

Spokane Regional Health District 2011 Quality Improvement Plan



Prepared by the Quality Council: December 2007

Implemented: January 2008

Reviewed and revised: December 2008, December 2009, December 2010, August 2011

Purpose and Scope

- A. **Quality Improvement** is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization.¹
- B. **Vision:** The Quality Council (QC) will aid in creating, implementing, maintaining, and evaluating the quality improvement (QI) efforts at Spokane Regional Health District (SRHD) with the intent to improve the level of performance.

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

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

I. Reporting Structure

(See Appendix B: Communication Flow Chart)

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

A. Quality Council

The Administrator has charged the QC with carrying out the purpose and scope of quality improvement efforts at Spokane Regional Health District. The QC consists of cross-sectional representatives from executive management, program managers, and line staff, as well as two members from each division. In addition, the agency HIPAA officer and program evaluation staff are on the QC. Ad hoc members will be solicited via open recruitment and given six month temporary rotations on the Council. Less than half of the council membership can rotate off of the committee each year to maintain continuity. Co-chairs will be selected by the QC for a two year term with a staggered rotation. One co-chair must be an Executive Team member. Administrative support will be available through one of the members on the QC. The QC meets on a regular basis and maintains records and minutes of all meetings. Team norms will be followed by QC. QI documents will be centralized for access by others.

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

¹ Performance Management Glossary, Public Health Improvement Partnership, 2007

B. Board of Health

The BOH receives a report annually on health data with recommended actions for health policy decisions (Standard 1.3.3L); progress toward program goals (Standard 9.1.8L); recommendations based on after-action reviews (Standard 9.1.8L); and other QI efforts. Board members may be asked to attend and participate in meetings.

C. Staff and Administrative Support

Staff and administrative support is responsible for:

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

D. Program Managers

Managers are responsible for:

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

E. Division Directors

Directors are responsible for:

1. Reporting to the QC on logic model results, selected outcome measures, program evaluation efforts, QI projects (BPA, RCI), audit results (if applicable), customer service evaluation, public health state standard gaps, and QI training needed
2. Identifying and selecting up to two areas needing improvement to bring to the QC as priorities annually (see Section V for how to select two areas)
3. Assuring implementation of QI projects

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

F. Executive Team

The Executive Team will be notified of the QC's activities periodically and hear recommendations for revision to the QI plan annually. Through the Strategic Plan Review, Agency logic model review, and as needs are observed, the Team will forward recommended QI initiatives to the QC to incorporate into the QI Plan. The Executive Team will work with the QC regarding interdivisional or agency-wide QI projects.

II. Approval of QI Plan and Annual Evaluation

The QC will annually review and make suggested revisions to this QI Plan. When reviewing, the QC will work to maintain alignment with *Spokane Counts*, Washington State Public Health Standards, statewide indicators, and national QI efforts. A report summarizing the review process, findings, and suggested modifications will be submitted to the Executive Team for approval no later than January 15th of each year. Subsequent to Executive Team approval, the revised Plan will be provided to the Board of Health in January for their information.

III. Quality Improvement Efforts

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

A. Customer Service

All employees with job functions that require interactions with the general public, stakeholders, and partners will receive appropriate customer service training. Training needs will be identified by the program evaluator and program managers and reported to their director. Customer service training for appropriate staff will be periodically offered by Human Resources or other applicable resources. Training attendance should be documented electronically to verify staff participation and to produce aggregate reports. If training is provided by Human Resources, documentation of attendance will be kept by HR staff. (Standard A1.2B)

Customer service satisfaction will be evaluated at program and service levels, and periodically rolled up at the agency level, to assure customer service standards are met. Providers and coalitions should also be evaluated to ensure that SRHD is meeting the customers' needs. Division reports will include results from program and/or service satisfaction surveys. A core set of questions will be used by all customer service surveys. Community Health Assessment staff will assist program staff in developing and implementing surveys. (Standard 9.1.6B)

B. Evaluation for Agency Divisions and Programs

Evaluation is defined as the systematic application of social (or scientific) research procedures for assessing the conceptualization, design, implementation, and utility of SRHD services. It will consist of creating a logic model for each program and division in the agency, creating effective data collection tools to measure each of the impact and population outcomes, reviewing data with staff on an annual basis, updating the logic models or other framework, and reporting on the outcomes to the division director. Staff and program managers are responsible for conducting evaluation. . Findings will be used to inform planning and QI efforts. (Standards A2.2.3B, A2.2B, 3.1.3B, 9.2.1B)

C. HIPAA Compliance

Issues surrounding HIPAA policies, confidentiality, data sharing, security, and records retention will be evaluated and reported to the QC by the HIPAA/Quality Assurance Coordinator. (Standard A1.2B)

D. Improvement Plans from After Action Reviews

After Action Reviews are conducted after preparedness exercises, epidemiologic outbreaks, or other public health events. An improvement plan is created after identifying issues. Primary findings and major improvements will be reported to the QC within 30 days after completion of the improvement plan when impacting 2 or more divisions. (Standard 1.2.1B, 2.2.3B)

E. Strategic Plan Review

The SRHD Strategic Plan includes objectives around assessment activities, use of health data to make program and policy decisions, After Action Review issues, and prevention priorities. The Strategic Plan goals, objectives, and performance measures will be reviewed periodically by the Executive Team with recommendations for QI activities reported to the QC. From the Strategic Planning review of local health data (including the State's core Public Health Indicators, *Spokane Counts*, access indicators, and other data) and the Plan's goals, objectives, and performance measures, recommendations for quality improvement efforts will be reported to the QC. (Standard 5.2B, 5.2.1B, 5.2.2B, 5.2.3B, 5.2.4B, 5.3.1B, 9.2.1B)

F. Washington State Standards Review and Public Health Accreditation Evaluation

Every three years, SRHD is evaluated by independent consultants on our level of compliance with the Washington State Public Health Standards. Division directors, program managers, and program staff are responsible for meeting the Standards that apply to their programs. Programs are selected for evaluation, and documentation is provided demonstrating the level of compliance. Each Standard measure is scored with a value for either fully, partially, or not meeting the requirements. A report is generated from the scoring mechanism, which compares local health jurisdictions across Washington and individually as an agency, with recommendations for improvements. The report is shared with Executive Team, Joint Management, Board of Health, program staff and the Quality Council. The Quality Council will continually review and discuss both the Standards and the movement towards Public Health Accreditation, making recommendations to the Executive Team. Organizational inefficiencies, identified by standards review, will be reported to QC.

(See Appendix C: 2011 Quality Council Reporting Calendar)

IV. 2011 Selected Quality Improvement Projects

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

The QC will monitor up to 15 quality improvement projects at any one time. From each of the Division Reports to the QC (annually in March), up to two prioritized quality improvement areas from each division will be selected for monitoring and assessment of improvement within an established timeframe not to exceed a year. The QI Project Form and the Progress Report Form will be used for reporting to the QC, with improvement objectives selected prior to the meeting. If areas are selected by the QC, program managers or other appropriate staff will be asked to fill out the form and return it to the QC. A Quality Improvement Projects Log will be kept by the QC. The QC will use both forms to monitor work and schedule reports.

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

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

V. Communication Plan

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

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

Formal recognition of staff who have completed QI projects will be considered by the Council annually. Recognition may include 'In the Loop' updates, storyboard displays, presentations to the Board of Health (BOH), presentations at Quality Council meetings, or for local, regional, state, or national awards and conferences. Twice a year, completed QI projects for each division or reporting body will be made into storyboards and posted around SRHD. There will be up to 5 projects posted at a time to enable showing all projects without overwhelming the viewer. (9.2.1 A h)

VI. Training Plan

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

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

Division-wide training-Each year divisions report their QI training needs to the quality council. Division trainings are created to meet these identified needs. Trainings will be held on data analysis, logic models, program evaluation, quality improvement methods (RCI, BPA, survey development, etc.), and the Public Health Standards for SRHD staff. The PH Standards describe the measures around program evaluation, quality improvement, and data-driven decision-making that result in program and policy changes.

QI workshops- Workshops are held twice a month and are open to all staff and community partners to attend. There are no set training objectives and staff is welcome to bring their questions, concerns, and ideas to the workshops.

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

(Standard 9.2.1A d)

VII. Evaluation

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

VIII. References

- A. *Performance Management Glossary, Public Health Improvement Partnership - 2007*
- B. *Standards for Public Health in Washington State – January 2007*
- C. *Standards for Accreditation of Managed Behavioral Healthcare Organizations. National Committee for Quality Assurance.*

IX. Appendices

- Appendix A: Quality Council Goals & Activities Work Plan, page 6-7
- Appendix B: Communication Flow Chart for Quality Improvement, page 8
- Appendix C: 2011 Quality Council Reporting Calendar, page 9
- Appendix D: Selected Quality Improvement Objectives Log (Sample), page 10
- Appendix E: Quality Improvement Objectives & Performance Measures Tracking Form and Division Report Form, page 11-14
- Appendix F: 2011 Quality Council Membership List, page 15
- Appendix G: Division Report, page 16
- Appendix H: Logic Model, page 17
- Appendix I: Glossary of Terms, page 18-19

APPENDIX A**QUALITY COUNCIL GOALS & ACTIVITIES/WORK PLAN*****2011 (revised December 2010)***

Individual: Enhancing skills, knowledge, attitudes and motivation	LEAD	BY WHEN
a. Maintain intranet page with resource list, Quality Improvement (QI) training, and information on QI efforts	Liz (input from QC members)	Bi-Yearly
b. Conduct QI trainings with divisions	Lyndia + Liz	One week after Division Report
c. Hold technical assistance (TA) workshops	Quality Council (QC)	Monthly
d. Identify, review, monitor and make recommendations on QI projects	Quality Council (QC)	Monthly
Interpersonal: Increasing support for QI with peers	LEAD	BY WHEN
a. Submit QI projects to In the Loop	Amy	Monthly
b. Annual SRHD recognition of submitted and completed QI projects with storyboard	Torney	Dec
c. Encourage QI project lead staff to submit applications for broader acknowledgement of QI Efforts (Coordinate with Exec Team/QC)	QI Project Leads	Ongoing
Organizational (QC): Improving policies and practices of the QC	LEAD	BY WHEN
a. Conduct and evaluate agency review of QI	QC	Yearly
b. Present and report on updated QI plan and council progress	QC chair	Jan JM and BOH
Community: Increase interdivisional collaboration and partnerships to effect QI at SRHD	LEAD	BY WHEN
a. Make recommendations to Exec Team for interdivisional/agency QI projects based on identified needs	QC Exec Team member	When needed
b. Assure that programs conducting similar work know about QI projects completed in another division	QC Council	As needed
Public Policy (Agency): Developing and influencing SRHD QI policy	LEAD	BY WHEN
a. Monitor agency customer service	Liz	November
b. Hear/review division reports and progress on performance measures to determine how better to improve QI projects	Quality Council (QC)	See meeting schedule
c. Monitor program evaluation efforts and progress	Liz	January
d. Monitor agency movement toward QI, including standards information	QC	November
e. Monitor agency performance measures and report improvement	QC	Annually

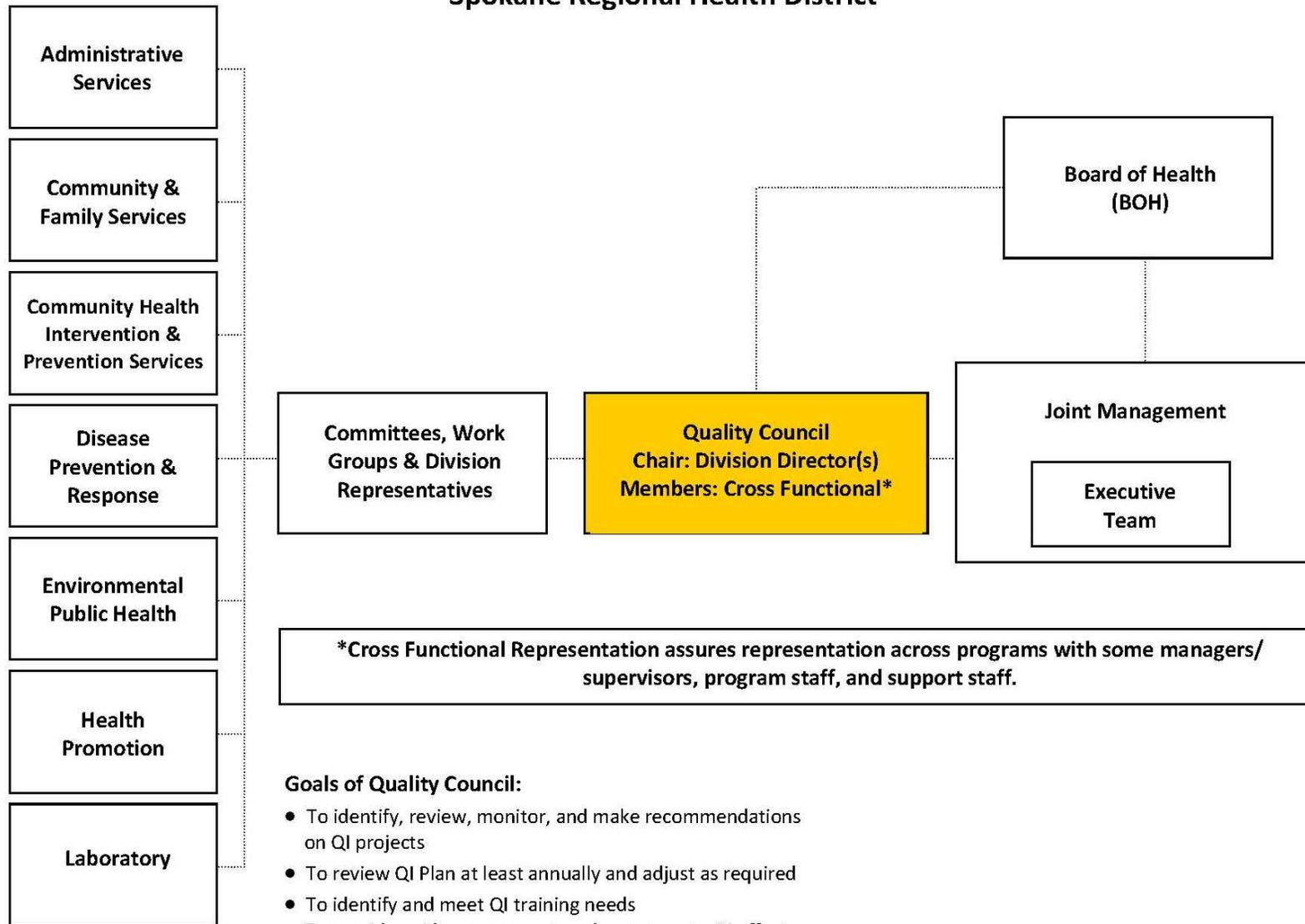
Quality Council Focus



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

Communication Flow Chart for Quality Improvement Spokane Regional Health District

Appendix B



Goals of Quality Council:

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

APPENDIX C

2011 QUALITY COUNCIL REPORTING CALENDAR

	DATA REVIEW BY QC Date Scheduled:	REPORT TO
2011 PH Standards Review and National Accreditation Evaluation	June 9	Joint Management
Customer Service	November 10	Executive Team
HIPAA Compliance	January 13	Joint Management
Division and Program Evaluation Update	January 13	Joint Management
Logical Decisions Work	July 14	Executive Team
Strategic Plan Review	August 11	Joint Management
Division Reports		
Administration	April 14	
Community and Family Services	May 12	
Community Health Intervention & Prevention Services		
Disease Prevention and Response	April 14	
Environmental Public Health	March 10	
Health Promotion	June 9	
Laboratory		
Quality Improvement Projects		
Scheduled throughout year	See log	
QC Evaluation and Data Compilation		
QI Plan Review	November 18 and December 8	Executive Team, Joint Management, Board of Health (January 2012)
QC Logic Model data review	November 18 and December 8	

Sample Selected Quality Improvement Objectives Log – ACTIVE

Reporting Area	Lead Staff	SMART Objective	Start Date	Complete Date	Report Date to QC	Status	Storyboard (y/n)
Admin/ HR							
BOH							
CFS					March 2010 with annual updates		
OTP							
DPR							
EPH							
Add, Standards, Customer service, etc.							
HP							
Lab							



QI Objective and Performance Measures Tracking Form
One project/form
(Used to create storyboard)

Title of Project: _____

Division/Area Reporting: _____

Start date: _____

Initial report to QC date: _____

Overall Goal for Project: _____

Lead staff: _____

Complete date: _____

Report back to QC date: _____

1. a. What is the identified issue that you would like to work on?

b. How did you determine that this was an issue (background)?

c. What quality improvement tools did you use to the identify problem? (See referenceⁱ)

2. What is your specific objective and timeframe for improving the identified area? This should be your one overall objective for the project and should be SMART: Specific, Measurable, Achievable, Realistic, and Time bound. (See example and referenceⁱⁱ)

(verb, e.g. increase) (what you are improving) (by how much, e.g. by 10%) (by when, e.g. by Nov. 30th) (to do what- health outcome, e.g. decrease preventable disease)

Type yours here:

3. a. What activities are you considering for improvement?

b. What QI tools will you use to work on project? (See referenceⁱⁱⁱ)

Please fill out performance measures below in relation to your objective.

	Measure #1	Measure #2	Measure #3	Measure #4
Statement of measure: <i>(e.g. Percent of high risk pregnant women with prenatal visit in 1st trimester)</i>				
Target Population: <i>(e.g. All pregnant women)</i>				
Numerator: <i>(e.g. # high risk pregnant women with 1st trimester prenatal visit)</i>				
Denominator: <i>(e.g. # of high risk pregnant women)</i>				
Source of data: <i>(e.g. Clinic visit records)</i>				
Baseline: <i>(e.g. 85%)</i>				
Target or Goal: <i>(e.g. 95%)</i>				

ⁱ QI tools or methods for identifying a problem could include logic models, work plans, data analysis, or from resources listed:

The Public Health Memory Jogger™ II

http://srhdweb/how_to_guides/QI.asp

ⁱⁱ QI tools or methods for improving a problem could include conducting a Plan, Do, Check/Study, Act (PDCA/PDSA) cycle or Rapid Cycle Improvement (RCI) project, Business Process Analysis (BPA), pre/post evaluation, or from resources listed in ⁱ

ⁱⁱⁱ 2009 WA State Public Health Standards, 9.1.3B

Progress Report to Quality Council
(Used to create storyboard)



Title of Project: _____

Division/Area Reporting: _____

Start date: _____

Initial report to QC date: _____

Overall Goal for Project: _____

Lead staff: _____

Complete date: _____

Report back to QC date: _____

1. What was/were the performance measure(s) at the start and completion of your improvement activities? Give actual percentage, rate, or other measure.

	Measure #1	Measure #2	Measure #3	Measure #4
Statement of measure: <i>(e.g. Percent of high risk pregnant women with prenatal visit in 1st trimester)</i>				
Target Population: <i>(e.g. All pregnant women)</i>				
Numerator: <i>(e.g. # high risk pregnant women with 1st trimester prenatal visit)</i>				
Denominator: <i>(e.g. # of high risk pregnant women)</i>				
Source of data: <i>(e.g. Clinic visit records)</i>				
Baseline: <i>(e.g. 85%)</i>				
Target or Goal: <i>(e.g. 95%)</i>				
Results: <i>(e.g. 90%)</i>				

2. Did you reach your target or goal for your objective?
 - a. If yes, how will you sustain or continue improving?
 - b. If no, what variables were involved in not reaching your goal?
 - c. What is your plan to address the variables that prevented you from reaching your target or goal?

Please provide an abstract regarding your QI project for *In the Loop*. The abstract should include all of the following descriptive:

Title of Project

Project Description, including Problem and QI Activities

Objective

Results

Contact Information

2011 Quality Council Members

Julie Awbrey, EPH

Lisa Breen, EPH

Lindsay Burns, Admin/Client Serv

Judy Diehl, CHIPS

Gwen Dutt, HIPAA Coordinator

Diane James, Lab

Caroline Law, CFS

Bob Lutz, BOH member

Ida Ovnicek, CFS

Torney Smith, Admin

Lyndia Tye, DPR

Kyle Unland, Co-Chair, HP

Liz Wallace, Co-Chair,
Program Evaluator

*The Quality Council was
created in late 2007*

IN DEVELOPMENT

See Quality Improvement intranet tab for details.

Appendix H

SRHD		Committee: Quality Council			Responsible: Kyle Unland, Liz Wallace				
		Revision: Nov 30th, 2010			Completed: Nov 30th, 2010				
Program Theory	Inputs	Activities	Outputs	Process Outcomes	Impact Outcomes	Population Outcomes	Measurements	Standards	
The QC will aid in creating, implementing, maintaining and evaluating the quality improvement efforts at SRHD with the intent to improve the level of performance of key processes and outcomes.	QC members, division directors, QI Plan, staff, managers, Board of Health	Individual: Enhancing skills knowledge attitudes and motivation							
		Maintain intranet page with resources list (including QI training) and information on QI efforts.	# updates	Links worked. Content was easy to navigate and understand. Resources were up to date.	Increased access to QI information, tools, and resources.	By 2015 90% of employees will be able to define and use QI tools and methods and implement them.	Survey end of year.		
		Conduct QI trainings with divisions.	# trainings	Trainings were rated at 4/5 on all satisfaction questions on evaluation. Met all identified training needs.	Increased awareness of QI processes. Increase use of QI tools		Training evaluations. End of year survey.	9.1.7 Require staff participation in evaluation methods and tools training.	
		Conduct T.A. workshops.	# workshops # participants	Q.C. members are seen as a resource for QI. Assistance was helpful/ useful. QI stories were concise and tailored to target audience.	Increase quality of reporting to QC. Increased appropriate implementation of QI tools.		End of year survey.		
		Identify, review, monitor and make recommendations on QI projects.	# projects started # projects completed	Lead project staff had enough support, information and access to resources. Recommendations were appropriate and useful.	Increased support for science based methodologies. Improved program/ project outcomes.		End of year survey. Review of key processes and outcomes performance.	9.1.4 Monitor performance measures for processes, programs and interventions.	
		Interpersonal: Increasing support for QI from peers							
		Recognize and acknowledge QI efforts	# articles # events	Events were appropriate for QI promotion. Staff felt encouraged to apply for recognition.	Increased staff/ manager awareness of QI projects that are occurring.		End of year survey.		
		Encourage QI project lead staff to submit applications for broader acknowledgment of QI	# award recipients # presentations.	Staff felt encouraged and supported to submit applications. Applications were appropriate for recognition.	Increased visibility and recognition of the QI efforts employees were involved in. Increased % of submitted projects		Review awards earned for QI projects. End of year survey.		
		Organization: Improving policies and practices of the QC							
		Present and report on updated QI plan and council progress.	# presentations (JM, Exec team, BOH)	Information was concise and easy to understand. Met BOH presentation standards.	Increased awareness of QI processes and agency improvements. Exec Team and BOH approved plan.		Improved level of performance of key processes and outcomes.	End of year survey. Presentation feedback.	9.1.1 B Engage governing entity in establishing agency policy direction re: performance management system. 9.2.1 Establish a quality
The QC will aid in creating, implementing, maintaining and evaluating the quality improvement efforts at SRHD with the intent to improve the level of performance of key processes and outcomes.	QC members, division directors, QI Plan, staff, managers, Board of Health	Community: Increase interdivisional collaboration and partnerships to effect QI at SRHD							
		Make recommendations to Exec Team for interdivisional/ agency QI projects.	# project recommendations	Recommendations were based on identified needs.	Increased agency level measures improvement. Increased agency efficiency.	By 2015 90% of employees will be able to define and use QI tools and methods and implement them.	QI report from Exec Team. End of year survey.	9.1.1 B Engage governing entity in establishing agency policy direction re: performance management system.	
		Public Policy: Influencing SRHD QI policy							
		Monitor agency customer service.	# programs and divisions participating.	Report covered the five selected agency measures of customer service.	Increased understanding of customer service QI needs. Maintain level of customer service. Increased use of customer service evaluation.		Review customer service QI needs identified. Customer Service report.	9.1.6 B Implement a systematic process for assessing and improving customer's satisfaction with agency services.	
		Hear division reports	# reports	Division directors had enough support/ supervision to properly complete report. Recommendations were appropriate.	Increased awareness of division status and improvement projects needed and ongoing.		Review division QI needs. End of year survey.		
Monitor program evaluation efforts.	# reports	Received adequate information and assistance to complete.	Increased logic model use, data reviews, and utilization of work plans. Improved logic model indicators.	Year end survey	9.1.5 B Evaluate the effectiveness of processes, programs, and interventions and identify needs for improvement.				

Glossary of Terms

<http://www.phaboard.org/assets/documents/Glossary-07-15-2009.doc>

In the Performance Management Glossary you will find definitions and the page number for the following terms:

Access, 5
Accessibility, 16
Accreditation, 5
After Action Report, 5
Agency, 5
Alignment, 6
All-hazards preparedness plan, 5
Annual, 10
Assessment, 6
Asset mapping, 9
Assurance, 6
Benchmarks, 6
Biennial, 7
Board of health, 13
Capacity, 7
Capacity-building, 9
Coalition, 8
Collaboration, 8
Collaborative leadership, 8
Communication, 7
Community / Community involvement, 7
Community development, 9
Community health assessment, 9
Community health improvement, 9
Community health improvement plan, 7
Community mobilization, 9
Compliance, 9
Conditional accreditation, 6
Conformity assessment, 6
Continuous quality improvement, 25
Cooperation, 8
Coordination, 8
Core indicators, 23
Core public health competencies, 9
Cultural competence, 10
Current, 11
Customer and customer service, 10
Denominator, 24
Determinants of health, 24
Diverse workforce, 10
Documentation timeframes, 10
Domain, 11
Effectiveness, 15
Efficiency, 15
Environmental hazards, 11
Environmental public health, 11
Environmental risk, 11
Epidemiologic investigations, 11
Epidemiology, 11
Equivalency, 11
Evaluation of public health services, 20
Evidence-Based Practices [EBPs], 12
Exemption, 12
Gap analysis, 24
Goals, 20
Governing entity, 12
Governmental public health agency, 13
Health, 13
Health care provider, 14
Health care services, 14
Health communication, 14
Health determinant indicator, 24
Health disparities, 14
Health education, 18
Health information, 14
Health marketing, 19
Health needs, 14
Health professional shortage areas, 14
Health promotion, 19
Health promotion activities, 19
Health risk, 24
Health status, 24
Health status indicator, 24
Human Resource Manual, 15
Human Resource System, 14
Impact, 20
Impact objective, 21
Indicated prevention. See Tertiary prevention
Indicator, 23
Infrastructure, 15
Internal audit, 15
Law, 18
Local health department, 13
Locally-established health priorities, 27
Logic model, 20
Mandated public health services, 15

Meaningful improvement in public health, 15
Media advocacy, 16
Medical home, 16
Mission statement, 27
Notifiable conditions, 16
Numerator, 24
Objectives, 20
Operations, 16
Outbreak, 16
Outcome objective, 21
Outcomes, 21
Outputs, 21
Partnership, 8
Performance improvement, 16
Performance management / measurement, 16
Performance measure, 16
Performance standard, 17
Periodic, 17
Personal health care workforce, 17
Policy, 17
Policy development, 17
Population health, 18
Prevention, 18
Primary prevention, 18
Priorities, 27
Procedure, 22
Process objective, 21
Program, 19
Program activities, 19
Program evaluation, 20
Program planning and evaluation, 20
Programs, processes and interventions, 22
Promising practices, 12
Protocol, 22
Public, 8
Public health, 22
Public health data, 23
Public health emergency, 25
Public health system, 22
Qualitative analysis, 24
Qualitative data, 24
Quality, 15
Quality improvement, 25
Quality improvement plan, 25
Quality methods, 26
Quantitative analysis, 24
Quantitative data, 24
Regular, 26
Reliable, 26
Research, 26
Risk communication, 26
Secondary prevention, 18
Selective Prevention. See Secondary Prevention
SMART criteria, 22
Social marketing, 19
Stakeholders, 8
State health agency, 13
State Health Improvement Plan, 26
Statewide Health indicators, 23
Strategic goal, 27
Strategic plan, 26
Strategic planning, 27
Strategies, 27
Stretch standard, 17
Substantial Equivalency Recognition - SER, 12
Surveillance, 27
Surveillance site, 28
Surveillance, Active, 27
Surveillance, Passive, 28
Technical assistance/consultation, 28
Ten Essential Services, 23
Tertiary prevention, 18
Three Core Functions, 23
Timely, 11
Training, 28
Training documentation, 28
Trended data, 25
Universal Prevention. See Primary Prevention
Up to Date, 11
Urgent, 29
Values, 27
Vision, 27