

# Spokane Regional Health District 2010 Quality Improvement Plan



Prepared by the Quality Council: December 2007

Implemented: January 2008

Reviewed and revised: December 2008, December 2009

Approved by the Executive Team and BOH: January 2008; January 2009

## I. Purpose and Scope

- A. **Quality Improvement** is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization.<sup>1</sup>
- 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 of key processes and outcomes.
- C. **Goals:** The Quality Council's goals in supporting this effort are:
  - 1. Identify, review, monitor and make recommendations on QI processes/efforts
  - 2. Review QI Plan at least annually and adjust as required
  - 3. Identify and meet QI training needs
  - 4. Provide guidance, support, and resources for QI efforts
  - 5. Recognize and acknowledge QI efforts

*(See Appendix A: QC Goals and Activities Work Plan)*

## II. 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 each division. In addition, the agency HIPAA officer and program evaluation staff are on the QC. Ad hoc members, such as Human Resource staff, will be added as necessary. 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 committee 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 efforts will be centralized for documentation and 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.

#### B. Board of Health

The BOH receives a report annually on health data with recommended actions for health policy decisions (Standard 1.2.2L); 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

---

<sup>1</sup> Performance Management Glossary, Public Health Improvement Partnership, 2007

Staff 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 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, state standard gaps, and identified QI trainings with no resources available
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, state standard gaps, and QI training needed by staff (see section V)
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 give 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, the Team will forward recommended QI initiatives to the QC to incorporate into the QI Plan.

### **III. 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 15<sup>th</sup> of each year. Subsequent to Executive Team approval, the revised Plan will be provided to the Board of Health in January for their information.

#### **IV. 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. Administrative Responsibilities**

Organizational efficiencies dealing with finance, contracts management, human resources, public information, information systems, facilities maintenance, and general administration will be evaluated considering confidentiality of information, time and labor cost, methodology utilized, audit results, recruitment and retention, employee status, legal compliance and safety. Identification of issues and/or processes that limit effectiveness will be reported to the QC by Administrative staff. (Standards A1.1B, A1.2B, A1.3B, A1.4B, A.1.5B, A1.6B, 9.1.2B, 9.1.3B, 2.2.1L, 6.3.4B)

##### **B. After-Action Reviews**

After-Action Reviews of emergency preparedness/response exercises, epidemiologic outbreaks, or other public health event will analyze the following areas: monitoring and tracking processes, disease-specific protocols, investigation/compliance procedures, laws and regulations, staff roles, communication efforts, access to essential public health services, emergency preparedness and response plans, and other SRHD plans, such as facility/operations plans. Primary findings and proposed improvements will be reported to the QC by the Public Health Emergency Preparedness and Response (PHEPR) program staff or other appropriate program staff. (Standard 1.2.1B, 2.2.3B)

##### **C. 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. 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)

##### **D. 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)

#### **E. Program Evaluation**

Program evaluation is defined as the systematic application of social (or scientific) research procedures for assessing the conceptualization, design, implementation, and utility of SRHD programs. It will consist of creating a logic model or other framework for each program in the agency, creating effective data collection tools to measure each of the program's impacts, 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 program evaluation. A division director or designee will report key findings to the QC. Findings will be used to inform program planning and QI efforts. (Standards A2.2.3B, A2.2B, 3.1.3B, 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 for their programs. Four 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.

#### **G. 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, 9.2.1B)

*(See Appendix C: 2009 Quality Council Reporting Calendar)*

#### **V. 2010 Selected Quality Improvement Objectives & Performance Measures**

From reports to 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 about 25 indicators at any one time. From each of the QI effort reports to the QC, up to two prioritized quality improvement areas will be selected for monitoring and assessment of improvement within an established timeframe. The Objectives and Performance Measures Tracking 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 Selected Quality Improvement Objectives 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 activities to monitor that are **high-risk, high-volume, or problem-prone** and can be tracked and reported as aggregate statistics.

*(See Appendix D: 2009 Selected Quality Improvement Objectives Log and Appendix E: Quality Improvement Objectives and Performance Measures Tracking Form )*

## **VI. 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 Program Evaluation. As new resources become available, they will be posted to the Intranet and announced to staff.

## **VII. Training Plan**

Periodically, 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. Identified training needs around quality improvement and program evaluation will be solicited from managers and staff by the QC. Training will be developed to meet those needs.

Joint Management 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)

## **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.*

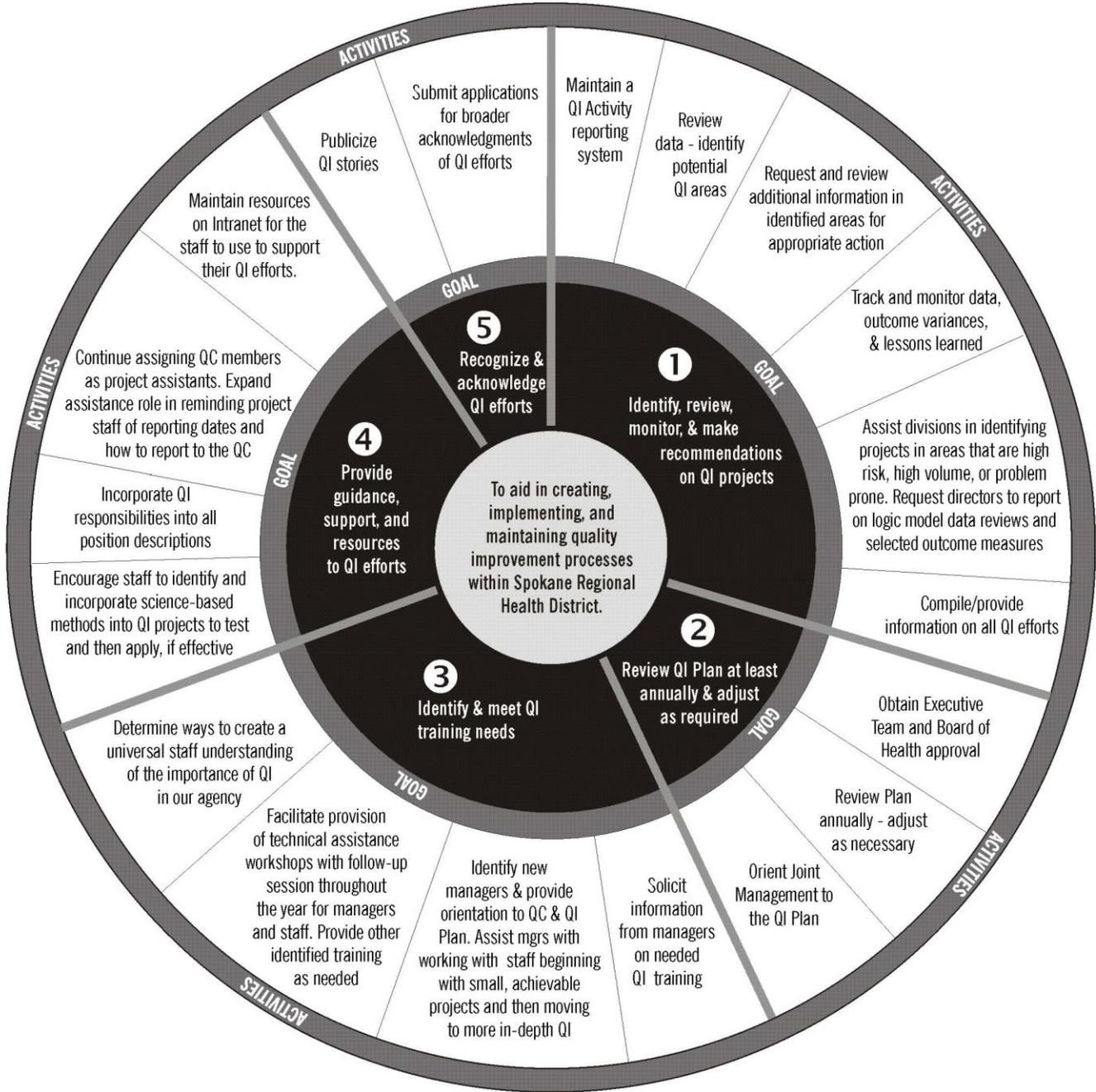
## **IX. Appendices**

- Appendix A: Quality Council Goals & Activities Work Plan, page 7
- Appendix B: Communication Flow Chart for Quality Improvement, page 9
- Appendix C: 2009 Quality Council Reporting Calendar, page 11
- Appendix D: 2009 Selected Quality Improvement Objectives Log, page 12
- Appendix E: Quality Improvement Objectives & Performance Measures Tracking Form, page 13
- Appendix F: Glossary of Terms, page 16

**QUALITY COUNCIL GOALS & ACTIVITIES/WORK PLAN****2010 (revised November 2009)**

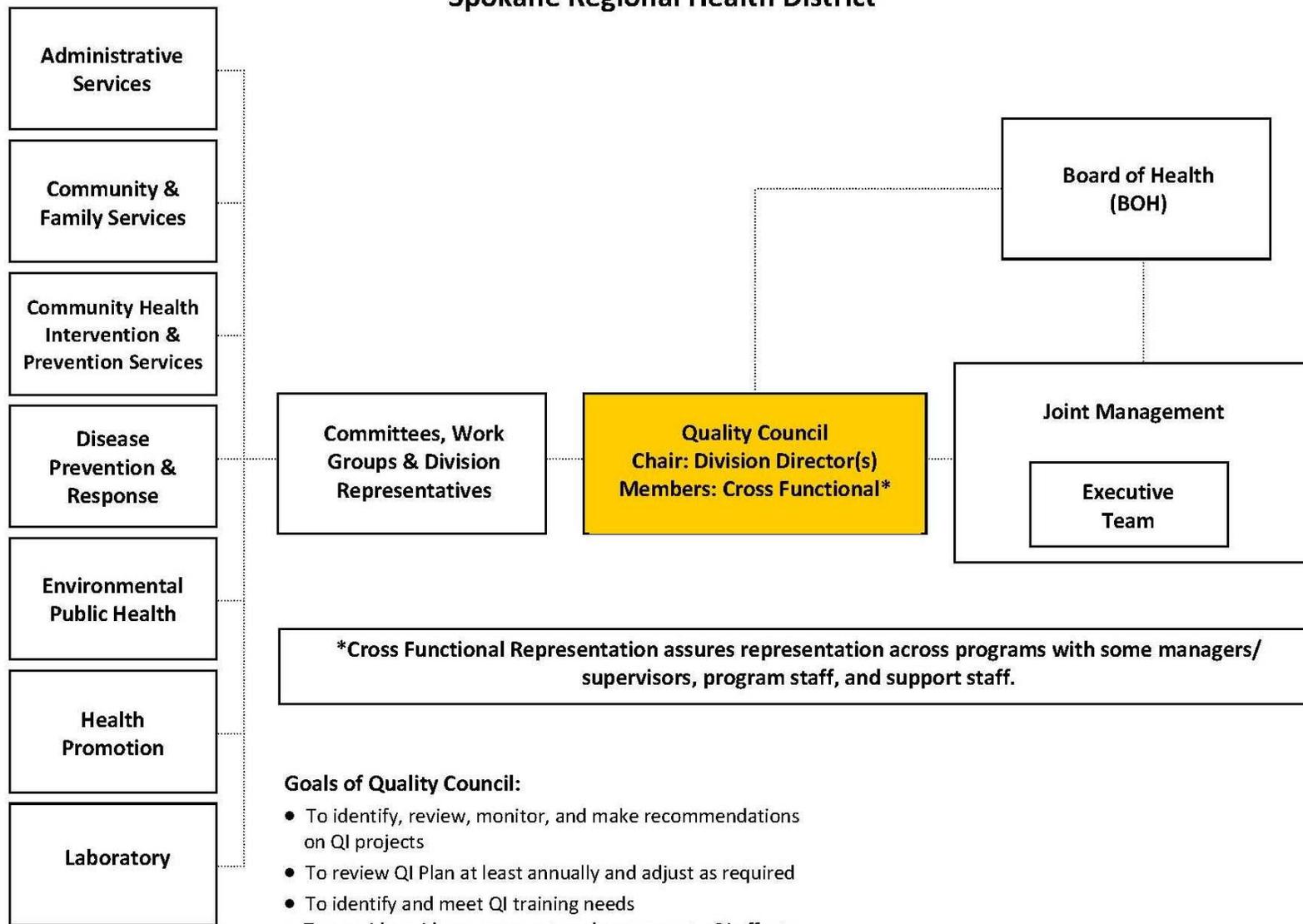
<b>Objective #1: To identify, review, monitor, and make recommendations on Quality Improvement (QI) projects</b>	<b>LEAD</b>	<b>BY WHEN</b>
a. Maintain a reporting system [from divisions, administrative services, and other groups] on QI activities	Jeannie	Monthly
b. Review data reports to identify potential QI areas	Quality Council	Monthly
c. Request and review additional information in identified areas for appropriate action	QC, Divisions, Special Projects	Monthly
d. Track and monitor data reports and outcome variances, and inquire about lessons learned	Quality Council	Monthly
e. Assist divisions in identifying projects in areas that are high risk, high volume, or problem prone. Request directors to report on logic model data reviews and selected outcome measures.	QC division reps	Ongoing
f. Compile [and make available] information on all QI efforts/ documentation	Jeannie	Ongoing
<b>Objective #2: To review the QI Plan at least annually and adjust as required to ensure ongoing quality improvement activities</b>	<b>LEAD</b>	<b>BY WHEN</b>
a. Obtain approval through Executive Team and engagement of Board of Health	Bob, Lyndia	1/31/10
b. Review plan annually and update as necessary	Quality Council	12/09/10
c. Orient Joint Management to the QI Plan	Liz	1/31/10
<b>Objective #3: To identify and meet QI training needs</b>	<b>LEAD</b>	<b>BY WHEN</b>
a. Solicit information from managers on needed QI training	Sue, Lynne	6/10
b. Identify new managers and provide orientation to QC and QI Plan. Assist managers with working with staff beginning with small, achievable projects and then moving to more in-depth QI.	Lyndia, Liz	Ongoing
c. Facilitate provision of technical assistance workshops with follow-up session throughout the year for managers and staff. Provide other identified training, as needed.	Liz	Ongoing
d. Determine ways to create a universal staff understanding of the importance of QI in our agency.	Gwen, Torney	Ongoing
<b>Objective #4: To provide guidance, support, and resources to QI efforts</b>	<b>LEAD</b>	<b>BY WHEN</b>
a. Maintain resources on Intranet for staff to use to support their QI efforts. Periodically, assess use and effectiveness of materials.	Julie	Ongoing
b. Continue assigning QC members as project assistants. Expand assistance role in reminding project staff of reporting dates and how to report to the QC.	QC reps	Monthly
c. Incorporate QI responsibilities into all position descriptions.	Lyndia, Gwen	1 <sup>st</sup> qtr 2010
d. Encourage staff to identify and incorporate science-based methods into QI projects to test and then apply, if effective.	Liz	Ongoing
<b>Objective #5: To recognize and acknowledge QI efforts</b>	<b>LEAD</b>	<b>BY WHEN</b>
a. Publicize QI stories in "In the Loop" and seek ongoing space in the District Times. Post story boards on a rotating basis in the rotunda on first floor. Present projects to the BOH and at monthly forums.	Jeannie, QC Exec Team members	At least quarterly
b. Submit applications for broader acknowledgements of QI efforts. Work with PIO on submitting recognition of agency when awarded to the local newspapers and posting on website.	Torney	Ongoing

# Quality Council Focus



## 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****2010 QUALITY COUNCIL REPORTING CALENDAR**

	<b>DATA COMPILED</b> (send forms to Jeannie Schueman by this date) <b>Date Due:</b>	<b>DATA REVIEW BY QC</b> <b>Date Scheduled:</b>	<b>REPORT TO</b>
<b>2011 Standards Review and National Accreditation Evaluation</b>		<b>November 18</b>	<b>Executive Team</b>
<b>Administrative Responsibilities</b>	<b>September 2</b>	<b>September 9</b>	
<b>After Action Reviews</b>	<b>February 4</b>	<b>February 11</b>	<b>Board of Health</b> February or March
<b>Customer Service</b> (Training & Evaluation)	<b>November 10</b>	<b>November 18</b>	
<b>Division Reports</b>			
Administration	<b>June 2</b>	<b>June 10</b>	
Community and Family Services	<b>July 1</b>	<b>July 8</b>	
Community Health Intervention & Prevention Services	<b>May 6</b>	<b>May 13</b>	
Disease Prevention and Response	<b>April 1</b>	<b>April 8</b>	
Environmental Public Health	<b>March 4</b>	<b>March 11</b>	
Health Promotion	<b>October 7</b>	<b>October 14</b>	
Laboratory	<b>August 5</b>	<b>August 12</b>	
<b>HIPAA Compliance</b>	<b>January 7</b>	<b>January 14</b>	
<b>Logical Decisions Work</b>	<b>November 10</b>	<b>November 18</b>	<b>Executive Team</b>
<b>Quality Improvement Projects</b>			
Business Process Analysis Projects	<b>See log</b>	<b>See log</b>	
Rapid Cycle Improvement Projects	<b>See log</b>	<b>See log</b>	
Other Identified Projects	<b>See log</b>	<b>See log</b>	
<b>Strategic Plan Review</b>	<b>June 3</b>	<b>June 10</b>	
<b>QC Evaluation</b>	<b>NA</b>	<b>November 18</b>	<b>Executive Team</b>
<b>QI Plan Review and Annual Report</b>	<b>NA</b>	<b>December 9</b>	<b>Executive Team, Joint Management, Board of Health (January 2011)</b>

## QUALITY COUNCIL

### Quality Council Division Representatives

**Julie Awbrey**, EPH

**Karen Crouse**, Lab and CHIPS

**Gwen Dutt**, HIPAA Coordinator

**Diane James**, Lab

**Bob Lutz**, BOH member

**Lynne Quimby**, HP

**Jeannie Schueman**, Support

**Susan Schultz**, CFS

**Torney Smith**, Admin

**Lyndia Tye**, Co-Chair, DPR rep

## 2009 Selected Quality Improvement Objectives Log – ACTIVE

Reporting Area	Lead Staff	Project Assistant	Type of QI Effort	Project Description or Objective	Start Date	Complete Date	Report Date to QC	Status
Admin/ HR	Barb Lorang	Torney	Program Eval	<a href="#">Expand Diversity Recruitment</a>	May 15, 2008	May 15, 2009	Update - 2 <sup>nd</sup> qtr 2010	Update annually
After Action Review	Susan Sjoberg	Lyndia	Program Eval	<a href="#">ERT functionality</a> : to increase understanding of major components, roles, responsibilities	February 2009	February 2010	March 2010	
BOH	Bob Lutz	NA	Program Eval	Board orientation and education	TBD	TBD	Initial report Nov. '09	
CFS	Caroline Law	Sue	RCI	<a href="#">CFS Chart Audits</a>	Sept 1, 2009	Feb 2010 (initial review)	March 2010 with annual updates	
CHIPS	Julie Albright	Liz	Program Eval	<a href="#">Continuity of Discharging Patients from Program</a>	May 1 2009	Nov 2009	Jan 2010	
DPR	Liz Wallace	Lyndia	Program Eval	<a href="#">Increase logic model completions</a> to 95% and baseline data reviews to 80%	Jan 2009	Dec 2009	Jan 2010	
EPH	Julie Awbrey	NA	RCI	Develop on-line complaint option for EPH-regulated programs	March 15, 2009	Dec 31, 2009	March 2010	
HIPAA	Gwen	NA	Program Eval	At least 90% volunteers are trained using alternative HIPAA education methods	October 12, 2009	Ongoing	March 2010	Need report
HP	Christopher Zilar	Julie	RCI	<a href="#">Pilot use of pre-authorization numbers w/lg vendor (CHAS)</a>	July 21, 2008	Ongoing	TBD	f/u report req'd
Lab	Karen Crouse, Diane James	Gwen	RCI	<a href="#">Improve water lab billing</a> system by utilizing KIPHS	2/1/09	7/15/09	Jan 2010	

**QI Objective and Performance Measures Tracking Form  
(One project/form)**

**Title of Project:**

**Division/Area Reporting:**

**Start date:**

**Initial report to QC date:**

**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)?**

**2. What is your specific objective and timeframe for improving the identified area, such as “Increase x by 10% by November 30<sup>th</sup>?” This should be your one overall objective for the project.**

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

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

Data Collection

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



## Glossary of Terms

<http://www.doh.wa.gov/PHIP/documents/PerfMgmt/material/StdGlossary.pdf>,

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

*Accessibility, 8*  
*Activities, 10*  
*Annual, 3*  
*Assessment, 3*  
*Asset Mapping, 4*  
*Best practices, 5*  
*Capacity-building, 4*  
*Coalition, 3*  
*Collaboration, 4*  
*Community, 3, 4*  
*Community Mobilization, 4*  
*Compliance, 4*  
*Cooperation, 3*  
*Coordination, 4*  
*Core indicators, 6*  
*Critical Health Services, 4*  
*Current, 4*  
*Customer Service, 5*  
*Denominator, 7*  
*Effectiveness, 8*  
*Efficiency, 8*  
*Evidence-based, 5*  
*Gap analysis, 7*  
*Goals, 10*  
*Government Management, Accountability, and Performance (GMAP), 5*  
*Health Data, 6*  
*Health Determinants, 6*  
*Health Disparities, 7*  
*Health Education, 10*  
*Health Policy, 7*  
*Health Promotion, 9*  
*Health Provider, 7*  
*Health Status Indicators, 6*  
*Impact, 11*  
*Indicated Prevention. See Tertiary Prevention*  
*Indicators, 11*  
*Internal Audit, 7*  
*Local Health Jurisdiction (LHJ), 7*  
*Local public health indicators, 6*  
*Logic model, 11*  
*Medical Home, 8*  
*Mission, 14*  
*Monitoring, 8*  
*Notifiable Conditions, 8*  
*Numerator, 7*  
*Objectives, 11*  
*Outbreak, 8*  
*Outcomes, 11*  
*Outputs, 11*  
*Partners, 3*  
*Performance management, 9*  
*Performance measure, 9*  
*Performance measurement, 9*  
*Policy development, 9*  
*Primary Prevention, 9*  
*Priorities, 14*  
*Procedure, 12*  
*Program, 10*  
*Program evaluation, 10*  
*Promising practices, 5*  
*Protocol, 12*  
*Public, 3*  
*Public Health, 12*  
*Public Health System, 12*  
*Qualitative analysis, 6*  
*Qualitative data, 6*  
*Quality, 8*  
*Quality improvement, 12*  
*Quality methods, 13*  
*Quality Plan, 12*  
*Quantitative analysis, 6*  
*Quantitative data, 6*  
*Secondary Prevention, 9*  
*Selective Prevention. See Secondary Prevention*  
*Stakeholders, 3*  
*Standards, 13*  
*Status Indicator, 6*  
*Strategic Goal, 14*  
*Strategic Plan, 10, 13*  
*Strategic Planning, 13*  
*Strategies, 14*  
*Surveillance, 8*  
*Technical assistance, 14*  
*Ten Essential Services, 12*  
*Tertiary Prevention, 9*  
*Three Core Functions, 12*  
*Training, 14*  
*Training documentation, 14*  
*Universal Prevention. See Primary Prevention*  
*Up to Date, 4*  
*Values, 14*  
*Vision, 14*  
*Washington State Board of Health, 14*  
*Washington State Department of Health, 15*