Spokane Regional Health District
2013 Quality Improvement Plan

Prepared by the Quality Council: December 2007
Implemented: January 2008
Reviewed and revised: December 2008, December 2009, December 2010, August 2011, February 2012, February 2013

Purpose and Scope

A. **Quality Management:** Is the act of overseeing all activities and tasks needed to maintain a desired level of excellence. This includes creating and implementing quality planning and assurance, as well as quality control and quality improvement. It is also referred to as total quality management (TQM). **Quality Improvement,** one aspect of quality management**,** is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization.[1]

B. **Vision:** The Quality Council (QC) will aid in creating, implementing, maintaining, and evaluating the quality management (QM) efforts at Spokane Regional Health District (SRHD) with the intent to improve the level of performance.

By providing a shared vision that can serve as an effective guide to set the stage for quality management, we hope to encourage a quality organizational culture that emphasizes learning, teamwork and customer focus; strives for institutional excellence and staff empowerment; and total quality and human resource management. As we achieve greater excellence standards, the more we hope to engrain and reinforce an enduring culture of quality improvement and excellence, which will show via improved quality of outcomes and services.

(For goals, objectives, activities, and measurements for the Quality Council, see Appendix H: Logic Model)

I. Reporting Structure

(See Appendix B: Communication Flow Chart)

Everyone has a role in SRHD's quality improvement efforts.

A. Quality Council

The Administrator has charged the QC with carrying out the purpose and scope of quality management, including improvement efforts at Spokane Regional Health District. It is intended that membership in the QC consists of one management and one non-management position for each division and for the non-divisional programs as a unit. The QC consists of cross-sectional representatives from executive management, program managers, and line staff, as well as two members from each division. In addition, the agency HIPAA officer and designated representative from the CHAPE Program are on the QC. Assignments to the QC are for a minimum two-year period of time with only one member from each division rotating off each year. Longer term participation from at least one divisional representative is encouraged to build and disseminate expertise throughout the agency, thereby helping us to sustain expertise over time, despite potential changes in funding or staffing. Every year, rotational members will be solicited via open recruitment and given six month temporary rotations on the council. Less than half of the council membership can rotate off of the committee each year to maintain continuity. When new members rotate on to the council, individuals who have participated as ad-hoc members will be given primary consideration to participate as a regular member from their division for the next time period. Co-chairs will be selected by the QC for a two year term with a staggered rotation. If possible, one co-chair must be a Joint Management Team member and the other must be a staff person. Administrative support will be available through one of the members on the QC or by QC

[1] Performance Management Glossary, Public Health Improvement Partnership, 2007

member designation from available administrative support staff. The QC meets on a regular basis and maintains records and minutes of all meetings. Team norms will be followed by QC. Documents will be centralized for access by others.

1. The QC reports to Executive Team and Board of Health.
2. The QC will assure ongoing membership renewal and replacement by reviewing annually. The current list of QC members can be found on the QIP Membership Roster. Up to four ad hoc members may rotate onto the QC on a semi-annual basis, as interest and space allows.
3. It is expected that the cost of time for each member to participate will be covered by their respective divisions and administration. No other resources are solicited nor spent by the QC.

B. Board of Health

The BOH receives a report at least annually with updates on agency QM efforts. Updates may include recommended actions for health policy decisions; progress toward program goals; recommendations based on after-action reviews; and other QM efforts. Board members may be asked to attend and participate in meetings. (Standards 1.4.1A, 9.1.1A, 9.2.1A)

C. Staff and Administrative Support

Staff and administrative support are responsible for:

1. Completing a program logic model or other framework to evaluate activities
2. Compiling program data for measures
3. Participating in annual logic model reviews
4. Working with managers to identify areas for improvement and suggesting improvement projects to address these areas, including meeting the WA state public health standards and Public Health Accreditation Board (PHAB) standards.
5. Conducting quality improvement projects in conjunction with managers and other appropriate staff (program evaluator, community health assessment staff, HIPAA coordinator, etc.)
6. Reporting QM training needs to managers

D. Program Managers

Managers are responsible for:

1. Orienting all staff to Quality Council process, plan, and resources
2. Developing an initial logic model and/or work plan for each program, including identification of performance measures and a data collection plan
3. Reviewing the data from logic models and/or work plans on an annual basis with staff
4. Initiating and participating in problem solving processes and/or QM projects
5. Identifying staff QM training needs, providing access to training, and tracking attendance
6. Reporting to their directors their findings from their logic model review, QM projects, public health state standards gaps, and identified QM training needs
7. Revising program logic models and/or work plans based on findings from annual review and QM

E. Division Directors

Directors are responsible for:

1. Reporting to the QC on logic model results, selected outcome measures, program evaluation efforts, QM projects (BPA, RCI), audit results (if applicable), customer service evaluation, public health standard gaps, and QM training needed (i.e. the annual Division Reports).
2. Identifying and selecting up to two areas needing improvement to bring to the QC as priorities annually (see Section V for how to select two areas) and presenting these ideas to the QC during the Division Report. At least one of these projects should be a new project idea.
3. Ensuring that an initial QI/QP Project Definition Document is completed for each project and presented to the QC within 2 months of the Division Report.
4. Assuring implementation and follow through of QM projects by: 1) providing monthly updates to the QC through the divisional QC representative; and 2) ensuring that the project lead completes the final Quality Project/Activity Summary Report and Storyboard.

Division Directors must provide an annual division report to the QC personally or jointly with staff. QM project reports during the year can be presented by designated staff. Directors may be asked to participate in QM committees and work groups.

F. Executive Leadership Team

The Executive Leadership Team (ELT) will oversee all aspects of the Strategic Management System and establish the specific processes, schedules and reporting methods that govern the creation and usage of the strategic plan, QI plan, agency priorities, Community Health Improvement Plan, agency operational plan, program evaluation, standards implementation, and budget process. The ELT will assure that the QC develops an annual quality improvement plan and assists in implementing continuous quality improvement methodology throughout the organization with approval by the ELT.

ELT will identify areas from the strategic plan, priority areas or program evaluation efforts that will be added to the QI plan for improvement, and/or down-streamed and measured at the program level.

II. Approval of QI Plan and Annual Evaluation

The QC will annually review and make suggested revisions to this QI Plan. When reviewing, the QC will work to maintain alignment with *Spokane Counts,* Public Health Accreditation Board *(*PHAB) Standards, statewide indicators, and national QM efforts. A report summarizing the review process, findings, and suggested modifications will be submitted to the Executive Team for approval within the first quarter of each year.

III. Quality Improvement Efforts

QM efforts include review and improvement of all programs and processes that have a direct or indirect influence on the quality of public health services provided by SRHD. The following QM efforts will be reported to the QC:

A. Customer Service

All employees with job functions that require interactions with the general public, stakeholders, and partners will receive appropriate customer service training. Training needs will be identified by the program evaluator and program managers and reported to their director. Customer service training for appropriate staff will be periodically offered by Human Resources or other applicable resources. Training attendance should be documented electronically to verify staff participation and to produce

aggregate reports. If training is provided by Human Resources, documentation of attendance will be kept by HR staff. (Standard 11.1.2A)

Customer service satisfaction will be evaluated at program and service levels, and annually rolled up at the agency level and reviewed by the QC, to assure customer service standards are met. Providers and coalitions should also be evaluated to ensure that SRHD is meeting the customers' needs. Division reports will include results from program and/or service satisfaction surveys. A core set of questions will be used by all customer service surveys. Community Health Assessment, Planning, & Evaluation (CHAPE) staff will assist program staff in developing and implementing surveys. (Standard 9.1.4)

B. Evaluation for Agency Divisions and Programs

Evaluation is defined as the systematic application of social (or scientific) research procedures for assessing the conceptualization, design, implementation, and utility of SRHD services. It will consist of creating a logic model for each program and division in the agency, creating effective data collection tools to measure each of the impact and population outcomes, reviewing data with staff on an annual basis, updating the logic models or other framework, and reporting on the outcomes to the division director. Staff and program managers are responsible for conducting evaluations. Findings will be used to inform planning and QM efforts. (Standards 1.1.3A, 9.1.3A, 9.2.1A)

C. HIPAA Compliance

Issues surrounding HIPAA policies, confidentiality, data sharing, security, and records retention will be evaluated and reported to the QC, either directly by the HIPAA/Quality Assurance Coordinator or through the annual Administrative Division Report. (Standard 11.1.2)

D. Improvement Plans from After Action Reviews

After Action Reviews are conducted after preparedness exercises, epidemiologic outbreaks, or other public health events. An improvement plan is created after identifying issues. Primary findings and major improvements will be reported to the QC, ideally within 30 days after completion of the improvement plan when impacting 2 or more divisions. (Standards 1.3.1A, 2.2.3A)

E. Strategic Plan Review

The SRHD Strategic Plan includes objectives around assessment activities, use of health data to make program and policy decisions, After Action Review issues, and prevention priorities. The Strategic Plan goals, objectives, and performance measures will be reviewed periodically by the Executive Team with recommendations for QM activities reported to the QC. From the Strategic Planning review of local health data (including the State's core Public Health Indicators, *Spokane Counts*, access indicators, and other data) and the Plan's goals, objectives, and performance measures, recommendations for quality improvement efforts will be reported to the QC. (Standards 5.2.1L, 5.3.1A, 5.3.2A, 5.3.3A, 9.2.1A)

F. Public Health Standards Review and Public Health Accreditation Evaluation

Every five years, SRHD will be evaluated on our level of compliance with the Public Health Accreditation Board (PHAB) standards. Accreditation through PHAB provides a means for a department to identify performance improvement opportunities, to improve management, develop leadership, and improve relationships with the community. The process is one that will challenge the health department to think about what business it does and how it does that business. It will encourage and stimulate quality and

performance improvement in the health department. It will also stimulate greater accountability and transparency.

Accreditation documents the capacity of the public health department to deliver the three core functions of public health and the Ten Essential Public Health Services. Thus, accreditation gives reasonable assurance of the range of public health services a department should provide. Accreditation declares that the health department has an appropriate mission and purpose and can demonstrate that it will continue to accomplish its mission and purpose. Site visits will be conducted by a peer team of three to four PHAB trained site visitors.

The visit serves several purposes: verify the accuracy of documentation submitted by the health department, seek answers to questions regarding conformity with the standards and measures, and provide opportunity for discussion and further explanation. Site visits will typically last two to three days, depending upon the complexity of the application.

Within two weeks following the site visit, the site visit team will develop a site visit report. The report will describe: (1) how conformity with each measure was demonstrated, or detail what was missing; (2) areas of excellence or unique promising practices; and (3) opportunities for improvement.

The report is shared with Executive Team, Joint Management, Board of Health, program staff and the Quality Council. The Accreditation Team will review and discuss both the Standards and Measures, including site reviewer summaries and findings, making recommendations to the Executive Team. Organizational inefficiencies, identified by standards review, will be reported to QC; recommendations will be integrated into the QIP as indicated, including opportunities for QM projects.
(See Appendix C: 2012 Quality Council Reporting Calendar)

IV. 2012 Selected Quality Management Projects

From Division reports or other information obtained by the QC, projects may be recommended for focused QM efforts. QM projects may also be submitted to the QC for technical assistance. Projects could use many QM methodologies, such as Rapid Cycle Improvement (RCI), Business Process Analysis (BPA), focus groups, surveys, and more. A follow-up progress report to the QC after project completion will be required.

The QC will monitor up to 15 quality improvement projects at any one time. From each of the Division Reports to the QC (annually in March), up to two prioritized quality improvement areas from each division will be selected for monitoring and assessment of improvement within an established timeframe not to exceed a year. The QI/QP Project Definition Document, QM Project Log, and the Quality Project/Activity Summary Reports will be used for reporting to the QC, with improvement objectives identified prior to initiation of the project as identified in the Project Definition Document. If areas are selected by the QC, program managers or other appropriate staff will be asked to fill out a preliminary Project Definition form and report back to the QC within 2 months of project selection. At the conclusion of a project, the program manager or other staff will be required to complete a Quality Project/Activity Summary Report and Storyboard. The QM Project Log will be kept by the QC and divisional QC representatives will be charged with posting regular updates. The QC will use these forms and mechanisms to monitor work and schedule reports.

In addition to divisional projects, the QC will also review available aggregate data (e.g. Division Reports, aggregated customer service information, etc.) and identify opportunities for cross-divisional projects. The QC will prioritize potential project ideas and submit a recommendation to ELT at least annually. The QC may provide technical support to subsequent, authorized cross-divisional QI teams and will monitor project progress via the tools and mechanisms described above.

Staff and the QC should select quality improvement projects to monitor that are **high-risk, high-volume, or problem-prone** and align with the strategic plan and SRHD's mission, vision and values.

(See Appendix D: Sample Selected Quality Improvement Objectives Log and Appendix E: Quality Improvement Objectives and Performance Measures Tracking Form and Progress Report to Quality Council.)

V. Communication Plan

On a periodic basis, articles about QM efforts will be published in a variety of venues. Presentations may be given at District and Joint Management Meetings. Periodic updates about the QC activities will be given to Executive Team, the Board of Health, and Program Managers. Managers will be responsible for ongoing communication to staff about the QI Plan and process established within our agency.

Resources (materials, templates, data collection tools, and trainings) available to staff are posted on the SRHD Intranet under Quality Improvement. As new resources become available, they will be posted to the Intranet and announced to staff.

Formal recognition of staff that has completed QM projects will be considered by the Council annually. Recognition may include storyboard displays, presentations to the Board of Health (BOH), presentations at Quality Council meetings, or for local, regional, state, or national awards and conferences. (9.2.1 A)

VI. Training Plan

Joint Management and the Board of Health (BOH) will receive an annual update on changes made to the plan. Managers will be responsible for orienting all of their staff to the Quality Council roles and process, QI Plan, and available resources.

The manager's orientation checklist for new staff includes providing an overview of the Quality Council, QI Plan, resources, and program specific evaluation efforts in each manager's area and division. (Standard 8.2.1A)

Training - Each year divisions report their QM training needs to the Quality Council. Agency trainings are created to meet these identified needs and to advance QM knowledge, skills and practices in the agency. Trainings may be held on a variety of performance and quality management topics, including: data analysis, logic models, program evaluation, quality improvement methods and tools (RCI, BPA, survey development, etc.), and the Public Health Standards for SRHD staff. The PH Standards describe the measures around program evaluation, quality improvement, and data-driven decision-making that result in program and policy changes.

Technical Assistance – Technical assistance will be available through the CHAPE office upon request as well as through divisional QC members. Additionally, technical assistance/workshops will be built into trainings as appropriate.

Topical Trainings- Trainings will be offered if a trend emerges that employees in different divisions and work groups are interested in the same topic of training. (Standard 9.2.1A d)

VII. Evaluation

On an annual basis, the QC conducts an evaluation of their work including: an annual staff evaluation of awareness, knowledge, behavior, QC progress towards goals, quality of work, and other outcomes; a self-assessment using internal collaborative evaluation tools; and a review of the QC logic model data. The data and outcomes are discussed in a QC meeting, and an action plan is developed as part of the work plan for the upcoming year. Afterwards the QI plan is updated to reflect any improvements to process and protocol that were introduced.

VIII. References

A. *CDC, Performance Management and Quality Improvement: http://www.cdc.gov/stltpublichealth/Performance/index.html*
B. *Public Health Accreditation Board, Standards and Measures: http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/*
C. *Public Health Foundation, Turning Point Performance Management Framework: http://www.phf.org/programs/PMtoolkit/Pages/Turning_Point_Performance_Management_Refresh.aspx*
D. *Washington State Public Health Performance Management Centers for Excellence: http://www.doh.wa.gov/PublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/PerformanceManagementCentersforExcellence.aspx*

IX. Appendices

APPENDIX A

QUALITY COUNCIL GOALS & ACTIVITIES/WORK PLAN
2012 (revised January 2012)

Individual: Enhancing skills, knowledge, attitudes and motivation	**LEAD**	**BY WHEN**
a. Maintain intranet page with resource list, Quality Management (QM) training, and information on QM efforts	Communication Sub Committee	Bi-Yearly
b. Conduct QM trainings with staff	Community Health Assessment, Planning, & Evaluation (CHAPE) Staff	Refer to Training Sub Committee Training Calendar
c. Hold technical assistance (TA) workshops	Quality Council (QC) Division Reps and CHAPE	Ongoing
d. Identify, review, monitor and make recommendations on QM projects	Quality Council (QC)	Monthly
Interpersonal: Increasing support for QM with peers	**LEAD**	**BY WHEN**
a. Submit QM projects to Intranet/SharePoint	QC Support	Monthly
b. Annual SRHD recognition of staff and completed QM projects with storyboard	Health Officer, BOH QC Member	Periodic
c. Encourage QM project lead staff to submit applications for broader acknowledgement of QM Efforts (Coordinate with Exec Team/QC)	QM Project Leads	Ongoing
Organizational (QC): Improving policies and practices of the QC	**LEAD**	**BY WHEN**
a. Conduct and evaluate agency review of QM	QC	Yearly
b. Present and report on updated QI plan and council progress to JM and BOH	QC Co-Chair to JM; Health Officer to BOH	1st Qtr
Community: Increase interdivisional collaboration and partnerships to effect QM at SRHD	**LEAD**	**BY WHEN**
a. Make recommendations to Exec Team for interdivisional/agency QM projects based on identified needs	QC Exec Team members	Third Qtr
b. Assure that programs conducting similar work know about QM projects completed in another division	QC	As needed
Public Policy (Agency): Developing and influencing SRHD QM policy	**LEAD**	**BY WHEN**
a. Monitor agency customer service	QC, CHAPE support	June
b. Hear/review division reports and progress on performance measures to determine how better to improve QM projects	Quality Council (QC)	See meeting schedule
c. Monitor program evaluation efforts and progress	Division Director with QC asst.	June
d. Monitor agency movement toward QM, including standards information	QC	November
e. Monitor agency performance measures and report improvement	QC	June

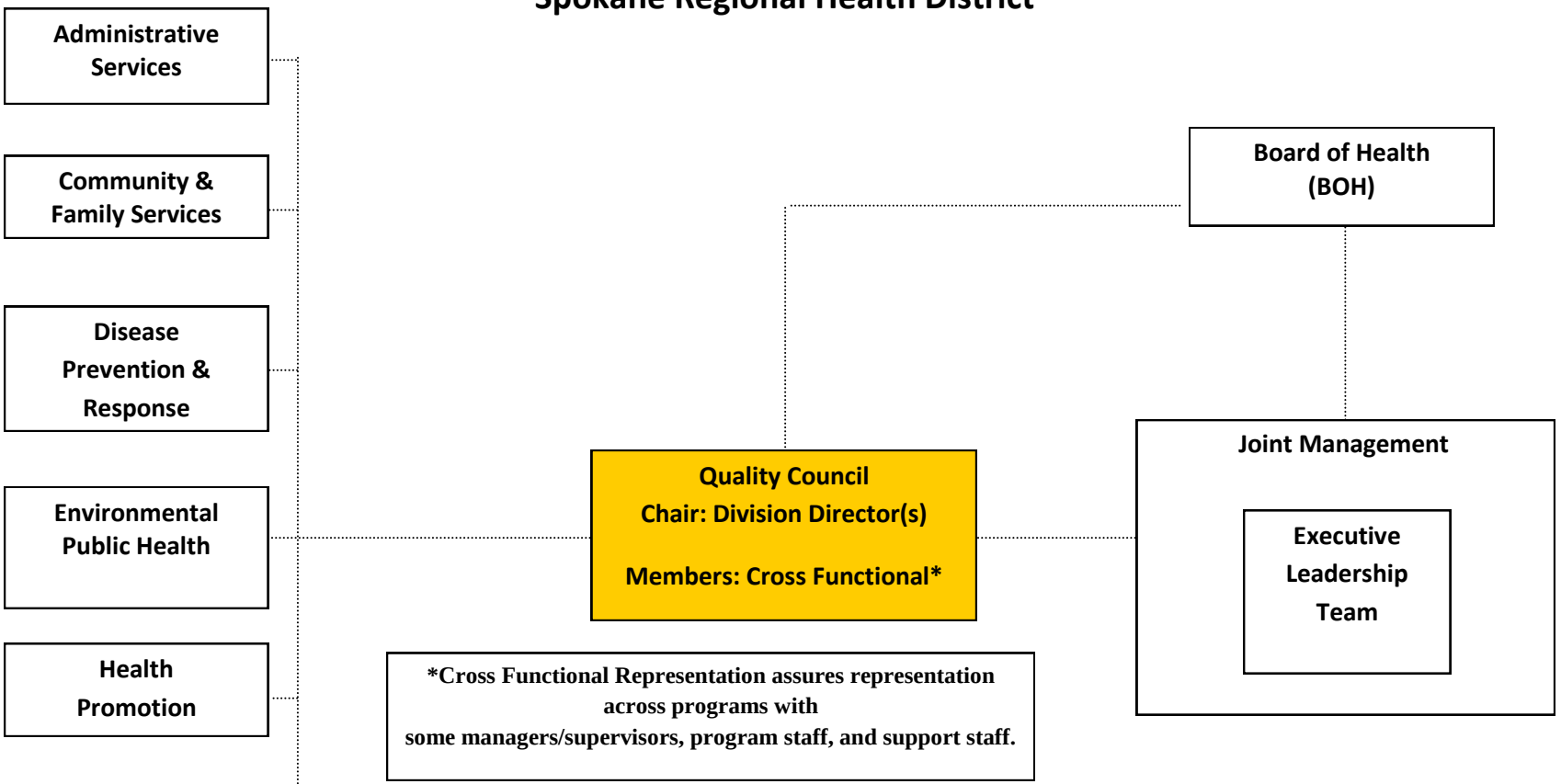
Quality Council Focus

The Socio Ecological format was adjusted to fit internally within SRHD as it pertains to the QC activities.

APPENDIX B

Communication Flow Chart for Quality Improvement

Spokane Regional Health District



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

APPENDIX C

2013 QUALITY COUNCIL REPORTING CALENDAR

	DATA REVIEW BY QC Date Scheduled:	REPORT TO
Customer Service	**Second Quarter**	**Executive Team**
Quality Improvement Update	**First & Third Quarters**	**Joint Management**
Division Reports		
Administration	**March 14**	
Community and Family Services	**May 9**	
Disease Prevention and Response	**April 11**	
Environmental Public Health	**May 9**	
Health Promotion	**April 11**	
Quality Improvement Projects		
Scheduled throughout year	**See log**	
QC Evaluation and Data Compilation		
QI Plan Review	**Fourth Quarter**	**Executive Team, Joint Management, Board of Health**
QC Logic Model data review	**Fourth Quarter**	

Appendix D

Selected Quality Improvement Objectives Log – ACTIVE

Reporting Area	Lead Staff	SMART Objective	Start Date	Complete Date	Report Date to QC	Status	Story Board (Circle Yes or No, If yes insert date of storyboard completion)
Admin							
							Y/N (Date):
							Y/N (Date):
CFS							
							Y/N (Date):
							Y/N (Date):
DPR							
							Y/N (Date):
							Y/N (Date):
EPH							
							Y/N (Date):
							Y/N (Date):
HP							
							Y/N (Date):
							Y/N (Date):
Non-Divisional							
OTP							Y/N (Date):
Lab							
BOH							

Appendix E

Quality Project / Activity Summary Report

Title of Project:
Division/Area Reporting: **Lead Staff:**
Start Date: **Complete Date:**
Initial report to QC Date: **Report back to QC Date(s):**
Overall Objective for Project:

Method Utilized:	☐ QI (cross-programmatic or larger scope process improvement ☐ QI (single program or smaller scope process improvement) ☐ QP (new process/service design)		
Analysis Summary:	If QI: What root causes were identified? If QP: What key customer needs were identified?		
Analysis tools Utilized: *(Check all that apply)*	☐ Flow Charts ☐ Pareto Diagram ☐ Histogram ☐ Cause-Effect Diagrams ☐ Data Collection Matrix ☐ Other:	☐ 5s ☐ BPA/ Work Flow Analysis ☐ Other:	☐ Qualitative Survey ☐ Affinity Diagram ☐ Customer Needs Matrix ☐ Benchmarking ☐ Other:
Change Summary:	Briefly describe changes made and how they address either identified root causes or customer needs:		

	Measure #1	**Measure #2**	**Measure #3**
Statement of measure: *(A %, number, count, average)* *(e.g. Percent of high risk pregnant women with prenatal visit in 1st trimester)*			
Target Population: *(e.g. All pregnant women)*			
Numerator: *(Fill this out if your measure is a %) (e.g. # high risk pregnant women with 1st trimester prenatal visit)*			
Denominator: *(Fill this out if your measure is a %) (e.g. # of high risk pregnant women*			
Source of data: *(e.g. Clinic visit records)*			
Baseline: *(e.g. 85%)*			
Target or Goal:			

(e.g. 95%)			
Results: *(e.g. 90%)*			

Did you reach your target or goal for your objective?

1. **a. If yes, how will you sustain or continue improving?**

b. What ongoing measures did you put in place? Specify.

c. Who is primary owner of the process and responsible for monitoring the measure(s) and how frequently will this be done?

d. What tools will you use for ongoing evaluation of the process (i.e., process control)?

☐ Logic Models ☐ Trend/Run Charts ☐ Control Charts
☐ Histogram ☐ Box Plots ☐ Other _____

2. **If no, what variables were involved in not reaching your goal?**

3. **What is your plan to address the variables that prevented you from reaching your target or goal?**

If project is complete, <u>please provide</u> an abstract regarding your project for the Monday Mail. The abstract should include all the following descriptive:

Title of Project

Project Description, including Problem and QI Activities

Objective

Results

Contact Information

The Quality Council may ask you to develop a story board and may request that you report back on your efforts to sustain or further improve the process you studied/designed.

Quality Improvement/Quality Planning Project Definition Document

Project Name: *1 – 3 word identifier*	**Sponsor(s):** *Who is governing and resourcing this project? (Division, Program, Manager or Exec Leader)*
Problem/Opportunity: *1-3 sentence description of the problem/opportunity (without assumption of cause or solution) and why it is important (Impact on Program or Division/Agency strategic goals)*	
Type of Problem/Opportunity: ☐ QI (cross-programmatic or larger scope process improvement ☐ QI (single program or smaller scope process improvement) ☐ QP (new process/service design)	
Overall Objective): *1 sentence declaration as to what the project team is to do without assumption of cause or solution. (A.k.a. mission statement, purpose statement, etc.). (Remember S.M.A.R.T. = direction + measure/what you are improving + target + timeframe).*	
Performance Measure(s): *The quantitative indicator(s) which would demonstrate performance had improved. More than 2-3 measures may indicate lack of focus. (i.e., %, number, count, average, etc.)*	**Target(s):** *How much improvement is expected/hoped for?*
Process(es) to be addressed: *Describe the boundaries/scope (i.e., the "start" and "stop") of the process(es).*	**Customer(s):** *Who is/are the PRIMARY recipient(s) of the "output" or service?*
Team Leader: *Who is primarily responsible for the conduct and success of this project? (May coincide with the process owner)*	
Team Facilitator: *Who will be assisting the leader with QI methods and tools and group process facilitation? (Tip: Start with division's QC representative)*	
Team Members: *Who will be active participants on the project team? Ensure representation of process steps and other key stakeholders. For projects of smaller scope, you may not have team members other than lead and/or process owner)*	
Constraints: *Are there time, space, financial, system, policy, organizational or other constraints that the team leader and members should be aware of?*	**Resource Requirements:** *What resources are available to the team to support completion of its mission? (Time, IT, budget, CHAPE staff support, etc.)*
How do you think you will proceed with analyzing this problem for root cause (QI) or customer need (QP)? *(Tip: Consult with your QC representative if needed)*	
Target Start Date:	
Target End Date:	
Process Owners: *Who will be primarily responsible for maintaining process performance after completion of the project?*	

2013 Quality Council Members

Julie Albright, OTP

John Arvan, DPR

Julie Awbrey, EPH, Co-Chair

Lisa Breen, EPH

Gwen Dutt, Admin, HIPAA Coordinator

Mishelle Earley, Admin

Alexandra Hayes, HP

Caroline Law, CFS

Bob Lutz, BOH member

Patricia Rhoades, Admin/Support

Julie Scholer, HP, Logic Model Subcommittee Lead

Sue Schultz, CFS

Torney Smith, Admin

Jennifer Timoney, OTP

Lyndia Tye, DPR, Tools Subcommittee Lead

Kyle Unland, HP, Communications Subcommittee Lead

Stacy Wenzl, DPR, Co-Chair, Training Subcommittee Lead, CHAPE Representative

The Quality Council was created in late 2007

SRHD

Committee: Quality Council

Responsible: Quality Council Chair and Quality Council Team

Revision: Nov 30th, 2011

Program Theory	Inputs	Activities	Outputs	Process Outcomes	Impact Outcomes	Population Outcomes	Measurements	Standards
The QC will aid in creating, implementing, maintaining and evaluating the quality improvement efforts at SRHD with the intent to improve the level of performance of key processes and outcomes.	QC members, division directors, QI Plan, staff, managers, Board of Health	**Individual:** Enhancing skills knowledge attitudes and motivation						
		Maintain intranet page with resources list (including QI training) and information on QI efforts.	# updates	Links worked. Content was easy to navigate and understand. Resources were up to date.	Increased access to QI information, tools, and resources.	By 2015 90% of employees will be able to define and appropriately use QI tools and methods and implement them.	Survey end of year.	
		Conduct QI trainings with divisions.	# trainings	Trainings were rated at 4/5 on all satisfaction questions on evaluation. Met all identified training needs.	Increased awareness of QI processes. Increase use of QI tools		Training evaluations. End of year survey.	9.1.5 Require staff participation in evaluation methods and tools training.
		Conduct T.A. workshops.	# workshops # participants	Q.C. members are seen as a resource for QI. Assistance was helpful/ useful. QI stories were concise and tailored to target audience.	Increase quality of reporting to QC. Increased appropriate implementation of QI tools.		End of year survey.	
		Identify, review, monitor and make recommendations on QI projects.	# projects started # projects completed	Lead project staff had enough support, information and access to resources. Recommendations were appropriate and useful.	Increased support for science based methodologies. Improved program/ project outcomes.		End of year survey. Review of key processes and outcomes performance.	9.1.3 Monitor performance measures for processes, programs and interventions.
		Interpersonal: Increasing support for QI from peers						
		Recognize and acknowledge QI efforts	# articles # events	Events were appropriate for QI promotion. Staff felt encouraged to apply for recognition.	Increased staff/ manager awareness of QI projects that are occurring.		End of year survey.	
		Encourage QI project lead staff to submit applications for broader acknowledgment of QI	# award recipients # presentations.	Staff felt encouraged and supported to submit applications. Applications were appropriate for	Increased visibility and recognition of the QI efforts employees were involved in. Increased % of submitted		Review awards earned for QI projects. End of year survey.	

		efforts		recognition.	projects receiving awards.			
		Organization: Improving policies and practices of the QC						
		Present and report on updated QI plan and council progress.	# presentations (JM, Exec team, BOH)	Information was concise and easy to understand. Met BOH presentation standards.	Increased awareness of QI processes and agency improvements. Exec Team and BOH approved plan.	Improved level of performance of key processes and outcomes.	End of year survey. Presentation feedback.	9.1.1 B Engage governing entity in establishing agency policy direction re: performance management system. 9.2.1 Establish a quality improvement plan based on organizational policies and direction.

The QC will aid in creating, implementing, maintaining and evaluating the quality improvement efforts at SRHD with the intent to improve the level of performance of key processes and outcomes.	QC members, division directors, QI Plan, staff, managers, Board of Health	**Community:** Increase interdivisional collaboration and partnerships to effect QI at SRHD				By 2015 90% of employees will be able to define and appropriately use QI tools and methods and implement them.		
		Make recommendations to Exec Team for interdivisional/ agency QI projects.	# project recommendations	Recommendations were based on identified needs.	Increased agency level measures improvement. Increased agency efficiency.		QI report from Exec Team. End of year survey.	9.1.1 B Engage governing entity in establishing agency policy direction re: performance management system.
		Public Policy: Influencing SRHD QI policy						
		Monitor agency customer service.	# programs and divisions participating.	Report covered the five selected agency measures of customer service.	Increased understanding of customer service QI needs. Maintain level of customer service. Increased use of customer service evaluation.		Review customer service QI needs identified. Customer Service report.	9.1.4 B Implement a systematic process for assessing and improving customer's satisfaction with agency services.
		Hear division reports	# reports	Division directors had enough support/ supervision to properly complete report. Recommendations were appropriate.	Increased awareness of division status and improvement projects needed and ongoing.		Review division QI needs. End of year survey.	
		Monitor program evaluation efforts.	# reports	Received adequate information and assistance to complete.	Increased logic model use, data reviews, and utilization of work plans. Improved logic model indicators.		Year end survey	9.1.3 B Evaluate the effectiveness of processes, programs, and interventions and identify needs for improvement.

Glossary of Terms

http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf

Appendix I

Quality Council Member Roles

Board of Health: The BOH member of the quality council is a liaison between the board and council. As a BOH member the liaison provides strategic guidance and expertise in areas of knowledge and experience. Additionally, the liaison may seek clarity regarding concepts and actions in order to clarify methodologies, metrics and outcomes to assist in assurance that changes reflect improvement and not simply change. As a liaison s/he informs the BOH and engages them in matters addressing quality improvement and application within SRHD.

Co-Chairs: The co-chairs are responsible for developing the agenda and facilitating the Quality Council meetings monthly. They assure that minutes are sent out after the meeting. Their oversight of the work plan assures that activities are progressing and subcommittees are meeting. At the end of the year, they coordinate the evaluation of the Quality Council and the update of the Quality Improvement plan. The Executive Team Co-Chair presents the work of the committee to the Board of Health annually at the first of the year.

Community Health Assessment Planning and Evaluation (CHAPE) Liaison: The member presents the agency data for program evaluation, including completion of logic models and evaluation plans, and results of analysis and data reviews; aggregate customer service, coalition, and presentation survey results; annual quality improvement survey results; and other data as requested by the Quality Council. The member serves as conduit for sharing learning gained from Centers for Excellence. The member supports development, implementation and evaluation of QI-related training activities.

HIPAA Coordinator: The HIPAA Coordinator will evaluate and report to the QC with regards to issues surrounding HIPAA policies, confidentiality, data sharing, security, and records retention.

QC Support: This member provides administrative assistance to the QC chair/co-chair. The preparation and distribution of monthly meeting minutes, as well as file management of minutes, manuals, and other materials are the responsibility of this member. General assistance with quality improvement projects is another aspect of this role.

Divisional Representatives: Each Division will have two representatives on the Quality Council. They will act as a liaison between the Quality Council and their Division Director, Program Managers and other staff involved in quality improvement projects. They will provide assistance and/or direct project inquiries to available resources. The Divisional Representatives will provide accountability on progress of projects to the QC.

Rotational Members: The members review all materials provided prior to attending first QC meeting to gain overall understanding of committee, which includes SRHD Quality Improvement Plan, previous meeting minutes, and other documents that are provided. Members should:

- Become familiar with area of SRHD intranet –Quality Improvement and documents, materials available to staff;

- Attend monthly QC meetings during scheduled rotation;
- Participate in discussions at QC meetings;
- Participate in subcommittee meetings to provide input; and
- Take information from QC meetings back to division meetings

QUALITY MANAGEMENT PROJECT ASSISTANCE

All members:

Quality Council members are available to provide assistance to staff considering or conducting quality management projects, including quality planning (new process design) and quality improvement (process improvement) projects. A Quality Council member can:

- Assist with project selection and development (e.g., project type, data sources, etc.)
- Direct project lead toward available resources and provide technical assistance
- Explain/assist with applicable paperwork, including completion of initial QI/QP Project Definition Documents, Quality Project/Activity Summary Report, and Storyboards
- Help troubleshoot
- Keep project lead apprised of project/report deadlines and content and provide assistance with scheduling presentations to the QC

To request assistance, first contact the identified divisional representative serving as primary point of contact on the Quality Council (QC). If that member is not best suited to the project, she/he will coordinate with another QC member to provide assistance. The QC may also assign a member to each quality improvement project presented to the Council in order to offer assistance and ensure the project lead is aware of upcoming project/report deadlines. A project lead is expected to contact their QC resource if additional assistance is requested beyond the established contact schedule.