CERTIFIED PUBLIC MANAGER PROJECT

PRE-DISCHARGE HOME VISITS

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PRE-DISCHARGE HOME VISITS

In 1991, the South Carolina Department of Health and Environmental Control began to offer a new and different service. The service was targeted to any infant who had stayed in the Neonatal Intensive Care Unit (NICU). Because of the high postneonatal mortality rate in our state, (5.8 infant deaths per 1,000 live births in 1991)[1], it was felt that a home visit to these families, could impact the outcome for the infant. The *NICU Pre-Discharge Visit* was developed, with the purpose of determining if conditions were present in the home, which would impact negatively on the health of the infant.

The visit is provided by Public Health Nurses in the infant's home, prior to the infant's discharge from the hospital. NICU staff determines which infants may benefit from the service and make a referral to the county health department in which the infant resides. During the home visit, the public health nurse assesses the home for any health hazards to a fragile infant and also assesses the family's ability to care for the child. If a problem is identified, the infant's hospital discharge is postponed, until the family and/or home is ready for this transition. The NICU Pre-Discharge Visit is provided to any family that is referred, regardless of a payment source.

Since 1991, there have been minimal referrals for the NICU Pre-Discharge Visit. On average, 3,000 infants are placed in neonatal intensive care units each year.[2] (See

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[1]SC Department of Health and Environmental Control, The Health of South Carolinians, p p. 7.

[2]SC Department of Health and Environmental Control, SC Perinatal Regionalization Surveillance Data: Report of Perinatal Indicators, p. 361.

Appendix I for a breakdown of NICU admissions by year.) However, an average of only fifty-seven NICU Pre-discharge Visits is provided each year. (See Appendix II for a breakdown of NICU Pre-Discharge Visits provided by fiscal year.) There is not a clear rationale as to why so few infants are referred for the visit. It appears to be a general concern, as these visits are equally distributed throughout the state.

The problem is clear. There are many potential high risk infants who may benefit from this service. However, there are obvious barriers/issues that prohibit infants from being referred to their local health department.

The goal of this project will be to: Increase by fifty percent, the number of NICU Pre-Discharge Visits provided in fiscal year 1998-1999. Current research validates the value of early home visiting to prevent future problems in at risk infants and families. The Journal of the American Medical Association's August issue supported the efforts of early home visitation programs to improve outcomes of at risk families.[3] Research on all fronts validates that nursing home visitation programs are valuable as early and preventive interventions in which public health needs to be involved. [4]

The question remains, why are referrals low? The customer who refers to public health must value the NICU Pre-Discharge Visit. What issues are there that impact the immediate customer--the referring body. This project will seek the customers input regarding the dimensions of service quality, in order to determine needed changes.

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[3]Kitzman, H, et. al., (1997, August) "Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing," The Journal of the American Medical Association, 278 (8), p. 644-653.

[4]Melton, G, et.al., (1997) "Home Visiting," Family Futures, 1(3), p.4-30.

To determine the contributing factors to the problem, meetings were held with two key players in the public health network. The Department of Health and Environmental Control has thirteen Public Health Districts. (See Appendix III.) Within the Public Health Districts is the County Health Department system of care. Each Health District has a key contact for issues relating to children. The first meeting was held with the thirteen key contacts, the Child Health Program Managers. The second meeting was held with the State's Regional Systems Developers. The Regional Systems Developers are the liaisons between Public Health and the hospitals in the state. There are four Systems Developers who work with the hospitals regarding services to mothers and babies. The Systems Developer's first priority is issues relating to care of high risk pregnant women and high risk children.

The issues that came to the forefront during both meetings were:

- *Hospital staff in NICUs are not knowledgeable of the service.*
- *Hospital staff are not aware of whom the NICU Pre-Discharge Visit is for.*
- *Staff working in NICUs are focused on the medical need and often do not think about needs in the child's environment that could impact their care after discharge.*
- *If the baby is transferred to another nursery--a Level II nursery, the staff in those settings may not be familiar with the service.*
- *If the hospital staff are not familiar with the service, then they do not place value in it.*

- *If the hospital staff are not comfortable explaining the service, then it may not be offered to the client.*
- *Hospital staff are not aware of whom to contact with questions regarding the visit.*
- *Hospital staff do not know who to call with questions.*

After discussion with both groups, it was suspected that a possible cause for the problem, was a lack of knowledge/understanding of the service by hospital staff, as well as potential clients. In further evaluating this suspicion, it was learned that when the visit was created in 1991, the only marketing done about the service was through a Medicaid bulletin. This bulletin went to Medicaid providers. After the bulletin went out, there were some informal meetings to discuss the visit and how to refer clients for the visit. However, DHEC did not create any educational tools for the NICU staff or for the clients who may receive the service. Currently, there is nothing to explain the service to new hospital staff, new physicians or potential recipients of the visit.

After evaluation of the data gathered from the meetings with the Program Nurse Managers and the Regional Systems Developers, it was suspected that the root cause of the problem was related to the knowledge/awareness of the service. Thus, the need to market the NICU Pre-Discharge Visit.

In an attempt to gather more data and validate the need for educational materials to market the visit, telephone calls were made to the Transition to Home Care Coordinators (THC) at three of the four NICUs--Medical University of South Carolina, McLeod Regional Medical Center and Palmetto Richland Memorial.

Greenville Memorial also has an NICU. However, they do not have a Transition to Home Care Coordinator at the present time. The THC Coordinators are the responsible entities for assuring NICU babies are linked to appropriate resources upon discharge from the hospital and are our customers. They were asked three questions:

1. *Is there a need for NICU staff to be educated regarding the NICU Pre-Discharge Visit?*

All three coordinators felt there was a need for staff to be "reoriented" to the visit and its purpose.

2. *Are there any materials available to educate the staff?*

All three coordinators said there were no materials available to educate staff.

3. *Are there any materials available to educate clients about the service?*

All three coordinators said there were no materials available to explain the service to potential clients.

The following issues were also identified as problems impacting the visit:

- *There is confusion as to which service offered by DHEC will meet the needs of the family--NICU Pre-Discharge Visit, a Home Health Services Referral or a Family Support Service Referral.*
- *There is a need for a clear line of communication when a referral for a visit is sent. Specifically, who is the best person to receive the referral and how should the visit be requested.*
- *Something to leave with the client explaining the service would be beneficial.*

- *The mechanism utilized to "reorient" NICU staff needs to be simple!*
- *Client education material also needs to be developed for the Postpartum Newborn Home Visit.*

Three consistent factors or causes emerged from all three data collection efforts. First is the need for education of the customer--NICU staff. Second is the need for the client who will receive the service, to have some consistent information regarding the visit. The third factor revolves around communication between the county health departments and the NICU. The project outcomes will be as follow:

- *Develop a concise video describing the purpose, as well as intended benefit of the NICU Pre-Discharge Visit. The video will be targeted to the NICU staff.*
- *Develop a patient education brochure explaining the service they will receive--the NICU Pre-Discharge Visit.*
- *Develop a statewide contact list that includes contacts at each county health department. This will establish a contact for the NICU staff.*
- *Develop a standard referral/communciation tool to be utilized by NICU staff when referring clients to DHEC for an NICU Pre-Discharge Visit.*

For the project plan, see Appendix IV. The Gantt Scheduling chart in Appendix IV lists the process steps needed to complete the project. It also has the anticipated time frames for completion of each step. The responsible person for each step will be myself. The key players involved in identifying the issues are also utilized throughout the process to gain needed input. The Program Managers, Regional Systems

Developers and the Transition to Home Care Coordinators are key stakeholders to improving the number of NICU Pre-Discharge Visits provided. Therefore, their continued involvement with the project is vital for its success.

To continue to insure the commitment of the Women and Children's Services Branch, regular meetings will be held with the Directors, to obtain their input into the process, as well as to assure the availability of resources for the project. Teamwork within the Branch and the thirteen public health districts will be vital for the success of the project. As referrals begin to increase, the districts will have to be committed to providing the service, as well as have the staff resources available. In April, work will continue with the program managers regarding resource availability. When the program managers convened to identify issues related to the low number of referrals, they were all committed to the need to provide the NICU Pre-Discharge Visit. However, time and resources can often interfere with one's ability to do as they wish! These potential obstacles will be discussed at the Women and Children's Services Management Conference in April. As a group, we will develop strategies to overcoming these obstacles.

Any change, in and of itself, can be an obstacle! The marketing of the service with the NICU staff will be a change. The request that brochures be distributed to potential clients is another change. The utilization of a standardized referral form is yet another change for the NICU staff. The Regional Systems Developers will be utilized to develop the distribution/education plan, but will also be key players in the education of the NICU staff. The Systems Developers work with the staff regularly, so they are

familiar with the day to day workings of the nursery. Because of their linkage with the NICUs, their expertise will help assist DHEC "pave the way" in communicating the need for change.

DHEC is fortunate to have a wealth of internal "resources." Many of these will be utilized throughout the project. The Office of Communication Resources provides for the Art Department and the Video Communications Department. The agency also has access to printing facilities. The use of these three areas in developing the marketing information will make the cost of the entire project minimal. Therefore, cost should not be an obstacle.

The resources outside of the agency, will continue to be the Regional Systems Developers and the Transition to Home Care Coordinators. Their expertise will be utilized throughout the project.

The project will be evaluated in July 1999. The evaluation method will involve two phases. The first phase will be to assess the number of NICU Pre-Discharge Visits provided during Fiscal Year 1998-1999. This will be done by review of the Children's Health Data System. The second phase will involve the NICU staff. Two questions will be asked--*Are you utilizing the video with new staff and new physicians* and *Are you utilizing the brochure with potential clients?* If the project is successful, there should be an increase in visits, as well as utilization of the video and brochure by the NICU staff.

Ultimately, the project should have demonstrated two values of the agency's strategic plan--*customer service* and *teamwork*. By working with our customers, as a team, service delivery will improve!

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APPENDIX I

BREAKDOWN OF NICU ADMISSIONS BY YEAR

YEAR	*#NICU ADMISSIONS*
1992	*3,262*
1993	*3,268*
1994	*3,036*
1995	*2,991*
1996	*Not Available*

SC Department of Health and Environmental Control, SC Perinatal Regionalization Surveillance Data: Report of Perinatal Indicators, November, 1996.

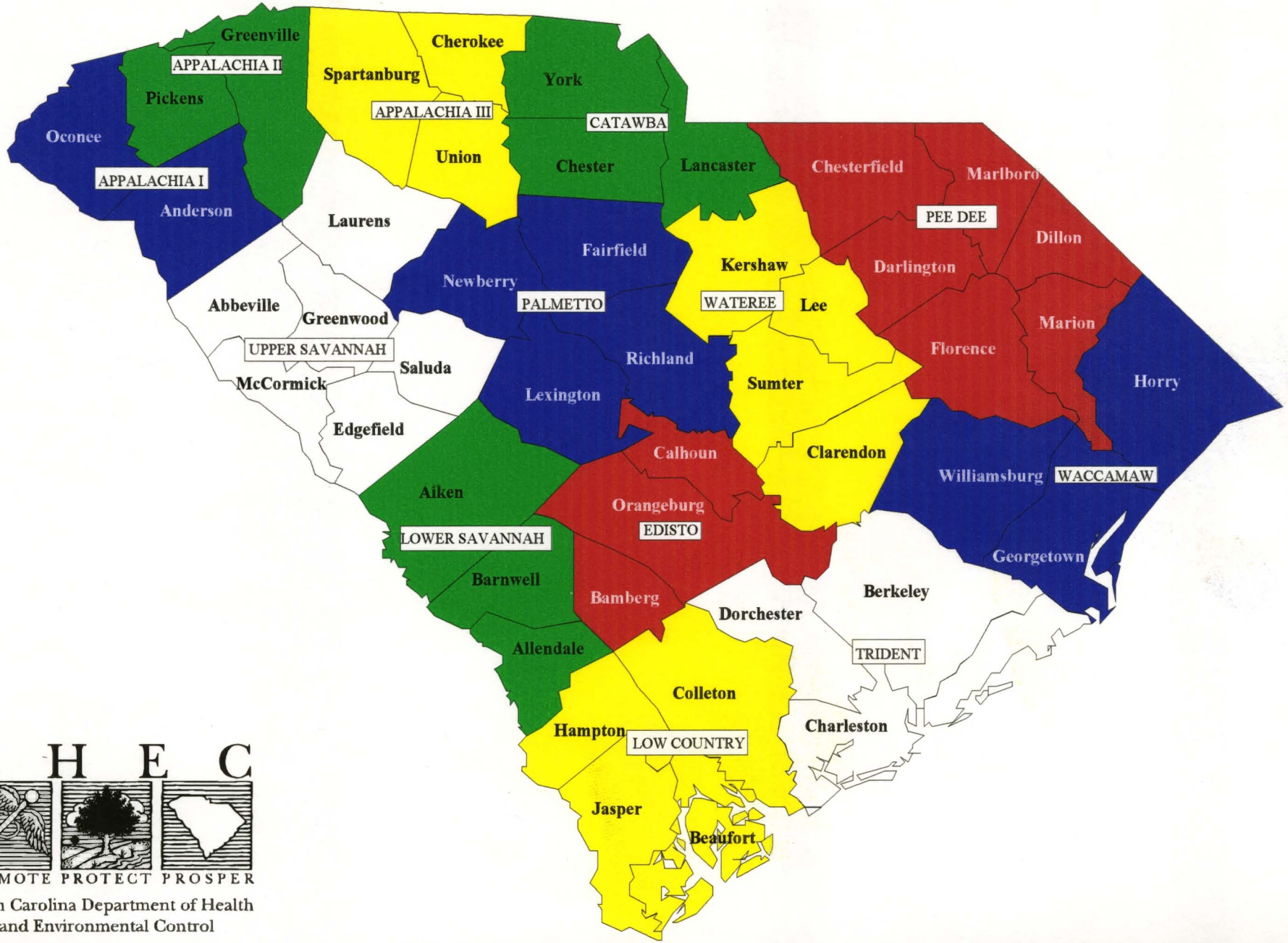
APPENDIX II

BREAKDOWN OF NICU PRE-DISCHARGE VISITS BY YEAR

FISCAL YEAR	*#NICU PRE-DISCHARGE VISITS*
1991-1992	*72*
1992-1993	*31*
1993- 1994	*80*
1994-1995	*50*
1995-1996	*53*
1996-1997	*58*

SC Department of Health and Environmental Control, Women and Children's Services, Child Health Data System.

South Carolina Counties and Public Health Districts



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APPENDIX IV

PROJECT PLAN

ACTIVITY	MARCH 2 9 16 23 30	APRIL 6 13 20 27	MAY 4 11 18 25	JUNE 1 8 15 22 29	JULY 6 13 20 27
Meet with Marge and Sarah for initial plans.	___				
Meet with RSD's and THC's to get input re: video, brochures, & referral form.	____	____ (4/3/98)			
Meet with Program Managers to get input re: video, brochures, referral form & contact list.		____ (4/15/98)			
Meet with Media Arts Department re: video and brochure development.	____	____			
Draft referral form, contact list, video, script and brochures.		____			
Submit drafts to: Program Managers, RSD's and THC's for input.			____		
Order needed supplies: i.e., video tapes for duplication.			____		
Meet with Marge and Sarah to review work to date.			____		
Finalize referral form, contact list, video script and brochures based on feedback received.				____	
Submit referral form to Art Department for typesetting and printing.				____	
Meet with Art Department re: brochure development.				____	
Meet with video communications re: video to include review of script planning for footage needs and finalize shooting date.				____	
Draft distibution/education plan.				____	
Submit draft distribution/education plan to Program Managers and RSD's for input.				____	
Finalize distribution/education plan based on feedback received.				____	

ACTIVITY	MARCH 2 9 16 23 30	APRIL 6 13 20 27	MAY 4 11 18 25	JUNE 1 8 15 22 29	JULY 6 13 20 27
Shoot video footage.				_ _ _ _ _ _	
Edit video.					_ _ _ _ _ _ _
Meet with Marge and Sarah to review work to date.					_ _ _ _ _ _ _
Submit video for duplication.					_ _ _ _ _ _ _
Finalize brochures and submit for printing.					_ _ _ _ _ _ _
Put distribution/education plan into action.					_ _ _ _ _ _ _

_ _ _ _ _ _ _ *Anticipated time frames to complete each activity.*