A Collaborative Journey Along the Road to a Culture of Quality: A Regional Effort

OPHA 69th Annual Meeting and Conference
Corvallis, OR
October 15, 2013
Today’s Objectives

1) Identify the benefits of collaborative efforts in implementing activities related to public health accreditation

2) Learn ways to engage senior leadership in creating a culture of performance management within their agency

3) Be aware of tools available to assist in implementing quality improvement initiatives

4) Learn about the different “Exits” along the “Roadmap to a Culture of Quality”
Regional Accreditation Initiative

NACCHO Accreditation Grant

Partnership with Clackamas & Washington Counties

Regional Collaborative
# Nuts & Bolts of the Grant

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<tr>
<th>Multnomah County Health Department</th>
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<tr>
<td>- 3 work sessions with Marni Mason</td>
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<td>- Department Leadership Team</td>
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<th>Washington County Health &amp; Human Services</th>
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Marni Mason facilitated 3 work sessions with the Regional Public Health Leadership Group
Roadmap to an Organizational Culture of QI

1. NO KNOWLEDGE OF QI
2. NOT INVOLVED IN QI ACTIVITIES
3. INFORMAL OR AD HOC QI ACTIVITIES
4. SOME FORMAL QI ACTIVITIES
5. FORMAL AGENCY-WIDE QI
6. QI CULTURE
Roadmap to an Organizational Culture of QI

Characteristics:
- Lack awareness/understanding of QI
- Overwhelmed with other issues
- Satisfaction with status quo
- Don’t value or link QI to PH practice
- Begin to embrace/understand QI
- Data are not available or not used

http://qiroadmap.org/

EXITS 1-2

1. NO KNOWLEDGE OF QI
2. NOT INVOLVED IN QI ACTIVITIES
Washington County Public Health Division:
Journey Along the Road to a Culture of Quality

OCTOBER 15TH, 2013

OREGON PUBLIC HEALTH ASSOCIATION
ANNUAL CONFERENCE
Background

Prior to Grant/Regional Accreditation Initiative:

• Between Exits 1 & 2

  • 2011 – 2012:
    • AmeriCorps VISTA focused on Quality Improvement
    • PHLT participated in QI Training

  • 2012 – 2013:
    • AmeriCorps VISTA focused on document collection and Workforce Development Plan
    • Clinic staff conducted a QI project but had no formal training in QI
    • PHLT conducted Turning Point Performance Management self-assessment
Gaps:

- No Performance Management system
- No Quality Improvement Plan
- Lack of capacity to prioritize PM and QI
Benefits of Regional Accreditation Initiative for WCPH

- Public Health Leadership Team participated in a half-day PM/QI Training with Marni Mason (PM/QI Specialist)

- Marni Mason provided training to the Regional Public Health Leadership Group (PH Administrators and Health Officers)

- WCPH Public Health Administrator aligned Public Health Division budget to prioritize Accreditation, PM, and QI
  - WCPH Workforce Development Plan prioritized PM/QI
  - WCPH reconfigured positions in order to hire a Senior Program Coordinator devoted to Accreditation, PM/QI, and Workforce Development activities
Where WCPH is now: Exit 2 - 3

- Hired Senior Program Coordinator devoted to Accreditation, PM/QI, and Workforce Development
- Established PHLT as PM/QI Council
- Developed a PM system picture
- PM/QI Council adopted PM system plan
- Program supervisors are preparing to work on Next Steps with staff to develop performance measures and identify potential QI projects
Performance Management System

Washington County Public Health Division Performance Management and Quality Improvement Work Plan Proposal

I. Standards & Priority Areas
- Accreditation Standards
- Community Health Assessment
- Community Health Improvement Plan
- Strategic Plan
- Other Standards: Healthy People 2020

II. Developing Performance Measures
- Division Wide Performance Measures
  - Leadership Team
  - Performance Management Coordinator
  - Program-Level Measures
    - CD
    - Emergency Prep
    - EMS
    - Environmental Health
    - Epidemiology
    - Health Clinic
    - Health Promotion
    - Home Visiting
    - PIO
    - WIC

III. Reporting
- Report Out Annually
  - "Line of Sight"

IV. Identifying Potential QI Projects
- Quality Improvement
  - Potential QI Projects Identified by:
    - Accreditation Standard Gap Area Assessment
    - Customer/Client Satisfaction Surveys
    - Staff and Leadership Input
    - Performance Data

Report Out Quarterly


PM System Roles

- **PM/QI Council (Public Health Leadership Team):**
  - Develop division-wide performance measures
  - Report out on division-wide measures annually
  - Track and monitor program and division-level performance data
  - Identify areas for improvement using performance data
  - Prioritize Quality Improvement focus areas
  - Support and dedicate resources to prioritized projects (staff time, etc.)

- **Program Areas:**
  - Develop program specific performance measures
  - Identify potential QI projects
  - Report out on performance measures quarterly
Next Steps

- **PM/QI Council**
  - Development of PM/QI Council Charter
  - Determine method for QI project prioritization

- **Senior Program Coordinator**
  - Attend program staff meetings
    - Familiarize staff with PM/QI
    - Familiarize staff with standards and priority areas that will inform development on performance measures

- **Program Areas**
  - Develop performance measures at the program level
  - Determine a system for staff to identify potential QI projects
Long-Term PM/QI Goals

- All staff involved in one QI project a year and receiving “Just-In-Time” QI training
- Continuous cycle of prioritizing and addressing potential QI opportunities
- Established system for documenting QI projects (i.e. storyboards)
- Every program reports out on performance measures quarterly
- Division reports out on performance measures annually

Where will WCPH be at time of Accreditation application submission? (December 2015)
  - Exit 5
Roadmap to an Organizational Culture of QI

Characteristics:
• Data not routinely used
• Discrete QI activities
• QI not part of organization’s strategy
• Greater reliance on data
• People viewed as critical to success
• QI is a part of the job

http://qiroadmap.org/
Multnomah County Health Department: A Collaborative Journey along the Road to a Culture of Quality

Marisa McLaughlin & Cally Kamiya

OREGON PUBLIC HEALTH ASSOCIATION CONFERENCE

OCTOBER 15TH, 2013
Community Health Services Systems and Quality Council formed in FY 08-09.

1st Public Health Accreditation Readiness Assessment completed in FY 09-10.

Primary Recommendations from both were to:
Establish agency policy and capacity to implement a performance management system and quality model.
CHS Performance Management Efforts

Training series with CHS managers/supervisors & staff:

- Performance Management training series
- Development of 13 program scorecards
  - Communicable Disease;
  - Early Childhood Services;
  - WIC;
  - HIV Care Services;
  - HIV/Hep-C Prevention Programs;
  - STD Disease Intervention;
  - STD Clinical;
  - Health Inspections;
  - Healthy Homes and Families;
  - Lead Poisoning Prevention;
  - Vital Records;
  - EHS Program Development;
  - Vector Control
- Initial attempt at Service Area Level scorecard
Disease Intervention Program: Q4
Multnomah County Health Department, Portland, Oregon

Internal Processes/Services

Client Complaints
- Syphilis and Gonorrhea Case Interview Rate
- % of gonorrhea cases interviewed vs. target
- % of syphilis cases interviewed vs. target

Financial Perspective
- STD Grant/GF Spent
- % of overall STD grant and county general funds spent vs. target

Learning and Growth
- QI Project Participation
- % of HIV cases interviewed
- % of new HIV + individuals tested at MCHD who get results**
- HIV Interview & Test Results Received Target
- % of HIV cases closed in appropriate time frame vs. target

Capacity and Growth: Increase staff satisfaction
- # of DIS staff who participate in QI projects
- % of gonorrhea cases closed in an appropriate time frame vs. target

Client Satisfaction: Increase client satisfaction
- % of complaints
- Financial: Good stewards of community resources through monitoring funds, & targeting funds towards priority populations

Internal Processes and Services: 1) Partner Counseling and Referral Services; and 2) Monitoring disease trends & outbreaks to ensure timely & appropriate response
CHS Quality Improvement Projects/Efforts

Training:
• Introductory Trainings on QI
• Just in Time trainings

Projects:
• Improvements in client intake into programs (WIC, ECS, & HBI);
• Improvements in efficiencies related to IT (ECS, EHS, TB, STD)
• Practice based improvements (STD, CDS, ECS)
• Improvements in documentation efficiencies (ECS & EHS)

QI Models:
• Model for Improvement
• Lean Tools for Process Improvement

Lean focuses on the elimination of waste in a process:
- Overproduction: Producing too much, or producing too soon
- Transportation: Any nonessential transport is waste
- Inventory: Any more than the minimum to get the job done
- Waiting: Waiting for an appointment, for signatures, for a printer that has a long queue
- Processing: Over-processing, unnecessary steps, signatures, reviews
- Rework: Correcting any errors or doing completion steps not done before
- Intelllect: Any failure to fully utilize the time and talents of people

What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?

Act
Plan
Study
Do
**BACKGROUND**

**Problem Statement:** The referral process is long, cumbersome, mysterious, non-static, unknown, technologically outdated (paper aspects), siloed, multi-stepped/idiosyncratic which leads to delays in each process step and delays in people getting services which results in adverse health consequences, frustration for clients, and inhibits ECS and HBI from meeting their goals and creating health communities/fulfilling HD mission. **Voice of the Customer:** Customers would want: opportunities for service expansion, no delays, no confusion, easy access and entry into services, easier access for staff to information, less silos, better communication, unique and value added services for clients, and ability to look at clients holistically, instead of possessively or siloed.

**CURRENT CONDITIONS**

**GOALS**
- Reduce average time from referral received to 1st visit from 38 to 20 days.
- Reduce average time from referral received to client assigned from 14 days to w/in 5 business days (7 days).
- Reduce average time from 1st attempt to 1st visit from 21 days to 10 days.
- Reduce average time from client assigned to contact from 4 days to 2 days.
- Find a way to refer non-qualifying African American clients into other services available.

**ANALYSIS**

**Referral Received to Client Assigned**

**Total Time from Referral to Visit**

**PROPOSAL:** Affinity diagramming and brainstorming led to the ranking of development of new referral and client contact processes. Process map of new referral through client scheduling below.

**PLAN**

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<tr>
<th>What</th>
<th>Who</th>
<th>When</th>
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<tr>
<td>-Central referral training on new referral scheduling protocol</td>
<td>Central Referral</td>
<td>1st week Nov.</td>
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<td>-HBI CM team training on:</td>
<td>Susana/HBI CM team</td>
<td>Nov. 6th – 3 – 4:30pm</td>
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<tr>
<td>-Centralized scheduling &amp; Google calendar demo; Client Contact &amp; Referral protocols</td>
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<tr>
<td>-Implement new Referral and Contact policies</td>
<td>All</td>
<td>Nov. 6th, post training</td>
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<tr>
<td>-Implement Google calendar policy</td>
<td>HBI team</td>
<td>Nov. 7th</td>
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<tr>
<td>-60/90 day check to measure results and adjust</td>
<td>HBI and QI team</td>
<td>Feb. 20th</td>
</tr>
<tr>
<td>-6 month check to measure results and adjust</td>
<td>HBI team</td>
<td>May 21st</td>
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**RESULTS**

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<tr>
<th>Pre-PILOT All Visits</th>
<th>Dec, 2012 – June 2013</th>
<th>Aug, Sept, Oct 2012</th>
<th>Baseline Data</th>
<th>ACTUAL CHANGE 3-months prior</th>
<th>ACTUAL CHANGE Baseline</th>
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</thead>
<tbody>
<tr>
<td>Revd-&gt;Assigned</td>
<td>3.2</td>
<td>7.3</td>
<td>13.9</td>
<td>-4.2</td>
<td>-10.8</td>
</tr>
<tr>
<td>Assigned-&gt;1stAttempt</td>
<td>0.7</td>
<td>8.3</td>
<td>3.8</td>
<td>-7.7</td>
<td>-3.1</td>
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<tr>
<td>1stAttempt&gt;1stVisit</td>
<td>17.1</td>
<td>32.2</td>
<td>21.2</td>
<td>-14.7</td>
<td>-3.8</td>
</tr>
<tr>
<td>Revd-&gt;1stVisit</td>
<td>20.9</td>
<td>47.4</td>
<td>38.1</td>
<td>-25.9</td>
<td>-16.5</td>
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<tr>
<td>Had Scheduled appt</td>
<td>47 (78.3%)</td>
<td>20 (57.1%)</td>
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**TEAM** Ellie Myrick (Lead); LaRisha Baker; Lauren Fries-Brunderidge; Monique Allen; Tim Holbert; Anna Dyer; Rachael Banks; Susana Betancourt; Marisa McLaughlin (QI facilitator)
Gaps:
• No Health Department QI Plan
• No integrated department performance management system
NACCHO Grant

- 3 work sessions with Marni Mason
  - Department Leadership Team
  - Quality Leadership Team
  - Public Health Quality Council

Marni Mason facilitated 3 work sessions with the Regional Public Health Leadership Group
Which Exit Are We At Now?

Exit 4: Formal QI in Specific Areas

• Draft QI Plan
• Evolution of Quality Councils
• Leadership driven Performance Management System
• Stronger Communication
Where MCHD Will Be By Accreditation Submittal?

Our Plan Exit 5: Formal Agency Wide QI

- Formalizing Training & Development Plans around Quality
- Systems level quality improvement efforts
- Formalized Strategic Plan measurement which drives data-based decision making
Characteristics:
- More data-driven decisions
- QI integrated in operational plans
- QI policies
- QI champions throughout organization
- Data and tools used daily
- Integrate with strategic plan

http://qiroadmap.org/
Clackamas County Public Health Division:
Journey Along the Road to a Culture of Quality
Performance measures have been in place within the Health Housing & Human Services Department since July 2008.

Public Health created first QI Committee in August 2012.
QI Committee Charter

Function of the Quality Improvement (QI) Committee:
The QI Committee will assure the implementation of QI efforts and activities for the Clackamas County Public Health Division, which includes:
- Development and evaluation of an annual Performance Management Plan;
- Support CCPHD’s efforts to obtain national accreditation and assist in accreditation activities relative to QI as needed;
- Development and evaluation of QI projects; and
- Support for the development and implementation of the department’s performance management system.

Committee members will be asked to prioritize, plan and participate in QI training activities. Members will become skilled in the implementation of QI tools through involvement in this committee.

Overarching Goals of the QI Committee:
- To support the development of a culture of quality and quality improvement, in alignment with the mission, vision and values of Health, Housing and Human Services;
- To improve workforce capacity and skills related to developing, monitoring and evaluating performance improvement efforts and to contribute to the success of these efforts.

Primary Activities:
- Create, review and revise annual Performance Management Plan;
- Solicit and identify QI projects;
- Monitor status, review results and provide feedback on QI projects;
- Plan, assist with and attend staff QI trainings;
- Evaluate QI Committee and Performance Management Plan on an annual basis;
- Support the development, implementation and on-going maintenance of the division’s performance management system through consultation.

Composition/Membership of QI Committee Members:
QI Committee members will be represented by one staff member of each of the four program areas of the Clackamas County Public Health Division. One member of the Public Health Managers Group will also participate and two additional staff members from any program area, along with the Policy Analyst (QI Coordinator) and Epidemiologist (Data Analyst) for a total of nine members. The Public Health Director shall serve as an ad hoc member of the committee.

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<thead>
<tr>
<th>PUBLIC HEALTH PROGRAM</th>
<th>REPRESENTATIVE NAME</th>
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<tbody>
<tr>
<td>PH Manager</td>
<td>Cathy Perry, CD/CMCH Manager</td>
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<tr>
<td>Environmental Health</td>
<td>Joel Ferguson, BH Staff</td>
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<tr>
<td>WIC</td>
<td>Erin Myers, Nutrition Counselor</td>
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<tr>
<td>Communicable Disease</td>
<td>Jan Rodriguez, CD Nurse</td>
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<tr>
<td>Health Promotion</td>
<td>Jamie Zarnier, SBHC Coordinator</td>
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<tr>
<td>Additional Staff</td>
<td>Liz Boga, Public Health Nurses (PHN) Staff</td>
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<tr>
<td>Additional Staff</td>
<td>Marco Enciso, Program Support (HHS Lean Facilitator)</td>
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<tr>
<td>QI Coordinator</td>
<td>Philip Mason, Policy Analyst</td>
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<tr>
<td>Data Analyst</td>
<td>Sunny Lee, Epidemiologist</td>
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<tr>
<td>PH Director (ad hoc)</td>
<td>Marti Franco, Administrator</td>
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QI Committee Members’ Roles and Obligations:
In August 2012, QI Committee members were selected based on their expressed interest in participating and their level of involvement with specific program areas. The committee determined that members will serve an 18 to 24 month term on the committee. A maximum term limit will be determined at a later date. Committee members will have some individual responsibility for the delivery of QI initiatives through collaborating with staff to identify potential projects and implement QI process improvements throughout the Public Health Division.

The schedule of meetings will initially be as follows:
- August 2012 to November 2012: occurring on a bi-weekly basis
- November 2012 to February 2013: occurring on a monthly basis
- Frequency of meetings will be reassessed at February 2013 meeting

In rare circumstances when members will be unable to attend for longer than 2 months it will be required that they find a temporary replacement from their program area. The specific processes by which members will resign from the committee could vary based on circumstances but there will be a strong attempt to adhere to the following process:
- Membership turnover will occur on a staggered basis (18 or 24 month appointments)
- Members will notify the committee and managers group of their decision to resign one month in advance, except for unforeseeable circumstances
- Resigning members will identify and recruit their replacement with input from managers group in order to determine if a staff member can take on the commitment and assess how it could potentially impact workload
- New recruits will officially become members of the committee after a majority vote of current QI Committee members and approval from managers group.

QI Committee members will be expected to communicate with Public Health Division staff through a variety of channels about progress on QI Committee projects. QI Committee members are responsible for providing and receiving feedback from their respective program team members. QI Committee members are also responsible for providing updates at the bi-monthly Public Health Division All-Staff meetings as a standing agenda item. The QI Committee will report to the Public Health Division Managers group at least on a quarterly basis to request approval of projects, present proposals for policy changes that may occur as a result of a QI Committee process, and report on committee participation.
Public Health QI Committee Members

Liz Baca, Additional Staff Rep.

Marco Enciso, Additional Staff Rep.

Joel Ferguson, EH Rep.

Sunny Lee, Data Analyst

Philip Mason, QI Coordinator

Erin Myers, WIC Rep.

Jan Rodriguez, MCH/CD Rep.

Public Health Program Managers

Steve Dahl, EH Manager

Dana Lord, WIC/Immunization Manager

Cathy Perry RN

Cathy Perry, CD/MCH Manager (QI, PH Manager Rep.)

Larry MacDaniels, Healthy Comm. Manager

Sherry Whitehead, Fiscal, Support Manager

Public Health Division Director


Mart Franc, PH Division Director

10-4-12
# Performance Management Plan

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   F. Public Health Advisory Committee

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**Clackamas County Public Health Division**

2012-2013 Performance Management Plan

Approved: February 28, 2013
# QI Committee Reporting Calendar

## 2012-2013 Quality Improvement Reporting Calendar

### QI Committee Review Timelines

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<tr>
<th>Performance Measures: Fiscal/Program Support, CD, PHN, WIC</th>
<th>Jan</th>
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### Public Health Managers Review Timelines

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<th>Legislative Review (BCC + Oregon Legislature) &amp; CLHO Subcommittee Updates</th>
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<td>Client Feedback/Incident Reporting Review</td>
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Lines-of-Sight

- Early Spring 2013: Meetings held with each team to discuss development of performance measures & their benefits:
  - Facilitates staff engagement in making improvements in their teams
  - Provides opportunity to focus on addressing priority areas
  - Helps guide decision-making processes
  - Help to align with the mission, vision, and strategic directions

- Prep for meetings:
  - What is the ultimate goal your program is trying to achieve?
  - What are ways that your team makes progress in achieving the goal described above?
  - Are there any current challenges that get in the way of achieving your program’s goals?
Line-of-Sight Example: Public Health Nursing

**Public Health Nursing Program**

*Line of sight*

**Increase engagement with referrals received in a timely manner**
*short-term outcome*
- ↑ % of phone contact with client within 10 days of referral receipt
- ↑ engagement with referral source

**Increase the number of completed initial appointments**
*medium-term outcome*
- ↑ % of completed initial visits
- ↓ % of refused visits

**Nurse & client have clearly formulated mutual concerns, goals & expectations**
*medium-term outcome*

**To assist high risk families, through case management, with successful pregnancies, infant & child’s development by educating & linking to community resources (including provider coordination)**
*long-term outcome*
- ↑ % of linkages (medical, nutrition, safety) made by client since last visit
- ↑ % of nurse follow-up to linkages
- ↑ % of infants born at later than 38 wks gestation
- ↑ % at [ ] birth weight
- ↓ % prenatal smokers

**Self-sufficient and healthy families in Clackamas County**
*ultimate goal*
- ↑ % of closed clients for services (based on TCM assessment form)
- ↑ % of infants who are fully immunized
- well-child checks

**Degree of influence/control**
Line of Sight Example: Drinking Water

Environmental Health Program
(drinking water)

Line of sight

Improving water sampling procedures
(medium-term outcome)
• ↓ % false positives
• ↓ # of alerts (coliform)

Improve operator knowledge
(medium-term outcome)
• ↑ % of operator trainings during water surveys

Complete expected EPA water system surveys
(short-term outcome)
• ↑ # of water system surveys
• ↑ % of expected water system surveys completed

So that

Test is more meaningful and reliable
(medium-term outcome)

To reduce the incidence of waterborne illnesses and increase safety
(ultimate goal)

Degree of influence/control
## Dashboard: Population Based Measures

**Outcome Measures**

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Benchmark</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rate of low birth weight babies per 1,000</strong></td>
<td>Healthy People 2020: 78</td>
<td>57.0</td>
<td>64.8</td>
<td>56.0</td>
<td>54.1</td>
<td></td>
</tr>
<tr>
<td><strong>Adult obesity</strong></td>
<td>Healthy People 2020: 30.5%</td>
<td>23.6% (08-09)</td>
<td>23.9% (08-11)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High school four-year cohort graduation rate</strong></td>
<td>State of Oregon: 88.4% (11-12)</td>
<td>69.0%</td>
<td>72.2%</td>
<td>73.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rate of Chlamydia cases per 100,000</strong></td>
<td>State of Oregon: 369.68 (2011)</td>
<td>238.4</td>
<td>287.4</td>
<td>294.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rate of suicide deaths per 100,000</strong></td>
<td>Healthy People 2020: 10.2</td>
<td>14.8</td>
<td>15.8</td>
<td>14.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Population-Based Immunization Rate</strong></td>
<td>State of Oregon: 72.8% (2011)</td>
<td>58.4%</td>
<td>73.4%</td>
<td>71.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rate of deaths due to falls per 100,000</strong></td>
<td>Healthy People 2020: 7.0</td>
<td>14.1</td>
<td>13.5</td>
<td>10.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rate of tobacco-related deaths per 100,000</strong></td>
<td>State of Oregon: 162.85 (2011)</td>
<td>139.5</td>
<td>143.8</td>
<td>137.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rate of drug-induced deaths per 100,000</strong></td>
<td>Healthy People 2020: 11.3</td>
<td>14.4</td>
<td>13.3</td>
<td>14.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adults with permanent teeth removed</strong></td>
<td>State of Oregon:</td>
<td>41.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Untreated decay among children 6-9 years of age</strong></td>
<td>State of Oregon: 20% (2012)</td>
<td></td>
<td></td>
<td></td>
<td>17%</td>
<td></td>
</tr>
</tbody>
</table>

**Behavioral/Environmental Measures**

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Benchmark</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage of all restaurants that are fast-food establishments</strong></td>
<td>State of Oregon: 43% (2010)</td>
<td>46.7%</td>
<td>45.8%</td>
<td>45.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current adult smokers</strong></td>
<td>Healthy People 2020: 12.0%</td>
<td>15.4% (08-09)</td>
<td>14.3% (08-11)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(100 cigarettes in lifetime and smoke every or some days)</td>
<td>State of Oregon: 15.4% (2008)</td>
<td>17.8% (07-08)</td>
<td></td>
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</tr>
</tbody>
</table>

**Current smokers among 11th graders** (at least one cigarette in the last 30 days)

**Key:**

**Priority identified within the Community Health Improvement Plan**

**Priority identified within the Healthy Columbia Willamette Collaborative (regional health needs assessment)**
## Dashboard: Programs Performance Measures

<table>
<thead>
<tr>
<th>Objective</th>
<th>Performance Measure</th>
<th>Frequency</th>
<th>Target</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMUNICABLE DISEASE</strong></td>
<td>number of reported communicable diseases investigated within established timelines</td>
<td>Quarterly</td>
<td>State</td>
<td></td>
<td>76.7%</td>
<td>89.4%</td>
<td>94.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EMERGENCY PREPAREDNESS</strong></td>
<td>percent of health care professionals who respond to exercise communications from Health Alert Network</td>
<td>Quarterly</td>
<td>90%</td>
<td>89%</td>
<td>90%</td>
<td>92%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WIC</strong></td>
<td>decrease the average number of days a newly pre-screened WIC applicant waits for an appointment</td>
<td>Quarterly</td>
<td>10 days</td>
<td>N/A</td>
<td>23 days</td>
<td>21 days</td>
<td>9 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>decrease incoming telephone calls</td>
<td>Quarterly</td>
<td>TBD</td>
<td>N/A</td>
<td>Baseline data collected</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>decrease calls that go to voicemail</td>
<td>Quarterly</td>
<td>TBD</td>
<td>N/A</td>
<td>Baseline data collected</td>
<td></td>
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<tr>
<td></td>
<td>decrease calls where caller hangs up before serviced</td>
<td>Quarterly</td>
<td>TBD</td>
<td>N/A</td>
<td>Baseline data collected</td>
<td></td>
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</table>
Program Big Page Example: Vital Stats

Public Health Division: Vital Records Performance Management Big Page

Program Description
Clackamas County Vital Records issues certified death certificates for those who have died in Clackamas County. Currently all front office staff members are appointed as Deputy Registrars of Clackamas County. Clackamas County files original death certificates are received and processed by Funeral Homes. We ensure the original death certificates are completed properly, file them, issue any needed certified copies and then send the original to the State.

Current Priorities
- Standardize and document current processes for training and backup purposes
- Work towards being able to accept electronic submissions and payments
- Automate Funeral Home billing process
- Create electronic death certificate order form and Report of Death card for easier submission

Key Challenges
- Web payments and submissions will take around 8 months
- Determine standardized template for documenting best methods
- Most of the death certificate registration process is completed by external entities

Performance Measures
- % of death certificates that leave the County with 1 day or receiving them

This is a performance measure that looks at the percentage of death certificates that leave the County with 1 day or receiving them. It measures the average days per event between death certificate registration and certification. We compare every quarter and by type of death certificate.

Long Term (>6 months)
- Create electronic death certificate order form and Report of Death card for easier submission
- Simplicity process for sending bills to funeral homes
- Allow web payments and submissions
- Create cheat sheet for funeral homes to use in completing death certificates

Short Term (<6 months)
- Standardize and document current processes for training and backup purposes
- Create a record card for each funeral home giving them basic stats
- Create cheat sheet for funeral homes to use in completing death certificates

Quality Improvement Projects

Average time for death certificate registration (Internal Only Measure)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Data Filed at County to date to State</th>
<th>Data Filed at County to Date Data Received</th>
<th>Date Received at County to Date Medical certified</th>
<th>Date Medical certified to date to Death to Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2012</td>
<td>3.07</td>
<td>3.90</td>
<td>3.90</td>
<td>1.82</td>
</tr>
<tr>
<td>Q2 2012</td>
<td>5.97</td>
<td>5.76</td>
<td>5.76</td>
<td>5.76</td>
</tr>
<tr>
<td>Q3 2012</td>
<td>7.65</td>
<td>7.65</td>
<td>7.65</td>
<td>5.52</td>
</tr>
<tr>
<td>Q4 2012</td>
<td>7.54</td>
<td>7.54</td>
<td>7.54</td>
<td>5.65</td>
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This is internal data we are keeping track of. It measures the average days per event between death certificate registration and certification. We compare every quarter and by type of death certificate.

We also include one of the best performing funeral homes to see what's potentially possible.

While the efforts we make are currently focused on the last 2 events on the graph, the only as we fully control, the majority of time where it seems an improvement can be made is on the front end with our funeral homes.

The State OAR states that we should register death certificates in 5 days. In the future we can hopefully work with our funeral homes to reach this goal.

Next Steps
- Analyze why we did not reach our 90% target in Q2 2013 of our performance measure
- Continue working with TS to be able to accept payments and submissions electronically
- Develop ways to make funeral homes aware of their current status and find ways to help them.
Program Big Page Example: Immunization
Performance Management System Visual

Public Health Division

- Strategic Plan
  - Performance Management Plan
  - Workforce Development Plan
  - Annual Employee Goals
  - Program Work Plans

Community Focus

- Community Health Assessment
- Community Health Improvement Plan
Questions?
Where do you think your agency is on the QI roadmap?

1. No knowledge of QI
2. Not involved in QI activities
3. Informal or ad hoc QI activities
4. Some formal QI activities
5. Formal agency-wide QI
6. QI culture

http://qiroadmap.org/
Discussion Questions

• Share examples of why you believe your agency is at this phase.
• What are your agency challenges?
• Share 1-2 ideas that you will use based on today’s session.
Thank You