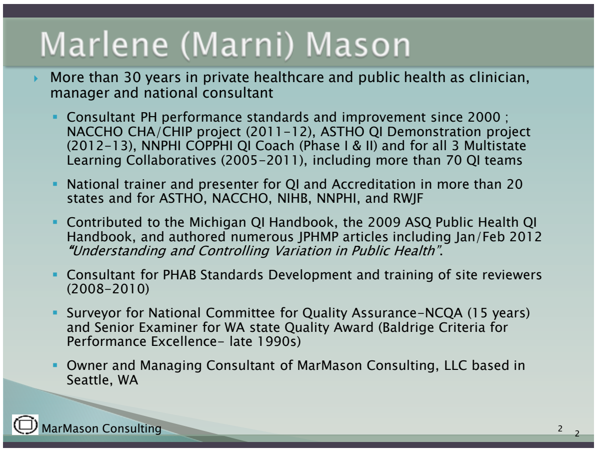
MCHD QI and Accreditation Training Session

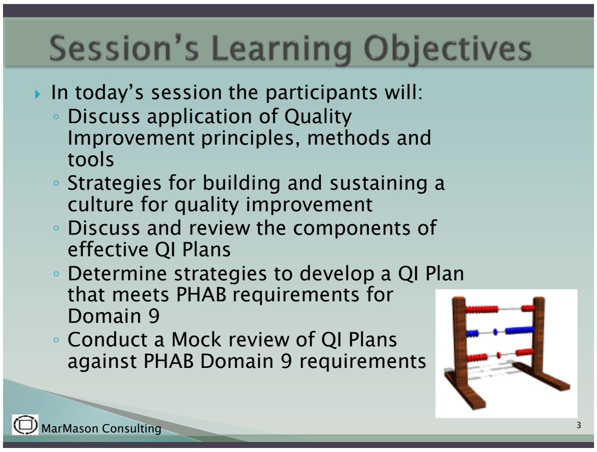
February 8, 2013

Marni Mason,
MarMason Consulting, LLC



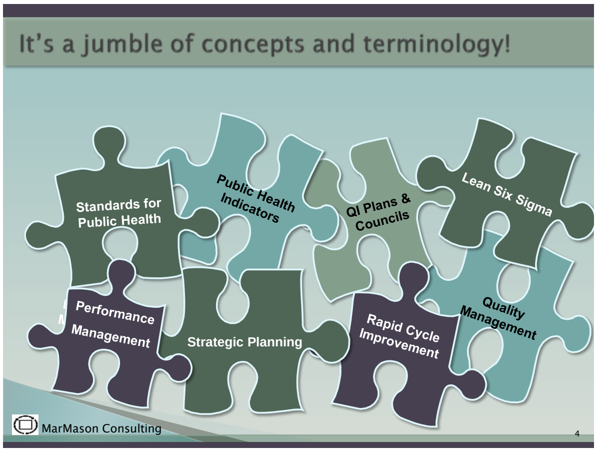
Marlene (Marni) Mason

- More than 30 years in private healthcare and public health as clinician, manager and national consultant
  - Consultant PH performance standards and improvement since 2000 ; NACCHO CHA/CHIP project (2011-12), ASTHO QI Demonstration project (2012-13), NNPHI COPPHI QI Coach (Phase I & II) and for all 3 Multistate Learning Collaboratives (2005-2011), including more than 70 QI teams
  - National trainer and presenter for QI and Accreditation in more than 20 states and for ASTHO, NACCHO, NIHB, NNPHI, and RWJF
  - Contributed to the Michigan QI Handbook, the 2009 ASQ Public Health QI Handbook, and authored numerous JPHMP articles including Jan/Feb 2012 *"Understanding and Controlling Variation in Public Health"*.
  - Consultant for PHAB Standards Development and training of site reviewers (2008-2010)
  - Surveyor for National Committee for Quality Assurance-NCQA (15 years) and Senior Examiner for WA state Quality Award (Baldrige Criteria for Performance Excellence- late 1990s)
  - Owner and Managing Consultant of MarMason Consulting, LLC based in Seattle, WA

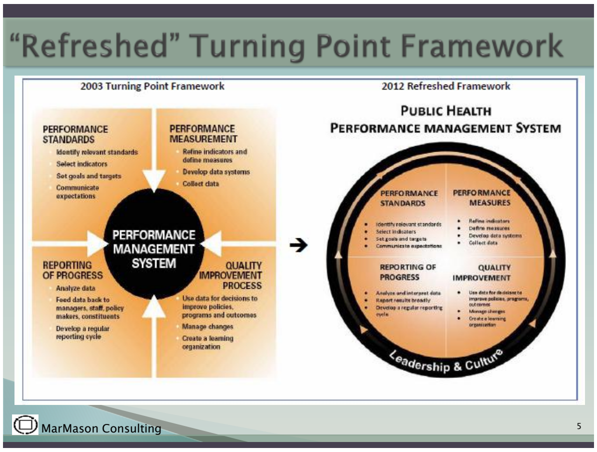


Session's Learning Objectives

- In today's session the participants will:
  - Discuss application of Quality Improvement principles, methods and tools
  - Strategies for building and sustaining a culture for quality improvement
  - Discuss and review the components of effective QI Plans
  - Determine strategies to develop a QI Plan that meets PHAB requirements for Domain 9
  - Conduct a Mock review of QI Plans against PHAB Domain 9 requirements

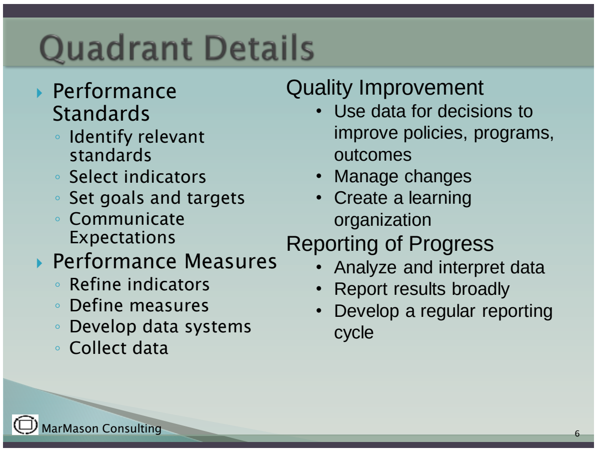


It's a jumble of concepts and terminology!



“Refreshed” Turning Point Framework

2003 Turning Point Framework
PERFORMANCE STANDARDS
Identify relevant standards
Select indicators
Set goals and targets
Communicate expectations
PERFORMANCE MEASUREMENT
Refine indicators and define measures
Develop data systems
Collect data
PERFORMANCE MANAGEMENT SYSTEM
REPORTING OF PROGRESS
Analyze data
Feed data back to managers, staff, policy makers, constituents
Develop a regular reporting cycle
QUALITY IMPROVEMENT PROCESS
Use data for decisions to improve policies, programs and outcomes
Manage changes
Create a learning organization
➔
2012 Refreshed Framework
PUBLIC HEALTH
PERFORMANCE MANAGEMENT SYSTEM
PERFORMANCE STANDARDS
Identify relevant standards
Select indicators
Set goals and targets
Communicate expectations
PERFORMANCE MEASURES
Refine indicators
Define measures
Develop data systems
Collect data
REPORTING OF PROGRESS
Analyze and interpret data
Report results broadly
Develop a regular reporting cycle
QUALITY IMPROVEMENT
Use data for decisions to improve policies, programs, outcomes
Manage changes
Create a learning organization
Leadership & Culture

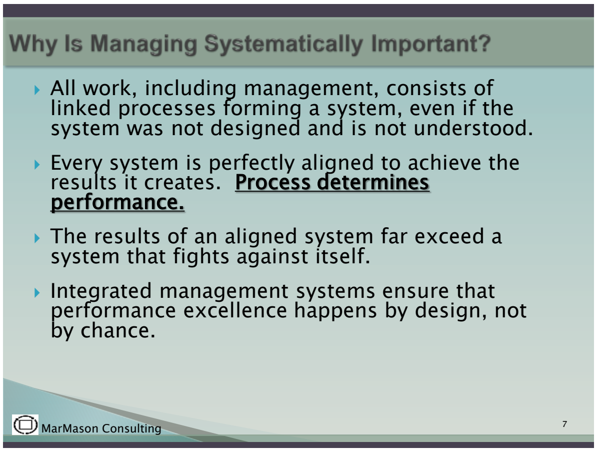


Quadrant Details

- Performance Standards
  - Identify relevant standards
  - Select indicators
  - Set goals and targets
  - Communicate Expectations
- Performance Measures
  - Refine indicators
  - Define measures
  - Develop data systems
  - Collect data

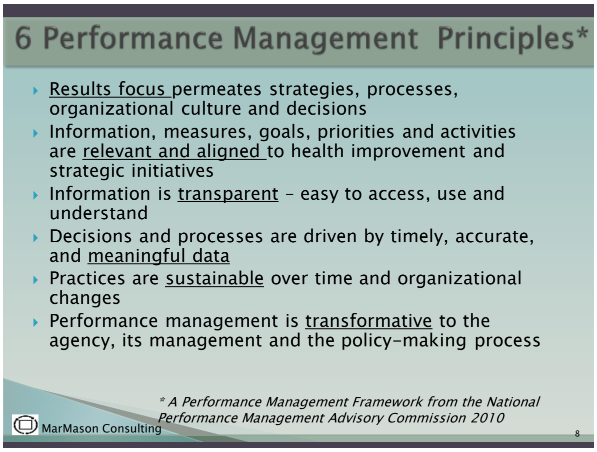
Quality Improvement
- Use data for decisions to improve policies, programs, outcomes
- Manage changes
- Create a learning organization

Reporting of Progress
- Analyze and interpret data
- Report results broadly
- Develop a regular reporting cycle



Why Is Managing Systematically Important?

- All work, including management, consists of linked processes forming a system, even if the system was not designed and is not understood.
- Every system is perfectly aligned to achieve the results it creates. **Process determines performance.**
- The results of an aligned system far exceed a system that fights against itself.
- Integrated management systems ensure that performance excellence happens by design, not by chance.

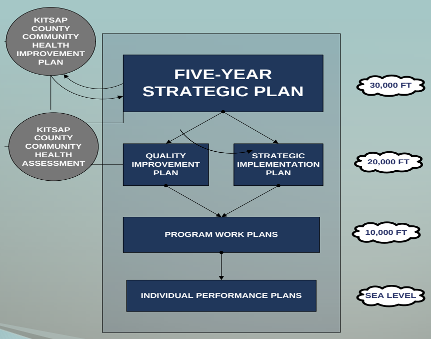


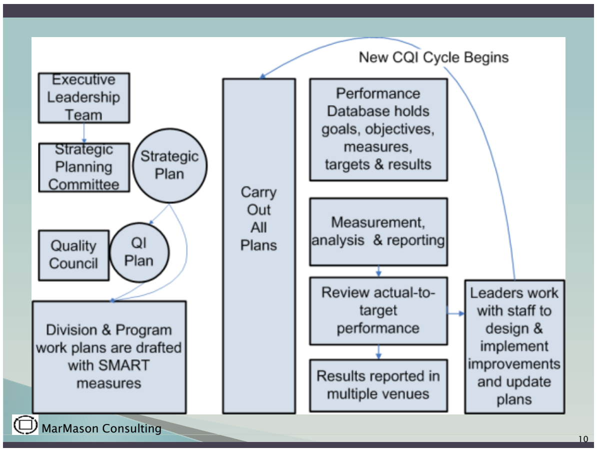
6 Performance Management Principles*

- Results focus permeates strategies, processes, organizational culture and decisions
- Information, measures, goals, priorities and activities are relevant and aligned to health improvement and strategic initiatives
- Information is transparent – easy to access, use and understand
- Decisions and processes are driven by timely, accurate, and meaningful data
- Practices are sustainable over time and organizational changes
- Performance management is transformative to the agency, its management and the policy-making process

** A Performance Management Framework from the National Performance Management Advisory Commission 2010*

Adapted from KCHD Strategic Management System


KITSAP COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN
KITSAP COUNTY COMMUNITY HEALTH ASSESSMENT
FIVE-YEAR STRATEGIC PLAN
QUALITY IMPROVEMENT PLAN
STRATEGIC IMPLEMENTATION PLAN
PROGRAM WORK PLANS
INDIVIDUAL PERFORMANCE PLANS
30,000 FT
20,000 FT
10,000 FT
SEA LEVEL


New CQI Cycle Begins
Executive Leadership Team
Strategic Planning Committee
Strategic Plan
Quality Council
QI Plan
Division & Program work plans are drafted with SMART measures
Carry Out All Plans
Performance Database holds goals, objectives, measures, targets & results
Measurement, analysis & reporting
Review actual-to-target performance
Results reported in multiple venues
Leaders work with staff to design & implement improvements and update plans

Effective Performance Management

- Establishing and implementing performance management systems helps state agencies:
  - Align agency plans to reduce duplication and increase efficiency and effectiveness
  - Prioritize planning and improvement efforts
  - Address accreditation requirements
  - Demonstrate the results of PH programs and services through performance measurement and reporting

Turning Point PM Assessment Tool

- http://www.turningpointprogram.org/toolkit/pdf/PM_Self_Assess_Tool.pdf
- For each component, several questions serve as indicators of your performance management capacity.
- These questions cover elements of your capacity such as having the necessary resources, skills, accountability, and communications to be effective in each component.

Let's Discuss!

- What is your experience with the four components of performance management at MCHD?

Definition of Quality Improvement

> "A management process and set of disciplines that are coordinated to ensure that the organization consistently meets and exceeds customer requirements."

QI Top management philosophy resulting in complete organizational involvement

qi Conduct of improving a process at the micro system level

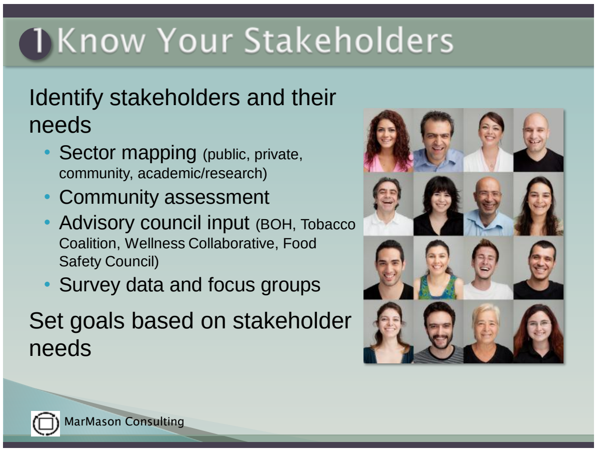
Bill Riley and Russell Brewer, Review and Analysis of QI Techniques in Police Departments, JPHMP Mar/April 2009

The Quality Environment

- Agency-wide commitment to assessing and continuously improving quality over time?
  - Decisions based on data?
  - Agency achieving goals?
- Use data to decide on improvement initiatives and to know if the improvements are successful?
- Measurement of results and progress are outcome based?

Principles of Quality Improvement

1. Know your stakeholders and what they need
2. Focus on processes
3. Use data for making decisions
4. Use teamwork to improve work
5. Make quality improvement continuous
6. Demonstrate leadership commitment



1 Know Your Stakeholders

Identify stakeholders and their needs
- Sector mapping (public, private, community, academic/research)
- Community assessment
- Advisory council input (BOH, Tobacco Coalition, Wellness Collaborative, Food Safety Council)
- Survey data and focus groups

Set goals based on stakeholder needs

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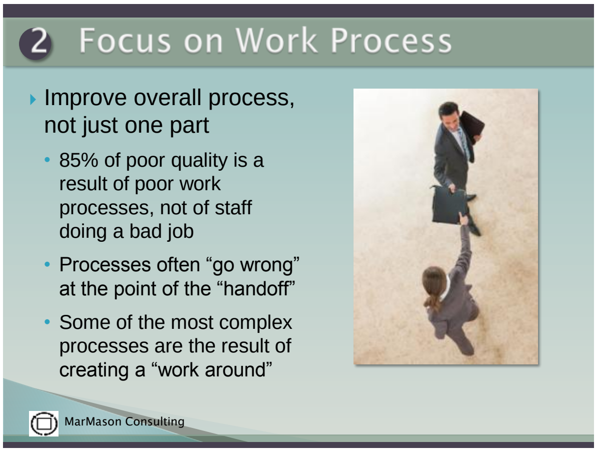

2 Focus on Work Process

- Improve overall process, not just one part
  - 85% of poor quality is a result of poor work processes, not of staff doing a bad job
  - Processes often "go wrong" at the point of the "handoff"
  - Some of the most complex processes are the result of creating a "work around"

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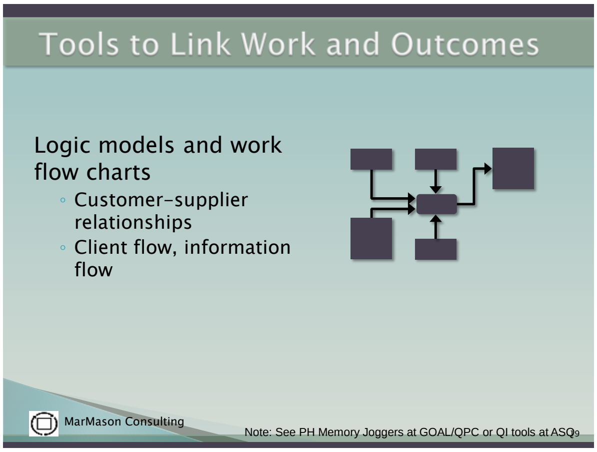

Tools to Link Work and Outcomes

Logic models and work flow charts
- Customer-supplier relationships
- Client flow, information flow

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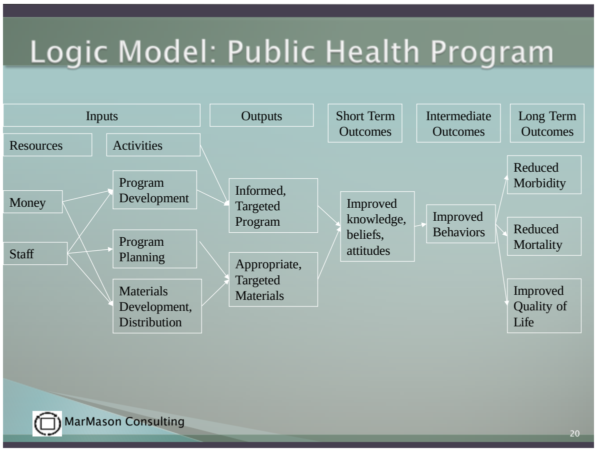
Note: See PH Memory Joggers at GOAL/QPC or QI tools at ASQ



Logic Model: Public Health Program

Inputs
Outputs
Short Term Outcomes
Intermediate Outcomes
Long Term Outcomes
Resources
Activities
Money
Staff
Program Development
Program Planning
Materials Development, Distribution
Informed, Targeted Program
Appropriate, Targeted Materials
Improved knowledge, beliefs, attitudes
Improved Behaviors
Reduced Morbidity
Reduced Mortality
Improved Quality of Life

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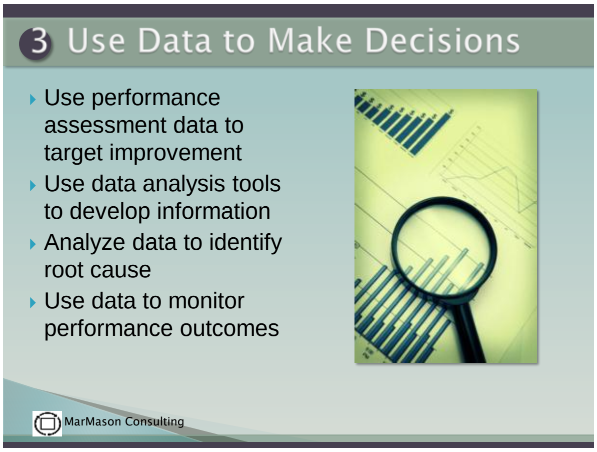

3 Use Data to Make Decisions

- Use performance assessment data to target improvement
- Use data analysis tools to develop information
- Analyze data to identify root cause
- Use data to monitor performance outcomes

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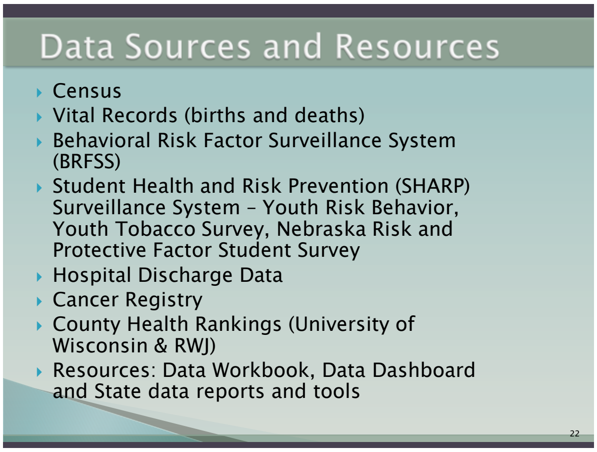
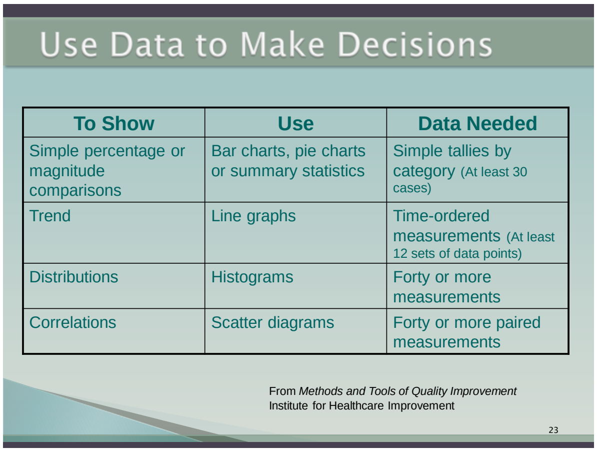


Data Sources and Resources

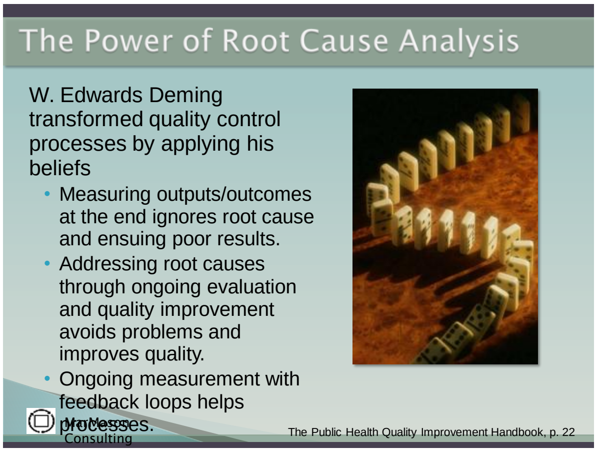
- Census
- Vital Records (births and deaths)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Student Health and Risk Prevention (SHARP) Surveillance System – Youth Risk Behavior, Youth Tobacco Survey, Nebraska Risk and Protective Factor Student Survey
- Hospital Discharge Data
- Cancer Registry
- County Health Rankings (University of Wisconsin & RWJ)
- Resources: Data Workbook, Data Dashboard and State data reports and tools



Use Data to Make Decisions

To Show	Use	Data Needed
Simple percentage or magnitude comparisons	Bar charts, pie charts or summary statistics	Simple tallies by category (At least 30 cases)
Trend	Line graphs	Time-ordered measurements (At least 12 sets of data points)
Distributions	Histograms	Forty or more measurements
Correlations	Scatter diagrams	Forty or more paired measurements

From *Methods and Tools of Quality Improvement*
Institute for Healthcare Improvement



The Power of Root Cause Analysis

W. Edwards Deming transformed quality control processes by applying his beliefs

- Measuring outputs/outcomes at the end ignores root cause and ensuing poor results.
- Addressing root causes through ongoing evaluation and quality improvement avoids problems and improves quality.
- Ongoing measurement with feedback loops helps processes.

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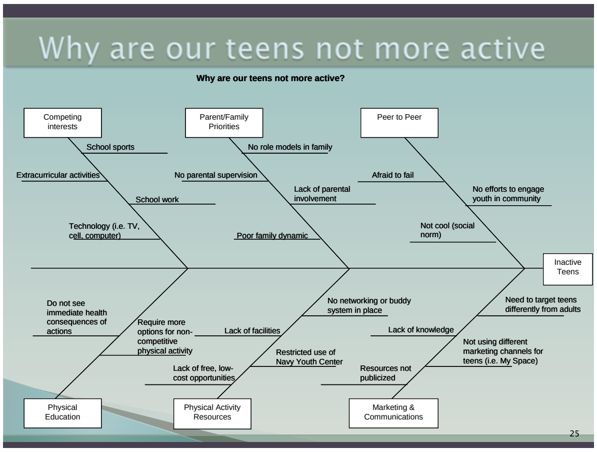
The Public Health Quality Improvement Handbook, p. 22



Why are our teens not more active

Why are our teens not more active?

Competing interests
School sports
Extracurricular activities
School work
Technology (i.e. TV, cell, computer)

Parent/Family Priorities
No role models in family
No parental supervision
Lack of parental involvement
Poor family dynamic

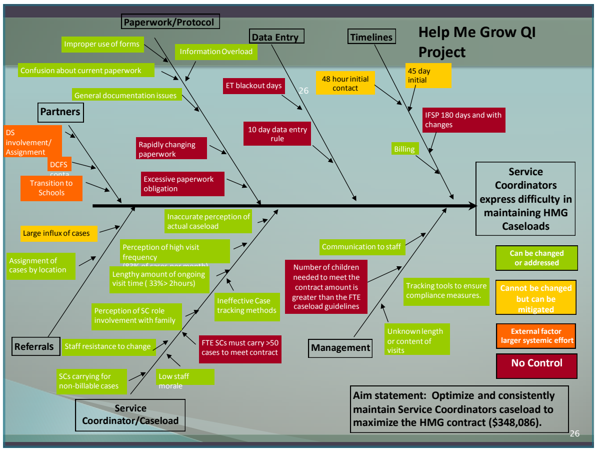
Peer to Peer
Afraid to fail
No efforts to engage youth in community
Not cool (social norm)

Inactive Teens

Physical Education
Do not see immediate health consequences of actions
Require more options for non-competitive physical activity

Physical Activity Resources
No networking or buddy system in place
Lack of facilities
Restricted use of Navy Youth Center
Lack of free, low-cost opportunities

Marketing & Communications
Need to target teens differently from adults
Lack of knowledge
Not using different marketing channels for teens (i.e. My Space)
Resources not publicized



Help Me Grow QI Project

Paperwork/Protocol
Improper use of forms
Information Overload
Confusion about current paperwork
General documentation issues
Rapidly changing paperwork
Excessive paperwork obligation

Data Entry
ET blackout days
10 day data entry rule

Timelines
48 hour initial contact
45 day initial
IFSP 180 days and with changes
Billing

Partners
DS involvement/ Assignment
DCFS conta
Transition to Schools

Service Coordinators express difficulty in maintaining HMG Caseloads

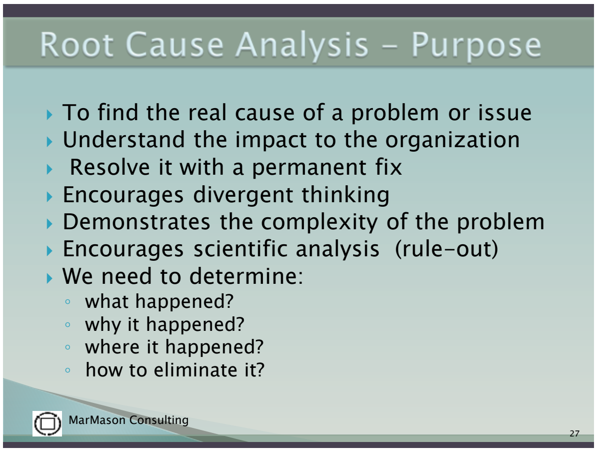
Referrals
Large influx of cases
Assignment of cases by location
Staff resistance to change

Service Coordinator/Caseload
Inaccurate perception of actual caseload
Perception of high visit frequency (83% of cases per month)
Lengthy amount of ongoing visit time (33%> 2hours)
Ineffective Case tracking methods
Perception of SC role involvement with family
FTE SCs must carry >50 cases to meet contract
SCs carrying for non-billable cases
Low staff morale

Management
Communication to staff
Number of children needed to meet the contract amount is greater than the FTE caseload guidelines
Tracking tools to ensure compliance measures.
Unknown length or content of visits

🟩 **Can be changed or addressed**
🟨 **Cannot be changed but can be mitigated**
🟧 **External factor larger systemic effort**
🟥 **No Control**

Aim statement: Optimize and consistently maintain Service Coordinators caseload to maximize the HMG contract ($348,086).



Root Cause Analysis – Purpose

- To find the real cause of a problem or issue
- Understand the impact to the organization
- Resolve it with a permanent fix
- Encourages divergent thinking
- Demonstrates the complexity of the problem
- Encourages scientific analysis (rule-out)
- We need to determine:
  - what happened?
  - why it happened?
  - where it happened?
  - how to eliminate it?

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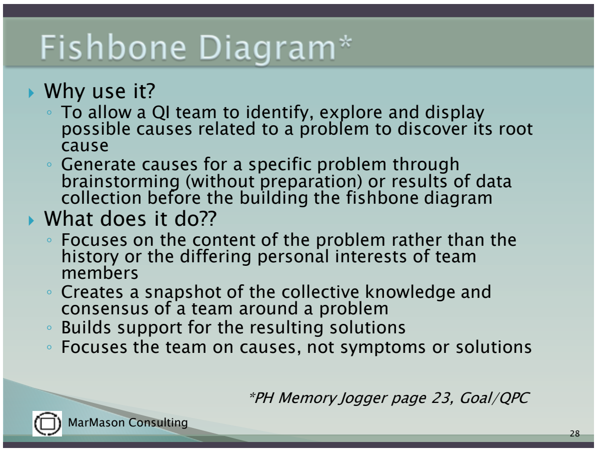

Fishbone Diagram*

- Why use it?
  - To allow a QI team to identify, explore and display possible causes related to a problem to discover its root cause
  - Generate causes for a specific problem through brainstorming (without preparation) or results of data collection before the building the fishbone diagram
- What does it do??
  - Focuses on the content of the problem rather than the history or the differing personal interests of team members
  - Creates a snapshot of the collective knowledge and consensus of a team around a problem
  - Builds support for the resulting solutions
  - Focuses the team on causes, not symptoms or solutions

**PH Memory Jogger page 23, Goal/QPC*

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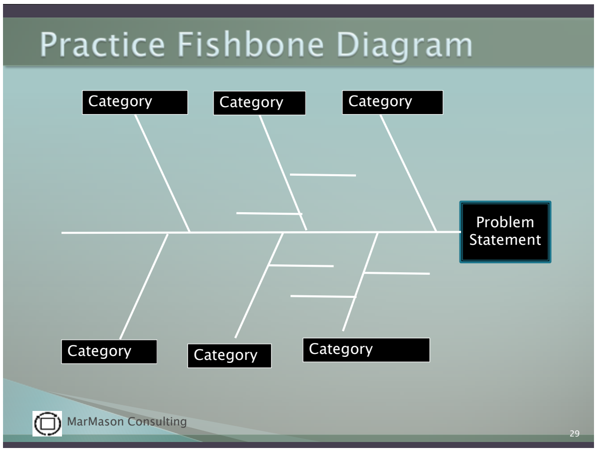


Practice Fishbone Diagram

Category

Category

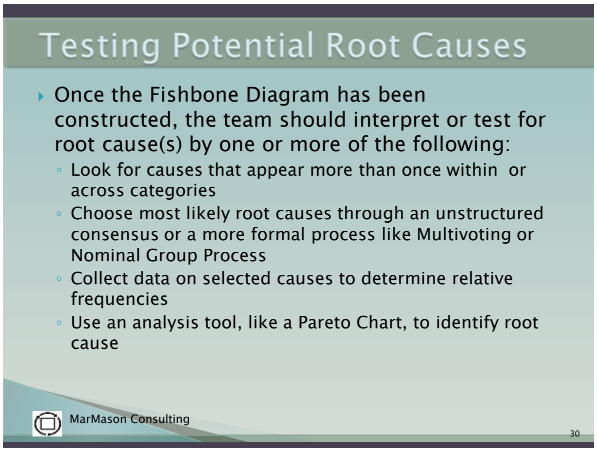
Category

Problem Statement

Category

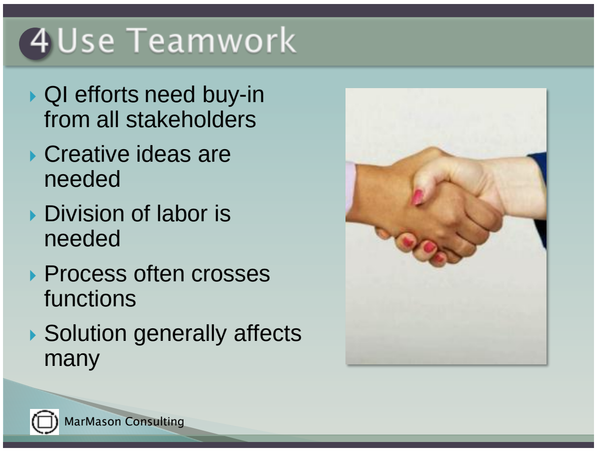
Category

Category



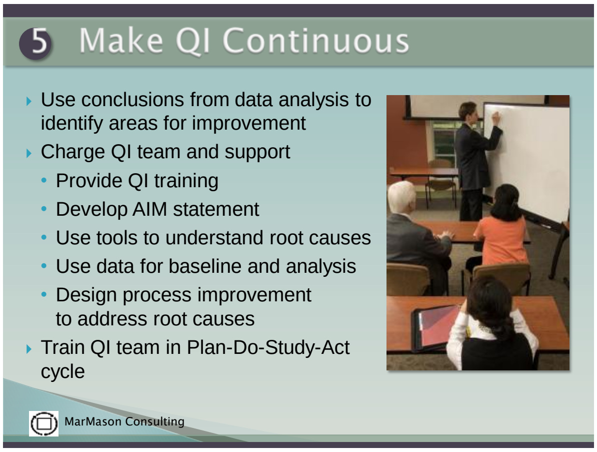
Testing Potential Root Causes

- Once the Fishbone Diagram has been constructed, the team should interpret or test for root cause(s) by one or more of the following:
  - Look for causes that appear more than once within or across categories
  - Choose most likely root causes through an unstructured consensus or a more formal process like Multivoting or Nominal Group Process
  - Collect data on selected causes to determine relative frequencies
  - Use an analysis tool, like a Pareto Chart, to identify root cause



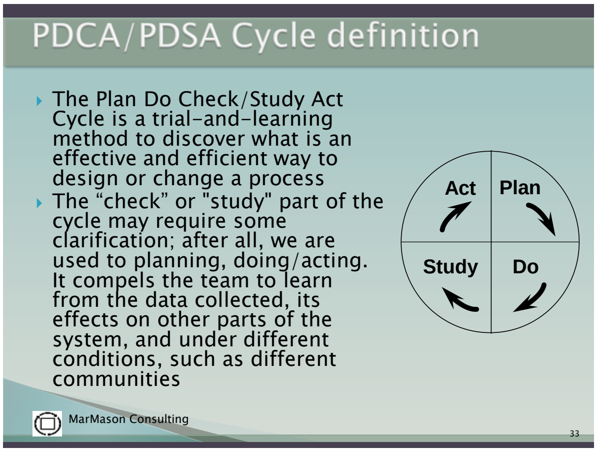
4 Use Teamwork

- QI efforts need buy-in from all stakeholders
- Creative ideas are needed
- Division of labor is needed
- Process often crosses functions
- Solution generally affects many



5 Make QI Continuous

- Use conclusions from data analysis to identify areas for improvement
- Charge QI team and support
  - Provide QI training
  - Develop AIM statement
  - Use tools to understand root causes
  - Use data for baseline and analysis
  - Design process improvement to address root causes
- Train QI team in Plan-Do-Study-Act cycle



PDCA/PDSA Cycle definition

- The Plan Do Check/Study Act Cycle is a trial-and-learning method to discover what is an effective and efficient way to design or change a process
- The "check" or "study" part of the cycle may require some clarification; after all, we are used to planning, doing/acting. It compels the team to learn from the data collected, its effects on other parts of the system, and under different conditions, such as different communities

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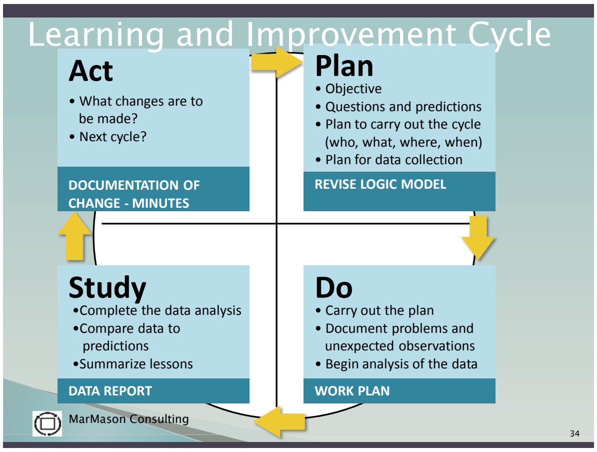

Learning and Improvement Cycle

Act
- What changes are to be made?
- Next cycle?

DOCUMENTATION OF CHANGE - MINUTES

Plan
- Objective
- Questions and predictions
- Plan to carry out the cycle (who, what, where, when)
- Plan for data collection

REVISE LOGIC MODEL

Study
- Complete the data analysis
- Compare data to predictions
- Summarize lessons

DATA REPORT

Do
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data

WORK PLAN

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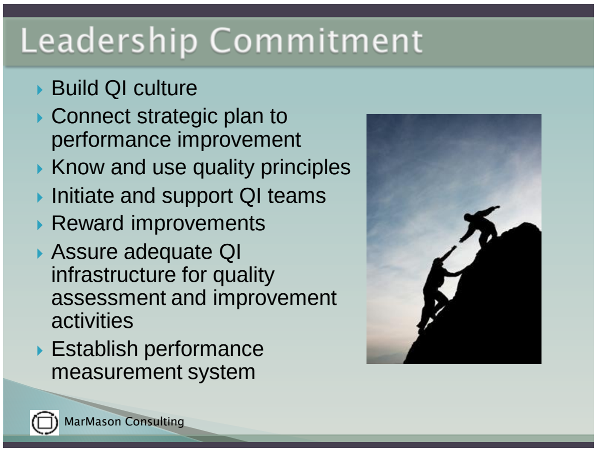

Leadership Commitment

- Build QI culture
- Connect strategic plan to performance improvement
- Know and use quality principles
- Initiate and support QI teams
- Reward improvements
- Assure adequate QI infrastructure for quality assessment and improvement activities
- Establish performance measurement system

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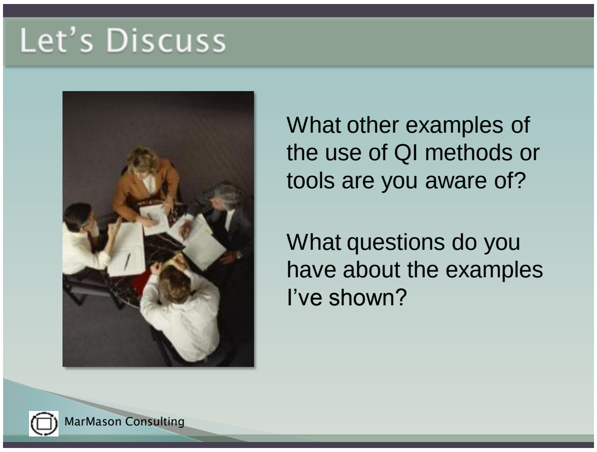

Let's Discuss

What other examples of the use of QI methods or tools are you aware of?

What questions do you have about the examples I've shown?

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Short Break!

- Be Back in 15 minutes, please!

Why do we need a systematic model for improvement?

- “All improvements require change but not all change will result in improvement. A primary aim of the science of improvement is to increase the chance that a change will actually result in sustained improvement from the viewpoint of those affected by the change.”

The Improvement Guide, 1996

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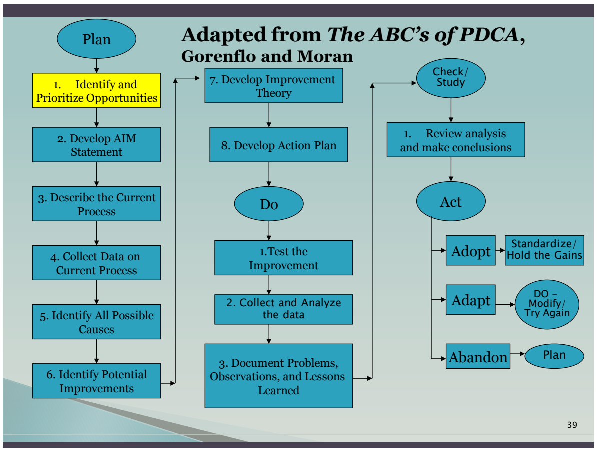
Adapted from *The ABC’s of PDCA*, Gorenflo and Moran


Plan
1. Identify and Prioritize Opportunities
2. Develop AIM Statement
3. Describe the Current Process
4. Collect Data on Current Process
5. Identify All Possible Causes
6. Identify Potential Improvements
7. Develop Improvement Theory
8. Develop Action Plan
Do
1.Test the Improvement
2. Collect and Analyze the data
3. Document Problems, Observations, and Lessons Learned
Check/Study
1. Review analysis and make conclusions
Act
Adopt
Standardize/Hold the Gains
Adapt
DO – Modify/Try Again
Abandon
Plan

PLAN Steps for Implementing QI Project*

* The ABCs of PDCA & MI Guidebook

- Identify QI opportunities
  - Performance measurement data or data related to health indicators
  - Community health assessment, health status report, or behavioral risk factor survey results
  - Data related to births, deaths, and diseases in your community
  - Survey data related to customer/client satisfaction
  - Data related to the internal operations of your LHD, such as, time studies, response rates, employee morale, or workforce development
- Prioritize issues to address for improvement

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Criteria for Selecting Opportunities

- Importance and Relevance
- Control and Influence
- High-risk
  - Health Alerts, Drinking Water, CD Investigations
- High-volume
  - WIC, Food Safety, OSS, Immunizations
- Problem-prone
  - Emergency Preparedness

Criteria Matrix Tool

	Importance			Control			Hi Risk	Hi Vol.	Prob. Prone	Total points
Improvement Area	HI (3)	MED (2)	LOW (1)	HI (3)	MED (2)	LOW (1)	(1)	(1)	(1)	
1. Immunization	X				X			X		6
2. Engage Community		X			X				X	5
3. CHIP	X				X		X			6
4. Food Safety		X		X			X	X		7
5. Family Planning		X				X	X	X		5

PLAN Steps for Implementing QI Project*

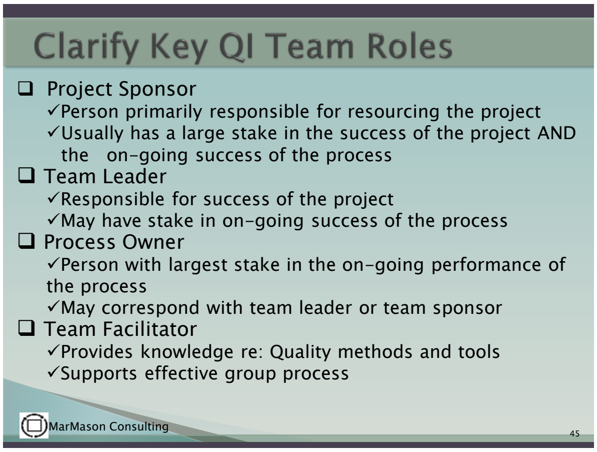
* The ABCs of PDCA & MI Guidebook

- ❑ Assemble The Team
- ❑ Develop an AIM Statement
  - ❑ AIM Statement Template
- ❑ Describe the current process
  - ❑ Work Flow or Logic Model
- ❑ Collect data on the current process
  - ❑ Run Charts, Histograms, Pie Charts
- ❑ Identify all possible causes
  - ❑ Fishbone Diagram, The Five Whys

Team Selection Criteria

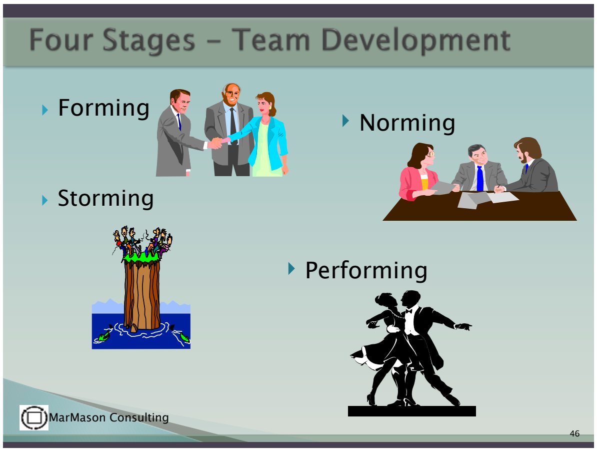
- Balance team/input “horizontally” (across process) and “vertically” (mgrs & staff)
  - Anticipate resistance – seek input from all stakeholders*
  - Remember: “People support what they help to build …”
  - 5-7 is ideal team size

*Not all stakeholders need to be team members – but you need to find a way to get their input and keep them updated



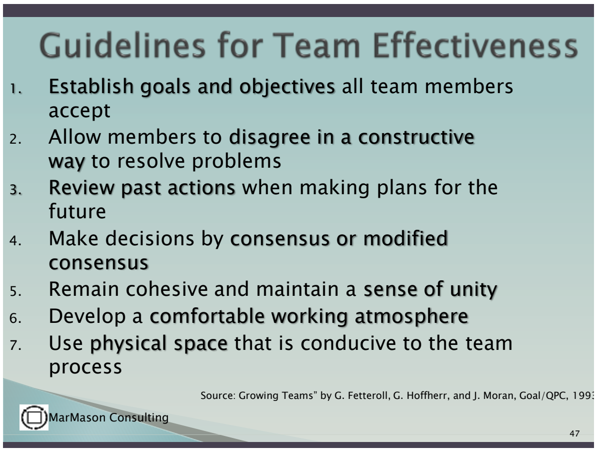
Clarify Key QI Team Roles

- ❑ Project Sponsor
  - ✓Person primarily responsible for resourcing the project
  - ✓Usually has a large stake in the success of the project AND the on-going success of the process
- ❑ Team Leader
  - ✓Responsible for success of the project
  - ✓May have stake in on-going success of the process
- ❑ Process Owner
  - ✓Person with largest stake in the on-going performance of the process
  - ✓May correspond with team leader or team sponsor
- ❑ Team Facilitator
  - ✓Provides knowledge re: Quality methods and tools
  - ✓Supports effective group process



Four Stages – Team Development

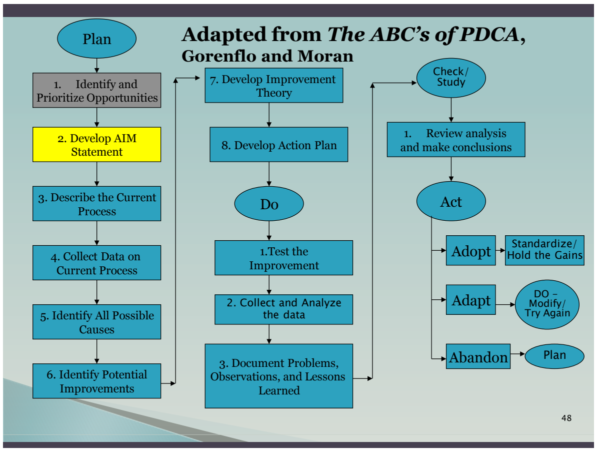
- Forming
- Storming
- Norming
- Performing



Guidelines for Team Effectiveness

1. **Establish goals and objectives** all team members accept
2. Allow members to **disagree in a constructive way** to resolve problems
3. **Review past actions** when making plans for the future
4. Make decisions by **consensus or modified consensus**
5. Remain cohesive and maintain a **sense of unity**
6. Develop a **comfortable working atmosphere**
7. Use **physical space** that is conducive to the team process

Source: Growing Teams" by G. Fetteroll, G. Hoffherr, and J. Moran, Goal/QPC, 1993



Adapted from *The ABC's of PDCA*, Gorenflo and Moran

Plan

1. Identify and Prioritize Opportunities
2. Develop AIM Statement
3. Describe the Current Process
4. Collect Data on Current Process
5. Identify All Possible Causes
6. Identify Potential Improvements
7. Develop Improvement Theory
8. Develop Action Plan

Do

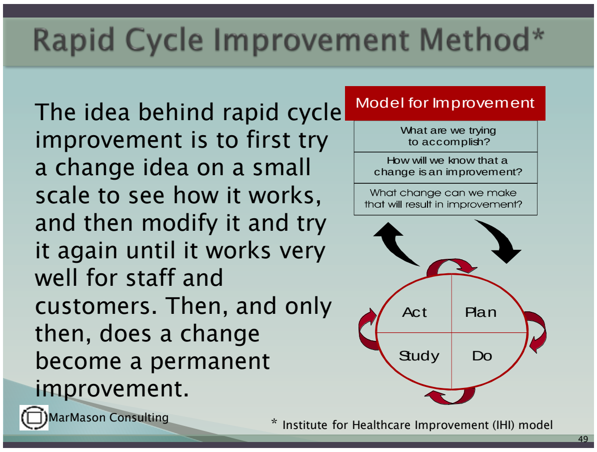
1. Test the Improvement
2. Collect and Analyze the data
3. Document Problems, Observations, and Lessons Learned

Check/ Study

1. Review analysis and make conclusions

Act

- Adopt → Standardize/ Hold the Gains
- Adapt → DO – Modify/ Try Again
- Abandon → Plan



Rapid Cycle Improvement Method*

The idea behind rapid cycle improvement is to first try a change idea on a small scale to see how it works, and then modify it and try it again until it works very well for staff and customers. Then, and only then, does a change become a permanent improvement.

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act

Plan

Study

Do

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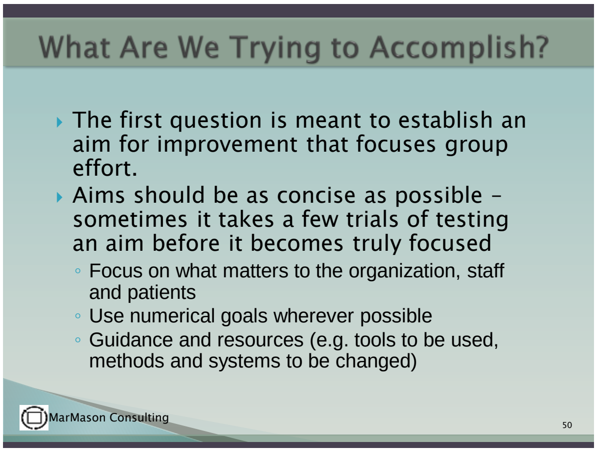
* Institute for Healthcare Improvement (IHI) model

49



What Are We Trying to Accomplish?

- The first question is meant to establish an aim for improvement that focuses group effort.
- Aims should be as concise as possible – sometimes it takes a few trials of testing an aim before it becomes truly focused
  - Focus on what matters to the organization, staff and patients
  - Use numerical goals wherever possible
  - Guidance and resources (e.g. tools to be used, methods and systems to be changed)

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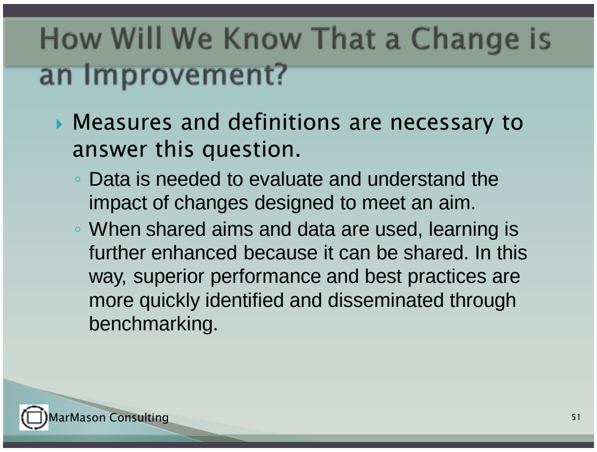
50



How Will We Know That a Change is an Improvement?

- Measures and definitions are necessary to answer this question.
  - Data is needed to evaluate and understand the impact of changes designed to meet an aim.
  - When shared aims and data are used, learning is further enhanced because it can be shared. In this way, superior performance and best practices are more quickly identified and disseminated through benchmarking.

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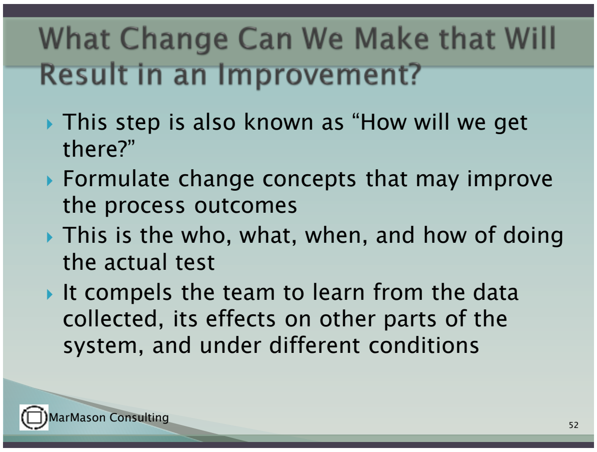
51



What Change Can We Make that Will Result in an Improvement?

- This step is also known as “How will we get there?”
- Formulate change concepts that may improve the process outcomes
- This is the who, what, when, and how of doing the actual test
- It compels the team to learn from the data collected, its effects on other parts of the system, and under different conditions

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52

AIM Statement

Step 1: What Are We Trying to Accomplish?

- Increase by 10% the number of mothers in the WIC program who initiate breastfeeding, and increase by 5% the number of moms in the WIC program who breastfeed for at least one year.
- We do this because it helps mothers return to their pre-pregnancy weight and lowers the rate of obesity and overweight in children.

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AIM Statement

Step 2: How Will We Know That a Change is an Improvement?

- Long term
  - 5 years – decrease % of adult females of childbearing age that are obese
- Medium term
  - 12 months – Increase the number of women still breastfeeding at 12 months by 5%.
- Short term
  - 6 months – Increase the number of women still breastfeeding at 6 months by 10%.

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PLAN Steps for Implementing QI Project*

* The ABCs of PDCA & MI Guidebook

- ❑ Identify potential improvements
  - ❑Steps: Conduct Root Cause Analysis, Review model or best practices to identify potential improvements and pick the best solution to test
  - ❑ Tools: Fishbone Diagram, Pareto Chart, Affinity Diagram
- ❑ Develop an improvement theory
  - ❑ Definition: a statement that articulates the effect that you expect the improvement to have on the problem
  - ❑ Steps: Make Conclusions, Promising Practices search
- ❑ Develop an action plan
  - ❑ Tools: Gantt Chart or workplan

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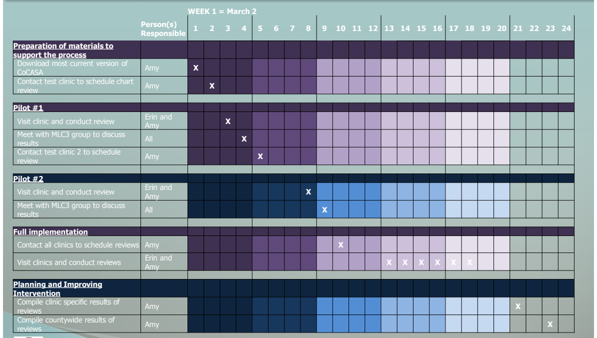
Develop an Action Plan (Gantt Chat)



WEEK 1 = March 2

	Person(s) Responsible	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Preparation of materials to support the process																									
Download most current version of CoCASA	Amy	X																							
Contact test clinic to schedule chart review	Amy		X																						
Pilot #1																									
Visit clinic and conduct review	Erin and Amy			X																					
Meet with MLC3 group to discuss results	All				X																				
Contact test clinic 2 to schedule review	Amy					X																			
Pilot #2																									
Visit clinic and conduct review	Erin and Amy								X																
Meet with MLC3 group to discuss results	All									X															
Full implementation																									
Contact all clinics to schedule reviews	Amy										X														
Visit clinics and conduct reviews	Erin and Amy													X	X	X	X	X	X						
Planning and Improving Intervention																									
Compile clinic specific results of reviews	Amy																					X			
Compile countywide results of reviews	Amy																							X	

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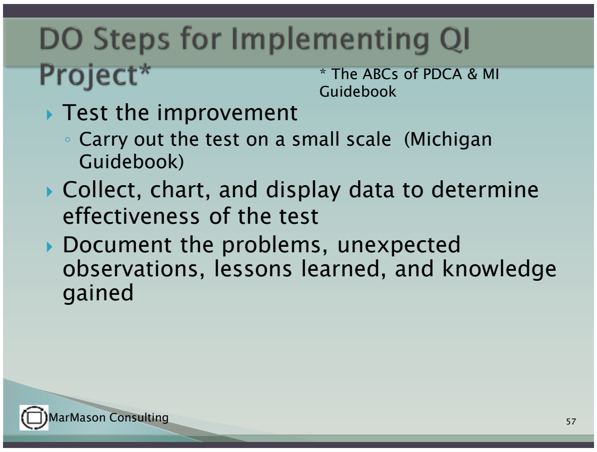
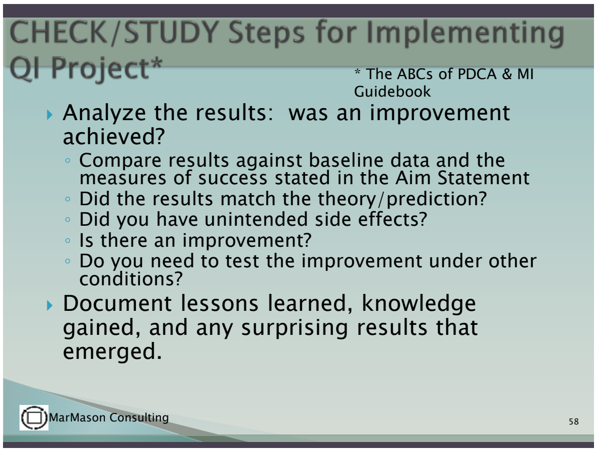


DO Steps for Implementing QI Project*

* The ABCs of PDCA & MI Guidebook

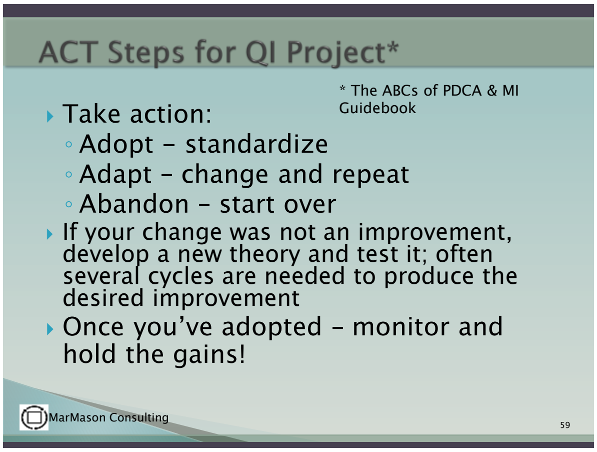
- Test the improvement
  - Carry out the test on a small scale (Michigan Guidebook)
- Collect, chart, and display data to determine effectiveness of the test
- Document the problems, unexpected observations, lessons learned, and knowledge gained



CHECK/STUDY Steps for Implementing QI Project*

* The ABCs of PDCA & MI Guidebook

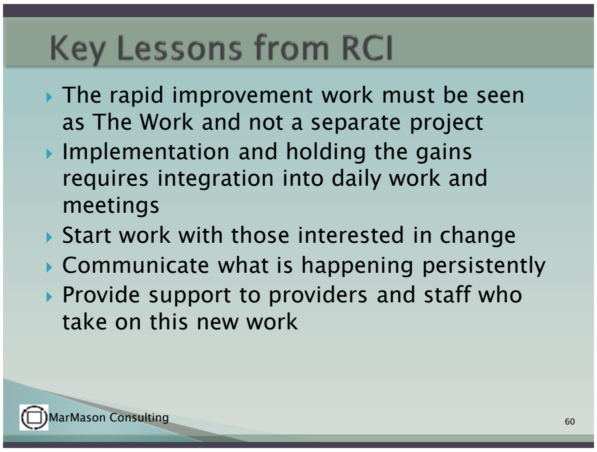
- Analyze the results: was an improvement achieved?
  - Compare results against baseline data and the measures of success stated in the Aim Statement
  - Did the results match the theory/prediction?
  - Did you have unintended side effects?
  - Is there an improvement?
  - Do you need to test the improvement under other conditions?
- Document lessons learned, knowledge gained, and any surprising results that emerged.



ACT Steps for QI Project*

* The ABCs of PDCA & MI Guidebook

- Take action:
  - Adopt – standardize
  - Adapt – change and repeat
  - Abandon – start over
- If your change was not an improvement, develop a new theory and test it; often several cycles are needed to produce the desired improvement
- Once you've adopted – monitor and hold the gains!

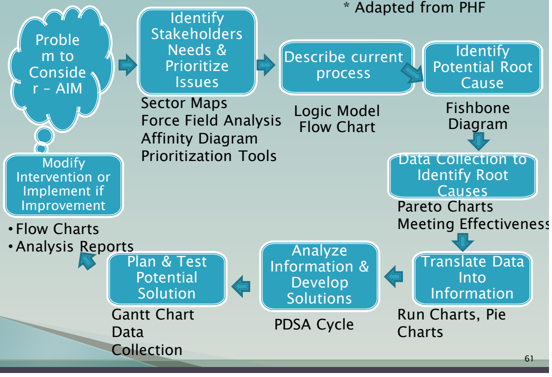


Key Lessons from RCI

- The rapid improvement work must be seen as The Work and not a separate project
- Implementation and holding the gains requires integration into daily work and meetings
- Start work with those interested in change
- Communicate what is happening persistently
- Provide support to providers and staff who take on this new work

Tying It all Together*

* Adapted from PHF



Proble m to Conside r – AIM

Identify Stakeholders Needs & Prioritize Issues

Sector Maps
Force Field Analysis
Affinity Diagram
Prioritization Tools

Describe current process

Logic Model
Flow Chart

Identify Potential Root Cause

Fishbone Diagram

Data Collection to Identify Root Causes

Pareto Charts
Meeting Effectiveness

Translate Data Into Information

Run Charts, Pie Charts

Analyze Information & Develop Solutions

PDSA Cycle

Plan & Test Potential Solution

Gantt Chart
Data Collection

Modify Intervention or Implement if Improvement

- Flow Charts
- Analysis Reports

Change vs. Improvement

> Of all changes I've observed, about 5% were improvements, the rest, at best, were illusions of progress.
>
> W. Edwards Deming

- We must become masters of improvement
- We must learn how to improve rapidly
- We must learn to discern the difference between improvement and illusions of progress

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Some QI References

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- Public Health Memory Jogger, GOAL/QPC, 2007, www.goalqpc.com
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- Bialek R, Duffy DL, Moran JW. The Public Health Quality Improvement Handbook. Milwaukee, WI: ASQ Quality Press; 2009
- Guidebook for Performance Measurement, Turning Point Performance Management National Excellence Collaborative, 2004, http://www.phf.org/pmc_guidebook.pdf
- Mason M, Moran J, Understanding and Controlling Variation in Public Health. *Journal of Public Health Management and Practice.* Jan/Feb 2012; 18(1), 74-78

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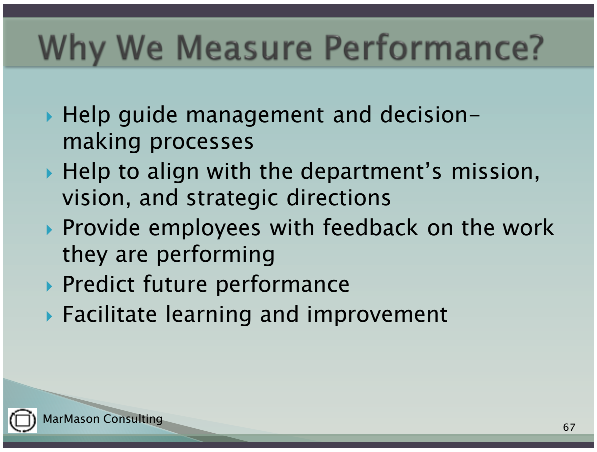
What Questions Do You Have?

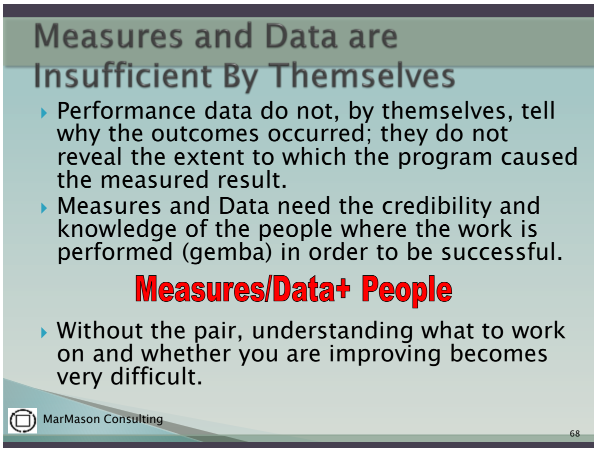
Lunch

Developing Effective Performance Measures



Why We Measure Performance?

- Help guide management and decision-making processes
- Help to align with the department's mission, vision, and strategic directions
- Provide employees with feedback on the work they are performing
- Predict future performance
- Facilitate learning and improvement

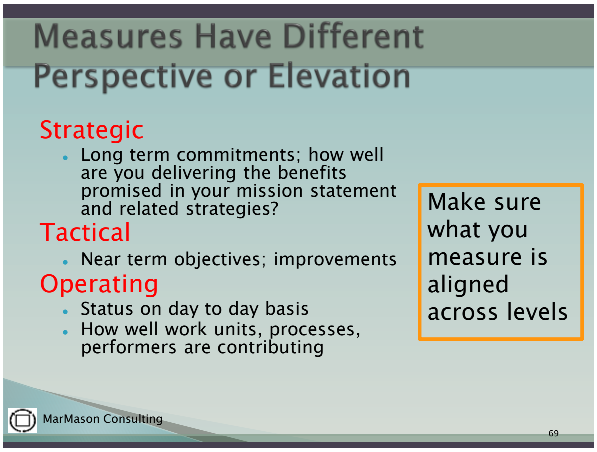


Measures and Data are Insufficient By Themselves

- Performance data do not, by themselves, tell why the outcomes occurred; they do not reveal the extent to which the program caused the measured result.
- Measures and Data need the credibility and knowledge of the people where the work is performed (gemba) in order to be successful.

Measures/Data+ People

- Without the pair, understanding what to work on and whether you are improving becomes very difficult.



Measures Have Different Perspective or Elevation

Strategic
- Long term commitments; how well are you delivering the benefits promised in your mission statement and related strategies?

Tactical
- Near term objectives; improvements

Operating
- Status on day to day basis
- How well work units, processes, performers are contributing

Make sure what you measure is aligned across levels

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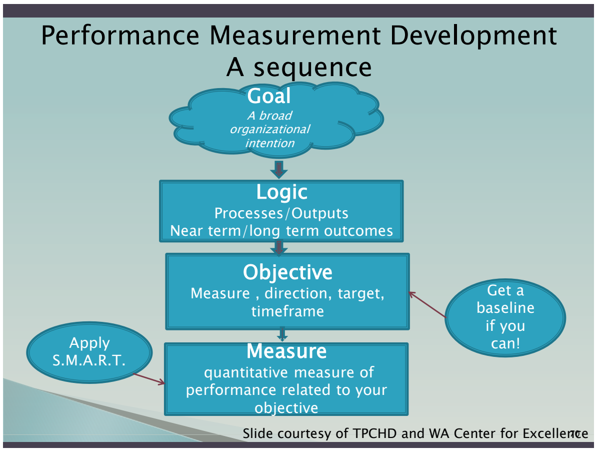


Performance Measurement Development A sequence

Goal
A broad organizational intention

Logic
Processes/Outputs
Near term/long term outcomes

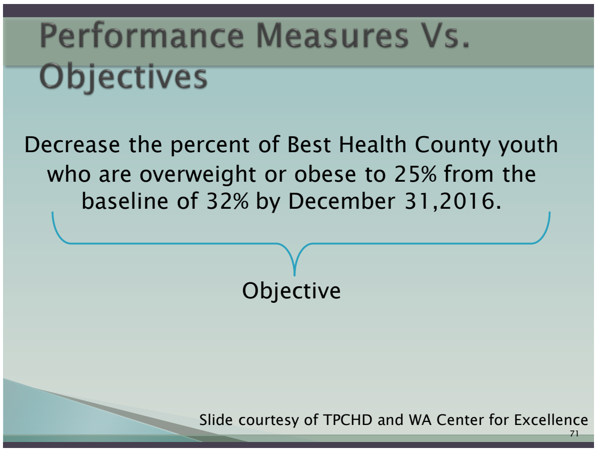
Objective
Measure , direction, target, timeframe

Measure
quantitative measure of performance related to your objective

Apply S.M.A.R.T.

Get a baseline if you can!

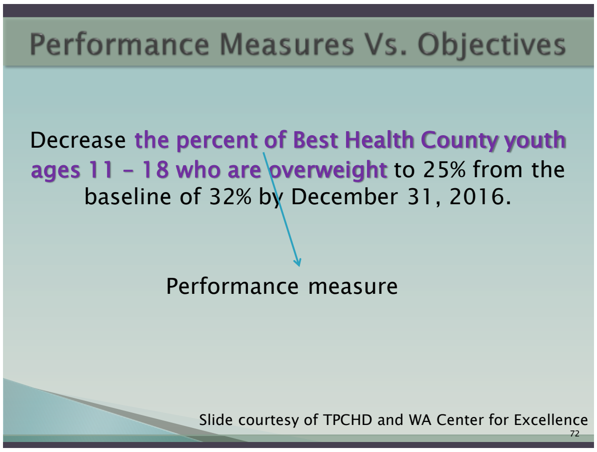
Slide courtesy of TPCHD and WA Center for Excellence



Performance Measures Vs. Objectives

$$\underbrace{\text{Decrease the percent of Best Health County youth who are overweight or obese to 25\% from the baseline of 32\% by December 31,2016.}}_{\text{Objective}}$$

Slide courtesy of TPCHD and WA Center for Excellence

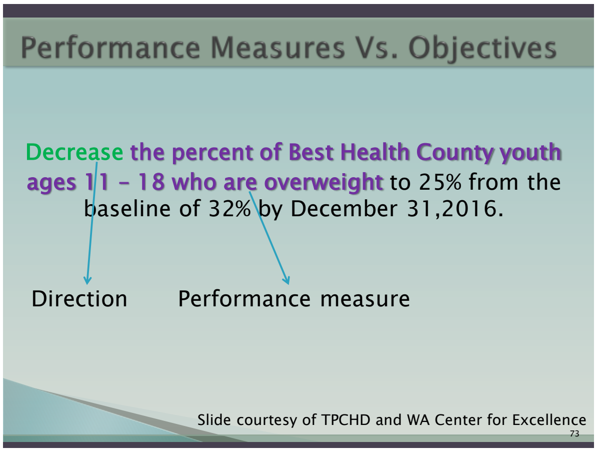


Performance Measures Vs. Objectives

Decrease **the percent of Best Health County youth ages 11 – 18 who are overweight** to 25% from the baseline of 32% by December 31, 2016.

Performance measure

Slide courtesy of TPCHD and WA Center for Excellence

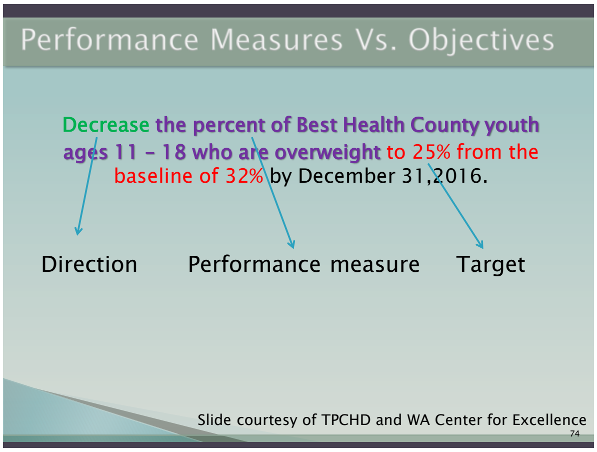


Performance Measures Vs. Objectives

Decrease the percent of Best Health County youth ages 11 – 18 who are overweight to 25% from the baseline of 32% by December 31,2016.

Direction Performance measure

Slide courtesy of TPCHD and WA Center for Excellence

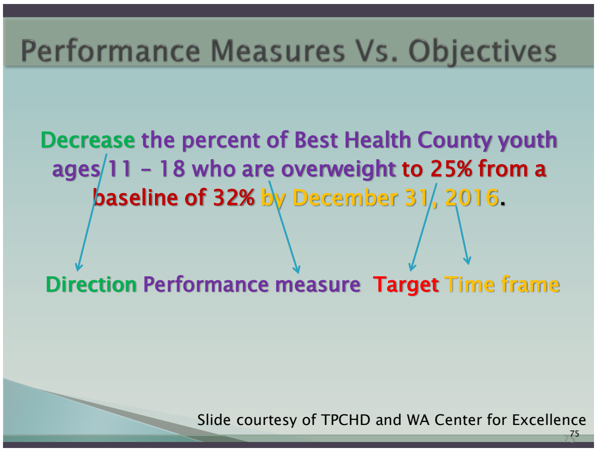


Performance Measures Vs. Objectives

Decrease the percent of Best Health County youth ages 11 – 18 who are overweight to 25% from the baseline of 32% by December 31,2016.

Direction Performance measure Target

Slide courtesy of TPCHD and WA Center for Excellence

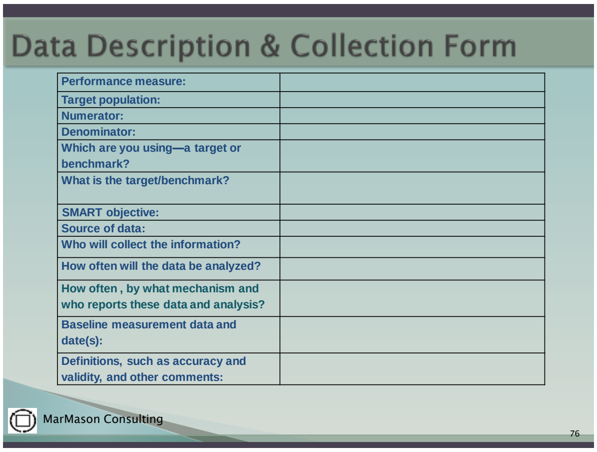


Performance Measures Vs. Objectives

Decrease the percent of Best Health County youth ages 11 – 18 who are overweight to 25% from a baseline of 32% by December 31, 2016.

Direction Performance measure Target Time frame

Slide courtesy of TPCHD and WA Center for Excellence



Data Description & Collection Form

Performance measure:	
Target population:	
Numerator:	
Denominator:	
Which are you using—a target or benchmark?	
What is the target/benchmark?	
SMART objective:	
Source of data:	
Who will collect the information?	
How often will the data be analyzed?	
How often , by what mechanism and who reports these data and analysis?	
Baseline measurement data and date(s):	
Definitions, such as accuracy and validity, and other comments:	

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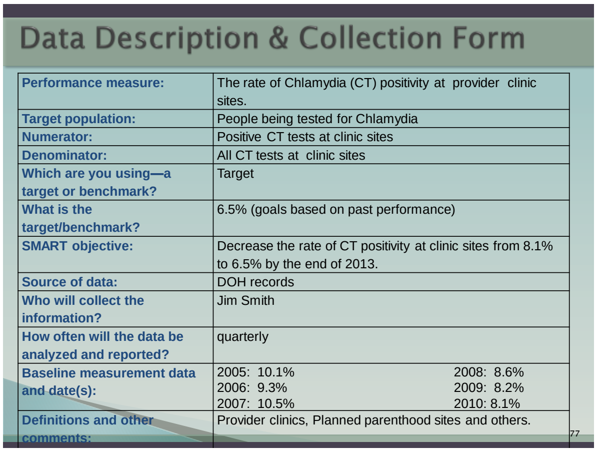
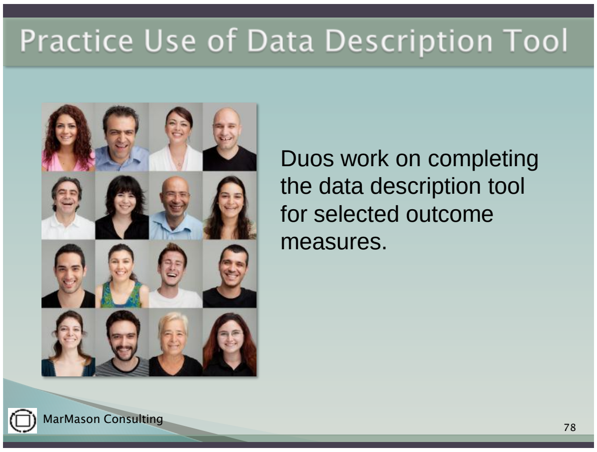


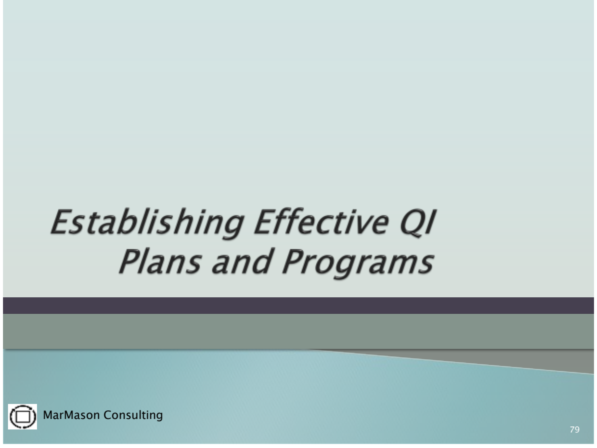
Data Description & Collection Form

Performance measure:	The rate of Chlamydia (CT) positivity at provider clinic sites.
Target population:	People being tested for Chlamydia
Numerator:	Positive CT tests at clinic sites
Denominator:	All CT tests at clinic sites
Which are you using—a target or benchmark?	Target
What is the target/benchmark?	6.5% (goals based on past performance)
SMART objective:	Decrease the rate of CT positivity at clinic sites from 8.1% to 6.5% by the end of 2013.
Source of data:	DOH records
Who will collect the information?	Jim Smith
How often will the data be analyzed and reported?	quarterly
Baseline measurement data and date(s):	2005: 10.1% 2008: 8.6% 2006: 9.3% 2009: 8.2% 2007: 10.5% 2010: 8.1%
Definitions and other comments:	Provider clinics, Planned parenthood sites and others.



Practice Use of Data Description Tool

Duos work on completing the data description tool for selected outcome measures.



Establishing Effective QI Plans and Programs

Capacities for QI Culture

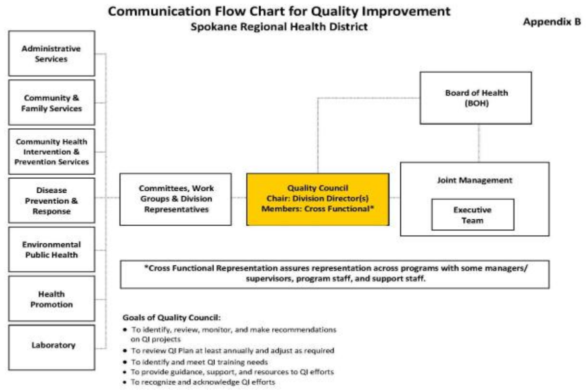
- Leadership commitment and knowledge
- QI infrastructure, governance and resources
- QI Program and/or Plan
- QI activities, including improvement teams
- QI training, leadership and QI teams
- Performance Measurement processes including data collection, analysis and reporting
- Recognition and actions to hold the gains

QI Infrastructure

- Governance (formal/informal)
  - Oversight and accountability through QI Council or Leadership Team
- QI Program Plan (infrastructure & capacity)
  - Who will do what when, with what processes for recommending or deciding QI activities
- Staff
  - Support for ongoing monitoring and analysis, for training and facilitating improvement activities
- Data system
  - Collect data and report in a user friendly way

Forming a Quality Improvement Council

- Establish Oversight group of 7-10 members, maybe ongoing leadership team, or mix of leaders, managers and front line staff
- Set regular meeting times, once a month
- Charter or description in QI Plan
- Regular reports of progress



Communication Flow Chart for Quality Improvement
Spokane Regional Health District

Appendix B

Administrative Services
Community & Family Services
Community Health Intervention & Prevention Services
Disease Prevention & Response
Environmental Public Health
Health Promotion
Laboratory
Committees, Work Groups & Division Representatives
Quality Council Chair: Division Director(s) Members: Cross Functional*
Board of Health (BOH)
Joint Management
Executive Team

*Cross Functional Representation assures representation across programs with some managers/ supervisors, program staff, and support staff.

Goals of Quality Council:

- To identify, review, monitor, and make recommendations on QI projects
- To review QI Plan at least annually and adjust as required
- To identify and meet QI training needs
- To provide guidance, support, and resources to QI efforts
- To recognize and acknowledge QI efforts

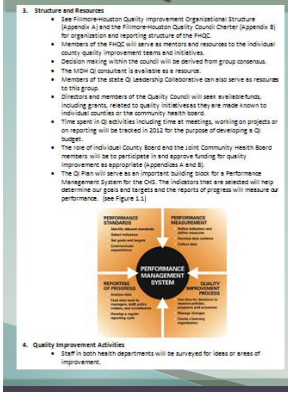
Spokane QI Plan, page 8

QI Activities and Plan Example

Example of the QI materials for Fillmore and Houston County Health Departments in Minnesota

- Fillmore – Houston Community Health Service (FHCHS) QI Plan
- FHCHS QI Calendar Excerpt
- FHCHS Project Proposal Form

FHCHS QI Plan Table of Contents



3. **Structure and Resources**
   - See Fillmore-Houston Quality Improvement Organizational Structure (Appendix A) and the Fillmore-Houston Quality Council Charter (Appendix B) for organization and reporting structure of the FHQC.
   - Members of the FHQC will serve as mentors and resources to the individual county quality improvement teams and initiatives.
   - Decision making within the council will be derived from group consensus.
   - The MDH QI consultant is available as a resource.
   - Members of the state QI Leadership Collaborative can also serve as resources to this group.
   - Directors and members of the Quality Council will seek available funds, including grants, related to quality initiatives as they are made known to individual counties or the community health board.
   - Time spent in QI activities including time at meetings, working on projects or on reporting will be tracked in 2012 for the purpose of developing a QI budget.
   - The role of individual County Board and the Joint Community Health Board members will be to participate in and approve funding for quality improvement as appropriate (Appendices A and B).
   - The QI Plan will serve as an important building block for a Performance Management System for the CHS. The indicators that are selected will help determine our goals and targets and the reports of progress will measure our performance. (see Figure 1.1)

4. **Quality Improvement Activities**
   - Staff in both health departments will be surveyed for ideas or areas of improvement.

Table of Contents:

1. Purpose
2. Scope
3. Structure and Resources

4. Quality Improvement Activities
5. Evaluation and Revision of QI Plan

Purpose and Scope

- The QI Plan should describe the purpose for the QI activities conducted by the health department, including a description of the scope of the activities.
- The scope may be as limited as conducting one or two quality improvement efforts or a comprehensive, formal initiative that is integrated across all sections of the health department.
- This section could also describe the alignment with other agency-wide policies such as the strategic plan and the community health improvement plan.

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FHCHS QI Activities

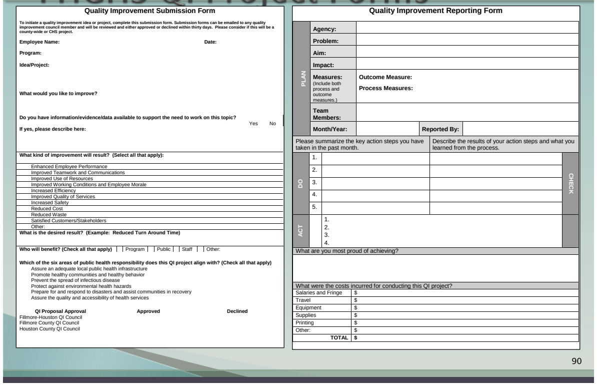
- Staff in both health departments will be surveyed for ideas or areas of improvement.
- Quality improvement language will be added to current job descriptions and to orientation checklists as applicable.
- Four health or quality indicators relevant to both health departments will be selected to monitor and possibly act upon to improve.
- The QI plan will take the form of a log of prioritized QI opportunities.
- The FHQC will develop and use an annual QI Calendar that schedules each of the QI activities for review by the Council.
- Advanced and ongoing training will be scheduled and documented throughout the year.

2012 Quality Improvement Calendar

Objective	Actions Necessary to Achieve the Goal	Staff Responsible	Completion Date	QIC Review Date
Develop QI Infrastructure	• Adopt QI Plan and Charter • Develop and adopt useful tools for implementation of QI processes	QI Chairman Joint QC members	12/16/2011	3/28/2012
Identify QI Improvement Projects	Review proposed/potential health indicators	JQI Council	11/21/2011	
	Determine how to display indicators	JQI Council	12/16/2011	
	Conduct staff survey to generate QI project ideas	JQI Council	10/05/2011 (H) 11/28/2011 (F)	
	Assist staff in documenting potential QI projects using the QI Project Reporting Form	Members of JQI Council	Ongoing	
	• Review data from indicators and define potential QI projects • Prioritize and create QI Project Log	JQI Council	Ongoing 12/16/2011	3/28/2012

2012 Quality Improvement Calendar					
Communicate to staff about QI efforts, and celebrate successes. Provide staff access to QI training materials and tools.	• Publicize QI stories • Present projects to the Joint Board of Health • Create story boards for public places • Publish articles in newspapers • Put stories on website	Project Team Leaders	Ongoing		
Provide education to staff and QI Council members	• Provide ongoing education to staff on concepts and tools of QI process and culture. • Provide ongoing education to council members to help them become the QI experts of their department. • QI Council members will participate in ongoing webinars, meetings, etc.	JQI Members	Ongoing		
Review the QI Plan at least annually and adjust as required to reflect current and emerging priorities	Review QI plan annually and adjust the list of projects as necessary.	Joint QI Council	November 2012	3/28/2012	

FHCHS QI Project Forms



Quality Improvement Submission Form

To initiate a quality improvement idea or project, complete this submission form. Submission forms can be emailed to any quality improvement council member and will be reviewed and either approved or declined within thirty days. Please consider if this will be a county-wide or CHS project.

Employee Name: **Date:**

Program:

Idea/Project:

What would you like to improve?

Do you have information/evidence/data available to support the need to work on this topic? Yes No

If yes, please describe here:

What kind of improvement will result? (Select all that apply):

Enhanced Employee Performance
Improved Teamwork and Communications
Improved Use of Resources
Improved Working Conditions and Employee Morale
Increased Efficiency
Improved Quality of Services
Increased Safety
Reduced Cost
Reduced Waste
Satisfied Customers/Stakeholders
Other:

What is the desired result? (Example: Reduced Turn Around Time)

Who will benefit? (Check all that apply) ☐ Program ☐ Public ☐ Staff ☐ Other:

Which of the six areas of public health responsibility does this QI project align with? (Check all that apply)

Assure an adequate local public health infrastructure
Promote healthy communities and healthy behavior
Prevent the spread of infectious disease
Protect against environmental health hazards
Prepare for and respond to disasters and assist communities in recovery
Assure the quality and accessibility of health services

QI Proposal Approval	**Approved**	**Declined**
Fillmore-Houston QI Council		
Fillmore County QI Council		
Houston County QI Council		

Quality Improvement Reporting Form

PLAN	**Agency:**			
	Problem:			
	Aim:			
	Impact:			
	Measures: (Include both process and outcome measures.)	**Outcome Measure:** **Process Measures:**		
	Team Members:			
	Month/Year:		**Reported By:**	

Please summarize the key action steps you have taken in the past month.		Describe the results of your action steps and what you learned from the process.	
DO	1.		CHECK
	2.		
	3.		
	4.		
	5.		
ACT	1. 2. 3. 4.		

What are you most proud of achieving?

What were the costs incurred for conducting this QI project?	
Salaries and Fringe	$
Travel	$
Equipment	$
Supplies	$
Printing	$
Other:	$
TOTAL	**$**

Link to PHAB v1 –Standard 9.2

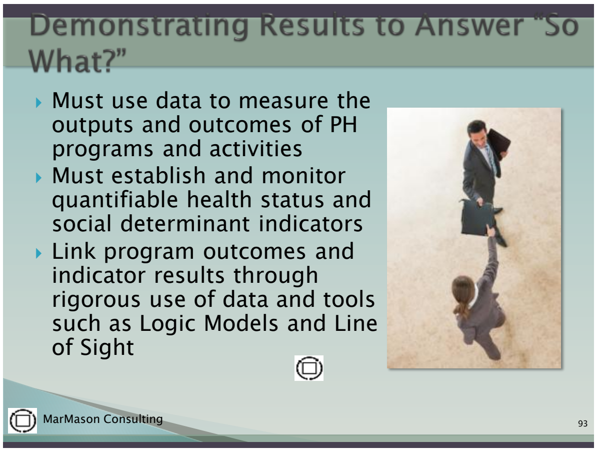
Standard 9.2
Develop and Implement Quality Improvement Processes Integrated Into Organizational Practice, Programs, Processes, and Interventions

9.2.1:
Establish a quality improvement program based on organizational policies and direction. (required documentation is a written QI Plan)

9.2.2:
Implement quality improvement activities

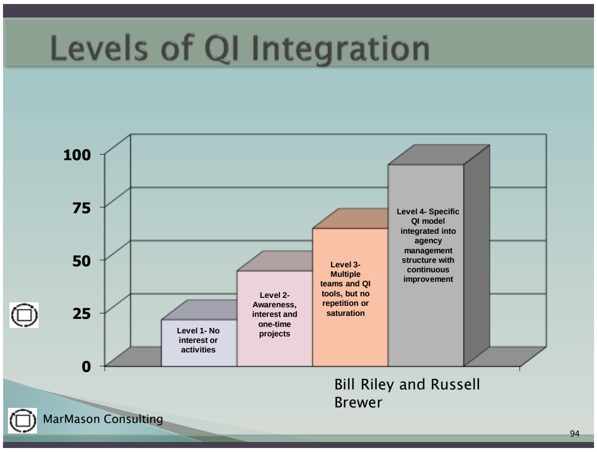
Conduct QI activities

- Measure performance against standards, health indicators or program outcomes
- Participate in improvement collaborative
- Conduct Rapid Cycle Improvement (agency or program QI teams)
- Just in Time training for managers and staff
- Regular reporting of progress and achievements



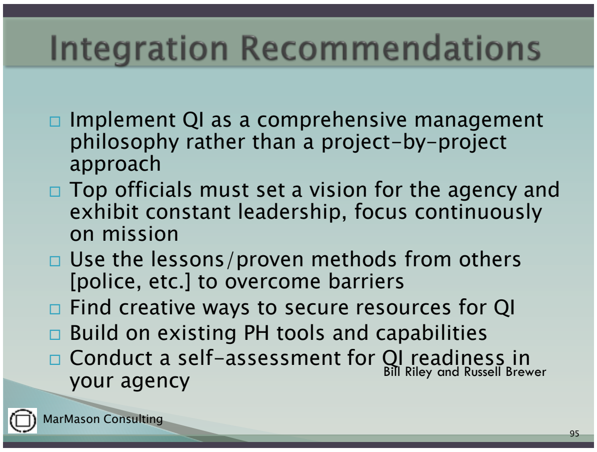
Demonstrating Results to Answer "So What?"

- Must use data to measure the outputs and outcomes of PH programs and activities
- Must establish and monitor quantifiable health status and social determinant indicators
- Link program outcomes and indicator results through rigorous use of data and tools such as Logic Models and Line of Sight



Levels of QI Integration

Bill Riley and Russell Brewer



Integration Recommendations

- ☐ Implement QI as a comprehensive management philosophy rather than a project-by-project approach
- ☐ Top officials must set a vision for the agency and exhibit constant leadership, focus continuously on mission
- ☐ Use the lessons/proven methods from others [police, etc.] to overcome barriers
- ☐ Find creative ways to secure resources for QI
- ☐ Build on existing PH tools and capabilities
- ☐ Conduct a self-assessment for QI readiness in your agency

Bill Riley and Russell Brewer

Break

CoffeeBreak

Preparing for Accreditation

Roles in the Accreditation Process

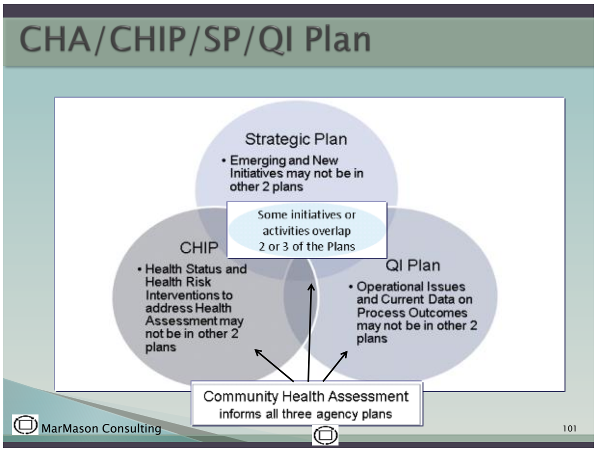
- Accreditation Coordinator
- Accreditation Team
- Health Department Director
- Health Department Staff
- Governing Entity
- Partner Organizations
- Community Partners
- Technical Assistance Providers

Establish HD Workgroup

- Assign coordinator for preparation project (12-18 months in advance)
- Assign specific categories/standards to individuals (usually managers)
- Develop detailed work plan that addresses each standard
- Establish meeting schedule for workgroup
- Report progress and barriers to leadership team

Accreditation Team

- Assist Accreditation Coordinator manage each step
- Identify potential documentation
- Sub-teams to manage specific aspects of the accreditation process
- Domain Teams – identify potential documentation
- Internal communication, site visit arrangements
- Consider and select documentation for each measure across a variety of public health programs
- Provide access to people in the department and other agencies and organizations
- Access to resources



CHA/CHIP/SP/QI Plan

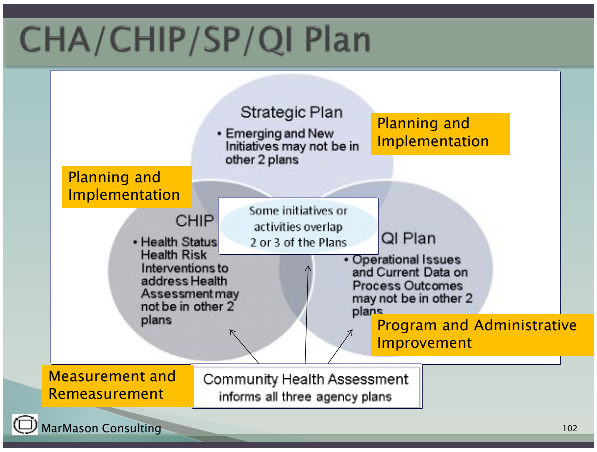
Strategic Plan
- Emerging and New Initiatives may not be in other 2 plans

Some initiatives or activities overlap 2 or 3 of the Plans

CHIP
- Health Status and Health Risk Interventions to address Health Assessment may not be in other 2 plans

QI Plan
- Operational Issues and Current Data on Process Outcomes may not be in other 2 plans

Community Health Assessment informs all three agency plans



CHA/CHIP/SP/QI Plan

Strategic Plan
- Emerging and New Initiatives may not be in other 2 plans

Planning and Implementation

Planning and Implementation

Some initiatives or activities overlap 2 or 3 of the Plans

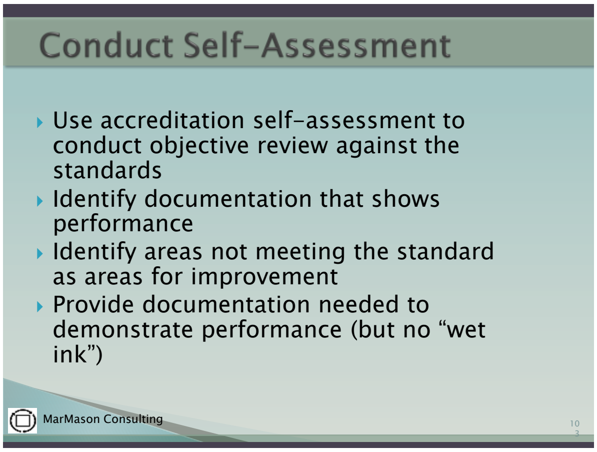
CHIP
- Health Status Health Risk Interventions to address Health Assessment may not be in other 2 plans

QI Plan
- Operational Issues and Current Data on Process Outcomes may not be in other 2 plans

Program and Administrative Improvement

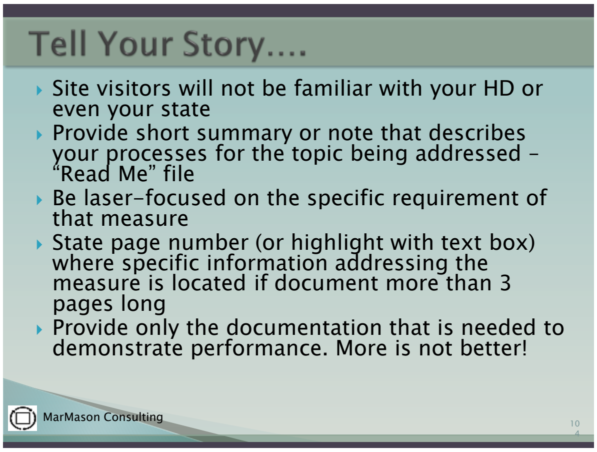
Measurement and Remeasurement

Community Health Assessment informs all three agency plans



Conduct Self-Assessment

- Use accreditation self-assessment to conduct objective review against the standards
- Identify documentation that shows performance
- Identify areas not meeting the standard as areas for improvement
- Provide documentation needed to demonstrate performance (but no “wet ink”)



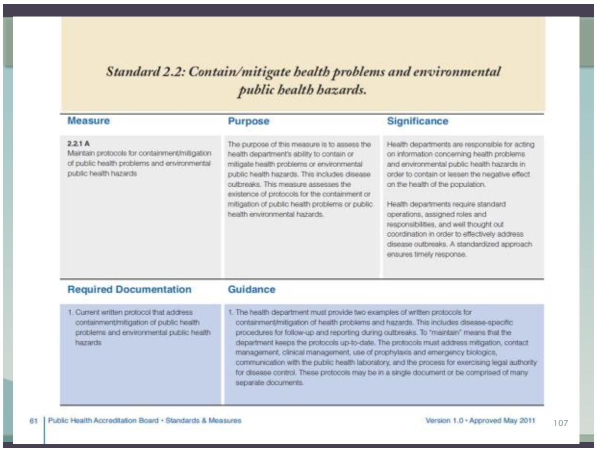
Tell Your Story….

- Site visitors will not be familiar with your HD or even your state
- Provide short summary or note that describes your processes for the topic being addressed – “Read Me” file
- Be laser-focused on the specific requirement of that measure
- State page number (or highlight with text box) where specific information addressing the measure is located if document more than 3 pages long
- Provide only the documentation that is needed to demonstrate performance. More is not better!

Mock Survey for Standard 9.2

Assessing Documentation

- Verify
  - to check whether or not the evidence is true by examination, investigation, or comparison
- Clarify
  - to make the evidence clear by examining it thoroughly
- Amplify
  - to make accounts fuller, clearer, or more detailed



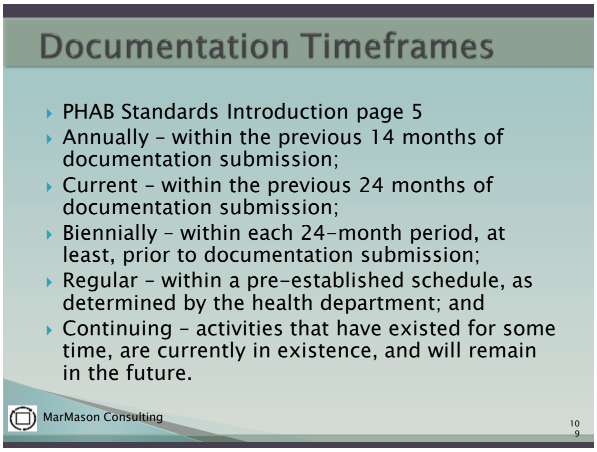
Standard 2.2: Contain/mitigate health problems and environmental public health hazards.

Measure	Purpose	Significance
2.2.1 A Maintain protocols for containment/mitigation of public health problems and environmental public health hazards	The purpose of this measure is to assess the health department's ability to contain or mitigate health problems or environmental public health hazards. This includes disease outbreaks. This measure assesses the existence of protocols for the containment or mitigation of public health problems or public health environmental hazards.	Health departments are responsible for acting on information concerning health problems and environmental public health hazards in order to contain or lessen the negative effect on the health of the population. Health departments require standard operations, assigned roles and responsibilities, and well thought out coordination in order to effectively address disease outbreaks. A standardized approach ensures timely response.

Required Documentation	Guidance
1. Current written protocol that address containment/mitigation of public health problems and environmental public health hazards	1. The health department must provide two examples of written protocols for containment/mitigation of health problems and hazards. This includes disease-specific procedures for follow-up and reporting during outbreaks. To "maintain" means that the department keeps the protocols up-to-date. The protocols must address mitigation, contact management, clinical management, use of prophylaxis and emergency biologics, communication with the public health laboratory, and the process for exercising legal authority for disease control. These protocols may be in a single document or be comprised of many separate documents.

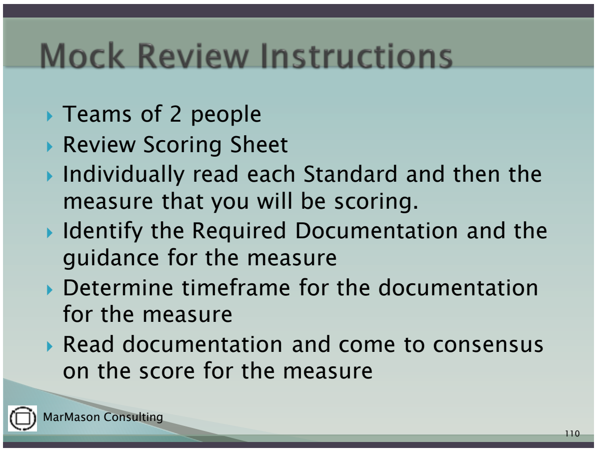
Using the PHAB Guidance

- Read the statement of the specific measure you are scoring
- Read each requirement carefully. You will need to validate that each of these requirements are present in the documentation to score the measure as "Demonstrates"
- Review the PHAB Acronyms and Glossary and use to clarify definition of terms and how they are used in the PHAB Standards



Documentation Timeframes

- PHAB Standards Introduction page 5
- Annually – within the previous 14 months of documentation submission;
- Current – within the previous 24 months of documentation submission;
- Biennially – within each 24-month period, at least, prior to documentation submission;
- Regular – within a pre-established schedule, as determined by the health department; and
- Continuing – activities that have existed for some time, are currently in existence, and will remain in the future.



Mock Review Instructions

- Teams of 2 people
- Review Scoring Sheet
- Individually read each Standard and then the measure that you will be scoring.
- Identify the Required Documentation and the guidance for the measure
- Determine timeframe for the documentation for the measure
- Read documentation and come to consensus on the score for the measure

What Questions Do You Have?