

Case Summary Narrative –
Allegan County Health Department

Quality Improvement Project Title:

The Sexually Transmitted Diseases Client Survey Process: Stabilizing the Process to Increase Client Survey Return Rate and Client Input

Quality Improvement Project Target Area:

Culturally Appropriate Services

LHD Overview:

Allegan County Health Department (ACHD) is located in Southwest Michigan in a rural agricultural county. There are approximately 113,449 persons residing in Allegan County. ACHD consists of five divisions to include Administrative, Personal Health, Environmental Health, Emergency Preparedness, and Health Education; with twenty nine employees working in these divisions.

Contact Name & E-mail:

Angelique Joynes, RN, BSN Email address: ajoynes@allegancounty.org

Introduction

The Sexually Transmitted Disease (STD) program wanted to evaluate and conduct a Continuous Quality Improvement (CQI) project on their current survey process. The STD program had only a four percent survey return rate for 2009. If changing the current survey process increases the amount of surveys returned, the data collected would have statistical significance. Program changes could occur related to client input/data thus increasing client satisfaction/ program efficiency and cultural awareness to provide appropriate services. The hope of this project was that if the STD team could get client input then program changes that occurred might reduce re-infection rates and allow the STD team time to provide additional outreach services. By providing additional outreach services more clients would be educated and reached; which would improve population health in relation to undetected or untreated STDS including HIV.

The MLC-3 team implemented a new survey process utilizing a process map to standardize and stabilize the process. This process was implemented from September 01, 2010 through November 30, 2010 after a rapid cycle improvement was implemented on August 31, 2010.

Initially the target was to have both culturally appropriate services and customer satisfaction. While the team was working in Step Three in the PDSA cycle, it was discovered that the process needed to be stabilized and standardized between the STD nurses. It was decided that the first PDSA project would be to develop a survey process that was standardized and utilized with all STD nurses. If the process was successful (an improvement was noted), then the next PDSA project would be evaluating the current survey and survey data to determine if the services provided are culturally appropriate for the clientele in Allegan County.

Step One: Getting Started

The Director of Personal Health (PH) at ACHD was approached by the Health Officer to think about possible proposals for the MLC-3 grant. The Director of PH was concerned about the low

survey return rates in all the PH programs. The STD program was the lowest survey return rate at four percent for 2009.

The Director of PH and the STD team thought about what might occur by implementing this project and increasing the amount of surveys returned. If programmatic changes could occur in the STD program to reach the target population in a more effective manner. By tailoring the program's visits, survey process, and educational opportunities, the client might be more open to education and prevention. If the client realizes and understands the importance of treatment, adhering to the treatment plan, knowing the signs/symptoms of common STDs, and modifying behaviors to decrease transmission; then the outcome would be lower incidence of infections and re-infections. This would increase the efficiency of the program with a decrease in case-investigations. There would be less incidence of Pelvic Inflammatory Disease, possible abdominal adhesions, urinary tract infections and many other illnesses that correlate with untreated STDs. The reduction of these infections in Allegan County would lower health care expenses for the individual or insurance companies involved. ACHD does not refuse STD services to those without the ability to pay. By implementing this QI project, the cost of unpaid services could decrease. In summary, the efficiency of the program would increase and additional outreach would occur because there will be less time spent doing case investigations. More outreach and education provides primary prevention and less infection. The additional health care costs related to untreated STD infections, the potential risk to unborn children would be reduced, and true population health would be reinforced. This project could have a huge impact on the health of our clients/residents of Allegan County.

The CQI team for this project needed to be interdivisional; the Director of PH included the STD team, Health Educator, and Health Officer in the MLC-3 grant proposal to ensure that they had a chance to provide input and ownership to the project. This would be essential in moving the project forward.

ACHD had been doing Quality Assurance (QA) in their programs. Most of the proposed team members were not as familiar with the PDSA cycle. They would require additional training in this method and also had limited training on QI implementation and measurements. The team members who worked in the STD program and on the MLC-3 team also work in other Personal Health programs. The staff would take experience gained from this proposed project and transfer their newly acquired QI knowledge and experience into other Health Department programs.

Step Two: Assemble the Team

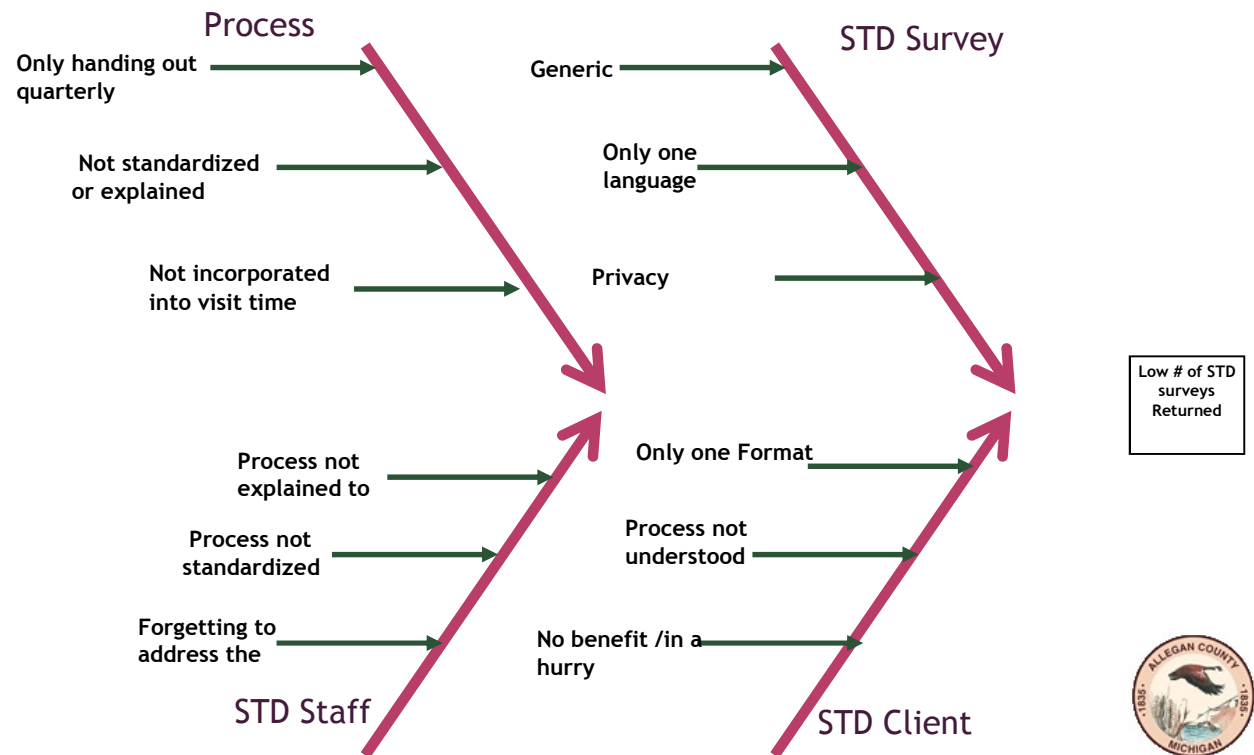
The team needed to be interdivisional as well as having all elements of the STD team represented. The MLC-3 team consisted of 6 team members to include the Director of Personal Health, the Health Officer, the Health Educator, two STD nurses, and one STD support staff. Having all of elements of the STD team represented gave the MLC-3 team different perspectives for input. The team had internal meetings at a minimum of every other week, with a monthly mini-collaborative teleconference with their partner health department and mentor. A work plan, team charter, and a timeline were created to outline roles and activities that needed to be accomplished. The documents, meeting agendas, minutes, reports, data, and other tools were on the shared drive for all team members to view as needed. If updates were made then they were made on the shared drive so everyone could see the updates. The meetings were also scheduled in Outlook as a recurring event which helped to provide maximum participation during meetings from all team members.

The Director of PH also took time to update the staff at ACHD initially about the grant proposal and then the project's progress via the General staff meetings and PH staff meetings. The Health Officer did a presentation to the Allegan County Board of Commissioners as well to ensure they were aware of the project's target and the importance of CQI.

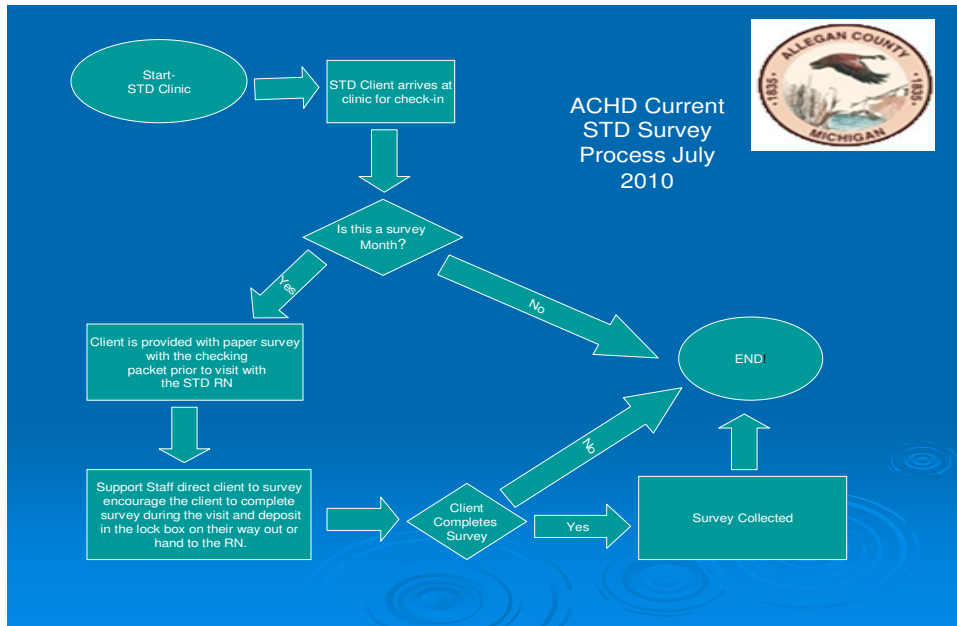
The MLC-3 team then needed to develop their Aim statement. The initial Aim Statement for the project was "Between September 01, 2010 and November 30, 2010 fifty percent (50%) of STD clients at ACHD will complete and return and individualized culturally appropriate survey to STD staff. This Aim Statement changed as the steps in the project were completed.

Step Three: Examine the Current Approach

The team utilized a fish bone diagram to determine possible root causes of the low survey return rate.



It was determined that in numerous "bones" of the fish the process was not standardized or explained and was a possible root/cause of the low survey return rate. The MLC-3 team with the STD team created a process map of the current STD survey process.



It was discovered that the process was stable when the client saw the support staff for check-in but after that each STD nurse handled the survey process differently; some addressed the survey during the appointment, some sometimes addressed the survey, and some never addressed the survey.

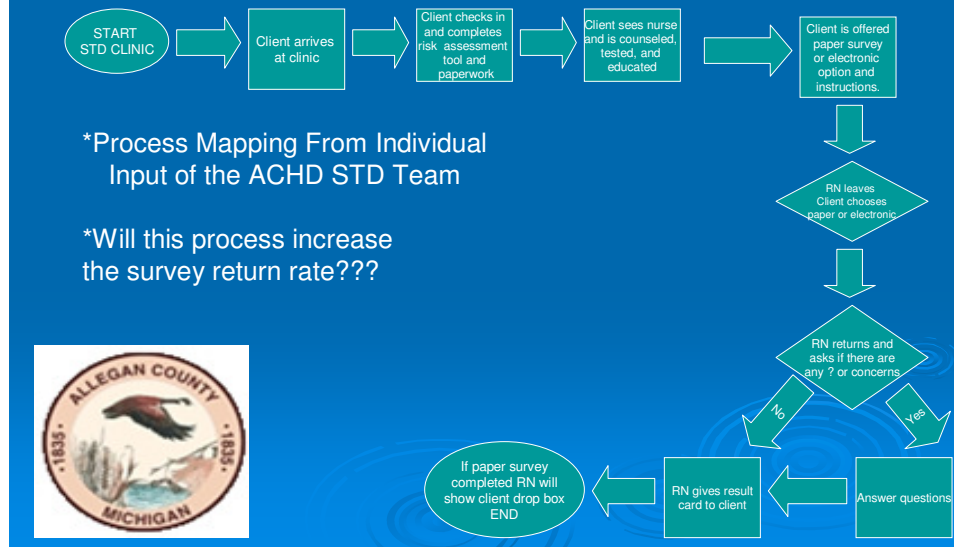
The MLC-3 team and STD team wanted to see how other Local Health Departments (LHDs) in Michigan implemented their STD client survey. The MLC-3 team sent out a survey via Survey Monkey to gather data on how other LHDs implemented their STD client survey. The questions were very brief (only 7 questions) to encourage participation.

A literature review was also conducted on survey processes and validating a survey tool. It was very difficult to find studies that were specific to the STD survey processes. The data reviewed and collected from that literature review will be utilized in "next steps" for another PDSA CQI project.

Step Four: Identify Potential Solutions

The MLC-3 team met with the STD team to discuss how they thought the process might work better. This meeting helped the MLC-3 team identify barriers and the STD team felt vested to this project and process. The teams discovered that the survey was only being offered for one month in each quarter; so each STD client did not even have the opportunity to fill out the survey. They also discovered that each STD nurse handled the survey process differently once the client was in the clinic room. The STD nurses felt the client might be more apt to complete and return a survey if the survey was incorporated into the visit. A process map was created to map out the new process and would be a resource during the project.

New STD Survey Process 9/1/2010-11/30/2010



The STD team and MLC-3 team created this process map which was implemented during the “Do” part of the PDSA cycle. This process map differed from the current survey process in these ways:

- Every client will receive a STD survey and will receive it from the nurse instead of the support staff.
- The nurse will offer both paper and electronic format during the clinic appointment .
- The STD survey will be incorporated into the appointment. The nurse will leave the clinic room for 5-10 minutes to give each client time to fill out the survey.

At this time the MLC-3 team with guidance from their mentor revised their Aim statement. The revised Aim statement was: Between September 01, 2010 and November 2010 fifty percent (50%) of all STD clients at Allegan County Health Department will complete and return an STD survey.

First, the STD program needs to get an increase in survey return rate that is statistically significant. Then based on client input and needs determine what “cultures” they serve.

The team also compiled data from the respondents of the LHDs survey via Survey Monkey. There were twenty two respondents out of forty five LHDs after sending out the invitation three different times. (See attachments in the appendices)

Step Five: Develop an Improvement Theory

The MLC-3 team developed the following theory for improvement:

- If the STD program stabilizes the process and develops a process map that all STD team members can refer to then there will be an increase in staff awareness and compliance to the standardized STD survey process.

- If the STD staff follows the STD stabilized process then there will be an increase in survey return rate.

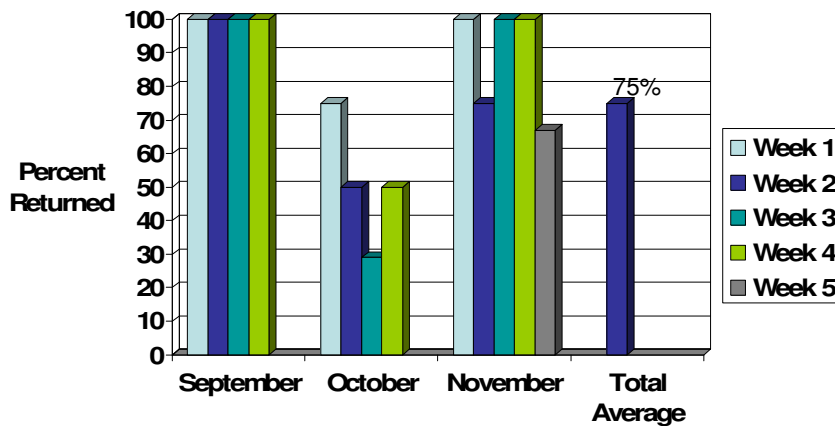
The ACHD MLC-3 team decided to implement this new STD survey process during a rapid cycle improvement on August 31, 2010. The return rate for that clinic day was one hundred percent.

Step Six: Test the Theory

ACHD STD team tested the theory by implementing the new STD survey process from September 01, 2010- November 30, 2010. The STD client survey return rate was monitored weekly to evaluate the trends. The MLC-3 team and STD team noted that the October rates were significantly lower. The charts were reviewed with both the MLC-3 team and STD team and it was discovered that one Public Health nurse did not follow the process map. The nurse did not allow the client time to complete the survey during the appointment. In November, the STD Public Health nurses followed the process map and ensured that the client had time during the appointment to complete the survey.

The STD team also discovered an unintended consequence of incorporating time into the appointment; the nurse was able to complete the charting while the client completed the survey. This decreased charting time after the appointment which increased efficiency.

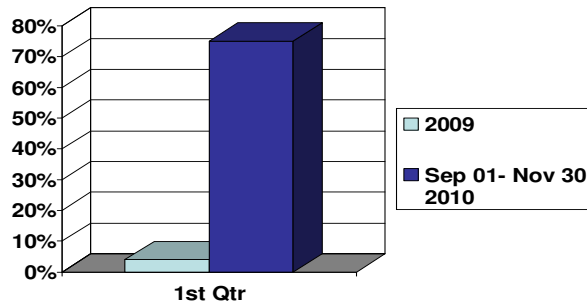
Percent of Surveys Returned by Week



Step Seven: Study the Results

The MLC-3 team compared the STD survey return rate of 2009 to the return rate for the project. The STD rate rose from four percent in 2009 to seventy five percent during the project.

STD Survey Return Rates



The team also analyzed and compared ACHD “new” STD client survey process to those from the LHDs that responded to the survey sent out via Survey Monkey. Those findings are shown in the tables below. The team was interested to compare ACHD new STD survey process to other LHDs. It was extremely interesting to see that sixty percent of the LHD respondents did not incorporate the survey into the appointment. ACHD STD team found that when the STD nurses did not incorporate it into the appointment the return rate dramatically dropped.

When does the STD client receive the survey?	Response Percent	Response Count
During the check-in process	36.4%	8
At the beginning of the appointment	4.5%	1
At the end of the appointment	27.3%	6
During the appointment	9.1%	2
Other	36.4%	8

*Allegan County STD program during the “Do” part of this project gave the survey to the client “*During the appointment*”.

What types of surveys does your STD program offer?	Response Percent	Response Count
Paper	76.2%	16

Electronic	0.0%	0
Both	14.3%	3

*Allegan County STD program during the "Do" part of this project offered **"Both"**.

Does your STD clinic incorporate the survey into the appointment process itself? (give time during the appointment)	Response Percent	Response Count
Yes	40.0%	8
No	60%	12

*Allegan County STD program during the "Do" Stage gave **time during the appointment to fill out the survey"**

What is your current survey return rate?	Response Percent	Response Count
< 10%	18.8%	3
10-24%	6.3%	1
25-50%	31.3%	5
51-74%	12.5%	2
75-100%	31.3%	5

* Allegan County STD program during the "Do" Stage had a 71% return rate.

Step Eight: Standardize the Improvement or Develop a New Theory

The STD client survey process that was implemented for the project was successful and has been standardized. The return rate went from four percent to seventy-five percent The survey return rate will be monitored quarterly to ensure that the process is still effective.

The MLC-3 team is aware that there is a need for the survey to be analyzed and evaluated. To be able to move towards providing culturally appropriate services the clients have to provide the appropriate data.

Step Nine: Establish Future Plans

ACHD communicated their accomplishments with this project through various venues. The Director of PH gave monthly updates at the PH team meetings. The Director of PH also discussed the CQI tools that this project utilized at other program meetings to help other staff become aware of these tools and their uses. General Staff meetings occur quarterly and there was an MLC-3 update at these meetings. At the last General Staff meeting each staff member received a Public Health Memory Jogger II purchased by funds from the MLC-3 grant. This will help to create and continue to foster a culture of CQI in the department. The STD coordinator and the Director of PH also plan to present the project at a regional STD meeting to share the

results and findings of the project. The Director of PH will do a presentation on the project, outcomes, and the importance of CQI at the 2011 Legislator and County Commissioner Orientation. The Health Officer will present at the 2011 Public Information Session.

ACHD is in the process of implementing a culture of CQI throughout the entire health department. The MLC-3 team encountered some barriers with creating process maps and other CQI tools. It was very time consuming with the current software the department had access to. The MLC-3 team decided to utilize funds from the grant to purchase an update to Visio to make it easier for staff newer to CQI to create these tools and in return they might be more apt to utilize them.

The MLC-3 team and the STD team plan to evaluate the current survey and determine if another CQI project is needed for 2011.

ACHD plans to utilize the MLC-3 team as the start of a CQI committee. There will be additional members from the Environmental Health division with a goal is create a policy, strategic plan, and training for health department staff.

Closing Commentary

CQI is an important tool to ensure maximum effectiveness and efficiency of any process. It was beneficial for ACHD as a whole to begin CQI in an area where a vast improvement was possible and realistic because the team members can now directly relate the 71 percent increase in the survey return rate to this process. The team has gained basic knowledge on CQI and now knows that it can work to improve processes. The team can use this as a platform to move CQI into other areas within the department and create a culture of CQI throughout ACHD.

What we achieved through the process:

- An increased understanding of how willing and open clients are to providing feedback. Clients will provide feedback if given the appropriate time and setting to provide comments on the quality of service they received.
- Developed some ideas of a roadmap to improve the actual survey as a future project.
- Improved the knowledge base and understanding of QI tools for members of the STD Team.
- Enabled us to use this project as a springboard for future QI projects because several members of the STD members were involved with other CQI projects; helped build a CQI culture within our department.

Implications for the target area:

- Improved comfort level for clients to provide feedback on the service they received.
- Provided alternate forms of completing the survey to improve ease and accessibility to the survey (i.e. electronic and paper form available).

What we learned about CQI:

- The benefit and impact of implementing CQI activities may not be seen overnight, but it can be used as a starting point for long-term changes and improvements.
- In identifying some of the root causes of the issues, we were already able to design some solutions.
- Solutions do not have to be complex to show the greatest impact, even the smallest changes like changing who gives them the survey makes a big difference and when the survey is given.

- You have to consciously make an effort to implement CQI tools, otherwise you'll be stuck in the status quo of what you've always been doing without trying to make any improvements.
- In order to foster a culture of CQI, you have to make the tools accessible and practical to everyday activities in people's jobs.

MLC-3 team looks forward to continuing their efforts to sustain the progress that has been made in CQI throughout the department and continuing to expand as well.

Appendix

[Demo graphs.ppt](#)

[MLC-3 STD survey data table for Study.doc](#)

[Demo data tally sheet.doc](#)

[Survey Return Rates.ppt](#)