PERFORMANCE AND QUALITY IMPROVEMENET PLAN

2017-2021

PROJECT NAME: *PERFORMANCE IMPROVEMENT*

DEPARTMENT: *DEPARTMENT OF INTEGRATED BEHAVIORAL. HEALTH CARE AND POVERTY ALLEVIATION*

FOCUS AREA: *BEHAVIORAL HEALTH & POVERTY ALLEVIATION PROGRAMS AND STAFF*

PRODUCT: *A COMPREHENSIVE PERFORMANCE MANAGEMENT SYSTEM WITH DEDICATED QUALITY IMPROVEMENT*

Prepared By:

DOCUMENT OWNER(S)	PROJECT/ORGANIZATION ROLE
Edward-T Moises	EXECUTIVE DIRECTOR
Zora Moses	Director IT and Tech Support
Dr. Suzy Fletcher	CQI COORDINATOR, PRIMARY CARE SERVICES
Robert Jud	CQI SPECIALIST, POPULATION HEALTH SERVICES
Lindsey Kyles	CQI COORDINATOR, BEHAVIORAL HEALTH SERVICES

Contents

I EXECUTIVE SUMMARY

1.1 INTRODUCTION

Performance management is the practice of actively using performance data to improve the public's health.[1] A Performance Management (PM) system is defined by the activities and methods that help Orpe Human Rights Advocates meet its goals in the most effective and efficient manner possible. As all organizations want better outcomes, we are concerned about improving the safety and quality of the services, care, and treatment provided. The best way to achieve better outcomes is by measuring the performance of processes that support the services, and then using that data to make improvements. Performance management is a system that allows the organization to answer the questions:

- How good are we at achieving our goals and objectives?
- Are we improving?
- How do we know?

The OHRA Integrated Behavioral Health Center (OBHC) performance management system is integrated into the health department 's daily practices , including : 1) setting organizational goals and objectives across all levels of programs, 2) identifying indicators to measure progress toward achieving goals and objectives on a regular basis, 3) identifying responsibility for monitoring progress and reporting , and 4) identifying areas where achieving objectives requires focused quality improvement processes.[2] The PM system creates alignment between the Community Health Improvement Plan (CHIP), the OIBHC's strategic plan, programmatic goals, and individual employee performance. Performance improvement priorities must be established. Data collection is the foundation of performance improvement . Data is obtained from staff, patients, clients, records, observation, and the community . Process failures that have the potential for exposing patients or clients to a high risk of harm or injury are a particular focus of PM priorities.

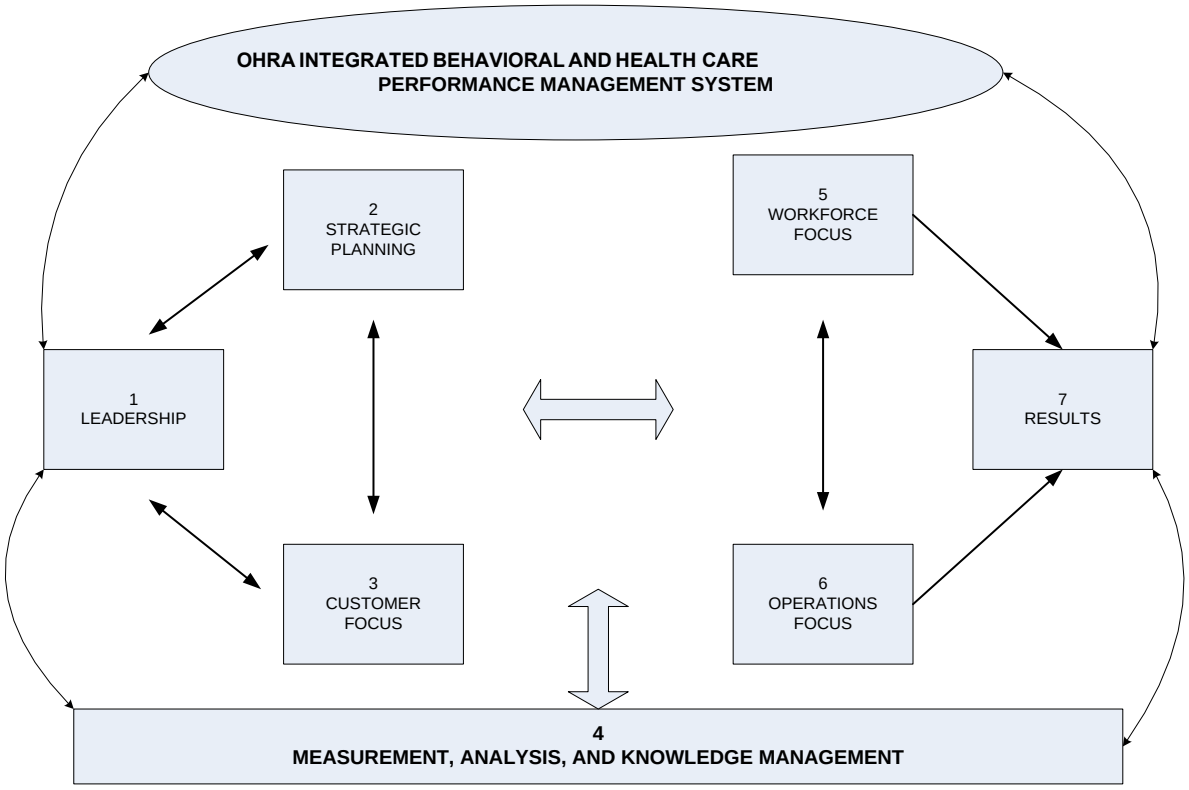
The components of the performance management system are:

1. Leadership
2. Strategic Planning
3. Customer Focus
4. Measurement, Analysis, and Knowledge Management
5. Workforce Focus
6. Operational Focus
7. Organizational Performance Results

Each component of the performance management system generates feedback information that allows the organization to assess changes and performance, promoting a continual process of individual and organizational learning. Selected measures are meaningful to the organization and address the needs of the community/patients served. Analyzing data over time from internal sources allows the organization to identify patterns and trends to monitor its performance. External databases allow the organization to compare and benchmark with other organizations.

[1] *(Public Health Foundation, 2019)*
[2] *(Public Health Accreditation Board, 2019)*

The purpose of the performance management system is to ensure the mission of the OHRA Integrated Behavioral Health Center is being met. The goal is to promote a systematic, program-wide approach to performance improvement. This involves measuring the selected outputs and outcomes to ensure that improvements are made and sustained. All initiatives are planned and implemented in a collaborative manner through the performance improvement team (PI Team).



2020 Criteria for Performance Excellence.

1.2 OHRA INTEGRATED BEHAVIORAL HEALTH CENTER MISSION STATEMENT

The OHRA Integrated Behavioral Health Center will promote physical and emotional health; prevent disease, injury and disability; and protect the environment, through the assessment of needs, the development of policy, and the provision of accessible, quality services.

1.3 OBHC VISION

Healthy People. Healthy Choices. Healthy Pregnant and Parenting Women.

1.4 OBHC VALUES

Employees of the OHRA Integrated Behavioral Health Center are committed to carrying out the mission of the Orpe Human Rights Advocates and providing services that adhere to our organizational values

Outstanding Teamwork

- We value integrity, cooperation, diversity, competence, and respectful and constructive feedback that are provided in a positive manner.

Outstanding Customer Service

- We value service, communication, real listening, and compassion when interacting with customers, employees and the community.

Outstanding Professional Competence

- We value a highly skilled and trained workforce that brings positive results to the agency and community.

Fiscal Responsibility

- We value fiscal responsibility and continuous improvement in all services we provide to the community.

1.5 PERFORMANCE MANAGEMENT SYSTEM SCOPE

To assure the agency's mission, vision, and values are met, the performance management system includes the following activities:

- Setting performance measures that align with the agency's strategic plan, the OBHC improvement plan, Health Resources and Services Administration (HRSA) measures , The Joint Commission Standards and Healthy People 2020 Goals.
- Systematic review and monitoring of performance measures, including clinical outcomes, population based outcomes, quality of care/services delivered, and the quality of services offered;
- An organized and comprehensive approach to quality improvement of the performance measures as described in Section V of this plan;
- Utilizing comparative data to evaluate program processes and outcomes; and
- Reporting of results.
- ACH Accreditation

1.6 BENEFIT ANALYSIS

A performance management system will allow for increased accountability, increased transparency, and service improvements . This system will also meet the requirements for maintainin g accreditation by The Joint Commission and the Public Health Accreditation Board (PHAB). The proposed system generates alignment throughout the agency and into the community with the ultimate goal of improving health outcomes for residents of Baltimore, Howard, and Frederick Counties.

1.7 DEFINITIONS

Performance Management System

Activities and methods that help this organization meet its goals in the most effective and efficient manner possible.

Quality Assurance (QA)

The systematic measurement, comparison with a standard, monitoring of processes, and associated feedback loop.

Quality Improvement (QI)

Systematic and continuous actions that lead to measurable improvement. The use of the Plan-Do-Study-Act cycle.

II PROGRAM DESCRIPTION

2.1 LEADERSHIP

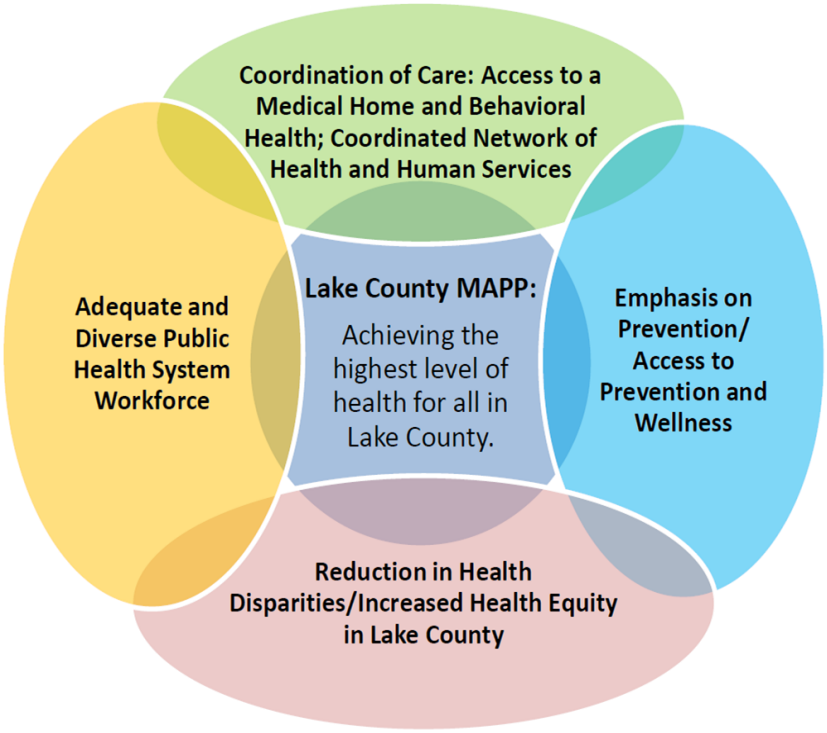
The OHRA Board Committee of Integrated Behavioral and Care Health is ultimately responsible for assuring the high quality of services provided to our customers , clients , and community and are ultimately accountable for the safety and quality of care, treatment , and services provided . The Board and Council delegate the responsibility for implementing the performance management plan to the Health Department 's leadership and to the Performance Improvement Team . The leadership defines the Mission , Vision , and Values of the OHRA Integrated Behavioral Health Center (OIBHC) to create the cultural context for performance improvement and provide a unifying framework to align and direct the activities of programs and employees.

Leaders are responsible for the services provided and the care and treatment in their program areas. The Performance Improvement Team assumes the responsibility for all performance improvement processes and initiatives in the Health Department. The Performance Improvement Team reports to the Health Department leadership, the Board of Health, and the Governing Council on performance improvement initiatives and outcomes.

2.2 STRATEGIC PLANNING

The strategic planning process describes the goals and objectives that the OBHC adopts to prepare for future challenges and public health needs of our communities and the strategies that are implemented to improve health; ameliorate injury, disparities, and inequities; and insure long-term sustainability of our organization.

As part of the overall approach to strategic community health improvement planning, OHRA embarked on a community-based approach called OBHC, which stands for Mobilizing for Action through Planning and Partnerships. OBHC is a tool that "helps communities improve health and quality of life through community-wide and community driven strategic planning [3]." By following this approach, four assessments were conducted: Community Themes and Strengths, Community Health Status, Local Public Health System, and Forces of Change. These assessments were reviewed by an engaged and broad representation of persons who share the commitment to, and have a role in, the community 's health and overall well-being. This process places an emphasis on a community-driven, community-owned approach which helps the community take responsibility for its own health. The OBHC Community Health Improvement Plan's strategic priorities are: 1) Coordination of Integrated Care: Access to a medical home and behavioral health; Coordinated network of health and human services; 2) Emphasis on prevention/Access to prevention and wellness; 3) Adequate and diverse public health system workforce ; and 4) Reduction in health disparities /Increased health equity in Pregnant and Parenting Women with Substance Use Disorders (SUD); especially, those in the state of homeless or at-risk homelessness.



Four strategic priorities developed by the OHRA Steering Committee

The Department's internal strategic planning process was conducted from January 2020 through April 2020 .

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The OBHC approached this strategic planning process with a number of objectives in mind. The primary objective is to affirm the department 's commitment to addressing the community health strategic priorities that are articulated for the State of Maryland through the Community Health Improvement Plan. This process creates a framework from which the department continues to build public health partnerships with a wide range of organizations such as academia, health care providers, hospitals, community-based organizations, businesses, schools, local governments, and individuals that contribute to the health and well-being of the community.

2.3 CUSTOMER FOCUS

Without the demand from customers, patients, or clients for the products or services supplied by an organization, that organization would not need to exist. The questions a customer focused organizations needs to be able to answer are:

- Who are the customers? The customer segments?
- Which customers are most important?
- What are the needs and the dislikes of each segment?
- Which needs are most important to each customer segment?
- Are the concrete needs expressed concretely and positively for each customer segment?
- Can you measure how well the important needs are being met? How?

Internally, each step in a process involves a supplier and a customer. It is important for the organization with a customer focus to ensure that internal customer/supplier relationships are executed systematically, while keeping sight of the needs, likes, and dislikes of the final end-user customer. Understanding customer needs and developing knowledge of our customers can be achieved through a variety of techniques such as surveys, interviews, simulation of the customer experience, direct observation, and employee feedback,

2.4 MEASUREMENT, ANALYSIS AND KNOWLEDGE MANAGEMENT

2.4.1 Defining Programs

The four service area directors (Administration, Primary Care, Behavioral Health, and Population Health) identified programs based on services, location, and common health outcomes. These programs went through the process of performance management.

2.4.2 Performance Management Training

Training is provided to introduce staff to PM, organizational alignment, and selection of appropriate and realistic performance measures. The training standardizes language used and familiarizes staff with the methodology for selecting appropriate performance measures.

2.4.3 Setting Performance Measures

Utilizing a modified balanced scorecard system as defined in Section 3.3 Performance Management System Model, all programs work with the Performance Improvement Team to develop performance measures that align with the agency's strategic plan. The program coordinators work with their staff to determine the most appropriate and realistic outputs and outcomes. The Performance Improvement Team provides guidance as needed.

2.4.4 Assurance and Improvement

The Performance Improvement Team conducts audits to assure measurement and reporting (quality assurance). The Performance Improvement Team also assists programs with improving areas where goals are not met (quality improvement).

2.4.5 Accountability and Reporting

Every six (6) months, each program is required to present the progress towards achieving their goals to senior leadership. The Performance Improvement Team assists the programs in developing their presentations. Each program creates an annual report based on their defined metrics, reporting progress and successes. The Board of Health and Governing Council are updated on progress and improvement initiatives at each of their respective meetings.

2.5 Workforce Focus

OIBHC is committed to fostering sustainable performance through an equipped and engaged workforce. The Agency measures and develops workforce performance through three primary means: an annual performance appraisal (individual), biannual Performance Management reporting (Program), and a biennial Employee Engagement and Organizational Culture assessment (Agency-wide).

The annual performance appraisal allows for review of competency gaps related to our corporate values and mission as well as job-specific objectives. When competency gaps are identified for current roles or as a means of developing high performers for future roles, trainings are offered through OBHC Human Resources as well as OBHC Human Resources. These trainings include, but are not limited to: Leadership Development and Emerging Leadership, Communication, Change Management, Computer Skills, Internal Processes, Coaching, Time Management, Project Management, Professionalism, etc. In total, over 100 courses are available for employees and management to continue growing their skills. In addition to internal trainings, continuing education is also coordinated with outside trainers to ensure ongoing certifications and licensures of staff.

The biannual Performance Management reporting allows for cross-functional review of program-level success and obstacles. As the Directors from each Service Area collectively review program measures and updates, it allows for pooled resources to build capacity or lend outside insights on techniques and innovation. This process also helps to review the manageability of individual standards within a Program to ensure fairness while still driving outcomes.

The biennial Employee Engagement and Organizational Culture assessment provides qualitative and quantitative insights into the overall culture of the organization. From this data, an Employee Task Force approach drives new implementations that foster an improved environment of success and engagement. These initiatives typically have centered around development opportunities for employees and leaders and leveraging technology in communication.

2.6 OPERATIONAL FOCUS

2.6.1 Quality Improvement Council

"What's measured improves." Peter F. Drucker

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

2.6.1.1 Organizational Structure

The QI Council is composed of:

Position	Membership	Responsibility
Executive Director (1)	Council Chair	• Provide vision and direction for QI program • Convene Quality Council • Allocate resources for activities • Report to Board of Health annually
Service Area Directors (4) and the Director of Finance	Council Member	• Identify appropriate staff for QI efforts • Oversee QI efforts within service areas • Assure QI-related performance and/or professional development goal for all division staff • Encourage staff to incorporate QI efforts into daily work • Provide administrative support on rotating basis • Assist in identifying program performance measures, monitoring progress, and recommending revision of measure as appropriate; • Articulating the business case for the projects selected and communicating that information to staff • Provide recognition of achievements
QI Specialist/ QI Coordinators / Planning and Assessment Coordinator (4)	Technical Advisors	• Facilitate QI teams as needed • Provide guidance to QI teams as necessary • Host QI trainings on a regular basis for new and existing staff • Provide staff coordination for the QI Council meetings • Provide technical assistance to programs and projects

The QI Council meets three times per month or as needed. Agendas, discussion, and decisions are recorded in minutes. The minutes are reviewed and accepted by QI Council members. At least annually, the QI Council will provide a report on the QI program to the Board of Health. Programs report progress or changes in performance measures semi-annually. QI project teams are chartered by the QI Council as required for specific initiatives. These teams are accountable to the QI Council and report activities and results on an ongoing basis.

QI Council members are responsible for monitoring performance measures, assisting with QI efforts, and for promoting, training, challenging and empowering employees to participate in the processes of quality improvement. Each QI initiative or project will have at least one QI Council member as sponsor/owner of the project. The sponsor approves the project AIM statement, assures fidelity with PDSA methodology, and reports progress at least semi-annually to the QI Council.

2.6.2 Performance Improvement Team

The Performance Improvement Team will form the core of the Quality Improvement Council for the agency and will be responsible for assuring that the functions outlined in this plan are completed. By routinely meeting with all programs and reviewing measures, the Performance Improvement Team will assure that the data obtained through performance measurement are analyzed and will derive any quality improvement initiatives that are required utilizing the Plan-Do-Study-Act cycle. The Performance Improvement Team will report on ongoing findings, recommendations, trends, and initiatives to the Stakeholders, including the Board of Health and the Governing Council. This team will also be responsible for identifying educational needs and assuring that staff education for quality improvement occurs.

2.6.2.1 Performance Improvement Team Members

All agency quality initiatives are directed by the Performance Improvement Team.

- **Edward-t Moises,** Assessment and Planning Coordinator
- **Dr. Debra Suzy**, Quality Improvement Coordinator
- **Robert Jud**, Quality Improvement Coordinator
- **Zora Moses,** Quality Improvement Specialist

2.6.3 Stakeholders

The stakeholders are made up of the governing bodies and the OHRA Committee on Health 's senior leadership .

- **Board Committee of Health**, Department Overseeing Entity
- **Governing Council**, OBHC Governing Entity
- **Dr. Debra Suzy Fletcher** , Executive Director
- **Dr. Cox**, Director, Primary Care Services
- **Jane Talley** , Director, Administration
- **Lauren Tephabock**, Director, Social Services
- **Shiney Withel Raj**, Director Supportive Services

* **Lindsey Kyles,** Director, Behavioral Health Services
* **Mary Shaan,** Director, Nurses
* **Melissa Busl,** Director, Residential Affairs

2.6.4 Quality Management

Quality management methods can be thought of as a systematic, data-driven approach to understanding work processes, solving process problems , and improving the results of our work . The Plan , Do, Study , Act (PDSA) cycle developed by Shewhart and referred to by Deming , or the Seven Step Process described by Juran and elaborated by Scholtes , are the most familiar expressions of the quality management approach to process improvement . The objective of process improvement is to reduce variation in the results of our work and to focus on system improvements , as opposed to individual behavioral change, as the means to achieving significant gains. Systems thinking, process improvement, and data-driven evaluation and change are the principles that are the basis for OBHC's quality improvement activities.

All process improvement initiatives are designed to promote quality , enhance cost effectiveness of services , and promote the safety of users and staff. Special attention is given to processes that are known to be high risk, high volume, and problem -prone areas . An analysis of high risk processes is conducted annually . The goal is to reduce factors that contribute to unanticipated adverse events or unfavorable outcomes.

The Health Department strives to comply with all relevant standards and Elements of Performance (EP) outlined in the Joint Commission Comprehensive Accreditation Manuals for Ambulatory Care and Behavioral Health Care . Sufficient staff and resources are to be allocated to promote adherence to the standards.

2.6.5 Quality Improvement Efforts

Quality improvement efforts will be chosen by the program coordinators in coordination with their staff and will be brought to the Quality Improvement Council for review. By assessing the progress of performance measures on a routine basis, programs will be able to use a data driven approach to determine which areas need improving. Team members for each effort will be selected so that the range of perspectives within the team of the problem/project is represented.

When selecting from among several identified project ideas, programs may consider

- Alignment with the Agency's strategic plan;
- Alignment with the community health improvement plan;
- Number of people affected;
- Financial consequences;
- Timeliness;
- Capacity; and
- Alignment with ACH and Joint Commission Accreditation.

2.6.6 Plan-Do-Study-Act (PDSA) Cycle

The PDSA model has two parts[4]:

1. Three fundamental questions, which can be addressed in any order.
2. The Plan-Do-Study-Act (PDSA) cycle to test changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.

Forming the Team

Including the right people on a process improvement team is critical to a successful improvement effort. Teams vary in size and composition. Each organization builds teams to suit its own needs.

Setting Aims

Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients or other systems that will be affected.

Establishing Measures

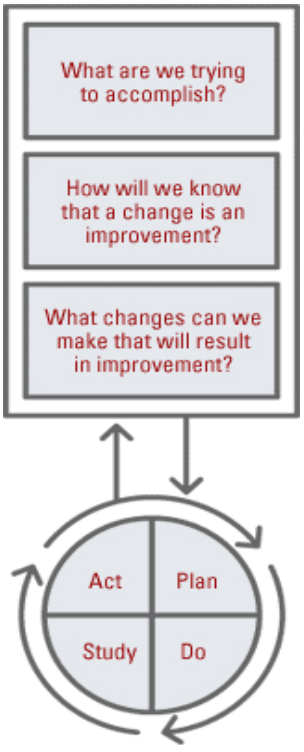
Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes

Ideas for change may come from the insights of those who work in the system, from change concepts or other creative thinking techniques, or by borrowing from the experience of others who have successfully improved.

Testing Changes

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method adapted for action-oriented learning.



The PDSA Cycle

[4] *(Institute for Healthcare Improvement, 2019)*

Implementing Changes

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team may implement the change on a broader scale—for example, for an entire pilot population or on an entire unit.

Spreading Changes

After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other organizations.

The Department of Integrated Behavioral Health Care of the Orpe Human Rights Advocates will be utilizing a variety of sources to collect data about patients , clients , residents and natural resources , and process performance . Birth , death , and morbidity data , mandatory reporting , medical record data , program data , summary data from State of Maryland reporting systems , documentation audits , and surveys provide information on the prevalence and incidence of disease , comparative health status , surveillance , program volume and trends, environmental data, and client learning and satisfaction . The information is collected and analyzed by programs to identify important aspects of public health and services are selected based on their relevance to clients, patients and residents . Variations in practice or gaps between performance and a goal or benchmark of performance are analyzed to identify and prioritize those aspects of care and service that should be the focus of continuous quality improvement initiatives.

2.7 ORGANIZATIONAL PERFORMANCE RESULTS

Goals, objectives, measurable outputs, and outcomes have been adopted by 41 distinct programs. Each program is responsible for monitoring and reporting their performance measurement metrics. Programs will report to the QI Council at least two times per year. Performance management measurements will be entered into spreadsheets available to all to ensure that achievements are transparent as well as closely monitored. Each program is responsible for achieving progress on their adopted goals or for developing remedial actions to improve performance.

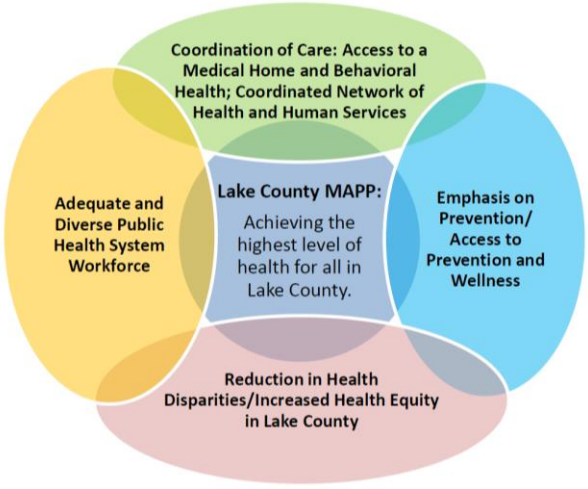
A summary of performance results will be incorporated into the Annual Evaluation of the program along with any recommendations to strengthen the program and improve results. Performance management results will also be reported periodically (at least annually) to the Board of Health and to the Governing Council. A summary of performance improvement accomplishments will also be accessible through the Health Department web site on its performance improvement page. Additional performance summaries will be provided to the county administration or the county board as requested.

III PERFORMANCE MANAGEMENT SYSTEM APPROACH

3.1 PUBLIC HEALTH SYSTEM ALIGNMENT

The performance management system will align programmatic performance measures with goals from the strategic plan. This creates linkages between programs, the agency's goals, and the community's priorities.

CHIP Priorities:



OBHC Strategic Plan Priorities and Goals:

Adequate and Diverse Public Health System Workforce

Goal 1: Attract and retain a high performing public health system workforce

Goal 2: Strengthen the public health system workforce and future workforce pipeline to improve the public's health

Goal 3: Ensure the appropriate number of well-trained health care providers to provide care to all residents

Coordination of Care: Access to a Medical Home and Behavioral Health Home; Coordinated Network of Health and Human Services

Goal 1: Increase the number of residents in Lake County who have health insurance

Goal 2: Promote the establishment of health care homes

Goal 3: Assess and reduce barriers to care and covered services

Reduction in Health Disparities/Increased Health Equity in in Howard and Baltimore Areas

Goal 1: Reduce disparities in birth outcomes

Goal 2: Improve health equity and reduce chronic disease in target populations Howard and Baltimore areas

Emphasis on Prevention/Access to Prevention and Wellness

Goal 1: Reduce illness, disability and death related to tobacco use and second hand smoke exposure

Goal 2: Reduce the incidence of infectious diseases

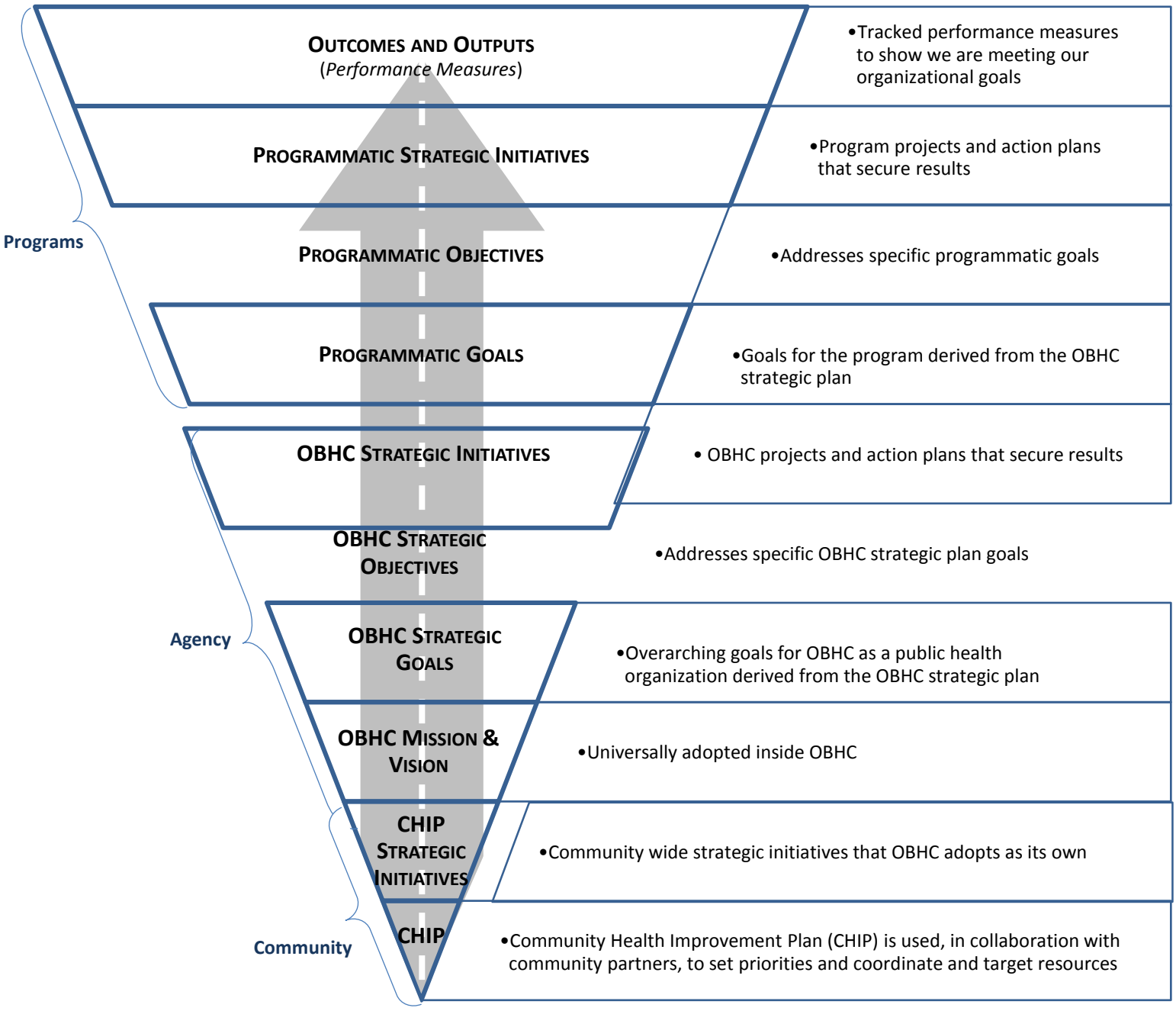
Goal 3: Reduce the percentage of adults and children in Lake County who are overweight or obese

Goal 4: Protect and improve surface and ground water resources

Goal 5: Reduce the number of substance abuse related emergency room visits and deaths

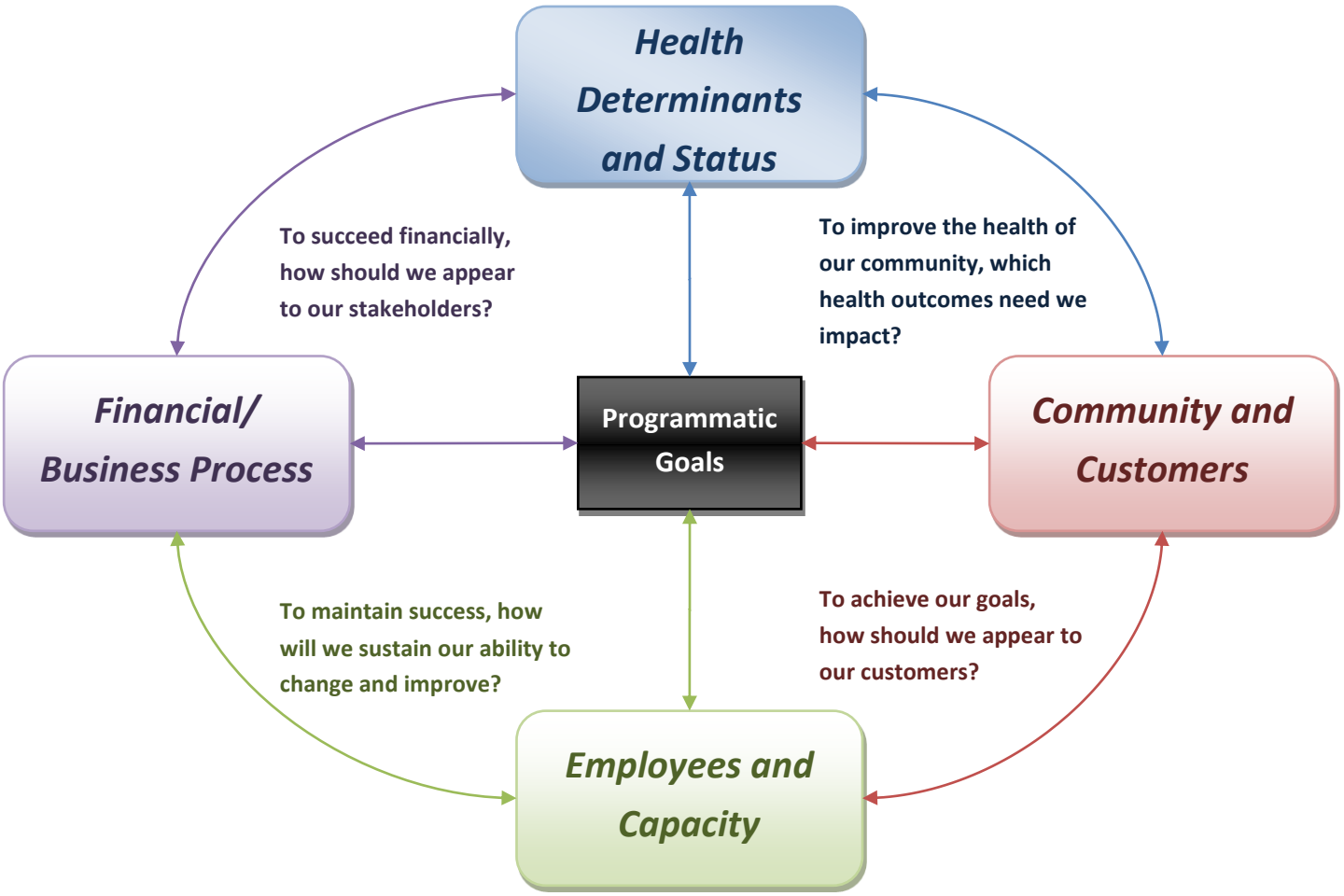
3.2 ORGANIZATIONAL ALIGNMENT

Within the performance management system, there is alignment through all levels of the agency and into the community. With the community health improvement plan serving as the root from which all health improvement stems, a common theme is referenced when creating programmatic goals.



3.3 MODIFIED BALANCED SCORECARD MODEL

The balanced scorecard is a management system (not only a measurement system) that enables programs to clarify their vision and strategy and translate them into action. It provides feedback on both the internal business processes and external outcomes in order to continuously improve strategic performance and results. When fully deployed, the balanced scorecard transforms strategic planning from an academic exercise into the nerve center of an enterprise. The balanced scorecard suggests that programs are viewed from four external perspectives to gain a better understanding of how the programs function. This approach allows for the development of metrics and the collection and analysis of data relevant to each of these perspectives.[5] This model is the modified balanced scorecard for the OHRA Integrated Behavioral Health Center .



[5] *(Balanced Scorecard Institute, 2019)*

IV SUSTAINABILITY

In order to maintain the success of the performance management system, the agency will sustain a systematic approach.

4.1 PERFORMANCE IMPROVEMENT TRAINING

Training in performance improvement and quality improvement is conducted for all new staff. This training includes an introduction to the community health improvement plan, the agency strategic plan and the reasoning and methodology for the agency performance management system. Comprehensive training has been conducted for all current managers on the purpose of the performance management system and how its results lead to quality improvement efforts. This will help build a culture of quality.

Quality improvement trainings offered:

- Orientation to the community health improvement plan, the agency strategic plan, and the reasoning and methodology for the agency performance management system for all new staff;
- Online introductory E-Learning to performance management systems;
- Online introductory E-Learning to quality improvement efforts and tools;
- Agency QI initiatives and policies; and
- Common quality improvement tools utilized.

4.2 PERFORMANCE APPRAISALS

The amount to which performance measures are achieved on the programmatic level is reflected on individual employee performance appraisals. This helps to ensure that the performance measures are attained, while engaging staff and allowing individuals to evaluate the difference they make with their work.

4.3 PLAN EVALUATION

The Performance and Quality Improvement Plan will be reviewed at least every three (3) years to reflect agency and program enhancements and revisions, or more frequently if necessary to reflect changes in structure or operations. The Performance Improvement team will conduct an annual evaluation of the performance management system and quality improvement efforts. This process may include surveying key stakeholders and end users on their satisfaction and knowledge of performance management and quality improvement. The evaluation will outline lessons learned and will delineate a path with which the program will head in the coming year. This evaluation will be approved by the stakeholders.

V APPENDIX

5.1 PERFORMANCE MANAGEMENT WORK PLAN

Program	Coordinator(s)/ Contact(s)	Meeting Phase	Team Contact	Training	Tony Meeting	Workshop	Final Program Meeting	Measures Submitted	Measures Approved	Net Work Days	1st Data Meeting	1 Hour Presentation
Child and Family Connections	Donna Nace	Pilot Group	Buddy	15-Jul	Yes	X	16-Aug	4-Nov	20-Nov	93	21-Jan	24-Apr
Sexually Transmitted Infections	Sara Zamor	Phase 1	Angela	11-Sep	Yes	X	2-Oct	6-Jan	6-Feb	107		
Supportive Services	Dhiya Bakr	Phase 1	X	11-Sep	No	X	2-Oct	9-Jan	7-Feb	108		
Mothers with SUD Residential Services	Margo Preston	Phase 1	X	11-Sep	No	X	3-Oct	4-Nov	20-Nov	51	3-Mar	22-May
Pregnant with SUD Residential Services	Robin Van Sickle	Phase 1	X	11-Sep	No	X	3-Oct	19-Nov	13-Dec	68	26-Feb	29-May
Adult & Pediatric Primary Care	Ed Esser	Phase 1	Rich	11-Sep	Yes	X	24-Oct	4-Nov	20-Nov	51	7-Mar	22-May
Outpatient with SUD Services - Therapy	Kathie Kostock	Phase 1	X	11-Sep	No	X	9-Oct	17-Dec	26-Dec	77		10-Jun
Child and Adolescent Behavioral Health Services – Trauma Treatment Program	Michele Esser	Phase 1	Vianey	11-Sep	Yes	X	9-Oct	4-Nov	20-Nov	51	6-Feb	8-May
Opioid Treatment Program	Susan McKnight	Phase 1	Seth	11-Sep	Yes	X	22-Oct	4-Nov	20-Nov	51	19-Mar	29-May
Materials Management	Joan Grasswick	Phase 1	X	11-Sep	No	X	10-Oct	4-Nov	19-Nov	50	24-Jan	24-Apr

Program	Coordinator(s)/ Contact(s)	Meeting Phase	Team Contact	Training	Tony Meeting	Workshop	Final Program Meeting	Measures Submitted	Measures Approved	Net Work Days	1st Data Meeting	1 Hour Presentation
Women's Health	Cathy Moreno	Phase 2a	X	4-Oct	Yes	X	29-Oct	4-Nov	19-Nov	33	16-Dec	8-May
Medical Education	Leslie Piotrowski	Phase 2a	X	4-Oct	Yes	X	30-Oct	20-Dec	30-Dec	62		10-Jun
Treatment of Pregnant & Mothers with SUD	Carol Craig	Phase 2a	X	4-Oct	No	X	1-Nov	3-Dec	26-Dec	60		17-Jun
Lab Service	Gloria Grillo	Phase 2b	X	28-Oct	Yes	13-Nov	2-Dec	9-Jan	7-Feb	75		
Social Works	Mike Adam	Phase 2b	X	28-Oct	No	13-Nov	2-Dec	20-Feb				
Maternal and Child Health	Damaris Montano	Phase 2b	X	28-Oct	No	13-Nov	21-Nov	20-Dec				
Case Management/ Health	Erin Williams	Phase 2b	X	28-Oct	No	13-Nov	13-Dec	13-Feb	17-Feb	81		
Case Mangmt/Court	Deb Warner	Phase 2b	X	28-Oct	No	13-Nov	9-Dec					
Legal Services (AID)	Chris Cerk	Phase 2b	X	28-Oct	No	13-Nov	4-Dec	10-Jan	10-Jan	55		17-Jun
Pharmacy	Karyn Lyons	Phase 2b	X	28-Oct	No	13-Nov	19-Nov					
Medical Management	Cheryl Aredia	Phase 2b	X	28-Oct	No	13-Nov	22-Nov	7-Feb	17-Feb	81		
HIV & Infectious Diseases	Ginger Locke	Phase 2b	X	28-Oct	No	13-Nov	6-Dec					
Nutrition Services	Katie Parry	Phase 2b	X	28-Oct	No	13-Nov	9-Dec	27-Jan	17-Feb	81		
Clients Self-Sufficient Income Programs	Susan McKnight	Phase 2b	X	28-Oct	No	13-Nov	3-Dec					
Child and Adolescent Behavioral Health Services – Outpatient	Michele Esser	Phase 2b	X	28-Oct	No	13-Nov	10-Dec	20-Feb	20-Feb	84		

Program	Coordinator(s)/ Contact(s)	Meeting Phase	Team Contact	Training	Tony Meeting	Workshop	Final Program Meeting	Measures Submitted	Measures Approved	Net Work Days	1st Data Meeting	1 Hour Presentation
Residential Services for Pregnant & Mothers with SUD-Homeless or At Risk-Homelessness	Tom Copenhaver, Pam Smith, Gloria Westphal	Phase 3a	Seth	7-Jan	Yes	12-Feb	14-Mar					
Crisis Care Program	Erin Williams	Phase 3a	Angela	28-Oct	Yes	12-Feb	18-Mar	20-Mar	20-Mar			
Workforce Training	Mike Kuhn	Phase 3a	Mike	7-Jan	Yes	12-Feb	20-Apr					
Veterans and Family Services	MJ Hodgins	Phase 3a	Rich	7-Jan	Yes	12-Feb	16-Mar					
Prevention Services	Kris Andersen	Phase 3a	Buddy	7-Jan	Yes	12-Feb	10-Mar					
Project Management	Lisa Zimmerman	Phase 3a	Seth	7-Jan	Yes	-	24-Mar					
Outpatient Behavioral Health - Psychiatry	Kathie Kostock and Dr. Hurtado	Phase 3a	Vianey	7-Jan	Yes	12-Feb	28-Mar					
Emergency Management	Bob Grum	Phase 3b	Seth	29-Jan	Yes	5-Mar	4-Apr					
Dental Care	Victor Plotkin	Phase 3b	Seth	29-Jan	Yes	5-Mar	16-Apr					
Tele Health	Dr. Cockey	Phase 3b	Vianey	29-Jan	Yes	5-Mar	7-Apr					
Out of Poverty Programs	Linda Lindas/Meryl Fury	Phase 3b	Mary	29-Jan	Yes	5-Mar	15-Apr					
Technology	Sam Johnson	Phase 3b	Rich	29-Jan	Yes	5-Mar	16-Apr					
Facilities	Bruce Robbins	Phase 3b	Mike	29-Jan	Yes	-	14-Apr					
Finance and Business Managers	Pam Riley and Mary Johnson	Phase 3b	Seth	29-Jan	Yes	5-Mar	8-Apr					
Management Information Systems	Laverne Halvey	Phase 3b	Angela	29-Jan	Yes	5-Mar	15-Apr					
Human Resources	Lorraine Harris	Phase 3b	Buddy	29-Jan	Yes	5-Mar	14-Apr					

5.2 QUALITY IMPROVEMENT

5.2.1 Quality Improvement Activity Timeline

Activity	Timeline/frequency	Person responsible
Quality Council meetings	At least every month	Agency director, Quality Council
Review, evaluate, revise, approve QI plan	Annually in January: Electronic survey to Council members Annually in March: Evaluation discussion and written report Annually in April: revisions, as needed	QI Coordinator Quality Council Quality Council
Select QI projects and teams	Ongoing	Quality Council
QI Project reports to Quality Council	Every 6 months	QI Team leaders
Storyboards to Quality Council	At next quality council meeting following completion of project	QI Team leaders
Evaluation to QI Team members	Within one month of project conclusion	QI Specialist/Coordinator
Report to Board of Health • Projects • Plan updates • Evaluation	Once a year: October	Agency director
Completed projects posted on LCHD/CDC QI website	Within one month of project conclusion	Performance Improvement Team
Reports in all-staff meeting: • Project reports • Team recognition • Quality Council report (plan updates, evaluations)	Annually in October	Quality Council members; Quality Team leaders; Performance Improvement Team
Reports to public: • Project feature on website • Annual report	Ongoing: updated at least annually in March Annually in February	Performance Improvement Team
Quality Improvement Impact posters displayed	Ongoing	Performance Improvement Team
Maintenance of Quality Council and team records on shared drive	Ongoing	Performance Improvement Team

5.2.2 Quality Improvement Workplan

Program	AIM	Rapid Cycle Improvement Plan/Goal	Project Leader	Resources	Start Date	Estimated Completion Date	Completion Date	Percent Completion	Progress Since Last Review

5.2.3 Quality Improvement Effort Proposal Template

Quality Improvement Project
Rapid Cycle Improvement AIM Statement

Quality Improvement Project Title:

Step 1: What are we trying to accomplish? (A brief statement of AIM)

Step 2: How will we know that a change is an improvement? (Potential measures of success, including implications for future improvements that build on the improvements made in this project).

Long term:

Medium Term:

Short term:

Step 3: What changes can we make that will result in an improvement?

How did you identify this opportunity, with what data, from what source(s)? Provide a brief description of the problem with any data currently available.

Initial hypotheses and description of data needed to focus the project and the development of an intervention. Are you aware of benchmark data or best practices?

Impact/overlay with other programs and activities

Who are the suppliers or customers in this project (process) and what are their concerns?

Step 4: What baseline data do you have for this AIM?

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