

NEED FOR SPEED

Increasing throughput to meet 48 hour dispensing goals

PRESENTERS:

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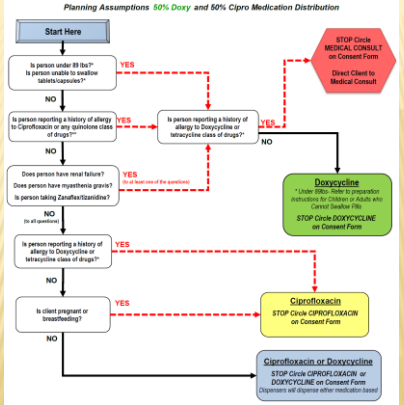
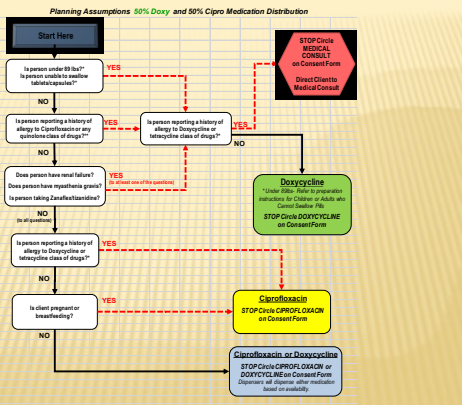
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HOUSEKEEPING

- ✦ Please make sure you have scanned your badge.
- ✦ Please silence your cell phones
- ✦ Please observe emergency exits

THE SCREENING PROCESS

Household Members	Self	Person # 2	Person # 3	Person # 4	Person # 5	Person # 6
First Name						
Last Name						
Allergic to Doxycycline or any tetracycline	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Allergic to Ciprofloxacin or any quinolone	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Weight under 88 pounds or cannot swallow pills	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Pregnant or Breastfeeding	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Taking Zolmitriptan (Ibuprofen)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
History of Myasthenia Gravis and/or Kidney Disease/Dialysis	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>



Household members	SELF <input type="checkbox"/> Male <input type="checkbox"/> Female	PERSON #1 <input type="checkbox"/> Male <input type="checkbox"/> Female	PERSON #2 <input type="checkbox"/> Male <input type="checkbox"/> Female	PERSON #3 <input type="checkbox"/> Male <input type="checkbox"/> Female	PERSON #4 <input type="checkbox"/> Male <input type="checkbox"/> Female	PERSON #5 <input type="checkbox"/> Male <input type="checkbox"/> Female
First Name						
Last Name						
Is/Does household member:	Check YES if ANY apply	Check YES if ANY apply	Check YES if ANY apply	Check YES if ANY apply	Check YES if ANY apply	Check YES if ANY apply
A • Allergic to Doxycycline or any tetracycline • Pregnant • Breastfeeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B • Allergic to Ciprofloxacin or any quinolone • Weight under 89 pounds • Unable to swallow a pill • Kidney Disease/Dialysis • History of Myasthenia Gravis • Taking Zanaflex (tizanidine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

ANSWER REFERENCE CHART - STAFF USE ONLY					
QUESTIONS		ANSWERS			
<ul style="list-style-type: none"> • Allergic to tetracycline (doxycycline)? • Pregnant (Planning pregnancy) • Breastfeeding 	A	NO	NO	YES	YES
	<ul style="list-style-type: none"> • Allergic to Quinolone (ciprofloxacin)? • Under 89 lbs. • Unable to swallow a pill • Renal Disease • Myasthenia Gravis • Taking Tizanidine 	B	NO	YES	NO
PROVIDE		DOXY OR CIPRO	DOXY	CIPRO	MED CONSULT

NEED FOR SPEED

The purpose of this session is to demonstrate through a screening exercise that the modified form and chart increase throughput and accuracy over the use of the standard form and algorithm.

FUNCTIONAL EXERCISE

Divide the room down the middle.

- ✘ Choose 2 screeners for each team.
- ✘ All other participants will be given pre-filled data collection forms. The medication requested will be equal for both teams.
- ✘ One side of the room will receive the standard form and the other side will receive the modified form.
- ✘ Screeners on the standard side will receive the algorithm.
- ✘ Screeners on the modified side will receive the algorithm and chart.
- ✘ Screening will continue for 20 minutes.

HOTWASH

- ✘ Teams will discuss their thoughts on the tools that they used.
- ✘ Preliminary results will be given to participants. Specifically how many prescriptions were screened by each team.
- ✘ Participants can leave contact information if they wish to receive the results on accuracy.
- ✘ Feedback on the session will be collected.

THANK YOU!!!

NEED FOR SPEED - PRESENTERS

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