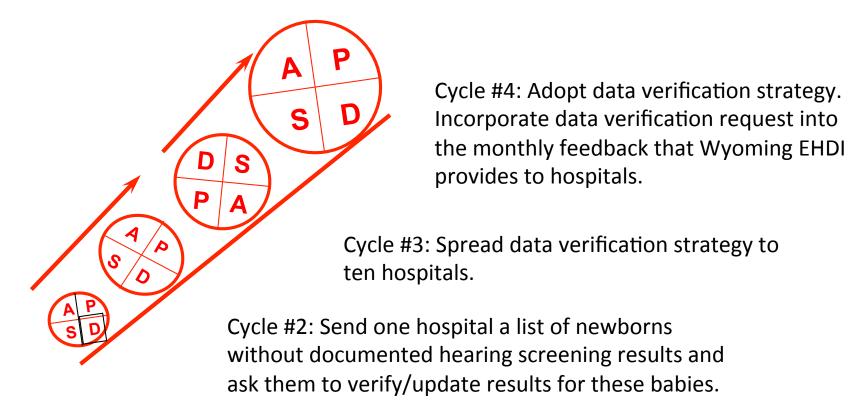
State Coordinator Meeting 2015 Wyoming

Hospital Data Accuracy/Report Card

- Why was this strategy tested?
 - Wyoming EHDI wanted a means of providing feedback to hospitals regarding their screened by one month performance (Sub-Aim 1.1) to acknowledge exceptional hospitals and help under-performing hospitals improve.
- What was the process for identifying the strategy?
 - The idea to try hospital report cards came from participation in a NICHQ Learning Collaborative. Several states had successfully used this strategy to improve the "1" in "1-3-6", so we felt it was worth trying in a PDSA cycle.
- What is the potential for the strategy to improve the number of babies screened by 1 month of age?
 - After the first cycle of this PDSA, it was clear that a hospital report card was not going to be an effective means of communicating with hospitals regarding their screened by one month performance. To address Sub-Aim 1.1, Wyoming EHDI adapted this PDSA from providing hospitals with a report card to asking hospitals for hearing screening results on babies who do not have any recorded in the Wyoming EHDI tracking system.

PDSA cycles



Cycle #1: Create a hospital report card. Send it to three hospitals and ask for feedback on it.

- Plan: Develop a hospital hearing screening report card and send it to three hospitals. Request feedback.
- Do: After creating report cards for the three test hospitals, it was clear that this strategy was not going to be an effective means of communicating with hospitals regarding their hearing screening performance.
- Study: The small number of births in some of Wyoming's hospitals made the report card an inefficient means of addressing Sub-Aim 1.1 with hospitals.
- Act: Adapt Although not completely ruling out using a report card in the future, we're putting it on hold in favor of sending hospitals lists of newborns without hearing screening results and asking them for information on these babies.

- Plan: Work with one hospital to identify newborns without hearing screening results and determine why there are no results documented in the Wyoming EHDI tracking system.
- Do: Wyoming EHDI sent the hospital a list of children without hearing screening results.
- Study: There was a 56% increase in the children recorded as having a screening by one month of age or confirmed waives or deaths.
- Act: Adopt Replicate with an additional ten hospitals.

- Plan: Replicate PDSA #2 with an additional ten hospitals.
- Do: Wyoming EHDI has requested hearing screening results for 36 newborns from ten hospitals.
- Study: We have heard back from all ten hospitals and have been able to update information on the 36 newborns: 22% had a hearing screening result at a Wyoming birthing hospital, 22% had results at a transfer hospital, 3% waived, 3% died, and 31% were confirmed to have been missed.
- Act: Adopt The increase in hearing screening results from this data verification PDSA is substantial.

- Plan: Improve screened and rescreened by one month performance numbers by providing hospitals with list of newborns with no documented hearing screening result.
- Do: Send list to hospitals on a monthly basis as Wyoming EHDI learns of newborns without a documented hearing screening result.
- Study: In progress.
- Act: To be determined.

Moving Forward

- Next PDSA cycle?
 - Provide monthly data to the hospitals on missed babies: to receive screening results not reported, bring awareness to babies that are missed, and identify training opportunities for hospital staff.
- Overall what have you learned from testing this strategy?
 - What you first think might be a solution to your problem is not always the solution that will best solve the problem.
 - It is important to present information in a way that is helpful for individuals to create change and yield the results you want.
- What advice would you give to other states who want to test this strategy?
 - We're very happy to talk with you about this if you are interested.