HealthySteps
PEDIATRIC CARE • SUPPORTING • PARENTING
A Program of ZERO TO THREE

Improving the Rate of Mothers Reached During Referral Follow-Up Attempts

Summit Healthcare Regional Medical Center

Why It Matters

Summit Healthcare Regional Medical Center serves community members who reside in a 3,000+ square mile area of the White Mountains in rural northeastern Arizona. Our community consists of full- and part-time residents, as well as visitors enjoying winter sports and seeking relief from the desert heat. Our service area includes nontribal communities in Navajo and Apache counties, and tribal communities of the Navajo, Hopi, White Mountain Apache, and San Carlos Apache reservations.

We were concerned with the incidence of perinatal mood and anxiety disorders (PMADs) in our community and the ability to connect moms with available resources. Research supports that early identification and treatment of PMADs lead to stronger attachment between mother and child.

One focus of the HealthySteps model is improving mental health outcomes for the mother-child dyad, but our community faces a lack of mental health care providers. Other obstacles include the vastness of our service area, prohibitive costs or insurance issues, and the likelihood that moms do not realize the impact their depression has on their family or on their child's development. Therefore, while we value the need to screen moms (our site also screens dads) for postpartum depression, we feel it is equally important to provide care coordination to affected moms, ensuring they can connect with services and receive needed support.

Where We Started

We have high screening rates for PMADs using the Edinburgh Postnatal Depression Screening (EPDS), partially due to our first continuous quality improvement (CQI) project completed as part of the HealthySteps Outcome Pilot Project. For our second CQI project, we focused on increasing referrals for moms with elevated EPDS scores (see callout box) before realizing there was a greater need to improve the referral follow-up process. At that time, our team typically contacted moms two and four weeks after a referral to see if they needed more support connecting to services. After collecting four months of baseline data, we found that:

- We only reached 40% of moms during the first follow-up attempt, meaning we did not know the outcome for most moms referred.
- Of those moms reached by the first follow-up attempt, 26% were connected with or enrolled in services.
- We reached 35% of moms during the second follow-up attempt, and only 10% of those reached were connected with or enrolled in services.

We were surprised that we did not connect with moms more often during follow-up attempts. We understood how important it was to connect with moms after providing a referral and believed this was an area where we could improve.

CQI Project #2: Improving Referral Rates

Before starting our third CQI project on the referral follow-up process, we set our sights on improving an already high referral rate with the following goal (SMART Aim): *By February 28, 2020, we will increase our referral rate for moms who score 12 or higher on the EPDS from 93% to 99%.*

We implemented two change strategies to work toward our goal, which we tested with one PDSA (plan-do-study-act) cycle each:

Change Strategy #1: Share a list of available primary care providers and obstetricians in the community with moms who had an elevated score on the depression screen (adopted).

Change Strategy #2: Place a binder of community resources in each exam room for HealthySteps Specialists to reference after an elevated score on the depression screen (adopted).

These change strategies allowed the HealthySteps Specialist to remain in the room with the family after a positive EPDS screen and to not disrupt the flow of the visit. We also felt that having the binders in the exam room helped normalize depression by implying their frequent use and conveyed the message that the mom and baby's health are equally important.

After achieving a referral rate of 100%, we felt ready to move on to the follow-up step of the process, which became the focus of our next CQI project.

Our team developed this goal (SMART Aim):

By September 30, 2020, the Summit Healthcare HealthySteps team will increase our percentage of mothers reached during referral follow-up attempts from 49% to 60%.

How We Diagnosed the Problem

Our team used two CQI tools to diagnose the problem. First, we created a process map to outline each step of the referral follow-up process. Doing so helped us identify opportunities for HealthySteps Specialists to improve how they ask moms for permission to follow up, learn moms' preferred mode of communication (e.g., text, phone call, email), and conduct the follow-up attempts. We also developed a fishbone diagram to determine the root causes of unsuccessful attempts, such as inadequate preparation of moms for outreach, use of outdated contact information, failure to persuade moms to respond to text and voicemail messages, moms' reluctance to answer calls from an unknown phone number, and community stigma around mental health.

During brainstorming sessions, HealthySteps Specialists indicated they wanted to feel more comfortable, confident, and strengths based when asking moms if they could follow up with them. They wanted the outreach to contribute to building relationships with moms, not to make moms feel bothered or judged for not connecting with services.

How We Tested Solutions

We chose to use a script when asking moms' permission to follow up with them. HealthySteps Specialists developed, practiced, and revised a script before testing with moms. Over the course of 15 weeks, we tested the following strategies to change current practices:

Change Strategy #1: Use a script to introduce referral follow-up (adopted)—We completed three PDSA (plan-do-study-act) cycles to test a script that asked about moms' preferred contact information, contact method, and time of day for outreach. The script was also designed to destigmatize the need for support.

We began with one HealthySteps Specialist testing the script with one mom. After adapting the script following a team debrief, a different HealthySteps Specialist used the script with two moms. Once the team decided to adopt the script, all HealthySteps Specialists used the script with all families. Our ability to reach moms during follow-up attempts **rose from 49% to 50%.**

The Script:

Research tells us that maternal depression affects babies' development in all kinds of ways and that moms get better and do better with treatment. And you deserve to feel well and enjoy your baby.

I know it can be challenging to connect with the resources we've given you and I'd like to check back with you in a week or two to see how you're doing and if you need support. Do I have your permission to do that?

What's the best way to reach you, phone call or text message? _____

What's the best number? _____

What's a good time of day? _____

Change Strategy #2: Complete a second follow-up attempt within 48 hours of the first attempt (adopted)—Since we did not make the progress expected during the first three PDSA cycles, our team hypothesized that moms might not see the first text message, be too busy to respond in the moment and forget to respond later, or respond better to two attempts in quick succession than a single attempt. We tested a rapid (within 48 hours) follow-up attempt via text for moms who did not respond to the initial follow-up attempts at two and four weeks post referral. Given the small sample size, all HealthySteps Specialists tested the change strategy with all moms requiring follow-up. Our ability to reach moms when we completed the PDSA cycle had **risen to 69%!**

Results

We were able to **increase our overall rate of connecting with moms during follow-up attempts from 49% to 67%** over the 15-week project, exceeding our goal! To sustain the gains we made, we integrated these change strategies into our daily practice. We also continue to monitor our follow-up rates.

What the Experience Was Like

Our team implemented this CQI project during the COVID-19 pandemic, amidst challenges related to staffing, clinic closures, and the burden of an overwhelmed hospital system. At the same time, families were experiencing employment changes, child care challenges, safety concerns, and limited availability of community resources to address PMADs. While it was difficult to focus on CQI in these circumstances, we saw the project as an opportunity to provide families with comprehensive support—a need exacerbated by the pandemic.

We also experienced challenges related to data collection and reporting. The relatively small number of moms who met criteria for inclusion in the CQI project caused dramatic fluctuations in the data on a week-to-week basis. This made it difficult to determine if we were seeing successful trends or small anomalies in the data.

Our team also had to wait one month after a HealthySteps Specialist provided a referral to obtain the needed data. To account for the lag between the change strategy and outcome, we created a detailed Excel spreadsheet to track quantitative and qualitative data for each follow-up attempt to help recall details about the case one month later.

We were pleased, yet not surprised that so many moms felt comfortable using text messaging as their preferred contact method. As part of the planning for the project, we determined that text messaging with parental consent did not violate patient privacy policies. We were then able to strategize how to use text messaging effectively to follow up on referrals.

In general, we were surprised and pleased by how helpful CQI has been to our practice, particularly the use of CQI tools such as root cause analysis and process mapping to identify and address personal and system barriers to achieving our goals.

> "We feel very confident that we are following up on all of the referrals we make within the designated timeframe. The follow-up system the CQI project helped us to create works very well for us and through CQI, we have the data to prove it!"
>
> *– Heidi Robison, HealthySteps Specialist*

Our CQI Team

The Summit Healthcare HealthySteps team consists of our physician champion (Daniel Brewer), three HealthySteps Specialists (Barbara Baum, Heidi Robison, and Maddie Nielson), a HealthySteps Coordinator (Leigh Parker), an administrative assistant (Shelly Hartman), a data analyst (Becky Benda-Dodd), and Department Director (DeAnn Davies). Each team member served a vital role in our successes with the CQI project.

Summit Healthcare