

2010-11 Quality Improvement Plan (July 2010 – December 2011)



Prepared by the Office of Community Assessment: August 26, 2010
Reviewed and approved by the Quality Improvement Council: September 28, 2010
Revisions approved: August 23, 2011; September 27, 2011

I. Scope and Structure

A. Mission & Scope

Quality improvement (QI) is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization.¹ In September 2006 the Tacoma-Pierce County Health Department (TPCHD) developed its first QI plan and formed the QI Council. In 2011 the QI council revised its mission as the following:

Improve the health of Pierce County by ensuring efficient, effective, customer-focused processes and programs.

This mission statement describes the fundamental reason for the existence of the QI Council. Actions and decisions by the QI Council will be compared against the mission statement to evaluate if those actions and decisions are consistent with the intent of this stated responsibility.

The QI program will include the activities detailed in Section II. Also in 2011, the QI Council revised its scope or objectives, which will guide and evaluate the QI program to the following:

- Defining and monitoring Department performance measures.
- Identifying, resourcing and monitoring Department (cross-divisional) improvement efforts.
- Monitoring Division improvement efforts that directly support Department priority measures.
- Ensuring the organization sustains the gains of its improvement efforts.
- Leading Department culture shift toward customer-focused, evidence-based, continuous improvement practices.
- Resourcing staff development of quality improvement knowledge and skills.
- Reviewing selected program evaluation reports and making recommendations on program improvements.
- Reviewing after-action reports and making recommendations to the appropriate managers/leads.
- Reviewing recommendations for improvement from Washington State Standards for Public Health site visit and ensuring that all appropriate recommended policy and process changes are implemented.
- Reviewing and revising Quality Improvement Plan on an annual basis.

¹ National Committee for Quality Assurance.

B. Organizational Structure

The Director has charged the QI Council with carrying out the purpose and scope of the QI program at the Department. Management Team members are responsible for conducting QI efforts and for promoting, training, challenging and empowering TPCHD employees to participate in the processes of QI.

The QI Council is composed of TPCHD executive and senior management staff, including:

- Director
- Deputy Director
- Division Directors (3)
- Community Assessment Manager
- Business Services Manager
- Human Resources Manager
- IT Manager
- Public Information Officer

The QI Council meets on the fourth Tuesday of each month at 1 p.m. and maintains records and minutes of all meetings; these minutes are presented for review and acceptance by QI Council members. Meetings are one hour except during the quarterly review of performance measures, which are 90-minute meetings.

At least annually the QI Council will provide a report of the QI program to the Board of Health.

QI Council members will make every effort to come to consensus on issues requiring a decision. However, if consensus cannot be reached, the QI Council will make decisions by a majority vote.

QI project teams are convened by the QI Council as required for specific initiatives. These teams are accountable to the QI Council and report activities and results on an ongoing basis.

C. Dedicated Resources

The Office of Assessment, Planning & Improvement (OAPI) provides administrative and technical support to the QI Council and the Department's QI initiative. This support includes:

- Providing staff coordination for the monthly QI Council meetings, including:
 - Facilitating meetings.
 - Developing and distributing the agenda.
 - Maintaining meeting minutes.

- Providing staff training in QI methods and tools.
- Assisting program staff to track and trend their performance data.
- Providing technical assistance to programs conducting continuous QI or quality planning, which may include data collection/analysis, advice on quality methods/tools or meeting facilitation.
- Providing technical assistance to QI projects, which may include data collection/analysis, advice on QI methods/tools, meeting facilitation/project management services, or participation as a team member.

As needed, training specialists and consultants are also available to QI project teams and to QI Council.

D. Roles and Responsibilities

Director:

- Provides vision and direction for the QI program.
- Convenes the QI Council.
- Responsible for the allocation of resources for QI programs and activities.
- Reports on QI activities to the Board of Health.
- Requests the review of specific program evaluation activities or the implementation of QI projects.
- Serves as a voting member of the QI Council.

Deputy Director:

- Responsible for the administration of the Department's QI initiative.
- Counsels QI Council staff on implementation of the QI program.
- Requests the review of specific program evaluation activities or the implementation of QI projects.
- Serves as a voting member of the QI Council.

Division Directors:

- Responsible for the implementation of QI projects and for the reporting of activities and results to the QI Council; identify appropriate staff to participate in QI projects as needed.
- Responsible for the implementation of ongoing program-level quality improvement/planning for his division.
- Encourage program staff to incorporate QI concepts into daily work.
- Report to the QI Council on program evaluation activities.
- Report to the QI Council the monitoring of their quarterly division-level performance measures and department-level performance measures that fall within their divisions.
- Serve as voting members of the QI Council.

Community Assessment Manager:

- Directs the administrative and technical support for the Department's QI initiative.
- Responsible for the development of the annual QI plan and evaluation.
- Provides training specialists and consultants to QI project teams, to QI Council and for other staff as needed.
- Responsible for the implementation of ongoing program-level quality improvement/planning for Vital Records and OAPI.
- Responsible for monitoring and reporting quarterly performance measures.
- Serves as a voting member of the QI Council.
- Encourage assessment staff to incorporate QI concepts into daily work.

Other Administrative Services Managers (Human Resources Manager, IT Manager, Business Services Manager and Public Information Officer):

- As members of the senior staff within the Office of the Director, provide guidance to the Department's QI program.
- Responsible for the implementation of QI projects and for the reporting of activities and results to the QI Council; identify appropriate staff to participate in QI projects as needed.
- Report to the QI Council on program evaluation activities.
- Determine appropriate messages to communicate selected QI activities and results to staff, the public and other audiences (PIO).
- Serves as voting members of the QI Council.
- Encourage administrative services staff to incorporate QI concepts into daily work.
- Responsible for the implementation of ongoing program-level quality improvement/planning for his/her administrative program.
- Responsible for monitoring and reporting quarterly performance measures.

Population-Based Public Health Nurse (OAPI):

- Facilitates the agenda and meetings for QI Council.
- Provides technical consultation to the QI Council and other QI projects.
- Works with the Community Assessment Manager to define and document QI issues.
- Assists with the development of the annual QI plan and evaluation.

Other OAPI Staff:

- Provide technical support for QI projects, program evaluation activities, reporting quarterly performance measures and other data analysis involved in QI activities.

Administrative Support:

- Maintain minutes of QI Council meetings.
- Provide administrative support for other QI activities as needed.

All TPCHD Staff:

- Participate in QI projects, as requested by division directors or administrative managers.
- Collect and report data for reporting of performance measures; use data to identify areas needing improvement.
- Understand how performance measures related to their work affect department-level (strategic) performance measures.
- Participate in QI training.
- Incorporate QI concepts into daily work.

E. Approval of QI Plan and Annual Evaluation

The QI plan is revised annually to reflect program enhancements and revisions. Activities listed in the annual QI calendar are developed based on the recommendations from the annual QI program evaluation. The QI plan and program evaluation are approved annually by the QI Council.

In addition, QI Council members evaluate each QI Council meeting at its end. Periodic summaries of these evaluations are provided to QI Council members, and revisions to meetings are made accordingly based on QI Council member feedback.

II. Activities

The activities listed in this section include review and improvement of Department programs and processes that have a direct or indirect influence on the health of Pierce County residents. These activities will be implemented and reported to the QI Council during the 18-month period from July 2010 to December 2011:

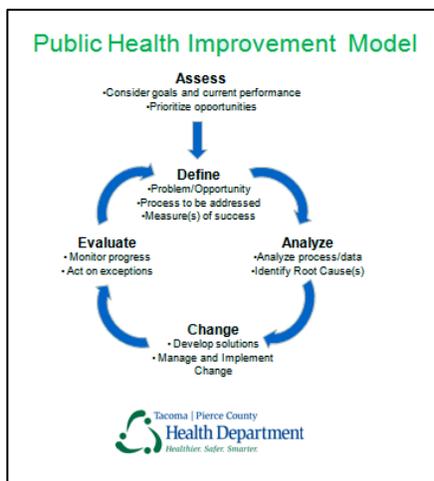
A. Quality Projects

At least three projects will be conducted in 2010-11 to improve the quality of TPCHD's processes and services. Within each project, the team will:

- 1) follow the principles of quality improvement/planning, using the Department's public health improvement model (see Figure 1 on p. 7),
- 2) participate in training on QI methods/tools,
- 3) use data to evaluate and understand the impact of changes designed to make improvement,
- 4) conduct quality cycles to discover what is an effective and efficient way to improve a process, and
- 5) understand how their project relates to the overall QI plan.

Each team will have a sponsor (typically, a QI Council member) and a team leader, who has authority to allocate resources to the project and implement changes to the process/project. The team leader and/or sponsor will provide at least three reports to the QI Council: interim (midway through a cycle), final (at the project's conclusion) and follow-up (at a point or points determined by the QI Council during the final report to report if improvements have been sustained). After review and approval by the QI Council, a project report may be provided to the Board of Health. Project results will also be shared with TPCHD staff at an all-staff meeting, by displaying a storyboard poster in a common area and/or in The Latest employee newsletter. Each team will receive training and technical support at a minimum at the project kick-off meeting and at an interim point to be determined by the project lead. When a project has ended, performance measures established during the project phase will be continually monitored to ensure improvements are sustained.

Figure 1



The Director or Deputy Director may request that a specific quality project be conducted. In addition, any member of the QI Council may request the implementation of a quality project by completing the “QI Project Proposal” form (see Appendix A) and submitting it to the QI Council for approval. These project proposals will be discussed at the subsequent QI Council meeting during the agenda item for new business/QI proposals at the end of each meeting.

Two projects have been identified so far for 2010-11: Title XIX Administrative Match and Contracts Management.

1) Title XIX Administrative Match—During the 2010 budget development, the Director requested that a QI project be implemented to increase revenue generation through the Title XIX Administrative Match program. The team’s sponsor is the Director, and the team’s co-leads are the Division Director for Strengthening Families and the Business Services Manager. The QI project team began meeting in May 2010, with the QI Coordinator providing team facilitation, project management and QI technical consultation to the team.

2) Contracts Management—At the request of the Business Services Manager, the QI Council approved a quality project to be implemented for the contracting management process starting June 2010. Data collected from the Administrative Services Customer Satisfaction Survey in 2007-2009 and from facilitated group discussions conducted with staff in 2009 suggested that this process could benefit from a quality project. The team’s lead is the Business Services Manager, and the QI Coordinator provides team facilitation, project management and QI technical consultation to the team.

A third quality project will be selected by the QI Council after completion of these two projects. Priority will be given to 2009 performance measures that did not meet their established thresholds or to other revenue-generating processes.

In addition to these three new quality projects, performance data from previously conducted QI projects (STD Case Reporting, Maintenance requests, Purchasing requests and Solid Waste Code Enforcement complaints) will continue to be periodically monitored to ensure sustained improvements. Performance monitoring data will be shared with QI Council members at least once a year. If improvements are not sustained, the appropriate Division Director/Administrative Manager will notify the QI Council and make recommendations for further actions.

B. Ongoing Program QI

In contrast to a QI/QP project, which has a limited scope and defined ending point, program-level QI is continuous and becomes a part of regular daily work. As the Department continues to move toward a learning/quality culture, ongoing program-level QI should become more prevalent. During the 2010-11 plan year, at least three programs will begin incorporating quality tools and methods into their everyday work processes. Training in QI methods and tools will be provided to these program staff and the QI Coordinator will provide technical assistance and project management services in the start-up phase of program-level QI implementation.

As QI and QP projects come to end, the team leader or sponsor may decide to transition into ongoing program QI if appropriate. An example of this transition is the Chlamydia health indicators project, which has transitioned into ongoing program-level QI.

The Director or Deputy Director may request that a program begin a continuous quality improvement effort. A QI Council member may request the implementation of a program-level continuous quality effort by completing the "Program QI Proposal" form (see Appendix B) and submitting it to the QI Council. These project proposals will be discussed at the subsequent QI Council meeting during the agenda item for new business/QI proposals at the end of each meeting.

In 2010 two programs began ongoing program-level QI: Vital Records and CD Control Vaccine program.

Vital Records—Staff identified three performance measures (reported as part of the TPCHD Performance Measures set) that are continually monitored and reported to staff: customer satisfaction, transactions per month and revenue per quarter. QI tools were used to identify priority areas for improvement: Point of Sale system, printers, "call-back" process for replacing incorrect certificates and the front counter work flow. When improvements have been sustained in those priority areas, other processes will be identified for improvement.

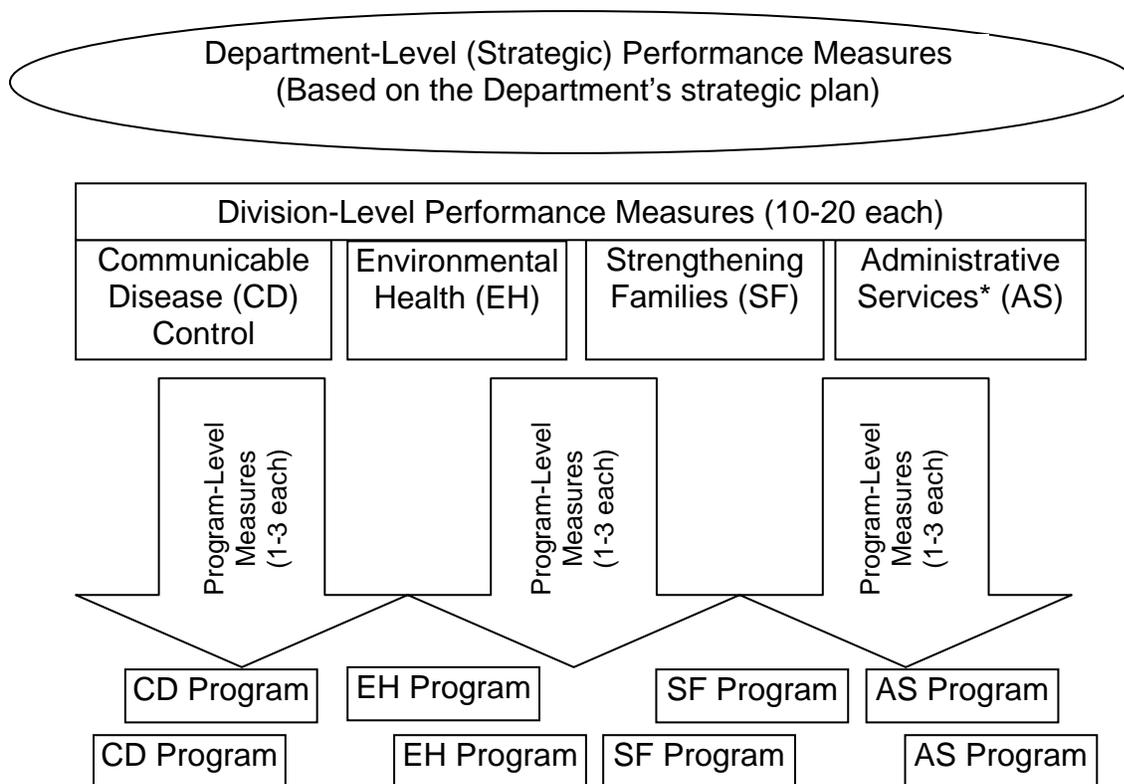
CD Control Vaccine program—The QI Coordinator will provide technical assistance on QI methods/tools for Immunization program staff. The Vaccine program will define, standardize and establish measures for each of its core processes, including vaccine allocation and distribution, vaccine quality assurance, and immunization COCOSA monitoring. The initial focus will be on improving provider satisfaction vaccine allocation and quality assurance. Additional improvement efforts will be identified as the program evaluates its measures and processes.

A third program will begin implementing ongoing QI by the 1st quarter of 2011. Potential programs include food safety/inspections and the EH permitting front counter.

C. TPCHD Performance Measures

The selection and measurement of performance measures enables the QI Council to understand a) if the Department is improving the health of Pierce County residents and b) if divisions are implementing efficient and effective processes and programs. Performance measures are developed at three levels: department, division and program (see Figure 2). All measures include a valid benchmark or target to measure data against.

Figure 2



*For reporting purposes, Vital Records is included within Administrative Services.

Department-Level (Strategic) Measures

For 2009 and 2010, QI Council members identified 12 performance measures taken from the Healthy People 2010 Leading Health Indicators that were used as mission/purpose-level success measures in the Department's LogFrame model.

For 2011, QI Council members identified 12 performance measures aligned with the Department's new 2011-15 strategic plan.

These performance measures:

- Are meaningful to Management Team and Board of Health members.
- Reflect how well the Department is working toward strategic outcomes (aligned with outcomes in strategic direction logframes).
- Say something about how well the Department is achieving or moving toward long-term outcomes (impact).
- Measure work from multiple divisions, with an emphasis toward cross-functional processes.

Table 1 Department-level (strategic) performance measures for 2011

Objective	Performance Measure	Who's Responsible
1. Decrease the percentage of youth who are overweight or obese to 25% by 2016 (stratify by race/income).	Percent of youth who are overweight or obese	Steve
2. 85% of population served by smaller public water systems has drinking water that meets health-based standards.	Percent of population served by smaller systems that meet drinking water standards	Steve
3. Maintain at a minimal level or reduce trend in incidence rate of 8 key communicable diseases from 60% to 70% by 2014 (stratify by race/zipcode)	Percent of 8 key communicable disease incidence rates that do not change or decrease	Nigel
4. The percent of adults that did not seek care due to affordability remains at 14.9% or below by 2013	Percent of Pierce County adults who did not seek medical care due to lack of affordability	David
5. Decrease incidence of CT by 3% in 5 years	Incidence rate of chlamydia	Nigel
6. Decrease the percentage of youth who smoke to 11% by 2016	Percent of youth who smoke	Steve
7. Decrease the percentage of adults who smoke to 15% by 2016	Percent of adults who smoke	Steve
8. Decrease the Substance Use Disorder Treatment Gap to or below 70% by 2016	Substance use disorder treatment gap rate	David
9. Decrease # of days with Air Quality Index of "unhealthy for sensitive groups" or worse by 5 days by 2016	Number of days with "unhealthy for sensitive groups" air quality	Steve
10. 80% of 5 key vaccine preventable diseases have decreasing rates the current year compared to the previous two years by 2014	Percent of key vaccine preventable disease incidence rates that decrease	Nigel

Table 1 continued

11. Increase to 76.8 % the proportion of parents who use positive parenting and communicate with their doctors or other health care professionals about positive parenting.	Percent of parents who use positive parenting	David
12. Increase by 11% eligible children who receive dental sealants by 2015 at participating schools.	Number of dental sealants	David

OAPI and program staff will collect data for the above measures. Persons identified as responsible for reporting data in the above table will monitor and report the progress of the performance measures toward reaching the mission of the Department. Depending on the availability of data, some measures will be reported annually while others will be reported every two years. Annually and after review by the QI Council, a summary of the data documenting progress toward the Department-level (strategic) performance measures will be provided to the Board of Health. Results will also be shared with TPCHD staff at an all-staff meeting, by displaying a storyboard poster in a common area, and/or in The Latest employee newsletter.

Division-Level Measures

For 2009 and 2010, Division Directors/Administrative Managers and staff developed 10-20 performance measures for per division. Division-level performance measures will again be developed for 2011. These division-level performance measures followed these criteria:

- Are meaningful to directors/managers.
- Say something about a) how well business processes are working (efficiency), b) how well short-term/ intermediate outcomes are being met (effectiveness), or c) how well the program is moving toward its long-term outcomes (impact).
- Reflect how well the division is working toward its priorities (aligned with outcomes in lower level logframes).
- Compare what actually happened to what was planned or intended (i.e., tie to a goal or objective).
- Are written with the intent of using the data to improve processes and interventions, not just to collect data.

On a quarterly to annual basis, program staff will collect and report data for division-level performance measures to monitor the achievement of objectives within programs. Division Directors/Administrative Managers will provide a brief summary of division-level performance measures to the QI Council quarterly, with an emphasis on measures that are not being met. Annual results will also be shared with TPCHD staff at an all-staff meeting, by displaying a storyboard poster in a common area and/or in The Latest employee newsletter.

Several division-level performance measures for Administrative Services activities have been measured by the survey, “Administrative Services Customer Satisfaction Survey.” This survey will continue to be administered by OAPI twice a year to monitor improvements in internal administrative processes. In August 2010 Administrative Managers began developing new performance measures that better met the criteria listed above. The customer satisfaction survey will then be revised to collect data for these new performance measures.

Program-Level Measures

In Fall 2011, Division Directors/Administrative Services Managers and their staff will develop program-level measures. Updates on progress toward these measures will be reported at QI Council each quarter. Measures will follow the criteria listed below:

- Are meaningful to directors/managers and program staff.
- Data are collected monthly or quarterly.
- Say something about a) how well business processes are working (efficiency), or b) how well short-term/ intermediate outcomes are being met (effectiveness).
- Reflect how well the program is working toward its priorities (aligned with activities in lower level logframes).
- Compare what actually happened to what was planned or intended (i.e., tie to a goal or objective).
- Include a valid benchmark or target to measure data against.
- Are written with the intent of using the data to improve processes and interventions, not just to collect data.
- Must be reliable (repeatable).

Figure 3 shows the relationship between the three levels of performance measures, as well as how they are aligned with the Department’s strategic plan and financial dashboards.

Figure 3 Performance Measures Framework/Alignment

Strategic Planning/ LogFrames	Quarterly Reporting/QI Performance Measures	Financial Dashboards
Vision & Mission	--	--
Strategic Directions	--	--
Outcomes (SD Level)	Dept Level Performance Measures	Department
Outcomes (Lower Level)	Division Level Performance Measures	Division
Activities	Program Level Performance Measures	Program
Individual work plans	Not reported (mgrs/supervisors may have)	Cost Center

All current performance measures can be found at LIBSHARE\COMMON\QI\ Performance Measures\2011.

D. Program Evaluation Reports

Multiple program evaluation activities—predominantly outcomes-based, but also some process-focused—are conducted throughout the Department’s divisions. The appropriate Division Director/Administrative Manager will report the results of selected evaluation activities to the QI Council. The Division Director/Administrative Manager will be responsible for selecting which evaluation activities are reported; the Director or Deputy Director may also request a report on a specific program evaluation project. Examples of past program evaluation reports have included sales data and customer behavior survey data for menu labeling, client outcomes data for Family Support Partnership programs, multiple evaluations for cross-cultural tobacco use and community behavior survey data for the Dirt Alert program.

E. Review of Health Indicators

Health indicators aid internal Department staff, as well as external key public health stakeholders, in program planning and evaluation by monitoring key outcomes that are affected by public health programs and policy. Many indicators are used as intermediate or long-term outcome measures as part of program evaluation.

In 2007 and 2009, the QI Council reviewed several sets of indicators, including the Washington State Local Public Health Indicators and TPCHD Indicators. These indicator sets are updated and reviewed every few years to monitor overall trends in the health of Pierce County residents. Based on the original review of indicator sets in 2007, three priority indicators that had both a significantly worse outcome compared to the Washington State average and a worsening trend in Pierce County—low birth weight, Chlamydia and adult obesity—were selected as objectives to be included in the 2008 QI plan. Performance measures were developed and reported quarterly beginning in 2008. In the 2009 review of health indicator sets, only two priority indicators were identified (following the same criteria as in 2007)—Chlamydia and adult obesity. Based on these data, the QI Council approved the following: 1) Continue the QI project team and reporting performance measures quarterly for Chlamydia. 2) Discontinue the QI project team for low birth weight after its grant from the WA State Department of Health ends in December 2010. 3) At the request of Physical Activity and Nutrition (PAN) program staff, change the adult obesity indicator to a childhood obesity indicator since program interventions are predominantly aimed “upstream” at children, families and school systems. In September 2010, PAN staff and their Division Director will present their proposed quality project and selected performance measures.

Table 2 shows the performance measures for each of the three health indicator projects. (See 2010 QI Calendar for listings of time frames and responsible staff.) Data showing results of these performance measures will be shared with the QI Council quarterly and the Board of Health annually. Results will also be shared with TPCHD staff at an all-staff meeting, by displaying a storyboard poster in a common area and/or in The Latest employee newsletter. An updated indicator report by the WA State Department of Health in 2010 showed that the Pierce County LBW rate was comparable to that of WA State. At the end of 2010 QI Council approved dropping the indicator LBW for ongoing review.

Table 2 Objectives and 2009 performance measures for three priority health indicators

Indicator	Objective	2009 Performance Measures
Chlamydia	Lower the prevalence rate of Chlamydia among 15-24 year old females (measured by the positivity rate for CT tests conducted at Infertility Prevention Project-IPP sites).	The number of interviews of Chlamydia cases (target = 2,500)
		The number of exposed partners who receive treatment (target = 2,200)
		The number of Chlamydia outreach events at Pierce Co high schools, colleges or other community venues (target = 45)
		The rate of positivity at IPP sites (target = 8.0% or less)
Low Birth Weight (LBW)	Improve the LBW rate by decreasing disparities in maternal risk factors.	Percent of MSS eligible African American (AA) women who receive prenatal MSS in Pierce Co (target = 75%)
		The number of women enrolled and tracked through Health Ministers -Black Infant Health project (target = 30)
		The number of new Black Infant Health Project referral churches/organization sites (target = 2)
		The number of networking meetings with community partners working toward elimination of health disparities in AA birth outcomes (target = 12)
Childhood Obesity	Reduce the childhood obesity rate.	The number of systems, policy and environmental changes that promote healthy eating and physical activity among school-aged children.
		The percent of children who eat five or more servings of fruit/vegetables.
		The percent of children who participate in moderate physical activity for at least 30 minutes each day.

F. Review of After-Action Reports and Issue Debriefs

For significant outbreak investigations and emergency preparedness events and exercises, after-action reports or internal debrief reports are produced to record recommendations for improvement. The Division Director or designee will provide summaries of those reports, including recommendations, to QI Council members for review.

Staff also develop internal debrief reports for projects or processes that involve multiple divisions or multiple community partners to record recommendations for internal improvements. The appropriate Division Director/Administrative Manager will provide summaries of those reports, when available, to QI Council members for review.

G. Public Health Standards Review

In 2010, the Washington State Standards for Public Health adopted the national Public Health Accreditation Board's (PHAB) framework for public health standards, which are based on the ten Public Health Essential Services. A formal review of the WA State Standards has occurred every three years since 2002 for all local health jurisdictions and the state health department. The most recent review cycle took place in spring of 2011.

Based on the 2008 Standards review results, the QI Council identified needed improvements in three areas: Human Resources policies and procedures, sharing data with community groups and "closing the Plan-Do-Study-Act (PDSA) cycle" throughout the agency. The Council approved two QI project teams to address these areas for improvement using the "model for improvement" method. In July 2010 the QI Council approved recommendations from the two teams for improvements in those areas, which were implemented later that year. The 2011 review results show that 100% of the measures related to human resources policies/procedures were fully demonstrated, and 71% of the measures related to sharing data with community groups/closing the PDSA cycle were fully demonstrated.²

The QI Council also reviewed the results of the Department's 2011 site visit. The Department's Standards committee recommended that the QI Council approve at least one quality project based on the results of the review. The Standards committee prioritized three areas: workforce development; customer service; community health improvement planning (CHIP). The QI Council approved a quality project to implement a systematic approach to assess and improve the Department's customer service (PHAB Standards & Measures Version 1.0: 9.1.4A). The customer service project will follow the guidelines described in section II A. The objectives are 1) to develop a customer service policy, and 2) to complete two projects following the Dept's public health quality

² Although we fell short of the target for "closing the loop" measures, this represents a great improvement over 2008. Scores for the "closing the loop" measures increased from 0% fully demonstrated (2 pts), 80% partially demonstrated (1 pt), and 20% not demonstrated (0 pts) in 2008 to 71% fully demonstrated (2 pts) and 29% partially demonstrated (1 pt) in 2011.

model to identify customers/stakeholders, collect/analyze customer/stakeholder feedback and use that information to improve processes by June 30, 2012.

QI Council members will also approve the time line for the Department to apply for national accreditation, which is scheduled to accept applications in fall of 2011.

H. QI Training and Recognition

In 2010-11 the following four trainings covering QI principles, tools and techniques will be provided to TPCHD staff in an effort to build a quality-focused culture at the Department. At the end of the year, a summary of QI training and participation will be provided to the QI Council.

1. Program managers, supervisors and other key staff will receive additional training on how to develop meaningful performance measures.
2. After the strategic plan has been developed, extended management team members (e.g., supervisors, managers and directors) will receive training on how performance measures should be aligned with the strategic plan and how quality improvement aligns with strategic planning.
3. A training covering the key principles of QI will be offered to staff participating in ongoing program-level QI to encourage the use of data to make program decisions and to help staff identify potential areas for improvement.
4. Additional training on specific QI tools and techniques will be offered to staff involved in QI projects, health indicator workgroups and quarterly reporting of performance measures. Team members of previous QI projects have requested ongoing and additional training after the QI project has ended to maintain and build upon their knowledge of QI tools and methods.

Based on feedback from the evaluation of the 2009 QI initiative and plan, each training will include an overview of the Department's QI initiative, its major components and how these components support the overarching mission of the QI Council.

At the beginning of each QI Council meeting, members discuss successes in using QI tools and methods and recommend opportunities for recognition of staff participating in QI efforts in the department. Recognition can include thank you letters signed by QI Council members, articles in The Latest employee newsletter, announcing successful QI projects at monthly all-staff meetings, placing a storyboard in the main customer waiting area, etc. QI Council should make concrete efforts to recognize and thank their staff for participating in QI teams and using QI methods and tools in their work.

III. Alignment of QI Plan with Other Department Systems

A. Employee Performance Evaluations

In September 2010, the employee performance evaluation process was revised. A new employee performance evaluation form was developed and included a key competency of using QI tools and methods. All non-management staff will be reviewed according to the following competency and criteria:

- Demonstrates ability to use quality principles and tools: Uses quality principles, methods and tools to analyze and improve work processes. Actively participates in quality teams, when applicable to their work. Participates in training opportunities to learn more about quality principles, methods and tools. Uses data to better understand the effectiveness and efficiency of work.

In addition to the above competency and criteria, all management staff will be reviewed according to the following:

- Work processes and results: Measures, understands, analyzes, and continuously improves business processes and the performance of the department to achieve desired results. Effectively adapts work processes in response to changing expectations, resources and capabilities.
- Vision and change management: Creates, strategically plans, prepares for and moves the program toward a preferred vision. Maintains a clear focus on internal and external customer needs. Anticipates and adjusts resources and work processes to accommodate emerging needs. Works collaboratively within and across systems. Acts to improve, streamline, and redesign work processes to provide superior products or services. Understands and effectively manages the impact of change on employees, the business process and the system.

B. Strategic Planning

A comprehensive performance management system involves strategic use of performance measures and standards to establish performance targets and goals, to prioritize and allocate resources, to inform managers about needed adjustments or changes in policy or program directions to meet goals, to frame reports on the success in meeting performance goals, and to improve the quality of public health practice.³ Development of a strategic plan is a first step in the Department's performance management system. The QI Council will use the Department's strategic plan to identify and prioritize issues and opportunities for improvement within the Department and to determine which areas of focus may generate the most improvement for the time invested. These opportunities may focus on improving quality and customer service and/or to reduce service delivery costs.

³ Source: Turning Point - <http://www.turningpointprogram.org/Pages/perfmgt.html>

The Department began a process in 2009 to develop a new five-year strategic plan. This plan, which will be finalized by the end of 2010, will guide the selection of new Department-level performance measures (see section II C) and will help identify opportunities for improvement projects (see section II A) and programs that could benefit from continuous quality improvement programs (see section II B).

IV. June 2010 - December 2011 Quality Improvement Calendar

	Accountable Staff	Completion Date	QI Council Review Date	Additional Review Dates
A. Quality Projects				
Title XIX Ad Match	David Vance	December 2010	Jul 27 (interim report) Oct 25, 2011 (final report)	Feb 15, 2011— BOH study session
Contracts Management	Marcy Kulland	December 2010	Jul 27 (interim report) Dec 28 (final report)	Feb 15, 2011— BOH study session
Customer Service	TBD	TBD	TBD	TBD
Follow-up reports from previous QI projects --STD case reports --Maintenance --Purchasing --Solid waste code enforcement	Nigel Turner Marcy Kulland Marcy Kulland Steve Marek	N/A	Apr 26, 2011 Apr 26, 2011 Apr 26, 2011 Apr 26, 2011	TBD
B. Ongoing Program QI				
Vital Records	Cindan Gizzi	N/A	Jul 27 Oct 26 Jul 26, 2011 Sep 27 2011	Feb 15, 2011— BOH study session
CD Control Vaccine	Nigel Turner	N/A	Nov 23 Apr 26, 2011 Sep 27, 2011	
Food	Steve Marek	N/A	Sep 27, 2011	

IV. June 2010 - December 2011 Quality Improvement Calendar

	Accountable Staff	Completion Date	QI Council Review Date	Additional Review Dates
C. TPCHD Performance Measures	See Section II C	Jul 31 Oct 31 Jan 31, 2011 Apr 30, 2011 Jul 31, 2011 Oct 31, 2011	Aug 24 Nov 23 Feb 22, 2011 May 24, 2011 Aug 23, 2011 Nov 22, 2011	Apr 6, 2011—BOH
D. Program Evaluation Reports				
Dental evaluation	David Vance Linda Gillis		Apr 26, 2011	
PAN school mini grant evaluation	Steve Marek Kirsten Frandsen		Aug 23, 2011	
QI training evaluation	Scott Davis	N/A	Sep 27, 2011	
E. Review of Health Indicators (Health indicator project updates)	Nigel Turner (Chlamydia) David Vance (LBW)- dropped as Health Indicator end of 2010 Steve Marek (Adult Obesity)	Jul 31 Oct 31 Jan 31, 2011 Apr 30, 2011 Jul 31, 2011 Oct 31, 2011	Aug 24 Dec 28 Feb 22, 2011 May 24, 2011 Aug 23, 2011 Nov 22, 2011	Apr 6, 2011—BOH
F. Review of PHEPR After Action Reports	Nigel Turner	N/A	Dec 27, 2011 (other dates as needed)	

IV. June 2010 - December 2011 Quality Improvement Council Calendar				
	Accountable Staff	Completion Date	QI Council Review Date	Additional Review Dates
G. PH Standards Review				
QI workgroup(s)	Barb Vane John Britt	Jul 26	Jul 27	
Recommendations from Public Health Standards Team	John Britt	N/A	Mar 22, 2011	
2011 Review Results	Cindan Gizzi John Britt	N/A	Jul 28, 2011	Nov 2, 2011—BOH
H. QI Council Training (Review of training calendar)	Cindan Gizzi		Dec 28 Oct 27, 2011	
I. Approval of 2010-11 QI Plan	Cindan Gizzi		Sep 28	
J. Evaluation of QI Plan				
2009 evaluation recommendations	Cindan Gizzi		Jun 22	
2010 evaluation	Cindan Gizzi		Mar 22, 2011	

Appendix A Tacoma-Pierce County Health Department Quality Improvement Project Proposal

<i>Project title:</i>	<i>Submitted by:</i>
<i>Date submitted to QI Council:</i>	<i>Logic model attached:</i> Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Briefly identify or describe the program, project or process that should be addressed with an QI project:</i>	
<i>Priority:</i> <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	<i>Please explain why you selected this priority level:</i>
<i>Departmental Implications</i> <i>a. How does this project support our mission, vision, and/or strategic directions?</i> <i>b. Who are the stakeholders (internal and external) and what are their concerns?</i> <i>c. What resources and support will be needed to complete the project?</i> <i>d. What potential impact could there be on other programs/activities if this QI project is conducted?</i>	
<i>What are we trying to accomplish? (A brief goal statement)</i>	
<i>How will we know that a change is an improvement? (Potential measures of success, including implications for future improvements building off of this project)</i> <i>Long term:</i> <i>Medium term:</i> <i>Short term:</i>	
<i>What changes can we make that will result in an improvement? (Initial hypotheses and description of data needed to focus the project and the development of an intervention)</i>	
<i>Who should be on this QI team?</i>	<i>Who should lead this QI team?</i>

Appendix B Tacoma-Pierce County Health Department Program QI Proposal

Program Name:	Program Leader: <i>Who is leading this effort?</i>
Strategic Directions/Goals : <i>What is your Division Director/Admin Manager expecting your program to contribute to the Department's strategic plan?</i>	
Measure(s): <i>The PRIMARY quantitative indicator(s) which would demonstrate performance had improved. Consult your program logic model/log frame.</i>	Target(s): <i>How much improvement is expected/hoped for?</i>
Customer(s): <i>Who is/are the PRIMARY recipient(s) of the program's "product" or service?</i>	Customer Needs Assessment? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>Have you recently assessed what customers need/want from the program?</i>
Process(es) to be addressed: <i>What are the core work/service processes within the program?</i>	Which of these will you focus on first? <i>Which process(es) are most directly related to the PRIMARY measures and strategic directions? Where will you have the biggest impact?</i>
Division Director/Administrative Manager: <i>Who is the program leader accountable to? Who is responsible for guiding and resourcing the program's improvement efforts?</i>	
Constraints: <i>Are there time, space, financial, system, policy, organizational or other constraints that the program leader should be made aware?</i>	
Team Members: <i>Who will be active participants in your improvement efforts? All staff may be involved in some way, at some point, but who are your PRIMARY participants?</i>	
Support Resources: <i>Who are the internal or external analysts, facilitators, consultants that have been assigned to support your improvement efforts?</i>	
Target Start Date:	
Target date for completion of first improvement cycle:	