
Welcome to the Performance Improvement Managers Network Call

Creating a Culture of Quality Improvement

March 22, 2012

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Centers for Disease Control and Prevention

Office for State, Tribal, Local and Territorial Support

Agenda

Today's Presenters:

Grace Duffy, Public Health Foundation

Joe Kyle, Maxine Williams & Janice Tapp
SC Department of Health & Environmental Control

Moderators:

Liza Corso & Teresa Daub, CDC/OSTLTS

Objectives

1. Describe the characteristics of a Culture of Quality Improvement (QI)
2. Share an overview of the Greenville, SC DPH Fast Track implementation pilot
3. Identify benefits and barriers encountered as SC rolls this successful pilot out to all PH regions
4. Provide Q&A with Quality and Implementation specialists

What is a Culture?

Culture is what holds an organization's DNA together

It helps define its personality and explain its performance

“It is how we do things around here”



Indicators of an Organization's Culture

- Rituals and Routines
- Symbols
- Power Structures
- Organizational Structures
- Control Systems
- Stories

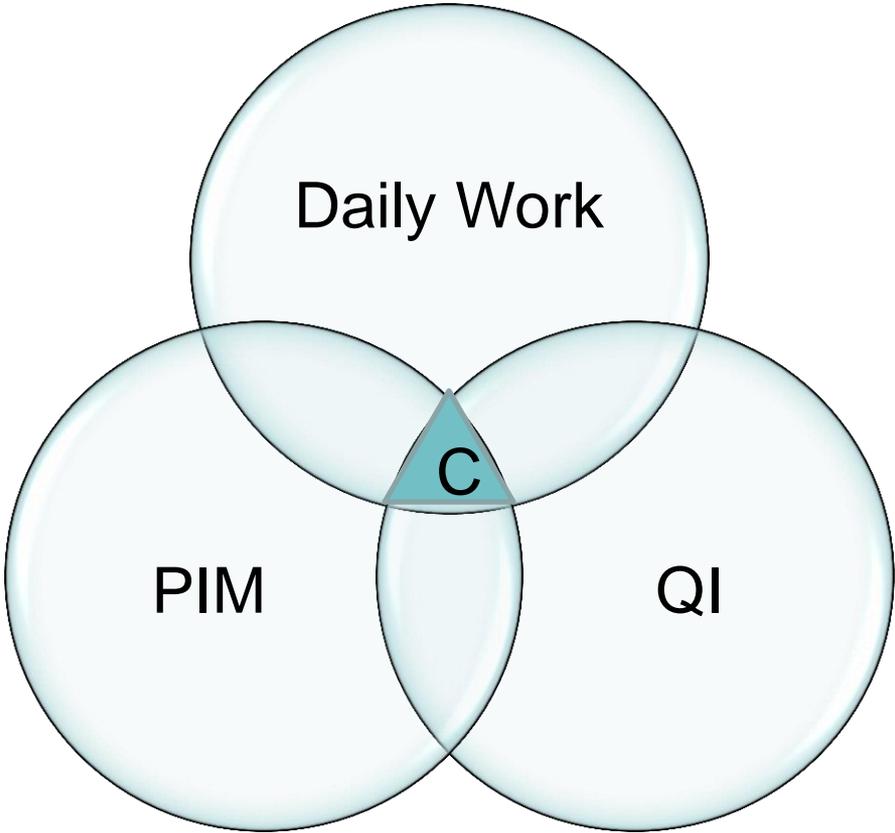
Quality Culture

- Building a quality culture is not an easy task.
- Developing a focus on quality seems very easy but it really is not a straightforward thing to achieve.
- Organizations spend years of efforts and budget to achieve the goal.

The Ingredients of a Quality Culture

- Commitment
- Capability
- Understanding of Customer Expectations
- Empowerment
- Process Focus
- Institutionalization

How Public Health Activity Creates and Sustains a Culture of QI



South Carolina DHEC Case Study



South Carolina – Organizational Context

- Fully centralized governmental public health system – all local health department employees work for state government
- All local (county) health departments are organized into Regions
 - Minimum of 3 counties, maximum of 10
- Local substantive management decisions made at the region level
- Office of Performance Management and Health Improvement began in 2004
 - Currently has 2 employees working on PM and QI



Fast Track Definition:

**Lab work and minimum education only,
for asymptomatic clients presenting
at an STD clinic (no physical exam)**

Fast Track...rationale for testing

- Discussions around Fast Track (FT) begun in 2009
- Recognition that there was increasing pressure on STD clinical appointment slots due to decrease in clinical and administrative staff
- FT had been implemented in other states with apparent success and in Region 7 (DHEC) unofficially
 - Limited implementation in the South
- Potential to use non traditional providers as providers of FT services, freeing up clinical slots for symptomatic clients and contacts

Fast Track...Pilot AIMS

Implement STD FT in 3 pilot regions for asymptomatic clients that:

- 1) satisfies customer expectations;*
- 2) increases the number of clinic slots for symptomatic clients;*
- 3) is done efficiently with a low number of referral errors;*
- 4) results in a low total time in clinic, and*
- 5) results in high employee satisfaction*

Fast Track...Pilot Set Up

- Original intent to pilot in 4 Regions (2, 5, 7 and 8), ending up in Regions 2, 3, and 5 (two counties)
- Region 2, with support of PHF consultant, got started first, and informed the work on the other two regions
- General parameters:
 - Screening protocol for appointment staff resulting in FT or non FT appointment slot
 - Client shows up, screened again (questionnaire), continues in FT or non FT
 - FT clients have lab work done, receive specific messages, check out
 - Lab results communicated as with any other client

Pilot Preparation

- FT policy developed by Office of Nursing and Division of STD/HIV staff, with input from medical consultants
- Metrics developed by Office of Performance Management (PM) in consultation with Division of STD/HIV and Office of Nursing
- Phone consultation provided to pilot site managers by STD/HIV Division, Office of Nursing and PM staff
- Training of FT staff in the regions.

Fast Track...Region 2 initial work...

Greenville County HD: South Carolina Pilot; PHF Quality Improvement Project
Thursday, December 02, 2010

AIM: Providing STD Testing only services to clients that meet specific screening criteria.

Goals:

- A. Increase asymptomatic STD testing services
- B. Decrease clinic wait time to all clients
- C. Increase clinic efficiency & capacity

AIM characteristics: (SMART)

Specific: (See above)

Measures:

Content:

- Lab Processes
- Fast Track Service
 - Walk-in
 - Turn-away
 - #, %appointed
 - Intake
 - Complete
 - Screening
- # Positive by category

Process:

- Patient Flow Analysis
- Satisfaction:
 - Staff
 - Patient
- Documentation
 - Share
 - Brag
 - Educate
- Milestones

Actionable: FAST Track is in use within other Health Departments

Realistic: Goals are tangible and measurable

Time Bound:

Content timing:

- Scheduling within FAST Track
- Service time within clinic
- Test results

Process timing:

Dec 2, 2010	Kickoff and "As Is" flowchart
Jan 26, 2011	Cause & Effect, Prioritize, Task Identification
Feb, 2011	Pilot development and project definition
Mar/Apr 2011	Pilot test, data gathering, documentation
May 2011	Final close out of CDC grant activities, next steps locally



Fast Track...Region 2 initial work...

“Yes...But’s”

- Clinic appointed or Walk-ins or both? What is best??
- Staffing issue
- Staff utilization/ Costs of staff to provide
- Phone volume*
- Turn - a ways
- Asymptomatic - No DIS in building to serve: What happens?
- Health Education
 - What is it?
 - Time to do it

*Anticipate increase in volume:

- Phone
- Intake
- Lab
- Admin
- Social work

From Dec
2010 mtg.



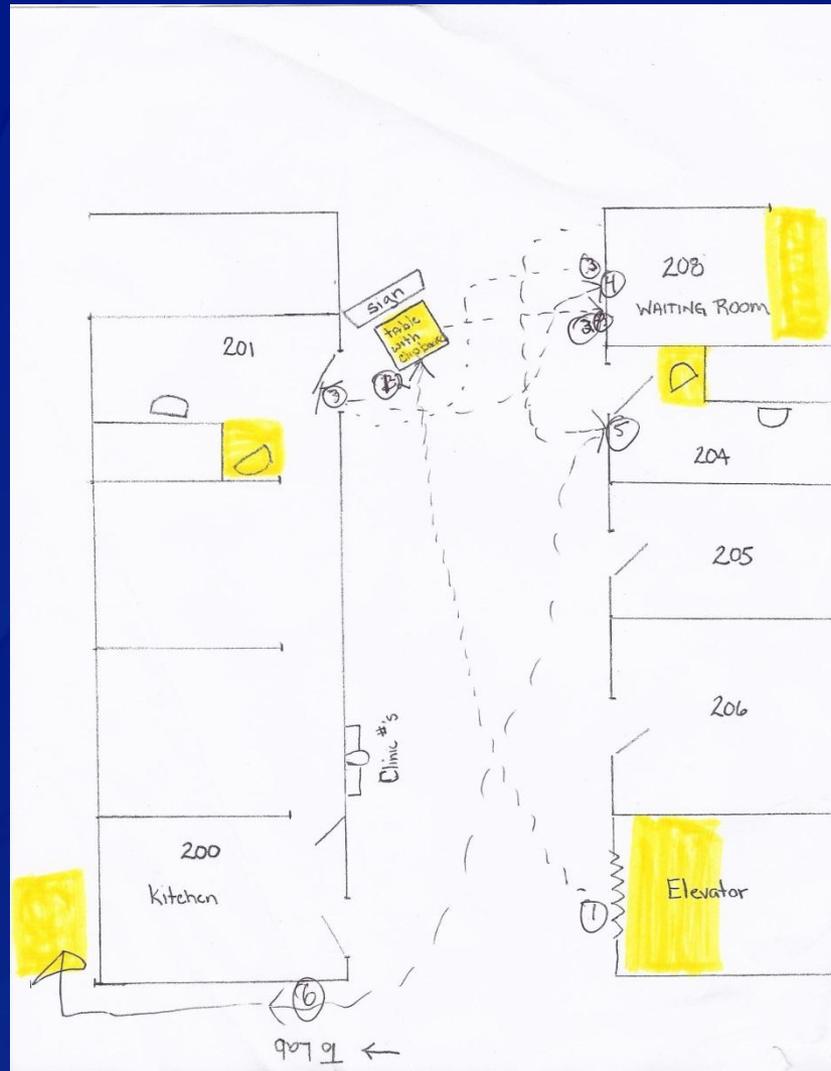
Fast Track...Region 2 initial work...

SCDHEC/PHF STD QI Demonstration Project
Current state definition and initial QI skills training session
Greenville, South Carolina – Wednesday, January 26, 2011
9:00 AM – Noon

Agenda

9:00AM	Welcome, intros and expectations	Maxine
9:20	Project review- AIM and As Is Flowchart	
9:40	Review of “Yes...but’s” from December	Grace facilitate
	<ul style="list-style-type: none">• Transfer interim brainstorm results to stickies• Add any additional barriers or benefits to stickies	
10:00	Affinity and Theme Identification Activity	Team members
10:20	Create Cause & Effect Diagram	
	<ul style="list-style-type: none">• Select priority FAST track barriers for Root Cause Analysis (RCA)	
10:50	Break	
11:00	High level flowchart for GCHD Fast Track System pilot	
	<ul style="list-style-type: none">• Suggestions for RCA of priority barriers• Tasks, measures, and To-Do list for running pilot in one GCHD Clinic	
11:45	What’s next- clinic pilot and February workshop	Grace/Maxine
Noon	Adjourn	

Fast Track...Region 2 initial work...



Initial Flow
Concept,
beginning to
end

Fast Track...Region 2 initial work...

SCDHEC/PHF STD QI Demonstration Project
Cause & Effect and Fast Track Pilot Design QI skills training session
Greenville, South Carolina – Thursday, March 3, 2011
2:00 – 4:00 PM

Agenda

2:00 PM	Welcome, intros and expectations	Maxine
2:15	Project review – Status of “To Do” list From February 11 Internal session	
	▪ Staffing	Maxine, Constance
	▪ Screening	Charlotte, Phyllis,
	▪ Evaluation	Grace w/ Doug, Maxine
	▪ Scheduling	Charlotte & Co.
	▪ Clinic volume, flow, geography	Char, Chancey et al
	▪ RR Counseling	Michelle, Mary, Page
	▪ Uncontrollable events	Roslyn
3:00	Translate clinic flowchart into pilot week 1 work procedure	
	• People	
	• Equipment: medical, administrative, I/S	
	• Methods: clinical, administrative, measures – clinical, process	
	• Timing: start and stop of 1 week pilot , STD visit cycle, bottlenecks	
	• Materials, supplies, furniture	
	• Escalation procedure	
	• Last minute To Do’s and Yes... buts – assigned with due dates	
3:45	Final huddle before kickoff	Maxine, Doug, Grace
4:00 PM	Adjourn	

Getting ready to
launch pilot



Fast Track...Region 2 initial work...

4/13/11 FTS Clinic Results

X Performance Management/CQI/PHF-STD proj

Maxine Williams to Gale, Kendra, Sylvia, Charlotte, [show details](#) Apr 14

Thanks again to all who participated in yesterday's second FTS clinic "live" pilot!

Our clinic capacity was 11 fifteen minute slots. 9 appointments were scheduled w in slotted into an open access slot. Total scheduled were 10 of 11 (**91% utilization**) 9 total scheduled appts, 7 kept (**77.7% show rate**) + 1 walk-in = 8 total clients.

Five of the eight clients seen met the eligibility criteria for scheduling into FTS - 3 indicated symptoms, 1 stated "?contact to HIV?" - this was our walk-in client. So, eight were screened through central appointment and should have been appoint STD evaluation appt. making this a **37.5% ineligibility rate**.

One big difference in this clinic was that **we did proceed with testing (a recom policy revision approved by central office)** for those who were symptomatic ar contact and appointments were made prior to their departure.

Clinic Set-up: A bank of 4 connected chairs were placed in the FTS client seating looked like the other chairs. Worked well for client flow. Signage worked well in cases. A few clients stopped off at the switchboard to ask where the clinic was lc Several did pull a number from the FP check in area, but otherwise found the che and followed the directions on filling out the form.

Arrival Time to Appt Time - 3 clients were early ranging from 3-15 mins; 4 client late ranging from 15-16 mins; 1 client walked in at 1:00 pm and put in the 1:45 pr access slot.

Appt Time to Last Stop - Due to 4 of the 8 clients being late, did not measure tl

Arrival Time to end of Lab Draw - Range was 19 mins - 47 mins; average time mins.

Station Times - Admin Intake - Average 14.375 mins; FTS Provider - Avg. - 5.625 Avg. - 3.43 mins (with 1 client near fainting), without the 1 client incident, 2.17 min

Between Station Times - Arrival to Admin Intake - Avg - 8.5 mins; Admin Intake t 0.625 mins; FTS to Lab - 2.14 mins; we also measured average time spent after la obtaining the urine specimen and returning it to lab - Avg.- 5 mins.

Test of Policy/Telephone Algorithm/Training: Of the 8 clients in our clinic, 3 r "Yes" to either having symptoms or indicated they were a contact to a STD. Beca change in policy allowing us to proceed with testing, all were tested and all 3 clie scheduled a clinician evaluation appointment. One client was a walk-in, so only 2 clients were not eligible due to the telephone screening algorithm. We will need

Example of summary results and analysis communication of 1 pilot day



Fast Track...Region 2 initial work...

**Greenville Health Department
Fast Track Service Clinic Pilot, March 23, 2011**

**Client Satisfaction Survey Summary
Total Clients = 7**

Rating Scale:

5-Completely	4-Mostly	3-Moderately	2-Hardly	1-Not at all
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Question	Rating				
	5	4	3	2	1
1. To what extent were you satisfied with the services you received today?	x6	x1			
2. To what extent were you satisfied with the professionalism of the staff that took care of you today?	x7				
3. To what extent were you satisfied with the length of time it took to complete the Fast Track service today – from the time you entered clinic to the time you were asked to complete this survey?	x5		x1 (see note)	x1 (see note)	
4. To what extent are you satisfied with how you will get your test results?	x5	x1			x1 (see note)

NOTE: #3: Clients required treatment services (not Fast Track only).

#4: Client wanted lab results "ASAP" per her survey response.

Responses to Questions 5 – 7:

5. What was the most satisfying aspect of participating in today's Fast Track Service?

- "It was a new program that moved along smoother & quicker."
- "Respect & nice, kindness"
- "Rapid Service – courteous staff"
- "The testing is free & confidential."
- "...Quick & easy"
- "Quick"
- "Everyone was nice and very knowledgeable."

6. How can our Fast Track Services be improved? Please be specific.

- "Do not use outside company for appointments and etc."
- "I think that you are doing a great job. Thank you."
- "Hot dogs & root beer"
- "Advertise to public more on this new service/program."
- "From what I can tell – nothing."
- "Just fine"

Example of client satisfaction survey and 1 day pilot results



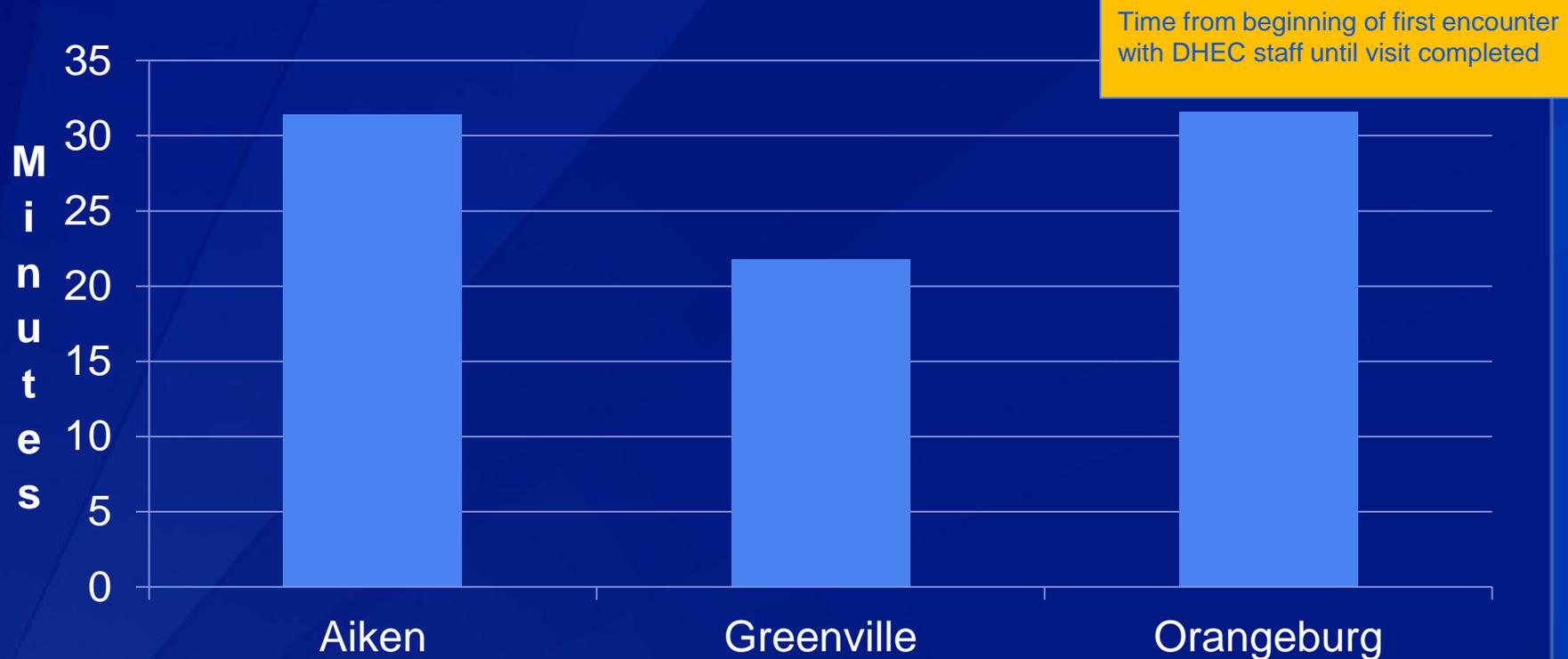
Overall Pilot Results

Appointments and Referral Error

Appointment Data	Aiken	Greenville	Orangeburg	Richland
# appointed into FT slot	33	66	86	59
# Showing	20	54	51	36
Show Rate	60%	82%	59.3%	61%
Of Show, Percent Ineligible (referral error rate)	0%	20.4%	25.5%	19.4%

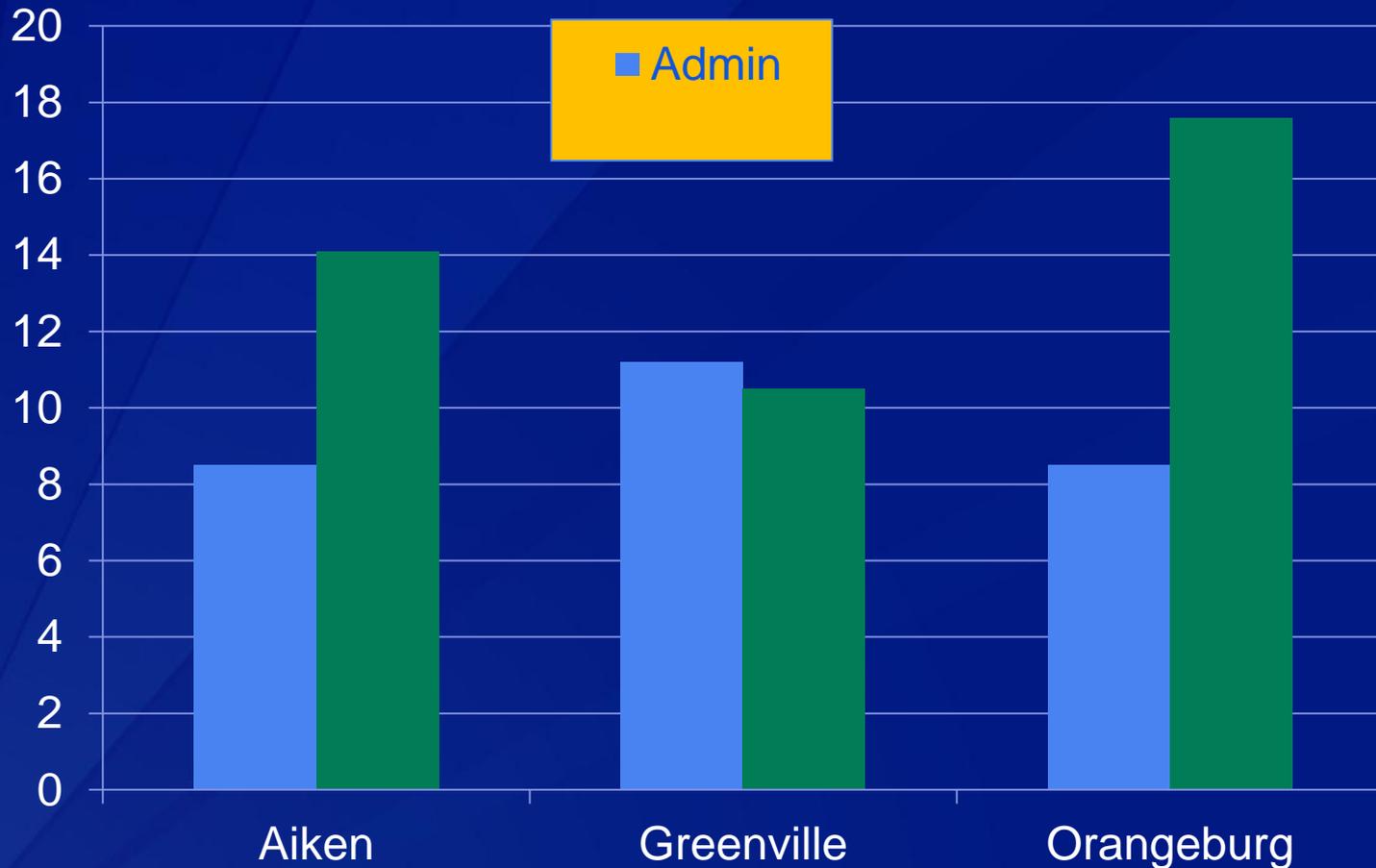
Fast Track Pilots

Summary Average Time of Service



Greenville, with support from the PHF, undertook several PDSA cycles to improve time in clinic.

Average Admin and FT Provider Times Minutes by Type

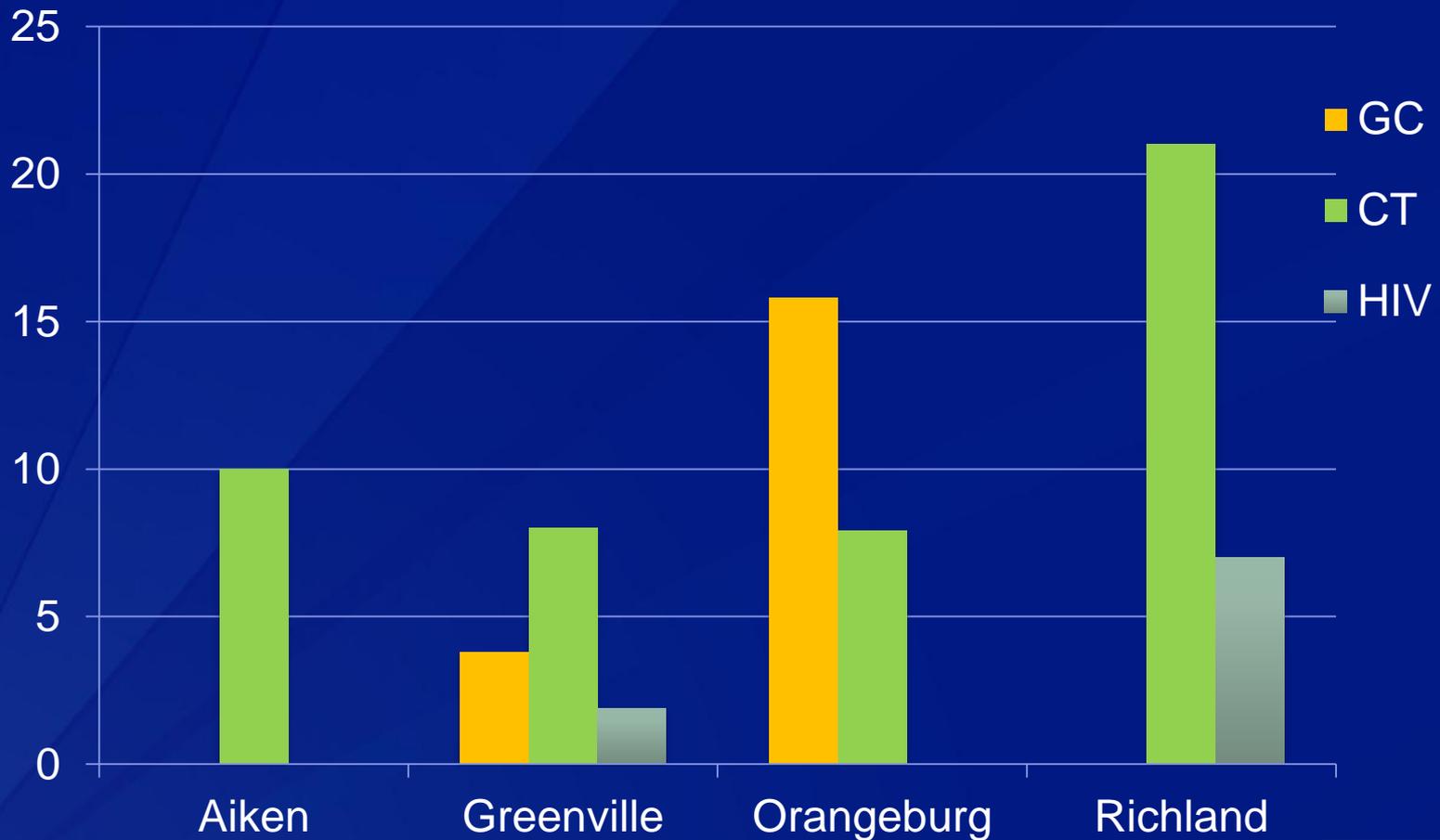


FT Providers in Region 2 were various types of staff, and in Regions 3 and 5 they were lab technicians



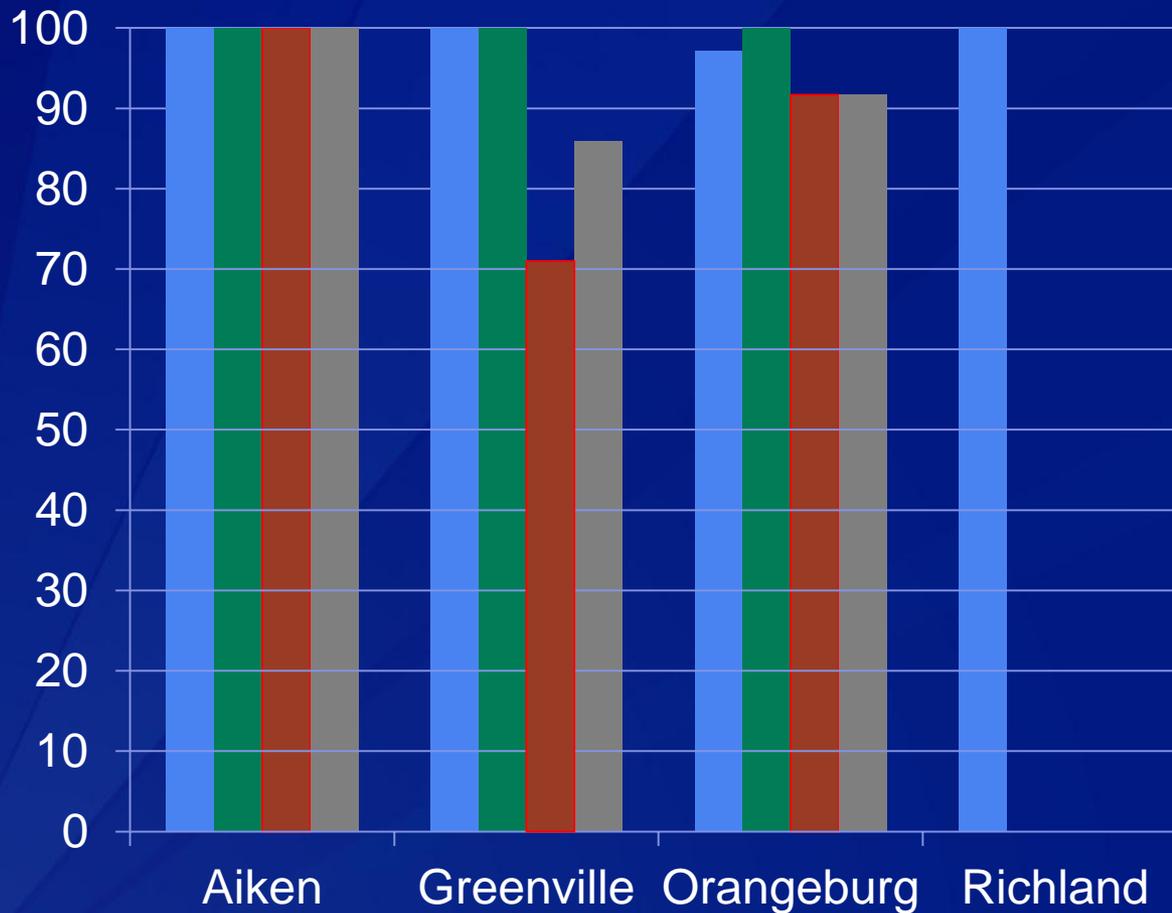
FT Positivity Rates

Percent of FT clients seen



Client Satisfaction with FT

Percent of Responses



Reporting a 4 or 5 on 1-5 Scale Client Satisfaction Survey

- Satisfied
- Professional Staff
- Time of Service
- Test Result Process

Fast Track...lessons learned from pilots

- Feasible to do in DHEC context
- Time in and out is variable, can be shortened further with onsite rapid cycle testing and evaluation
- Fewer “handoffs” increases efficiency, consider one provider doing all parts of FT (Minute Clinic model)
- Overall clients appreciate speed and simplicity of service
- Some error rates in referral processes, but within acceptable limits
- Very important to have good communication and coordination between appointment, admin and clinic staff

Fast Track...storyboard as summary

HEALTH SERVICES QUALITY IMPROVEMENT STORYBOARD



REGION/CENTRAL OFFICE AREA: Division of STD/HIV and Region 2, 3, and 5
 CONTACT: Janet Tapp
 PHONE NUMBER: _____
 SIZE: Statewide
 POPULATION SERVED FOR PROJECT: DHEC STD clients
 PROJECT TITLE: STD Fast Track Pilot

PLAN

Identify an opportunity and Plan for Improvement

1. Getting Started

HS recognized that providing full clinical evaluation STD services routinely to asymptomatic clients was taking valuable appointment slots from symptomatic clients. In addition, the total number of STD clinic slots was also decreasing due to loss of nursing staff related to state budget cuts. Fast Tracking (FT) of asymptomatic clients, is a testing only service where the client receives lab tests and brief counseling services. This testing only model has been used in other states with varying success. The question for South Carolina is would FT provide better customer service, free up valuable clinic slots for symptomatic clients, utilize non-nursing resources and improve clinic efficiency. Based on initial work in Regions 7 and 8, formal piloting of Fast Track in Region 2 took place from December through May 2011, and in Regions 3 and 5 in the summer of 2011.

2. Assemble the Team

For the pilots, teams were assembled in each of the three pilot regions from the Greenville HD, Richland HD, and Aiken and Orangeburg HDs. Team members were recruited by regional leadership, and consisted of 3-5 clinical and administrative staff. In Greenville, QI TA was provided by an expert from the Public Health Foundation. The Office of Performance Management assisted in developing metrics for the pilots, and HS' Division of STD/HIV and the Office of Nursing provided content expertise.

AIM Statement

Implement STD Fast Track in 3 pilot regions for asymptomatic clients that: 1) satisfies customer expectations; 2) increases the number of clinic slots for symptomatic clients; 3) is done efficiently with a low number of referral errors; 4) results in a low total time in clinic, and 5) results in high employee satisfaction.

3. Examine the Current Approach

Per policy, standard treatment of asymptomatic STD clients required a full risk assessment and clinical exam. No differentiation was made between asymptomatic and symptomatic clients in this regard. Overall, clients were satisfied with STD services based on the 2010 customer service regional survey.

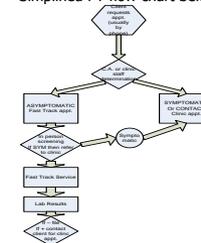
4. Identify Potential Solutions

STD/HIV Division and Office of Nursing staff working with region partners, identified the components that would need to be developed and included in a formal FT pilot including: change in policy to allow for FT, telephone screening tool (protocol), in person screening tool, use of non-nurse staff to provide service, provision of lab services, specific educational messages, training of these staff, and how results would be shared with clients.

5. Develop an Improvement Theory

A FT policy was developed, screening tools for phone and in person client encounters were drafted, education messages created, and lab results tracking and referral procedures identified. Potential decision algorithm also developed for both FT and treatment of symptomatic clients.

Simplified FT flow chart below:



Fast Track...storyboard as summary

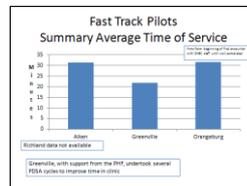
capacity.

STUDY

Use Data to Study Results of the Test

7. Check the Results

- Results from the four pilot sites demonstrated that FT could be successfully implemented in DHEC sites with rapid service delivery time.



- Error rates (clients showing up for FT appointment who were not eligible for the service) were also within acceptable limits from a low of 0% to 25.5%.
- Clients reported a high degree of satisfaction with the FT service from time in clinic to the overall service.



- All staff involved with the pilots expressed a very high level of satisfaction with implementing the FT process in their area.

ACT

Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop New Theory

To better standardize and increase the efficiency of FT within each clinic setting, it is important that:

- "Handoffs" within the FT should be kept to a minimum. If possible, work to develop a model of one staff doing all aspects of FT.
- Continuous rapid cycle PDSA should be conducted around clinic time to reduce variability and to shorten the length of services as much as feasible.
- Continuous coordination and communication between appointment, administrative support and FT clinic staff must be in place, particularly until FT is fully operational and the delivery of the service done consistently and at a high level.
- Additional data around lab result follow-up may be required, and if so, different follow-up procedures tested and evaluated.

9. Establish Future Plans

The best way to spread the FT clinic model to all DHEC STD clinics is to implement a virtual Institute for Healthcare Improvement "light" learning collaborative.

- A Change Package should be developed and disseminated that contains the policy, forms, agreed upon metrics and measurement tools, a primer on the Model for Improvement, pilot results and lessons learned.
- Three virtual learning sessions followed by action period would be implemented with teams from each of the 8 regions.
- The first learning session would focus on sharing the change package, training staff in rapid cycle PDSA work (Model for Improvement), and development of first region workplan. The first action cycle would be used to fully develop a region testing and deployment plan, implement initial rapid cycle change package testing,

compiling, analyzing and submitting data.

- The second learning session would focus on sharing statewide data and results, further PDSA consultation and troubleshooting, followed by the second action cycle which would continue further testing, expansion and spread, refinement of any of the elements within the change package.
- The third and final learning session would focus on strategies to ensure full spread with fidelity, and how to ensure that FT continues after the collaborative work is completed.
- Expected full deployment of the entire change package statewide will be completed by no later than July 1, 2012.

DHEC Health Services Fast Track Pilot Team Leaders and Members

Central Office:

Janet Tapp, Angie Olawsky, Joe Kyle

Region 2:

Sylvia Elliot, Kendra Douglas, Gale Davis, Chancey Rich, Bren Blevins, Phyllis Thomas, Michelle McKinzie, Mary Haywood Roslyn McReynolds, Donna Cook, Charlotte Leonard, Angela Rice, Tonya Woodard, Caroline Snow, Kevin Poole, Virginia Painter, Maxine Williams

Region 3:

Sandra Tucker, Jo Ellen Roberson, Richland-Daphne Scott, several administrative support staff

Region 5:

Vicki Greene, Diane Bolin, Marge Heim, April Boone and centralized appointment staff, Linda Strader, Tanisha Ryan, Debbie Lotz, Pam Carn, Barbara Charley, Johnnie Watson, other admin staff

Public Health Foundation:

Grace Duffy



Fast Track Pilot

Final Recommendation

Fully deploy FT statewide through an IHI-like simplified virtual learning collaborative

Develop Change Package

- Policy, forms, agreed upon metrics, Model for Improvement (PDSA primer), pilot results and lessons learned
- There may be aspects to FT that will require new data to be collected (i.e., percent of positive clients who do not receive treatment)



Fast Track Pilot

Final Recommendation

Implement IHI virtual learning collaborative with 8 region teams beginning December 2, 2011

- Call/training 1 to share change package
- Action Cycle 1 to develop region testing and deployment plan, implement first rapid cycle testing, submit results and other data
- Call/training 2 to share statewide results and data, further PDSA orientation, troubleshoot
- Action Cycle 2 further testing, expansion, refinement, data submissions by regions
- Call/training 3 final refinement and full and final spread statewide by June 2012



Fast Track Deployment Challenges

In deployment phase, challenging to get staff to send data in, PDSA worksheets

For the “good of the whole” a difficult argument to make, given increasing limited staff and management time to do, much less to document and report

As a result, reporting to date not consistent somewhat sporadic, despite good intentions of region staff – continue to work with staff, will have deployment lessons learned discussion with them, for next QI project(s)

Questions & Discussion

All lines are open and live!

*Please remember to use your mute button or *6*

Thank you!

Please send your questions and
comments to:

pimnetwork@cdc.gov



Centers for Disease Control and Prevention

Office for State, Tribal, Local and Territorial Support