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

Sue Stiles, LISW-S
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.

BACKGROUND

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

Source: CCHMC Gen Peds registry 12/2018

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

Source: Robert Wood Johnson Foundation

Determinants of Health

- Social and Economic Factors
- Health Behaviors
- Clinical Care
- Physical Environment

Source: CCHMC Gen Peds registry 12/2018
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!
RESULTS

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

Desired Direction of Change

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

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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