1. **Getting Started**
The problem addressed was the communications between the Environmental Health (EH) and Clinical Divisions during the rabies protocol.

2. **Assemble the Team**
The team is composed of the beta test coordinator with the addition of a disease specialist and an EH senior sanitarian.

**Original Aim Statement:**
To increase performance of communication between EH and Clinical to enhance timely series follow-up for human rabies exposures.

3. **Examine the Current Approach**
Thirty samples per year for three years were used as baseline data. The samples reflect rabies events for exposed and non-exposed individuals, for domestic and wild animal species. Baseline data indicate that reporting from Environmental Health and Clinical ranges from 1 day to 150 days.

A cause-and-effect diagram was completed to understand what affects timely communication, and it was discovered that external influences were a significant factor.

4. **Identify Potential Solutions**
By using the Nominal Group technique, the team decided that the an electronic form 487 would be the most useful to test, because among other things, it would expedite communications involving external partners.

5. **Develop an Improvement Theory**
Using an electronic form 487 when a rabies call is received by the health department from external partner will facilitate a 3 day notification between the EH and Clinical Division.

The following flow chart reflects the reporting process using the electronic form 487.

6. **Test the Theory for Improvement**
A new protocol, based on the flow chart, was established to test the Improvement Theory. Five calls were received in the month of October and November (two non-human exposures and three human exposures with non-rabid animals) and the protocol was followed.

**Current Aim Statement:**
By Nov 15th 2010 reduce to real time (day 3) the reporting of rabies confirmations between Environment Health and Clinical.

7. **Check the Results**
As can be seen from the results, all reports were communicated within three days.

8. **Standardize the Improvement or Develop New Theory**
The test has been adapted to be lengthened – it will continue until the new protocol has been applied to several confirmed positive rabies human exposure cases. At that time it will be feasible to analyze the results and determine whether it is appropriate to standardize the protocol.

9. **Establish Future Plans**
Flow charting of the rabies communication protocols in the EH and Clinic Divisions, respectively, revealed that unnecessary duplication of activities was occurring in the Clinical Division. Therefore, a new chart was established and shared with staff to ensure that duplication was eliminated in the human rabies exposure reporting process.

Furthermore, while charting the data for the purposes of the QI project, the team realized that the data could be geographically displayed, thus providing a new way to analyze the rabies problem in the county. The areas of concern are within populated areas near water sources. Additionally, a cluster event occurred in 2007 that had gone previously undetected.

In addition to using this information in a more proactive fashion, the health department plans to implement quality improvement efforts in other programs.