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South Carolina Department of Health and Environmental Control

Health Services Quality Improvement
Fast Track Services

REGION/CENTRAL OFFICE AREA: Division of STD/HIV and Region 2, 3, and 5 CONTACT: Janet Tapp PHONE NUMBER: (803) 898-0625
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.

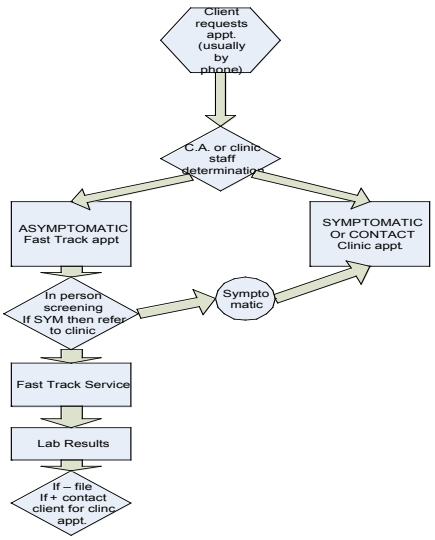
2. Assemble the Team
For the pilots, teams were assembled in each of the three pilot regions from the Greenville HD, Richland HD, and Aiken and Orangeburg HDs. Team members were recruited by regional leadership, and consisted of 3-5 clinical and administrative staff. In Greenville, QI TA was provided 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.

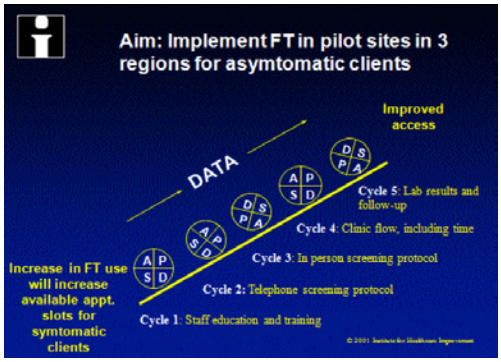
5. Develop an Improvement Theory
A FT policy was developed, screening tools for phone and in person client encounters were drafted, education messages created, and lab results tracking and referral procedures identified.
Potential decision algorithm also developed for both FT and treatment of symptomatic clients. Simplified FT flow chart below:



DO
Test the Theory for Improvement

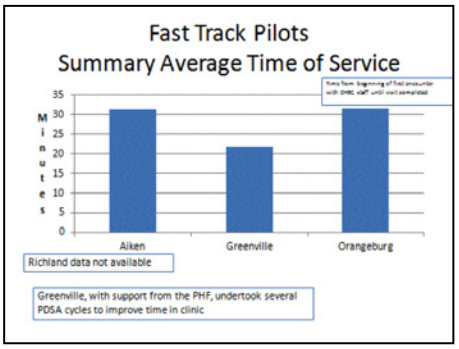
6. Test the Theory
During the pilot phases in all three regions, staff implemented the new FT policy and procedures and tested the telephone and in person screening forms. Data was collected from staff and clients, and operational changes were made as appropriate, using a rapid cycle improvement method.

In Regions 3 and 5, lab technicians were the FT provider, and in Region 2 various staff served in this capacity.

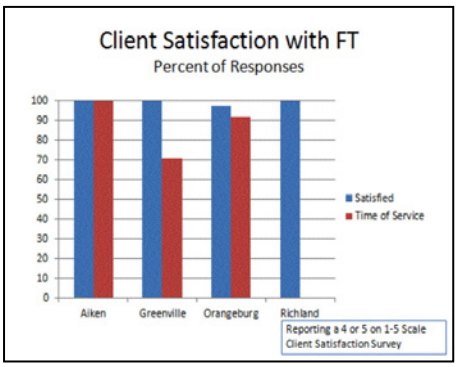


STUDY
Use Data to Study Results of the Test

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), a nd 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

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