

Kent, Washington | September 4, 2013

Case Study

“I’m So Confused” Documentation Assessment

DOCUMENTATION CASE STUDY

The Acme County Health Center has applied for accreditation and is in the process of uploading their documentation. You are a member of the Accreditation Team, maybe even the Accreditation Coordinator, and you are responsible for the documents in Domains 5 and 9. Those are important domains as they contain the Community Health Improvement Plan, the Strategic Plan and the Quality Improvement Plan. You have collected potential documents for Measures 5.4.1 A and 9.1.3 A. It's time to look them over, evaluate what would be best and decide which ones, if any, to use.

INSTRUCTIONS

1. Read through the two measures from the Standards & Measures.
2. Look over the documentation provided for the measure. Note that the documents are to be viewed independently and not as a related collection. For example, an agenda and a separate set of minutes may not necessarily match or go together.
3. Evaluate the documents against the requirements and guidance from the Standards & Measures. Look at the documents separately, not as part of a package.
 - Use the Document Assessment Check Sheet to guide your evaluation of the documents
 - Consult requirements in the Standards and Measures as needed while evaluating documents
 - Consult the PHAB Documentation Guidance as needed
4. All documents are lacking in some regard or could be made stronger. Note the elements that are missing, need further clarification or are not useful for the conformity to the measure.
5. Review the sample measure narratives and select the best choice among the examples given.

MEASURES STUDIED

From the PHAB Standards & Measures, Version 1.0

Measure 5.4.1 A

Sample Documents

1. After Action Report Review Guide
2. Local Emergency Planning Committee (LEPC) Agenda
3. ACHC Emergency Operations Response Plan (EORP)
4. Local Emergency Planning Committee (LEPC) Minutes
5. Meeting Memo
6. After Action Report
7. Meeting Minutes
8. MOU Regional Health Departments
9. Meeting Agenda
10. Record of Changes

Measure 9.1.3 A

Sample Documents

1. QI & PI Team Meeting Notes 1-11-12
2. QI Team Meeting Agenda and Notes 3-19-12
3. 2012 Objectives
4. Excerpts from PI Plan
5. Leadership Team Agenda 11-29-12
6. Leadership Team Minutes 11-27-10
7. Admin Project
8. PI Plan with Updates
9. WIC Storyboard

"I'm So Confused"
Selected Measures for Training



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Public Health Accreditation Board

STANDARDS
& Measures
Selected Measures

VERSION 1.0

APPLICATION PERIOD 2011-2014

APPROVED MAY 2011

Standard 5.4: Maintain an all hazards emergency operations plan.

Measure	Purpose	Significance
<p>5.4.1 A Participate in the process for the development and maintenance of an All Hazards Emergency Operations Plan (EOP)</p>	<p>The purpose of this measure is to assess the health department's collaborative activities to organize coordinated responses to emergencies.</p>	<p>Health departments play a central but not exclusive role in response to emergencies. It is critical to ensure effective coordination of many agencies and organizations involved in responding to emergencies and in managing the many response activities.</p>
Required Documentation	Guidance	
<ol style="list-style-type: none"> 1. Collaborative planning through preparedness meetings with other government agencies 2. Collaborative testing of the All Hazards EOP, through drills and exercises <ol style="list-style-type: none"> a. Description of a real emergency or exercise, including documented coordination with emergency response partners 	<ol style="list-style-type: none"> 1. The health department must document that it participates in preparedness meetings with other government agencies. This documentation could be meeting agendas and minutes, meeting rosters, calendar of meetings, email exchanges, and phone calls, as shown on a log or other record. 2. The health department must document its participation in a test that implements the All Hazards Emergency Operations Plan. <ol style="list-style-type: none"> a. The documentation can be of either an actual or a simulated emergency (drill or exercise). This description must include documentation of how the health department coordinated with emergency response partners during the emergency or drill/exercise. Emergency response partners may be Tribal, state or local emergency 	

Measure 5.4.1 A, continued

Required Documentation	Guidance
<ul style="list-style-type: none">b. Debriefing or After-Action Report (AAR) 3. Collaborative revision of the All Hazards EOP<ul style="list-style-type: none">a. Documentation of a collaborative review meeting within the last two yearsb. Documentation of updated contact informationc. Documentation of coordination with emergency response partnersd. Revised All Hazards/EOP	<p>services agencies, including law enforcement, or community partners, such as a hospital. Partners may also come from the Tribal, state or local planning committee.</p> <ul style="list-style-type: none">b. Documentation must include debriefing or evaluation reports from the emergency or drill/exercise. Examples could include an evaluation report, minutes from a debriefing session, or the AAR produced by the health department or a partner health department. 3. The health department must document its collaboration in revising emergency plans.<ul style="list-style-type: none">a. Documentation must include a collaborative review within the last two years of the All Hazards Emergency Operations Plan by those responsible for its implementation. This can be demonstrated by meeting agendas and minutes or attendance rosters.b. A contact list of respondents that has been updated within the last two years must be provided. This could be shown by presenting the most current contact list and demonstrating through minutes or previous listings that it has been updated.c. Coordination with emergency response partners includes the delineation of roles and responsibilities in the Emergency EOP and the various roles that partners play in responding to a public health emergency or hazard.d. A copy of the revised emergency operations plan must be provided to document the result of the work to maintain the plan and ensure that it is up-to-date and reflects current practice and information.

Standard 9.1: Use a performance management system to monitor achievement of organizational objectives.

Measure	Purpose	Significance
<p>9.1.3 A Use a process to determine and report on achievement of goals, objectives, and measures set by the performance management system</p>	<p>The purpose of this measure is to assess the health department's use of a continuous process to evaluate and report on achievement of the goals, objectives, and measures set by the performance management system.</p>	<p>Public health has long recognized the essential role evaluation plays in effectively managing practice and in producing desired results. Performance management uses a systematic process to evaluate organizational excellence by monitoring a set of selected indicators that can analyze progress toward achieving goals and objectives by specific dates.</p> <p>While numerous types of evaluation are used in public health practice, this measure focuses on the process that the health department designs, adapts and uses to formally examine progress toward achieving objectives and performance measures within time-framed targets.</p>

Required Documentation	Guidance
<ol style="list-style-type: none"> Written goals and objectives which include time frames for measurement Demonstration of a process for monitoring of performance of goals and objectives 	<ol style="list-style-type: none"> The health department must provide two examples that demonstrate implementation of the performance management system in monitoring and evaluating achievement of goals and objectives with the identified time frames. One example must be from a programmatic area and the other from an administrative area. These examples could be provided in narrative, table, or graphic form, depending on the chosen reporting method. The health department must demonstrate that actual performance towards the two objectives cited in 1) above was monitored. Evidence can come from run charts, dashboards, control

Measure 9.1.3 A, continued

Required Documentation	Guidance
<p>3. Demonstration of analysis of progress toward achieving goals and objectives, and identify areas in need of focused improvement processes</p> <p>4. Documentation of results and next steps</p>	<p>charts, flowcharts, histograms, data reports, monitoring logs, or other statistical tracking forms demonstrating analysis or progress in achieving measures. Also useful: statistical summaries and graphical presentations of performance on the measures, such as run charts, control charts, and meeting minutes from a quality team.</p> <p>3. The health department must provide evidence that actual performance of the two objectives identified in 1) above was analyzed according to the time frames. Evidence for determining opportunities for improvement can be shown through the use of tools and techniques, such as root cause analysis, cause and effect/Fishbone, force; or interrelationship digraphs or other analytical tools.</p> <p>4. The health department must provide evidence that actual performance results, opportunities for improvement, and next steps for the identified goals and corresponding objectives were documented and reported.</p>



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ACME County Health Department

AFTER ACTION REVIEW - Hot Wash Review Guide

Welcome and Introductions

Purpose and Ground Rules

1. The purpose of the After Action Review is to bring out insights, observations and questions to help identify and correct deficiencies or maintain strengths. It is used to determine what happened, why it happened and how to improve or sustain the response quality.
2. An After Action Review is a learning event, not a critique or a discussion about “the right answer”. Focus on working through the process.
3. An After Action Review does not grade success or failure. There are always weaknesses to improve upon and strengths to sustain. There is no single, unique, correct response to an incident.
4. Do not take comments personally.
5. Everyone has an equal say. Nobody, regardless of rank or strength of personality, has all the answers.
6. Please be prepared to participate. Everyone should have something to say.

Areas for Consideration/Target Capabilities

- Timeline of Events
- Command and Control
- Public Information and Communication
- Surveillance and Contact Investigation
- Lab Response/ Courier
- Medical Countermeasures/ Materials Distribution
- Non-Pharmaceutical Interventions/ Control Measures / Guidance
- Responder Health and Safety
- Public Health and Outside Partners Coordination
 - School Systems
 - Hospitals
 - Medical Providers
 - Dental Providers
 - Mental Health Providers

- Rest Home & Assisted Living Facilities
- Day Care Centers
- Hospice Home
- Training Needs

Questions for Discussion

- What went well? How do we maintain that?
- What were the challenges?
- What was supposed to happen (e.g. the Plan)? What actually happened?
- Why there were differences and what can we learn from that?
- How did agencies work together?
- Were there any safety issues?

Summary and Closing Comments

Preparation for the Written Report

Adopted May 19, 2009

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ACME COUNTY
EMERGENCY SERVICES
9-1-1

ACME COUNTY LEPC AGENDA

April 10, 2012

Welcome and Introductions

Topics

- **County EOP Update**
- Hazard Risk Analysis
- Medical Surge Components
- Essential Data Resources
- Special Needs Population
- Short-term Shelters (Communities)
- Citizen Corps
- Family Preparedness Training
- NIMS Training
- Disaster GIS
- Segmented Sheltering Concept
- Public Safety Sheltering
- Animal Concerns
- DOT Traffic Plan

Adjournment

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ACME COUNTY HEALTH CENTER

Public Health Emergency Operations: Response Plans and Standard Operating Guidelines



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This Document Contains Sensitive Information and is Not for Public Dissemination

This Plan is Exempt from Public Records
In Accordance With NC GS 132-1.7 A and 132-1.7 B

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NOTE: The full Manual is available upon request.

APPROVALS

The Public Health Emergency Operations: Response Plans and Standard Operating Guidelines

The Public Health Emergency Operations: Response Plans and Standard Operating Guidelines (SOG) have been:

Approved
or

Modified as noted

The Public Health Emergency Operations: Response Plans and Standard Operating Guidelines will be used by Acme County Health Center (ACHC) staff, first response personnel and support agencies to provide guidance for mitigation, preparedness, response, and recovery from public health emergencies impacting Acme County.

Approved by:

Beth Lovette 1/28/2008
Health Director Date

Approved by:

Beth Lovette 1/19/2009
Health Director Date

Approved by:

Beth Lovette 1/17/2010
Health Director Date

Approved by:

Beth Lovette 1/25/2011
Health Director Date

Acme County LEPC

June 18, 2012

10:00 PM – 12:00 PM

Human Services Center Conference Room

Attending:

Staff	Agency	Please sign in
Beth Lovette, Vice-Chair	Acme County Health Center	<i>Beth Lovette</i>
Charles Austin	Acme County Health Center	
Claire Batten	Acme County Health Center	
Edith Lawton	Acme County Health Center	<i>Edith Lawton</i>
Tammy Wynne	Acme County HR	<i>Tammy Wynne</i>
Janet Dunaway	Acme County DDS	<i>Janet Dunaway</i>
Dr. Bob Weave	Acme Memorial Hospital	Dr. Bob
Wayne Rascal	Acme Memorial Hospital	<i>Wayne Rascal</i>
Ellen Hamrick	Dotson City	Ellen Hamrick
Sheryl Duffy	Wilkeville City	<i>Sheryl Duffy</i>
Tony Jefferson, Chair	Acme EMS	
Scarlett Bode	Acme EMS	
Sandra Leeble	Acme EMS	<i>Sandra Leeble</i>
Brittan Wood	Dotson PD	<i>Brittan Wood</i>
Fred Flint	Wilkeville PD	Fred Flint
Evan Jonas	Dotson FD	Evan Jonas
Anna Script	Wilkeville FD	Anna Script
Patty Scales	Dotson Chamber of Comm	Patty Scales
Terry Canton	Dentist	Terry Canton
Maggie Mae	Acme Health Associates	Maggie Mae
Sam Sudoku	Acme County Schools	<i>Sam Sudoku</i>
Etta Burger	Acme House of Faith	<i>Etta Burger</i>
Tanya Teaching	Dotson Ministerial Assoc	<i>Tanya Teaching</i>
Ray Breeze	Sheriff's Department	<i>Ray Breeze</i>
Chad A. While	Animal Control	<i>Chad A. While</i>
Cherri Pitts	Ag Extension	

Vice-Chair Lovette moderated in Chair Jefferson's absence.

Welcome and Introductions

Beth Lovette

Ms. Lovette welcomed everyone to the meeting. Each person introduced themselves and the agency they represented.

Approval of March Minutes

All

The minutes were approved as emailed with one change. Fred Flint arrived late at the last meeting and did not sign in. He wanted to note that he did attend.

Local and Regional Program updates

All

Each organization present gave preparedness updates for their agency. Of significance is the hospital's infectious disease control nurse is retiring in December. The School System will be undergoing a re-write of their emergency operations plans based on new state guidelines. The new Health Department PIO will be Tommy Champion.

Review of the Acme County Emergency Operations Manual

All

The group went thru the recommended additions and revisions for each section of the manual. There was good discussion and edits made during the meeting. The recommended changes are attached.

Next Meeting: **June 18, 2012**

Human Services Center Conference Room

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ACME COUNTY
EMERGENCY SERVICES
9-1-1

MEMORANDUM

TO: Local Emergency Planning Committee Members

FROM: Randall Baxley, Director
Acme County Emergency Services

DATE: September 3, 2012

SUBJECT: LEPC Meeting

The next meeting of the Local Emergency Planning Committee is scheduled for Wednesday, September 12, 2012, at 10:00 am in the Human Services Center Building, Room 121 of the Workforce Development office, located at 468 Pine Street.

Members invited are:

Acme County Emergency Services
Acme County Health Department
Acme Memorial Hospital
Local Police and Fire Departments
Acme School System
Acme Sheriff's Department
Acme County Government
Acme County DSS
Local City Representatives
Business and Faith Representatives

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Desktop Drill Assessment Report

North Carolina 8-Ball Drill 4

Introduction

Thank you for participating in the February 2, 2012 Desktop Drill, assessing Avian Flu preparedness. We hope you have found it to be a rewarding experience, and one that will be useful in your future planning efforts. In an effort to help increase your level of preparedness, Joint Commission Resources has assessed your performance on this drill, and created the following evaluation of community preparedness.

This assessment is *not* a score-card of your state of readiness, nor is it a hazard vulnerability analysis. Instead, it is a systematic evaluation of your community's performance during *this* particular drill. Based upon the two hours that the emergency management community spent on-line during the drill, we have noted several trends that bear further discussion and training in your individual organizations.

Participants

JCR is committed to the notion that effective preparedness for disasters and catastrophes must include the participation of all community resources. As such, we are listing the organizations who participated in this drill below. During your preparedness discussions, we strongly encourage you to refer back to this list. Consider how each entity will be impacted by disasters, what they will need from their community, and what resources they might bring to bear to support your mission.

Thomasville Medical Center
Hugh Chatham Memorial Hospital
Wilkes County Health Department
Rowan County EMS
NC Baptist Hospital
High Point Regional Medical Center
Lexington Memorial Hospital
Davie County Health Department
Moses Cone Health System
Stokes-Reynolds Memorial Hospital
Forsyth Medical Center
Acme County Health Center
Acme County Community College
Davidson County Community College
Catawba County Public Health
NC Department of Agriculture
Iredell County EMS

Methodology

JCR consultants have assessed this desktop exercise by evaluating the emergency responses and performances of the participating organizations or agencies. This report is based upon their expert understanding of emergency preparedness. The information they used to draw their conclusions is based upon the actions and comments they observed during the two-hour drill.

This approach is necessarily limited. Most notably, some hospitals may only provide a portion of their complete answer, leading us to conclude that there are gaps in their knowledge where none exist. Any comments that suggest deficiencies should not imply that a community's plan is substandard. Instead, it

simply means that certain competencies were not in evidence during this particular drill, and *may* be a fertile area for additional training. However, we feel that there is value in scoring more rather than less rigorously. It is far better to highlight areas for improvement where little improvement is possible than ignoring areas for improvements where great gains still need to be made.

Areas of Preparation

Our drill focuses on four main areas of preparation: surge management, appropriate knowledge of personal protective equipment, communication, and incident command structure activation.

Drill Critique

During a two-hour session, the drill facilitator led the participants through the events associated with the disaster as they unrolled over a period of several months starting from initial reports of deaths of farm workers in SE Asia, to the initial occurrences of the illness in the USA, to the arrival of air passengers with flu-like illnesses to the area, to the inundation of sick patients presenting at local health care facilities, and finally the eventual decline in the number of new cases presenting.

The focus of this “blended learning” exercise was to build on, and improve, the existing preparedness level. The drill was critiqued by assessing the responses of key participants to questions posed by the facilitator. The critique focused on four components – Communication, Incident Command Structure, Surge Management and Infection Control. While the participants responded extremely well to the questions posed, the critique identifies “opportunities for improvement” - issues that could have been handled more effectively, were not adequately addressed during the drill or were raised during discussion and merit further consideration. Based on the issues identified for each component, examples of recommended best practices are presented.

Communication - Issues

A. Transfer of Information

The first information that there was a serious threat to the population of North Carolina arrived via a message from the Health Alert Network alerting hospitals to the newly identified ability of the virus to transmit person to person. This message arrived at 5.30 pm on a Friday afternoon when most personnel would have already left for the day. It was not clear what mechanisms would be in place to ensure efficient and timely transfer of this information to those individuals with responsibility for taking appropriate action.

B. Initial Communication

Several hospitals expressed uncertainty as to how the first information about the potential threat to the community population would reach them. Some participants seemed unfamiliar with the “Health Alert Network” (HAN).

C. Communication Networks

The importance of two-way communication (i.e. receiving and contributing) with formalized networks such as Joint Information Command - JIC, and Interstate Crisis Communication Enhancement Network - ICE Net, was not adequately addressed by the participants.

D. Media Communications

The events of this type of disaster would capture the intense interest of the media. However, the importance of developing and implementing a media plan, including the identification of public information officers at an early stage of the emergency and also of preparing these individuals to handle all types of media communications, was not identified until relatively late in the emergency drill. The participants were also uncertain as to the types of information that could be, or should be, shared with the public.

Communication – Best Practices

- Establish responsibilities for monitoring the Health Alert Network and other communication networks to ensure timely and effective transfer of information to the organization's leadership. Monitoring responsibilities should extend beyond normal working hours.
- Pursue "active" (e.g. via telephone calls or meetings at Incident Command Center) versus "passive" (e.g. via fax, media) means of communication whenever possible.
- Avoid reliance on any one method of communication e.g. media, telephone or email. Develop multiple methods for communication to maximize impact and effectiveness. Include back-up plans for communication technology during all types of disaster and consider the possibility of multiple events (e.g. a storm or flood occurring at the same time as a pandemic) that may severely limit the availability of communication mechanisms.
- Ensure two-way communication with local authorities and networks at all times by providing them with frequent updates on the situation at individual health facilities using "active" forms of communication whenever possible.
- Minimize miscommunication / misinformation by avoiding communication via informal contacts and by verification from multiple sources whenever possible.
- Develop a media plan and implement the plan at an early stage of the emergency. Require strict adherence to the plan by all (including physicians, staff, contractors and volunteers).
- Identify Public Information Officers as part of the media plan. Prepare / rehearse these authorized spokespersons and ensure that questions from the media are *always* referred to these individuals. Include arrangements for 24/7 coverage by authorized spokespersons.

- Address the need for increased security to deal with media attention.
- Establish links with federal and state and local agencies to promote a coordinated approach to public communications. Monitor and participate in formalized networks such as ICE Net and JIC.
- Utilize information gleaned from established communication networks to provide timely, regular, and well-structured statements to the media and to the public in order to dispel rumors and eliminate misinformation.
- Include communications to the public on agricultural issues such as interaction with farms and livestock and the preparation of pork and poultry for human consumption.
- Establish multiple mechanisms to communicate with patients, families and the general public e.g., prerecorded phone messages, written materials, frequent web site updates, and an on-site information center.
- Develop mechanisms to enlist the help of the general public in the prevention and control of this type of epidemic (e.g. campaigns on hand-washing, respiratory etiquette, avoidance of large public gatherings, and isolation).

Incident Command Structure - Issues

A. Monitoring of the Situation

Several organizations described the need to monitor the situation rather than activating the disaster plan during the early stages of the emergency. However, the utility of this period of time as an opportunity for the organization to review plans and begin preparations (e.g. notification of pharmacy and laboratory staff, improving stocks of PPE, “just in time training” for infection control, etc.) was not adequately described.

B. Activation of Disaster Plan

Participating hospitals varied in their responses as to when to activate the facility’s disaster plan and establish the command center in order to facilitate communication. Also, the role of the command center at different stages of the emergency and in relation to other essential functions including facility management, security, staffing, and supply of other resources was not adequately addressed.

C. Interface with School Systems

The importance of the public and private school systems in preventing the spread of the virus was mentioned during discussion. However, the mechanisms for communication and the decision process for school closures were unclear.

D. Security

Excellent participation by representatives of the police department highlighted the need for enhanced communication and collaboration with hospital security departments to identify how the police department could assist at the hospital campus with crowd control, traffic control, patrolling peripheral areas, as well as providing security for the transport of vaccines and antivirals.

Incident Command Structure – Best Practices

- While links to state and federal organizations are critical, the responsibility for managing the emergency is assumed at the local level.
- Each organization clearly understands the role of local, state and federal agencies (including law enforcement, EMS, Office of the Governor and Department of Public Health) in responding to this emergency.
- Incident Command staff is familiar with when and how to access help federal help (e.g. the Center for Disease Control – CDC - needs to be invited by the state to intervene).
- Staff is realistic about the availability of outside help during a widespread or national emergency and makes requests for assistance / supplies as early as possible. Back –up plans are developed in case requested help (e.g. a request for ventilator equipment) is not available in a timely manner
- The Incident Command Structure reflects a team of individuals including administrators, clinicians and engineers, with clearly defined roles and responsibilities relevant to all aspects of emergency management. The emergency preparedness plan allows for fluidity in membership of the team in reference to the type of disaster.
- Members of the incident command are provided with appropriate training in reference to their roles and responsibilities during different types of disasters including:
 - When to initiate the disaster plan
 - Internal and external communication mechanisms
 - Setting objectives and priorities
 - Surge capacity
 - Alternate care sites
 - Staffing issues
 - Access to resources
 - Dealing with the media
 - Security

- Staff is retrained on their roles and responsibilities in reference to the specific type of impending disaster faced by the organization as early as possible and at frequent intervals thereafter (i.e. “just in time” training). For influenza pandemic, retraining should emphasize characteristics of the illness, recognition of symptoms, isolation techniques, hand washing, and the use of PPE.
- The incident command team is familiar with all alternate care sites available to the facility and to the community at large. The team knows how to access them (e.g. mobile facilities available via EMS) including how to obtain any required local or state authority approvals.
- The incident command team is prepared to address all logistics issues associated with using alternate care sites including staffing, supplies, security, equipment, utilities, parking, patient tracking, transfer of patient records, transport, communication, etc.
- Security staff is increased to deal with issues including crowd control, media access, emergency room access, and transportation and distribution of vaccines and anti-viral drugs.
- Hospitals communicate and collaborate with local law enforcement to address security issues. Security staff is increased to deal with issues including crowd control, media access, emergency room access, and transportation and distribution of vaccines and anti-viral drugs.

Surge Management - Issues

A. Isolation Rooms

One hospital described their current and usual practice of assigning isolation rooms to all patients presenting with “flu like” symptoms. While the hospital should be commended for this excellent practice, it was evident that most hospitals (especially smaller hospitals) would not have a sufficient number of isolation rooms available to cope with the number of patients presenting during this epidemic.

B. Staffing

Hospitals expressed concern as to their ability to maintain adequate staffing levels in response to this type of emergency that would place staff directly at risk for exposure to the virus. However, discussion on staffing issues did not adequately address strategies to improve the willingness or ability of staff to come to work. Also, hospitals did not adequately address shortages of non-nursing staff including those essential to the minimization of infection control risks (e.g. housekeepers, facility management).

C. *Supplies*

The types and quantities of supplies (including Personal Protective Clothing, PPE), required to respond to this emergency, were not adequately explored during the drill.

D. *Alternate Care Sites*

The process to obtain approval for the use of alternate care sites was not well understood by the participants.

E. *Morgue Capacity*

The discussion did not adequately address the capacity for storage, burial, infection control issues, or associated religious or cultural issues, of the deceased in the event of a disaster with the potential for high mortality rates.

Surge Management – *Best Practices*

- Hospitals regularly assess facilities and capabilities for airborne isolation in the ED and the ICU, as well as in non-ICU settings. Updated information on isolation capacity is communicated to local and state health departments. Hospitals evaluate whether additional rooms or even entire units could be converted to negative pressure if needed. The ability to expand isolation capacity is considered for any new construction or expansion / renovation projects.
- During the emergency, function tests are performed daily for all negative pressure rooms including rooms / areas created as surge capacity (e.g. use smoke tests for newly created rooms).
- Hospitals clearly define and communicate their maximum surge capacity in reference to this type of disaster. Hospitals identify all potential alternate care sites including:
 - Unused areas of the hospital
 - Closed hospitals
 - Ambulatory care sites
 - Government buildings
 - Military facilities
 - Community, recreation centers
 - Schools, libraries, hotels
 - College dormitories
 - Halls, warehouses etc.
 - Sport stadiums
 - Tents, trailers
 - Mobile medical facilities
- The set-up of temporary triage areas outside of the hospital, but near to the ED, is considered in order to deal with a large influx of infectious patients while minimizing the

risk for infection of other patients and staff.

- In order to decrease parental anxiety and the potential for aggressive behavior, staff at triage areas are instructed to give priority to sick children whenever possible.
- All organizations ensure that each staff member completes a “Family Care Plan” detailing the needs of their family if they were unavailable to return home due to work responsibilities. Plans are developed to address the needs identified by staff (e.g. child/ senior adult care, banking, meals, transport, etc.).
- Hospitals plan for the potential of severe shortages in all staff categories including those providing support services (e.g. housekeepers, facility engineers, security, trans- porters, clerical, etc.).
- Organizations include provisions for psychosocial counseling for all staff during and after an emergency of this nature.
- Staff is well prepared and informed for this type of emergency through frequent training and regular updates on new and emerging illnesses.
- Timely distribution of available prophylaxis and protective equipment to staff for use at home is ensured.
- A list of essential supplies (e.g. oxygen, medications, PPE - including eye protection) and equipment (e.g. wheelchairs, stretchers, IV pumps, suction machines) is established. A 72-hour stand-alone capability for these supplies and equipment is maintained in storage or readily accessible.
- Vendor agreements are pre-established for essential supplies and equipment. Multiple (back-up) vendors are identified whenever possible.
- Local and state authorities are contacted at an early stage in the emergency to request supplies to be made available from the Strategic National Stockpile (SNS).
- Morgue capacity is established and communicated to local and state authorities. Plans for temporary morgues (e.g. refrigerated trucks) are developed. Strategies to comply with religious or cultural issues related to the deceased are developed

Infection Control - Issues

A. Diagnostic Tests

The mechanism to confirm incidences of the virus via rapid tests or cultures was not adequately addressed.

B. Personal Protective Equipment (PPE)

While the participants addressed the need to have additional supplies of PPE available, it was unclear whether there would be sufficient supplies (including eye protection) for this type of emergency.

C. Quarantine

There was discussion on the need, advisability and feasibility of implementing quarantine measures in an attempt to contain the epidemic. It was concluded that quarantine measures would be difficult to enforce and that strategies would need to be developed at an early stage of the emergency in order to be effective. As an alternative to quarantine, the participants were in favor of “voluntary” isolation, such as “snow days” for schools and businesses, and cancellation of large public gatherings. However, the process and identity of who would make these kinds of decision were not explored.

D. Distribution of Vaccine

Questions were raised as to how to prioritize who should receive the influenza vaccine once it becomes available. The importance of predetermining these priorities by means of well-defined protocols was stressed. However, the roles of the individual hospitals, and local, state (including the Governor) or federal authorities (including the Center for Disease Control - CDC) in these decisions were not clearly understood.

E. Ethics of Clinical Triage

Questions were raised on the ethics associated with decisions on who should receive scarce supplies of vaccine and antiviral medications. Several information resources on this topic were shared with the participants.

Infection Control – Best Practices

- Contacts are established via local, state health authorities and the CDC to determine the utility and availability of rapid diagnostic tests for detecting the virus strain. Staff is familiar with the process for sending lab samples to the appropriate entities for verification of the presence of the virus
- “Just in time” training of all staff on the use of PPE and other infection control measures is performed at an early stage of the emergency and at frequent intervals thereafter. The mandatory use of PPE is strictly enforced. Sufficient supplies of PPE including eye protection are made available.
- As early as possible, hospitals work together with local and state authorities to determine whether quarantine measures could contribute to containing the epidemic. The legal requirements and ramifications for imposing quarantine are fully investigated and understood. Other measures, including the cancellation of public events, and the use of “snow-days” for schools and businesses, are

encouraged in order to minimize exposure to the virus.

- Disaster plans are updated in reference to federal, state and local guidelines for established priorities for the distribution of available vaccines. Additional security when receiving, transporting and distributing vaccine is made available.

Summary

The participants are to be congratulated for their active participation in the drill, the challenging questions they presented, and the high level of knowledge and preparation they brought to the discussion.

The critique raised a variety of challenging issues including how hospitals are first alerted to the potential pandemic, when to activate the organization's disaster plan, how and what to communicate to the public, surge capacity in reference to isolation rooms and staffing, and the ethics of vaccine and antiviral distribution. Participating organizations should consider these issues as they review and revise their disaster plans.

Disaster plans should be tested repeatedly and leaders should consider a drill successful only if it identifies issues that could be improved on next time. Scenarios involving multiple disasters should challenge performance during disaster drills. For example, what would need to be considered if a severe storm or flood occurred at the same time as influenza pandemic? As occurred during this scenario, how would supplies of vaccines and antiviral drugs be delivered to hospitals when the one access road from the airport is blocked by a multiple vehicle accident caused by inclement weather? Even without a multiple disaster event, a major pandemic would deplete the community workforce dramatically and preparedness plans should consider the effects of potential disruptions in water, power, transportation, police, mail, trash collection, etc., caused by such a man- power shortage.

No disaster plan can be successful unless staff can rapidly and effectively assume their assigned role in an emergency. As disaster plans are tested and modified to include any new, potential threats as well as any improvements, staff training at all levels must be regularly and repeatedly reinforced.

Conclusion

We hope that this assessment has been useful. However, both the drill and assessment process can only have limited utility without further improvement efforts. To that end, we hope that you carefully consider the recommendations outlined above. Regardless of which recommendations you take, we also suggest that you perform the following two activities. These simple actions can make a great deal of difference in any potential disaster or catastrophe.

Meet with your community partners

Consider re-convening the community members that participated in this drill for a "lessons learned" conference. Using this report, consider how you can collaborate, communicate, and prepare better for future emergencies. The best way to do that is to bring together key

decision makers from each organization, along with members of the “front- line” staff, to discuss and share ideas and emergency plans. A well-rehearsed, comprehensive disaster plan is one key to success. Understanding the efforts, resources, and limitations of other agencies in your community can also greatly contribute to your success, especially if a disaster does not proceed as expected, and requires some measure of improvisation. In either event, meeting and sharing with other community entities and leaders will help your overall level of preparedness.

Share within your own organization

In many ways, developing an emergency plan is much easier than disseminating and instituting that plan. Getting “buy-in” from staff members requires more than a well-thought out plan. It requires keeping those staff members informed of the rationale for the plan, and—more importantly—taking their advice and suggestions into consideration. In order for the system to function effectively as a coherent unit, everyone must be on the same page. That requires sharing our successes and our failures. Sharing this report with staff members, and inviting their insights and suggestions for improvements is an excellent way to refine the plan and to increase your staff’s ownership of it.

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Acme County LEPC Meeting

September 12, 2012

Location: County Human Services Center Conference Room

Meeting Minutes

Meeting called to order at 10:00 am

Attendance sign-in sheet passed around

Welcome and Introductions

Minutes from June reviewed and adopted as presented

Old Business:

Reminder to the committee on reporting all releases. Release notifications need to be made to thru Acme County EMS and the County PIO.

New business:

Tab Q-7

Tab Q-7 Review Committee will need to review all Tab Q-7 plans. We need to set a date for the Tab Q-7 reviews in November. (November 12). The change number will be 021- 12-11. Highlight all changes on the CD for review. Will need one CD with no highlights and two hard copies (front and back with three-hole punch. Six Tab Q-7 plans are being presented to the general membership with a recommendation from the sub-committee that all six Tab Q-7 plans approved. We are waiting on approval from the NC ESO.

Regional Hazmat Update

No incidents in the past quarter. No other updates to report at this time.

Exercises

A review of the Regional SNS Exercise on July 26th was presented. Participants in the exercise were Allen Joyner, Beverly Landau, Justin Bailey, Charles Naismith and Ellen Miller.

County drills were last held in the spring in April. Those went very well. Fall drills are scheduled for next week on Monday, Tuesday and Wednesday.

Next Exercise

In early 2013 we will conduct a functional exercise. The EOC will be activated and all exercise activities will be conducted at the EOC. The alternate EOC will be

activated during the exercise. Each participating agency is to open their own departmental EOC as a part of the exercise.

NIMS compliance update

A review of the ICS class participants was presented. Almost all of the member agency's management teams have completed ICS. As folks complete, please remember to submit the names and records to the EMS office. The Health Department reported that they need to schedule another ICS 400 training. All Animal Control staff have completed IS-00011 (Animals in disaster)

Other

Discussions were held about LRS and checklist that is to be completed for PHRST 5. A site visit will be made by the County Preparedness Coordinator, Health Director and EMS Director at Human Service Center. Eleanor Beasley from PHRST 5 will assist as needed for this site visit.

Radio checks were performed on Monday, August 20, 2012 by Eddie Smith and Steve Simandle. No problems were noted for checks on this date. With the two previous checks there were problems with the ability of all sites to connect in and report. Steve Simandle is currently working on a presentation for county agencies on how to use the radio. This information will be provided at a future LEPC meeting.

Discussion was held about neighboring counties having potential outbreaks and what we should do here in ACME when this occurs. It was decided that when the health department EPI team meeting is called, members will be notified and information that is relative would be shared with the LEPC. It was brought to our attention that our local health department staff had been questioned about health concerns in Bowman county. Evidently this caused bottled water and catered lunches to be used in the school system for a couple of days. All agreed this was an overreaction and was not necessary.

Motion to adjourn was made and seconded by Marty Simpkins. Passed
Meeting ended at 11:39 am

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Memorandum of Understanding for Mutual Aid

This Memorandum of Understanding is entered into by and between the following health departments:

Acme County Health Center

AND

Appalachian District Health Department

AND

Bowman County Health Department

AND

Elkin County Health Department

AND

Franklin County Health Department

AND

Lowgap County Health Department

AND

Surry County Health and Nutrition Center

AND

Westfield County Health Department

The Organizations named above hereby acknowledge their intent to provide services and/ or resources to the other Organizations party to this agreement under the terms of this Mutual Aid Understanding.

This agreement is made and entered into upon signature of the Memorandum of Understanding by and between the above named health departments/ districts and will be activated when a localized public health need or public health emergency extend beyond the capacity and resources of a single organization.

WHEREAS, it is desirable that the public health resources of the departments party to this agreement are made available in cases of crisis or emergency to assist one another in preventing morbidity and mortality within the region;

WHEREAS, it is necessary and desirable that an appropriate agreement be executed for the interchange of such mutual aid;

NOW, THEREFORE, it is hereby agreed by and between each and all of the Organizations party to this agreement hereto as follows:

I. Organizations

The Organizations agree to the following:

1. It is hereby understood, unless otherwise required by law or other agreement of the Organizations, that all services and/ or resources provided under the terms of this

Memorandum of Understanding for Mutual Aid

Agreement are furnished and/ or supplied voluntarily and at the discretion of the Furnishing Organization.

2. The Furnishing Organization(s) shall have the primary interest of protecting the welfare of its own constituency and does not assume any responsibilities or liabilities in not providing resources and/or services to other parties of this agreement.
3. It is hereby understood that the agreements entered into hereunder shall not supplant existing mutual aid agreements nor deny the right of any party hereto to negotiate supplemental mutual aid agreements.
4. Allow use of its resources including staff, equipment, services, facilities, and grounds:
 - After meeting the Furnishing Organization's own responsibility requirements and upon request of the Borrowing Organization, the Furnishing Organization will permit to extent of the Organization's ability, the use of its staff, equipment, services, facilities, and grounds by the Borrowing Organization and other borrowed resources, within 12 hours of the request and for the time period being requested.
5. Each party to this agreement will maintain a current list of staff members who have agreed to be the point of contact during a public health emergency.
 - This list will be maintained within each Organization and updated with the Organization's PHRST (Public Health Regional Surveillance Team).
 - Each Organization will designate an individual and alternates (3-deep) who are authorized to allocate staff and resources upon receipt of mutual aid requests. Contacting one of these individuals should be possible 24 hours a day, 7 days a week.
6. When responding to a request for aid, the Borrowing Organization will be responsible for compensating the Furnishing Organization for replacing expended equipment and staff boarding unless arrangements to the contrary have been made between the Borrowing and Furnishing Organizations.
 - When funds are available through a federal or state declaration of emergency to reimburse an Organization's direct costs in support of emergency operations and shelter and feeding, costs are eligible for reimbursement. The Borrowing Organization will receive reimbursement through those channels first. The Borrowing Organization will closely monitor the reimbursement process to ensure the Furnishing Organization has been appropriately reimbursed for its financial obligation as agreed upon.
7. Staff provided by the Furnishing Organization will receive permission to respond from their agency and will remain employees of their Organization throughout the duration of the response. Supervision of the furnished employee, however, will be provided by the Borrowing Organization.
8. This agreement will be reviewed annually by all Organizations party to this agreement. Any Organization may withdraw after notifying the other parties to this agreement at least 90 days in advance.

II. Time of Performance

Memorandum of Understanding for Mutual Aid

This agreement shall be effective on January 1, 2010, or when all parties have signed, whichever is later. It shall be in effect until terminated by one or more members

III. Liability

- A. The Furnishing Organization employee is designated as a volunteer of the Borrowing Organization. All liability policies covering the Borrowing Organization, including but not limited to professional liability, tort liability, and premises liability, are applicable to the Furnishing Organization during the time under which he/she/it is acting as a Furnished resource.
- B. The Borrowing Organization shall be liable for any and all claims, demands, expenses, liabilities, and losses (including reasonable attorney's fees) as a result of incidents or damages to any Furnished resource which may arise out of any acts or failures to act, in connection with the public health crisis or emergency.
- C. Property damage not covered by any of the above conditions shall be the responsibility of the Borrowing Organization.

An Organization's participation in this Memorandum of Understanding may be terminated by any of the Organizations party to this agreement by giving written notice at least 90 days prior to the effective date of such termination.

The parties to the Agreement hereby agree to any and all provisions as stipulated above.

	Signed	Date
Acme County Health Center	<u>Beth Lovette</u>	<u>1-9-10</u>
Appalachian District Health Department	<u>Daniel King</u>	<u>12-28-2009</u>
Bowman County Health Department	<u>Donald Byrd</u>	<u>12-28-2009</u>
Elkin County Health Department	<u>Sandra Shelton</u>	<u>1-9-2010</u>
Franklin County Health Department	<u>Bill Grymes</u>	<u>01-09-10</u>
Lowgap County Health Department	<u>Matthew Easter</u>	<u>Jan 9, 2010</u>
Surry County Health and Nutrition Center	<u>Melissa Cooper</u>	<u>dec 28, 2009</u>
Westfield County Health Department	<u>Alex Martinez</u>	<u>1-9-10</u>

Memorandum of Understanding for Mutual Aid

IV. List of Terms

Borrower – the organization that is party to this agreement that receives services or resources from another party to this agreement in response to a request for mutual aid. For example, Wilkes County Health Department releases a communicable disease nurse to help Appalachian District Health Department in an infectious disease investigation in Boone. In this case Appalachian District Health Department would be the borrower.

Furnishing Organization – the organization that is party to this agreement that provides services or resources to another party to this agreement in response to a request for mutual aid. For example, Wilkes County Health Department releases a communicable disease nurse to help Appalachian District Health Department in an infectious disease investigation in Boone. In this case Wilkes County Health Department would be the furnisher.

Party to this agreement – Those Organizations that have signed this Memorandum of Understanding who have not terminated their participation in the agreement in writing beyond 90 days of the termination notice.

Public Health Emergency- any incident related to public health where the resources available to a party to this agreement, as determined by the health officer or their delegate, are insufficient to properly respond.

Public Health Resources - people or items that are owned or used in the routine function by any of the parties to this agreement. Examples of public health resources include staff time, computers, vehicles, vaccines, etc.

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Acme County LEPC Meeting

Acme County Health Center

Agenda

All Hazards and Emergency Operations Plan Review and Update

June 18, 2012

1. Communications Plans
 - a. Equipment additions
 - i. Training in use
 - b. Contact list and telephone trees
 - c. Forms and templates

2. Adjustments to EOP
 - a. Pandemic annex
 - b. Animal safety annex
 - c. Homebound annex
 - d. Central morgue annex

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Acme County Health Center Emergency Operations Plan

RECORD OF CHANGES

Date Made	Description of Change	Initials
Oct 2012	SNS, additional revisions based on review by staff	B. Keston
June 2012	Training requirements updated	B. Keston
Feb 2012	All Job Action Sheets revised based on county plan	B. Keston
Jan 2011	Reviewed reportable diseases and updated	J. Benny
Jan 2011	Annual review and update	J. Benny
Sept 2011	Updated Emergency Communications Plan	J. Benny
July 2011	Updated Community Partners List	J. Benny
May 2011	Emergency Communications Plan: Updated based on staff changes to telephone tree	S. Lavel
April 2011	Laboratory Response Plan - reviewed and updated	S. Lavel
March 2011	Updated Emergency Communications Plan	S. Lavel
Jan 2011	Updated Incident Command System section	S. Lavel
Jan 2011	Annual review and update	C. Chaplin
Nov 2010	Updated Emergency Communications Plan	C. Chaplin
Nov 2010	Major overhaul of plan in response to H1N1	C. Chaplin
March 2010	Updated Influenza Pandemic Response Plan	C. Chaplin

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Case Study - Possible Narratives for Measure 5.4.1 A



Note that these examples are for training purposes only and are not meant to represent actual narratives.

Example 1

The ACHC is very active in our preparedness efforts with other local government agencies. At least annually, we participate in a test with our partners to implement our All Hazards Emergency Operations Plan. Each exercise results in an evaluation reports. We also work closely with our partners to revise the emergency operation plan. We regularly review the plan and revise, as needed to keep it current. We also update our contact list with each revision and review roles of all partners.

Example 2

We have provided documentation to show that we take very seriously the need to be ready to respond to any emergency. Our department and our partners collaborate frequently to ensure that we can address any hazard that needs a response. Our documentation demonstrates that we test our plan, develop and share an AAR and then revise the plan, along with partners.

Example 3

The documentation demonstrates consistent involvement by other local governmental partners. The All Hazards EOP used by the department is revised annually. We meet quarterly with all partners to talk about preparedness issues and roles and to plan our exercises. We have two annual exercises and at least one is co-sponsored by the state. They also participate in all our exercises and drills. An AAR is produced by our Emergency Services Department in the County.

Example 4

The documentation demonstrates consistent involvement by other local governmental partners, in planning and in exercises. The latest copy of our plan is submitted, with documentation showing the process we used to evaluate and revise the plan. The two exercises included are from 2012 and the report includes the elements of the plan tested, the results and the recommendations that were incorporated into the revised plan. The contact list, with assigned responsibilities, is also reviewed annually and is updated as soon as a change is made.

Acme County Health Center

QI/PI Team Meeting Notes

January 11th, 2012

1:00-3:00 pm

Team Member Present: *Ginger Bowman, Jan Eller, Sherry Gammons, Jean Reddington, Susan Ricketts, Verona Mabry, David Derby, and Sam Booker*

Material Distributed: *PowerPoint presentation handout regarding QI*

- 1- Audits (Charts & Billing)
 - a. Standardize Chart Audits
 - i. How are they chart pulled
 - ii. % of records reviewed
 - iii. How often are they done
 - b. Local Programs that will need to develop new tools: Adult Health
 - c. Our group will need to review audit finding
 - i. Review all results – determine measurable outcomes
 - ii. What do we do about problems
 - iii. Are there any trends
- 2- Customer Satisfaction Surveys
 - a. Survey Schedule
 - b. Agency vs departmental
- 3- Orientation for Staff-- Competency check list for all disciplines
- 4- New policy dissemination to staff
- 5- On-going QI
 - a. Service delivery
 - i. How efficient are we?
 - ii. Are staff happy?
 - iii. Look at staff side/customer side to increase efficiency as well as customer satisfaction
 - iv. Workforce development – staff education
- 6- Things to do at the Next Meeting:
 - a. Define roles & responsibilities of staff
 - i. Team Leader (Coordinator)- Jan or Sherry??
 1. Set agenda
 2. Administer meetings -Place, time, tools
 3. Ensures that whatever gets done
 4. Oversees assignments
 5. Focuses team
 6. Models good leadership
 7. Good communication & CQI skills

- ii. Team Sponsor- David
 - 1. Defines resources
 - 2. Reviews process and outcomes and final decision of team recommendations
- iii. Facilitator- Gay/Lynn
 - 1. Help set up team
 - 2. Look at our data
 - 3. Coaching
- iv. Scribe (Jeanna & Sam)
 - 1. Takes minutes
 - 2. Distribute minutes to members
 - 3. Summary and decisions made
 - 4. Assists in prep of letters and reports
- v. Team Members
 - 1. Participate in formal /informal training
 - 2. Attend all meetings
 - 3. Complete assignments between meetings
 - 4. Contribute expertise
 - 5. Listen to other ideas
 - 6. Apply knowledge and skills to whatever we are working on
- vi. Time Keeper (David Brown)
 - 1. Meeting has begun on time
 - 2. Meeting follows agenda
- vii. Rules Keeper
 - 1. Keeps team on task
 - 2. Fouls - items that you are stuck on
- b. What does David expect of us?
- c. Complaint log
 - i. Develop measurement tools for each process
 - ii. How can we tell if things are improving

7- Ground Rules

- a. Process Oriented/Focused
- b. Positive Attitude
- c. Be Prepared - do assignments (allowed rarely-not being prepared)
- d. Confidentiality
- e. Active Participation of All Members

8- Committee Values/Ethics

- a. Honesty
- b. Dedication
- c. Perseverance
- d. Commitment
- e. Courtesy

9- Task Assignments:

- a. Jan & Sherry- Roles and responsibilities from David and additional members
- b. Verona- Gathering of tools currently used for chart audits
- c. Sam - Customer satisfaction survey schedule currently used
- d. Jan - email workforce plan, orientation, and complaint process policy to team
- e. Everyone - look at your areas of service delivery system

10- Goals:

- a. Clear outcomes for meeting
- b. Agenda with defined process to reach outcomes
- c. Effective dialogue and feedback
- d. Start and ending time
- e. Evaluate how we met those goals
- f. Make decision about how often we evaluate ourselves
- g. Set date for next meeting

11- NEXT MEETING →

- a. January 29th Conference call (duration of 30 minutes) after lunch for Jan, Sherry and Gay only
- b. February 12th at 1-3pm in the main conference room For ALL of TEAM

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AGENDA
Acme County Health Center
Quality Improvement & Performance Improvement Team
March 19, 2012 1:00 to 3:00 pm

1:00 PM – 1:15 PM

Welcome/Call to Order

Team/Program Expectations – Beth Lovette

Review of Ground Rules and Committee Values/Ethics

Approval of Minute Notes from January

1:15 PM – 2:30 PM

Old Business

Member Update and Terms

Appointment of a Rules Keeper

Assignments

Verona – Audit Tools

Samantha – Customer Surveys

Competency Tools

Service Delivery

2:30 PM – 3:00 PM

New Business

Policies Update

Complaints

Evaluation of Team

Set a Meeting Schedule

Other

Adjournment

Acme County Health Center

QI/PI TEAM

Minutes from 3/19/07

Attending:

Jan Eller
Sam Booker
Jean Reddington
Sherry Gammons

Verona Mabry
Kim Whitaker
Teresa Smith
Ginger Bowman

Susan Miller
David C Derby

David Stone – *Sponsor*

Beth Lovette – Team Expectations

- Coordinate paper process that governs us
- Issues that need more attention (example: en. health cases going to court)
- Personnel dealings – policies, expectations for positions, and disciplines clearly lined out (example: varicella requirements)
- Process for employee issues (probation, etc.)
- ACHC setting the standard for policies, procedures, manuals
 - Getting rid of things not necessary
 - Putting quality processes into place
 - Goal is to make things easier

Central Clearinghouse for QA, policies, etc.

- Ensure things are done properly and don't cause problems

* Will report to staff in December.

1. Introduction

- QI in-service for all staff in March complete
- Ground Rules – Jan made each member a laminated copy as personal reminders.
- Approval of Minutes – Discussed January minutes and clarified “fouls”. Susan Rhodes moved to approve. David made a second. Minutes were approved.

2. OLD BUSINESS

Member update and terms

- Discussed 2-3 year terms.
- Updated policy re: language surrounding members.
- Update re: Jan's role.

- All members send e-mail to Jan regarding whether you'll serve 2 or 3 year term.

Rules Keeper Appointment

* Verona reminds everyone of what the rules are.

Assignments

A. Verona – Audit tools

1. QIT made a list of all tools and how of ten each clinic uses, and requirements.
2. Need standardized sampling method (% possibly, no #).
3. Jan and Susan attempted billing audit with a less than favorable outcome.
4. Consultant to bring state form and train QIT to complete audit.
5. Consultant to do billing audit sample will return to train.
6. Overall chart audit needed? Gaye says not now.
7. Need to gather sampling information from programs – Gaye to provide guidance.
8. Evidence collection of required compliance.

B. Sam – Customer Surveys

1. QIT made a list of survey tools collected.
2. Some survey tools have not been turned in.
3. Agreement Addendas need to be reviewed for survey requirements.

Competency tools – staff knows it is coming. Need workgroups started.

Service delivery: trouble with computer clocks during time change (discussed).

Label problems – to be addressed at next QIT meeting (Susan to lead)

* Let Jan know if other things arise for agenda next month.

* Susan states – watch for trends re: issues. Team can catch before it becomes an issue.

NEW BUSINESS

QI Success

1. Policies update – issue to be reviewed at management team meeting; policy on policies to be reviewed, QIT added as a step in policy.
2. Complaints – complaint logs to be gathered quarterly. To be reviewed by Jan, then brought to team.

“3 Formal Written Complaints”

- Animal Control (poor customer service)
- Interpreter (co-worker complaint “rudeness”)
- Animal Control (procedure not followed)

* Reports from outside auditors; Jan has 3 to share at next meeting.

Evaluation of Team

- Team needs to rate QIT.
- Tasks and complete date; process (good, fair, etc.)
- Jan to work on tool to evaluate goals met.

Set a Meeting Schedule

- Policy says quarterly
- Need says monthly
- 1st of month, 1-3 Monday
- Next meeting May 7th, 1-3 p.m.
- Also put June 4th on schedule

Audit Tools

SCHNC

1. CSC – state - every 3 months (required yearly)
2. HV for postnatal assess – state - 2x a year (required yearly)
3. HV for newborn care – state - 2x a year (required yearly)
4. MOW – state – every 3 months (required yearly)
5. MCC – state – every 6 months (required yearly)
6. Home Health Risk Management: Audits / internal – quarterly (required quarterly)
7. Home Health – state – quarterly (required quarterly)
8. Home Health Adverse – state – monthly (required quarterly)
9. CAP Services – internal – quarterly (required quarterly)
10. Pediatrics – state – annually (required annually)
11. Comm. Disease (STD/TB) – state – annually (required annually)
12. Family Planning – state – annually (required annually)
(2 new, 2 return, 10 total)
13. WIC/Nutrition – state – quarterly (required annually)
14. Health Education Program Review – state – annually – process evaluation

Need to Develop

- Home Health Billing Audit
 - Environmental Health – 2 tools for audits (permit/inspections and food/lodging)
15. Dental – working on tool (not required)
 16. PCC – working on tool (not required)
 17. Lab – state – quarterly (by consultant)
 18. Environmental Health – draft permit audit created monthly vs. quarterly being discussed. Food and lodging draft being created as well – internal (none required)
 19. Diabetes – informal – internal tool (audit required on every chart by ADA)

20. Health Check – no information, no response to request
21. Immunizations – did not request – to follow up

Customer Surveys

1. Home Health (required) x 3: Admission (packet), Discharge (mailed), Physician
2. Agency – wide created by Brooke Worsley – Eng/Span (done once)
3. MCC – as they were closing (required)
4. CSC – open clients
5. WIC/Nutrition – Bf survey at 8-10 months of age (random for WIC – 1x per year)
6. Peds-
7. Exit survey for staff
8. County considering county wide – internal satisfaction survey
9. Evaluation tool for new employee orientation

Brainstorm

- Frequency of audits (required vs. agency-wide)
- Sample size
- Sampling method
- Billing audit
- Outside person involved in each audit

Homework

Audits – Verona and Supervisors

- Sampling guidance from programs
- Evidence collection of required compliance and individual processes for dealing & results
- Copy the Director on e-mail requests
- Jan to remind management team to comply with requests

Customer Surveys (Sam)

- Finish collecting surveys after supervisors are prodded to cooperate
- Each supervisor to check their Agreement Addendas for survey requirements (Jan will remind)

Competency Tools (Susan)

- Look for competency tools in individual programs, bring to next meeting.

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Acme County Health Center

2012 Quality Improvement and Performance Improvement Objectives

Adopted by Leadership Team on December 12, 2011, as recommended by the QI/PI Team

Administrative

By December 31, 2012:

- Cross train at least two staff to serve as back-ups for each admin function and process
- 100 of supervisors will a) receive training on monthly budget reports, including accounts payable and receivable; and b) will review monthly reports for accuracy and/or action
- The department will have the capability to accept credit/debit payments for 75% of fees and services.

Programmatic

By December 31, 2012:

- 100% of Food and Lodging Inspection Reports (from 2010 to present) will be available for viewing on the department website.
- 95% of all notifications, reports and required submission to the State Department of Public Health will be completed by the stated deadline.
- Animal Control will work with community partners to place or adopt 30% of cats and dogs surrendered or picked up.

Clinical

By December 31, 2012:

- The department will meet or exceed a customer satisfaction rating of 90% in all clinical programs.
- The immunization clinic will maintain 100% coverage from 8:00 until 5:30 each day the department is open, including during lunch hours.
- The dental program will add 5 insurance carriers to the current roster.

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Selections from the Acme County Health Center Performance Improvement Plan

312.1 Monitoring and Documenting Process

Departmental program performance reviews are conducted every 4-6 months with representation from each program division. The current state audit tool will be utilized to review a designated number of charts from each clinical program. These charts will be reviewed for program requirements and compliance with local policies (approved abbreviations, error correction, chart order etc.). Strengths, problems and recommendations will be added to the audit too.

A designated nursing supervisor for each program will serve as administrative leader and provide follow up and clarification for program guidelines. Audit results will be tallied, corrective action will be based on identified that fall below the desirable percentage. Audit results and minutes will be prepared by the administrative leader of each program within 30 days following the audit. The results will be sent to each member of the audit team, each nursing supervisor and the health director. The lead nurse in each program will be responsible to inform appropriate staff of strengths, and corrective action plan. Corrective action plan will includes problem, timeline and method of corrective action. The lead nurse and designated staff responsible for items requiring corrective action will perform an in county audit three months (90days) after the audit. The follow up review will be shared with the QI/PI Team who will develop an updated corrective action plan. Both corrective action plans will be reviewed at the next scheduled audit.

One meeting for each program will include program policy review and review of current contract addendum.

103.4 Defining Strategic Public Health Issues

A strategic public health issue is a significant question or concern about prevention of disease, provision of basic health services, or protection of environment that may impact the character or direction of the organization.

It should meet the following four criteria:

1. Have organization-wide significance
2. Can be clearly defined and communicated
3. Will have definite negative consequences if not addressed
4. Has a reasonable chance of being addressed successfully

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Acme County Health Center

Leadership Team Meeting

November 29, 2012

Agenda

Full Group

1. Personnel Issues - Carol/Jan
 - Telephone etiquette policy
 - FLMA & COBRA
2. Finance Issues - Chuck
3. Accomplishments/Achievements
4. Revisions & Updates to the PI Plan
5. General
 - Web updates
 - 2013 staff meetings
 - Travel prior approvals
 - Holiday lunches
 - Annual Report material

Round Robin – Judy, Lori & Health Promotion POD

Core Team

1. New Board of Health Members
2. State Health Director's meeting update
3. PH Task Force 2013
4. Possible grant sources
5. New Preparedness Team members
6. Organizational changes

Round Robin

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Acme County Health Center

Leadership Team Meeting

November 27, 2010

Agenda

Full Group

1. Personnel Issues - Carol/Jan
2. Finance Issues - Chuck
3. Accomplishments/Achievements
4. Performance Job Descriptions
5. General
 - Accreditation
 - Complaint Logs
 - Sign off on policies and manuals
 - County Holiday Lunch Numbers
 - Smoking within 50 ft. of Building
 - Speaking of smoking – fire alarm status
 - Epi/Preparedness Team contact info updates

Round Robin – Judy, Lori & Health Promotion

Core Team

1. Board of Health Report
2. Health Director's Meeting Report
3. QIT Report
4. Strategic Planning - January
5. Other??

Round Robin

Acme County Health Center

Leadership Team Meeting
Minutes for November 27, 2010

Full Group

1. Personnel Issues – If you have any items that need to be filed in Personnel Files, get those in as soon as possible.
2. Finance Issues - Teresa raised concern over who gets county printouts from MUNIS. Names for private pay are listed on revenue. Only county finance and specific departments get printouts. County finance is aware that names are not to be released, though county finance transactions are public record. Jan will reaffirm with them not to release publicly any finance records with client/patient names.
3. Accomplishments/Achievements
Animal Shelton Adoption Center dedication today - Nov. 27
Successful monitoring of Women's/Child Health programs this year
Accreditation preparation is coming along
4. There was discussion to clarify “ongoing education” in the county personal policies – especially in regards to tuition reimbursement, which must come from our own program budgets. This pertains to lifelong learning and not necessarily formal education, which is a part of this. Employees are expected to be up to date on standards of practice related to their positions. This will now be incorporated into job descriptions and evaluations and is titled the Performance Evaluation Job Description System. Carol will be checking with County Personnel about where to place this in the County Personnel Ordinance, since it will only apply to the health department. The guidance from the state is still in draft form and we should get the final packet of info sometime in January. This will be an addition to our PI Plan and the intent of the new system is to build performance improvement into each job type.
5. General
 - Accreditation – discussion of last minute items
 - Complaint Logs – A form from May 2008 was redistributed along with the investigation form from the recently approved policy. Programs may have their own complaint logs or individuals may use a phone log. The key is to be sure that complaints/concerns are tracked and resolved. The complaint resolution form is to be used in those situations that involved investigation and a more in depth record. All records are forwarded to the QIT.
 - Sign off on policies and manuals – will need doing on Tuesday.

- County Holiday Lunch Numbers need to be submitted by Dec. 8th. The menu will be a Turkey dinner. The meal will be served on the 21st. We will close from 12:00 to 2:00. Senior Services will handle the phone. Also programs and work units are planning lunches also. For these, any time beyond the lunch hour must be leave time.
- Smoking within 50 ft. of Building – We have staff not adhering to this. Please let your folks know that smoking is prohibited around our building. We are a tobacco free facility (includes chewing). This is for all ACHC offices. There should not be any tobacco use inside the buildings.
- Angie sent an email that our fire alarm is currently out of service. It is to be repaired next week. Until done, remember that any fire/evacuation situation would require use of the paging system to alert staff.
- The Epi/Preparedness Team contact list was circulated for updates.

Round Robin – Judy, Lori & Brooke

Judy – Fileroom being worked on to get organized. Flu clinic is still up and running

Lori – Will conduct a training for the CA network on Friday at the HSC. Will be in Bowman County next Tuesday to conduct training for ESC on Healthcheck, will conduct training in Acme County on Wednesday. ADRC chronic care project underway.

Brooke – Kristy reported 10 restaurants participated in smoke free dining days. Working with Acme Schools on smoke free issues. Worked with a health fair at ACC. Brian awarded six mini-grants thru the diabetes today program. Celena will take over the SCC tobacco free program when she returns from leave. She will also work with data collection for the restaurant heart survey. Brooke discussed the CHA, we know have the final report and awaiting the EH report. Workgroup convened and will be working on childhood obesity, diabetes, aging, & heart diseases. These four link with four of the top five concerns of the report.

Core Team

1. Board of Health Report – Summary of agenda from November meeting
2. Health Director's Meeting Report
3. QIT Report – Sherry gave an update on the first meeting. Next meeting is scheduled for January
4. Strategic Planning – At the January L-Team meeting, we will begin the first of our quarterly reviews of the plan
5. Other??
 - Flu vaccine is still available. We have about 3000 doses. Remember that we are closed for immunes from 11:30 to 1:00

- Next employee recognition for longevity will be held on Dec. 18th at the Commissioner's meeting. Employees who will be recognized will receive a letter from Sandy.
- An update from the IOG regarding serving immigrant clients was discussed. The document was emailed to M-Team members.
- Reminder to look over the MOA draft with Crossroads. Beth will email again to those affected for review.

Round Robin

Deborah – CNA and CMA on board and doing well. Going to dental clinic in Bowman on Dec. 5th and going to see operatories at Bowman Tech. Looking at fees and excessive balances. Finishing up obtaining NPI for May deadline. Numbers are up in clinic – running above each month last year. Looking at patient mix in dental (child vs. adult).

Jan – nothing more to add

Brian – Having an adoption fair on January 13th. Will want to do some advertising. Seeking grant money for spay/neutering (ouch).

Sherry – Lisa doing well. She and Tisha will be trained by Kelly. Meeting with Acme OB on Dec 5th. Sherry is doing chart review for billing. State issued CSC forms that will contain all info needed for documentation purposes. After holidays, will be working on concerns raised during community review.

Susan – continuing issue of encounters not being submitted timely. QA is needed for Primary care. This will be forwarded to the QI/PI Team.

Sylvia – Accreditation, Accreditation, Accreditation, Accreditation. And then there was flu. Also will be participating in meningococcal vaccines to high school seniors in spring.

Teresa – Billboard for ADRC up in Dotson near Lighthouse restaurant.

Johnny – nothing from him either.

Sam – Will be helping with Go for the Green healthy holiday eating (this after the big taco salad lunch). Will be held Dec 7th at HCS and Dec 20th at Gov't center. Also working on one for judicial center. Kelly and Sam are going to a Diabetes conference on Dec 12. Ruth will be holding a cultural awareness training surrounding food habits for WIC/Nutrition on Dec 15th. All are invited.

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Acme County Health Center

2012 Quality Improvement and Performance Improvement Objectives

Administrative objective - By December 31, 2012, Cross train at least two staff to serve as back-ups for each admin function and process							
Admin Function	Currently Trained	Back-up 1	Back-up 2	Function Lead	Start Date	Complete Date	Results/Comments
Front Desk	Charles Austin Claire Batten	Janet Dunaway	Tammy Wynne	Jan	Jan 1	Feb 1	
Eligibility	Anna Script Patty Scales	Scarlett Bode		Deborah	Jan 15 Oct 15	March 10 On-going	Back-up 2 resigned effective Oct 10
Patient Check-in	Etta Burger Brittan Wood	Sheryl Duffy	Scarlett Bode	Deborah	Jan 15	March 10	Probably will need one more trained
Patient History	Maggie Mae Tanya Teaching	Ellen Hamrick	Wayne Rascal	Deborah	Jan 15	March 10	
Collections	Colleen Catching Cherri Pitts	Fred Flint	Brenda Drillin	Susan	Feb 1	May	
Daily Deposit	Brenda Drillin Cherri Pitts	Chad A. While	Ray Breeze	Susan	Feb 1	Mar 1	
Mail	Nancy Needle	Jack Rabbit	Ellen Hamrick	Jan	Feb 1	Feb 12	
Central Supply	Arlene Cooke	Tom Pressure	Sandra Leeble	Jan	Feb 15	Apr 1	
Travel & Expense Reimbursement	Pete Moss	Biff Stew	Tony Jefferson	Jan	Mar 1	May	

Performance Improvement Plan

2011 Revisions

Performance Improvement is to be an ongoing process at the Acme County Health Center with primary responsibility resting with the Health Director and Leadership Team based upon recommendations of the QI/PI Team. This document will be reviewed quarterly at Leadership Team meetings and may be revised/updated at any time. The document will be reviewed with all staff and the Board of Health. Reports will be shared with the Board of Health two times a year. At that time, local health status data and information can be used to set and/or update goals and objectives.

We acknowledge that ensuring the ten essential functions of public health, as we attempt to do in our performance improvement plan, requires a collaborative community approach. This is present throughout the work that we do at ACHC every day, and is also reflected in this plan.

Diabetes Management

- 1) Work with Diabetes collaborative
 - i) Effective as of: FY 2009- 2010
 - 2) Examine Sustainability
 - i) Effective as of : January - June 2010 **Renew application for ADA in mid 2011.**
 - 3) Increase numbers/reach out to more in community
 - i) Effective as of: August 2009 - ongoing
 - 4) Maintain relationship with NW Medical Partners **get a list of other new partners from Sam/Kelly**
 - i) Effective as of: August 2009 – ongoing
- Responsible Party: Sylvia & Samantha & Kelly

- Diabetes- has increased the number of programs we offer 1- DM Classes 2- Community Classes, & 3- DM Support Group.
- No longer with NWMP-have sites, in Elkin, Mt Airy, and 2 in Mt Airy in which our services are offered

Adult Health

- 1) Maintain program at current level **Received Komen Grant for 2010-11.**
 - i) Effective as of: August 2009 – Ongoing – Agreement addendum

Adult Primary Care **Restructuring of Clinic for 10-11.**

- 1) Sustainability with revenue/increase revenue
 - i) Effective as of: January – June 2010
- 2) Medical director on site
 - a) 40 hrs/week
 - i) Effective as of: September 1, 2009

- 3) Establish productivity expectations
 - i) Effective as of: Phase 1 – August 2009
Phase 2 – Wellness Ctr. June 2010
- 4) Collaboration on patient care among clinics (avoid turf wars)
 - i) Effective as of: Ongoing

Jail Health Look at staffing issues and to implement changes to benefit both parties of SCHND & Sheriff.

- 1) Work with Sheriff's office to improve acceptance of HC staff to treat patients
 - i) Effective as of: Ongoing – as per November election
- 2) Access for jail health
 - i) Effective as of: January 2010

Health Education/ Tobacco

- 1) More Community Presentations
 - a) Goal of # of Presentations (Tobacco has done 8 presentations this fiscal year as of 12-01).
 - b) Civil Groups, churches and schools Coordinator presented to: a 4-H group on 10/9, the Children's center on 10/16, SADD students at SCHS on 11/15, SADD students on 10/21 at CMS, Surry County Board of Education on 2/5 about 100% TFS, Way Station in Dotson about dangers of smoking on 2/16, Way Station about spit tobacco use and dangers on 2/23, and Acme Schools Board of Education along with youth on 3/23 about 100% Tobacco Free Schools.
 - c) Responding to request of Speakers 6 out of the 8 were requested; the two to the Boards of Education were not.
 - d) Business Community
 - i) Effective as of : September 1, 2009
Responsible Party: Selena & Thomas
- 2) Process for Responding
 - i) Effective as of : September 1, 2009
Responsible Party: Selena & Thomas
- 3) Successful Recertification of H. Car
 - a) Application & Documentation
 - b) Evidence of Community Involvement
 - i) Effective as of : April/ June 2010- 2nd quarter
Responsible Party: Brooke
- 4) Define better Internal Group Structure
 - a) Coordination/ linkage with each other and other programs
 - i) Effective as of : January 1, 2010
Responsible Party: Management Team
- 5) Assess effectiveness of role of school health educator
 - a) Implement Health Foundation Funding
 - i) Effective as of : October 2009

- 6) Implementation & follow-up to CHA
 - a) Waiting on draft report(9/09)
 - i) Effective as of : After December 2009- Ongoing
 - ii) Responsible Party: Management Team & Brooke
 - b) Assess CHA results for correlation to Strategic Plan
 - i) Effective as of : January 2010 - Ongoing
- 7) Assess improvements in county health indicators as Strategic Plan and CHA are implemented
 - a) Determine baseline data
 - b) Determine follow-up parameters and goals
 - i) Effective as of : After December 2009

Family Care Coordination

- 1) FCC
 - a) Customer Service Survey **CSC & MCC surveys done in Fall 11 w no neg comments**
 - i) Develop Instrument & Process For Doing & For Use of Data
 - ii) Audit in October **CSC audit was very positive, no conditions**
 - iii) Outcome = Increase Case Loads & Better Service
 - (1) Effective as of : October 2009
Responsible Party: Sherry & Jeanna **We are very close to starting a waiting list. Referrals have increased significantly**
- 2) Outreach to Community
 - a) Visiting MD offices
- 3) Policy Development
 - a) Update Book in Prep. For Accreditation
 - i) Effective as of : October 2009 to November 29, 2009
Responsible Party: Sherry
- 4) FCC Promotion to DSS
 - a) Staff Turnover at DSS
 - i) Effective as of : January 1, 2009
Responsible Party: Sherry **Some of the DSS staff continue to be a problem, others work very well with us. Several complaints have been given to Mr. Black recently because some of his staff are not properly doing their jobs. This is not something that will be settled any time soon. We seem to take one step forward and fall back two.**
- 5) CSC
 - a) Increase non-Medicaid #'s for Contract Agreement Addendum
 - b) Partner with WIC Regarding non-Medicaid referrals
 - i) Referrals from WIC to CSC
 - (1) Effective as of : Ongoing
Responsible Party: CSC & WIC & Samantha & Jeanna
 - c) Outreach to MD Offices & OB Floors **Outreach done at Dotson OB in December. Office established there in January.**
 - i) One time per year & follow-up calls **Will plan to do this in spring**
 - (1) Link with community resource data ??
 - ii) Develop a system to maintain contacts → Carolina Access

- CSS & WIC have had several meetings to discuss the referral process b/t the two programs
- Continue to make/discuss about referral during the monthly Pediatric Rounds Meeting

- Letter of invitation have been mailed to DSS and other local agencies to increase participation in Pediatric Rounds Meeting

- (1) Effective as of : January of each Year **Not sure what we were thinking with this one. Send to QI/PI Team to determine and revise.**
Responsible Party: Sherry
- d) Establish better report with Surry County Physicians
 - i) Out reach/ Communication/ Lunch Meetings
Responsible Party: Sherry
- e) Strengthen Pediatric Rounds/ FCC Attend & Help Rebuild
 - i) Effective as of : Ongoing Monthly **FCC continues to participate in Peds Rounds**
Responsible Party: Sam & Jeanna
- 6) Monitor Case load to create Opportunity for a new Position
 - i) November- December **Client case loads are almost full. However, billing does not support having another staff member.**
 - ii) Annual Monitoring
 - iii) Effective as of : Budget Process Begins in January
Responsible Party: Sherry

MCC

- 1) Hire staff for Vacant Positions **Vacancy filled Lisa is doing great, caseload is building. Having a strong full time person in MCC feeds into all the other programs and increases their client base**
 - i) August 2009 – Ongoing
Responsible Party: Sherry
- 2) Increase case loads (meet needs/ Increase Revenue) **Ongoing and increasing with new staff**
 - i) Effective as of : January
Responsible Party: Sherry
- 3) Start Second Office in Dotson OBGYN **Established Jan 11**
 - i) Effective as of : September to October 2010
Responsible Party: Sherry
- 4) New Documentation Training for new employees (Evaluate System)
 - i) Effective as of : January **This has been done**
Responsible Party: Sherry

MOW

- 1) Continue WIC Outreach
 - a) Referrals/ Dropouts **Outreach continues to be a problem.**
 - i) Effective as of : August 2009 & Ongoing
Responsible Party: Tisha
- 2) Improve Documentation (training) **This has been done. Documentation problems resolving. Case load increasing due to referrals by new staff**
 - i) Effective as of : By January 2010
Responsible Party: Sherry & Tisha

PPNB

- 1) Include Staff in Pediatric Rounds

- a) WIC updates **Attendance at all meetings**
 - i) Effective as of : September 2009- Ongoing
Responsible Party: Karen & MCC Staff
- 2) WIC Support
 - a) Training Nurses in WIC Documentation **This has been done**
 - i) Effective as of : September 2009 – Ongoing
Responsible Party: Karen & MCC Staff
- 3) Increase Home Visits **Home visits have doubled-they have waiting list**
 - a) Collaboration with Hospitals **Susan making weekly trips to HCMH and our referrals have increased; gradually seeing more referrals from Forsyth**
 - b) Forsyth & Hugh Chatham
 - c) Training on how to get your foot in the Door ??
 - d) Improve Information Sharing with Hospitals
 - i) Effective as of : Ongoing
Responsible Party: Sherry & Karen

- CSS & WIC have had several meetings to discuss the referral process b/t the two programs
- Continue to make/discuss about referral during the monthly Pediatric Rounds Meeting

WIC

- 1) Strengthen Education with FCC & Ped Staff
 - a) 2 way referrals **New in house referral form developed for WIC staff to use for MCC referrals**
 - i) Effective as of : August 2009 & ongoing
Responsible Party: Sam & Sherry
- 2) Strengthen Pediatric Rounds (Multi-Disciplinary Team) (See above box)
 - i) Effective as of: September 2009
Responsible Party: Sam
- 3) Staff Orientation & Dev.
 - a) Policies (HC & WIC) **WIC Policies Updated**
 - b) Nutrition Education **On-going nutrition education session for the entire staff. At least 2 to 3 times per month**
 - i) Effective as of: September 2009
Responsible Party: Sam
- 4) Meeting WIC Program Guidelines (from WIC Audit) **Met**
 - a) Focus on Documentation
 - i) Effective as of: September 2010
Responsible Party: Sam
- 5) Improve / Enhance Community Partnerships – **Letter and meeting have been implemented with much success. Continue**
 - a) Some weak links(Dr.'s offices, DSS, Others)
 - i) Effective as of: January 2010
Responsible Party: Sam
- 6) Strengthen Breast Feeding Program
 - a) Education & Train Staff – **Brenda has IBCLC, Brandi goes to training in April**
 - b) Community Support- **Support Group to start in May; Perfect Start to start in April**
 - c) Restart Aspects of Program Dropped - **Met**
 - d) Reestablish ties with MD offices – **3 Week outreach efforts completed**
 - i) Effective as of Spring 2010
Responsible Party: Sam & Staff

- 7) Bits and Bites Program/ Healthy Families
 - a) Initiate New Program- **completed**
 - b) Clarify Rules and Tasks- **Completed as much as possible continues to improve**
 - c) How to mesh with WIC(connection)
 - i) Effective as of: October 2009 & ongoing
Responsible Party: **Sam & Carmen**
- 8) Nutrition & Winner Circle –**Did not receive grant**
 - a) Applied for grant working with SCC
 - b) SCC Cafeteria Manager – **WC to be implemented through school system nutritionist**
 - c) Get Students Involved – **Completed over 20 classes worth of education (approx 20+ students each class)**
 - i) Effective as of: Fall 2009
Responsible Party: **Sam**
- 9) Increase Involvement with Community
 - a) Schools * Diabetes Program = Determine what exists now (**Kelly has done program with the schools –need is great**)
 - b) Diabetes – Add value with Nutrition Component (**Worked with Surry County Schools list of CHO in menu is now on line for parents to see**)
 - i) Effective as of: Ongoing
Responsible Party: **Sam & Sylvia & Kelly**

Environmental Health Plan (Separate Plan)

Effective as of: FY 2009-2010

Responsible Party: David & Env. Health

New Supervisor in October

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Acme County Health Center

QI Storyboard

The Acme County Health Department is located at

856 Hambry Street
Dotson, NC 27617

The building is situated in the downtown area. The Acme County Health Center has 34 employees.

Quality Improvement / Performance Improvement Team members are:

Beth Lovette
Charles Austin
Claire Batten
Edith Lawton
Ellen Hamrick

Sheryl Duffy
Tony Jefferson
Brittan Wood
Patty Scales
Candy Kane

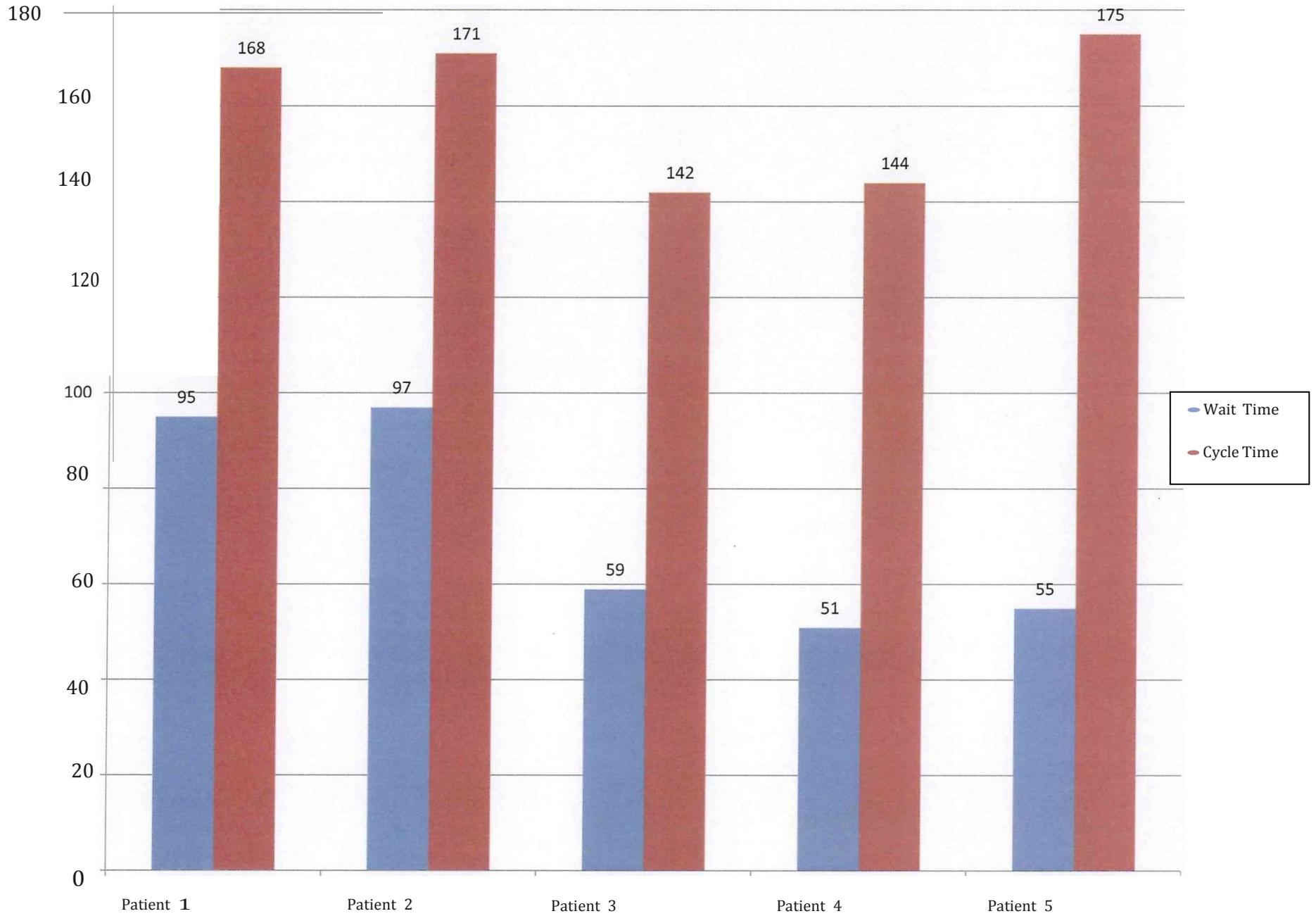


ACHC Aim Statement

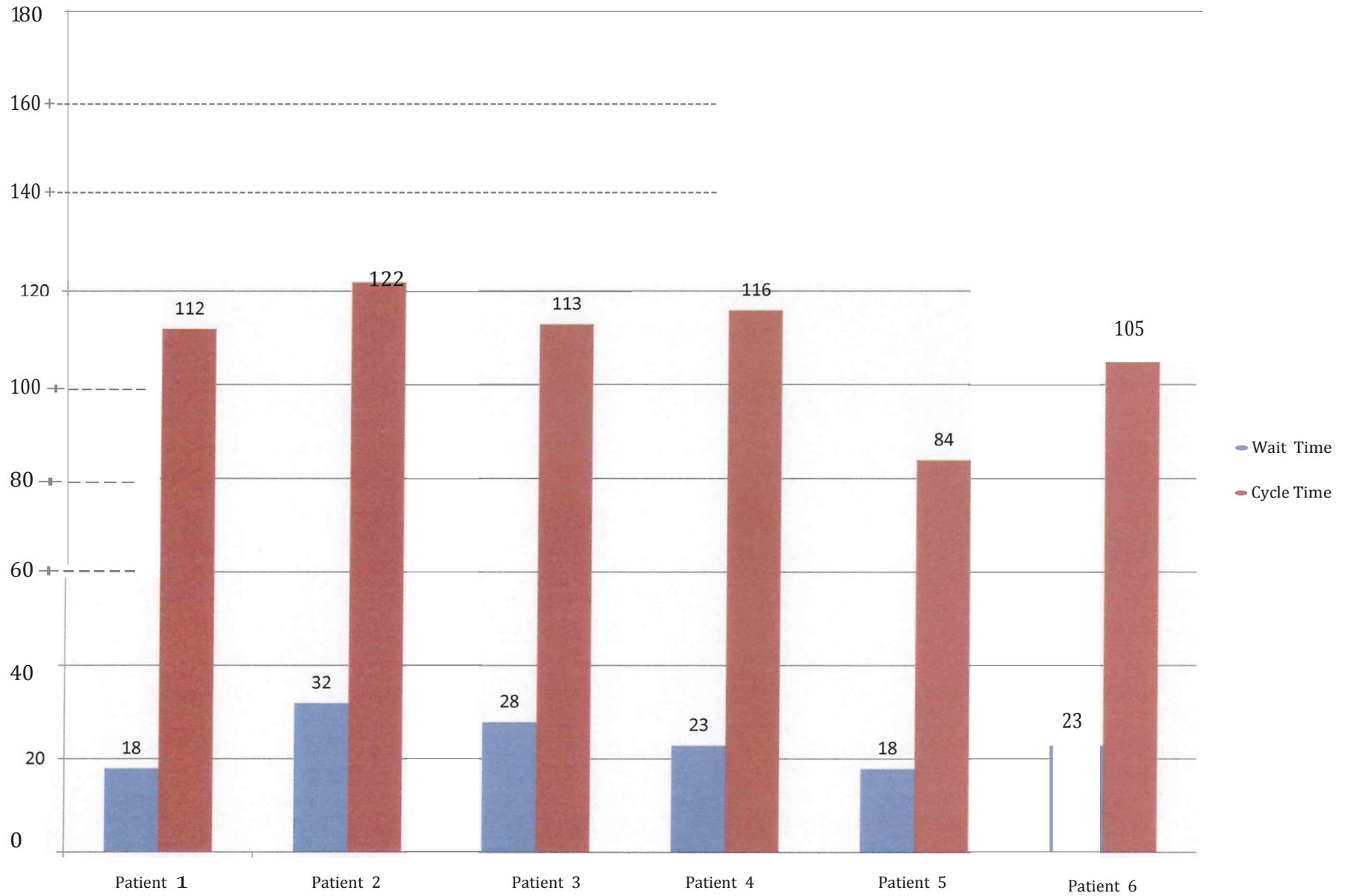
We aim to reduce the amount of time that new/annual WIC clients are in the health department by 50%. We will accomplish this by December 31, 2011. This is important because we want to increase client satisfaction, decrease cost to the agency, and improve staff productivity therefore increasing the number of clients seen per day. We will achieve this by monitoring the clinic, conducting time and motion studies, completing observational walks, examining data collected and implementing changes where we can. Our specific goals include:

- >-Decrease total cycle time by 50% from 2.6 hours to 1.3 hours.
- >-Improve client/clinic flow by decreasing movement between stations by 50%.
- >-Improve overall client satisfaction to 90% from baseline.

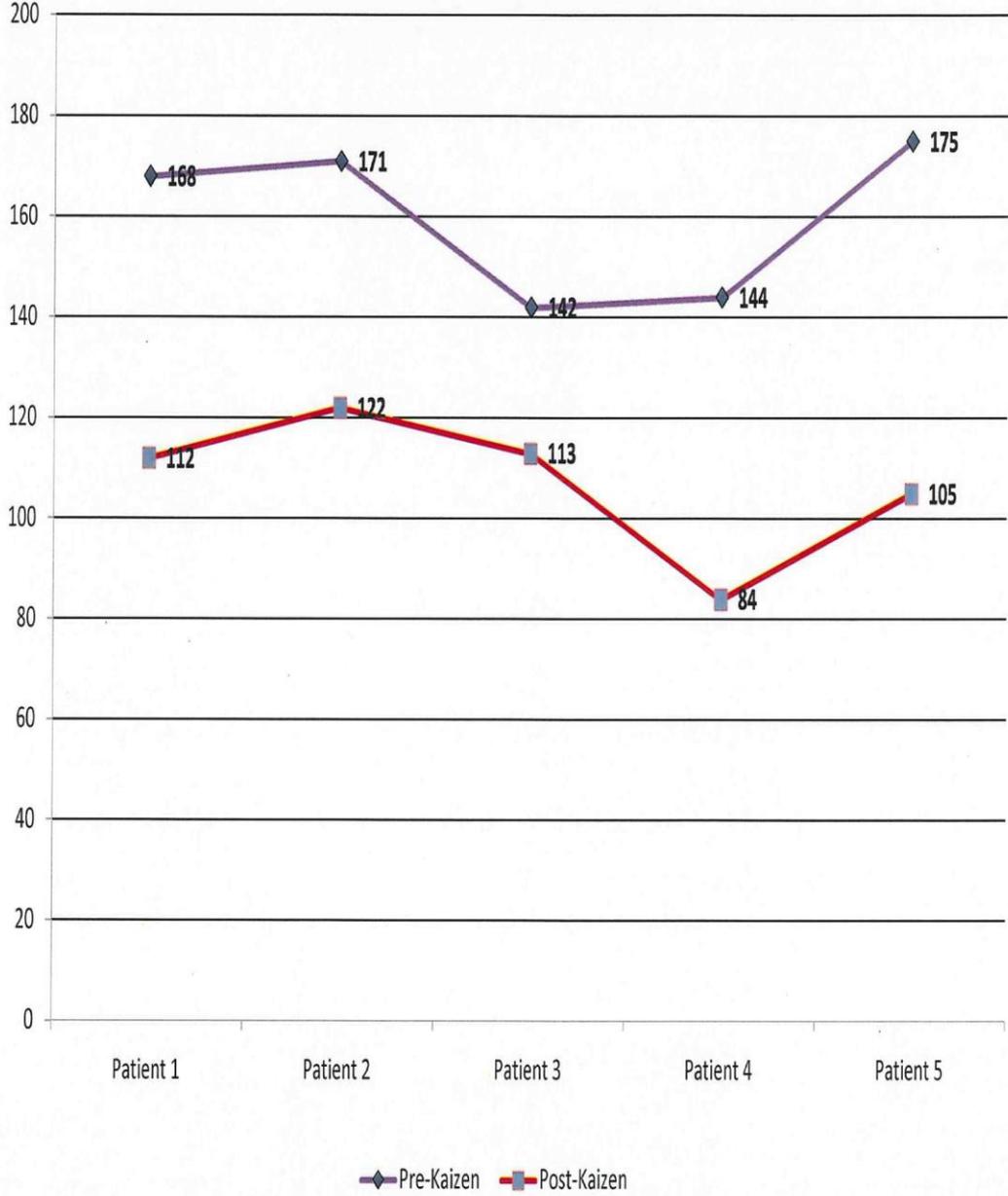
WIC Cycle Times Pre-Kaizen Event



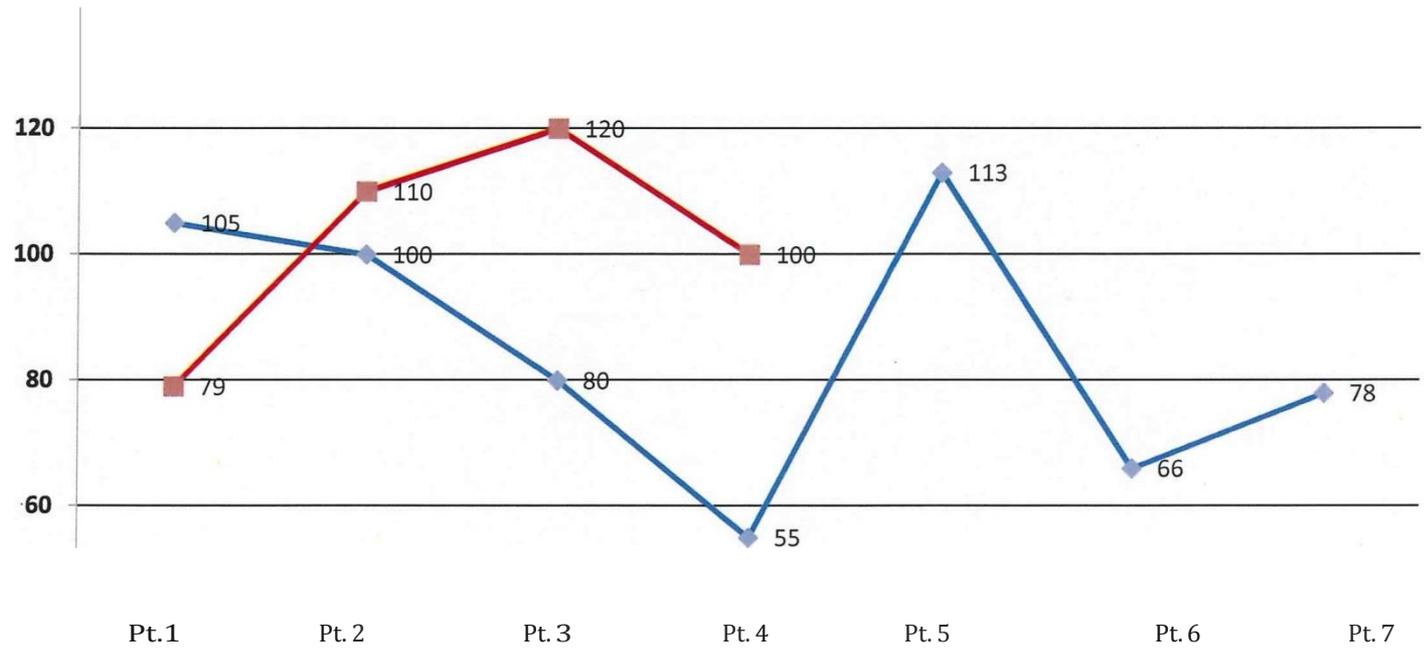
WIC Cycle Times From Kaizen Event



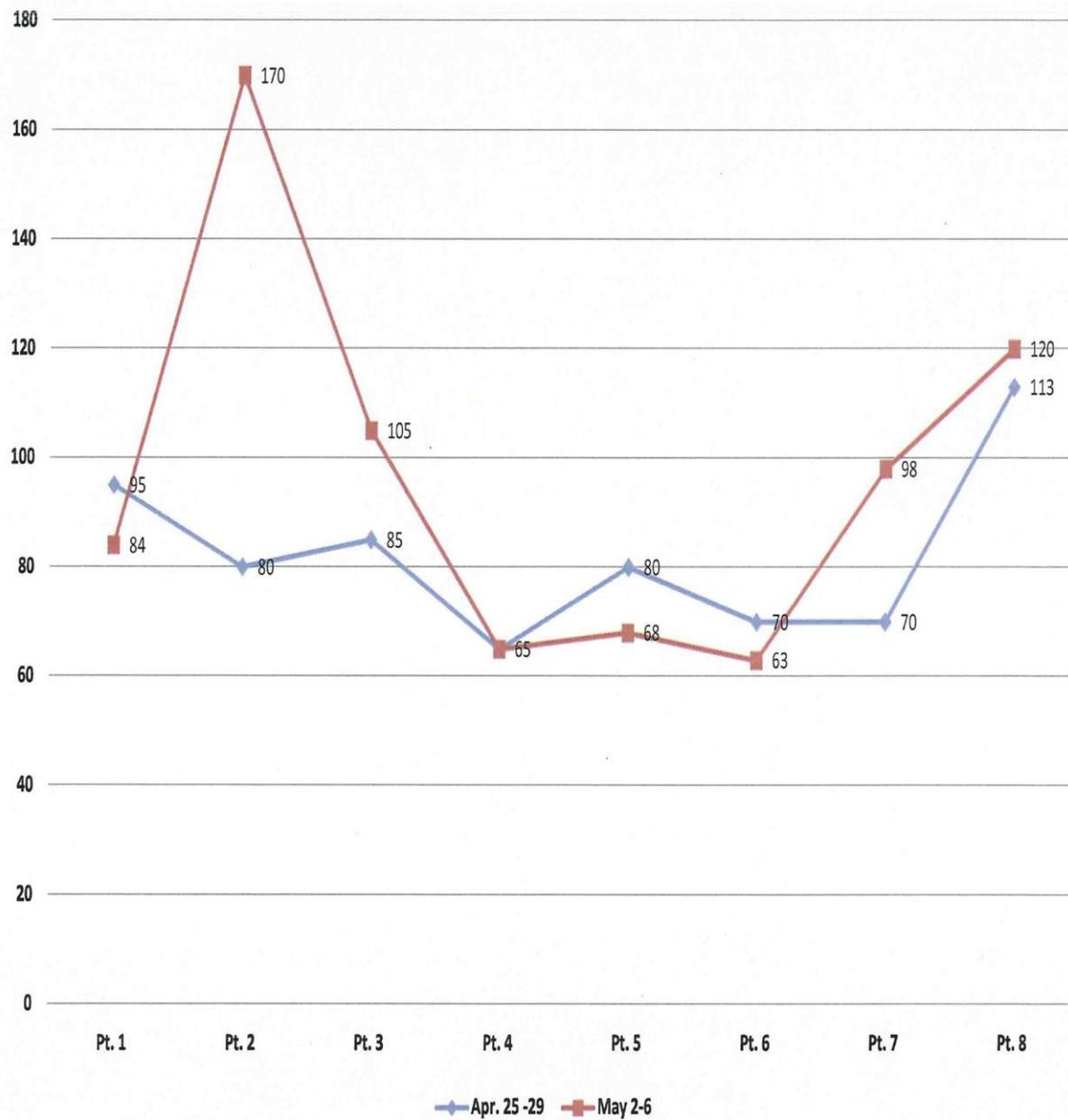
WIC New/Annual Patient Cycle Times Pre-Kaizen and Post-Kaizen



WIC New/Annual Patient Cycle Times



April 4-8 April 11-15



WIC New/Annual Cycle Times

Our Ah HA Moment

Our biggest "Aha" Moment would have to be:

What if we flexible in how we proceeded through the appointment with the order when the lab work, education and client was seen by the provider?



Challenges We Overcame:

Our own internal attitudes

Fear of staff and supervisors

Having to keep to a traditional and set appointment order

“We’ve always done it this way”

“It’s not my job”

“I don’t have time”

Our Advice to Others:

Don't be afraid of real change

Involve everyone!

Keep the customer in mind

Always think QI

Look at everything as being able to be improved

Set deadlines

What's Ahead for QI/PI at ACHC?

- Continue to monitor progress with the current QI/PI project through 12/31/12
- Continue to discuss QI/PI at each staff meeting
- Continue to solicit staff input on QI/PI storyboards posted throughout the health department
- Already thinking about a new project in clinic services (probably Maternity Clinic)
- A separate QI/PI project team will be formed for the next initiative, already talking to potential team members
- A new project was started in the Primary Care Clinic in April, looking at diabetic clients and best practice to control blood sugars
- By year-end 2012 have each department within the Health Center working on a QI/PI project

NOTE: This document is for training purposes only and does not represent actual documentation, nor is it indicative that similar documentation would be accepted or rejected by site visitors.

Case Study - Possible Narratives for Measure 9.1.3 A



Example 1

We have provided two examples that show how we are implementing and achieving our PI goals. We have analyzed the results and have made revisions and improvements as a result.

Example 2

The ACHC believes strongly in PI and in improving the way we serve our residents. This evidence shows that we are a quality organization and take seriously our responsibility to continuously seek performance and quality improvement.

Example 3

We have chosen our billing consolidation project and the Environmental Health On-Site Waste Water permitting process as our examples. Using LEAN principles and balanced scorecards, we demonstrate the implementation and success of quality improvement in these two programs. We migrated from program collections to a central collections & billing system and increased revenue by 32%. We had a three month backlog in Environmental Health that was reduced to less than two weeks, better responding to the needs of homeowners.

Example 4

We provided two examples that show implementation of our performance management system in monitoring and evaluating achievement of our objectives and time frames. One example was programmatic and one was administrative. The documents show that performance objectives were appropriately monitored and analyzed according to the stated time frames. We also report performance results, opportunities for improvement we found, and next steps that we will take.

Note that these examples are for training purposes only and are not meant to represent actual narratives.



DOCUMENT ASSESSMENT CHECK SHEET

Measure _____

1. What document is present to demonstrate conformity with the measure?

Document Title _____

File Name _____

2. How does the document demonstrate conformity to the measure?

Does it have what the measure requires to be in the documentation? Yes No

If not, what's missing? _____

Does it fit with the guidance? Yes No

Is it reasonable and appropriate? Yes No

Is the required elements flagged or highlighted? Yes No

3. What does the evidence say to a reviewer?

Does it meet the intent? Yes No

Is it appropriate based on the guidance? Yes No

File Description _____

Measure Narrative _____

4. In what way would the evidence be assessed?

How does it meet requirements? Fully Largely Slightly Not (Demonstrated)

What are areas of strength? _____

What are the areas of weakness? _____