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Quality Improvement in Public Health, Lessons Learned

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Quality Improvement in Public Health, Lessons Learned

Presented by:

Scott Davis

Tacoma-Pierce County Health Department

June 20, 2011

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Introductions

Moderator

Scott Davis QI Coordinator, Tacoma-Pierce County Health Dept.

Panel

Cindan Gizzi Community Assessment Manager, Tacoma-Pierce County Health Dept.

Susan Pfeifer Assessment Program Coordinator, Tacoma-Pierce County Health Dept.

Diana Ehri Performance Management Consultant, Washington State Dept. of Health

Lyndia Tye Disease Prevention and Response Director, Spokane Regional Health District

Stacy Wenzl Program Manager, Community Health Assessment, Spokane Regional Health District

Liz Wallace Epidemiologist, Spokane Regional Health District



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Learning Objectives

- List 7 success factors for QI teams
- Demonstrate multiple approaches/QI languages
- Review case studies which demonstrate those success factors (or the absence of those success factors!)

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Seven Success Factors

1. Clear focus
2. Right people in the room
3. Clear roles
4. Method keeps people on track
5. Steady progress
6. Organizational support during and after project ... holding the gains emphasized
7. Teams recognized and progress celebrated

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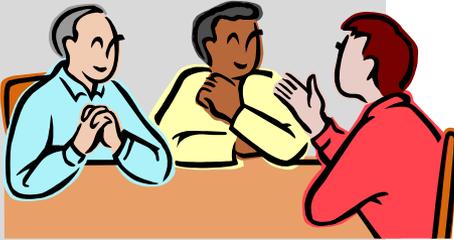


Clear Focus

- AIM Statement, or
- Team Charter, or
- Project Definition Document
- *Something* which defines (at a minimum)...
- Problem/opportunity
- Measures of success (targets and goals as appropriate)
- Team

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Right People in the Room



- Represent ...
- Functions
- Steps
- Other stakeholders
- 5-7 team members is ideal
- Sometimes other stakeholder needs can be met through regular communication/updates

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Clear Roles



- Team leader - *who is responsible for success of the project?*
- Facilitator - *who brings tools/methods knowledge and meetings/group dynamic management skills?*
- Sponsor - *who is governing and resourcing this effort?*
- Process owner - *who is responsible for on-going success of process?*

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Methods and Tools



- PDCA/PDSA, or
- Business Process Analysis, or
- Public Health Model, or
- 6Sigma-Lean, or
- *Some kind of recipe(s) which ...*
- Guides team
- Helps them be efficient and productive
- Sets up process for continuous improvement

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Steady Progress

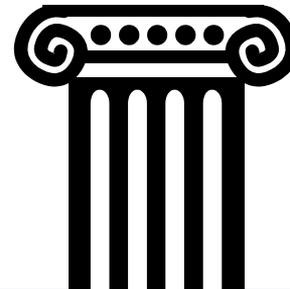
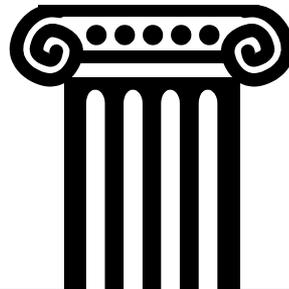
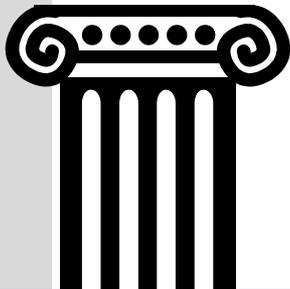
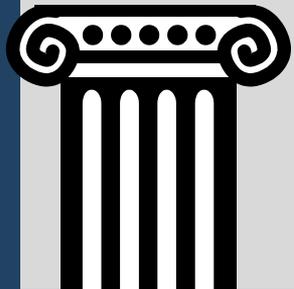


- Meeting regularly, for defined period of time
- Manage team timeline
- Avoid ... “one hour every few weeks” ... you may never finish

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Organizational Support

- Team members *and their managers* understand importance of project
- Sponsor is clear on expectations, resources and constraints
- Sponsor understands the project is just the beginning
- Process owner(s) will need to be determined
- On-going management of the process is necessary



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Holding the Gains

- Sometimes the project is the easy part
- Are measures being maintained?
- Who is accountable for controlling and improving from here?



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Recognize and Celebrate



- Staff pay attention to what leaders pay attention to
- Greatest incentive to participate in future efforts is management appreciation
- Spread value and learning through attention
- “Failure” may still be a success

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Stories from the field (click a link to see the presentation)

From Spokane

- [Opioid Treatment Program: Improving the Client Discharge Process](#)
- [Immunization Outreach Program: Improving School Immunization Records](#)
- [Vaccine for Children Program: Improving Monthly Provider Reporting](#)

From Tacoma-Pierce County

- [Title XIX AdMatch](#)
- [Low Birth Weight](#)
- [Contract Management](#)
- [Vital Records](#)

From DOH

- [Verifying Applicant Qualifications](#)

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Spokane Regional Health District

Opioid Treatment Program

**Quality Improvement Project: Improving the Client
Discharge Process**

2011

Opioid Treatment Team Members



- Program manager
- Nurses
- Epidemiologist
- Counselors
- Administrative staff



Project Description

Problem:

- Inconsistency in the detox and discharge process of non-compliant patients.

How identified:

- Committee review revealed multiple inconsistencies in the detox and discharge process
- Used Process Navigator (flow chart) to understand current process(es) and need for improvement.

.

Aim statement and Change Theory



- Reduce the percent of non-compliant patient discharges among all Opioid Treatment Patients (OTP) by 10% by March, 2010

Strategies

Reduce non-compliant discharges

- Process Navigator (flow chart) and Process Redesign to develop one unified process
- Staff education and training on new process

Most successful QI tools and methods

- Process Navigator-understand problem
- Process Redesign-develop solution
- Brainstorming-create buy-in and a great solution

•

Results: Health Outcomes

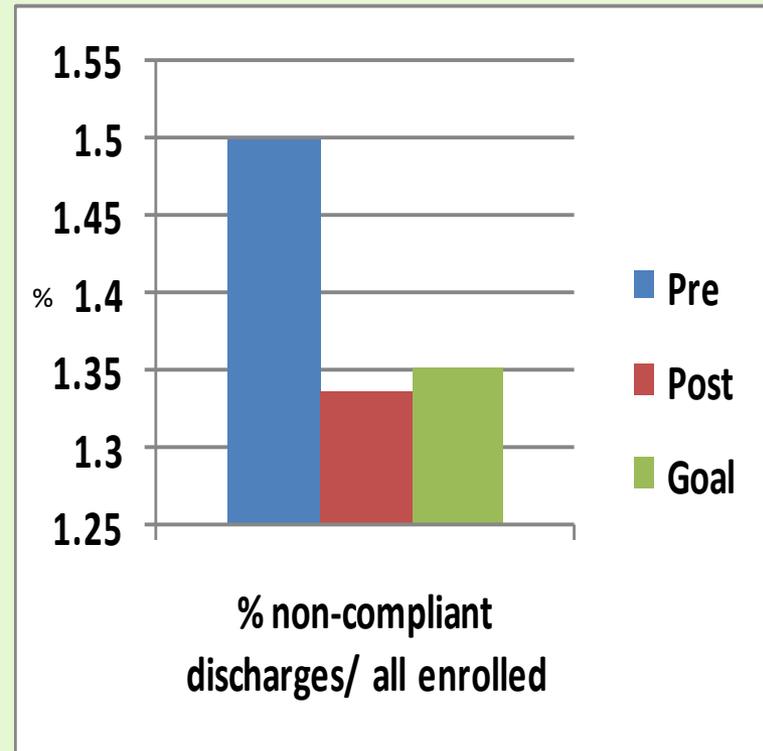
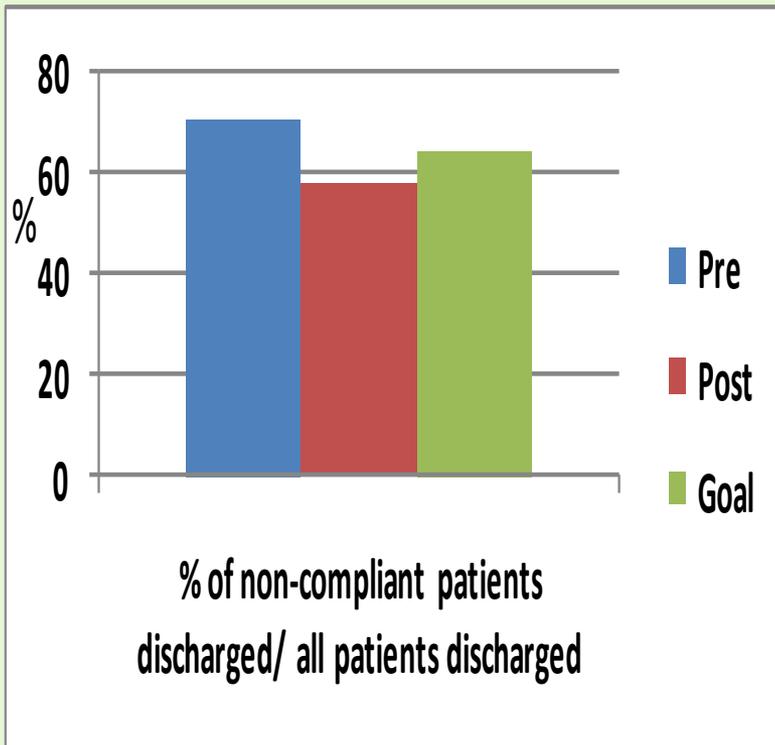


- Improved overall program efficacy by 11%

Results: Process Outcomes

- Reduced the percent of non-compliant patient discharges among all Opioid Treatment discharges by 18.7%

Results: Process Outcomes



Celebration

- This QI project was presented to the SRHD Board of Health in February of 2011 for recognition of their efforts and accomplishment.



Lessons Learned

- Unless a process is defined, everyone creates their own best practice
- Staff like to be part of the solution
- Consistency helps understanding and staff moral

Overall Goal: Reduce non-compliant discharges from Opioid Treatment CHIPS –



Problem Description: (How was need identified?)

Committee review revealed multiple inconsistencies in the detox and discharge process of non-compliant patients.

Objective:

Reduce the percent of non-compliant discharges among all Opioid Treatment patients by 10% by March, 2010.

Quality Improvement Tools Used:

Process Navigator
Brainstorming

Activities for Improvement:

- Process Navigator/ Process Redesign to develop new process
- Staff Training and Education on new process

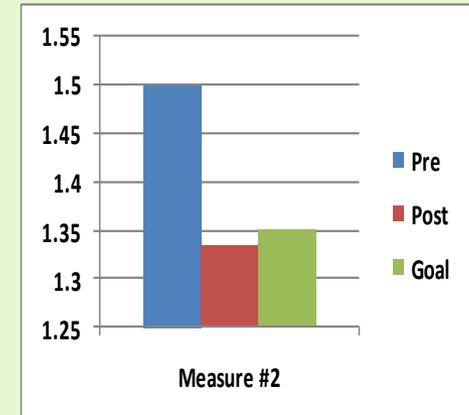
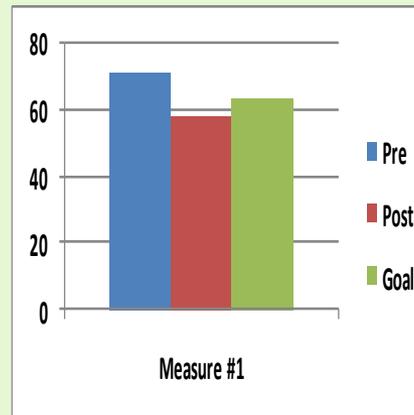
Project Results:

- Increased efficacy of program by 10%
- Reduced percent of non-compliant patient discharges among all Opioid Treatment patients by 18.7%

Project Measures:

Measure #1: % of non-compliant patients discharged among all patient discharged

Measure #2: rate of non-compliant discharges among all patients enrolled in Opioid Treatment program



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Stories from the field (click a link to see the presentation)

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Spokane Regional Health District

Immunization Outreach Program

Quality Improvement Project: Improving School Immunization Records

2011

School Record Review Project



Problem Description:

- Immunization rates in Spokane (72.6%) are lower than the state (76.4%) and nation (80.9%).
- Exemption rates in Spokane (2008/2009 school year) were higher (7.4%) than the state (5.7%).

Quality Improvement Tools Used:

- Logic Model Measurement Data
- Multiple tools – brainstorming, problem solving, spreadsheets and charts.
Customized for each school.

AIM Statements

- **Decrease convenience personal exemptions of children attending in participating school Districts by 15% by July 2010.**
- **Increase immunization rates of children attending in participating school districts by 15% by July 2010.**

Baseline: *varied by school and antigen*

Interventions

Activities for Improvement:

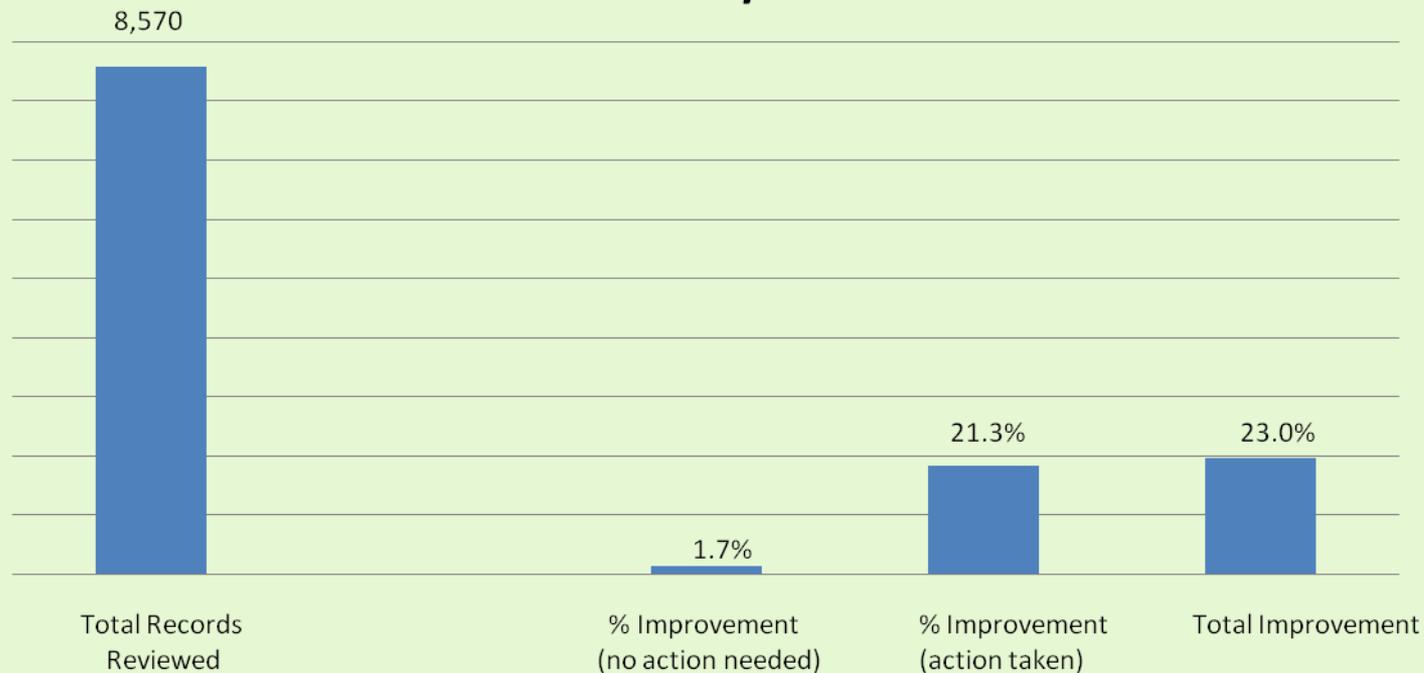
Worked with school staff to review immunization records on file.

Provided training on Child Profile to school personnel.

Provided information (letters and phone calls) to parents with children attending school and childcare on the consequences of exempting their child from immunizations.

Project Measures: Out of Compliance

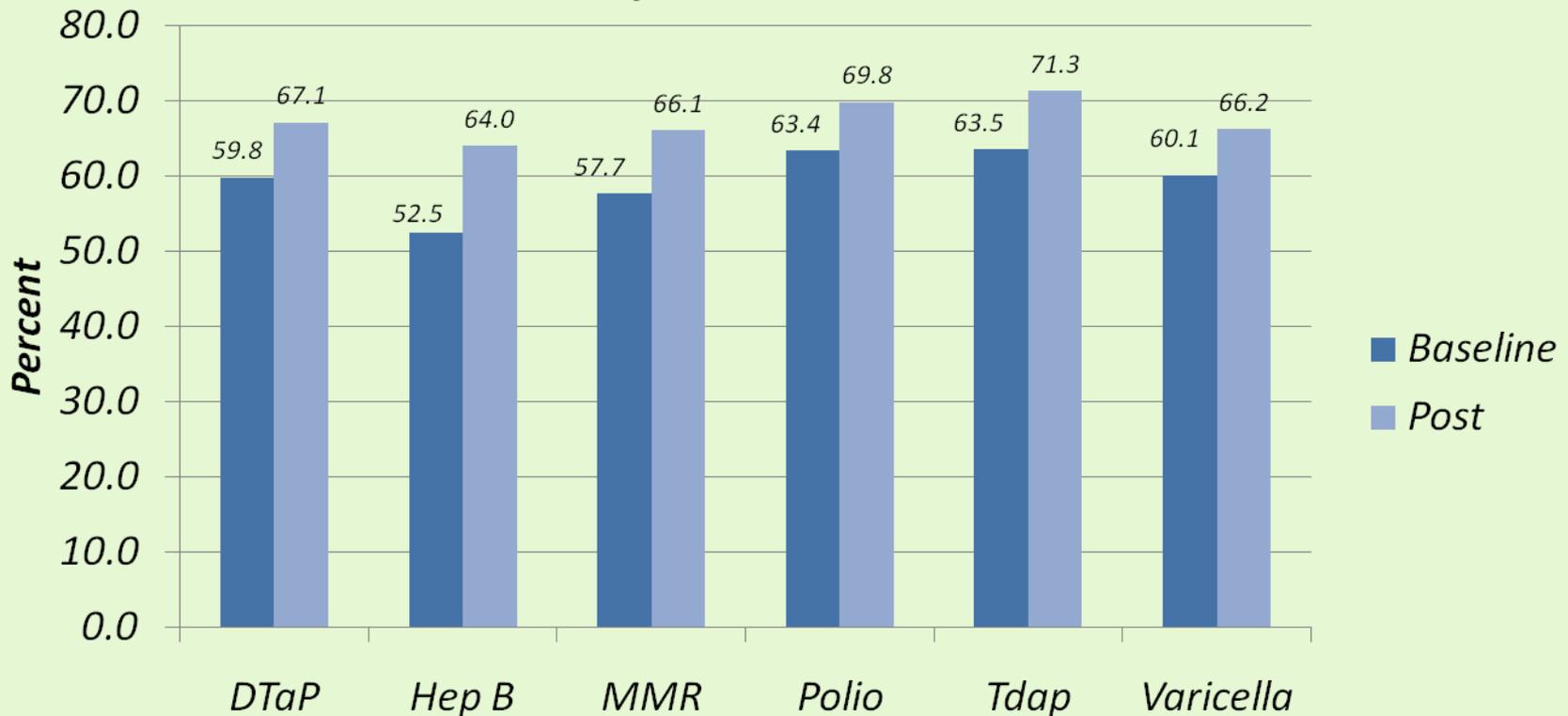
Increase in Students Up-to-Date for School Immunizations from Records Identified as Out-of-Compliance



Project Results: Compliance

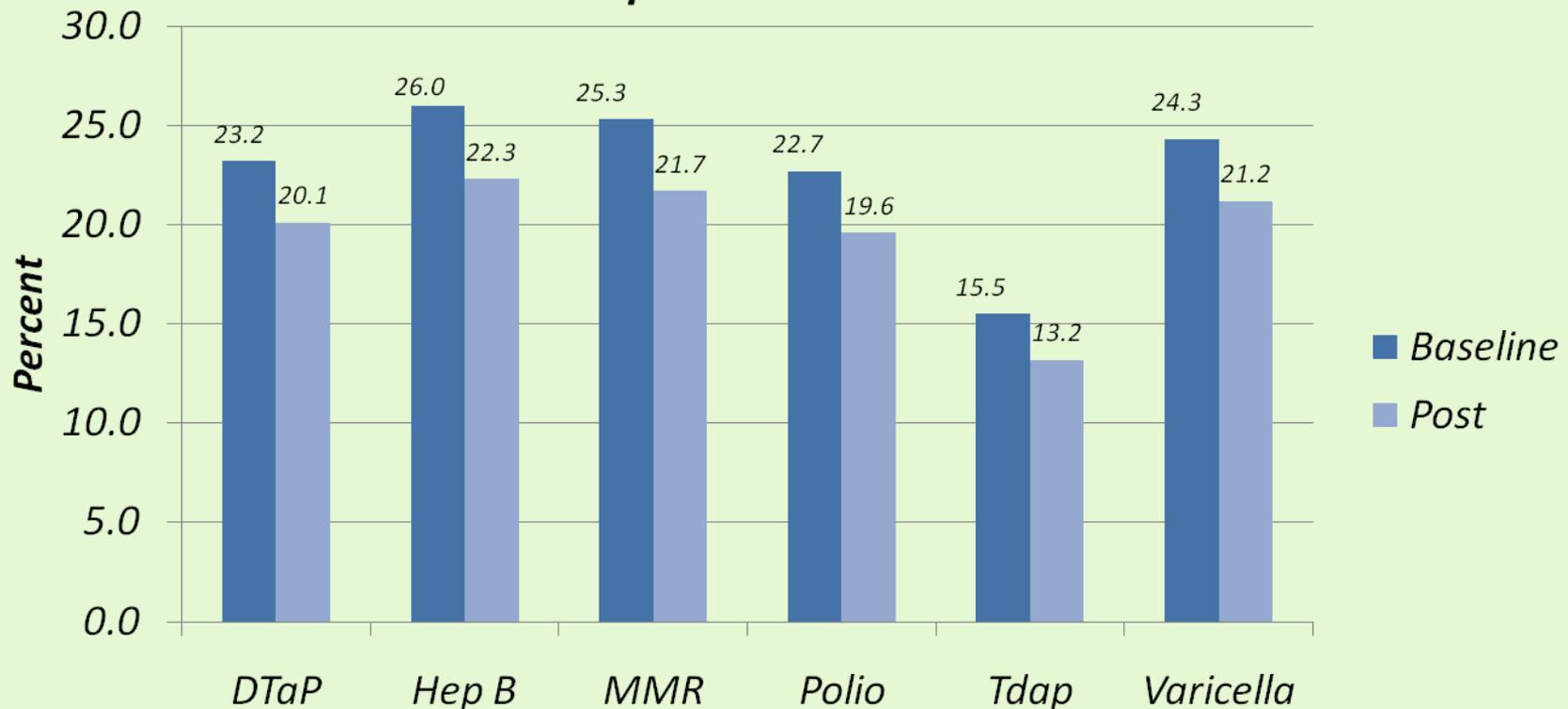


Change in Students Considered Up-to-Date for School-Required Immunizations



Project Results: Exemptions

Change in Personal Exemptions for School-Required Immunizations



Goal: Improve age appropriate school-based immunization status
Disease Prevention & Response – School/childcare Immunization Record Review Project

Problem description:

Immunization rates in Spokane are lower than the state and nation. Additionally immunization exemption rates are higher than the state.

Objective:

- Decrease convenience personal exemptions of children attending school and childcare by 15% by July 30,2010
- Increase the number of children in compliance attending school and childcare by 15% by July 30,2010
- Enter 100% of provider verified information in to Child Profile immunization registry by July 30,2010

Quality Improvement Tools Used: The quality improvement tools used to compile and analyze data were brainstorming, prioritization, problem solving, spreadsheets, and charts. These tools helped to customize the project for each school or childcare center in order to increase the impact on personal exemption rates, compliance rate, and use of Child Profile.

Activities for Improvement:

- Provided information to parents with children attending school and childcare on the consequences of exempting their child from immunizations.
- Information was provided to parent by letter and phone calls.

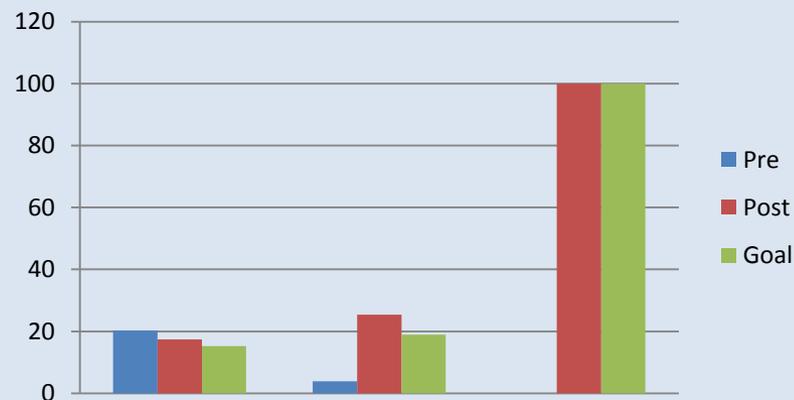
Project Results:

- Reduction in convenience personal exemptions on file by an average of 3.2% for the school project and 0.8% for the childcare project
- Increase number of children in compliance by 21.5% for both school and childcare project
- All 132 provider verified immunization records were entered into Child Profile

Project Measures:

- Percent of children with personal exemptions on file for school project
- Percent of children that are in compliance
- Percent of records entered into Child Profile (132)

Performance Measurements and Goals:



Lessons Learned

- Every school district tracks immunizations differently
- Discrepancies with parent-reported data
- Exemptions of “convenience” = unreliable data
- Phone calls to parents got the best results
- Schools need to take on project to make it sustainable
- AIM statements developed prior to having a clear understanding of data quality, resulting in challenges with project measures

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Stories from the field (click a link to see the presentation)

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Spokane Regional Health District

Vaccine for Children Program

Quality Improvement Project: Improving Monthly Provider Reporting

2011

Vaccine For Children Program - Monthly Provider Reporting



Problem Description:

2009 logic model data: 48% provider reports required follow-up due to errors

July 2010: 87% provider reports required follow-up due to errors

Quality Improvement Tools Used:

- **Logic Model Measurement Data**
- **Fishbone Diagram**
- **Check Sheet**

AIM Statement

- Decrease the percentage of monthly accountability reports submitted by Spokane County medical providers who participate in the Vaccine for Children program needing staff follow-up by 50% by September 2010.

Baseline: 87% reports had errors in July 2010

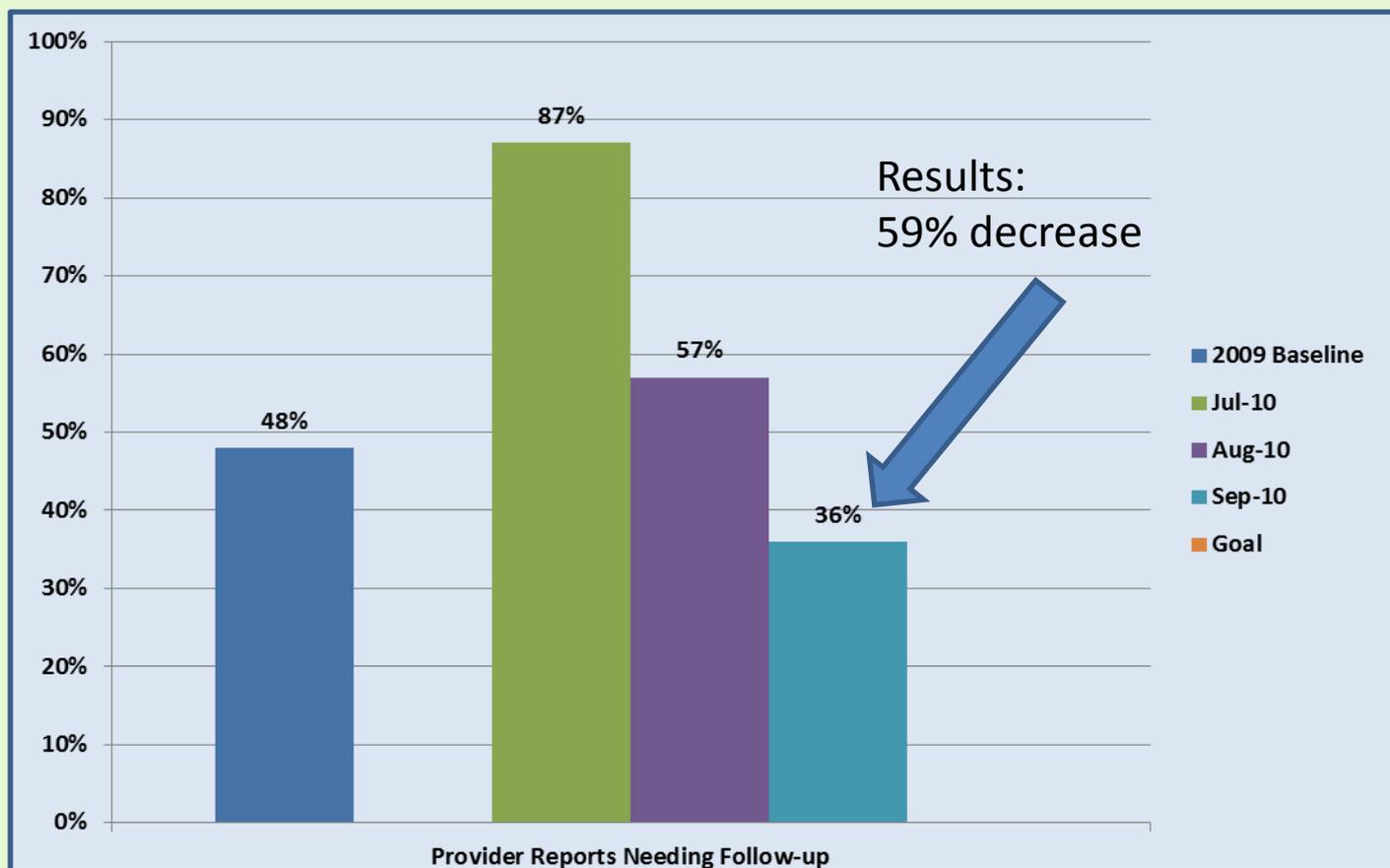
Interventions

Activities for Improvement:

- 1. Created instruction manual with sample provider reports for the problem providers to follow when completing their own reports.**
- 2. Met with problem providers one-on-one to educate them on how to correctly complete reporting documents.**
- 3. After report received and errors found, contacted providers by email, fax and phone to discuss reporting issues and educate them how to properly do it next time.**

Project Measure

**Percentage provider reports submitted
requiring staff follow-up due to errors**



Goal: All submitted monthly vaccine accountability provider reports will not require follow-up
Disease Prevention & Response – Vaccine For Children Provider Monthly Reporting

Problem Description:

2009 logic model information showed that 48% of provider reports required follow-up. Data collected in July 2010 showed an increase to 87% of provider reports required follow-up.

Objective:

Spokane County medical providers who participate in the Vaccine for Children program will submit 50% fewer monthly accountability reports needing follow-up by September 2010, compared to the amount of reports submitted needing follow-up in July 2010.

Quality Improvement Tools Used:

- 1) Fishbone Diagram
- 2) Check Sheet

Activities for Improvement:

- 1) Met with problem providers one-on-one to educate them on how to correctly complete reporting documents.
- 2) Created instruction manual with sample provider reports for the problem providers to follow when completing their own reports.
- 3) Contacted providers by email, fax and phone to discuss reporting issues and educate them how to properly do it next time.

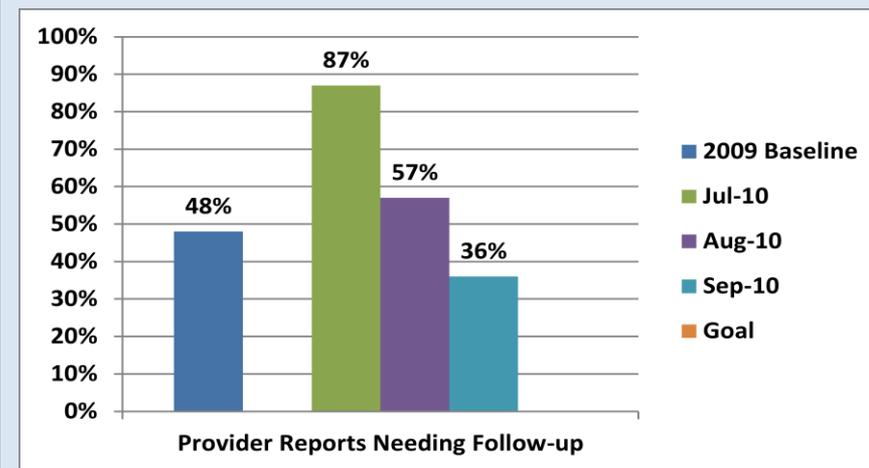
Project Result:

- Over 50% decrease in the number of provider reports submitted by September 2010 needed follow-up

Project Measure:

- Percentage of provider reports submitted requiring follow-up by September 2010

Performance Measurements and Goals:



Lessons Learned

- Educating providers “real time” is more effective
- Ongoing challenge with staff turnover
- Some providers do not use technology

Next Steps:

1. Developed auto fill form – continue to implement with providers who are computer literate
2. Annual mandatory meeting for all VFC providers coming up

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XIX AdMatch QI Project

A “hybrid” between QI-QP



AdMatch Improvement Project Summary

Define

Mission: “Increase the total Title XIX administrative match dollars appropriately reimbursed to the agency annually (by 30% or more)”

Measures:

- **Outcome:** \$ collected under Title XIX
- **Process:**
 - % Matchable Moments (appropriate/accurate)
 - MER % (appropriate/accurate)
 - # FTE/\$ in positive cost pools (appropriate/accurate)

Project Definition Document

| | |
|---|---|
| <p>Project Name: Administrative Match Improvement <i>1-3 word identifier</i></p> | <p>Sponsor(s): Anthony Chen <i>Who is governing and resourcing this project?</i></p> |
| <p>Problem/Opportunity: Administrative match revenue has been trending downward over last two years. Additionally, the Admin Match primary vendor indicates that health departments in similar communities receive substantially more reimbursement than TPCHD has historically. An opportunity exists to determine if improvements in our processes/coding/practices could result in substantial Admin Match revenue increase for the agency. <i>1-2 sentence description of the problem/opportunity (without assumption of cause or solution)</i></p> | |
| <p>Measure(s): Billed Admin Match Revenue (\$) Secondary... # Unanswered Random Moments # "non-matchable" moments that could have been "matchable" #/% eligible staff participating; MER %? <i>The indicator(s) which would demonstrate performance had improved. More than 2-3 primary measures may indicate lack of focus</i></p> | <p>Target(s): 30+% increase (roughly an additional \$400,000 or more p/y) <i>How much improvement is expected/hoped for?</i></p> |
| <p>Mission: Increase the total Title XIX administrative match dollars appropriately reimbursed to the agency annually (by 30% or more) <i>1 sentence declaration as to what the project team is to do (without assumption of cause or solution)</i></p> | |
| <p>Process(es) to be addressed: Start: Staff determined to be eligible Stop: Successful billing NOTE: A second process is also critical to the billing result: MER rate calculation <i>The "start" and "stop" of the process(es) to be improved/built</i></p> | <p>Customer(s): Primary: DSHS (they pay us) Secondary: Staff, Anthony (the Department) <i>Who is/are the customer(s) of the process/processes?</i></p> |
| <p>Team Leader: David Vance & Marcy Kulland Co-Leaders <i>Who is primarily responsible for the conduct and success of this project? (Ideally, will coincide with the process owner)</i></p> | |
| <p>Team Facilitator: Scott Davis <i>Who will be assisting the leader with QI methods and tools and group process facilitation?</i></p> | |
| <p>Team Members: Stevie Fanshier – Finance Linda Miner – F.S. Partnership Claudia Castini – Comm Disease Supervisor Susan Pfeiffer – OCA Dave Bischof (or designee) – Substance Abuse Lea Johnson – SF Nursing supervisor Andy Rohr – Strengthening Families MA Anne Harrington – QA/coding "Consultants" as needed ... Hansine Fisher, Chris Morrison (billing), staff/contract EE, Rebecca Casey (MER data) <i>Who will be active participants on the project team? Ensure representation of process steps and other key stakeholders.</i></p> | |
| <p>Constraints: Deadlines/system requirements of AdMatch program/system \$\$ (budget tbd) <i>Are there time, space, financial, system, policy, organizational or other constraints that the team leader and members should be aware?</i></p> | |

XIX AdMatch Improvement Team: Analysis Summary

As of 7-22-10

Cost Allocations +



Marginal impact
 *Small \$ shift to cost pool 6
 *Keep costs in pools 1&2
 If maximizing matchable moments

Indirect Federal Rate X



Team cannot affect

X

RMTS Matched Moments



Late/Non-Responses



Less than 1%

Mis-code/
Bad Description



30%

Canned responses



50%

X

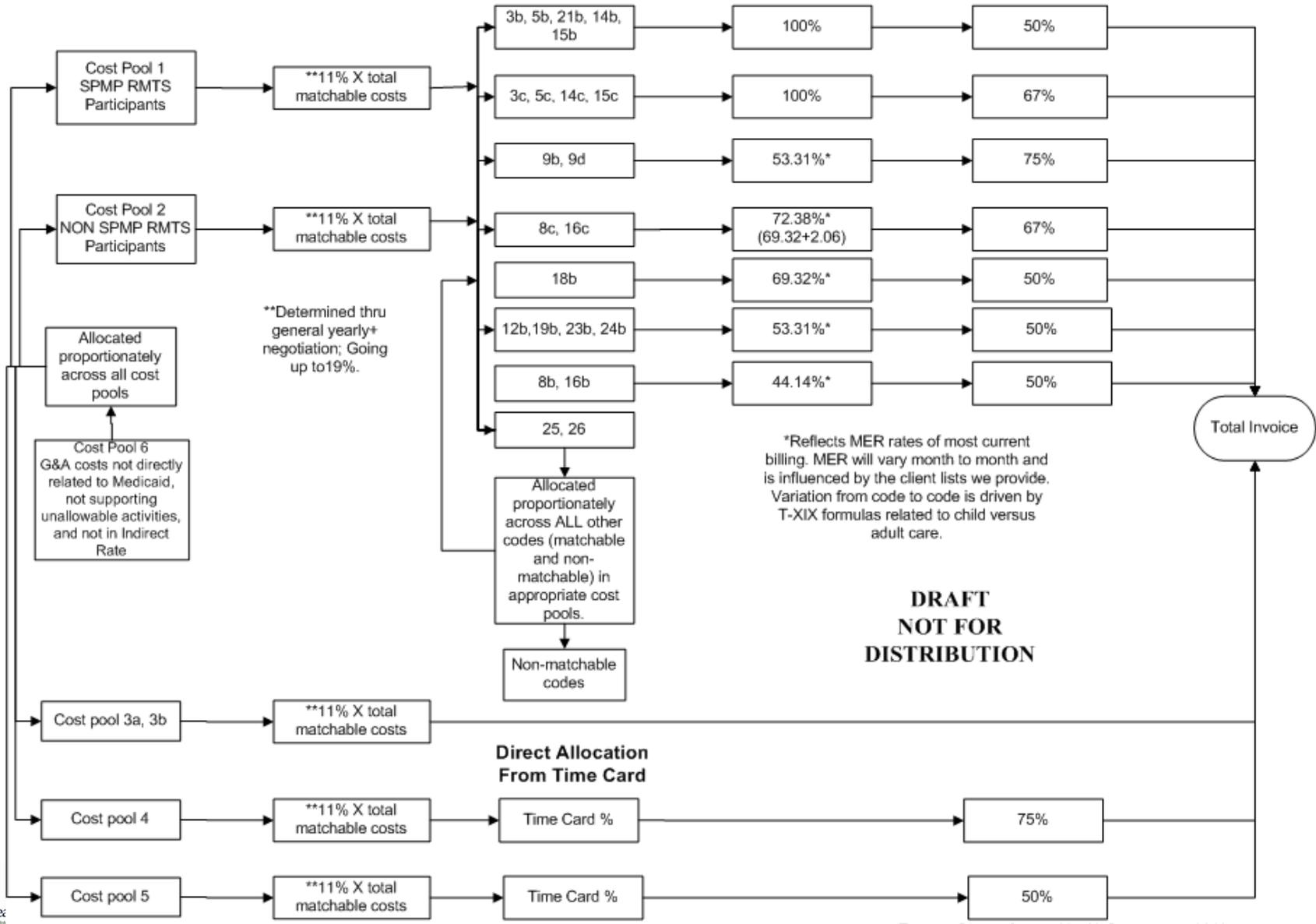
MER %



*Currently at 50%; King Co. at 70%
 *Incomplete, inaccurate client list info in FSP (60% MER now)
 *Inaccurate filter by State(?)
 *CD largely anonymous and fewer Medicaid clients
 *SA expanded Client list

Title XIX Admin Match Invoicing/Reimbursement Components (7-9-10)

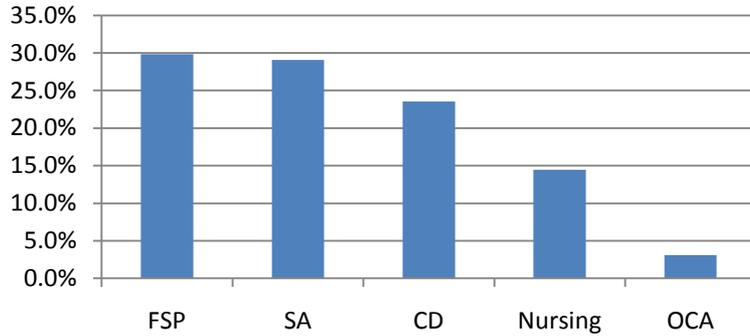
$$\left(\begin{matrix} \text{Expenditures} \\ \text{by Cost Pool} \end{matrix} + \begin{matrix} \text{Indirect Cost} \\ \text{Reimbursement} \end{matrix} \right) \times \begin{matrix} \% \text{ time/cost} \\ \text{Code Allocation} \\ \text{From RMTS} \end{matrix} \times \begin{matrix} \text{MER} \\ \text{Medicaid Eligible Clients/} \\ \text{Total Clients Served} \end{matrix} \times \begin{matrix} \text{Federal Reimbursement} \\ \text{Rate} \end{matrix} =$$



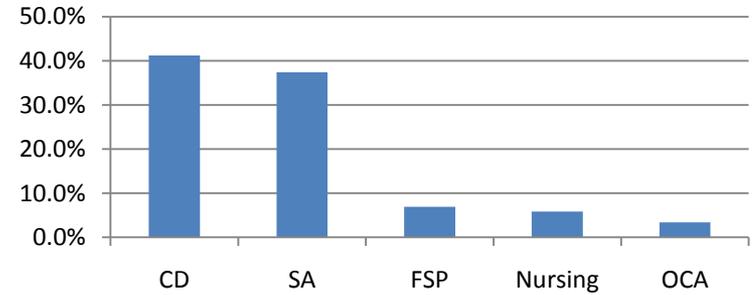
Data Analysis

(a sampling)

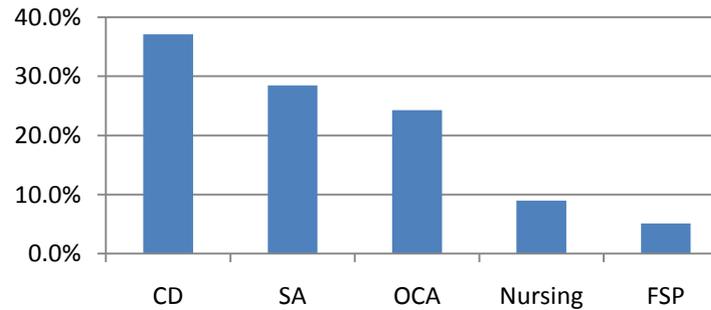
% of Total Dept Moments



% of Dept. Matchable Moments

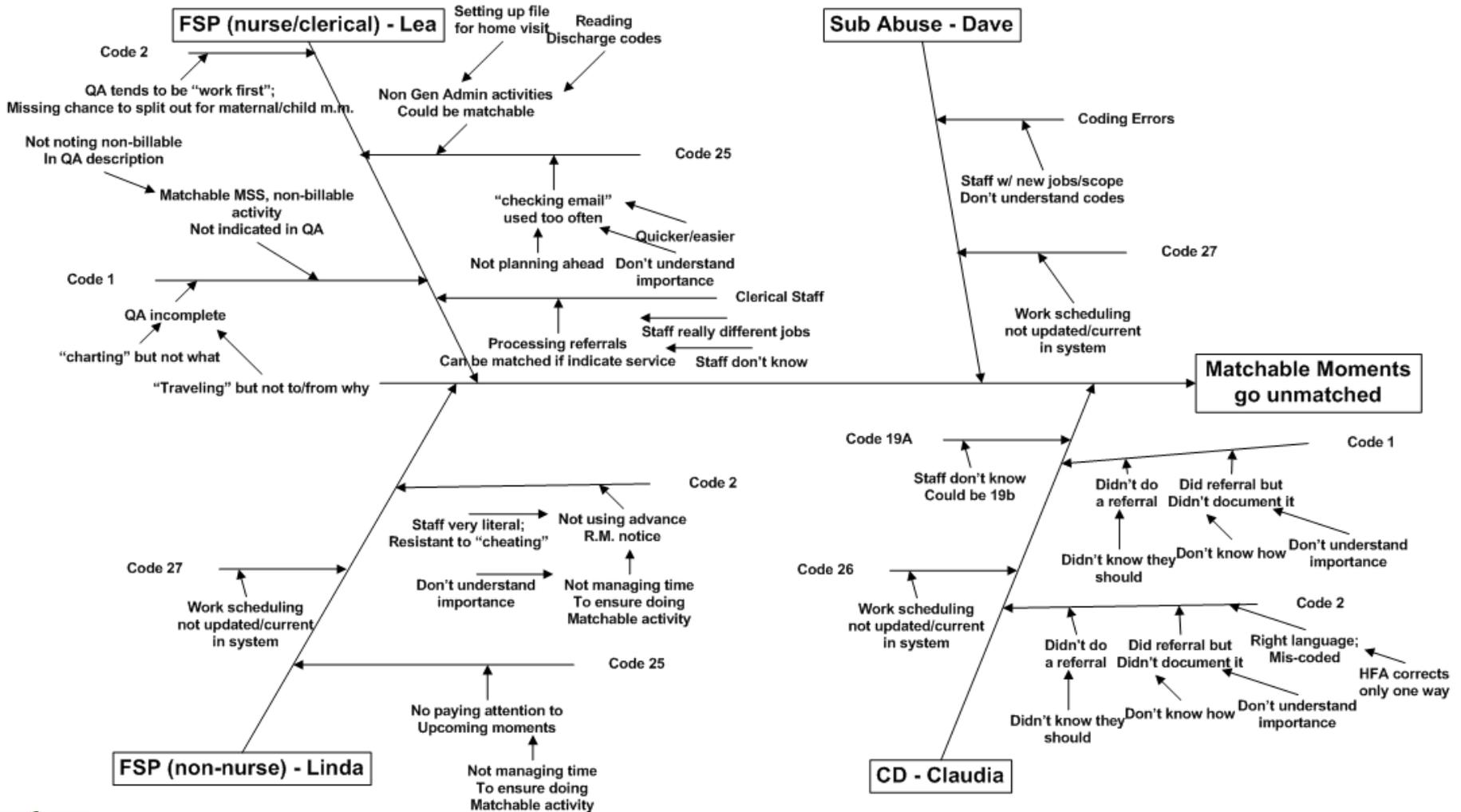


% Matchable Moments by Unit



Cause-Effect Diagram

(one of several)

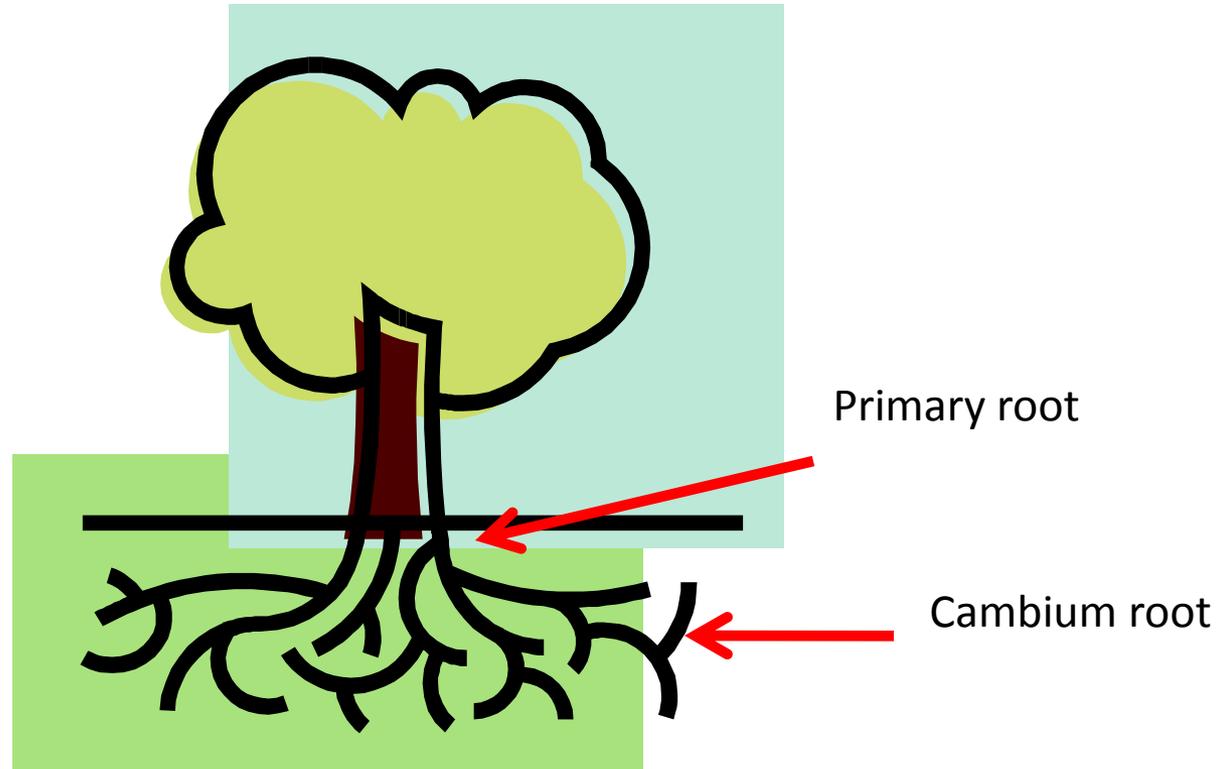


AdMatch Improvement Project Summary

Analyze ... Key Findings:

- FSP by far the largest opportunity (most Random Moments/Lowest % matchable)
- AdMatch program not understood, valued or managed in most of Department
- Most staff & supervisors don't understand how to accurately and effectively code/describe
- Cost pool assignments not optimal or accurate
 - – too much in cost pool 3
- MER/Client Lists can be marginally improved
- No one is “in charge”

Hey! Where's the “Root Cause”?



AdMatch Improvement Project Summary

Change

Summary of Key Changes:

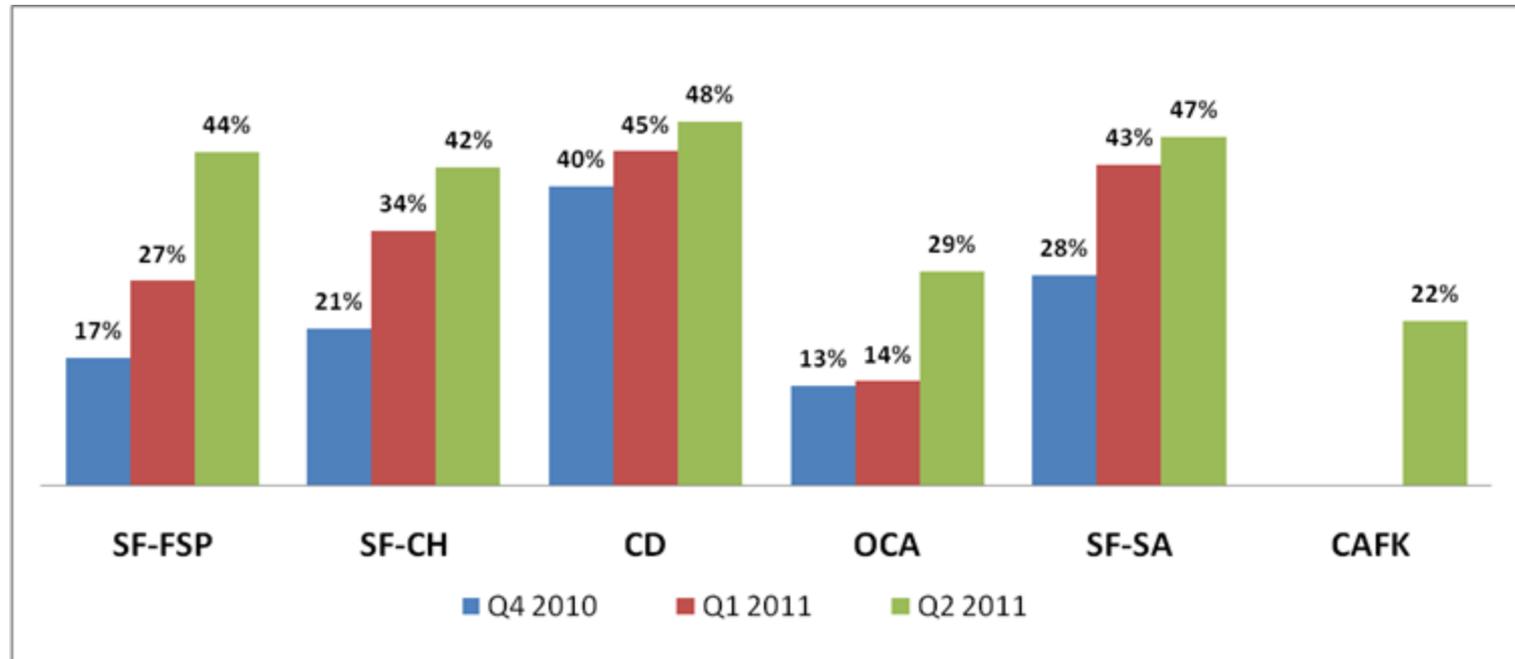
- Copy/Improve CD performance aid – customize for each Program
- Communicate value of AdMatch (now and on-going)
 - “MOR4ALL” in and of itself
 - \$\$ reimbursement (\$375 per moment on average)
- Improve evaluation/qc measures for supervisors and staff
- Create cross-Department AdMatch “coordinator” role
- Audit current cost pool/RMTS assignments
- Tweak MER/Client list collection in FSP and SA
- Incorporate AdMatch into EE evaluation

Admatch

Evaluation Phase

We now measure, trend and provide feedback on ...

- % matchable by program (division/dept)
- \$ by program (division/dept)
- Cycle time of invoice submittal
- Costs per cost pool/claiming unit
- MER % by program



Success Factors?

Did well

- **Clear focus** ... took time to get there
- **Right people in the room** ... all programs and functions represented (big!)
- **Methods & Tools** ... facilitator took team through defined phases and steps ... avoided tangents and dead ends
- **Steady progress** ... analysis phase complete within 8 weeks; recommendations in place within 12
- **Organizational support** during and after ... priority clearly communicated; time made; holding the gains funded

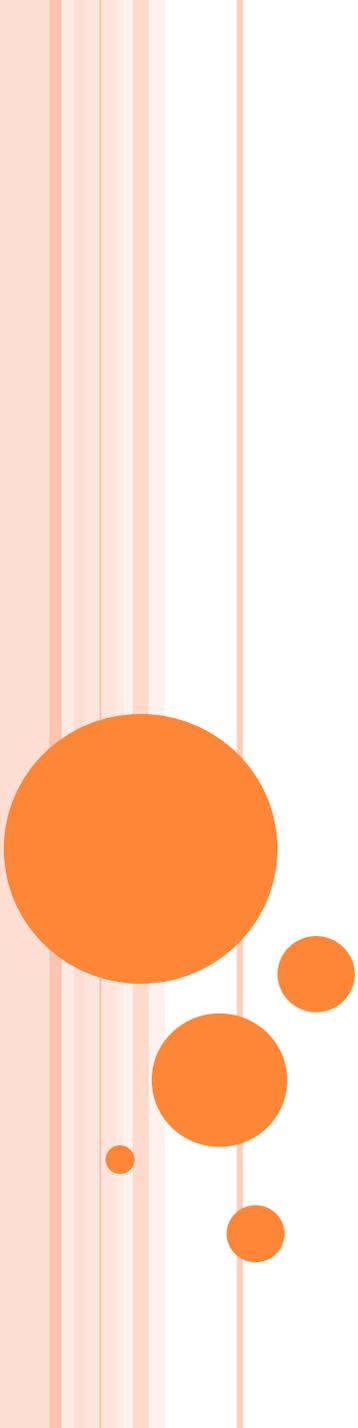
Could Improve

- **Role Clarity** ... two leaders ... facilitator filled the void
- **Recognition and celebration** ... Took a while

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Stories from the field (click a link to see the presentation)

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LOW BIRTH WEIGHT – QI PROJECT

TEAM MEMBERS

Initial project team

Nursing Supervisors
Assessment staff person
Home visiting nurses

Revised project team

Nursing supervisor
Assessment staff person
Health educator



#1 PROJECT DESCRIPTION

Problem: The Pierce County low birth weight rate (LBW) for singletons is worse than the WA State rate. LBW is associated with developmental and growth problems.

How identified: Review of WA State and TPCHD health indicators by TPCHD Quality Improvement Council led to convening a LBW Priority Health Indicator workgroup.

We elected to work on improving our internal process for providing Maternity Support Services (MSS) to Medicaid eligible women in our county. MSS includes public health nursing home visits for prenatal/postpartum education and referrals.

#2 PROJECT DESCRIPTION

Opportunity: MSS changes starting in July 2009 resulted in variation of service levels based on risk. Pierce County African American enrollment in prenatal MSS for eligible women was below the state rate.

How identified: Data analysis from DSHS indicated that improved AA birth outcomes were associated with Maternity Support Services.

Used QI tools and concepts to increase the capacity of the Black Infant Health (BIH) project. Health ministers are supported and trained to provide health messages, linkage with services including medical care and referral to MSS.

AIM STATEMENT

#1 Increase by 20% the number of opened Maternity Support Services (MSS) referrals who received a Public Health Nurse (PHN) office or home visit within 20 working days from referral. (Baseline 60%)

#2 Increase by 10% the number of MSS eligible AA women who receive prenatal MSS in Pierce County. (Baseline 70.4%, WA State rate 78.9)

BLACK INFANT HEALTH PERFORMANCE MEASURES

Process measures reported quarterly to TPCHD Quality Improvement Council:

- Number of women enrolled and tracked through Health Ministers -Black Infant Health project.
- Recruit and support two additional Black Infant Health Project referral churches/organization sites.
- Facilitate networking meetings with community partners working toward elimination of health disparities in AA birth outcomes.

MOST SUCCESSFUL QI TOOL AND METHOD

- Fishbone (What are some of the barriers?)
- Dashboard and trend charts. (How are we doing?)

Black Infant Health

- Selecting and tracking performance measures.

Comm capacity

CHC not taking
CSO referred

incomplete info - not enough to
prioritize ACCESS
online or
call center referrals
preferred mode of contact

CSO meeting
point out what is
missing how to
improve info on
referral

info - dispo use
Common
MSS

FSC process or different

no protocols FSW - MSS
to PHN - DW to
V on

diff coord
schedules
"yellow" stays on
fax - Brenda

TPCHD not
taking

Staffing
high case load
↓ PHS

ACSHCN → NFP start up
turn over
PCM time competition
CARENET

mon
working
hard to
schedule

links
to step by
step
Early Referral
Late referral
1st tri

Delayed
engage
ment
not interested
MSS
PHN

↑ training

priority cases
↑ contacts

↓ Staff
same ref #

don't under-
stand
services

doesn't want
MSS

had it before
L don't need it

time limits - WF - EIP
Sense of ↑
acuity

not explained
at time
apply for
coupon

MA issues
Privacy
L dirty house

TPCHD
capacity

↓ involvement
↑ other agencies

↑ chronic cases
Δ's @ CPS on how
they manage → creates in including
↑ time for PHN's
(transfer CPS caseworker)

Client
Specific

DV focus internal

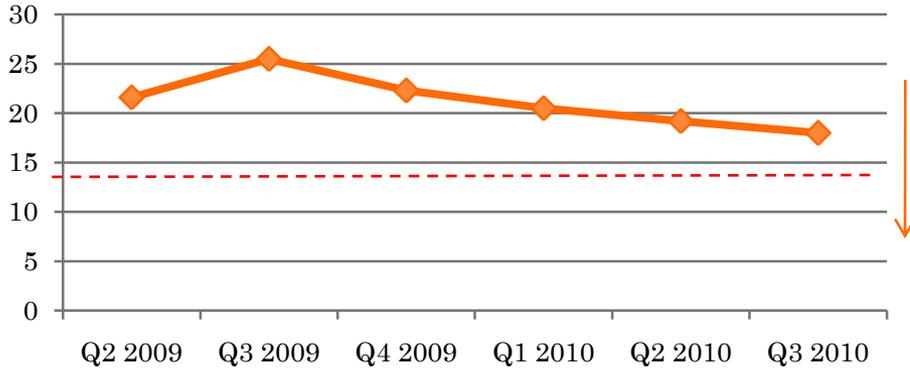
DASHBOARD

| | 2009 2nd Q | 2009 3rd Q | 2009 4th Q | 2010 2nd Q | 2010 3rd Q |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| % referrals PN | 90% | 92% | 86% | 65% | 52% |
| % opened in same quarter | 30.50% | 38.00% | 30.20% | 44.00% | 83.00% |
| Wks pregnant at ref (mean) | 21.6 | 25.5 | 22.3 | 19.2 | 18.0 |
| Working days ref to 1st attempt to contact (mean) | 3.8 | 6.9 | 4.7 | 3.7 | 3.6 |
| % 1st attempt to contact within 10 days from referral (target 90%) | 96% | 85% | 92% | 96% | 96% |
| Wks pregnant at open (mean) | 23.2 | 29.1 | 25.4 | 19.4 | 21.6 |
| Working day 1st attempt contact to open (mean) | 13.2 | 8 | 11 | 16.4 | 12.7 |
| Working days referral to open (mean) | 15.9 | 10.5 | 14.6 | 18.9 | 15 |
| % of referrals opened that were opened within 20 working days form referral (target 75%) | 66% | 89% | 89% | 67% | 84% |
| Prenatal care began 1st trimester(where information known) | 87% | 93% | 88% | 87% | 90% |

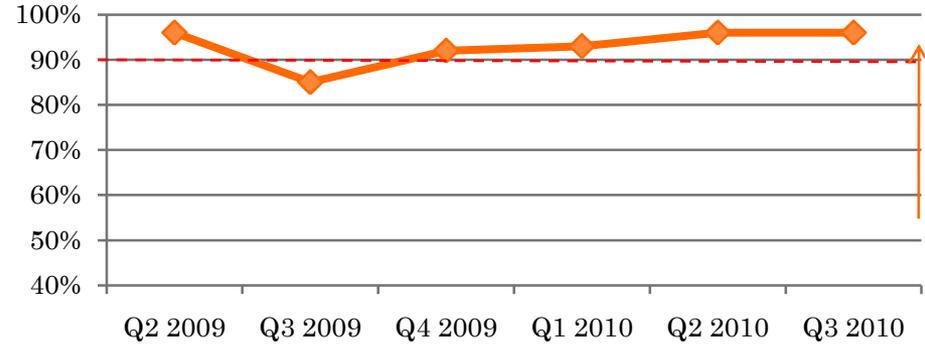
Skipped 1st Q 2010 due to H1N1

Trend Charts

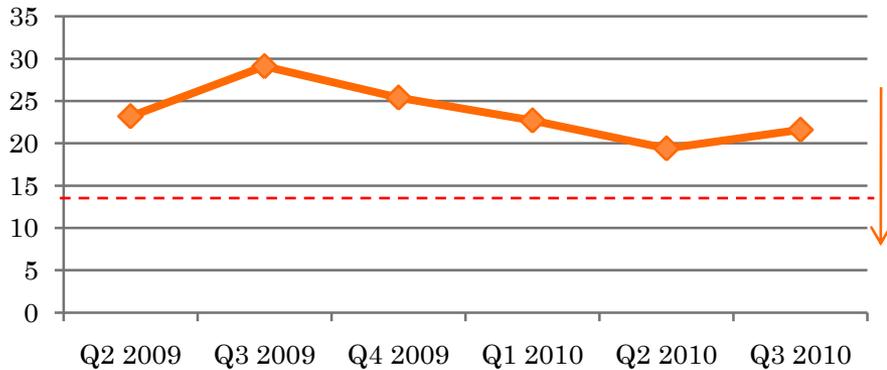
Weeks pregnant at referral (mean)



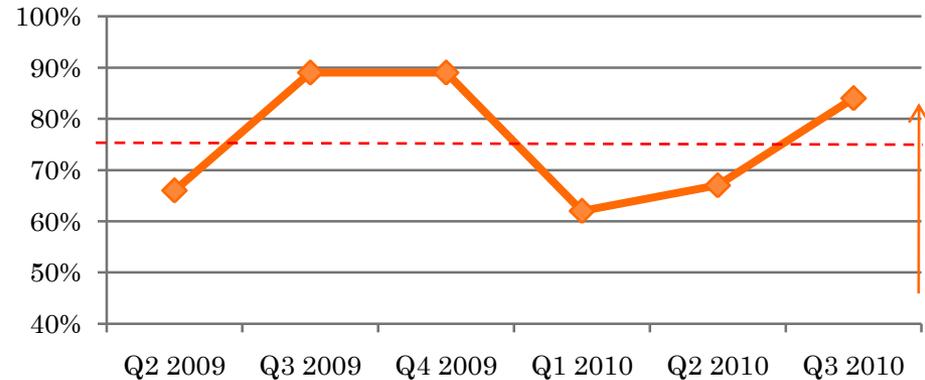
Percent first attempt to contact within 10 working days of referral



Weeks pregnant at open (mean)



Percent open within 20 days of referral



MOST SUCCESSFUL ACTIONS

- Informal data collection with an RCI process.

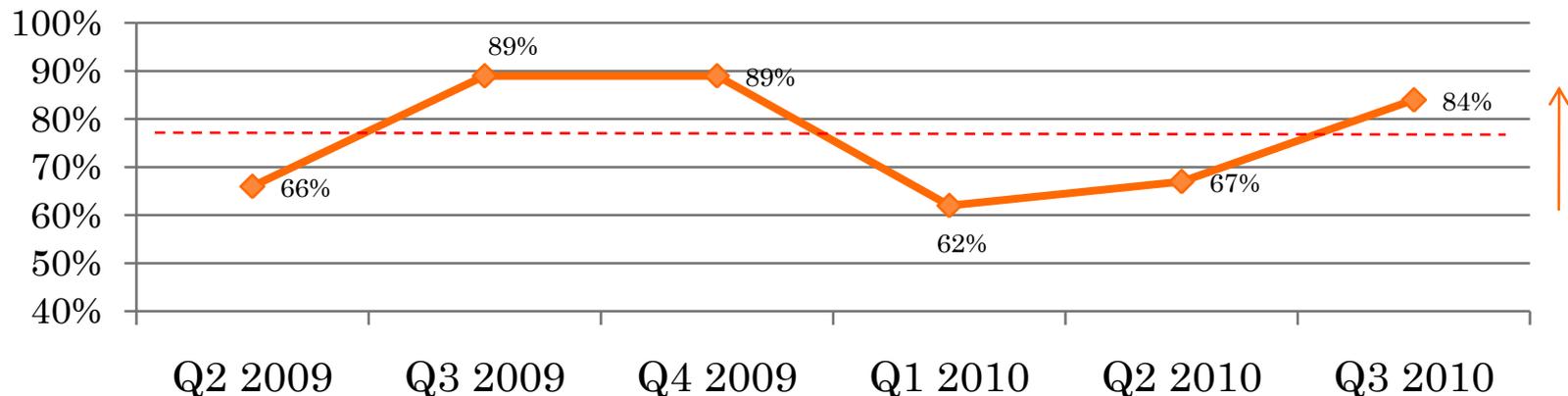
Black Infant Health

- Added staff outside of Maternal Child Health for different perspective and skills.

RESULTS: MISSED TARGET (75%) OF 20 WORKING DAYS TO OPEN 2 QUARTERS IN A ROW

- Data now part of weekly supervisors' meeting.
- Possible impact from total of holidays, furloughs and LOA's? Staffing?
- Need more data point to understand variation?

Percent that are opened to services who receive home visit within 20 days of referral



RESULTS: BLACK INFANT HEALTH

- Aim statement – data available annually
- Exceeding 2010 targets

Process measures:



| Measure | 2010 target | Q1 | Q2 | Q3 | Q4 | % of target |
|----------------------|-------------|----|----|----|----|-------------|
| # women enrolled | 30 | 8 | 6 | 9 | 14 | 123% |
| # new referral sites | 2 | 1 | 3 | 0 | 0 | 200% |
| # networking mtgs | 20 | 4 | 10 | 6 | 4 | 200% |

LESSONS LEARNED

- QI takes time but it has become the *way* we do our work not the *work* we do.
- Having a QI infrastructure helped support our project.
- Budget and staffing challenges are also continuous!
- Things don't always go as planned!
- Brought someone onto team outside MCH.
- Kept a calendar of meetings and follow-up items.
- MLC collaboration model- experience and knowledge shared, technical support and iLincs all enhanced our learning!



Description of the

Problem: The Pierce County low birth weight rate (LBW) for singletons is worse than the WA State rate.¹ LBW is associated with developmental and growth problems.
How identified: Review of WA State and TPCHD health indicators by TPCHD Quality Improvement Council led to convening a LBW Priority Health Indicator workgroup.

#1 Aim Statement

Increase by 20% the number of opened Maternity Support Services (MSS) referrals who received a Public Health Nurse (PHN) office or home visit within 20 working days from referral. (Baseline 60%)

Theory for Improvement

IF we engage MSS eligible women early (1st trimester) in pregnancy for health promotion education and referral for behaviors and conditions associated with LBW, such as smoking, drug-use, poor nutrition and lack of medical and dental care THEN we can impact positive birth outcomes.

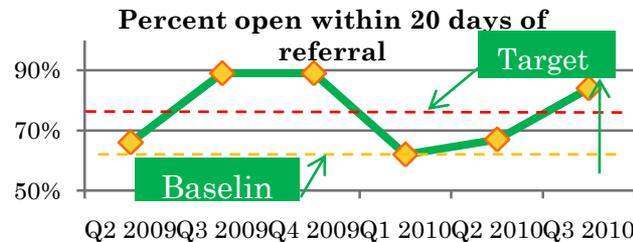
QI Tools

Work flow analysis showed that there wasn't a single, consistent process for handling referrals across sites. Through root cause analysis (fishbone) we identified the competing responsibilities in addition to MSS that PHNs faced. Trend charts provided visual display for monitoring our intervention outcomes. A Pareto chart helped us identify and further define reasons some referred clients did not receive services (never opened).

PDSA Results & Discussion

Our project focused on internal processes for improvement.

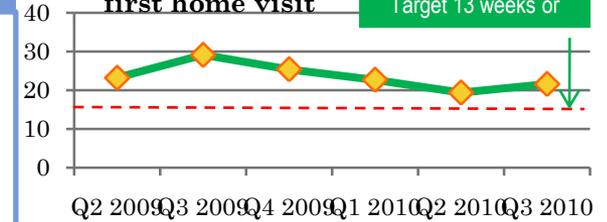
1. Developed standardized referral process.
 2. Developed practice standard: PHNs to attempt 1st contact within 10 days of referral.
 3. Created new data collection fields (ex. due date, trimester care started).
 4. Revised disposition codes (reasons referrals closed or not opened).
- The **Aim Statement** measure has remained above baseline but did not meet the target for the last two quarters. Using the (S) Study phase for Q1 and Q2 2010 we theorized impact of furloughs, holidays, and increased leave times as causes. The average gestation for a first home visit has been getting earlier but is not yet in the first trimester. Common cause or special cause variation? We did not make any changes Q1 and Q2 2010 (A- Act) electing to continue to (S-study) data. With Q3 2010 above target we shared findings and considered factors for variations.



Outcomes

- Data review now part of weekly supervisor meeting-work processes.
- Now capture number of referrals that received telephone consultation, but did not open for services (non-billable).
- After observing an increase in prenatal referrals we learned that one referral source was holding referrals then sending a "batch", delaying early referrals. Referral was educated and process now improved.
- A more than 250% increase in post-partum referrals over the project period. With further study we found that an increasing number not referred for prenatal MSS. We are continuing to understand the causes for this and improve on targeted outreach and education directly to selected MSS referral sources in Pierce Co. to encourage prenatal referrals.

Weeks pregnant at first home visit



Project refocused

In July 2009 the MSS program underwent major changes including a 20% budget cut. Data analysis from DSHS at that time indicated that improved African American (AA) birth outcomes were associated with MSS enrollment. A new team convened and applied QI methods to the Black Infant Health (BIH) project. The BIH project recruits, trains and supports AA churches in efforts to enroll pregnant women in health services, including MSS. The percent of Pierce County MSS eligible AA women who receive prenatal MSS was below the WA State rate of 78.9%.

#2 Aim Statement

Increase by 10% the number of MSS eligible AA women who receive prenatal MSS in Pierce County. (Baseline 70.4%).

Performance measures

1. Number of women enrolled and tracked through BIH project.
 2. Recruit and support two additional BIH project referral churches/organization sites.
 3. Facilitate networking meetings with community partners working toward elimination of health disparities in AA births.
- 2010 targets for these measures have been met or approaching.

Challenges: Impact of continued budget cuts on MSS.

¹ Based on 2003-2005 data from the Washington State Department of Health. Pierce County LBW rate is 10.5%.

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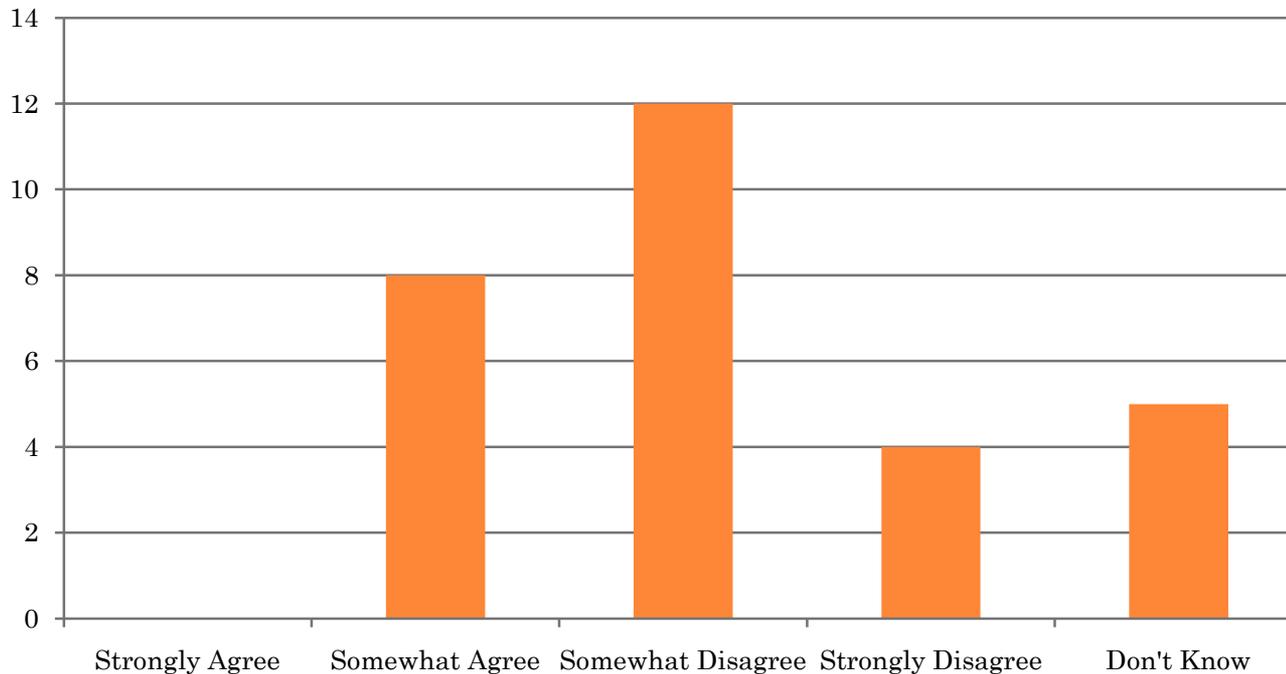
CONTRACT MGMT PROJECT SUMMARY

Project Definition: Reduce the cycle time of, and increase user satisfaction with, the contract management process, while supporting the Contracts and Signature Authority Department Policies.

INTERNAL SATISFACTION BASELINE

Contract Mgmt Process Easy to Understand, Predictable and Timely?

10-6-10 Pre-Implementation



CONTRACT MGMT TEAM MEMBERS

- Marcy Kulland, David Vance – Co-Leaders
- Claudia Catastini – CD/Customer
- Brad Harp – EH/Customer
- Gina Nelson – EH/Customer/Supplier
- Gina Shackelford – Purchasing/Supplier
- Patty Hart – HR/Supplier
- Selina Chambliss – OOD/Supplier/Customer
- Kathie Wise – Central Contracting/Supplier
- Chris Schuler – Bus. Office/Supplier/Customer
- Stevie Fanshier – Bus. Office/Supplier

Contract Management Customer Needs Assessment –7-6-10

| Customer Words | Translation (if needed) | Comments/Notes/Design Implications | Service Feature(s) |
|--|--|---|--------------------|
| “I want to know which draft or version is most recent/current.” | Version control | | |
| “I want to know and understand the differences between different contract types and how the requirements differ” | Understand, quickly and simply, what they need to do | | |
| “Simplicity. I want to know what I’m supposed to do, easily. A flow chart, a check sheet, or something like that.” | Understand, quickly and simply, what they need to do | | |
| “Give me good, simple check lists, so I get everything right but don’t have to read a big long procedure.” | Understand, quickly and simply, what they need to do | | |
| “I don’t want to have to read some long procedure. Takes too long.” | Understand, quickly and simply, what they need to do | | |
| “I need to know what I’m supposed to do. Where is the procedure? How do I know it’s current? How can I trust that this is actually the right thing to do and everyone else is doing this too?” | Understand, quickly and simply, what they need to do | | |
| “Show me what’s relevant. I don’t want to have to read a bunch of stuff that isn’t relevant to what I’m trying to do.” | Understand, quickly and simply, what they need to do | | |
| “I don’t like following the rules. I like to do it my way. Rules are for other people.” | Understand, quickly and simply, what they need to do | No they aren’t. If the standard is simple and quick enough, they won’t need to end run the rules/process. | |
| “I want to know where the contract is in the process. Tracking.” | Tracking | We need this too – so we can build in ability to measure for control/improvement later | |
| “Electronic, so less paper waste, easier to keep track of, hopefully more efficient.” | Tracking | | |
| “I want a signed contract that allows me to get the work done” | Timely approval to move forward | | |

CONTRACT MGMT PROJECT SUMMARY

(CONT)

Analyze: (QP mode)

- Customers (initiators) need:
 - Clear expectations of what they need to do
 - Clear expectations of how long things will take
 - Provide information once
 - If there is a form, make it one form, as easy to complete as possible
 - Make renewals and amendments easier

CONTRACT MGMT PROJECT SUMMARY

(CONT)

Analyze: (QP mode)

- Customers (Management) need:
 - Adherence to Dept. Policies
 - Contracts
 - Signature Authority
 - Ethics
 - Technology Review

Benchmarking Questionnaire

Contract Management Benchmarking Information Collection Sheet (revised 7-19-10)

Target (company/organization):

Collected by:

Date:

(Soft script)...

The Tacoma Pierce County Health Department is trying to identify organizations which have excellent contract management processes/systems. A “contract” for us includes all levels of agreements. For us, an “excellent” process or system would:

- *Be relatively easy for the requestors;*
- *Be relatively quick;*
- *Have good tracking so you would know where a contract was in development and how long things took;*
- *Support consistent contracting practices/policies*
- *Support the organization’s budget and risk management concerns/policies*

Would you be willing to share information about your organization’s contract management practices/processes/systems? If yes ...

- How many contracts does your agency/organization support/process on an annual basis?
 - How many employees are dedicated to supporting the contract management process?
 - Do you currently track how long it takes to service agreement/contract requests? If so, how long do such requests typically take to process from start to finish? Do these vary by type of contract? If so, how?
 - In general, are your users satisfied with the contract management process/system? Why or why not?
 - Do you use a specific contract management system? Which one(s)? Do you use *any* electronic systems to aid your contract management? How? Which one(s)? If not, why not? What do you use instead?
 - How do you ensure that requestors provide the right kind of information, for the right kind of contract/agreement, at the beginning of the process?
 - Do you have any tools/ways of making the initial request as easy (and complete) as possible for users? If so, what are these?
- Would you be willing to share a copy?*
- How do you ensure that the correct current version (and only the correct/current version) of a contract is available for users/reviewers?
 - What is your contract/agreement review process? Does this vary by size (\$), risk, or type of contract? How do you determine this? How do you make sure that contract/agreements go through the review process quickly but appropriately?
 - How do you deal with contractor requested changes to standard language?
 - If there was one thing you would recommend an organization do to make its contract management process/system successful, what would that be?

CONTRACT MGMT PROJECT SUMMARY

(CONT)

Analyze (QP Mode)

- Benchmarking/Best Practice Findings
 - Electronic as much as possible; SharePoint and/or contract mgmt software utilized
 - Templates/checklists utilized to help users
 - Legal review available
 - Contracting and/or management analyst staff available for advice/counsel

CONTRACT MGMT PROJECT SUMMARY

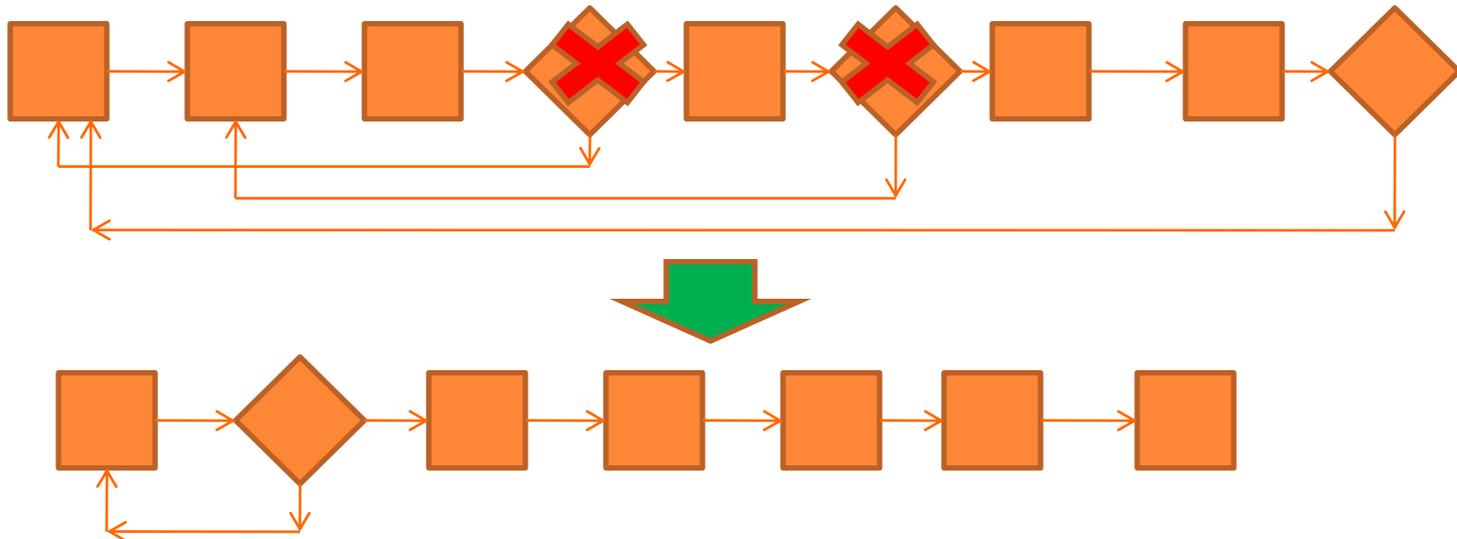
(CONT)

Change:

- 1st Improvement Cycle:
 - Electronic Form developed
 - Form guides clearly guides initiators on what they need to provide
 - Educates them on process and sets timeline expectations
 - Reviews moved earlier in process
 - Utilize M.A.'s for reviews
 - Initiators more responsible for providing key info upfront
 - Renewal/Amendment process easier
 - SharePoint used for storage of signed contracts
(paper still retained)

QUALITY PRINCIPLE:

- Eliminate unnecessary/redundant inspection.
- Substitute “failure proofing” for inspection whenever possible
- When not possible, locate the inspection as close to the “defect” as possible.

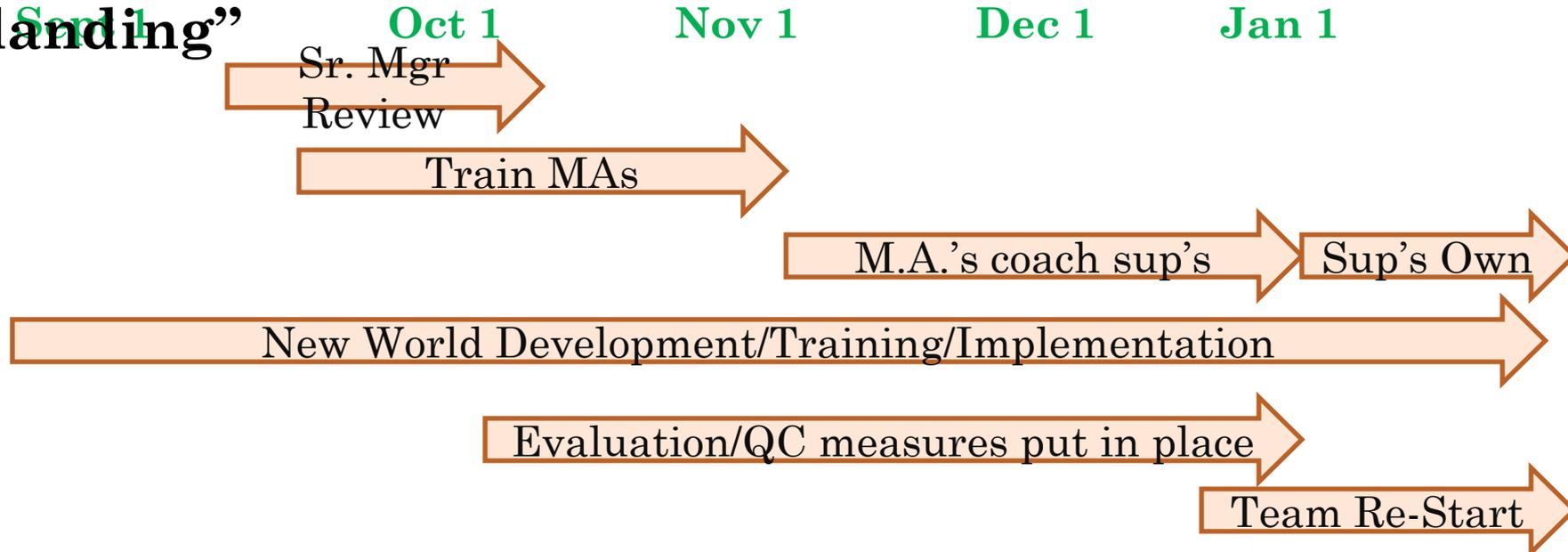


CONTRACT MGMT PROJECT SUMMARY

(CONT)

Change Implementation: “Soft

landing”



How will/may New World Contract Module and/or more sophisticated use of SharePoint be utilized to improve process further?

SUCCESS FACTORS?

Did well

- **Right people in the room** ... all programs and functions represented
- **Methods & Tools** ... facilitator took team through defined phases and steps ... avoided tangents and dead ends

Could Improve

- **Clear focus** ... got there, but took a side trip
- **Role Clarity** ... two leaders ... facilitator filled the void
- **Recognition and celebration** ... Took a while
- **Organizational support** during and after ... became clear that this was not the most important thing to be working on ... so hard to get full participation
- **Steady progress** ... moved quickly and productively when we met ... but gaps
- **Holding the gains** ... waiting on other aspects of financial system to be put

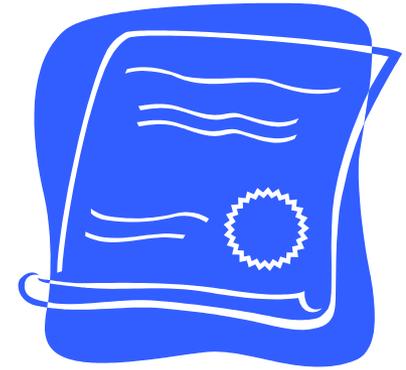
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Vital Records



A Program QI Effort

Assess

Mission: Provide birth and death certificates to the community efficiently and effectively

Measures:

- # transactions per week/FTE
- % customers satisfied
- \$ sales revenue

Customer Needs?

| Customer Segment | Customer Responses (In their own words) | Translation (if appropriate) | Comments/Implications for Service Features? |
|-------------------------------------|--|---|---|
| Funeral Home Directors/Staff (2) | Hours: "9-4 hours are fine. I wouldn't be coming here at the beginning of the day or the end of the day, anyway." | Normal business hours. | For this customer group, no change of hours appears needed. |
| | Space: "I feel like I'm in the way sometimes if I take up a window, so I go over here by the door." "People think I'm cutting in line." "I often have 20-30 transactions to do and lots to sign. Pretty hard to do standing at the door." "I liked the old space, with a place for me to sit down." "Seattle has a great space – a large room where you can sit down, have room to write, use the type writer if you need to." "I see that sign, but that room usually isn't open." | Need designated window with space to write. Sometimes could use a larger space, where it's possible to sit down, look stuff up, etc. | Deb has ordered a transaction top for the half door – Need to get it installed. We have a dedicated space for funeral directors, but it is not always open, and it is occupied by the volunteer. Funeral Directors/Staff don't seem to know it exists or have discounted it. May want signage to indicate door window is dedicated to Funeral Directors so people don't think "they are cutting." NOTE: I did not hear from any general public customers that they were in anyway upset, or even noticed, different treatment for Funeral Home staff. |
| | Parking: "Parking is not good." "I liked the parking at the other space better." "Non Funeral Home people take the dedicated spaces." "I have to park on the street all the time." | Want an open space as close to the door as possible. | Parking seems to be a bigger concern for Funeral Home staff than general public. Seems like an issue larger than vital records. |
| | Customer Service: "The service I receive from these | Need not to wait at all. Like being treated as an | Priority given to Funeral Home customers is noticed and |

Customer Satisfaction



Tacoma - Pierce County
Health Department
 Healthier. Safer. Smarter.

Customer Survey: Vital Records Program

What did you come in for today?

- Birth Record
- Death Record

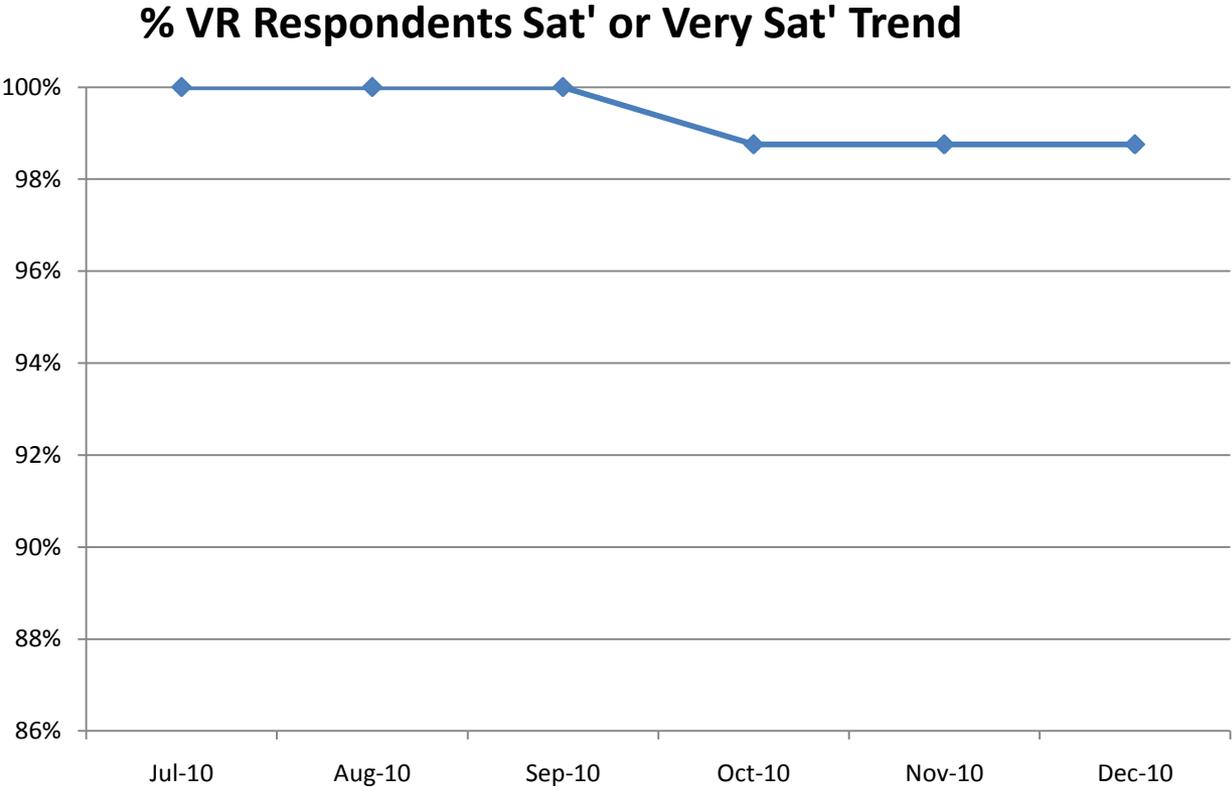
You are:

- General Public
- Funeral Home Director/Staff

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|--------------------------|---------------------------|------------------------------|--------------------------|
| The hours of operation met my needs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I was served promptly. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Staff listened to my concerns and treated me in a respectful way. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Staff gave me helpful information or resources. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Very Satisfied | Somewhat Satisfied | Somewhat Dissatisfied | Very Dissatisfied |
| Overall, how satisfied were you with our service today? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

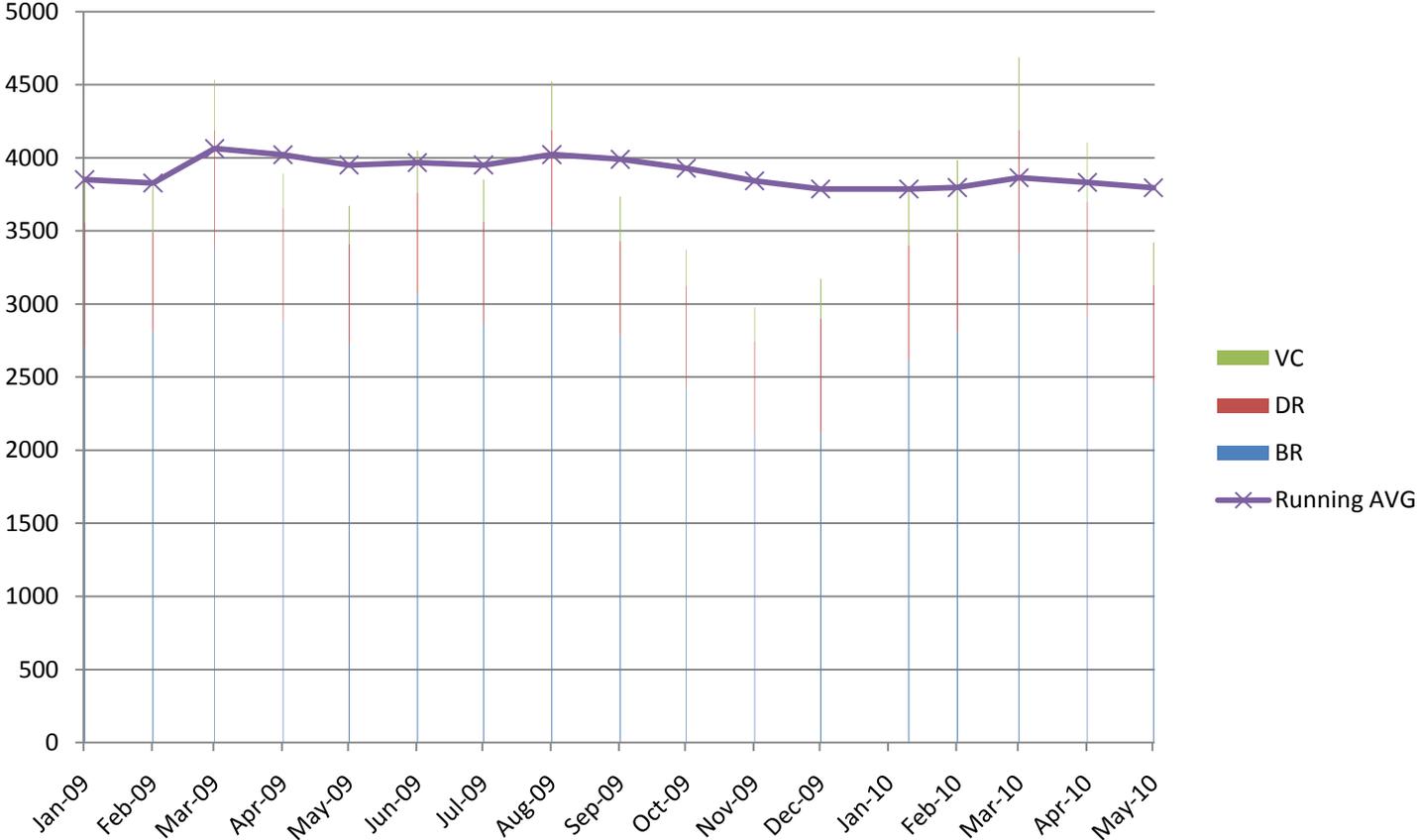
How can we improve for you?

Customer Satisfaction Baseline



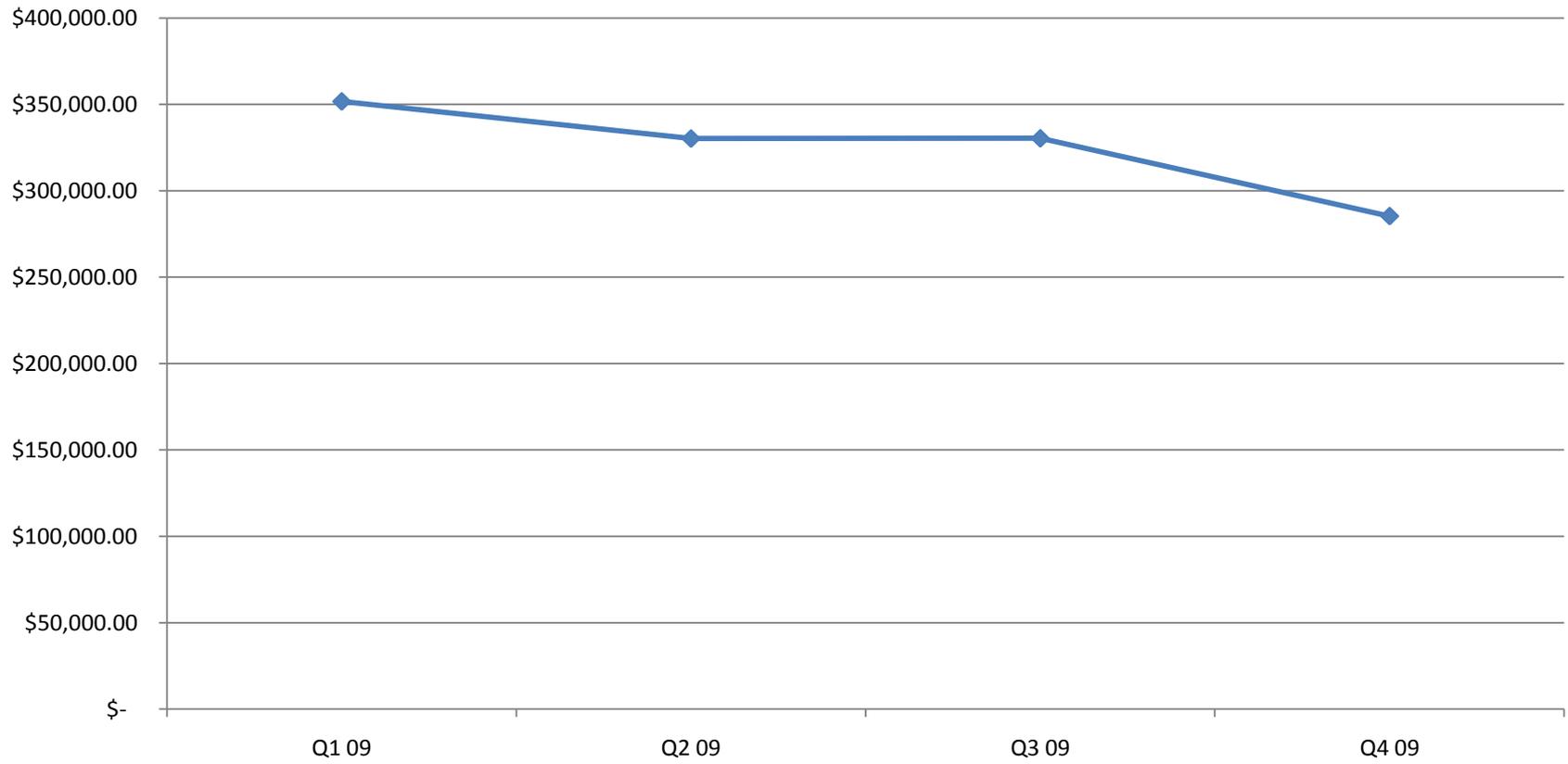
Transaction Baseline

Vital Records Transactions Per Month



Revenue Baseline

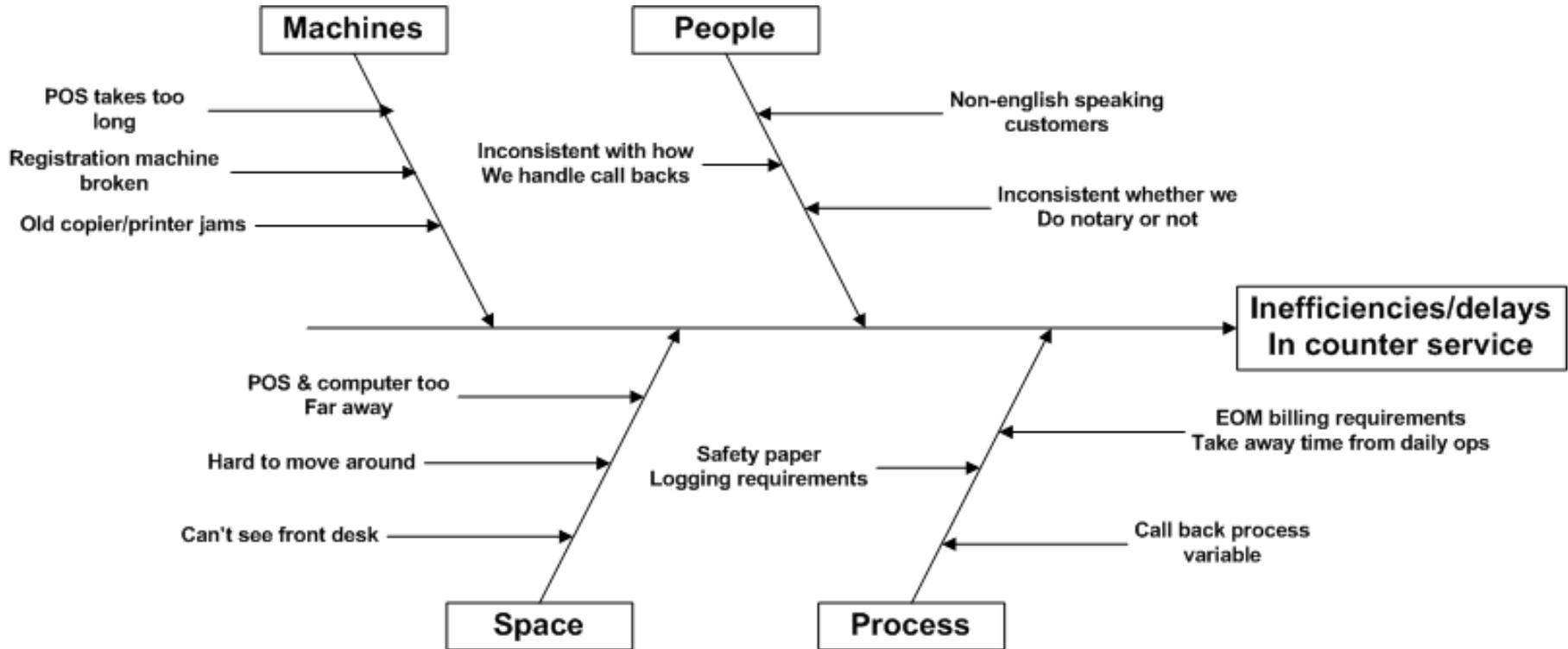
Total Revenue Trend



Define

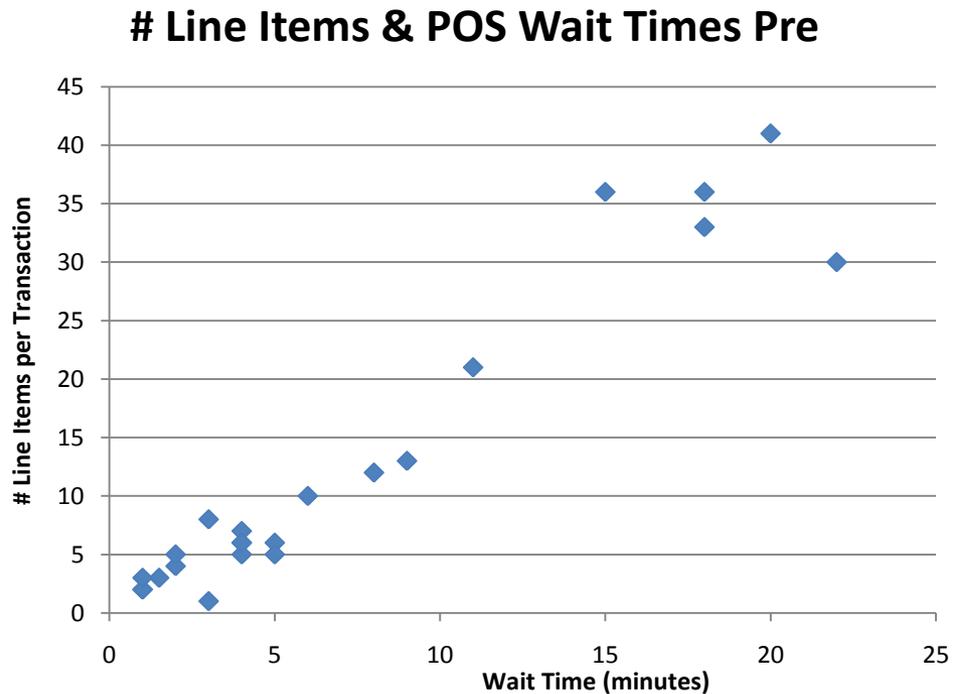
- Where to focus?
 - Customer satisfaction very high
 - Transactions are dependent on demand
 - Revenue – fees already at max
 - Staff reductions while maintaining all of the above
- Improve counter efficiency so as to maintain transaction and revenue levels with less ee stress

Analysis



Analysis

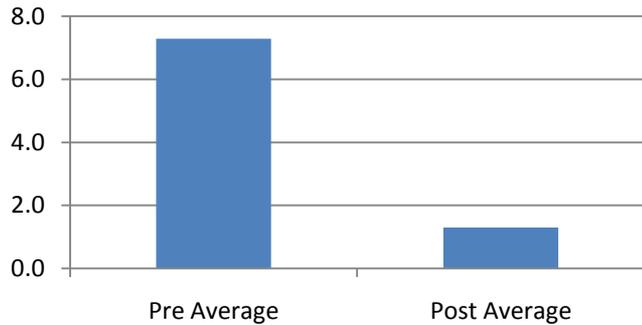
- POS wait time represented biggest opportunity



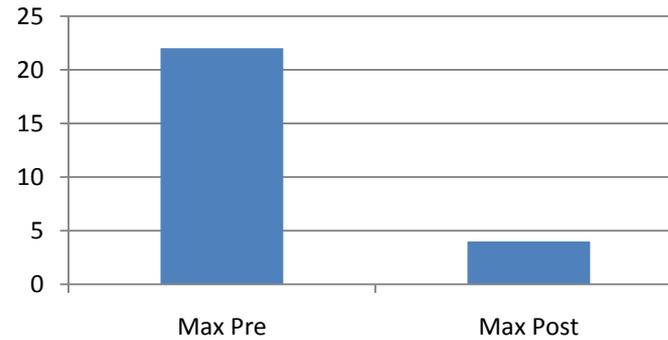
Change

POS coding changed

**POS Avg Wait Times Pre-
Post**

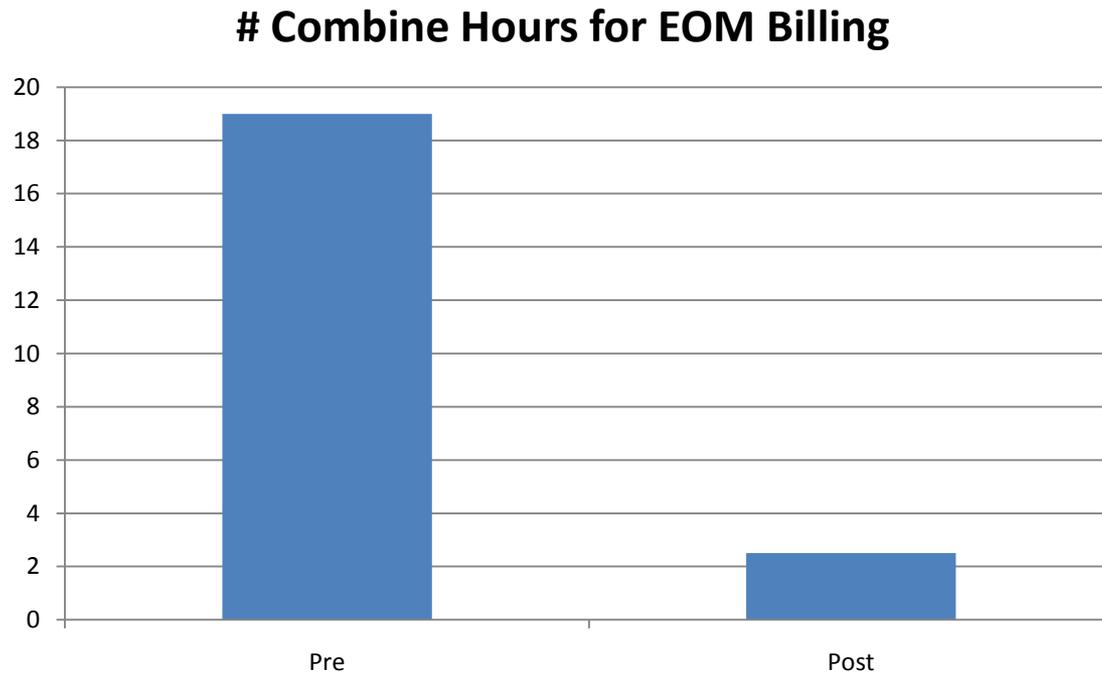


**POS Max Wait Times Pre-
Post**



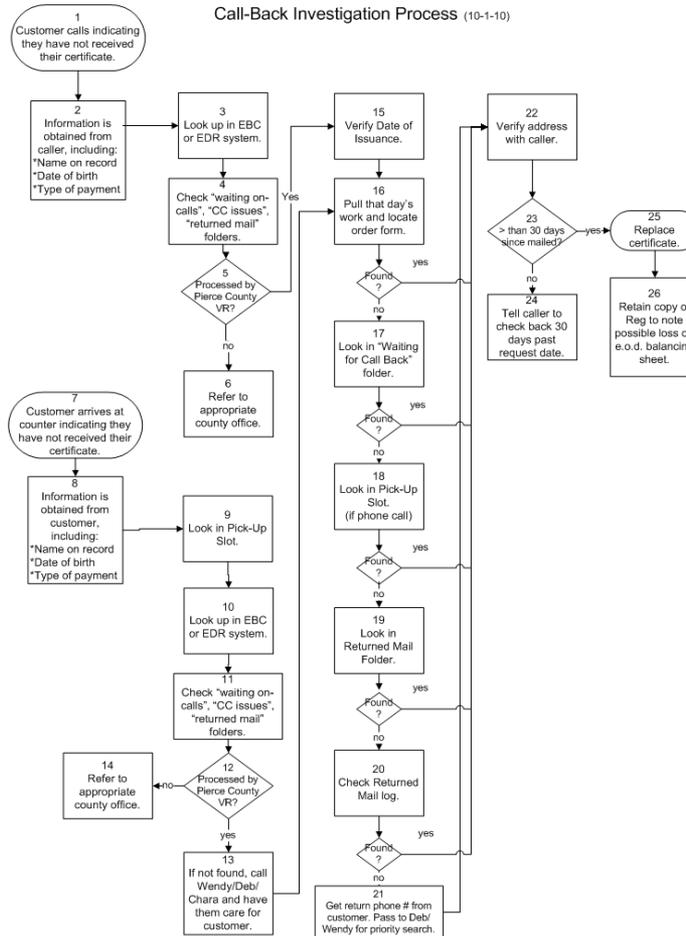
Change

- E.O.M. Billing Process Changed



Change

Call-Back Process Standardization



Success Factors?

Did well

- **Clear focus** ... defined program measures then focused on biggest opportunities
- **Right people in the room** ... all staff
- **Methods & Tools** ... low tech approach at first; consultant available to supervisor
- **Steady progress** ... improvement cycles 30-60 days in length
- **Organizational support** during and after ... on-going expectation from manager
- **Holding the gains** ... manager checks measures

Could Improve

- **Recognition and celebration** ... Informal (but present)
- **Holding the gains** ... measures not always sensitive; labor intensive; goals and targets not yet set
- **Steady progress** ... progress has slowed after 3 improvement cycles



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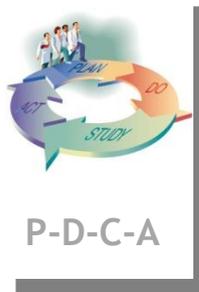
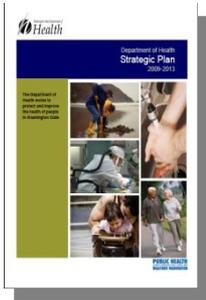
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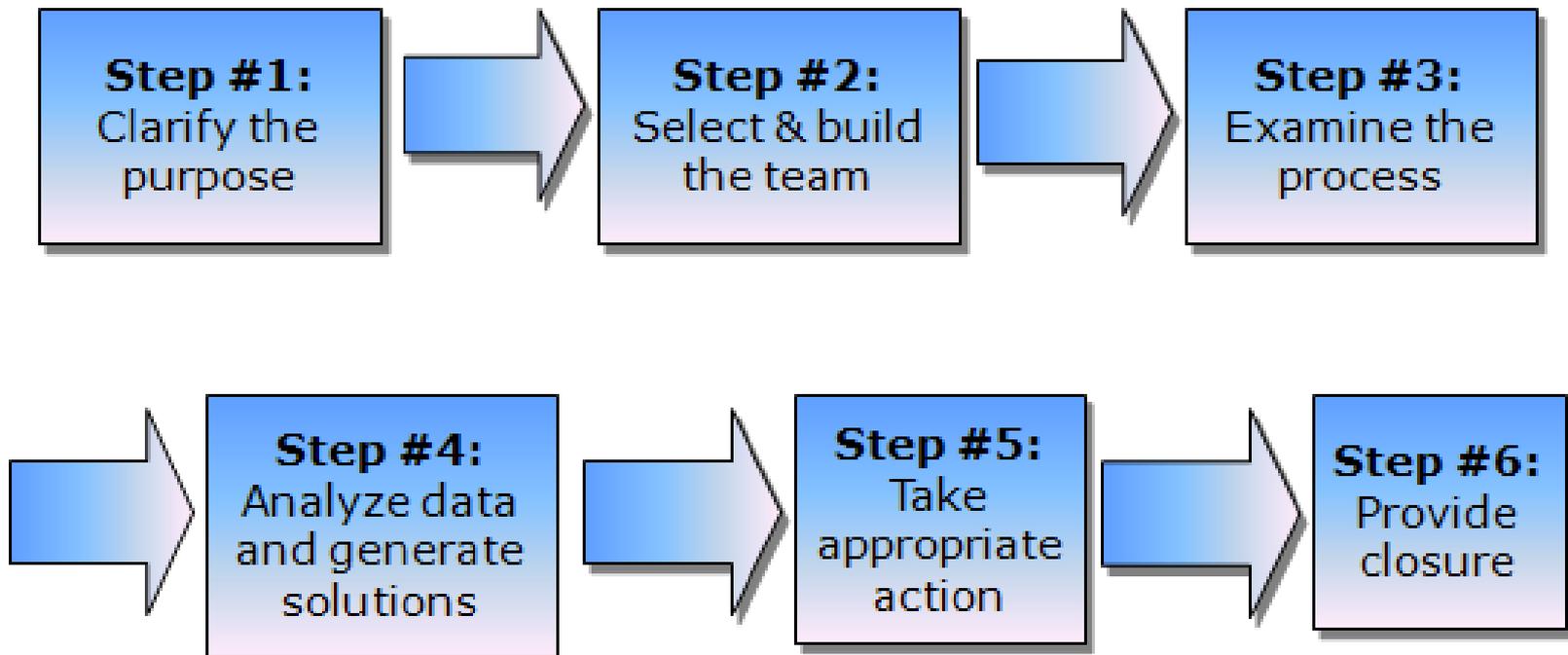
Washington State Department of Health

Verification of Applicant Qualifications



Diana Ehri
June 20, 2011

DOH Quality Improvement Process



CLEAR FOCUS

Opportunity

Increase the percent of applicants whose qualifications are verified prior to making a job offer. PHAB Standard 8.1.3

Assembled Our Team

Strong support from senior management. Broad spectrum of hiring and human resource experience.

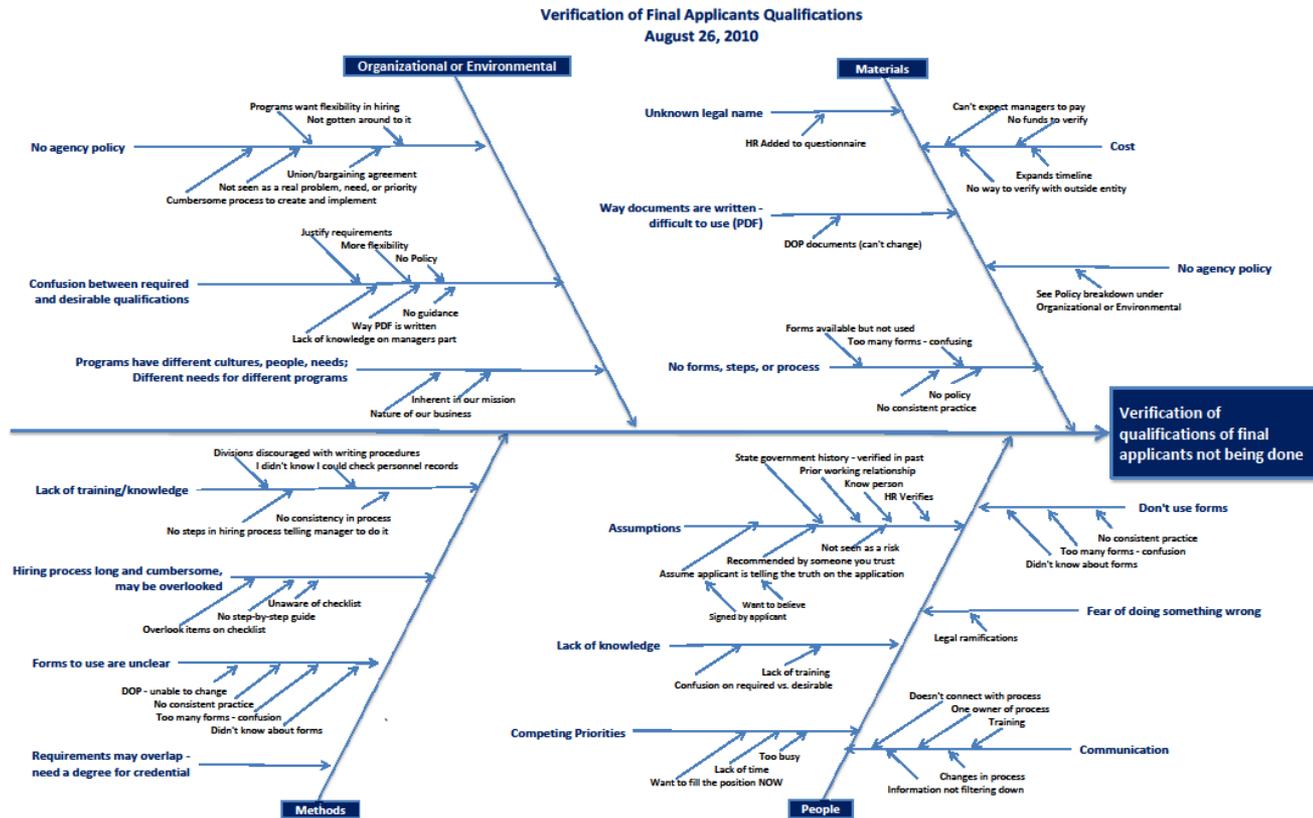
AIM Statement

Update, implement, and communicate changes to our process for hiring supervisors/managers to increase the percentage of final applicants whose required qualifications are verified to 100% by December 2011.

What was the Current State?

- Verification of required qualifications occurred in only 33% of the individuals hired between January and June 2010.
- High agency risk – exposure to lawsuits.
- No policy or procedure.
- No consistent process across the agency.

Fishbone Diagram

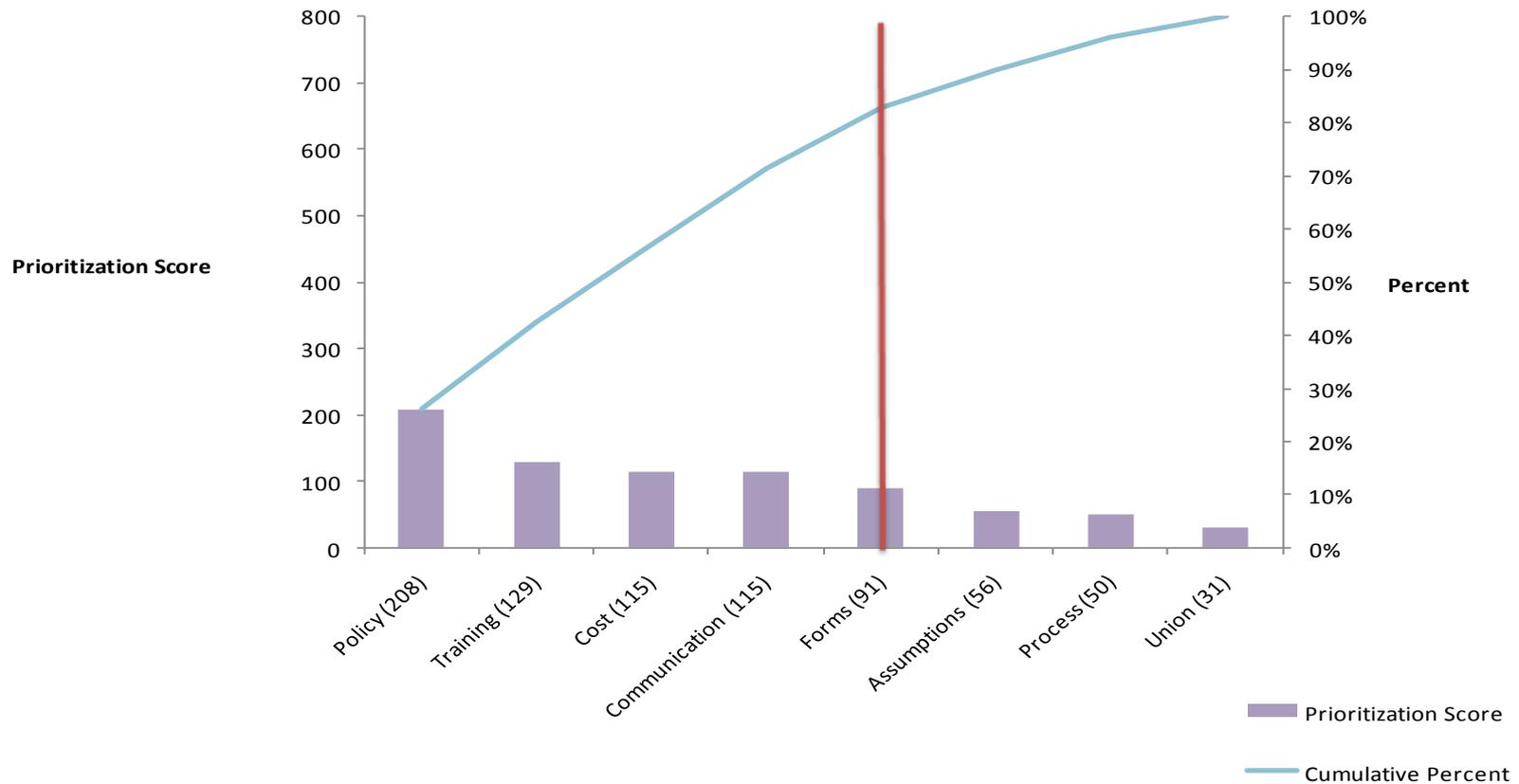


Priority Matrix

| Potential Root Cause | Issue 1 Training | Issue 2 Communication | Issue 3 Policy | Issue 4 Forms | Issue 5 Assumptions | Issue 6 Cost | Issue 7 Union | Issue 8 Process | Total |
|-----------------------|------------------|-----------------------|----------------|---------------|---------------------|--------------|---------------|-----------------|-------|
| Issue 1 Training | | 15 | 2.5 | 23 | 27 | 13.2 | 36 | 12.4 | 129.1 |
| Issue 2 Communication | 5.1 | | 4.3 | 10 | 27 | 17.2 | 37 | 14 | 114.6 |
| Issue 3 Policy | 37 | 19 | | 26 | 36 | 19 | 31 | 40 | 208.0 |
| Issue 4 Forms | 3.5 | 5.2 | 2 | | 23.2 | 8.4 | 31 | 18 | 91.3 |
| Issue 5 Assumptions | 2.7 | 2.7 | 1.8 | 8.2 | | 6.6 | 22.2 | 11.6 | 55.8 |
| Issue 6 Cost | 8.4 | 7.6 | 4.3 | 13.2 | 31.2 | | 31 | 19 | 114.7 |
| Issue 7 Union | 1.8 | 2.5 | 1.9 | 1.9 | 7.5 | 1.9 | | 13.2 | 30.7 |
| Issue 8 Process | 12.4 | 4.4 | 1 | 3.6 | 16.4 | 4.3 | 8.4 | | 50.5 |

Pareto Chart

Verification of Final Applicants Qualifications
Pareto Chart
August 26, 2010



What were some Successes?

- Developed and implemented an agency wide policy/procedure to ensure all individuals hired have required qualifications.
- Distinguished verification requirements of desirable and required.
- Established verification roles within the agency.
- Established contract with outside vendors to verify applicant education.

What were some Successes?

- Centralized the verification of educational requirements with Human Resources.
- Licensure, employment history, and reference checks remains with program.
- Maintained flexibility within all programs.
- Notified hiring managers of changes.

Next Steps

- Continually monitor and document verification of required qualifications.
- Conduct re-measurement between January and June 2011.

Goal

- 100% of all staff hired have required qualifications verified by December 2011.

Quality Improvement Success

Verification of Applicant Qualifications

Strategy Description and Purpose: Based on the Public Health Accreditation Board Self-Assessment, the Department identified an opportunity to improve its performance through a quality improvement project to increase the percentage of qualifications verified on final applicants for employment.

Plan: Increase the number of final applicants whose qualifications are verified prior to being hired.

Objective: Update, implement, and communicate changes to verification of qualifications of final applicants' process.

Eleven (11) team members developed a standardized process to verify final applicant qualifications. (Pictured: Front L to R: Kathy Deuel, Diana Ehrli, Robin Burkhart, Kris Kerman, Romesh Gautom (screen), Dennis Anderson, Ashley Bazarov, Paula Smith, Linda Riggle, and Susan Anderson. Not pictured: Kathryn LePome and Patty Woolman)



DO: The Quality Improvement Results

- Revise the procedures to include credential verification.
- Utilize outside vendors to verify applicant education and licensure and/or certification.
- Communicate changes to hiring supervisors and managers through:
 - Frequently Asked Questions.
 - Presentation to Senior Management Team and Chief Administrators Group.
 - Sentinel article.
 - New procedure and tools disseminated.

CHECK: Survey all managers who have hired employees between January and June 2011.

ACT:

- 100% of all final applicants will have the required qualifications verified prior to being offered the position by December 2011.
- Continually monitor and document all final applicants have required qualifications verified.

Supports 09- 13 Strategic Plan Goal #4 and the Public Health Standard 8.1.3 which requires all staff meet qualifications for their positions, job classifications and licensure.

Public Health Performance Management Centers for Excellence

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