CQI STORYBOARD TITLE: "All is Well Baby"

Agency: Kansas City Health Department – NFP
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1. AIM STATEMENT	2. PLAN	3. DO
Statement of what you are trying to accomplish (aim), how you will know if a change is an improvement (measurement), and what change will result in improvement (method). Define the start date, end date, and team leader. *Start Date*: July 1, 2019 *End Date*: June 30, 2020 *Team Leader/Scribe*: Candice Bondon *AIM Statement:* By June 30, 2020, KC-HD NFP program, will increase the percentage of completed AAP recommended well child visits from 84% to 90%, as determined from submitted age forms.	Define the problem and expected outcomes. Identify potential causes and change solutions. Select change solution(s). **In July 2019, our data showed that 84% of children have completed their well child visits.** The team spoke with client participant, who identified barriers to include: caregivers forgetting the appointments, caregivers having a lack of transportation, and caregivers not understanding the importance of the well child visits. *Potential Solutions:* • *Caregiver Forgets*: Create a tracking chart, if completed 6 and 15 months well child visit, client will receive a $25 gift card. *Gift cards are being funded through KCHD Health Levy.	Develop action plan(s). Identify data measuring both the change and change results (process and outcome measures). Implement planned change and collect data. Team created a folder with tracking chart and educational materials. Nurse Home Visitors reviewed with all clients on their caseload, during a home visit. Client and Nurse Home Visitor signed acknowledgment form that education was received. In addition, Nurse Home Visitors will review NFP Facilitators "What's New, What's Next" every month, according to the child's age. Nurse Home Visitors also provided bus passes, for those clients who had issues with transportation.

	• *Lack of transportation*: Nurse Home Visitor will provide client with an all-day bus pass. • *Understanding the Importance*: Team will create a folder with educational materials. Client and Nurse Home Visitor will sign acknowledgment form that education has been received. In addition, Nurse Home Visitors will review NFP Facilitators "What's New, What's Next" every month. • *Goal Mama*: All clients, who are using the NFP Goal Mama App, will be encouraged to list completing well child visits, as one of their goals.	
4. STUDY	**5. ACT**	**6. FUTURE CQI**
Describe the plan in which the data will be collected and analyzed. Analyze both the change process and the results. Data was collected by nurse home visitors and captured via REDCap and analyzed by a MDHSS Senior Epidemiology Specialist, looking at the percentage of children who have completed their well child visits. *Results*: September 2019 – 89% December 2019 – 98% February 2020 – 98% **June 2020- 93%**	Recommend the next steps towards process improvement. Since our improvement theory was successful, the team will adopt the plan and standardize the improvement by continuing to offer bus passes to client in need, provide well child visit education and a well child visit tracking sheet.	Define any future plans for process evaluation and/or areas for improvement. Include any lessons learned throughout the process. • Looking at how to continue Impact of COVID on home visits and access to healthcare (well child visits) • Take steps, as needed, to maintain our improvements by acting to sustain our accomplishments. This can be done through regular review of the performance data and the continuous application of PDSA cycle.

		• Future CQI Project: New strategies to support moms in the continuation of breastfeeding.