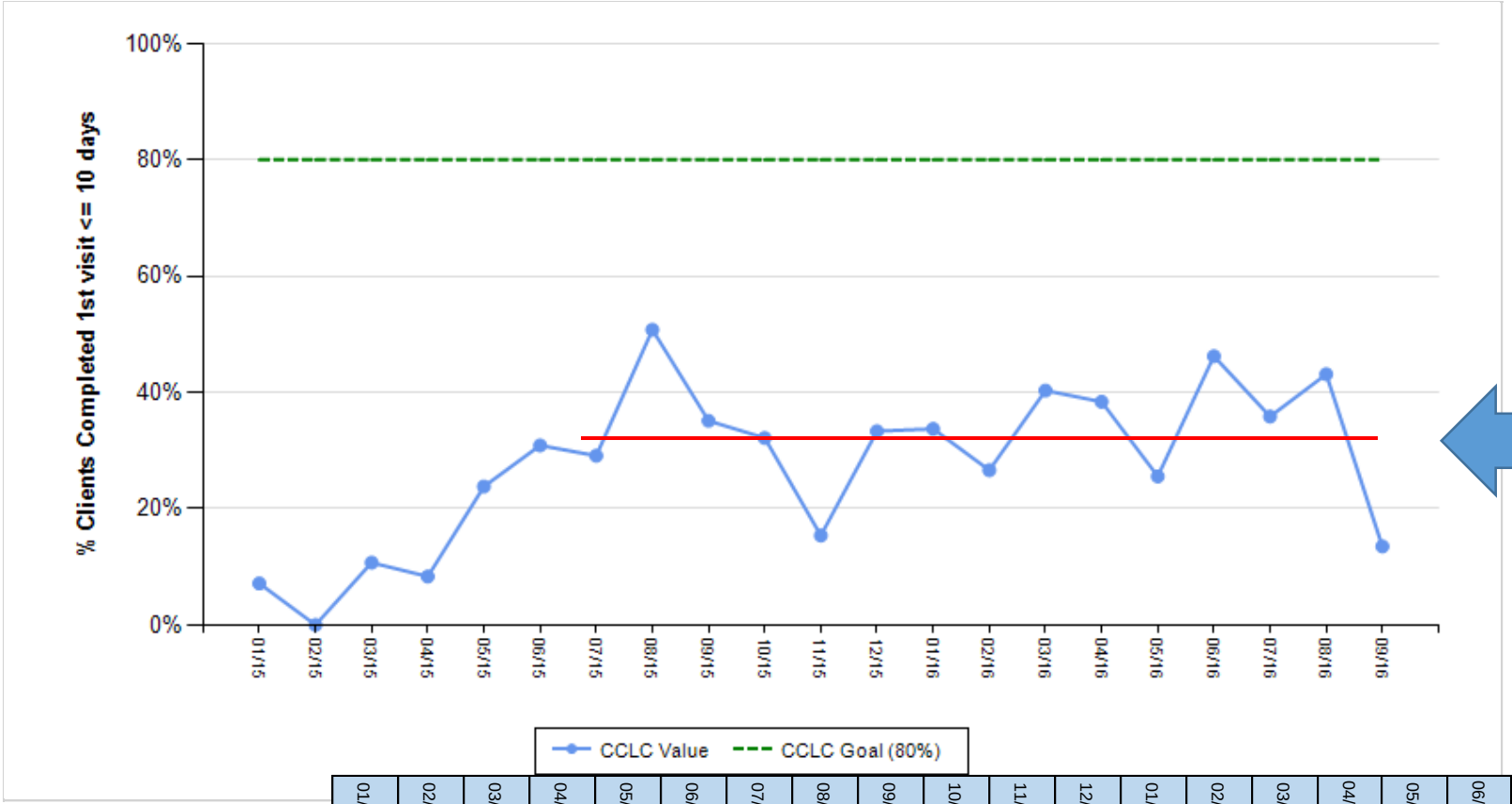
Desired Direction of Change



Baseline Median 33% (centerline)

	01/15	02/15	03/15	04/15	05/15	06/15	07/15	08/15	09/15	10/15	11/15	12/15	01/16	02/16	03/16	04/16	05/16	06/16	07/16	08/16	09/16
# Community Health Worker (CHW), Home Visitor (HV), or Case Manager(CM) first visits completed <= 10 days of receipt *receipt = date documented that referral was received by community team	1	0	3	2	5	21	39	98	33	91	8	38	29	29	50	38	35	49	57	47	5
# Clients referred for first CHW, HV, or CM visit	14	11	28	24	21	68	134	193	94	283	52	114	86	109	124	99	137	106	159	109	37
Measure Value	7.1%	0%	10.7%	8.3%	23.8%	30.9%	29.1%	50.8%	35.1%	32.2%	15.4%	33.3%	33.7%	26.6%	40.3%	38.4%	25.6%	46.2%	35.9%	43.1%	13.5%
# of Sites scoring >= 80%	0	0	0	0	0	0	2	2	1	3	1	1	2	1	1	0	2	2	2	3	0
# of Sites Reporting	2	2	2	2	2	3	8	9	7	9	7	9	9	8	9	8	11	10	11	10	4

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LEARNING COLLABORATIVE

Discussion

- What are your experiences with CHW/HV referrals?
- What have you tried?
- What are your biggest barriers?
- Does your team know each other and have confidence you can count on one another?
- Do you have a way to talk to clients about the benefits of a community health worker?
- How do you overcome objections?