MCHD QI and Accreditation Training Session
February 8, 2013

Marni Mason, MarMason Consulting, LLC

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!

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, NIH, 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)
- Owner and Managing Consultant of MarMason Consulting, LLC based in Seattle, WA
MarMason Consulting

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.

MarMason Consulting

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

MarMason Consulting

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

MarMason Consulting

"Refreshed" Turning Point Framework

MarMason Consulting
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

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.
  - Top management philosophy resulting in complete organizational involvement
  - Conduct of improving a process at the micro system level

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

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”

Tools to Link Work and Outcomes

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

Logic Model: Public Health Program

Inputs
- Resources
- Money
- Staff

Activities
- Program Development
- Program Planning
- Materials Development, Distribution

Outputs
- Informed, Targeted Program
- Appropriate, Targeted Materials

Short Term Outcomes
- Improved knowledge, beliefs, attitudes

Intermediate Outcomes
- Improved Behaviors

Long Term Outcomes
- Reduced Mortality
- Reduced Morbidity
- Improved Quality of Life

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

### 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

### 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

---

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

From Methods and Tools of Quality Improvement Institute for Healthcare Improvement
Why are our teens not more active?

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?

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
Problem Statement

Category

Category

Category

Problem Statement

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

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

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
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.

**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

**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?
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

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

PLAN Steps for Implementing QI Project*

- **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

* The ABCs of PDCA & MI Guidebook
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

<table>
<thead>
<tr>
<th>Improvements Area</th>
<th>Importance</th>
<th>Control</th>
<th>Hi Risk</th>
<th>Hi Vol</th>
<th>Prob Prone</th>
<th>Total points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immunization</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>2. Engage Community</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>3. CHIP</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>4. Food Safety</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>5. Family Planning</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
</tbody>
</table>

PLAN Steps for Implementing QI Project*

- 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

---

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

---

Four Stages – Team Development

- **Forming**
- **Norming**
- **Storming**
- **Performing**

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
- **Check/Study**
  1. Review analysis and make conclusions
- **Act**
  1. Review analysis and make conclusions
  2. Collect and Analyze the data
  3. Document Problems, Observations, and Lessons Learned
  4. Adapt
  5. Plan
  6. Evaluate
  7. Standardize/ Hold the Gains
- **Adapt**
  1. Review analysis and make conclusions
  2. Collect and Analyze the data
  3. Document Problems, Observations, and Lessons Learned
  4. Adapt
  5. Plan
  6. Evaluate
  7. Standardize/ Hold the Gains
- **Abandon**
  1. Review analysis and make conclusions
  2. Collect and Analyze the data
  3. Document Problems, Observations, and Lessons Learned
  4. Abandon
  5. Plan
  6. Evaluate
  7. Standardize/ Hold the Gains

---
**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.

**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)

**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.

**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
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.

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%.

PLAN Steps for Implementing QI Project*

- 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

Develop an Action Plan (Gantt Chat)
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

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.

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!

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*

- Problem to Consider - AIM
- Identify Stakeholders
- Needs & Prioritize Issues
- Sector Maps
- Force Field Analysis
- Affinity Diagram
- Prioritization Tools
- Describe current process
- Logic Model
- Flow Chart
- Data Collection to Identify Root Causes
- Fishbone Diagram
- 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

* Adapted from PHF

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

Some QI References

- Breakthrough Method and Rapid Cycle Improvement www.ihi.org

What Questions Do You Have?
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

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

Get a baseline if you can!

Performance Measures Vs. Objectives

Decrease the percent of Best Health County youth who are overweight or obese to 25% from the baseline of 32% by December 31, 2016.

Objective

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
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: 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: Time frame

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:
Performance measure: The rate of Chlamydia (CT) positivity at provider clinics.

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%
- 2006: 9.3%
- 2007: 10.5%
- 2008: 8.6%
- 2009: 8.2%
- 2010: 8.1%

Definitions and other comments: Provider clinics, Planned parenthood sites and others.
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

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

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.

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

<table>
<thead>
<tr>
<th>Objective</th>
<th>Actions Necessary to Achieve the Goal</th>
<th>Responsible</th>
<th>Completion Date</th>
<th>QC Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop QI infrastructure</td>
<td>• Adopt QI Plan and Charter • Develop and adopt useful tools for implementation of QI processes</td>
<td>Chairman Joint QC members</td>
<td>12/16/2011</td>
<td>3/28/2012</td>
</tr>
<tr>
<td>Identify QI Improvement Projects</td>
<td>• Review proposed/potential health indicators • Determine how to display indicators • Conduct staff survey to generate QI project ideas</td>
<td>Joint QC</td>
<td>11/21/2011</td>
<td>12/16/2011</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Joint QC</td>
<td>10/05/2011</td>
<td>11/28/2011</td>
</tr>
<tr>
<td></td>
<td>• Assist staff in documenting potential QI projects using the QI Project Reporting Form</td>
<td>Members of Joint QC Council</td>
<td>12/16/2011</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>• Review data from indicators and define potential QI projects • Prioritize and create QI Project Log</td>
<td>Joint QC</td>
<td>12/16/2011</td>
<td>3/28/2012</td>
</tr>
</tbody>
</table>
Publicize QI stories
Conduct Rapid Cycle Improvement (agency or program QI teams)
Publish articles in newspapers
Create story boards for public places
Publish articles in public places
Put stories on website
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.
Review QI plan annually and adjust the list of projects as necessary.

<table>
<thead>
<tr>
<th>2012 Quality Improvement Calendar</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commitments to Staff about QI Efforts</strong></td>
</tr>
<tr>
<td>- Publicize QI stories</td>
</tr>
<tr>
<td>- Present projects to the Joint Board of Health</td>
</tr>
<tr>
<td>- Create story boards for public places</td>
</tr>
<tr>
<td>- Publish articles in newspapers</td>
</tr>
<tr>
<td>- Put stories on website</td>
</tr>
<tr>
<td>- Provide ongoing education to staff on concepts and tools of QI process and culture.</td>
</tr>
<tr>
<td>- Provide ongoing education to council members to help them become the QI experts of their department.</td>
</tr>
<tr>
<td>- QI Council members will participate in ongoing webinars, meetings, etc.</td>
</tr>
<tr>
<td>- Review QI plan annually and adjust the list of projects as necessary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>2012 Quality Improvement Calendar</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commitments to Staff about QI Efforts</strong></td>
</tr>
<tr>
<td>- Publicize QI stories</td>
</tr>
<tr>
<td>- Present projects to the Joint Board of Health</td>
</tr>
<tr>
<td>- Create story boards for public places</td>
</tr>
<tr>
<td>- Publish articles in newspapers</td>
</tr>
<tr>
<td>- Put stories on website</td>
</tr>
<tr>
<td>- Provide ongoing education to staff on concepts and tools of QI process and culture.</td>
</tr>
<tr>
<td>- Provide ongoing education to council members to help them become the QI experts of their department.</td>
</tr>
<tr>
<td>- QI Council members will participate in ongoing webinars, meetings, etc.</td>
</tr>
<tr>
<td>- Review QI plan annually and adjust the list of projects as necessary.</td>
</tr>
</tbody>
</table>

**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

**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

**Levels of QI Integration**

- **Level 1:** No interest or indication
- **Level 2:** Awareness, interest and one-time projects
- **Level 3:** Multiple teams and QI tools, but no repetition or saturation
- **Level 4:** Specific QI model integrated into agency management structure with continuous improvement

**Break**

![Coffee Break](image.png)
Preparing for Accreditation

- 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

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

- Assist Accreditation Coordinator manage each step
- Identify potential documentation
- Subteams 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
**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

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?