

Transcription for October 10, 2012

## SDPI Training

### Moving Forward: SDPI's Role in the Improvement Process – Part 2

#### Speakers:

- Kelli Wilson, IHS DDTP Training Facilitator
- Pat Lundgren, IHS DDTP Nurse Consultant
- Teresa Chaudoin, Cherokee Nation Diabetes Program Director

Kelli Wilson:

With that, we will go ahead and start and I just want to welcome Pat Lundgren and Teresa Chaudoin to today's session. Pat has been – she has worked a really long time with Indian Health Service as a nurse consultant and a nurse in general over many years, and Pat, I am sure you can do a better introduction than I am doing right now, but we will go ahead and turn it over to Pat and go from there.

Dr. Pat Lundgren, RN, MN, EdD, CDE:

Well, thank you! Hi everybody! Thanks for joining today's call! One point I would like to make is the title, the main title, that's up in the right-hand corner of the slide is "Moving Forward." So we are hoping that because of this session you are all going to get on a train and just move forward using the ideas that we talk about today.

I am Pat Lundgren, and I know many of you. I recognize so many names. I retired three years ago after working for about 25 years in the Indian Health System. I did diabetes work that whole time in Montana and Arizona. And during the last few of those 25 years, I had the opportunity and the gift to work both for IPC at the Improving Patient Care program, and also the Division of Diabetes. So I am really pleased to be here with you today.

This is the second of a two-part series of Training on Improvement; the first part as Kelli had mentioned, happened in July, and in that July session we talked about a few basic improvement concepts and introduced the IPC program; what it is, what it's attempting to do, and we had two guests from two SDPI programs who shared their experiences and their work with local IPC teams.

So that session really very much introduced you to IPC and the ways that SDPI programs have partnered with their local IPC teams, working to enhance patient care in their communities. But this session is going to focus on improving your program. Because so many of your programs are community-based and prevention-focused, we want to introduce ideas that will help you to address your goals and improve your outcomes. That's what the next several minutes is going to be about.

In today's session we are going to look at improvement tools that can be useful as you provide both care and services to your community members.

And there are three learning objectives, and our hope that at the end of the session you will be able to describe one basic improvement concept, and you would be able to relate one way that your SDPI work contributes to program improvement.

And that last bullet has one little typo, it's supposed to read, "suggest at least one tool that you can use in your SDPI program."

I am going to bet that each of us who are at today's call have at sometime in our lives received medical care for a health issue, and the heading of this slide notes the process that's followed for medical care – "Assessment, Diagnosis, and Treatment".

A person would present themselves at clinic because they have an issue. Let's just say somebody had really low energy levels for several weeks and now they just can't see, their glasses don't work, vision is totally impaired, and it's like, uncle, I need help. I don't know what's going on. They show up.

So in the assessment, a provider asks questions, probably about recent weight gain or weight loss and thirst and urination, maybe even family history of diabetes. Then to diagnose what's going on, the person has a finger-stick blood sugar and lo and behold, holy cow, it's checked and it's 372. So the person is diagnosed. They are told, "you have diabetes".

As a treatment approach, the provider talks with the person about the fact that it's a serious problem, but one that can be managed. Talks about maybe what they drink when they are thirsty. Talks about the team that is available to them, refers people, sets up appointments, and the treatment plan begins to lift off.

Well, looking at the second point on the slide, that "Assessment, Diagnosis, and Treatment" is the process that we use to improve healthcare, let me just talk a little bit. Well, we self-assess. We can take steps to look at what we are trying to accomplish, what we are doing to get there, how it's working. We can self-assess our programs. And then as we gather information that we have collected, we can diagnose. You can see a picture almost.

Identify problem areas, gaps and services, unnecessary duplication, you can find all kinds of issues, that if you look, they are there.

And after you have a feel for what you might want to deal with or address, then you would begin a treatment plan. You need to treat program components that need a little bit of work. Things that we can do differently given what we have learned. We can make small changes, and if they work, we can tweak them a little more to make them better, make other changes. So it's all working towards the goal of improving our services.

Today we are going to introduce tools that can be used to help you do the self-assessment, help you diagnose issues that might be there, and help you come up with ideas of what you might use as a treatment plan.

Ask for a lot of suggestions. I believe that each one of us as a member of the healthcare team has two jobs. We provide care and services, and we need to improve our care and services.

Well, you may say, "I am busy doing my job. I don't have time to work on improvements". I'd like to suggest that we just need to examine how we approach our work. Are we doing what needs to be done to get by? Are we looking hard in seeing the problems? Is there more that we can do? Are there things we can do to enhance the systems that we use?

Well, if we accept that we do have a responsibility for improving our services, then we need to consider three questions, and they are considered the three foundational questions for improvement. And the questions are “**What are** you trying to do? What are you trying to accomplish?” “**How will you** know if what you do makes things better?” And well, “**What can you** do to make things better?”

In your SDPI planning and grid requirements, you choose at least one best practice to implement, and you develop goals and objectives to guide your work. And by doing that, you are defining what you are trying to accomplish.

The best practices suggest key measures that you might track. Using some of those measures you collect data, come up with ways to sort the data, and record it and track it in a way that it's meaningful, so that over time when you look at it, you can see what changes are happening, and if you are having an effect that you want.

And you do many different kinds of activities. I believe in the grant documents they are called “Major Activities”. These are all things that you do through which you hope to accomplish your objectives.

So you can see that the structure of your work is in fact an improvement process. It follows those three questions in a very real way, and you can use those questions, and I encourage you to use them.

In program planning how do you make decisions about your program activities? Well, I am sure there's all kinds of ways, but I have listed a few available resources. If you don't have the resources, you don't do it... “Ideas within the best practice documents”. You have heard of “success stories.” **But for improvement purposes**, it's really important to make decisions based on the results of your ongoing data collection, to look at that data over time and see what's going on, to answer the question, “how will you know if what you are doing making things better?”

We have been asked to share a tool that IPC teams are using. It's called the “Green Book”. It's affectionately called the “Green Book”. It's on the website that's on your slide. I encourage you to note that website's address and go to it and check things out.

The formal name of the Green Book is “Assessing, Diagnosing, and Treating your Outpatient Specialty Care Practice.” It's many, many pages long, maybe 40 or 50. And it provides tools and methods that can be used to improve the quality and value of care and services.

And as a heads up, it has got a very real clinical care orientation, because it's a tool for outpatient care practice, but it has got good stuff, and it has got stuff that's going to be very valuable to you.

There are three tools in particular that we believe that you can really use effectively to work with your program and those are what we are going to be talking about here. So the three tools we are going to cover are called: “Through the Eyes of Your Patients”, “Process Mapping”, and “Satisfaction Surveys”.

I am going to go backwards for a second, I am sorry. So notice it says, “Through the Eyes of Your Patients”. Well, I know that you all don't work in clinics in general, and you might call the people with whom you work participants, clients, or customers. Today I am going to try to use the term; not “patient”, but “client” when we are talking about the people who are receiving our services. Here's a heads up in the “Green Book” - , it all refers to “patients”.

So let's go back to what we are trying to accomplish today. We are introducing tools that can be used to improve services and care. Let's assume that maybe in our work setting we know that we have gotten some negative input from clients and staff. Clients say, "You know, different staff ask me questions, the same information over and over. I am tired of it". And staff say, "I waste my time waiting for certain things to happen, and there are things that have to be corrected before I can do what I need to do. This needs work".

So **what** are you trying to do? Well, let's say, we are trying to decrease wasted time and duplicated work. Well, **how would you know** if what you do makes things better? I just pulled out my little arrow, improve satisfaction surveys and encounters, they take less time.

Well, **what can you do** to make things better? Well, not only can we identify problems using the "Process Map" tool and "Through the Eyes of Your Patient", but we can also look at, well, what can we use that information for to make changes?

The first tool I am going to talk about is "Through the Eyes of Your Patient". And it's really very much not really a document or a tool, but there is a form on your slide that's "Form 1\_Through\_the\_Eyes\_of\_Your\_Patient". So that if you want to download that and save it, you will be able to have something that you can use after you close out on this session.

"Through the Eyes of Your Patient" is a way to gain you insight into how your program participants experience receiving your care, your services. And you actually experience getting the service yourself. You have staff members do what's called a "walk-through" of a client's visit to the program, and you try to make the experience as real as possible, and you document the experience.

In the file as I said, I wonder if I can bring the arrow down there, and I don't know if you can see that, "Form 1".

There are several steps to take as you are doing the walk-through and this slide lists several tips that you can do, which actually continue on to the next slide, as you are doing a walk-through. And it says, first decide where the starting and ending points are; consider making an appointment or make believe, have an actual visit; or make-believe do follow-up after a visit; or what other processes. And you want to have a staff member play the role of a client.

Set aside a reasonable amount of time to really experience the client journey. You might not want to do it just once, you might want to do it several different times, and it really is a good idea to make this as real as possible.

Some people say not only to sit where the client sits, but to wear what they would wear, and make a realistic paper trail, not just make-believe that you are creating the papers. You get the papers. Create the papers.

During the walk-through you want to note positive and negative experiences, as well as surprises. What was frustrating? What was gratifying? What was confusing? And then at the end, you debrief. Pull your staff together to talk about what you did and what you learned.

So here's a format to use as you are documenting that experience. Note the date, the staff member, where the walk-through began and where it ended, and as I say, these criteria that you want to note as a summary of the experience.

So for the sake of time I am going to try to very briefly make-believe that a staff person plays a woman who has just left the hospital. She has just been told that she has pre-diabetes, and she

walks into the Community Fitness Center without an appointment, but she is carrying a hospital referral for the Diabetes Prevention Program.

She is not a member of the Fitness Center, so the receptionist welcomes her and gives her forms, lots of forms to complete. They are on the clipboard and she is given a pen.

She doesn't ask for help, even though she has trouble understanding some of the words, but she guesses what the words mean and fills out the form as well as she is able. She waits five minutes after she returns the form.

The receptionist wants her to see a personal fitness trainer and asks if she would like to see a male or a female trainer. She selects a woman, and the receptionist tells her it will take a few minutes before the trainer is available. So she waits maybe four, five minutes and then she is asked to go see the trainer.

The receptionist tells her where the trainer is, and the client comes into the Fitness Center, roams around a bit, not knowing where the heck to go. And another staff person sees that she looks a little confused, asks if she can help, and walks her to the trainer's office.

The trainer is really knowledgeable and friendly, welcomes the client, gives her information, asks what she'd like out of coming to the center. They talk about her fears and thoughts and concerns. She shares information about available classes and takes her through that, and she really encourages her to think about what she is interested in doing in the program, and to return for an appointment.

They arrange a mutually convenient time to get together for the appointment and the trainer walks the client to the door and says goodbye.

So the walk-through happened today, Amy, the staff member did it. I will try to use this arrow. The walk-through began when the client enters the clinic and ended when she left with an appointment with the trainer.

And then moving down the line, the "positive" was the trainer was very friendly and knowledgeable. "Negative", the clerk gave forms to complete, didn't ask if I needed help, and the fact is I did. The clerks told me where the trainer was but didn't bring me to them or bring the trainer to me.

My "surprise" is, my goodness, I have my own trainer. They asked me when I could be available for an appointment. They scheduled around me, so that was really a surprise.

The most "frustrating" part was getting lost in the Fitness Center when I was looking for the personal trainer.

And "gratifying" was that the trainer really made me want to come back. It was a very positive and encouraging visit. So that's using the form.

So when looking at this form, what did we learn? Well, the trainer seems very capable and skilled, and there's a program in place and it seems to be pretty well organized.

The receptionist, the clerk needs a little fine-tuning. Maybe she is new at the job, who knows, but she did give the client the forms and she offered her a choice of a personal trainer, but she didn't suggest that she might provide support when the person completed the forms, and she didn't walk the client to the trainer or have the trainer come to her.

Is there useful information on this form? Are there any “actionable ideas” or things you can act on? I think so. Certainly we need to – we’d benefit from further trainings for the clerk, and from working out a system where when somebody comes to the clinic for the first time, someone greets them and brings them to where they need to go, rather than sending them on their way.

What if you had three or four staff members do walk-throughs like this with different scenarios? Would you get other insights? Well, I think you would. So this “Through the Eyes of Your Patient’s” visit is one very valuable way to develop insights into your program and where you might need to focus a little attention to improve it.

The next tool I would like to cover is “Process Mapping”. One of the founders of improvement science, a man named Deming said, “if you can’t draw a picture of your process, you can’t improve it”. Creating and using process maps helps you to see not only waste, but frustration, and it shows all kinds of ways that teams take more time or resources than should be used.

It identifies rework, people doing the same thing, unnecessary delays; all kinds of problems. So when you want to do a process map, it’s important to get together with your whole team and create a flowchart of a work process. It’s a good idea to make it be a process that involves patients and staff.

And start with just one flowchart. Later it may be so beneficial you want to do more, but let’s just do one, and review it after you have completed it to identify any unnecessary rework, delays, duplications, any kind of opportunities where you might be able to make improvements.

Here’s one example of a very basic diabetes education process map. And using my arrow, a patient with newly diagnosed diabetes, they are referred to clinic for diabetes education, and an appointment is scheduled. And then on the day of the appointment the client checks in.

The client completes a needs assessment form and other paperwork. And then the educator reviews the referral form and the completed paperwork. And then they do the diabetes education interaction. At the end of that, the patient leaves.

This is a very basic diagram. Can you see anything that might waste time on it? Well, the client comes, just completes their forms after checking in. That’s something that could be worked on.

Did the educator have to wait for them to complete the forms or were they doing something else in the meantime? Certainly the client had to wait while the educator reviewed what was written on the forms.

In showing you this map, I might be doing a bit of a disservice, because it’s almost too basic. Under each of these headings we really need to include all the different steps that occur and the things that are done under those headings. And I am sorry I don’t have a slide, which demonstrates that, but after the basic processes are identified, like what you see on this slide, you can place post-it notes. Put it on post-it notes and put it on the wall.

And then you can take different signs or color notes and add some of the details under each of these steps to really get a feel for what happens in this particular process in your program. And doing this with all of your team members will show how different people might do things differently, and they might use different resources. Who knows what kind of non-uniformity there is out there? This is a way to find out, and it gives insights galore.

In summary, regarding the Process Mapping steps, you know, I encourage you to choose a process that you want to identify. Map out the way that work is currently done, with your team. Get everybody involved. Identify gaps. What isn't happening that needs to happen. Work on problem areas or waste. Find out if there is stuff that is problematic.

Keep in mind the goal to identify the process and find areas for improvement. Brainstorm strong solutions, and then you have ideas to test, to work on improving the processes.

So some of the details you might look for are client time, the staff, barriers within the facility, or equipment inadequacy; things that needed to be on hand that weren't. Paperwork issues. Duplication is a real problem. Reworking something somebody else has already done. Where does unnecessary waiting occur? Those are just a few ideas.

And this is also another diabetes education diagram, but it only contains very, very broad general activities, and for those of you who have diabetes education interventions, you might use this sort of a process map as the jumping off point for your discussion in your work.

Other possible process maps might be creating grant progress reports, referral processes, getting information about new patients to staff, or setting up appointments, providing feedback to clinical providers. There are all kinds of ideas you can come up with. But choose one first. Do it. Learn from it. Have some fun. Use the information you learn and make some progress.

The last tool that I want to cover is "Satisfaction Surveys". And both staff and patients, clients, can be asked to provide data through the use of surveys. Clients have very valuable insights into the quality and process of the service we provide. We need to ask them.

And if we do a survey, it gives real-time feedback that can open the door for doing things quickly to try to make improvements. And you have the data right there at the end of the visit, so you have a good opportunity to collect information.

I have two examples of patient satisfaction surveys. This one is from Chinle (AZ) in the Diabetes Department. The diabetes staff worked for months to develop this form. I love it! Many patients and many staff people were engaged and gave feedback in its development.

I won't read through it; you read through it yourselves. Notice that the "Health Coach" is a new term for "Diabetes Educator".

Now, you can take this, use some of the format ideas, adapt some of the questions, and use them to address items that you are working to improve.

For example, if you are focusing on not asking clients the same information more than once, you can ask, "well, how are we doing with that", or anything that you are focusing on, you can ask for feedback.

The second is a clinical patient satisfaction survey, and I have included it because it's a good example of another one, even though it's clinical, but I have included it because I have a couple of other slides that show what the people from Shiprock (NM) are doing to manage the data that they obtain by using this form. So there are nine questions and then there is an open field box asking people to tell what can be improved in their care.

And the Shiprock folks developed a Quarterly Summary Sheet. This is an Excel spreadsheet and they assign a staff person to tally all of the patient responses. So the patient's response to every question is tallied.

Here's question number one; there is a range of 1-5, so for the person who got their care on October 18<sup>th</sup>, these were their responses; their responses 1-5 for questions 1-8.

And then on the end, there is a box where they can type in the text, the person's answer regarding what can we do to improve things.

In addition to that, Chinle manages the information that's put into those comments in the right-hand column, that people write information in, and they have over time come up with these categories of responses that they have received.

So they will produce a report. I am going backwards for a second. So all the comments in this right-hand column, and there will be probably dozens, if not hundreds, of comments, are then organized according to these categories.

And you will notice that there are – there is a waiting category, which doesn't include pharmacy wait time, they put that under the pharmacy category, and there is another category; and they also added a category of positive comments.

And in terms of some of the sample responses, for example under waiting, somebody said, "you cut waiting time to an hour, but you need to tell patients". This is another person's comment, "how long waiting time is going to be?"

Under the customer service, somebody said, "you really need a microphone to call out our names, especially for elderly people". And "come on receptionists, give us a smile and please use our language".

And in terms of the availability of providers, they talk to the fact that they want to be able to talk to their doctor by phone, and they had their own doctor and that doctor left and now they don't have one. That's just a few examples of the type of comments that you can get. And those are valuable comments.

And if you have a long list categorizing everybody's comments, you can over time really see a difference of whether what you are trying to improve is getting better, or whether it's still a problem, or whether it's getting worse. This gives you good information to recognize positive changes.

In summary, I encourage you to plan to work to improve what you do. Use these tools. Learn from using them. Use them. I am going to repeat that again. Learn from using them. Use them over time. Put on your calendars, a month from now, two months from now, three months from now, to use them again. Track your results and keep learning. Make these changes. Test little things that you do to see if they make a difference, and with that sort of perseverance, your processes will improve and your outcomes will too. They will!

So I challenge you to move forward. Good luck with it!

The last slide of my presentation includes my email address. If you have any questions or problems, or you would just like to visit about anything regarding this, please feel free to contact me. In the meantime, Teresa Chaudoin, the Diabetes Program Director from Cherokee Nation will follow. She

and her staff have used each and every one of these tools and they have lots of stories to share, so Teresa, it's yours.

Teresa Chaudoin, MPH, MA:

Thanks Pat! That's who I am. I am Director of the Diabetes Program. I have been with Cherokee Nation for 11 years now, and just as a little bit of background information, this is where we are. We are in the northeast corner of Oklahoma. We are part of – Cherokee Nation. It covers all or parts of 14 counties in northeastern Oklahoma. And our Health System includes eight outpatient clinics, an employee health clinic, and one hospital. We provide services to about 10,000 diabetes patients.

We have been an SDPI grant recipient since the beginning in 1998, and while our Community-Directed Grant program provides some resources to support the community work of our Health Promotion Disease Prevention Department, the main focus of our Community-Directed Grants has been on improving clinical care for our diabetes patients.

Since 2001, we have used the Systems of Care Best Practice, and we have experienced considerable success with that. And so when IPC came along in 2006, we wanted to be a part of it, because we were hoping to use the same model to be able to provide the same level of service to all our patients that we had been doing with our diabetes patients and to see improvements across the board.

So we were one of the original 14 IPC pilot sites and we continue to be involved with IPC. And I will just tell you the reason I am here today is because I was very involved with our first IPC site; our Amo Health Center at Salina, Oklahoma, and we were – so I was asked to share how we used these tools for improvement at Salina.

So Pat has already shown you “Through the Eyes of Your Patient” form, and when we used this first tool at Salina and did the walk-through, actually IPC had already been in place about a year. So the Quality Improvement Director and I – the Quality Improvement Director for Cherokee Nation was the patient and I was the family member, and so I am just going to show you the next few slides to show you the results of how we – what we found as we did our walk-through using this tool.

One of the things we noticed was that the new employee registration was very friendly and helpful, and the fact that she was new, she didn't know who we were, so that was very encouraging.

We also were – when we were in the waiting room, the LPN came to get us and actually escorted us to where we were going. So as new patients we didn't have to try to figure out where it was.

Some of the “negatives”, and this first one, having a soap opera on the TV. I guess that all depends on whether you like watching your soap operas and not missing them. I know my grandmother would have been very happy to have found her story on the TV at the doctor's office. But that's been changed now so that we have more health-related tapes and information on the TVs.

There was a sign at the registration window in English saying that interpreters are available on request. We thought that was kind of funny because we thought, well, if you are a Cherokee speaker and you don't understand English, that sign is not going to help you much. Hopefully we have gotten that translated into Cherokee and up there in the signage.

We signed papers saying that we had reviewed the privacy practices, but we didn't actually get to see them. We saw what the walk-in hours were posted as and we knew that wasn't always the case.

Since then we don't have walk-ins anymore. We have same day appointments, so this is not an issue.

When we were in the lab area and waiting, we didn't have anything to read, except look at the signs in the lab. And so that's been remedied.

And then a couple of other things we noticed was that we – had to do with the blood pressure. We weren't told what her blood pressure was, and she had her legs crossed and we think that was a case of the nurse being probably a little nervous, because she did know who we were, and also we were probably visiting and got her distracted.

The “surprises”; we were sitting in the waiting room waiting for the physician to come in and we saw a sign that said that there were going to be changes in pharmacy today in July of '07, and we there on May 6<sup>th</sup> of 2008!

A lot of the things that we noticed; some are shown here on this slide; showing things that we found that were frustrating and confusing. One of the forms asked if the patient was “CDC eligible” and that would be somebody that's eligible for our Breast and Cervical Cancer Prevention Program. And a patient – that's something that the staff would understand, but a patient wouldn't necessarily know what that meant.

The Health History Questionnaire showed that – had an instruction to “read above and complete below”, and there was nothing above to read. This was probably a case of cut and paste on doing a form and somebody just missing that, because they don't look at it all the time.

So a lot of things that we noticed were related to signage and paperwork, which was easily corrected, but just having someone look at it as a participant or a patient or a client, rather than people who see it everyday and know what it's supposed to be and just take for granted that everybody understands it as they do. That was very helpful, and I think that's something that would apply in a lot of other settings, not just clinical ones.

On “gratifying” we found out that they were practicing proactive care, which is one of the things that we want to do through IPC, and that was that all new patients – we found out that all new patients who were 40 and older that don't have medical records with them, get an EKG as a baseline. So that was very gratifying to know.

Process Mapping is also something that we used at that clinic, and we used it. We use Process Mapping to standardize our processes and this has resulted in our measures improving. If you have several staff in an organization that are doing the same thing, but doing it differently, it's just – there's a lot more margin for error and things getting omitted or not done or done wrong.

So this has helped – by mapping the processes we have been able to reduce that variability and produce more reliable processes and those are measurable.

We also use Process Mapping to identify bottlenecks in the system, and that's reduced the amount of time it takes patients to get through their appointment at the office.

I remember one process map we did, and the team identified that there was a holdup with lab, and so when they got lab involved in doing the Process Mapping, they found out that something that they had assumed was wrong, and lab couldn't tell when they called patients back whether the patient was there for a lab-only appointment or whether they were there for an appointment with the provider, and lab was just part of the visit.

So they were taking people as they came in, and if you had a lot of lab-only appointments that arrived before the appointment patient did, then that took longer to get the patient with the appointment through, and then that caused delays down the line and provider sitting round waiting for the patient to show up from lab.

That was a pretty easy fix and it was really – it was just enlightening to include the other department in there and to get them involved in the process and to identify the problem pretty quickly and get it resolved and to shorten the time it took to get patients through their appointments at the clinic.

We also used it to remove steps that didn't add value for the patient. When we did Process Mapping we noticed several times where the patient was taken back out to wait; did this, wait; did this, wait. And so they were able to revise the process to eliminate many of those patient waits which made the appointment more valuable to the patient, because it lessened the amount of time they spent there, and a lot of that time, that was – what was used to shorten their visit was – it happened because they didn't make them wait at so many different places as they were going through their appointment. And overall it just helped us to become a lot more efficient.

Process Mapping is a process too, and it's messy when you first get started, and it can be very complex. So all of the tips that Pat provided about how to do Process Mapping, those will be good to go back and look at, and to help you get through it so that it's not – you can start out simple and then work up to getting a little more detailed.

I am going to show you a graph right now. This is the length of a cycle, average office visit cycle time at Salina. And I am sorry that the data just goes through March of 2011, because that's actually when I was still tracking their data for them, and I haven't tracked it since March 2011.

But you can see that over these four years that their average office cycle time went from over nearly two hours, nearly three hours, to about an hour. And they are still tracking this. It's something that they track on a monthly basis. All of our clinics do. Over the last year, I looked at their scorecard. Their time was been between 55 and 58 minutes over the last 12 months, and that's including the time that patients go through pharmacy.

Another measure that they have tracked that would be interesting to us is that they tracked Diabetes Comprehensive Care, which includes six measures of things that need – important tests and exams that need to be done for patients with diabetes to prevent complications; A1c, blood pressure, LDL assessed, complete foot exam, a retinal exam, a nephropathy screen. And to get counted as having been done, you have to have all six of them done, not just – if anything is missing, you don't get counted.

Last month the percentage of patients who met all six measures in the past year was 77%. So being able to make these kinds of changes and use these tools and improve processes, standardizing processes to make sure that everything gets done; that helps with Process Mapping and does result in even clinical measures improving.

This is a process map that we have got here, and I know that in the handout you are not going to be able to see it very well, and it's hard to read right here. But this is a little bit more detailed process map. It's an adult routine appointment at Salina that we did. It's there on the screen, and I apologize that it's so small, but if you would like for me to send it to you, I can email it, and you would probably be able to see a little bit better.

“Patient Satisfaction Surveys” - at Cherokee Nation we use the “Balanced Scorecard” to ensure that the goals – our goals that we do, our work that we do, aligns with our strategic goals. And so we use a “patient satisfaction” on the scorecard that we track on a monthly basis, and we use the scores from our surveys. And then we trend comments in the different areas to identify things that we need to improve on.

This is just an example of the survey that we use. It's the one that IPC uses. It's very simple with six questions, and then this is how we also total that up, similar to what Pat was showing you, that I believe that Chinle uses. And using this, the staff at the clinic tabulates what their satisfaction percentage is for the month.

And then these are just some of the comments that we have and we have had. Reading the comments is very interesting, because we are able to – we feel like we are validated on some of the things that we are doing. It's always nice to hear that what you are trying to do you have succeeded at.

So here are some of the comments that we have. I will just let you read through those. I know we are getting short on time.

And then we always get some that are letting us know that we still have room for improvement.

Anyway, this is how we have used these tools in a clinical setting, and I agree with Pat that they could easily be modified to be used in more of a community setting to help you improve on the work that you do.

Anyway, Kelli!

Kelli Wilson:

All right, thank you very much! We actually do have some questions for you, and Teresa, they are primarily for you. There are about four or five, so we will do a couple and then I will move on to the evaluation. Then we can finish up questions at the end too.

So someone wants to know how many visits does Cherokee track per month for the cycle time study?

Teresa Chaudoin:

At Salina they had a goal of, I believe, 15 per provider per week. I haven't done this form for a while, but I know that in that – I know that it was usually anywhere from 45-60 a month. So I guess they weren't achieving that many, but they do run cycle times every week for each provider and then total them up at the end of the month, and I am thinking that it was around in the 45-60, 65 range, something like that.

Kelli Wilson:

Okay, thank you! Another question is for new employees and contractors. Are the improvements presented during the orientation process? I am guessing it's the Improvement Process or IPC in general.

Teresa Chaudoin:

IPC is presented to new employees. I don't know if by contractors you mean physicians. They would be included in that too. It's something that we don't feel like we do adequately, and we are working on that to improve the orientation right now.

Kelli Wilson:

Thank you! Another question is, someone would actually like you to define "Balanced Scorecard".

Teresa Chaudoin:

"Balanced Scorecard is" – it really is – it's more of a management tool and we have goals that we set for different departments based on what their role in Cherokee Nation is. They have goals that tie into the Tribe's overall strategic long-range plan.

And the way that it looks to clinics and anybody that wants to get into our intra-server is it's like a dashboard of the measures that we are tracking, what the goal is, and then what the percentage is by month. And so that's what the scorecard is.

And then there are quarterly management meetings with senior management to look at the measures that are not in. I think they have red, green, and yellow zones, and if you are meeting it, it is green. Anyway, they go through this to look at the ones that are in the red zone and discuss ways to bring them up.

Kelli Wilson:

Thank you! The next question is, does your program utilize Diabetes Standing Orders or Protocols to increase visit efficiency?

Teresa Chaudoin:

Yes.

Kelli Wilson:

That's a quick question. Here is another one. Who is responsible for getting the patients' surveys completed, and who tabulates the results, and how often?

Teresa Chaudoin:

The patients are given the satisfaction surveys when they check in at registration. They turn them in at the end of their visit. I don't know if it's a box, but there is a centralized place. They may just leave them. I honestly don't know. It may be at pharmacy or there may be a box. They are just kept till the end of the month and then there is a person designated that goes through and totals them up and provides a satisfaction – monthly satisfaction survey results to each provider and then for the clinic as a whole.

Kelli Wilson:

Thank you! I do have a quite a bit more questions, but we are going to go ahead and just go to the end so people can be doing the evaluation if they would like while we go through the rest of the questions.

Just wanting to let you know we do have some upcoming training and you can find those on our website. We don't have the next SDPI Required Training scheduled yet, so be on the lookout for that.

We do have some new pages to the website. There will be some new things pushed live this afternoon, so be on the lookout for that as well.

Just want to remind people that November is National Diabetes Awareness Month and we do have some things online that your program can use. We can forward it to your tribal newspapers or newsletters that you may have. Sorry, I am going through this pretty quickly.

The other thing is, whenever you do your evaluation, you will have the option to print the certificate of completion, and so I just want to show you. This is what your screen will look like and this is where the arrow is pointed is what you will need to click to get that certificate, so don't miss it at the end. I just wanted to show you that.

And then this is the link. If you click on the green box, you can get your training evaluation. It will probably pop up in a different window and actually may show it behind the screen.

So I just want to thank everyone for joining, and for Teresa and Pat for your time and everything that you were able to share with us, and the tools that both clinical and community programs can use in improving their program. So just want to thank you.

And we will go back to the questions now so you all can do your surveys if you like. Next question Teresa is, are the wait times specifically for diabetic programs or has this process been transferred to other clinics throughout the Health Center?

Teresa Chaudoin:

We track cycle times at all of our clinics and it's not just for – no, it's not just for diabetes patients at all. In fact, I think that this – the average visit cycle time that we show on this is not for what they do at yearly clinic, once a year, at Salina, during the patient's birth month, and they have them come in, they do their eyes, and they tell them that it will take probably two to three hours to get everything done. And for that one visit, that's a longer visit, so they don't use that to track, but the average visit cycle time is for a routine office visit, and we do that at all of our clinics.

Kelli Wilson:

Okay, thank you! And I just want to remind people that we will have these slides available on the website about a week from now, and we will actually have these tools available as well, so you can get them on the website in about a week, and I will be emailing you and reminding you of when it's ready.

Let's see. Someone wants to know, Teresa, if you have designated staff to complete cycle studies?

Teresa Chaudoin:

What we do is we give the patient the form when they come in the clinic and they write in the time when they get there, and then as they go to each – all the steps that we have identified in the process map; first they go here, they write down the time and how long they wait, and then take it to the next place, and then turn them in at the end.

Kelli Wilson:

Okay, so pretty much people are doing it handwritten?

Teresa Chaudoin:

Exactly! The patients are handwriting it as they go.

Kelli Wilson:

Okay. So do you use an EHR package to track cycle times; that was another question that we had?

Teresa Chaudoin:

I am not sure how you mean an EHR package?

Kelli Wilson:

I know some programs use iCare. I don't know if that's something that you all use.

Teresa Chaudoin:

We use iCare, but I don't – I honestly don't know. We used to – way back, way back when I was doing all this for them, we were using a spreadsheet, just an Excel spreadsheet. I am not sure. I think we have – it's a spreadsheet that one of our IT people put together. It's a lot fancier than the one that we started out using, but I could check on that. I will be glad to let you know.

Kelli Wilson:

Okay.

Teresa Chaudoin:

It's not something I did; it automatically gets done. Somebody happened to figure it out from the paper surveys. I mean, having to enter the times and then the spreadsheet figures out the time for you.

Kelli Wilson:

Okay. That sounds good! Let's see, there are a few people that would like a copy of the program standing orders. Would you be able to provide that Teresa?

Teresa Chaudoin:

Uh-huh.

Kelli Wilson:

Okay. And if you – I can get it to people if you just want to share it with me and we can do it that way.

Yeah, there are actually a lot of people wanting that, so that's good. And so many thanking you Teresa, I can share that with you as well privately.

Teresa Chaudoin:  
Thank you!

Kelli Wilson:

Actually they do have a question in here, can you comment on how leadership at Cherokee supports the improvement work?

Teresa Chaudoin:

When we started IPC, gosh, five years ago now, it was a priority with them. We knew that it was where we were all going. We had so much success in improving measures with our Systems of Care Best Practice, and it was very much like IPC using – if you look at the Care Model, the Chronic Care Model or the IPC Care Model, the Health System, what you do to improve things – and in fact, Pat can tell you more about this, but I believe the Indian Health Care Model for diabetes was really utilized when the MacColl Institute developed that Chronic Care Model.

And so, I lost my train of thought there. Tell me the question again, I am sorry?

Kelli Wilson:

Can you comment on Cherokee's leadership and how they support?

Teresa Chaudoin:

Oh yes, okay. So there was support for that from the very beginning. The people at Salina that were the pilot project knew that, that was a priority, and if the work was important they provided time for them to take out of their schedule in order to meet and work on improvement work.

Every system-wide meeting, it was a regular part of the agenda that we reported on this. As we had success for different things at Salina, we moved it out to the other facilities. All of our clinics have used the tools we have used in IPC and are using many of the measures in IPC. So IPC has spread throughout our entire system.

And it's certainly not where we want it to go everywhere, but it's a work in progress, and we could not have done that without the support that we have had from leadership.

Kelli Wilson:

Thank you! I know that's pretty common, any successful IPC site has had that leadership support, which is so valuable. Definitely make things a lot easier.

I think that's all the questions we have. Again, I just want to thank you both for sharing these tools, and it's really I think a tool or tools that any program can use to improve their processes or their program. Especially it's important to take a step back and view our processes and programs from the participant's point of view, so I think that's so valuable.

And in order to get something you have never had, you are probably going to have to do something you've never done. And so sometimes change is hard, but it can also be pretty fun. I want to thank you all for joining.

**Total Duration: 60 Minutes**