



Onondaga County Health Department

**15th Annual
Quality Improvement Summit**

January 27, 2012

15th Annual Quality Improvement Summit

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AGENDA

- 9:00 – 9:05 a.m. Welcome and Housekeeping: Rebecca Shultz
- 9:05 – 9:35 a.m. “Quality Improvement. Scaling the Summit” Cynthia B. Morrow, MD, MPH
- 9:35 – 9:55 a.m. Presentation by Linda Peressini
- 9:55 – 10:15 a.m. Presentation by Kathleen Corrado, PhD
- 10:15 – 10:35 a.m. Presentation by Sara Holmes
- 10:35 – 10:50 a.m. Break
- 10:50 – 11:10 a.m. Presentation by Tim Guhl, Beth Starkweather
- 11:10 – 11:30 a.m. Presentation by Jenny Dickinson
- 11:30 – 11:50 a.m. Presentation by Cindy Clift
- 11:50 – 12:10 p.m. Presentation by Brian Ehret, Catherine Unger
- 12:10 – 1:15 p.m. Lunch Break
- 1:15 – 3:00 p.m. Poster set-up and viewing
- 3:00 – 3:10 p.m. Certificates of Appreciation, Linda Karmen
- 3:10 – 3:20 p.m. Closing remarks: Cynthia B. Morrow, MD, MPH

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Healthy Families Special Children Services

Improving Provider Compliance with Medicaid Requirements for Written Orders

Objective: To determine if preschool providers updated their forms to obtain written orders for Medicaid-eligible preschool therapies to comply with current requirements.

Brief Description: Medicaid reimburses counties for health supportive services provided to children with disabilities through the Preschool Supportive Health Services Program (PSHSP). In 2010 Special Children Services (SCS) Program was audited by the NYS Office of the Medicaid Inspector General (OMIG) for a sample of 100 claims which had been paid to OCHD for services during 2009. For each of those 100 claims it was necessary to collect specific documentation to verify that all requirements in effect at that time were met. Of those 100 records, 53 claims for Physical Therapy and Occupational Therapy had to be substantiated with written orders. Eleven written orders (21%) were not accepted. Additionally, in June of 2010 NYS made a compliance agreement with OMIG which resulted in changes to the requirements of written orders retroactive to September, 2009.

Significance: The audit has not been finalized, but failure to comply will result in a disallowance of the claim audited as well as other related claims, with financial consequences. Before SCS presents additional claims to Medicaid for reimbursement, it is necessary to ensure that requirements for written orders be met.

Methods: The OCHD Compliance Officer conducted an audit of the preschool provider who serves the highest number of Medicaid-eligible students. In July 2011, a sample of 67 written orders was reviewed for services provided from September 2010 through June 2011.

Results: The provider produced 64 of the 67 written orders, however only 13 of them (19%) were Medicaid-compliant. Thirty-nine written orders (58%) lacked a diagnosis/or a reason for the service to be provided. Seven orders did not have the appropriate signatures, and 5 were missing the date on which the order was signed.

Discussion: Prior to September 2010, all providers were trained regarding new Medicaid requirements for written orders, so a more successful outcome was expected.

1. In October, 2011, we supplied providers with a template for written orders that contained all required elements.
2. SCS is currently collecting written orders obtained by providers from July 1, 2010, through August 31, 2011. We will only claim Medicaid reimbursement for those children who have compliant written orders.
3. SCS will also collect all written orders for services currently being provided, and if not correct we will direct providers to obtain a correct order. Medicaid will only be claimed from the date a correct written order is signed.

Conclusion: More oversight of the contents of written orders collected by preschool providers is clearly indicated. SCS must be confident that OCHD is not at risk for financial penalties when claiming Medicaid reimbursement.

Future Directions: Compiling all current written orders will target which providers need more direction regarding the collection of these written orders. The Compliance Officer will conduct additional audits, probably in October 2012, after more program specific training is completed. This is the first phase of a two year project.

Submitted by Linda Peressini, Michelle Mignano

Center for Forensic Science

Laboratories

Implementation of Y-STR DNA analysis to obtain additional probative information in criminal investigations.

Objective: Will implementation of Y-Short Tandem Repeat (Y-STR) DNA analysis as a secondary analysis tool provide enhanced sensitivity for sexual assault cases and additional probative DNA results to augment the investigation of violent crimes in Onondaga County?

Brief Description / Background: The CFS DNA laboratory currently utilizes autosomal STR analysis for source identification in sexual assault as well as other types of cases including homicide, assault, and property crime. This type of testing is typically performed because there is a high degree of individual variation providing a strong power of discrimination. One shortcoming to this type of testing is the inability to detect low levels of male DNA in the presence of higher amounts of female DNA. This issue is relevant in sexual assault cases involving low amounts of sperm, or sexual assault cases involving fluids other than sperm or other low-level DNA samples, or in situations in which the presence of male DNA is diminished due to the timing of sample collection post assault. Y-STR analysis allows for only the male DNA to be profiled thereby eliminating the issue of overwhelming amounts of female DNA. This allows for DNA typing of low level samples, a clearer interpretation of mixtures involving more than one male donor, and obtaining results from samples collected up to five days post assault rather than the three days currently possible. The laboratory has many cases that would benefit by the use of Y-STR analysis but until now this type of testing was not validated in our laboratory. This is year one of a two year project.

Significance: Y-STR analysis will allow the laboratory to provide additional information assisting investigations of sexual assaults and homicides, particularly in sexual assaults of children and sexual assaults that previously were not able to yield DNA results due to the length of time elapsing between the assault and the collection of evidence. This analysis was not previously available as a service in Onondaga County and was not normally sent out to private companies for testing due to the high cost incurred for analysis and testimony. Offering this service to our customers will enhance the investigation and prosecution of serious violent crimes in Onondaga County which will in turn improve the health and safety of the community.

Methods: Data will be collected regarding the number of cases and samples that are analyzed utilizing Y-STRs and whether or not the analysis provided probative information to the investigation and/or prosecution of the case.

Results: The laboratory has completed Y-STR analysis on five cases. One case was a current homicide with a piece of evidence that has a mixture of suspect and victim DNA. The combined probability index

for this inclusionary autosomal STR data was 1 in 52. The Y-STR data indicated that the suspect could not be excluded providing additional support for the presence of the suspect's DNA. A second case was a current sexual assault of a 16 year old girl. The vulvar swab did not provide any male DNA using autosomal STRs but did provide a Y-STR profile that was consistent with the suspect. The third case is a cold case sexual assault of 12 year old girl. A semen stain from her clothing provided a good autosomal STR profile that was entered into the Combined DNA Index System (CODIS) in 2002 but has not produced any hits. The autosomal STR profile was indicted to suspend the remaining of the statute of limitations. In the early stages of the investigation, a suspect was compared and while excluded, his DNA profile was similar to the indicted profile indicating that the perpetrator may have been a possible relative. This information was relayed to Police Department with caution. Recently the police agency has re-opened this case and asked if they should get DNA standards from all of the male relatives of the suspect (upwards of 10 people). Instead, the laboratory used Y-STRs to exclude the suspect and his paternal male relatives. This saved investigation time and lab resources of checking all relatives through autosomal STR typing. The fourth case is a cold case homicide from 1990. The sexual assault kit was negative for semen. The fingernail scrapings had a relatively high amount of DNA but female to male ratio was greater than 20:1 indicating that autosomal STRs would not be useful especially with the concern of DNA degradation. A full Y-STR profile was obtained from the fingernails. The laboratory is waiting for a comparison sample to be submitted. The fifth case is a current sexual assault case. The swabs from the victim's body and stains in her underwear were mostly negative for the presence of semen with the exception of a single sperm identified from a perianal swab. All of the swabs and the underwear tested positive for a test for saliva. Autosomal STR analysis either indicated low level male DNA not suitable for inclusion or no male DNA detected. Y-STR analysis generated a Y-STR profile consistent with the suspect in the vaginal, vulvar, and underwear samples.

Discussion: Y-STR analysis was useful in all five cases that it was attempted including two homicides and 3 sexual assaults. In particular, two of the sexual assault cases involving children had limited evidence and the Y-STR analysis provided a result when autosomal STR analysis did not. In two other cases, the Y-STR analysis enabled the laboratory to generate probative information in situations in which there was a mixture of DNA which would not have been possible with autosomal STR analysis due to the high female-to-male ratio. The final case demonstrated how Y-STR analysis can be used as a screening procedure to provide a shortcut to investigators by utilizing the fact that males of the same paternal lineage have the same Y-STR haplotype. Overall, this study demonstrated that while Y-STR analysis does have limitations, it can provide useful information in certain special situations.

Conclusion: Y-STR analysis provided useful information to the investigation in five out of five cases demonstrating that this technology provides additional probative information in criminal investigations.

Future Directions: This project will eventually be tied into a related project which is to utilize a male DNA quantitation system to screen sexual assault kit samples for the presence of male DNA in place of screening for body fluids.

Submitted by Kathleen Corrado

Facilitated Enrollment

Does receiving copies of our clients' Medicaid pending letters increase their chance of obtaining public health insurance?

Objective: Facilitated Enrollment's receipt of copies of the pending letters that Medicaid sends to applicants asking for more documentation would improve getting required information back to Medicaid in a timely manner and increase eligibility rates.

Background: Our program's mission is to assist clients in applying for and obtaining Public Health Insurance (Medicaid, Family Health Plus, and Child Health Plus). Facilitated enrollers (FE's) located at OCHD, the Dunbar Association, Syracuse Northeast Community Center and the Salvation Army meet with clients, help them gather necessary documentation, fill out the required application and follow up as necessary.

If applicants are missing documents or information, Medicaid will send out a "pending" letter informing them about what else is needed. Language used in the letter is not always clear and often applicants don't understand what they need to do.

Significance: If we received copies of the letters sent by Medicaid we could call our applicants and assist them. We felt that we were receiving only a small percentage of the pending letters sent to our clients.

Methods:

1. We randomly sampled the clients that were referred to our facilitated enrollers during the month of March 2011 (using methods that assured our sample would be representative at a 95% confidence level). Every client who was denied insurance for "failure to verify" facts was sent a pending letter by Medicaid. We should have received a copy of that letter. Every chart was examined for outcome (enrolled in insurance or denial) and whether or not we received a copy of the pending letter.
2. We contacted the Medicaid administrative supervisor in May 2011 and asked that we receive copies of every pending letter sent to clients who applied through our program. She spoke about this with all her staff.
3. We sampled the clients' applications that were referred to our facilitated enrollers during the month of August 2011 (again representative at a 95% confidence level). Every chart was examined for reason for denial and whether or not we received a copy of the pending letter. We looked at how many of those clients eventually obtained insurance.

Results: Before the intervention we received copies of only 6 out of 20 pending letters that were sent to our clients and we were able to assist 5/20 clients to obtain health insurance (25%). Following the intervention we received copies of 26 out of 27 pending letters sent and we assisted 21/27 clients to obtain health insurance (78%).

Discussion: Following the intervention we received copies of almost all pending letters sent to our clients. One limitation is that a different county department's (DSS) staff is involved in the process, so we don't have total control. Another limitation is that even when we receive copies of the clients'

pending letters and call them to see if we can help, it is still up to the clients so obtain and submit the necessary information Medicaid requests to make the application complete.

Conclusion: When we receive copies of the pending letter for a case and the enrollers can contact the client and offer assistance to help comply with the pending letter, the clients are more likely to obtain health insurance, which is our program mission.

Future Directions: During 2012 we will repeat the sampling of a month's applications to make sure we are receiving copies of all pending letters sent to our clients. The results of the 2011 study will be shared with the DSS Medicaid unit to demonstrate the importance of the FE program continuing to receive copies of pending letters.

Submitted by Sara Holmes

Health IT AND FOIL

Lead FOIL (Freedom of Information Law) request process improvement through use of electronic tools.

Objective: We want to use electronic tools to improve the efficiency of FOIL request processing. Our aim is to shorten the processing time and reduce the staff hours used to process lead FOIL requests.

Description: FOIL request processing is labor intensive and the volume of requests has increased dramatically in recent years due to lead litigation. This study will establish the baseline measurement of the manual process for handling FOIL requests for lead inspection records related to litigation. The baseline measurement will allow comparison of process segments as we transition to the use of electronic tools.

Methods: Select manually processed FOIL requests were tracked between **12/16/2010** and **11/23/2011**. The number of requests tracked in that period is **52**.

The manual process was mapped into steps to make time analysis possible. Tracking sheets for each FOIL request recorded time expended (in minutes) for each step, as well as, the number of pages processed, at 2 points in the process. In order to facilitate tracking of the number days each record took to process, start dates for each step were also recorded.

Items filled in on tracking sheets are shown in yellow below.

To understand better how various parts of the process contribute to the total number of days needed to fill a FOIL request, steps were grouped and elapsed days were calculated.

- Steps **1 – 4** were grouped to reflect collection of the information requested.
- Step **5** is labor intensive and tracked by itself. Protected information, not specific to the request is removed, page by page, in this step.
- Steps **6 – 10** reflect the process of insuring that what we release is appropriate.
- Days elapsed for complete processing of a FOIL record request are represented by steps **1– 10**.

Colors, other than yellow, show the groups of steps, in order to track days elapsed for that group.

Manual Process Steps		Measure
		Start Dates
1	Search	Minutes
2	Retrieve	Minutes
3	Copy	Minutes
4	Organize	Minutes
Steps 1-4		Elapsed Days
		Start Dates
5	Redact	Pages
		Minutes
Step 5		Elapsed Days
		Start Dates
6	Review	Minutes
7	Inspect	Minutes
8	Approve	Minutes
9	Copy	Minutes
		Start Dates
10	Release	Pages
		Minutes
Steps 6-10		Elapsed Days
Steps 1-10		Elapsed Days

Results: Minutes expended on each step are captured for possible comparison to an electronic counterpart.

The page per minute measure helps clarify productivity.

The elapsed days measure helps to show the amount of time that documents are untouched as they are passed between staff members who complete various steps.

The elapsed days represent business days, but do not account for time off for individual staff members who process FOIL requests. Average and median were calculated for comparison. Minimum and maximum data points are shown.

Manual Process Steps		Measure	Average	Median	Minimum	Maximum	Avg Pg / Minute
		Start Dates			12/16/2010	11/23/2011	
1	Search	Minutes	18.0	18.0	2	30	
2	Retrieve	Minutes	9.5	10.0	2	20	
3	Copy	Minutes	12.7	10.0	1	30	
4	Organize	Minutes	14.9	10.0	5.0	60.0	
Steps 1-4		Elapsed Days	25.9	21.0	2.0	75.0	
		Start Dates			2/10/2011	12/6/2011	
5	Redact	Pages	25.3	21.5	1.0	132.0	1.2
		Minutes	20.5	17.5	1.0	55.0	
Step 5		Elapsed Days	6.8	3.0	1.0	33.0	
		Start Dates			2/11/2011	12/16/2011	
6	Review	Minutes	11.3	6.0	1.0	120.0	
7	Inspect	Minutes	11.3	8.0	1.0	34.0	
8	Approve	Minutes	4.0	3.5	1.0	13.0	
9	Copy	Minutes	10.3	10.0	2.0	25.0	
		Start Dates			2/28/2011	1/4/2012	
10	Release	Pages	20.0	17.0	1.0	112.0	1.4
		Minutes	14.0	13.0	1.0	45.0	
Steps 6-10		Elapsed Days	12.2	11.5	2.0	52.0	
Steps 1-10		Elapsed Days	42.9	39.0	8.0	99.0	

N = 52

Conclusion: This is a baseline study that will allow the measurement of process improvement through the use of electronic tools.

Future directions: In 2012, some of the FOIL documents will be scanned so that content of the documents can be searched and stored electronically, and electronic redaction will be possible. When the electronic counterparts to present steps are in full production, the electronic and manual steps may be compared. Since electronically stored documents will not have to be moved between physical locations, as paper documents are, there may be some effect on time between process steps as well. Future interventions may include surveys of FOIL requestors, as well as, staff using the electronic systems.

Possible comparison between manual and electronic processes.

Time	Manual (Present)	Electronic (Intervention)
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↓	Search	1		Search
↓	Retrieve	2		Retrieve
↓	Copy	3		Scan
↓	Organize	4		Index
↓	Redact	5		Redact
↓	Review	6		Review
↓	Inspect	7		Inspect
↓	Approve	8		Approve
↓	Copy	9		Save
↓	Release to Requestor	10		Release to Requestor

Submitted by: Tim Guhl, Beth Starkweather

Bureau of Health Promotion and Disease Prevention

Cancer Services Program

The impact of the implementation of a structured and systematic reminder system on FIT Kit return rate

Objective: Increase the number and rate of Fecal Immunochemical Test (FIT) Kits completed and returned by eligible Cancer Services Program clients.

Brief Description / Background: Colorectal cancer is the second leading cause of cancer-related mortality among cancers that effect both men and women. The New York State Department of Health (NYSDOH) Cancer Services Program (CSP) provides free colorectal cancer screening for uninsured men and women aged 50 to 64. For those who are at average risk for colorectal cancer, screening is provided yearly by the CSP with an at-home test kit designed to detect human hemoglobin in the stool, a manifestation of colorectal cancer. Positive FIT Kit results are then followed-up with a referral for a colonoscopy.

The NYSDOH CSP monitors and ranks contractor performance based on the number of eligible clients who receive all of the CSP services they are eligible for. FIT Kit completion is a determinant of comprehensive screening. Overall state-wide FIT Kit completion rates are low.

Significance: This study aims to increase the number of clients who receive CSP colorectal screening services. Instituting a reminder system may increase the amount of one-on-one education clients receive. One-on-one education is a CDC recommended intervention.

Methods: From August 1, 2011 to November 30, 2011 Onondaga County CSP instituted a system designed to increase the number of FIT Kits completed by eligible CSP clients. The number of Kits completed during this time period was then compared with the number of Kits completed in the same time period in 2009 and 2010. In 2009 and 2010, the CSP of Onondaga County distributed FIT Kits only to clients who agreed to receive one. Clients who were eligible for a Kit under CSP guidelines, but declined to receive one were not sent a Kit. In 2011, the CSP switched to a system of distributing FIT Kits to all CSP clients who were eligible to receive a Kit under NYSDOH CSP guidelines. CSP clients were not given the choice to either agree to or deny a Kit. This new process means that all clients who may have declined a Kit in the past would now receive one.

FIT Kits were sent to all eligible clients after the registration process was completed. Clients were not given the option to decline the Kit. All CSP staff who qualified clients' eligibility utilized the same talking points when describing the FIT Kit to clients.

The assumption was made that the inclusion of those clients who would normally decline a FIT Kit in the distribution group could result in a decrease of the overall return rate. A literature review was completed to determine how to increase return rates. A reminder system was found to be the most cost-effective and sustainable best practice. Therefore, we included a reminder system as the intervention.

Reminders were made by both phone and U.S. mail to all clients who received a FIT Kit in the period of 08/01/2011 to 11/30/2011. One CSP staff person was responsible for making all calls and mailing all reminders. Tracking of FIT Kit distribution and reminder calls was made through a database newly created for this project. The reminder process consisted of:

1. Reminder 1: A phone call reminder was made 10 days after the mailing of the kit. This call was made to establish that the kit was in fact received, provide additional verbal instructions for the completion of the kit, and obtain a verbal confirmation from the client that they would complete the kit and return it.
2. Reminder 2: A mailed reminder was sent after the first phone call was made. The mailed reminder utilized CDC focus-tested imagery and design.
3. Reminder 3: A phone call reminder was to be made 20 days after the mailing of the Kit. This call would establish that the Kit was completed and mailed to the Lab. If not completed, staff would discuss individual barriers to their Kit completion.

Results: As a result of human error, Reminder 3 was not implemented. Therefore, the results below are based on a two-part reminder system.

Year	Total # of clients screened	# Kits Distributed	# Kits Returned	% Returned	# Positive Kits
2011	402	129	80	62%	7
2010	286	56	30	54%	2
2009	403	66	33	50%	2

(Note: There was no difference in the percentage of return rate from 2009 to 2011 (Chi square= 2.587; p=0.11) or 2010 to 2011 (Chi square= 1.155; p=0.28).

Discussion: This project increased the number of clients who received colorectal screening services through the CSP. The percent of kits returned in 2011 increased by 24% over 2009 returns and by 15% over 2010 returns when instituting a systematic reminder system and broadening the distribution pool. The number of Kits with a positive finding also more than doubled. The addition of a systematic reminder system in 2011 produced a return rate that appeared slightly higher than that experienced in 2009 and 2010, although this finding was not statistically significant. However, in 2011 the distribution pool included all eligible clients, including those who in the past would have had the option to refuse a FIT Kit.

It is possible that if the intervention included Reminder 3, we might have increased the return rate further. With a larger increase in the return rates, a statistically significant finding might have been found from 2009 to 2011. However, given that Reminder 3 was not implemented, the full value of the planned intervention was compromised and a statistically significant finding was not determined.

Conclusions: The CSP found that implementing a reminder system while expanding the client pool could result in an increase in the number of clients who receive colorectal screening services while achieving a FIT kit return rate that was trending higher than those observed in 2009 and 2010.

In order to avoid the human error that resulted in Reminder 3 being omitted, routine data review and analysis on regular and consistent intervals should have been included in this study.

Future Directions: The program will continue to distribute FIT Kits to all eligible clients. A second reminder phone call may be instituted at the 20 day mark. Adding Reminder 3 may further enhance the FIT Kit return rate. Continued study of this reminder system will be moved to a monthly QI monitor where results will be discussed during monthly staff meetings.

Submitted by Jenny Dickinson

Personnel

Improved Documentation of Mandatory Training for Article 28 and 36 Programs

Objective: Training records in personnel files will be examined to identify any reasons for missing documentation and identify ways to improve the rate of compliance.

Brief Description / Background: Documentation of mandatory training in the personnel records of employees working under Article 28 and 36 was found inadequate during reviews by the New York State Department of Health in January, 2007 and again in December, 2010.

Significance: This topic was chosen because many audits conducted by the NYSDOH require mandatory training documentation. We know we provide training and believe that most, if not all employees participate in the trainings offered. Improving training documentation should improve the overall results of future audits.

Methods:

- A list of mandatory trainings required by Article 28 and 36 was developed.
- A list of current employees who must comply with Article 28 and 36 requirements was compiled.
- Data were collected and reviewed utilizing two methods:
 - Manual Review: 22 personnel files were reviewed manually. A program heavily weighted with staff covered by Article 28 and 36 requirements was selected for review. The training section of each personnel file was reviewed for completeness.
 - Review of Database: 101 staff covered by Article 28 and 36 requirements were reviewed in the electronic data base maintained in the Administrative Unit. The data base tracks training by date for each Health Department employee.
- Findings from the manual review were compared to those from the electronic review.

Results: The manual review of 22 personnel files revealed that most files had training recorded but the certificates generated to document the training did not list the specific topics covered in New Hire and Annual Update trainings and could therefore be deemed inadequate. For example, the certificate for New Hire training simply stated that the employee completed OCHD New Hire Training on a given date. It did not list the eleven mandatory training topics that were covered. Since auditors would not know exactly what trainings were done, the documentation would likely be considered inadequate. One certificate was incorrectly filed in another employee's file. As the results of the initial manual review indicated that the certificates were problematic, further manual reviews were not conducted. All 101 staff covered by Article 28 and 36 regulations at the time of the study were reviewed in the data base training records. Virtually 100% were compliant for all mandatory trainings as documented in the data base.

Discussion: Manual documentation was unclear as training topics were not clearly listed on each certificate. This could be improved by redesigning the certificate to clearly state topics covered in each training. The New Hire Training certificate has since been redesigned to list training topics.

Electronic documentation was found to be excellent. Follow up with NYSDOH found that they will accept electronic records as long as a copy of the training outline and any sign-in sheets are also maintained.

Conclusion: It will be more accurate, efficient and use less personnel time and paper resources to maintain the training records in the central data base. Electronic records will keep us in compliance with NYSDOH requirements.

Future Directions: Work with the Training Coordinator to be sure documentation remains up to date. Monitor annually to ensure compliance. Expand the data base to include other trainings and certifications in the future.

Submitted by Cindy Clift

Office of the Medical Examiner

Utilizing the National Institute of Justice (NIJ)

“Death Investigation: A Guide for the Scene Investigator - Every Scene, Every Time” tool in the completion of medicolegal death investigation reports.

Objective: Implementation of the NIJ “Death Investigation: A Guide for the Scene Investigator - Every Scene, Every Time” investigation data entry screens to improve the quality of medicolegal death investigation reports.

Background: The Onondaga County Medical Examiner’s Office (OCMEO) Forensic Investigators conduct scene investigations by examining the body at the location of death, inspecting the scene environment, completing digital photo-documentation, interviewing witnesses, working collaboratively with law enforcement authorities, firefighters and emergency medical responders, and collecting physical evidence for further testing. This information is summarized in the medicolegal death investigation report. The NIJ “Every Scene, Every Time” investigation guideline was produced with participation of highly experienced professionals and officials who served on the National Medicolegal Review Panel. A technical working group of 144 professionals from across the country provided the grassroots input to the panel’s work. The tool provided national guidelines and standards for the conduct and documentation of medicolegal death investigation.

Prior to incorporating the NIJ “Every Scene, Every Time” tool into a new medicolegal death investigation report template in 2010, investigative reports were open-ended with only broad categories for narrative on sections of the report. Due to this open-ended design, the reports varied greatly among investigators in the manner and order in which they documented case information and investigators often failed to document much needed pertinent negatives. This made it challenging to complete quality review of reports and was also more difficult for medical examiners to know where to consistently locate information within the report. The reports had to be printed and signed for the file and often did not include a date and time of completion. Further, the old report was completed in MS Word and required duplicate data entry of case demographics and other information already tracked elsewhere.

With implementation of the OCMEO database system, new investigation data entry screens were designed based upon the NIJ “Every Scene, Every Time” investigation guidelines. In addition, with use of the database system, the data entry process was streamlined to include default pre-typed language and text from drop-down fields that populate a medicolegal death investigation report template that is digitally signed with a date/time stamp in the database. The goal of using the new data entry screens was to streamline completing reports, reduce duplicate data entry, and to capture the information most important to the medical examiner (ME) in a more succinct, consistent manner before the autopsy is completed.

Significance: MEs use scene information in the medicolegal death investigation report to assist in determination of cause and manner of death. Clear, concise and consistent documentation is paramount. Reports are often used in legal proceedings (criminal and civil) and are also relied upon heavily when death investigations are reopened years later when new evidence is discovered or advances in forensic science are made (e.g. DNA). The investigation reports are often used when cases

are reviewed by the Onondaga County Cold Case Task Force, a multidisciplinary task force working to close unsolved cases.

Finally, utilizing the NIJ “Every Scene, Every Time” tool supports the objectives of the American Academy of Forensic Sciences when sudden, unexpected and violent deaths are investigated by forensic investigators, MEs and other scientists. The effectiveness of their effort is lost if the death investigation is faulted by errors of omission or commission during the initial scene investigation.

Method:

Case Selection: In 2009, a total of 229 and in 2010, a total of 235 medicolegal death investigation reports where a scene investigation was conducted were completed. A representative sample of these reports was drawn (including a random selection of reports completed by each investigator) from 2009 (207 reports) and from 2010 (212 reports). These reports were reviewed by two Forensic Investigators that are board certified Fellows of the American Board of Medicolegal Death Investigators.

Evaluation protocol: Each report was scored using a tool where a yes or no scoring scheme was utilized. If required investigative information was present in an individual section, that section was scored a “1”. If the information was absent, that section was scored “0”. There were 45 points of information used in the scoring tool for each report reviewed. A rate of completion was then calculated for each report and the information summarized by year and by investigator. For example, if the report completion was 100%, documentation was completed or a “1” was scored on all 45 points of information. Data tracked by investigator were used to identify variation in completion rates among investigators. Completion rates were also summarized by each of the 45 points of information to determine if there were any trends by type of information. Pre and post intervention rates were compared using Chi-square test.

Results:

NIJ Every Scene, Every Time Documentation Rates of Completion

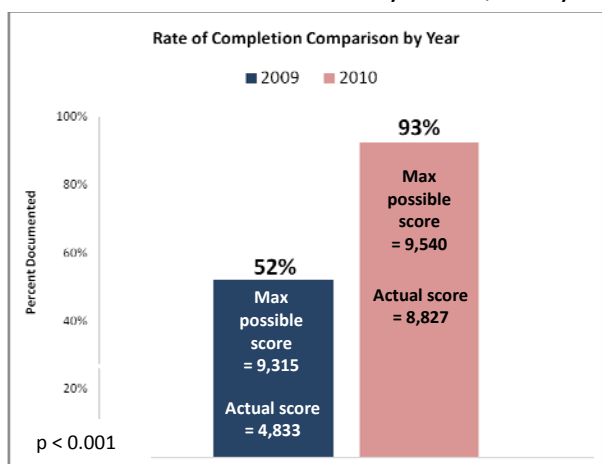


Figure 1

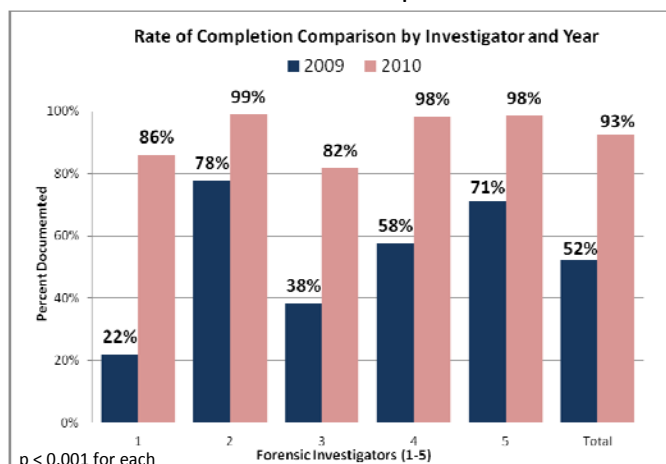


Figure 2

Table 1: Top Ten Most Improved Points of Information

Points of Information	2009 raw score	2009 rate	2010 raw score	2010 rate
Froth present from nose	9	4%	212	100%
Jewelry/valuables to family	10	5%	184	87%
Froth present from mouth	17	8%	212	100%
Physical characteristics	37	18%	158	75%
Feet	51	25%	202	95%
Decomposed	39	19%	147	69%
Color of lividity	53	26%	197	93%
Weather conditions	57	28%	210	99%
Type of camera used	57	28%	193	91%
Outdoor temperature	58	28%	193	91%

Table 2: 2010 Lowest Rates of Completion by Points Information

Points of Information	2010 raw score	2010 rate
Decomposed?	147	69%
Arrival of FI at OCMEO (Date/Time)	150	71%
Date/Time body pouch sealed	153	72%
Arrival on Scene (Date/Time)	157	74%
Physical Characteristics?	158	75%

Discussion: Results demonstrate a significant increase in overall “Every Scene, Every Time” documentation from only 52% in 2009 to 93% in 2010 (Figure 1). Results also demonstrate that each investigator significantly improved from 2009 to 2010 with the greatest improvement of 22% in 2009 to 86% in 2010 (Figure 2). In addition, variation among investigators in rates of documentation on the 45 points of information reviewed was far less in 2010 than in 2009 (Figure 2). It is also clear that by using the tool to better define specific points of information required, frequent missing points of information in the 2009 open-ended reports are now more frequently documented in 2010. For example, documentation of froth present from the nose was only present in 4% of the 2009 reports but in 100% of the 2010 reports (Table 1).

However, after use of the tool, the results identified the lowest overall rates of completion in 2010 by type of information as below (Table 2):

- Decomposed: Investigators generally typed specific information regarding postmortem decompositional changes in their scene narrative (i.e.: bloating, discoloration, skin slip) instead of using the drop-down (or a combination of both).
- Arrival Date/Times (three of the top 5): It appeared that investigators used the F4 key as a shortcut to populate the date field, but then skipped the time field.

- Physical Characteristics: Investigators left the section blank if the decedent didn't have noticeable scars, tattoos, piercings, instead of documenting a pertinent negative (i.e. None, N/A).

Conclusion: This quality improvement study demonstrates that incorporating the "Every Scene, Every Time" tool into the database system significantly improved consistency, accuracy, predictability and reliability in documentation of OCMEO death scene investigations. Moreover, a reduction and/or elimination of unanswered questions, confusion, or lack of attention to detail all contribute to the genuine acceptance that the scene was investigated thoroughly with a strong forensic foundation.

Forensic Investigators all agreed that faster turnaround time of reports, as well as improvement of overall quality were clear advantages of this new system. Use of the OCMEO database, as well as the individual investigation data entry screens freed up investigators to handle other duties, such as spending more time with grieving family members; whether on scenes, on the telephone or at the OCMEO. The sudden or unexpected death of an individual has a profound impact on families of the deceased and places significant responsibility on the agencies tasked with determining the cause and manner of death. The way in which death investigators do their job is crucial to family members who are mourning a loss.

Future directions: Each investigator will be provided with their individual results as a tool to improve their performance. The performance measure goal for each investigator and for the office as a whole will be to achieve a 100% completion rate of all 45 "Every Scene, Every Time" points of scene investigation information.

The OCMEO plans to add updates to our database system to make mandatory that certain fields (i.e. date/time of arrival, seal time, livery notification) are completed or the system will not allow the investigator to close out of the database or move on to other data entry screens in the program. Accuracy is critical with scene arrival date/time as the National Association of Medical Examiners accreditation requires documenting and monitoring investigation response times.

In the near future forensic investigators will be using handheld Motion Computing® tablet computers in the field that have direct access to the database. The investigators will have the ability to document scene information in the data entry screens while on scene, as well as have law enforcement officers digitally witness chain of custody on physical evidence collected for further testing. The database will also include "scene types" with default pre-typed language and text from drop-downs specific to the type of case they are investigating (i.e. hanging, drowning, stabbing, etc.) to further improve the quality of medicolegal death investigation reports.

The OCMEO will continue to strive for excellence in medicolegal death investigation with steadfast loyalty to documentation of every aspect of the scene investigation by continual use of the NIJ "Every Scene, Every Time" and general death investigation guidelines. By adhering to agreed-upon OCMEO and national standards, death investigators can arrive at the truth about a death.

Submitted by Brian P. Ehret, Catherine Unger

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Poster 1: Is There a Need for Rabies Clinic Scheduling?

Lisa Letteney, Stacy Napier, Paul Liechti. *Animal Disease Prevention Program*

Aim: To determine if clients prefer to make appointments, through the web or phone, for their pets to receive rabies shots.

Background: In the past there have been several rabies clinics at which clients had to wait an extended period with their pets. Some clients even get in line up to one half hour prior to the start of the clinic.

Measures:

- Use a survey tool to determine if clients would like to make appointments for their pet's rabies shots.
 - Perform time trials to ascertain average wait times.
-

Plan Clients always have to wait some period of time at the rabies clinics which presents an ideal opportunity to survey them.

- Time trials will allow exact data on wait time.
- A process for appointments, similar to what is done for flu clinics using the web or phone, can be implemented if clients indicate that it would be beneficial for them.

Do

- Develop a survey tool.
- Survey as many clients as possible at the clinics. Perform ten time trials at each clinic.

Study

- A total of 504 families out of a possible 1412 (36%) were surveyed at ten rabies clinics.
- 4 out of 504 clients (.8%) thought they had waited an unreasonable amount of time to have their pet vaccinated; 99.2% thought the wait time was reasonable.
- 38 clients (7.5%) said that they would like the opportunity to make an appointment to have their pet vaccinated.
- Time trials at nine clinics indicated that the average wait time was twenty minutes.

Act

- The survey indicated that clients did not think that their wait time was unreasonable and only a small percentage wanted to make appointments.
- Nothing more will be done at this time.

Poster 2: Grant Spending 2010-2011

Rob Cleghorn, Steve Smorol. *Fiscal – Grants Unit*

Aim: Regular exposure of grant spending lags to prompt improvement. The aim is to raise awareness of the extent of this problem, both for the staff who are in charge of spending, and for the administration which must cope with problems created by grant underspending and delayed spending.

Background:

The rate of monthly grant spending is variable, and is bunched heavily at the end of the grants.

Several harms can result from this:

- Incomplete spend-out of grant, leading to:
 - Reduced grant award in future years
 - Greater dependence on local revenues
- Last minute spending, leading to:
 - Purchase errors including overspending which cannot be claimed
 - Projection and budget modification errors
 - Claims to granting agencies filed late
 - Needed supplies and equipment items are unavailable to the grantee during most of the grant year if not purchased early on
 - Advertising campaigns which are most effective when continuous are instead squeezed into a few months

That this is a serious and widespread problem is evidenced by the recently developed New York State tendency to break one year grants into smaller periods and take back the unclaimed funding from each period.

Measures:

- Compare monthly to annual grant spending for Personnel Services
 - Compare monthly to annual grant spending for Other Than Personnel Services (OTPS)
-

Plan

- Build and populate a grant spending data table
- Design graph to pull from the data table, and clearly display monthly grant spending variances
- Schedule time to present graph to senior staff

Do

- Compile data from monthly summaries into a data table.
- Print copies of grant spending graph from that data
- Present copies to Senior Staff members

Study

The graphs display the percent of the total year's spending contributed by each month's spending. The month numbers indicate the relative position of the month in the grant year, but do not indicate a specific month. For example, if the grant ran from 10/1/10-9/30/11, then month number 1 was October, and month number 12 was September.

The grant spending graph is based on data tables which record the monthly spending totals for 24 public health grants. The data tables are based on the monthly summaries for the grants, which are linked to the grant ledgers and provide totals for all of the spending in each grant.

Act

In November 2011, a grant spending graph was presented at the senior staff meeting. An update will be given out to senior staff every quarter. The graph highlights current grants for which the percent of either personnel or OTPS spending to date is at least 20% less than the percent of the grant year elapsed. By November 2012, four interventions will have been completed. The graphs prepared then will be compared to the graphs prepared in November 2011 to see if grant spending has become less uneven.

Poster 3: Pilot to Increase HIV Testing Acceptance for HIV Contacts

Diane Rothermel, Towanna Morgan, Deborah Crouch, Darlene Carey
Bureau of Disease Control-PNAP Program

Aim: To see if the ability to offer Rapid HIV Tests to contacts to HIV positive individuals in the field at the time of notification increases the number of individuals who accept testing.

Background: OCHD Communicable Disease Investigation (CDI) staff are charged with notifying contacts to HIV positive individuals. During notification, CDI staff noticed an increase in individuals seeking Rapid HIV testing. Since OCHD did not offer a Rapid testing method we partnered with New York State Department of Health Regional Office Staff to perform the rapid tests, however NYSDOH staff is not always available to assist. OCHD CDI staff requested training to be able to perform HIV Rapid Testing in the field in order to increase the number of contacts testing at notification.

Measures:

- Gather data on how many individuals accept testing from May 1, 2011 to December 1, 2011
 - Train CDI Staff
 - Implement Rapid Testing in the field
 - Gather data on those who accept testing from January 1, 2012-August 1, 2012
 - Compare data for increase in test acceptance and make decisions on continuance of pilot
-

Plan

- Seek Administrative Approval
- Seek NYSDOH Support to Provide HIV Rapid Testing Kits
- Research Testing Methods

Do

- Write HIV Rapid Testing Policies
- Apply for CLIA Laboratory Waiver
- Order Test Kits

Study

- Gather pre-intervention data May 1, 2011-December 1, 2011

Act

- Move forward with Training and Implementation of the Pilot

Poster 4: Effectiveness of CNYMRC Volunteer Notification System

Bobbi Alcock. *Public Health Preparedness—Central New York Medical Reserve Corps*

Aim: To improve the percentage of volunteers correctly acknowledging communications received via the ServNY notification system.

Background: The ServNY notification system is used by the Central NY Medical Reserve Corps CNYMRC during times of need to contact volunteers quickly. To help volunteers become accustomed to properly using the system, it is also used to distribute non-emergency information and to make requests for assistance with non-emergency activities.

Measures:

- The percentage of volunteers who confirm receipt of communications. The communications are split into further categories by type of delivery method (email, phone) and who the message is sent to (all volunteers, volunteers in a specific county, and volunteers selected by profession). The percentages in each category are averaged in each quarter of the calendar year.
-

Plan

- To send communications to CNYMRC volunteers via ServNY notification system to assist volunteers in learning to use the system properly before a disaster strikes. Communications were also be sent by email in conjunction with ServNY to ensure communications were being received during the year-long adjustment period.

Do

- Each quarter an educational article or reminder was included in the CNYMRC newsletter with the goal of increasing the number of volunteers who correctly confirm receipt of communications. Periodic communications drills were also conducted for the same purpose. Volunteers are informed of these drills in advance.

Study

- Looked at the different categories of notifications each quarter to see if there was improvement in the percentage of volunteers correctly acknowledging communications.

Act

- It is unsure whether real improvements were made or not. For example, there were volunteers who signed up for programs but had not acknowledged the message concerning the request. Because of this, we are looking at other educational interventions for the upcoming year.

Poster 5: Improving Email Audience Readership of Health Related Recalls

David Czerkies. *Community Environmental Health*

Aim: To improve the level of readership of FDA Recall Notifications

Background: Timely email notifications of recalled Food, Drug, and Medical Devices, to the Recall Notification Group (representatives of the Health Department), may prevent the use of or exposure to various products which can cause serious adverse health consequences or death. This information is also used when investigating potential sources of reported illness.

Measures: Capture the number of recall emails forwarded to the Recall Notification Group that are opened by group members over several months.

Plan

- Evaluate current levels of readership by requesting return receipt of all emailed recalls sent to group members over a five month period. Implement intervention, then collect post interventional outcomes.

Do

- Email a reminder to ask recipients to click and open the U.S. Food & Drug Administration (FDA) Daily Digest Bulletin or FDA recall. Also include questions regarding usefulness of information and suggestions for improvement.

Study

- 49 FDA Recall emails were sent to 18 members in the Recall Notification Group pre-intervention. Out of the expected 882 (49 X 18) clicks to read events, 600 clicks (68%) were generated by group members. After the reminder email, 38 FDA Recall emails were sent to the same group members, in this group, 499 of the expected 684 open clicks(73%) were performed by group members. A 5% increase in readership of Recall Notifications was realized after sending the reminder email.

Act

- Reminder emails will continue as a result of this study. Also editing of recall notices to highlight critical information has been undertaken to improve audience's ability to quickly scan Recall Notifications for relevant information.

Poster 6: Feasibility of Electronic Health Records for FPS

Jean Reilly, Pamela LaBarge. *Family Planning Service*

Aim: Determine the feasibility of using electronic medical records (EMR), electronic billing and practice management systems. The ultimate goal is to utilize health information technology (HIT) to bring the program in alignment with 21st century best practices.

Background: The advent of health care reform will bring an increasing reliance on technology, including use of electronic patient records, billing and prescribing processes. The American Recovery and Reinvestment Act (ARRA) provides incentives to medical practices who successfully achieve “Meaningful Use” of an EMR for up to 5 years after implementation. The last year incentives will be provided under Medicaid is 2021. Therefore, if Family Planning Service (FPS) is to move toward electronic records, the system must be functional by mid 2016.

As a small program with limited revenue, costs of implementation may be a significant barrier. FPS plans a multi-year approach to determine feasibility, with a focus on research and evaluation of the pros and cons of EMR for the first year, moving toward purchase and implementation in year two and potentially year three.

Measures:

- Learn about EMR in order to be better able to recognize a potentially compatible system and to determine pros and cons of implementation.
 - Document steps in process of ensuring that patient records are complete and available during appointments, and accessible to staff, in order to identify potential changes and benefits of change from paper to electronic systems.
 - Initiation of incremental steps in increased use of technology for practice management systems.
 - Document capacity to meet “Meaningful Use” guidelines (Meaningful Use measures are specific clinical quality measures that must be met by practice)
-

Plan

- Learn about various EMR systems
 - Become conversant in the “lingo” of EMR
 - Consult with other Family Planning providers who have used EMR regarding success, pros & cons of the system, etc.
-

Do

- Attend training and informational sessions regarding EMR
- Speak with vendors, determine their capacity to meet existing data collection requirements
- Obtain estimates of start-up costs and annual costs, and potential incentives from ARRA
- Determine the cost/benefit
- Ensure integration with required reporting systems to eliminate “rework” and ensure best fit with Family Planning grant requirements and staff needs

- Determine capacity of current IT system to ensure connectivity at all times
 - Determine what hardware is needed (e.g., additional computers in clinics, desk work stations for reception and history staff; laptops or tablets for NPs)
 - Identify opportunities for funding (e.g., legislative or foundation funding)
-

Study

- Narrow choices (at this time three possible vendors with experience in NYS, NextGen, Athena, eClinical Works)
 - Consider staffing needs (e.g., fewer staff required to handle paper records, increased need for IT support)
 - Determine contract language for clinicians to obtain annual ARRA incentive payments which will offset most of the annual cost
-

Act

- Decide if FPS will go forward with EHR and determine rest of timeline
- Complete grant applications for the Verizon Foundation and the Gifford Foundation to request funding for start-up
- Arrange for “demos” by vendors
- Choose system with input from clinical and billing staff as well as OCHD IT
- Purchase system, design infrastructure, train all staff
- Install system, convert paper records to EMR as appropriate and go live!

Poster 7: Effectiveness of a Peer Counselor on Breastfeeding Initiation and Duration Among First Time Breastfeeding Mothers Participating in WIC

Merilee Mohr-Twardowski, Margaret Seiter, Sharon Tripolone. *Women Infant and Children Program*

Background: The Enhanced Peer Counselor Program was started by the OCHD WIC Program in June 2010. The intent of the Enhanced Peer Counselor Program is to increase initiation rates among prenatal women who participate on the WIC Program. WIC is also interested in looking at the duration rates of breastfeeding for those women assigned a peer counselor and who choose to breastfeed.

Measures:

- All pregnant women who have not breastfed previously and accept a breastfeeding peer counselor referral will be included in the study. Enrollment in the study will be conducted from June 1, 2011 – December 1, 2011.
 - Outcomes on breastfeeding initiation and duration will be compared between three study groups: (1) those women who intend to breastfeed without a peer counselor assigned, (2) those who intend to breastfeed with a peer counselor assigned, and (3) those women who intend to breastfeed and had a peer counselor assigned but did not have contact with the peer counselor.
 - Women who accept the peer counselor referral must have at least one informational visit, either in person or by phone, to be part of this study.
 - For Q.I. Summit XV, results will be reported on initiation. The second year of the study (Q.I. Summit XVI) duration of breastfeeding among the study participants will be collected and analyzed.
-

Plan

- Look at current breastfeeding initiation rates.

Do

- Train staff to ensure breastfeeding peer counselor referrals are offered to all prenatal women.
- Develop database to track women who are part of study.
- Monitor results of 3 study groups.

Study

- Review staff, WIC participant and peer counselor feedback.
- Review data and make changes as needed.

Act

- Fully implement project based on study results.

Poster 8: Physician Detailing Visits to Improve Blood Lead Testing Compliance

Debra Lewis. *Childhood Lead Poisoning Prevention Program*

Aim: Our aim is to improve Onondaga County's overall blood lead testing compliance rate by providing practice-specific education and technical support (physician detailing) to medical providers identified with a low 2-year-old testing compliance rate.

Background: New York State Department of Health (NYSDOH) requires blood lead testing at age 1 and again at age 2. The NYSDOH Childhood Lead Poisoning Prevention Program sets a target compliance rate for local health departments at 80% for children to have a blood lead test at both 1 and 2 years of age. For the 2008 birth cohort, Onondaga County boasts the 2nd highest (92.5%) overall testing compliance rate in New York State for children having at least one test before their second birthday. Of this age cohort, 76.6% had a blood lead test at age 1, while only 63.4% had a blood lead test at age 2. Because the rate of testing for 1 year olds is high, it is thought that targeting an intervention designed to increase the testing rate among 2 year olds will ultimately result in an increased percentage of children tested at both 1 and 2 years of age.

Studies of blood lead testing compliance rates were conducted in 1998 and 2007 and are available in the QI Summit archives. Both reports included recommendations for physician education and support. In addition, physician detailing visits are a required component of two NYSDOH Lead Program work plans. However, physician detailing visits have not historically included the type of practice level performance data that will be included in this proposed intervention strategy.

Measures:

A two year study will be conducted. Planning, research, and material development are undertaken in 2011. The intervention and analysis will be conducted six months after the conclusion of the intervention to evaluate the impact of the intervention on each medical provider's testing compliance rate.

- Using the LeadWeb statewide blood lead registry and the New York State Immunization Information System (NYSIIS) statewide immunization registry, identify practices with a low percentage of 2-year-old testing compliance.
 - The number of 2-year-old children served by each practice is determined from NYSIIS records. The number of children served by each practice with reported lead test results is obtained from LeadWeb to establish the testing compliance rate.
 - Pre-intervention analysis is conducted to establish a baseline 2-year-old testing rate for each practice.
 - Post-intervention analysis will consist of both an immediate post-intervention "snapshot" and a detailed post-post intervention analysis of LeadWeb/NYSIIS data to evaluate the impact of the intervention on each participating practice's testing compliance rate.
-

Year One:

Plan:

- Review local history of testing compliance, including previous QI studies and physician survey data to identify practice-reported obstacles to testing compliance.
 - Research best practices in providing practice-based technical assistance.
 - A training module entitled “Public Health detailing” was identified on the NYS Learning Management system. Staff assigned to this project will complete the training module and receive a training certificate.
 - Pursue a recommendation by the NYSDOH Childhood Lead Poisoning Prevention Regional office to develop practice-based technical assistance strategies similar to those currently used for immunization compliance.
 - Determine criteria to be used to select practices. Each practice selected must meet the following criteria:
 - Serve at least 200 children in the 2008 birth cohort
 - Service children residing in the City of Syracuse
 - Have a 2-year-old testing compliance rate of $\leq 80\%$
-

Do:

- Analyze LeadWeb and NYSIIS Data.
 - The NYSDOH NYSIIS database was used to determine the total number of children in the target population for individual pediatric and family practice providers in Onondaga County.
 - The NYSDOH LeadWeb database was used to determine the total number of children tested for the selected time period.
 - NYSIIS and LeadWeb data were compared to determine the percentage of children tested for each practice.
- Select practices for intervention.

Practice	# Patients with DOB: 1/1/08-6/30/08	# Patients tested between 19-35 months	Total % tested
Practice A	240	153	65.8
Practice B	250	169	69.6
Practice C	308	240	80.5
Practice D	299	170	71.6
Practice E	305	215	77.7
Practice F	281	187	76.9

Study:

- Assess the physician detailing model currently used by Lead Program staff.
- Consult with Maternal Child Health (MCH) Immunization Program staff and accompany MCH staff to a provider feedback visit.
- Identify modifications to the MCH strategy to fit the needs of the Lead Program.
- Assess Lead Program staff experience with using MCH and NYS Learning Management System (LMS) strategies.
- Assigned staff will complete “Physician Detailing” training module on NYS LMS.

Year Two:

Act:

Based on activities conducted in Year One, the intervention will be implemented for six selected practices. The planned intervention activities are described below:

- Determine whether one or more staff will be assigned to implement the intervention.
- Contact practices and obtain their commitment to participate in the intervention.
- Identify a primary contact for each selected practice.
- Develop structured interview format, performance improvement plan, and physician toolkit.
- Train assigned staff to conduct structured interview and provide performance improvement coaching.
- Develop individual practice education packets.
- Schedule initial appointment and implement intervention strategy.
- Collect and analyze data.
- Present findings at QI Summit XVI

Poster 9: Impact of Enterprise Content Management on Workflow in Vital Statistics

Rebecca Shultz. *Surveillance and Statistics, Office of Vital Statistics*

Aim: To ensure document protection and improve workflow by implementing an enterprise content management (ECM) system in the Office of Vital Statistics.

Background: Over 1,000,000 hard copy records dating to 1873 are stored in the Office of Vital Statistics without backup measures in place. An accident or destructive event could result in the permanent loss of information. In addition, older records are beginning to deteriorate. With ECM, these documents (including birth certificates, death certificates, and acknowledgement of paternity) would be scanned, and staff could issue copies from the images. The ability to store and retrieve documents electronically will automate workflow, increase productivity, improve service to both internal and external clients, and protect an important source of revenue for the County. Funding was approved for ECM in 2011. This multi-year study will examine baseline workflow processes in the Office of Vital Statistics and assess the effect of electronic records on these processes. In order to fully evaluate the impact, enough records must be scanned in to make practical the use of the system in daily business functions. This is year one of a two year project

Measures: Measures of success for Year 1 include:

- Identification of a vendor and full implementation of the system
- Initiation of scanning all types of documents
- Documentation of baseline data including workflow processes for a variety of daily business functions and time study data for processing a birth certificate order at the counter.

Plan:

- Visited other consolidated counties to view their electronic systems (occurred in 2008)
- Documented all requirements for ECM in Vital Statistics

Do:

- Sent out Request for Proposals
- Reviewed proposals and held demonstrations for the top three vendors
- Selected vendor
- Conducted time study on processing birth certificate orders at the window
- Documented baseline workflow practices for: requests for birth certificate orders at the window, requests for death certificates at the window, processing genealogy requests, processing newly received birth certificates and processing newly received death certificates

Study:

- Identified areas where workflow processes would be expected to improve following full implementation of ECM
- Identified and remedied issue with software capability, which postponed initiation of scanning activities
- Began scanning recent birth certificates at a pace of 1500 documents per week

Act:

- Continue building templates to scan additional document types
- Continue scanning and indexing recent birth certificates
- Explore opportunities to retain staff so that progress can be made in back-scanning