

# **PDSA #2 Worksheet**

**Instructions:** Each place-based community team that is testing improvement changes completes a worksheet for all PDSA cycles completed. Upload to CoLab on the 7<sup>th</sup> of each month for tests performed the previous month. (Hint: use this worksheet concurrently as you plan, implement, and evaluate the test – don't wait until the end of the month – it can be a good planning and documentation tool throughout the test)

Team: Indiana- IndyEast Promise Zone

**Primary Driver-P5:** Linked and coordinated systems promote continuity, collaboration, and cross-sector sharing in all aspects of monitoring, screening, referral and service delivery while ensuring privacy and legal rights of families **Primary Driver-P3:** Systems address social determinants of health, including related needs and stressors, and support families to minimize risk, and maximize healthy development

Objective for this PDSA Cycle:

To understand the systems that families are interfacing with that would result in a screening

Is this cycle used to develop, test, implement, or spread a change?

Develop a change

What question(s) do we want to answer on this PDSA cycle?

What systems are families accessing that could result in a screening?

- If yes, where? What system?
- If not accessing systems that could/would result in a screen, why not? What are the barriers?

## Plan:

Answer questions: Who, What, When, Where will the test of change occur?

act do do

Who-Families who are pregnant or have children ages 0-5
What-Asset map w/families that access public spaces throughout the neighborhood
(Community centers, libraries, churches, parks, etc.)

When- March 16th - April 4th

Where- Public spaces on the Near Eastside



Plan for collection of data: Who, What, When, Where?

Who- Whitley Wynns, Adis Coulibaly, and John H. Boner Community Center Interns
What- We will show families sample questions from the ASQ and ask the families if these questions look familiar?

- If yes, who asked the questions? Did you go to a doctor's office, did someone come to your home, were you in a hospital, etc.?
- If no, how often do you see a Dr.?

Predictions (for questions above based on plan):

Community members who have children birth-3 experience barriers to connecting with service systems that provide developmental screenings.

#### Do:

Report the completed change or test, data collected and begin analysis.

Over the course of 2 days each week, we have conducted in person interviews with families who are pregnant and/or who have a child in their household of 0-5 years of age. We interviewed families, at different public locations within the community (i.e. libraries, community centers, food pantries, homeless shelters, etc.), about their current reality of interacting with systems, specifically early developmental screenings and the monitoring and referral process.

## Study:

Complete analysis of data

Throughout our various meetings with the Local Place-Based Team and the ECCS Working Group, we have discovered that families were not familiar with developmental screenings focused on the Ages and Stages model. Before learning this information, we believed that out of the 75 families we talked to in both PDSA Cycles #1 and #2, around 56% of them received a developmental screening. Of the 56% who said they had been screened, 17% of families sited WIC clinics as their source of developmental screening, but upon consulting the WIC administrator for our local area, screening modeled after Ages and Stages is not the type of screening being conducted at these clinics.

We came away realizing we still didn't have a clear understanding of how many families within our community had received a developmental screen for their kiddos 0-5 years of age, but we were at least able



to pin point health programs who interact with families in this area, yet these families may still not be receiving the appropriate developmental screens.

In looking at the data further, we noticed the second highest percentage was that of families that were unaware if their child had received a screen. They have been connected to a home visiting program or have a medical home, but were not aware if their child was screened. Some families were able to recall the doctor asking if there were any concerns, but didn't remember if an actual developmental screen occurred. Some were recommended by their doctor to wait until the child entered school for some of their developmental concerns.

About 12% stated that they had not received a screen.

Compare the data to your predictions and summarize the learning

We predicted that community members who have children birth-3 experience barriers to connecting with service systems that provide developmental screening. Based on the analyses of our data, we have concluded that our prediction was incorrect and families are connected and have a medical home regardless of the barriers they may be facing.

### Act:

Are we ready to make a change? Plan for the next cycle.

Based on our data analysis, we have concluded that we are not ready to make a change. We will adapt our study, and change our target audience based on the realization that families are connected to some type of medical home. With that in mind, and recognizing that the Near Eastside is a high needs area, there are many families that are connected to WIC. WIC has been able to provide data down to the zip codes of the different WIC clinics that are utilized by families in the 46201 area (starting small with the opportunity to expand to the other focus zip codes areas).

We chose to pick a system that is being accessed by families in order to best understand the links of systems and within those links which systems are accessed by families for developmental screening, which systems are accessed by families that should be delivering development screens, etc. We will also be able to study the referral process of WIC and how well that system works for families when finding a medical home who should offer screenings.