

Creating a Culture of Quality Improvement

CDC Performance Improvement Managers Network Call

March 22, 2012

Today's Presenters: Joe Kyle, Maxine Williams and Janet Tapp, South Carolina Department of Health and Environmental Control
Grace Duffy, Public Health Foundation

Moderator: Liza Corso and Teresa Daub, CDC/OSTLTS

Laurie (Operator) : Thank you for standing by. At this time all participants are in listen only mode. Today's conference call is being recorded; if you have any objections, you may disconnect your line at this time. I will now turn the conference over to your hosts. We have Ms. Liza Corso with CDC. Ma'am, you may begin.

Liza Corso: Thank you very much. Welcome everyone to the March Performance Improvement Managers Network Call. I'm Liza Corso with the Office for State, Tribal, Local and Territorial Support, and I'm joined here today by numerous colleagues from OSTLTS. We're delighted that you could join us for today's call. This is our third call this year in the monthly webinar series for performance improvement managers throughout the country. The PIM Network is a forum intended to support all the performance improvement managers in learning from each other as well as from partners and experts in the field. And so on today's call, we'll explore the culture of quality improvement with the Public Health Foundation and how such a culture is being implemented through South Carolina's NPHII activities. But before we introduce our speakers, Teresa Daub will review some of the technological features of today's call.

Teresa Daub: Thanks, Liza. For those of you who are not able to join the web portion of the call, please refer to the slides that were emailed to you yesterday, and you can follow along with those. For those of you on the Live Meeting site, you will see your slides on the screen; you can also download these slides via the icon at the top right of your screen. This is the icon that looks like three sheets of paper. Also, if you're on the web, you will be able to see other sites participating in today's call by looking at attendees under the link at the top left.



We will be taking questions on the call today, and there are two ways for us to receive your questions and feedback. First, you may type in your questions and comments at any time during the call by using the Q and A box. You can find the box by clicking “Q and A” in the toolbar at the top of your screen and you can simply type in and submit your question there. Second, we will open lines for discussion after our presentations. So please mute your phone now in anticipation of that; you can either use the mute button on your own phone or press star six on your phone’s keypad to do that. Please note that we will identify the person submitting questions via Live Meeting, so if you prefer your question to be posed anonymously, please type “anon” either before or after your question. Today’s call will last approximately one hour. The call is being recorded, and the full presentation will be archived on the OSTLTS PIM Network web page.

As usual we’ll have a few calls... polls on today’s call, and we’ll begin our first poll right now. You may cast your vote by selecting your response with a mouse click when each poll question appears. And the first question is please indicate your affiliation. Okay, it looks like we’re at our maximum on our first poll, so thank you for voting. Our next question will give us an idea about how many people are on the line today. How many people are in the room where you are? Okay, all votes are in. Thank you for participating in the polls. We’ll also want to hear your feedback about today’s call, so we’ll have a final poll at the end where you can tell us your thoughts about today’s call. Thanks. And back to you Liza.

Liza Corso: Thanks, Teresa. Our presenters today are Joe Kyle, Maxine Williams, and Janet Tapp from the Department of Health and Environmental Control in South Carolina, and Grace Duffy of the Public Health Foundation. I’ll introduce them first, and then we’ll segue onto them. Joe Kyle has been with South Carolina DHEC for fourteen years, and he’s currently the Director of the Office of Performance Management for Health Services. He serves on the Agency’s Strategic Planning Committee. He’s the co-chair of the Agency Community Assessment Work Group, and he’s co-chair of the Curriculum Work Group that is a partnership effort between the University of South Carolina Arnold School of Public Health and DHEC. Maxine Williams is a Family Planning, STD/HIV Program Nurse Manager for Public Health Region Two. She’s also a family nurse practitioner and works with their clinical staff within the region. And as our third speaker from South Carolina, Janet Tapp is the STD/HIV Division Director at the South Carolina Department of Health and Environmental Control. The Division provides program management and policy development for all health department-based clinical services of STD and HIV testing, STD treatment, partner services, and provides care and support resources for persons living with HIV/AIDS. Grace Duffy, our speaker from the Public Health Foundation, is a Lean Six Sigma Master Black Belt specializing in organizational improvement, leadership, quality, customer service, and teamwork. She has authored eight texts on quality, process improvement, and leadership. She is an ASQ certified manager of quality, organizational excellence, certified quality improvement associate, and certified quality auditor. Grace, the floor is yours.

Grace Duffy: Thank you, Liza, I appreciate this. Let me give you just a short journey of where we’ll go today. I’ll spend just a moment or two to describe the characteristics of a culture of quality improvement, and then we’ll transfer quickly to Joe and Janet and Maxine to share their story – their



success story – for their DPH fast track implementation pilot. They’ll look at the benefits and the barriers that they’ve encountered as they’re rolling this successful pilot out to all of their public health regions in South Carolina. And then, as Teresa mentioned, we’ll provide plenty of time for questions and answers at the end of the session. So do input your questions and answers, and then be prepared to engage our wonderful success story relaters at the end of this session. Let’s go to the next slide.

What is a culture? My first degree is in anthropology, so I spent a lot of time working with cultures, and it’s what holds the organization together. It’s our DNA. It’s how we do things. All of us have a culture. However, it may not always reflect exactly where we want to go in the future. Let’s have another poll and find a little bit out about you and how far you are in your culture. How well integrated is a quality culture already in your health department? Have you barely started, emerging, are you beginning, or are you fully integrated? Ooh, good numbers. Ah, I see some brave people. Very, very nice. Very nice. So nobody’s totally fully integrated yet, but we’re getting there, and I’m really pleased that some of you... Everybody’s started. But nobody’s quite there yet. And it is a journey. Let’s go to the next slide here.

What are some indicators of an organizational culture? All of you have started working on the culture, so you know that there are certain things you do – rituals, symbols, routines – the way that you can identify the culture within your organization. How you respond during the good times. How you respond during emergencies. During anticipated or unanticipated disasters. Those sorts of things. What are the symbols that you keep around you? How do we deal with power in our organization? Do we use power in an enabling way, or do we use power that debilitates others and keeps us from getting the work done? How have we structured ourselves? How do we use control systems to sustain and maintain? I’m really pleased to have the PIM Network functional and talking to each other because now you’re working with what measures can we use to make sure that we are meeting the ultimate outcomes that our customers and our stakeholders need. And today you’re going to hear a phenomenal story that’s going to help show the culture, the strength, of what South Carolina DHEC has and where they’re going as a partnership. So those stories are very, very important. I know many of you use storyboards as you work through your journey for quality improvement. Let’s go to the next slide.

A quality culture is not an easy thing to build. So many of us think that quality is something separate, but it’s really not, and this is what’s so good about a culture of quality improvement. Quality is simply a characteristic of what we do every day. It’s not straightforward because we need to think about the quality tools that we have studied. We think about how we can work with the different stakeholders, our community partners, our internal staff, and professionals, and how we can get the work done without spending an awful lot of extra time and budget looking at quality things that are separate than what we do in our daily work. Let’s go to that next slide then.

So what we want to do in a quality culture is to look at the commitment not only of senior management, although that is critical, but for all of us – to make sure that we have the skills, that we have the capability, that we have the abilities and the energy to move forward, to meet those customer expectations. And many of you know that there are all kinds of customers in a public health environment. It is the whole community. The CDC is one of our customers. It’s also one of our significant



suppliers. So we need to understand that myriad of customer expectations, and help our staff to feel empowered. That we can work together to meet those requirements. It takes a process focus, and I'm absolutely delighted that all of the public health organizations that I've had the opportunity of working with have defined your processes, you're working with them, you're involved in the PIM Network, and you are getting measurements, and you are institutionalizing your designed processes so that you can integrate throughout the whole organization. Let's look at the next slide. And this will be the wrap-up, and the tie, then, that'll take us in to the South Carolina DHEC success story.

What we want to do, as a culture of QI, and what I've watched South Carolina do, at the beginning of this wonderful success story, is that they took, South Carolina took something that is critical to the support of the community in their daily work, and they combined the activities of the PIM Network – the measurements, the criteria, the goals and outcomes – with the quality improvement tools. And where those all intersect, is where you define those routines, rituals, and symbols. That is where your culture is going to strengthen. So I would encourage all of you to listen closely to the wonderful story that you're going to hear about the South Carolina DHEC and their work in a fast track system. Let me hand over to Janet Tapp. Janet.

Janet Tapp: Thank you. Good afternoon, everyone. The culture of quality is important to our agency here in the South Carolina Department of Health and Environmental Control. It's nickname is DHEC, so if you hear that acronym throughout our presentation, that is a reference to the state health department. As a fairly new state AIDS Director and a firm believer in quality improvement efforts, the Public Health Foundation provided us a terrific opportunity last year to use quality improvement in a live environment. We were given the opportunity to focus on an STD improvement area somewhere in our state. I asked our public health regions for volunteers, and Maxine, who you're going to hear in a little bit, and her region stepped up with a request to pilot a program that had been discussed for some time called "Fast Track." So we're excited to share a story with you today of our process.

Just a little bit about South Carolina Department of Health and Environmental Control. We're a fully centralized governmental public health system. We have 46 county health departments that are organized into 8 public health regions. The programs at the state office where Joe and I work really define the backbone of functions of our policies and procedures for accomplishing our agency's objectives. We make the most... The overarching management decisions are made at the state level and carried out at our local public health departments, where Maxine works. We work very closely with the Office of Performance Management and the Office of Public Health Nursing on this project and many projects, including the family planning program that's not housed in the bureau that I work in but at the local area where Maxine works, the nurse provides both of those services. So we are cognizant that this is truly a collaborative project. The local public health departments provide the direct services to clients, they enter that data. At the state office we retrieve that data and use that data to refine our practices and policies. Next slide, please.



So Fast Track Services came about several years ago as a discussion of a way to deal with the shrinking public health workforce due to budget cuts. And as a result of this collaboration between the local public health departments, program nurse managers, and our state office, my division, with Joe Kyle, and Jeremy Bandrick, and I at Office of Performance Management and Angie Olowski at our Office of Nursing, we were able to modify a similar program or service type that was being currently done or provided in two regions using a nursing model. What the regions asked us to look at is, is there a way that we could use a non-nurse model, again due to staffing – nursing staff. So the definition of Fast Track – is that this would be a lab work and minimum education only – only for asymptomatic clients presenting at a health department STD clinic. We make it very clear to the client that they would not receive a physical examination and would not see a medical provider, a nurse or a nurse practitioner, at this visit. Next slide.

The rationale for testing, as I was mentioning a few minutes ago, had begun in 2009. We recognized that there was increasing pressure on the STD clinical services appointment slots, again due to increased [sic] staff, both nurses and administrative staff, and an increase in client demand for services. And as you probably know, STD services are the one service you don't want to be short of because your incidence for sexually transmitted disease will go through the roof. Fast Track had been implemented in other states, with success. And we did collect information from two states about their processes. We had implemented Fast Track in two of our public health regions, using nursing staff, but our intent was to provide this or develop this using non-traditional providers. Our premise was that if we freed up clinical slots for symptomatic clients, then we could make steps to control the disease morbidity, which South Carolina is fourth in the nation for gonorrhea, fifth for chlamydia, and sixth for HIV and AIDS, and I think Columbia, our biggest city, is ninth in the MSA area for HIV. So we need to make all the appointment slots available we can for symptomatic clients. So our AIMS statements were to provide a service for asymptomatic clients, these are our "worried well" that present to the client, would like to be checked, for whatever reason, and our system that we had prior to Fast Track, they would be given an appointment slot just as a symptomatic person would. They would receive an exam, just as a symptomatic person would. And the staff were saying, you know, hold up, this is... we can do this better. So we wanted a service that provided... that would accommodate asymptomatic clients, that met their needs, that increased the number of clinic slots for symptomatic clients, that was done efficiently with a low number of referral errors, that resulted in a lower total time in clinic, and a high results of... results of...employee satisfaction. Can you go back one slide, if you will. Fast Track, the Pilot Set Up. Thank you.

Originally, we were going to pilot this in four sites. But we ended up piloting in three sites – Regions 2, 3, and 5 – and in Region 5 we piloted in two counties. Thanks to the Public Health Foundation, we were able to get... to get acquainted with Grace, and we've attached ourselves to her and hopefully won't let her go any time soon. She was able to visit with the Region 2 staff, and Maxine's going to talk more about that. But in general the parameters were that the screening protocol for appointment staff resulted in either Fast Track or non-Fast Track appointment slot. The client shows up and gets a screen again just to make sure that they're in the right appointment slot. The clients have their lab work done, so we test for HIV and syphilis, via conventional blood draw, and chlamydia and gonorrhea using a urine.



The client receives specific messages, including how to get their test results, and then we give those lab test results back just like we do with our other clients.

So my last slide that relates to the pilot preparation. And this has truly been a collaboration, both at the state and local level. We've worked diligently together on this process. In South Carolina it's easy to be stove piped, but at the local public health department level, programs are embodied by few staff. Our STD nurses and family planning nurses are the same person. They're probably the immunization nurse too, and sometimes work in the WIC clinic, due to decrease in personnel. In terms of the pilot, we developed the policy jointly with the Office of Public Health Nursing with the staff here in my division and with input from our medical consultants. Office of Performance Management helped us with developing the metrics. We did phone consultations to our pilot site managers, and, finally, we trained our Fast Track staff throughout the region. So at this point I'm going to turn it over to Maxine Williams to talk about Region 2, the initial work, and then Joe Kyle will bring it home for us.

Maxine Williams: Thank you Janet, and good afternoon, everyone. I had the dubious honor of being able to start the process in our region of the non-nursing model pilot. As Janet indicated, we were suffering greatly in our region. We have Greenville, South Carolina, for those of you who have had the pleasure of visiting South Carolina, a fairly big city with a lot of needs and shrinking staff and we really wanted our nurses to be able to serve those asymptomatic clients. So we were really, really one of the regions going after, can we do it differently, because we have other resources that could do Fast Track for an asymptomatic encounter. So we were very, very honored to be able to have Grace come in and help and assist us through this process because we learned a great deal about QI, but I would still say we're fairly babies in that evolution. But one of the first things we had to do, naturally, was define who are the participants that will need to participate in our sessions. And we had a cross sectional representation of nurses, social workers, our DIS, which is short for our Disease Investigation Specialists, so we were looking at any and all potential folks. Lab. We had just a gamut of different types of staff, not that many of them, but at least different types of staff who could potentially be our non-nursing model providers. So we brought a team together and began a series of meetings and sessions where Grace was our wonderful facilitator. So in our very first meeting, which you're looking at currently, we actually had our first what I would call kickoff meeting, and that was to essentially determine our goals, objectives, and certainly where do we take it from here and form our total plan for how we would like to proceed. So as you can see, Janet had mentioned, we had developed a AIM Statement. We certainly had to take some time to ensure that it was smart and develop the following AIM statement providing STD testing-only services to clients that meet specific screening criteria. And as Janet had mentioned, we identified those very specific goals being increased asymptomatic STD testing, decrease our clinic wait time for all of our clients, because we felt this would also help our symptomatic clinic processes as well and increase our clinic efficiency and capacity. And as you can see as we work through those SMART objectives, certainly we had some things we really needed to look at, whether it be content or process. And you can imagine a lot of discussion in the room certainly about how are we going to do this – what are the lab processes – what are we going to do with walk-ins – how are we going to deal with turn-a ways – number appointed – how are we going to intake – how are we going to screen – how many positives and



negatives we may encounter – a lot of unknown information, naturally. But we certainly wanted to capture as much of that information as possible. The processes that we did have in place that we were already using – we were already using PFAs, or the Patient Flow Analysis – so we knew we’d have some good ways in which to capture some of our flow. And naturally we knew we would need to look at satisfaction measures, both staff and patient, and then documentation, and certainly what would be our milestones along the way. As you can see, at the bottom of this slide, we developed our timeline processing, even in this very full packed first session, we tackled the next developing the As-is Flow Chart. We certainly had to determine where were we at that point in time as far as entry into the Greenville County Health Department, and then how would we then go about facilitating this concept of asymptomatic Fast Track. And we did put ourselves on a fairly good time measure. Process timing, as you can see, with an objective of having a pilot up and running by March, when we had our first meeting December 10 of 2010, and then having our final closeout and next steps in May of 2011, and I’m here to tell you we did accomplish that, which is in itself a fairly amazing feat in our organization. Next slide, please.

Part of the other, as I mentioned, much discussion about how we will go about doing this was to also be open and have the staff freely participate in, what are our concerns, issues, and barriers. And, so, I love the way Grace put it, it’s a nice succinct way – okay, well we understand you want to do this, but what are the issues that are going to be preventing us from moving forward or having huge barriers we’ll need to overcome, and she affectionately refers to it as “Yes... But’s.” We definitely knew, we were building this from the ground, so we had to determine how were we going to appoint clients in, or how would they be appointed, or would we do this as a walk-in, or both? What’s best? We had to look at the staff resources and who were we going to use? What are the cost elements with that as well. We also knew if we went with a combination appointed/walk-in, we’re going to increase volume. How would we accomplish that as well as facilitate that and then what about when we... if we’re fortunate enough to have many folks coming, how would we manage turn-a ways. And asymptomatic also was requiring a little support in the systems from our DIS, so what happens when they’re not in the building? And then really what was going to be our health education? We wanted this to be a streamlined, quick visit, so how would we facilitate adequate health education and ensure that we were providing some of that element. We definitely anticipated an increase in volume in our phones, our intake, lab, admin, and social work. Next slide.

So as you can see, there was a whole lot to take into consideration, even from the first session. So when we reconvened in our next meeting, what we had, we had already had our AIM Statement, we had our flow chart, we had our “Yes... But’s,” but then what did we want to do with that? I mean naturally, what we needed to do next was do the affinity and theme identification, and that was very fun. You can imagine a big auditorium room with about... we probably had close to 20 folks that participated in our whole process. And so we had to divide into groups with our wonderful stickies and write all of our issues and put them together, and then of course develop them into the cause and effect diagram. So we actually gained some real great skill development there, being able to take all the issues that



concerned many in the room and be able to organize them, tackle them, and then break them down for us to be able to develop our next processes. So, next slide.

One of the issues I mentioned was about patient flow. And I apologize for the real rudimentary appearance of this, but this is great. I mean again, we're in the room, we're saying, what does our area look like, and where's our patient processing flow going to be. And to me this is like a picture worth a thousand words. And by the way this is only part of the clinic because the rest of the processes of the clinic were way down the hall; you can see some little arrows pointing down that way. But we really... we really had an excellent opportunity to say, as we proceed to build this into this clinic area, how are we going to make this work where it'll be efficient and not be too many steps and processes for the client as well as the employees. So again I just say this is wonderful because this was the springboard by which we then said, "You know, there might be a better way. Let's see if we can figure out how to break that down a little more efficiently. Next slide, please.

And as we again continue to proceed through our process and our meetings, of course next was coming, we've got to get ready for the pilot. So we created a to-do list, identified who was responsible for what, looking into each of the areas that we needed to evaluate, assignments made, come back together and then determine, all right, what's left to still be uncovered, uprooted, determined, and tried to do the best we could to prepare for a test run, which is what we were able to do as well prior to implementing our pilot, the actual live pilot itself. So we did facilitate through all that until we had at least most if not all of our questions answered and at least everyone pretty comfortable with where we would be heading and what we were going to be doing, what we will be measuring, and then preparing to actually have the live pilot. Next slide.

Well in that pilot process naturally we had identified a whole list of things that we really wanted to measure. And then how would we communicate that and document that. That was an issue for us and has been, and I imagine many of you on the call will attest to this. It's very difficult at times to really document your process. Now we had a number of PDSAs we implemented and processed through, and made a number of changes in this short period of time that we wanted to truly do a good job of documenting that. I can honestly say it still was challenging, but what I tried to do if nothing else was let's just as soon as we finish clinics let's have a huddle and discuss what worked, what didn't, and then be able to document our findings and track that as we move along. And so literally, I mean I just had to craft emails and send them to Janet and Joe and Angie and the folks in Central Office and say, "Okay, here's what we said we were measuring, what we're looking at, we'll document that as we go", you know. Certainly we had set up the scheduling; we wanted to see if it was effective or not, measuring our show rates. We wanted to look at whether or not the clients when they came in were screened appropriately, because we did have a telephonic screening process to ensure they were asymptomatic, and how well was that working? And we were measuring that and realizing we had some work still to do, and even modified some of our intake processes so we could improve upon that and so we called that our ineligibility rate and measured and monitored that. We looked at of course the whole clinic set up; even though we thought maybe we had a good design in the beginning. Well, no, you know, still, the



male bathroom was way down the hall, around the corner, and was unmarked, so it was very difficult for our males to go get their urine. But we were able to finally process through that and improve that. We had great collection times, PFAs; I call them the little mini-PFAs, where we were really tracking all of our time elements and the gaps in between. And then part of our brainstorming process again was how do we continue to shorten that time down. So what you're seeing here essentially is a lot of that data being captured. We were testing the call algorithm, we were testing the policy, and determining what needed to be changed there as well and giving that feedback back to our central office. Next slide.

At the end of our pilot though, for each patient, we were also doing customer satisfaction. Now we did one actual employee satisfaction as well. We don't have that recorded here, but we were also looking at both... not only clients but our employees as well and asking how they felt about participating in this new process. So, but right here we have an actual summary of our client satisfaction survey and it was very helpful because, again, it helped us prime the pump too on what their thoughts were – if it was working the way we thought we intended it to, we really wanted to it to be a quick in and out visit. We ultimately said we were going to give this type of visit. One unit of time in our system equals 15 minutes. Now did we ever achieve that in our first pilot? The best time I believe we had was probably maybe 17 minutes, but, but more often than not, our average ended up being around 22. But we were very pleased. We were very pleased, and apparently our clients were as well. I mean we had one comment here that the thing you should be able to provide additionally is hot dogs and root beer, and we were really pleased to see that. So there were a lot of positive results and feedback in the customer satisfaction area. The only thing that the clients were really saying is we were wanting to get our test results the same day. And we respected that because there is of course some rapid testing but we weren't offering the rapid testing at this time. We were actually providing them the blood draw and the urine testing screening. But we really were doing all we potentially could do to get those results back to them quickly. Next slide. All right, I'm going to turn it over to Joe, who's going to also give you the overall pilot results from all the regions.

Joe Kyle: Great. Thank you very much, Maxine. Again, this is Joe Kyle; I hope you're all having a good day. I just want to go through a few quick slides here, just to kind of give you all a sense of the overall pilot results. You can see Greenville is the column – that middle column there is the area that Maxine was referring to now – and so there you can see the other pilot areas, Aiken, Orangeburg, and Richland. And you can see we were tracking things like numbers that were appointed into the slots, number showing, show rate, and then percent ineligible for receiving the service, so what that means is either – that they were either – that they were reportedly symptomatic at the time that they showed up for... not an asymptomatic Fast Track service. And you can see what those percents were, from a low of zero to a high of 25.5 percent. Next slide, please.

And then you can see there was some variation in terms of average length of service, and you can see I think the very good work that took place in Greenville, and they were able through all those rapid-cycle PDSA cycles that Maxine mentioned... I have something shown up here. Hold on here for a second. So



you can see that more or less that the Greenville was certainly much quicker than the other ones and that really then it shows the benefit of doing rapid-cycle PDSAs. Next slide, please.

And then you can see this is broken out. We also looked at time from... time, total time from a provider perspective as well as admin – in-take and out-take. Next slide.

This is an important slide here because even though we were.. Fast Track was provided to asymptomatic clients, there was a certain degree of positivity, so that even for asymptomatic you're going to get, you're going to detect some... persons who are positive for one STD or another. And so the good thing is by doing the lab work then you're able to detect them. And these are people that perhaps may be would not have been detected otherwise. So this is very much a very positive way, then, to lessen the spread of the disease, which is what this is all about in the bottom line. Next slide, please.

And you can see overall the clients were very satisfied with services across the various pilot sites. Next slide.

So basically lessons learned. It's feasible. Time in and time out is variable, but it can be shortened with rapid cycle improvement. Overall, fewer handoffs appear to increase efficiency. In other words, time and sort of the mini-clinic model where you have one provider doing everything probably is ultimately the best way to go. The clients overall do appreciate the speed and simplicity of the service. Next slide, please.

This is... and hopefully this will be available via download here. This is a high-level summary, a two-page storyboard, kind of outline describing the entire process we've shared with you all today. And we very much use this as a way to educate and inform staff, decision-makers, managers, and leaders, and other departments within DHEC about a way to go about doing quality improvement projects, and we very much appreciate and value this kind of structure in sharing our story. Next slide, please. The next one also.

So in terms of final recommendations. Where we are now, what we've decided to do is take the results of the pilot and do... fully deploy statewide. To remind you all again we are a centralized system, so we've developed sort of a simplified, very simplified learning collaborative approach based loosely on an IHI learning collaborative model. And it's a virtual learning collaborative, and so we developed a change package, and many of the materials and things, tools and forms and so forth that were used in the pilots now were developed, implemented into a change package. And we're right now fully deploying those across the state. Next slide, please.

Okay, and you can see then these are some of the specific steps where we are right now. We started in December of 2011, and the goal is to have full statewide deployment by June 2012. Next slide, please.

So even where we are now, some of the challenges that we're facing in the deployment phase; really it's very challenging to get staff to send in their data, the results from their deployment work, because we're continuing to monitor the data to make sure that the results from the pilot are also being seen as



we go statewide. And also to be submitting... we ask for some basic PDSA worksheets, and some sites are more diligent about sending those in than others. And it's very understandable why. People are extremely busy. And sort of this bullet point in the middle, sometimes it's difficult for staff... since they're going ahead and implementing and doing the work, it's hard for them to carve out of their very busy day, "good of the whole" time, if you will, to document and share that information with others. But from our statewide perspective, that's really important so that others can learn from the experiences, kind of in a continuous quality improvement way. So we're getting somewhat inconsistent information right now in the deployment phase, but we'll be doing an after action assessment of this, so that as we go about implementing this kind of piloting and then deployment concept in other areas, either in STD and HIV or in other parts of the agency, we can hopefully learn the best way to go about deploying and documenting minimally so that we can continue to learn going forward. I think that may be my last slide. Yes.

Teresa Daub: So, thank you so much, and thanks to all of your presenters. You've done a great job, so I say hot dogs and root beer for everyone. That was fantastic. We do have a couple of questions that we'll start with. Remember if you have questions, we'll be opening the lines in just a couple of minutes. A reminder here to mute your phones as we do that. You can continue to submit questions via the Live Meeting site as well. Maxine, our first question goes to you. You did a great job of describing the phases that you went through for the pilot. Can you say a little bit about how the staff responded as you went through the different phases and all the meetings to implement the project.

Maxine Williams: Sure. Sure. Definitely the staff had had some preliminary presentation about this concept, because as Janet had mentioned, this had been put in place in some of the regions as the nursing model. But I think because of the staff shortages and the issues we were facing, a number of our staff were already very receptive to the concept of learning Fast Track, i.e., like our DIS, social workers, health educator, I mean they really saw value in this as a process. So I was fortunate enough to already have a little bit of what I call good buy-in. And then once we met with Grace and, again, many of our staff have not been trained to the level of QI that we would love to have. I was one those respondents that, "We are integrating it", yes, but we'd like to get it further integrated with training and resourcing. So the staff were extremely excited about the tools that Grace showed us and used. I mean it took all of our issues, organized them into a process that all of us could relate to and value, so it was the best exercise I could ever ask for to convince our staff the value of QI in working an issue or a problem. Now, of course we had barriers. Of course we had issues like when it came time to say we would like to have not only our admin being a separate station, our Fast Track provider being a separate station, and our lab being a separate. We want to combine all of that now. And just to give you an example. We combined the FTS provider role with lab. Now, our DIS were already trained, but our social workers and our health educators were not. So there was some real resistance initially to that, but let me tell you what the big selling point was. When we put up on the wall the what I call the nice lovely stream mapping of our time elements and they saw we were wasting seven minutes of time going from one station to the next and to the next, they all of a sudden looked and went, well, I can learn how to draw labs. I can see where that would help. And then when we did that, and they started drawing labs and



they saw their time elements went down like three and four minutes, they were like excited, realized how valuable that was, and reinforced or continued to reinforce that we can come up with ideas using this as a process to make it better. And so resistance began to get less and less, and excitement began to grow. So I can truly say this is a process worth everything.

Teresa Daub: Maxine, thank you. I was really struck as you were describing how many of the ingredients of a quality culture that Grace listed earlier that this process really hit on for you all. The commitment, the empowerment, the process focus. You really found a pilot project that allowed you to draw in many of those elements. It sounds like it made a really big difference for the staff in overcoming resistance.

Maxine Williams: Oh absolutely. And by the way, we were working with a transitional area where we had been without a Health Director and then we got a Health Director, and then we were without a QI Coordinator and we're still without a QI Coordinator. But what I have to say is that we had buy-in and commitment. Even our new Health Director who came in, first words out were, "I'm glad we're doing this. This is great. I'm behind it, supportive. Keep on keeping on." And of course Central Office is definitely bought in to this. So we definitely have that part of the issue resolved, which I'm very thankful for.

Teresa Daub: Sounds great. I'll turn now to a question for you, Grace. And that is, do you perceive, or can you speak to the difference between changing a culture and building a culture.

Grace Duffy: Good questions. Sometimes it's more difficult to change an existing culture than to build one fresh. Although I'm not sure if... unless an organization is brand new, you're going to build one from ground up. Generally we're going to change the culture that already exists. A lot of the characteristics that you just mentioned are critical to changing the culture. Everyone in the organization knows what they need out of that organization. And if we can each be real specific about what our needs and expectations are, and then work to align those expectations to the critical outcomes of the health department, then we are going to be expediting ourselves in creating a culture that reinforces where we need to be within the community and being as effective as we possibly can in creating an organization with structures, and measures, and power and whatever kind of budgetary and finance allocations there are to adequately meet the requirements of that community. And we do that by talking with each other, we do that by some of the explanation that Maxine just had. If we're real clear with each other, if we are empowered to speak up and realize that we all have the benefit of the total community in mind, then we are going to change the culture because we are reinforcing each other as we move along.

Teresa Daub: Grace, thank you for providing that answer. I want to hear now any questions or comments from the open lines.

Laurie (Operator): All lines are open and interactive.

Teresa Daub: Thank you, Laurie. If you have a question or comment, please pipe up now.



Joyce Marshall: This is Joyce Marshall from Oklahoma. And I just first of all want to commend you on a wonderful job. I think it's exemplary. Just five to six months for your project, and the results that you achieved. I think those are great. And I'd be interested in receiving a copy, if I could get it, of your storyboard and your change package. Would that be possible?

Joe Kyle: This is Joe. Yes. The answer is yes to both. For our CDC colleagues, would it be appropriate for me to share them with you all and then somehow we can get it out, or what do you all suggest?

Teresa Daub: Yes, certainly Joe. We can do that.

Joyce Marshall: Thank you very much.

Teresa Daub: Any other questions? Okay, I'll turn it back to our panel, then, to see if any additional thoughts or words of wisdom have occurred to you as we are nearing the end of our time together. Any parting thoughts from our speakers?

Janet Tapp: This is Janet Tapp. I'd just like to say that we were very grateful to the Public Health Foundation and CDC for the opportunity that you've given us to work with Grace and explore and expand our quality improvement efforts. And in fact we have another opportunity, a program that we're going to start next... the week of April 9th-10th, with our DIS staff and nursing staff on another project we're embarking on, a pilot project for field delivery therapy. And it is within the division here but, it's to provide an opportunity for symptomatic clients who have come through the health department, have a positive test for chlamydia or gonorrhea and for whatever reason have not returned to clinic. After the second attempt, the nurse can make a referral, and it'll end up with our disease intervention specialists, who will deliver medication in the field. We do... we're piloting that now; been a little bit slow in getting some results, but hopefully we'll get it updated and we can make a decision and recommendation to our senior leadership team to expand that statewide. And again that's another way to improve service delivery for clients, increase their customer satisfaction and to decrease morbidity in our area.

Liza Corso: Great, and this is Liza, and while... just in the last minute or so another question came in so we'll take just another moment for a question that came in via Live Meeting, and Joe, this one's for you. It's obvious that this quality improvement work is a little bit more mature, and the question is about, to what extent has this helped or given momentum to some of the things that you're now doing through NPHII, perhaps.

Joe Kyle: I think it's very much helped in the sense that it... when we talk about quality improvement in the department, we don't have to be as abstract. So we can use this, for example, as an example, a real live example within the department, and all the ins and outs and nuances, cultural nuances within the department that we were able to successfully interact with those cultural nuances, if you will, and successfully deploy this kind of a project. So it certainly has helped us and I mentioned the storyboard and showed you all an example of the storyboard earlier. We're actually using the Fast Track storyboard as a way to illustrate to other parts of the department ways that they can go about, at a relatively high



level, document some of their quality improvement work as well. So where it's actively supported our work, and, again, using this real live example and then building on the success then to keep things going.

Liza Corso: Great. That sounds... it's just such exciting work to hear from all of you about this. And Grace, what you did in setting the stage and talking about the indicators and ingredients for a culture of quality improvement. I'm hoping this makes a lot of sense to folks because it certainly does to us.

Grace Duffy: Well thank you, Liza.

Liza Corso: I'm sorry. Another question just came up. And this question is from Debra Tews. How will DHEC spread this learning and methodology to other divisions within the health department. So Joe I think you kind of just got at that, but maybe there's a little bit that you can expand on that to answer Debra's question.

Joe Kyle: Well I mean concretely we're doing, as Janet and I think maybe Maxine mentioned earlier, at the service delivery level, at the local level, for the most part, STD and family planning services are done in an integrated clinic manner. The same staff are delivering the services. And so certainly family planning is... we're incorporating them now, so that's one way we're spreading this, if you will. And then some of our other... some of our other clinics that we were a major provider of WIC services, immunizations, tuberculosis – we're forming a clinic management team in Central Office, and we'll be bringing in region staff as well to look at the art and science of just clinic management overall, irrespective of which specific service is being delivered. So I think many of the lessons learned from this pilot will be incorporated into that kind of thinking, looking at how... what's the best way to evaluate and assess client flow in the clinic, regardless of the type of service being provided. What are different ways to train staff and bring very simple rapid cycle quality improvement methodology and things of that sort. So we're hoping to build on this success going forward in some of those... certainly in the clinic management areas, and over time then maybe incorporate more... some of the community... some more of the community-based services. That'll be probably phase two.

Liza Corso: Great. That sounds wonderful, and certainly the enthusiasm that you and Janet and Maxine are clearly showing in sharing your stories is probably helping to spread the message too. Well, we're nearing the end of our time, so I want to thank everyone for participating on today's call and I want to especially thank once again our four speakers. This was I think a really rich discussion and information that you've shared with the PIM Network and I think it really heavily coordinates with a lot of the interest that we know comes from other performance improvement managers.

Before we leave today, we do have one more poll and a few announcements. So first the poll. How would you rate this webinar overall? Excellent, good, fair, poor? And of course, as usual, if you'd like to give us any additional feedback on this call or suggest topics for future calls, don't hesitate to email us or call us, and the email, the general email address you can use is pimnetwork@cdc.gov or you can reach out and contact Melody or me. Certainly we hope you'll plan to join us on April 26 for our next call. Don't forget that you can view and download these calls and materials from the PIM Network Web Conference Call Series location on the OSTLTS PIM Network web site. Also, don't forget that in early



May, we've got the NPHII grantee meeting and also the optional Agency, Systems, and Community Health Improvement training. That's occurring right before the grantee meeting. The registration is open for both of those events. So if you're planning on attending, don't forget to register. We'll see you again in April, and thank you once again to all of you, especially our speakers. Good bye.

