

## Ingham County Health Department MIHP

Home Visiting Program Model: Maternal Infant Health Program (MIHP)

Counties Served: Ingham County, Michigan

Population Served: Pregnant women and children under the age of 1.

## CQI Team Members:

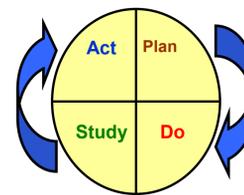
Regina Traylor- Public Health Nursing & Special Programs Administrator (Team Leader)

Kimberly Fiero – Public Health Nurse & MIHP Coordinator (Scribe)

Cassandre Larrieux- Health Analyst (Facilitator)

## Quality Improvement Story Board

Increasing the Length of time Families are Enrolled in the Program



## Plan

Identify an Opportunity and Plan for Improvement

### 1. Getting Started

In December 2012, the Ingham County Health Department (ICHD) submitted a proposal to engage in a statewide collaborative in order to implement Quality Improvement (QI) strategies through the Michigan Maternal Infant Early Childhood Home Visiting (MIECHV) program. After receiving funding, the first phase of the project was focused on families not receiving the number of home visits that they should. Since implementation of this phase, the team identified challenges with the number of families that are withdrawing/disengaging in the program before receiving their recommended service dose.

#### Problem Statement

The ICHD MIHP Program could keep families engaged until they receive a therapeutic dose.

### 2. Assemble the Team

The ICHD QI team members assembled based on different areas of expertise which are related to but not limited to MIHP, home visiting and infant mortality, and disparities. The team committed one hour per week to the QI project. The team focused on key issues identified when developing the problem statement.

#### Aim Statement:

By September 2013, HDI will increase the length of time families are enrolled in the Maternal Infant Health Program by 5%.

### 3. Examine the Current Approach

During the first PDSA cycle conducted by the QI Team, only one home visitor implemented the test during the DO stage of the project. Since this particular PDSA cycle is intended to build on the improvement theory tested through the first cycle, the team determined that it made sense to expand the initiative beyond one home visitor to all MIHP home visitors.

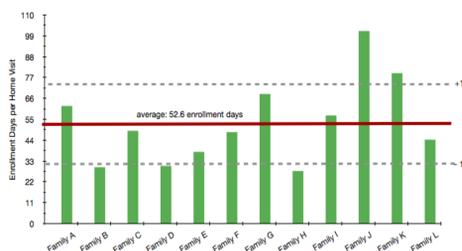
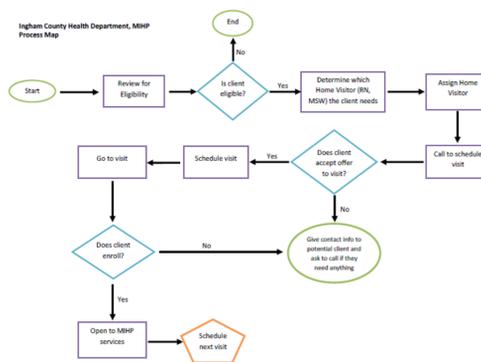


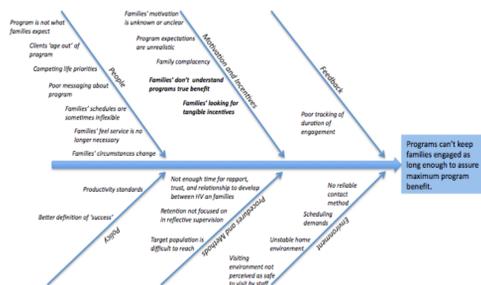
Figure 1

Figure 1 displays the number of days of enrollment for twelve families normalized for # of home visits for the month of May in 2013. The average number of enrollment days for the whole group, normalized for the number of visits, is 52.6 days. Among the different families there is wide variability in the number of enrollment days per visit. Some families experience 23.7 enrollment days per visit while others have as much as 101.5 enrollment days per visit.

### Process Map



### Fishbone Diagram



### 4. Identify Potential Solutions

- Incorporation of new magnets with ICHD contact information will be provided to each home visitor (HV) to distribute during first home visit. The magnet will be attached to the client's refrigerator with a reminder card containing the HV name, date of next visit and contact information. Phase I utilized one MIHP provider. At the end of the first PDSA cycle ICHD MIHP expanded implementation of the improvement to additional HV.
- The QI team brainstormed with MIHP providers during a staff meeting to determine how to maintain the interest of the program's clients. After that session, the QI team determined other possible incentives that could be offered, including:
  - All clients upon the second visit will receive a maternal and or infant/child journal. The goal of the journal is to encourage clients to write down questions for the home visit and doctor's appointments. The journal also provides information regarding the pregnancy or development of the child. Clients will also be encouraged to journal about their pregnancy.
  - A rattle will be provided to the postpartum clients as a developmental tool to encourage the baby to grasp.

### 5. Develop an Improvement Theory

If ICHD MIHP adds incentives in addition to refrigerator magnets, then the length of time families are engaged in the program will increase.

## Do

Test the Theory for Improvement

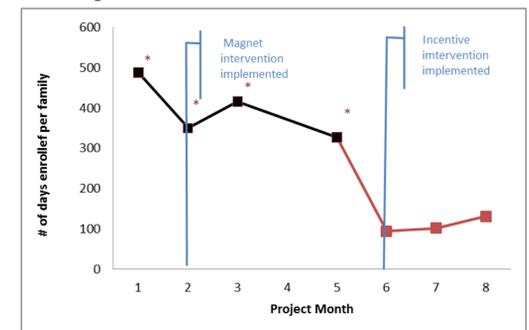
### 6. Test the Theory

The team reviewed enrollment data for each family each month. During the review the team came up with an average number of days per family. The team used the average number of days per family to test the theory by implementing use of the incentives outline in step 4.

## Study

Use Data to Study Results of the Test

### 7. Study the Results



A misunderstanding regarding reporting may have resulted in inaccurate reporting results for months 1 (January) through 5 (June) of the project. Nevertheless, preliminary data from months 6 (July) through 8 (September) show an increase of 8% in the average number of days enrolled per family between month 6 (July) and 7 (August). Between months 7 (August) and 8 (September) there was an increase in the average number of days enrolled per family of 18%.

## Act

Standardize the Improvement and Establish Future Plans

### 8. Standardize Improvement Theory or Develop New Theory.

The QI team will determine after review of data and further expansion of the project if the team will standardize the magnet reminders and/or incentives.

### 9. Establish Future Plans

The QIC team will present the results of the project to MIHP providers and the other administrative staff and managers via a quarterly leadership meeting. The ICHD QI team will continue to monitor the progress of the project over the next few months and determine whether or not the process should be standardized. Two social workers, a dietician, and two more nurses are being added to the project. The team will monitor the use of the new magnets and added incentives.