Welcome to

Quality Improvement in Public Health, Lessons Learned

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Public Health Performance Management Centers for Excellence

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• If you are attending via iLinc with a group, please send us the names of the other attendees who are with you in your chat window.
Quality Improvement in Public Health, Lessons Learned

Presented by:
Scott Davis
Tacoma-Pierce County Health Department
June 20, 2011

Public Health Performance Management Centers for Excellence

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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
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!)
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
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
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
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?
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
Steady Progress

- Meeting regularly, for defined period of time
- Manage team timeline
- Avoid ... “one hour every few weeks” ... you may never finish
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
• Sometimes the project is the easy part
• Are measures being maintained?
• Who is accountable for controlling and improving from here?
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
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
Please visit our website for more information...
www.doh.wa.gov/php/perfmgtcenters/index.htm

- Community and/or State Health Improvement Plans (CHIP/SHIP)
- National Accreditation
- Performance Measurement
- Public Health Standards in Washington State
- Quality Improvement
- Strategic Planning
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
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

% of non-compliant patients discharged/ all patients discharged

% non-compliant discharges/ all enrolled
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

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.

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

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

![Chart](image1.png)
![Chart](image2.png)
Spokane Regional Health District

Immunization Outreach Program

Quality Improvement Project: Improving School Immunization Records

2011
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*

- Total Records Reviewed: 8,570
- % Improvement (no action needed): 1.7%
- % Improvement (action taken): 21.3%
- Total Improvement: 23.0%
Project Results: Compliance

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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Percent (Baseline)</th>
<th>Percent (Post)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>59.8</td>
<td>67.1</td>
</tr>
<tr>
<td>Hep B</td>
<td>52.5</td>
<td>64.0</td>
</tr>
<tr>
<td>MMR</td>
<td>57.7</td>
<td>66.1</td>
</tr>
<tr>
<td>Polio</td>
<td>63.4</td>
<td>69.8</td>
</tr>
<tr>
<td>Tdap</td>
<td>63.5</td>
<td>71.3</td>
</tr>
<tr>
<td>Varicella</td>
<td>60.1</td>
<td>66.2</td>
</tr>
</tbody>
</table>
Project Results: Exemptions

Change in Personal Exemptions for School-Required Immunizations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Percent Baseline</th>
<th>Percent Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>23.2</td>
<td>20.1</td>
</tr>
<tr>
<td>Hep B</td>
<td>26.0</td>
<td>22.3</td>
</tr>
<tr>
<td>MMR</td>
<td>25.3</td>
<td>21.7</td>
</tr>
<tr>
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<td>22.7</td>
<td>19.6</td>
</tr>
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<td>Tdap</td>
<td>15.5</td>
<td>13.2</td>
</tr>
<tr>
<td>Varicella</td>
<td>24.3</td>
<td>21.2</td>
</tr>
</tbody>
</table>
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
Spokane Regional Health District

Vaccine for Children Program
Quality Improvement Project: Improving Monthly Provider Reporting
2011
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.
Percentage provider reports submitted requiring staff follow-up due to errors

Results: 59% decrease
**Goal:** All submitted monthly vaccine accountability provider reports will not require follow-up

**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.

**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:**

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

**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.

Contact Information: Danielle Cline, 324-1414, dcline@spokanecounty.org
Date: 11/04/10
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
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 Name:
Administrative Match Improvement

### 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.

### Measure(s):
- Billed Admin Match Revenue ($)
- Secondary...
- # Unanswered Random Moments
- # “non-matchable” moments that could have been “matchable”
- #% eligible staff participating;
- MER %?

The indicator(s) which would demonstrate performance had improved. More than 2-3 primary measures may indicate lack of focus.

### Target(s):
30+% increase (roughly an additional $400,000 or more p/y)

How much improvement is expected/hoped for?

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

A sentence declaration as to what the project team is to do (without assumption of cause or solution)

### 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

The “start” and “stop” of the process(es) to be improved/built

### Customer(s):
- Primary: DSHS (they pay us)
- Secondary: Staff, Anthony (the Department)

Who is/are the customer(s) of the process/processes?

### Team Leader:
David Vance & Marcy Kulland Co-Leaders

Who is primarily responsible for the conduct and success of this project? (Ideally, will coincide with the process owner)

### Team Facilitator:
Scott Davis

Who will be assisting the leader with QI methods and tools and group process facilitation?

### Team Members:
- Stevie Fanshier – Finance
- Linda Miner – F.S. Partnership
- Claudia Castini – Comm Disease Supervisor
- Susan Pfeifer – 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)

Who will be active participants on the project team? Ensure representation of process steps and other key stakeholders.

### Constraints:
- Deadlines/system requirements of AdMatch program/system
- $ (budget $0)

Are there time, space, financial, system, policy, organizational or other constraints that the team leader and members should be aware of?
XIX AdMatch Improvement Team: Analysis Summary
As of 7-22-10

Cost Allocations + Indirect Federal Rate × RMTS Matched Moments × MER %

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

Team cannot affect

Late/Non-Responses × Mis-code/Bad Description Canned responses
Less than 1% 30% 50%

*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
Expenditures by Cost Pool + Indirect Cost Reimbursement \( \times \) % time/cost Code Allocation From RMTS \( \times \) MER Medicaid Eligible Clients/Total Clients Served \( \times \) Federal Reimbursement Rate = 

**Cost Pool 1**
SPMP RMTS Participants

**11\% \times \text{total matchable costs}**

- 3b, 5b, 21b, 14b, 15b
  - 100\%
  - 50\%

- 3c, 5c, 14c, 15c
  - 100\%
  - 67\%

- 9b, 9d
  - 53.31\%*
  - 75\%

**Cost Pool 2**
NON SPMP RMTS Participants

**11\% \times \text{total matchable costs}**

- 8c, 16c
  - 72.38\%* (69.32+2.06)
  - 67\%

- 18b
  - 69.32\%*
  - 50\%

- 12b, 19b, 23b, 24b
  - 53.31\%*
  - 50\%

- 8b, 16b
  - 44.14\%*
  - 50\%

**Cost Pool 6**
G&As costs not directly related to Medicaid, not supporting unallowable activities, and not in Indirect Rate

**Determined thru general yearly+ negotiation; Going up to 19\%.**

- 25, 26

Allocated proportionately across all cost pools

**Non-matchable codes**

**Notes:**

*Reflects MER rates of most current billing. MER will vary month to month and is influenced by the client lists we provide. Variation from code to code is driven by T-XIX formulas related to child versus adult care.

**Cost Pool 3a, 3b**
**11\% \times \text{total matchable costs}**

**Cost Pool 4**
**11\% \times \text{total matchable costs}**

**Time Card %**

**Cost Pool 5**
**11\% \times \text{total matchable costs}**

**Time Card %**

**75\%**

**50\%**

**Total Invoice**

---

Tacoma Pierce County Health Department 2010

**Draft not for distribution**
Data Analysis
(a sampling)

% of Total Dept Moments

<table>
<thead>
<tr>
<th>Department</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSP</td>
<td>30%</td>
</tr>
<tr>
<td>SA</td>
<td>25%</td>
</tr>
<tr>
<td>CD</td>
<td>20%</td>
</tr>
<tr>
<td>Nursing</td>
<td>15%</td>
</tr>
<tr>
<td>OCA</td>
<td>5%</td>
</tr>
</tbody>
</table>

% of Dept. Matchable Moments

<table>
<thead>
<tr>
<th>Department</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD</td>
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<td>5%</td>
</tr>
<tr>
<td>OCA</td>
<td>0%</td>
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</tbody>
</table>

% Matchable Moments by Unit

<table>
<thead>
<tr>
<th>Unit</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD</td>
<td>40%</td>
</tr>
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<td>SA</td>
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<td>Nursing</td>
<td>10%</td>
</tr>
<tr>
<td>FSP</td>
<td>0%</td>
</tr>
</tbody>
</table>
Cause-Effect Diagram
(one of several)

FSP (nurse/clerical) - Lea
- QA tends to be “work first”;
  Missing chance to split out for matermatchchild m.m.
  Not noting non-billable
  In QA description

FSP (non-nurse) - Linda
- QA incomplete
  “charting” but not what
  “Traveling” but not to/from why

Sub Abuse - Dave
- Coding Errors
  Staff w/ new jobs/scope
  Don’t understand codes

CD - Claudia
- Did referral but
  Didn’t document it
- Right language;
  Mis-coded
  HFA corrects only one way

Matchable Moments go unmatched

Clerical Staff
- Processing referrals
  Can be matched if indicate service
  Staff don’t know
- Non Gen Admin activities
  Could be matchable

Not planning ahead
- Don’t understand importance
- Quicker/easier

Not using advance R.M. notice
- Staff very literal;
  Resistant to “cheating”
- Don’t understand importance

Reading Discharge codes
- Setting up file
  for home visit

“checking email” used too often
- Quick/easier

Matchable MSS, non-billable activity
- Not indicated in QA
- Not planning ahead

Code 2
- Coding Errors
- Staff w/ new jobs/scope
- Don’t understand codes

Code 25
- Don’t understand importance

Code 1
- Not using advance R.M. notice
- Not managing time
  To ensure doing Matchable activity

Code 27
- Work scheduling not updated/current in system
- Matchable Moments go unmatched

Code 25
- No paying attention to Upcoming moments
- Not managing time
  To ensure doing Matchable activity

Code 19A
- Staff don’t know
  Could be 19b

Code 2
- Staff very literal;
  Resistant to “cheating”
- Don’t understand importance

Code 26
- Work scheduling not updated/current in system
- Matchable Moments go unmatched

Code 25
- No paying attention to Upcoming moments
- Not managing time
  To ensure doing Matchable activity

Code 2
- Staff very literal;
  Resistant to “cheating”
- Don’t understand importance

Code 27
- Work scheduling not updated/current in system
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 Improvement Project Summary

Change Implementation Status *(a lot of moving parts):*

- **Sept 1**
  - Aids/Training Designed & Delivered to core units
  - Regular Team Meetings End
  - FSP Client List Changes
  - SA Client List Changes

- **Oct 1**
  - “other” Sup Training
  - New Evaluation/QC tools designed & implemented
  - “Audit”
  - Transition Team
  - Invoice Cycle-Time Mini-QI

- **Nov 1**
  - “coordinator” role defined & filled
  - “Audit”

- On-Going Sr. Mgmt Communication re AdMatch
  - On-Going AdMatch EE evaluation

*Note: Some tasks have a question mark indicating uncertainty or pending completion.*
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
<table>
<thead>
<tr>
<th>Success Factors?</th>
<th>Did well</th>
<th>Could Improve</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clear focus</strong></td>
<td>took time to get there</td>
<td><strong>Role Clarity</strong></td>
</tr>
<tr>
<td><strong>Right people in the room</strong></td>
<td>all programs and functions represented (big!)</td>
<td>two leaders</td>
</tr>
<tr>
<td><strong>Methods &amp; Tools</strong></td>
<td>facilitator took team through defined phases and steps</td>
<td><strong>Recognition and celebration</strong></td>
</tr>
<tr>
<td><strong>Steady progress</strong></td>
<td>analysis phase complete within 8 weeks; recommendations in place within 12</td>
<td>Took a while</td>
</tr>
<tr>
<td><strong>Organizational support</strong></td>
<td>during and after</td>
<td>priority clearly communicated; time made; holding the gains funded</td>
</tr>
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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

CSO meeting
- Point out what is missing
- How to improve info on referral
- Dispo use
- Incomplete info not enough to prioritize Aces
- Online or call center referrals preferred mode of contact

TPCHD not taking
- High case load
- Priority cases HT contacts
- Time limits - WF - ELP
- Sense of priority
- Involvement of other agencies
- Chronic cases

TPCHD capacity

FSC process
- DW to PHN
- No protocols FSW - MSS
- Different schedules
- "Yellow" stays on face - Brenda

ACEHCN QCM time competition
- CARENET
- NFP start up
- Working hard to meet goals
- Early referral
- Late referral

STAFF 
- HVF - MSS
- Some ref# do not understand services
- Had it before
- Paste at time
- Apply for coupon
- Privacy
- Dirty house

DV focus internal
**Dashboard**

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

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:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2010 target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>% of target</th>
</tr>
</thead>
<tbody>
<tr>
<td># women enrolled</td>
<td>30</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>14</td>
<td>123%</td>
</tr>
<tr>
<td># new referral sites</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>200%</td>
</tr>
<tr>
<td># networking mtgs</td>
<td>20</td>
<td>4</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>200%</td>
</tr>
</tbody>
</table>
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!
**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 work group.

**#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%)

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

**Theory for Improvement**
*IF* we engage MSS eligible women early (*1\(^{st}\) 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 *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).

**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. Referent 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.

**PDSA Results & Discussion**
Our project focused on internal processes for improvement.
1. Developed standardized referral process.
2. Developed practice standard: PHNs to attempt 1\(^{st}\) contact within 10 days of referral.
3. Created new data collection fields (e.g., 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.

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

Click here to go back to the list
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

![Bar chart showing responses to the question about the ease of understanding, predictability, and timeliness of the contract management process. The chart indicates a strong majority of respondents strongly agree or somewhat agree, with a small percentage strongly disagree or don't know.](chart.png)
**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
<table>
<thead>
<tr>
<th>Customer Words</th>
<th>Translation (if needed)</th>
<th>Comments/Notes/Design Implications</th>
<th>Service Feature(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I want to know which draft or version is most recent/current.”</td>
<td>Version control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I want to know and understand the differences between different contract types and how the requirements differ”</td>
<td>Understand, quickly and simply, what they need to do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Simplicity. I want to know what I’m supposed to do, easily. A flow chart, a check sheet, or something like that.”</td>
<td>Understand, quickly and simply, what they need to do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Give me good, simple check lists, so I get everything right but don’t have to read a big long procedure.”</td>
<td>Understand, quickly and simply, what they need to do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I don’t want to have to read some long procedure. Takes too long.”</td>
<td>Understand, quickly and simply, what they need to do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“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?”</td>
<td>Understand, quickly and simply, what they need to do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“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.”</td>
<td>Understand, quickly and simply, what they need to do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I don’t like following the rules. I like to do it my way. Rules are for other people.”</td>
<td>Understand, quickly and simply, what they need to do</td>
<td></td>
<td>No they aren’t. If the standard is simple and quick enough, they won’t need to end run the rules/process.</td>
</tr>
<tr>
<td>“I want to know where the contract is in the process. Tracking.”</td>
<td>Tracking</td>
<td></td>
<td>We need this too – so we can build in ability to measure for control/improvement later</td>
</tr>
<tr>
<td>“Electronic, so less paper waste, easier to keep track of, hopefully more efficient.”</td>
<td>Tracking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I want a signed contract that allows me to get the work done”</td>
<td>Timely approval to move forward</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
Analyze: (QP mode)

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

- **Sep 1**: Sr. Mgr Review
- **Oct 1**: Train MAs
- **Nov 1**: M.A.’s coach sup’s
- **Dec 1**: Sup’s Own
- **Jan 1**: New World Development/Training/Implementation
- **Jan 1**: Evaluation/QC measures put in place
- **Jan 1**: Team Re-Start

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

<table>
<thead>
<tr>
<th>Did well</th>
<th>Could Improve</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Right people in the room ... all programs and functions represented</td>
<td>• Clear focus ... got there, but took a side trip</td>
</tr>
<tr>
<td>• Methods &amp; Tools ... facilitator took team through defined phases and steps ... avoided tangents and dead ends</td>
<td>• Role Clarity ... two leaders ... facilitator filled the void</td>
</tr>
<tr>
<td></td>
<td>• Recognition and celebration ... Took a while</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• Steady progress ... moved quickly and productively when we met ... but gaps</td>
</tr>
<tr>
<td></td>
<td>• Holding the gains ... waiting on other aspects of financial system to be put in place</td>
</tr>
</tbody>
</table>
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?

<table>
<thead>
<tr>
<th>Customer Segment</th>
<th>Customer Responses (In their own words)</th>
<th>Translation (if appropriate)</th>
<th>Comments/Implications for Service Features?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funeral Home Directors/Staff (2)</strong></td>
<td><strong>Hours:</strong> “9-4 hours are fine. I wouldn’t be coming here at the beginning of the day or the end of the day, anyway.”</td>
<td>Normal business hours.</td>
<td>For this customer group, no change of hours appears needed.</td>
</tr>
<tr>
<td></td>
<td><strong>Space:</strong> “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.”</td>
<td>Need designated window with space to write. Sometimes could use a larger space, where it’s possible to sit down, look stuff up, etc.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td><strong>Parking:</strong> “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.”</td>
<td>Want an open space as close to the door as possible.</td>
<td>Parking seems to be a bigger concern for Funeral Home staff than general public. Seems like an issue larger than vital records.</td>
</tr>
<tr>
<td></td>
<td><strong>Customer Service:</strong> “The service I receive from these ladies is first rate.”</td>
<td>Need not to wait at all.</td>
<td>Priority given to Funeral Home customers is noticed and appreciated (by them).</td>
</tr>
</tbody>
</table>
Customer Survey: Vital Records Program

What did you come in for today?
- Birth Record
- Death Record

You are:
- General Public
- Funeral Home Director/Staff

The hours of operation met my needs.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

I was served promptly.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Staff listened to my concerns and treated me in a respectful way.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Staff gave me helpful information or resources.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Overall, how satisfied were you with our service today?
- Very Satisfied
- Somewhat Satisfied
- Somewhat Dissatisfied
- Very Dissatisfied

How can we improve for you?

Customer Satisfaction
Customer Satisfaction Baseline

% VR Respondents Sat' or Very Sat' Trend

- Jul-10
- Aug-10
- Sep-10
- Oct-10
- Nov-10
- Dec-10

- 100%
- 98%
- 96%
- 94%
- 92%
- 90%
- 88%
- 86%
Transaction Baseline

Vital Records Transactions Per Month

- VC
- DR
- BR
- Running AVG
Revenue Baseline

Total Revenue Trend

- Q1 09
- Q2 09
- Q3 09
- Q4 09
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 stress
Analysis

- Machines:
  - POS takes too long
  - Registration machine broken
  - Old copier/printer jams

- People:
  - Inconsistent with how we handle call backs
  - Non-English speaking customers
  - Inconsistent whether we do notary or not

- Space:
  - POS & computer too far away
  - Hard to move around
  - Can't see front desk

- Process:
  - Safety paper
  - Logging requirements

- Inefficiencies/delays in counter service:
  - EOM billing requirements take away time from daily ops
  - Call back process variable
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

# Combine Hours for EOM Billing
Change

Call-Back Process Standardization

Call-Back Investigation Process (10-1-10)

1. Customer calls indicating they have not received their certificate.

2. Information is obtained from caller, including:
   - Name on record
   - Date of birth
   - Type of payment
   - Look up in EBC or EPR system.

3. Check "waiting on caller," "CC issues," "returned mail" folders.

4. Customer arrives at counter indicating they have not received their certificate.

5. Information is obtained from customer, including:
   - Name on record
   - Date of birth
   - Type of payment
   - Look in Pick-Up Slit.

6. Refer to appropriate county office.

7. Processed by Pierce County.

8. If not found, call Wendy/DigiChase and have them care for customer.

9. Processed by Pierce County.

10. Look up in EBC or EPR system.

11. Check "waiting on caller," "CC issues," "returned mail" folders.

12. Processed by Pierce County.

13. If not found, call Wendy/DigiChase and have them care for customer.

14. Refer to appropriate county office.

15. Verify Date of Issuance.

16. Pull that day's work and locate order form.

17. Look in "Waiting for Call Back" folder.

18. Look in Pick-Up Slit (if phone call).

19. Look in Returned Mail Folder.

20. Check Returned Mail Log.


22. Verify address with caller.

23. If not, replace certificate.

24. Retain copy of Reg to note possible loss on x.o.o. balancing sheet.

25. Replace certificate.

* Tacoma – Pierce County Health Department
  www.gpchd.org
### Success Factors?

<table>
<thead>
<tr>
<th>Did well</th>
<th>Could Improve</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clear focus ... defined program measures then focused on biggest opportunities</td>
<td>• Recognition and celebration ... Informal (but present)</td>
</tr>
<tr>
<td>• Right people in the room ... all staff</td>
<td>• Holding the gains ... measures not always sensitive; labor intensive; goals and targets not yet set</td>
</tr>
<tr>
<td>• Methods &amp; Tools ... low tech approach at first; consultant available to supervisor</td>
<td>• Steady progress ... progress has slowed after 3 improvement cycles</td>
</tr>
<tr>
<td>• Steady progress ... improvement cycles 30-60 days in length</td>
<td>• Holding the gains ... manager checks measures</td>
</tr>
<tr>
<td>• Organizational support during and after ... on-going expectation from manager</td>
<td></td>
</tr>
</tbody>
</table>
Stories from the field (click a link to see the presentation)

Click here to go back to the list
Washington State Department of Health

Verification of Applicant Qualifications

Diana Ehri
June 20, 2011
DOH Quality Improvement Process

Step #1: Clarify the purpose

Step #2: Select & build the team

Step #3: Examine the process

Step #4: Analyze data and generate solutions

Step #5: Take appropriate action

Step #6: Provide closure
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.
# Priority Matrix

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue 1 Training</td>
<td>15</td>
<td>2.5</td>
<td>23</td>
<td>27</td>
<td>13.2</td>
<td>36</td>
<td>12.4</td>
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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 Ehri, Robin Burkhart, Kris Kerman, Romesh Gautom (center), Dennis Anderson, Ashley Bazakow, Paula Smith, Linda Riggle, and Susan Anderson. Not pictured: Kathryn LePone 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.