Kane County Health Department

KANE COUNTY HEALTH DEPARTMENT
QUALITY IMPROVEMENT/PERFORMANCE MANAGEMENT SUMMARY REPORT
Calendar Year 2013

I. Overview

Calendar year 2013 began with the selection of new Plan-Do-Check-Act (PDCA) projects and a change in the membership of the Quality Improvement/Performance Management (QuIPM) Committee. These members took the lead role on the PDCA project implementation that was begun in December 2012. A series of web-based training modules on 13 quality improvement (QI) tools was released to the Kane County Health Department (KCHD), with a requirement of all staff completing a specific set of six. As an additional means of communication, a quarterly QI-focused newsletter was developed and released by the QuIPM Committee beginning in January 2013, with subsequent issues released in April, July and October.

The first year of the Performance Management (PM) system was scheduled to conclude on June 30, 2013. At that time, a decision was made to integrate the PM system with the county fiscal year. As a result, the QI Plan and PM system measures were extended for a "fifth quarter" through September 30, 2013. During this fifth quarter, each KCHD section completed a process to identify and develop a new set of performance measures that aligned with key outcomes of each program. The expectations for these measures included representation of all programs, at least one customer-facing measure per section, and inclusion of measures developed for the agency budget. Simultaneously, the KCHD Leadership team and QuIPM Committee completed a process to evaluate the PM system and the QI Plan.

This QI Plan was also realigned to match the calendar for the PM system, and a new plan for county fiscal year 2014 was implemented on December 1, 2013.

II. Activity Summary

1. Governance of QI/PM

Monthly meetings of the QuIPM Committee focused on topics such as the integration and use of QI tools (e.g. sharing examples and best practices), providing updates and support on PDCA projects, development of materials (including QI Newsletters and training modules), supporting Public Health Accreditation preparation for Domain 9, and the integration of QI into the Performance Management system.

The KCHD Leadership team supported the work of QI/PM through quarterly meetings about the agency PM system and division-level performance measures. During these meetings, division leadership would review trends in performance measure data, and identify opportunities for quality improvement activities. Following the completion of the fourth quarter of the PM year (July 2013), this meeting was expanded to include the QuIPM Committee

representatives for each division, so that a more robust QI discussion could occur. These two groups also oversaw the process to select a new set of performance measures for the FY2014 plan, which took effect on December 1, 2013.

Both groups participated in a process to evaluate the existing QI/PM system, which included a Strengths-Weaknesses-Opportunities-Threats (SWOT) Analysis of the system and the QI Plan by the QuIPM Committee, completion of the Turning Point Self-Assessment (Performance Management) by the Leadership team, and evaluation and recommendations of specific components of the QI Plan by the Leadership team. In addition, all KCHD staff participated in a survey to evaluate their views and needs regarding the QI/PM system.

2. Policy Development

Two agency-level policies continue to govern the system of QI and PM: 9.1 (Performance Management) and 9.2 (Quality Improvement). In 2013, the Performance Management policy was revised by the QuIPM Committee, with review of the revision completed by the Leadership team. This policy was revised to outline the PM system and its alignment with the county fiscal year. In addition, a new protocol was developed, titled "Performance Management Data Management and Dissemination" (P35), which outlines the process by which PM data is collected, analyzed and distributed to the department, assuring the participation of all employees in the PM system.

A draft policy on systematically assessing Customer Satisfaction across the department was also developed in 2013, and this draft reviewed by the QuIPM Committee and Leadership teams. The need for this policy arose from work to prepare for the PHAB accreditation site visit. Additional information regarding this process can be found in #8 below.

No changes were made to the existing policy on Quality Improvement, last updated on September 26, 2012.

3. QI Plan

The QI Plan signed on June 29, 2012 originally governed the system of QI and PM from July 1, 2012 to June 30, 2013. With the decision to align the QI/PM system with the county fiscal year, an addendum was added to the plan on July 1, 2013, extending the existing plan from July 1, 2013 to November 30, 2013. In October 2013, a new QI/PM plan for fiscal year 2014 was drafted, and was approved by the Leadership team and QuIPM Committee in November 2013. This plan was approved by the KCHD Executive Director on December 3, 2013. The plan was shared with staff via e-mail and housed on the agency network shared drive; a copy was also posted to the KCHD website. This plan provides the framework for both PM and QI activities, including training, from December 1, 2013 to November 30, 2014.

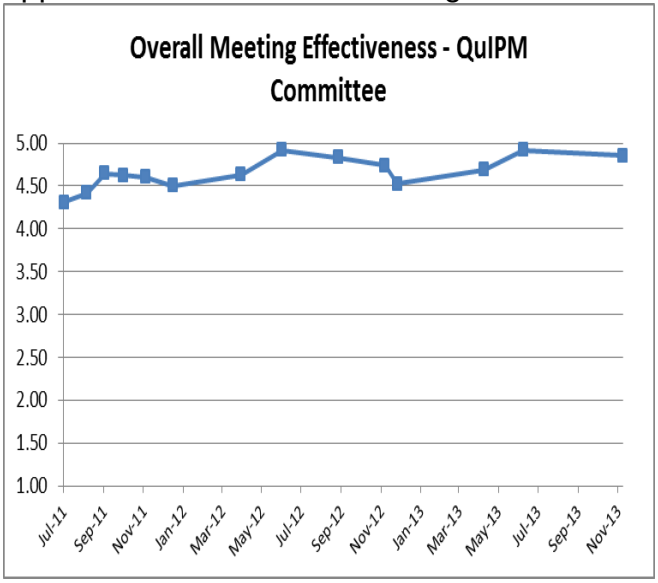
A performance measure specifically tied to this QI plan has been identified: "% of QI Plan strategies met". This data is evaluated on a quarterly basis, and is used to determine if the implementation of the plan is moving according to schedule. While this measure will be monitored quarterly, a full evaluation of the 2013-2014 QI Plan will not occur until November 2014.

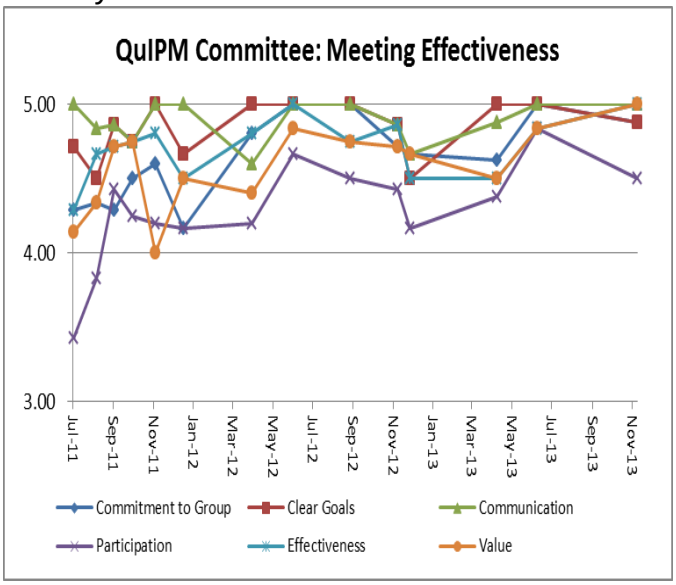
4. QuIPM Committee

Work by the QuIPM Committee in 2013 focused on:

- Evaluating the 2012 QI Plan. This process identified strengths and opportunities for improvement going forward.
- Completion of PDCA improvement projects in each section. QuIPM Committee members served as project leads, providing regular updates to the Committee and using time in Committee meetings to obtain feedback and suggestions from Committee members.
- Development of QI materials for use by KCHD staff. These materials included the quarterly QI Newsletter and a set of thirteen web-based training modules on QI tools.
- Integration and use of QI tools within programs and sections. On a monthly basis, QuIPM Committee members would report the number and types of QI tools used within each section, spotlighting at least one use of a QI tool to improve processes or programs. Over the course of the calendar year, a demonstrated increase in QI tools was recorded.
- Supporting the preparation for the PHAB Accreditation Site Visit, particularly in the area of Domain 9 (focused on QI and PM). The QuIPM Committee participated, along with the rest of the KCHD staff, in a mock audit of accreditation evidence, and contributed to the selection, finalization and evaluation of evidence specific to Domain 9.
- Integration of QI into the agency PM system. QuIPM Committee members participated in two of the quarterly meetings with Division leadership, which were focused on evaluating progress on performance measures and identifying opportunities to utilize QI to make improvements in these measures.

The QuIPM Committee continued to focus on increasing their own skills by completing the web-based training modules and leading the PDCA projects. Evaluation of the effectiveness of the QuIPM Committee was completed on a quarterly basis, and the results monitored and shared with the Committee. Overall, meeting effectiveness continues to remain high (above 4.5 on a five-point scale), with minor variation in the categories of effectiveness. The minor decline noted in early 2013 may be attributed to the QuIPM Committee transition, but this appears to have resolved through the 2013 calendar year.





5. Employee QI Training

Employee training in 2013 focused in several areas:

- Refresher training on the Turning Point Performance Management system, including development and monitoring of performance measures. All staff were involved the process to develop new performance measures for FY2014 during the fall of 2013.
- Development of web-based training modules on QI tools and methodologies. A total of thirteen modules have been created, which include a training module as well as a quiz to assess mastery:
    - Aim Statement
    - Brainstorming & Affinity Diagrams
    - Cause & Effect Diagrams (Fishbone)
    - Data Collection & Analysis (Run Chart, Bar Chart, Pie Chart & Pareto Diagram)
    - Five Whys & Five Hows
    - Flowcharts
    - Force Field Analysis
    - Gantt Chart
    - Prioritization Matrix
    - QI 101 (PDCA)
    - Storyboards
    - SWOT Analysis
    - Voice of the Customer

    A performance measure regarding completion of six required training modules (QI 101, Aim Statements, Cause & Effect Diagrams, Data Collection & Analysis, Flowcharts & SWOT Analysis) continued to be monitored through 2013. The baseline of 40.3% in July 2013 increased to 59.0% by November 2013. Although the goal of 100% was not met, it is to be noted that for a large majority of staff, only one or two trainings remain for compliance to be achieved. This measure will continue into the FY2014 performance measures, and work will be done with the Leadership team to make improvements. In addition, a performance measure has been added to indicate the percentage of staff that have completed all available training modules, and the baseline for FY2014 is 3.3%.
- Refresher training on QI tools on an as-needed basis through technical assistance provided by the KCHD Health Data and Quality Coordinator (HDQC) to individuals, teams, programs or sections. Much of this training occurred in conjunction with the section-level PDCA projects.
- Training needs were evaluated via survey in January and October 2013, and the results of that survey can be found in Section V of this document. This survey will continue to be conducted in October of each year, in order to evaluate progress and identify additional training needs.

6. Implementation of PDCA Projects

Section-level PDCA projects were selected in December 2012, and each PDCA workgroup completed a PDCA Project Plan, Project Proposal and Decision Matrix. PDCA workgroups tracked their project's progress through the use of worksheets for each of the nine steps of the PDCA, as well as the completion of a project storyboard. The Aim Statements for these projects are listed below:

Division of Disease Prevention

Communicable Disease Section

By December 2013, improve accuracy of Pertussis data entry into INEDSS by 30% (in order to more accurately discover disease outbreaks).

Public Health Nursing Section

By December 7, 2013, improve reporting of immunization coverage levels by 8% for Kane County children under the age of 19.

Division of Health Promotion

Community Health Section

By March 1, 2012, increase Community Health event evaluation scores by 20%.

Environmental Health Section

By June 30, 2013, increase the number of complete and accurately written food inspection reports from 45% to 95%.

Office of Community Health Resources

Administration Section

By August 1, 2013, improve the average employee scores of select Public Health Sciences Core Competencies by 20%.

Community Health Resources Section

By June 30, 2013, increase the number of monthly unique visitors to the KCHD website by 20%.

A summary of these projects and their results can be found in Section III of this document.

7. Communication

Efforts to encourage a culture of quality within KCHD have also focused on assuring regular and consistent communication of progress within the department. Strategies implemented in 2013 include:

- Development of a quarterly QI-focused newsletter,
- Dedicated time at All Hands all staff meetings to focus on QI/PM training, updates to PDCA projects and discussion,
- Dedicated QI webpage on the KCHD website,
- Inclusion of QI/PM in Health Matters, Kane County Board flash reports and on social media sites, and
- Housing of QI/PM materials on the KCHD network share drive, for access by all staff.

KCHD continues to promote their QI and PM efforts in local, state and national venues, including submission of projects to the Public Health Quality Improvement Exchange (PHQIX). KCHD's QI/PM work was also featured in presentations to both the Illinois and Wisconsin Public Health Institutes.

8. Links to Public Health Accreditation

KCHD submitted their evidence for public health accreditation in April 2013, and the site visit was completed in October 2013. KCHD received accredited status on November 19, 2013. Many of the systems and work in QI and PM were conducted based on the recommendations

of the PHAB Standards and Measures, and have allowed QI/PM to be integrated across the department. As a result of this process, KCHD identified areas of improvement in QI/PM, including ways to improve the performance management system and the need for a systematic way to evaluate customer satisfaction. Resultant from the work to meet PHAB requirements, QI/PM has also been formally integrated into program areas such as Workforce Development and Emergency Preparedness.

The development of a systematic process to evaluating customer satisfaction began in September 2013 with the creation of a draft policy. This draft was vetted through the QuIPM Committee and Leadership teams, and a pilot test of the policy was conducted in the first two weeks of November 2013. During this time, five KCHD programs/customer groups (Food, Immunizations, Health Advisor Visits, School Nurses and Hospital Infection Control Practitioners) were surveyed using an internally-developed tool, and the results analyzed. The programs debriefed their experiences with the pilot process and survey tool, and the results were used to finalize the process of collecting and analyzing customer feedback. The full rollout of the formal customer satisfaction survey will begin in January 2014, and the results are included in performance measures at the section and department level for FY2014.

II. Progress on Quality Improvement Goals

Goals and objectives for the 2012 QI Plan were based on the PHAB Standards and Measures, Version 1.0, released in 2011. Domain 9 requires evaluation and continuous improvement of health department processes, programs and interventions.

Goal 1: Establish a quality improvement plan based on organizational policies and direction.

Objective: Develop an annual agency QI Plan that seeks to increase staff knowledge of quality improvement and supports the development of PDCA implementation, while considering the importance of the PHAB accreditation requirements moving forward.

Measure: Approved 2012 KCHD QI Plan.

Key Strategies:
1. Creation of draft QI plan by the Health Data and Quality Coordinator (HDQC).
2. Assessment of draft QI Plan by KCHD Accreditation Team for compliance with PHAB standards.
3. Review of QI plan by Assistant Director for Community Health Resources, QuIPM Committee, Leadership Team and Executive Director.
4. 2012 KCHD QI Plan approved by KCHD Executive Director.
5. Dissemination of approved plan to KCHD staff, Health Advisory Committee and publishing of document on KCHD website.
6. Mid-year and year-end evaluation of 2012 QI Plan for compliance with goals and initiatives described therein.

SUMMARY: The 2012 QI Plan was approved by the KCHD Executive Director on June 29, 2012, following draft by the HDQC and review by the QuIPM Committee and Leadership Team. A mid-year evaluation of the plan was conducted in December 2012/January 2013 (2012 QI Summary Report), with this document serving as the year-end evaluation of the plan.

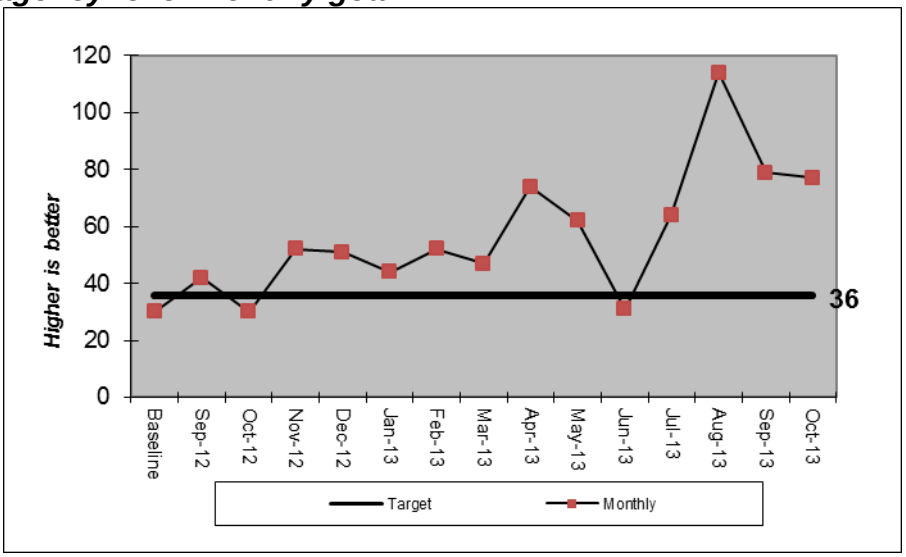
Goal 2: Implement quality improvement efforts

Objective: Based on the framework of the KCHD QI Plan, implement PDCA as a QI strategy at KCHD.

Measure: Achieve 100% compliance with development and completion of PDCA projects.

Key Strategies:
1. Health Data and Quality Coordinator will meet with each PDCA workgroup or representative at least twice monthly to provide training, technical assistance and support of PDCA project.
2. Health Data and Quality Coordinator will maintain an electronic database of PDCA project work for each workgroup and assure that it is available on the KCHD shared computer drive (S Drive) for review by all KCHD staff.
3. Health Data and Quality Coordinator will provide at least monthly updates to the Assistant Director for Community Health Resources on progress of PDCA projects.
4. All PDCA project workgroups will complete a storyboard at the completion of the project, as well as maintain progress notes during the process.
5. All sections will maintain a record of use of QI tools, both within the context of and independently from PDCA projects. This record will be submitted to the HDQC in advance of the twice-annual QI summary report.

SUMMARY: PDCA project implementation began in December 2012. QuIPM Committee members served as the project leads, with technical assistance provided by the HDQC. PDCA workgroups met on at least a monthly basis through 2013 until project completion (project completion dates varied based on projects), with regular reporting to the HDQC (who provided technical assistance and support) and the QuIPM Committee. An electronic file for each PDCA project was maintained on the agency network shared drive (S drive), with documentation of progress and tools used in the project. For projects that were finalized by the end of 2013, PDCA storyboards were completed. Finally, as "use of QI tools" was selected as a performance measure, members of the QuIPM Committee reported on use of tools at each month's Committee meeting. Progress on QI tool use can be seen in the graphic below – dramatic increase in QI tool use has been demonstrated during the 2013 calendar year. This measure continues into the FY2014 PM system, with section-level goals set along with an agency-level monthly goal.



Goal 3: Demonstrate staff participation in quality improvement methods and tools training

Objective: Provide an adequate level of QI training to all KCHD staff.

Measure: Train 100% of KCHD staff on QI Tools and QI processes as outlined in QI plan.

Key Strategies:

1. The Health Data and Quality Coordinator will create and maintain a training log of staff that have participated in QI Training, and will share a summary of that on a quarterly basis with the Assistant Director for Administration for use with the Workforce Development plan.
2. All staff will participate in a quiz of the material following training, as well as completing an evaluation of the effectiveness of the training/presentation. Results of both will be used to determine needs for additional training in each area.
3. The Health Data and Quality Coordinator will work with Assistant Director for Administration to assure that new employees receive orientation and initial QI training within six months of date of hire, as well as on-going training.
4. Self-study modules on at least 6 QI tools will be implemented in 2012.
5. The QuIPM Committee will be trained on and demonstrate competence with use of at least 6 QI tools (using the Train the Trainer modules) in 2012.
6. KCHD Leadership will show use of at least one QI tool in a Division/Section meeting on at least a quarterly basis, providing a brief refresher to staff as well as a hands-on practice example that directly relates to the work of the team.
7. Establish a baseline of KCHD staff that have included among their annual evaluation objectives at least one objective that is directly tied to the demonstrated use of QI tools or methodologies, with a goal of increasing this to 100% over time.

SUMMARY: A training log has been developed by the HDQC, with monthly updates reported as part of the performance management system. A baseline of 40% compliance with six required training modules has been indicated, with an increase to 59% by the end of 2013. While the majority of new hires have completed all of the training modules, a gap still exists in assuring that existing staff have completed all of the training modules. Web-based training modules have been completed for 13 QI tools; each training module has a quiz for participants, which not only demonstrates understanding, but requires demonstration of use of the tool. QuIPM Committee members completed a number of train-the-trainer QI modules, and practiced tool use in hands-on opportunities through the implementation of PDCA projects during 2013. Opportunities in this goal are to more fully integrate the use of QI tools by KCHD Leadership during staff meetings, and to determine the baseline percentage of evaluation objectives tied to the use of QI tools or methodologies.

III. Progress on Quality Improvement Projects (PDCA)

PDCA projects began officially in December 2012, with regular updates provided during monthly QuIPM Committee meetings.

- Office of Community Health Resources, Administration Section
  The Workforce Development PDCA (increasing core competence scores in Public Health Sciences) demonstrated significant improvement as a result of their project. The workgroup identified as a theory that, through the use of focused training, knowledge would increase (as evidenced from increases in pre-test to post-test scores) and Core Competence scores would also increase. Through an intervention designed to train staff in multiple fashions (including in-person PowerPoint training and a web-based module), results indicated an increase in knowledge (mean scores increased from 90% to 96%) and an increase in mean Core Competence scores in Public Health Sciences (increasing by nearly one full point on a five-

point scale). Evaluation of the intervention by participants was overwhelmingly positive. This project, including the use of QI tools to identify areas of focus in Workforce Development and using PDCA to increase Core Competence scores, has been submitted to NACCHO for consideration as a Model Practice.

- Division of Disease Prevention, Public Health Nursing Section (Immunization Program)
  Efforts to develop a PDCA in this section beyond the development of an initial Aim Statement were unsuccessful, and work focused instead on program-specific QI efforts. In 2013, the Lead program conducted a Quality Planning/Quality Improvement project designed to streamline and increase efficiencies, as well as to more formally document processes. The High-Risk Infant Follow-up (HRIF) program conducted a small-scale improvement project designed to increase the follow-up on newborn hearing screening referrals, a performance measure. This effort resulted in dramatic improvement on this performance measure, improving from 57% at baseline to 100% within less than six months.

- Division of Disease Prevention, Communicable Disease Section
  The PDCA focused on improving completion of INEDSS data entry for Pertussis, based on a performance measure and work they did in accreditation preparation (auditing files). The goal is that by improving documentation in this area, they will better be able to identify potential outbreaks earlier in the process, and find ways to improve completion of data entry across all reportable diseases, as well as to save time for investigators. The testing period began for this project in August 2013, and is to continue until 10 Pertussis cases have been reported. To date, only six cases have been reported, but results thus far indicate a far improved rate of documentation completeness. Because the testing period has occurred during a point in the year when Pertussis cases are traditionally few, it is difficult to know whether the intervention is fully successful. This project has resulted in the group building performance measures for FY2014 that are broader in nature, instead of disease-specific, and focus on looking at the entire Communicable Disease system.

- Division of Health Promotion, Environmental Health Section
  This project concluded on July 10, 2013 after significant improvements were noted. This project focused on increasing the completeness of food inspection reporting, and at baseline, 42% of inspection reports were complete. This increased to 75% by May 2013, and while the project did not meet the initial aim statement of 80% completeness, the project was deemed a success. The group identified that the project has resulted in an increased level of consistency and that team collaboration has also increased. In order to standardize their improvement, the Environmental Health group's intervention, an Inspection Standardization Form, has been implemented as standard practice for use by all staff during inspections. This data continues to be monitored on a quarterly basis as a performance measure. The results of this project have spurred this group to continue exploring ways to make improvements in their program, including working toward looking at consistency among reporting violations. This project has been submitted for inclusion in PHQIX.

- Office of Community Health Resources, Community Health Resources Section
  The focus of this project was to increase traffic to the KCHD website through the use of a specific intervention: targeted communication campaigns developed using a standardized tool, after it was determined that past, less-formal campaigns had proven successful in driving

traffic to the KCHD website and increased awareness of the website's existence (both identified as potential root causes). In July, August and September 2013, the plan was to implement three separate communications campaigns designed to increase web traffic; however, due to unforeseen challenges, only one of these campaigns was fully implemented using the identified process, with a level of success that could not fully be attributed to the dedicated campaign. Because the results were inconclusive, the group re-evaluated their project and intervention strategies, electing to attempt a second test beginning in January 2014; this test has been redesigned to more closely follow the intervention strategy, and it is hoped that increased web traffic will result from the test.

- Division of Health Promotion, Community Health Section
  While this project initially focused on improving evaluation scores for events, it was determined that no system of evaluation existed, and through using Line of Sight, the group determined that they first needed to increase the percentage of events that have written measureable objectives. Their intervention focused on retraining section staff on how to write SMART objectives, but results post-intervention determined that while objectives were developed, they were not all written in a manner consistent with SMART methodology. While the Aim Statement for this project was not achieved at the first iteration, this process helped the group to identify areas of focus for the next iteration. The goal remains the same: increasing the percentage of events with appropriately-written SMART objectives, but the intervention has changed: more direct feedback and discussion with the section leadership to improve the quality of objectives written. The group has also implemented performance measures regarding customer satisfaction, which should support the group's overall goal of improving the quality of their events.

IV. Progress on QI-focused Performance Measures

In the 2012-2013 Performance Management system, a total of five performance measures were directly related to quality improvement and performance management efforts:

1. Percentage of KCHD staff that have completed the six required QI training modules.
   - *The baseline of 40.3% increased to 59.0% by the end of the first year. While this improvement was not to the level hoped for (target: 100%), significant improvement occurred during the year. The majority of new hires and interns completed all of the required training modules, but more effort must be focused on completing training for existing employees. A new set of strategies will be implemented in FY2014 to increase this rate to 100%, including setting time in staff meetings specifically focused on training on these tools, and offering cross-section group training sessions.*
2. Percentage of key strategies in the annual QI Plan that are met or exceeded.
   - *The baseline of 0% increased to 88.9% by the end of the first year. This increase was incremental during each quarter, and all but 2 of the 18 strategies were met. More emphasis should be made on integrating the use of QI tools in division and section-level meetings. In addition, a vacancy in the Administration section prohibited the determination of a baseline measure for evaluations with QI-related objectives, but work will be done to establish the baseline now that the vacancy is filled.*
3. Percentage of section-level PDCA projects seen through to completion.
   - *The baseline for this measure, 57.1%, was calculated for PDCA projects conducted in 2011. During that period, some projects were initiated but not completed. For 2012-*

2013, the goal was to assure that at least 75% of the projects that were initiated were completed through one cycle. As of November 15, 2013, 60% (3 of 5) of projects were completed. Those projects not yet completed are on target to complete, with specific timelines and objectives set.

4. Number of QI tools used by KCHD sections.
    - *The 2012 baseline for this measure was an average of 30 QI tools used on a monthly basis. The QuIPM Committee set a target of an increase of 20%, to 36 tools used per month across the department. Due to increased integration of QI, the average for 2013 increased to 66 tools used per month. While this measure is not necessarily indicative of competence in use of tools, it does indicate increased proliferation of tool use, a proxy measure.*
5. Percentage of KCHD-identified performance measures remaining stable or improving.
    - *This measure was selected for the first year of Performance Management as a means to show that improvements were being made across the department's divisions/sections/programs in the area of Performance Management. The baseline of 0% increased to 81.4% by the end of the first year, nearing the target of 85% (which was selected without full knowledge of how this measure might progress). While not all measures made improvements over time, those that decreased from baseline have been discussed relative to root causes. Some measures were deemed inappropriate for inclusion in the system, while others had baselines that were inaccurate (too high).*

For FY2014, a total of seven performance measures are focused on quality improvement and performance management:

1. Percentage of KCHD staff that have completed all available QI training modules.
2. Percentage of KCHD staff that have completed six required training modules.
3. Percentage of KCHD customers satisfied with KCHD services (This is an aggregated calculation based on survey results across all programs. Each section of the department is also required to have a single customer-facing measure.)
4. Percentage of PDCA project objectives met according to projected deadlines.
5. Percentage of key strategies in annual Quality Improvement/Performance Management plan that are met or exceeded.
6. Number of QI tools used by all KCHD sections.
7. Number of QI tools used by OCHR. (Each section of the department also has set their own goal for QI tool use.)

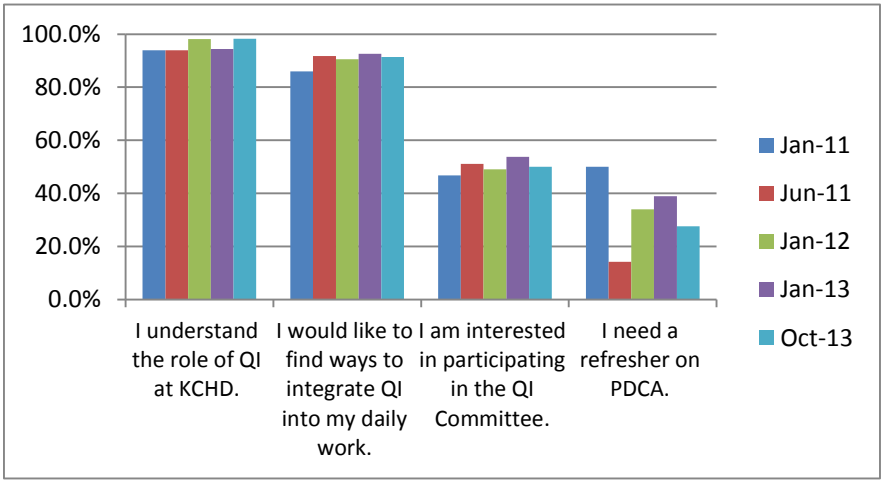
V. Evaluation of the QI & PM Systems

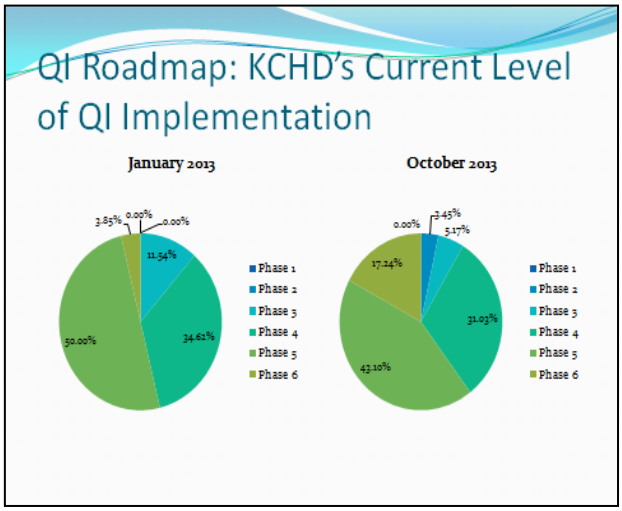
In January and October 2013, all KCHD staff were surveyed regarding their opinions of the QI/PM system, as well as their needs for training. These results were compared against similar surveys completed in January 2011, June 2011 and January 2012. Conclusions drawn from these surveys indicated:

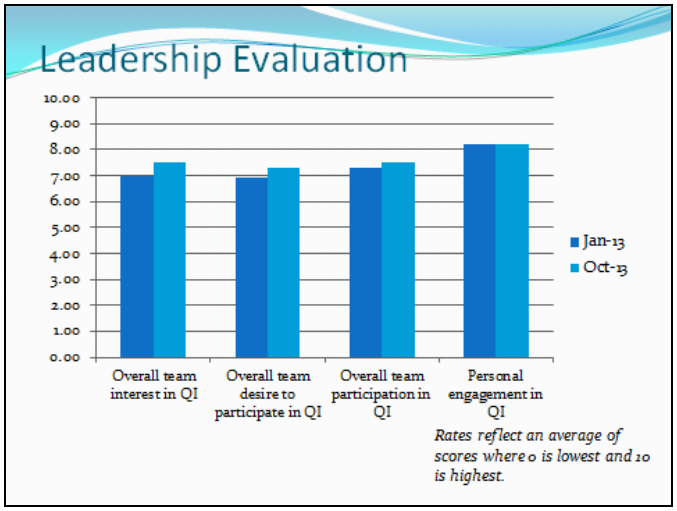
- Training needs still exist for staff, but they are decreasing over time. There is an increasing desire to see applicability of each tool: when it can best be used, and how.
- KCHD is increasingly integrating QI and PM into our work, but there are missed opportunities to bring the tools into use, including at existing staff meetings.
- Staff are increasingly using QI tools, but a core set of a few tools represent the vast majority of QI tools used. There is an opportunity to encourage the use of different tools.
- Half of the staff expressed a desire to participate in the QuIPM Committee.

- Over time, competence and understanding of QI, as well as desire and interest to participate, have increased among the KCHD staff.
- We continue to build a culture of quality at KCHD, as evidenced by increasing mean scores on the "QI Roadmap to a Culture of Quality".
- Despite the increases, there are some significant division-level differences in scores across all areas (e.g. training, integration of use, interest level).

Graphics below represent a selection of results from the QI Survey:







Also in October 2013, the KCHD Leadership team completed the Turning Point Performance Management Self-Assessment tool, a 47-question survey assessing the department's implementation of a performance management system in five key areas. The results were compared to the same survey completed in 2012 and shared with the Leadership team. These results also were integrated into the FY2014 QI/PM Plan. The mean scores (where 1 = never/almost never, 2 = sometimes and 3 = always/almost always) in each area were as follows:

	2012	2013
• Overall Readiness & Accountability	1.93	2.54
• Performance Standards	1.96	2.38
• Performance Measurement	1.89	2.58

• Reporting of Progress	1.66	2.57
• Quality Improvement Process	2.26	2.69
• **All Sections (Aggregated)**	**1.93**	**2.54**

While the results between 2012 and 2013 show improvement in all categories, and significant increase in many, there are specific areas in which KCHD can continue to focus their PM work, such as customer focus and satisfaction, assurance that PM is integrated into all program areas of the department, more specific and formalized guidelines for the processes of PM (particularly in selection of measures), and more department-wide dissemination of PM data and the PM system (inclusion of all staff).

Finally, the QuIPM Committee conducted SWOT Analyses of the QI/PM system and QI Plan. Overall, this evaluation indicated positive progress in integration of both areas, and that we have truly developed a culture focused on improvement, although some resistance continues to exist among a small population of KCHD employees. This group identified the existing resources of the plan and the training system as strengths, as is our PM dashboard. Opportunities for improvement include assurance that all KCHD employees are participating in the implementation of the plan, that they are utilizing resources available to them, and that as a department, we are finding creative ways to engage teams in using QI for resolving daily issues. This will also include the need to communicate the components of the QI/PM Plan to all staff.

VI. Conclusion & Next Steps

The 2013 calendar year saw KCHD moving closer to the full integration of a culture of quality. Half of KCHD employees now categorize the department as having reached “formal QI implementation at a system level” (level 5 on the NACCHO “Roadmap to a Culture of Quality Improvement), an increase from 2012 (when the average was level 4: formal implementation of QI in specific areas).

The future state of quality at KCHD includes the following:

- Continued growth of the QI & PM systems at KCHD, assuring participation in both systems by all employees of the department,
- Demonstrated competence by all staff in a wide range of quality improvement tools,
- Increasing use of quality improvement tools and methodologies in daily work tasks by individuals and by teams at meetings,
- Integration of Quality Planning into existing systems of Quality Improvement and Quality Control,
- Sustained or increasing levels of engagement and participation regarding QI/PM as evidenced through annual staff QI surveys,
- Completion of at least one PDCA project for all sections at least annually, and
- QI & PM not only impact daily operations, but serve to improve population level outcomes and indicators, as described in the Community Health Improvement Plan (CHIP) and Strategic Plan.