Santa Clara County Public Health Department
2016 Quality Improvement Plan

This plan was adapted from other quality improvement plans for local health jurisdictions that have a successful track record of fostering a culture of performance improvement in their organizations.[1-4]

1. Scope and Structure

1.1. Purpose and Scope

Quality improvement (QI) in public health is a "continuous and ongoing effort to achieve measureable improvements in efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community".[5] A glossary of key quality and performance management terms is included in Appendix A.

The purpose of this quality improvement plan is to provide the context and framework for quality improvement activities at the Santa Clara County Public Health Department (SCCPHD). The belief is that improving performance leads to improved community health and cost-effective use of public, private, and grant resources.

The objectives of the QI program are to:

- Build leadership skills in quality improvement and performance management
- Improve population health, contain and lower health-associated costs, and exceed customer/client expectations
- Define and monitor department performance measures
- Identify, provide resources for, and monitor department-wide improvement efforts
- Ensure the organization sustains its improvement gains
- Shift department culture toward customer-focused, results-oriented, evidence-based continuous improvement practices
- Build staff knowledge, skills, and resources to implement QI
- Utilize program evaluation results and after-action reports to make improvements
- Review and revise the QI plan on an annual basis

1.2. Policy Statement

A goal of the SCCPHD as outlined in its strategic plan is to strengthen the department's infrastructure to support a culture of performance improvement.[6] A sound quality improvement infrastructure includes three components—a QI plan, QI Council, and performance management system. To achieve a culture of continuous improvement, QI efforts will encompass all departmental areas. An agency policy on the performance management system and accountability is included in the agency policy book and updated regularly to ensure its effectiveness in guiding agency-wide QI efforts.

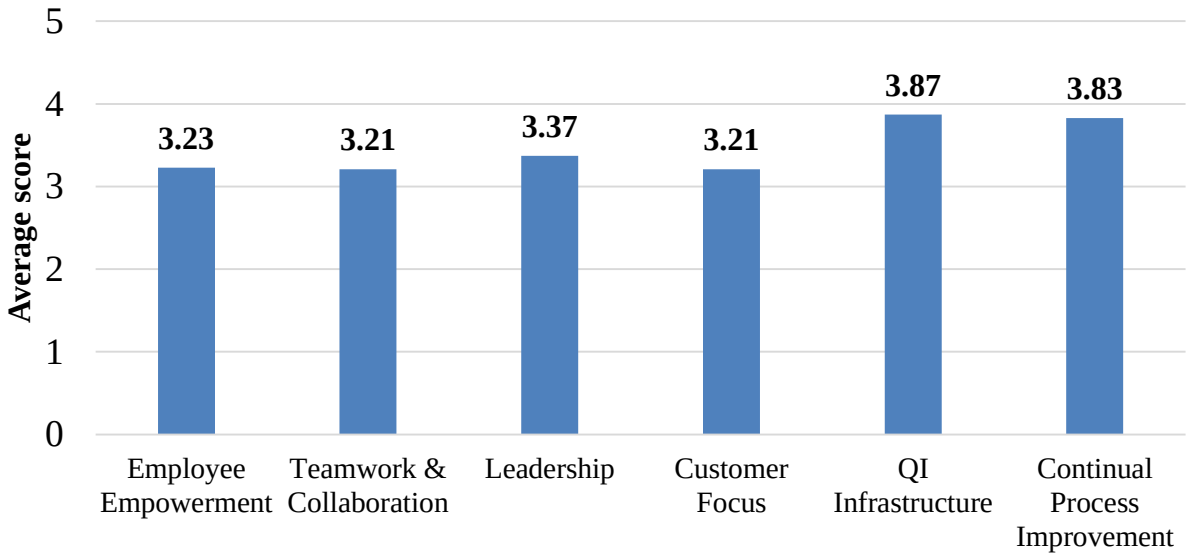
1.3. Overview of Quality

Although there is no proven formula for quality improvement in public health, SCCPHD has incorporated the strategies and resources outlined in the National Association of County and City Health Officials (NACCHO) QI roadmap since 2013 in order to progress through six levels of QI maturity. The NACCHO QI roadmap is based on six foundational elements of a QI culture that local health departments

should cultivate over time: leadership commitment, QI infrastructure, employee empowerment, customer focus, teamwork and collaboration, and continuous process improvement. Based on the NACCHO QI roadmap, SCCPHD's vision for a quality culture is one where.[7,8]

- Leadership commitment: Senior management is committed to continuous quality improvement.
- Teamwork and collaboration: Employees are capable of making improvements.
- Customer focus: Employees understand and respond to customer needs and ensure a positive customer experience.
- Employee empowerment: Employees are empowered to identify opportunities for improvement and make changes.
- QI infrastructure: Quality improvement tools and methods are used in everyday work.
- Continuous process improvement: Continuous quality improvement is the norm and is integrated into daily operations.

The SCCPHD assesses the culture of quality annually with a survey based on the abridged version of NACCHO's QI Self-Assessment Tool (SAT). Specifically, the Department monitors the number of six foundational elements with an average score of 4 or above. Baseline data from 2016 is shown below.



1.4. Organizational Structure

Refer to the Quality Improvement Council Charter and By-laws (Appendix B).

2. QI Activities

The activities listed in this section include review and improvement of SCCPHD programs and processes that have a direct or indirect influence on the health of Santa Clara County residents. These activities will be implemented and reported to the QI Council through December 2016 according to the workplan (Appendix C). This workplan reflects the Branch-specific workplans developed by the QI Council members in collaboration with the QI training cohort members in their Branch.

2.1. QI Projects

The Department will conduct at least four QI projects to improve the quality of SCCPHD's processes and services. At least one project is customer-service related and at least one project is program-related. The QI Council discusses QI projects at each meeting.

Each QI project team will:

- Have a Branch Director who sponsors the project
- Have a team leader who has authority to implement changes to the process/project
- Has a facilitator who participates in just-in-time trainings to support the project's implementation
- Include SEIU and CEMA representation
- Use data to evaluate and understand the impact of changes designed to make improvement
- Conduct quality cycles (i.e. PDCA/PDSA, Lean Six Sigma) to discover what is an effective and efficient way to improve a process
- Understand how their project relates to the overall QI plan
- Provide a report to the QI Council
- Summarize key findings that get posted on the Department website

The QI Council recommends using Plan-Do-Check-Act (PDCA) over other improvement models, such as Lean or Six Sigma, because PDCA is the most widely used improvement model in public health today.[8] PDCA is an iterative, four-step process. Information on the Department's QI projects and QI project roadmap using PDCA/PDSA can be found here.

The QI Council regularly identifies and evaluates proposed QI projects against the following criteria:

- The proposed project is aligned with the department strategic plan and/or the Community Health Assessment/Community Health Improvement Plan.
- The program is well established with ongoing work.
- There are resources available (data, QI experience) to complete the project.
- The project is operations-focused.
- The project outlines a clear process for improvement.
- The project addresses health equity.
- The project addresses activities that are sustainable over time (i.e. not a grant that will go away next year).

As QI projects come to an end, the team leader or sponsor may decide to transition into ongoing program QI if appropriate. In contrast to a QI project, which has a limited scope and defined ending point, program-level QI is continuous and becomes a part of regular daily work. As the Department expands its use of performance measurement and grows its quality/learning culture, ongoing program-level QI will become the standard rather than the exception.

2.2. Standing Committees

Improvement goals that require on-going cross-divisional organization and activity may be managed through the chartering of a standing committee. Such committees will address issues that cut across existing organizational structures in an effort to coordinate and manage processes and services to which multiple Branches might contribute. Current standing committees can be found on the intranet.

2.3. Performance Management System

The department is applying a performance management system to align and integrate the department's approach to improving results through evidence-based decision-making, continuous organizational

learning, and performance improvement.[9] The agency strategic plan is the primary driver of the performance management system. The performance management system enables the department to focus on learning and improvement by integrating all aspects of management, policy-making processes, and transforming practices and processes so the focus is on achieving improved results and better health outcomes. Performance measures enable the Department to understand a) if the Department is improving the health of Santa Clara County residents and b) if Branches are implementing efficient and effective processes and programs.

Every quarter, programs will report their progress on strategic plan and program objectives into an online database. The specific employees responsible for reporting data on performance measures are noted in the database. Appendix D documents how the performance management system is used to monitor progress.

The SCCPHD provides ongoing opportunities for the engagement of leadership and management in implementing or updating the performance management system. Specifically, the QI Council shares progress and solicits input through semiannual presentations to the Executive Team, an annual report to all staff and the community, community success story articles, and regular reports to the Health and Hospital System Executive Leadership Group and Health and Hospital Committee.

2.4. Public Health Accreditation Board (PHAB)

The department will participate in PHAB Accreditation to assess its performance against a set of national public health standards. This process will assist the department in identifying performance improvement opportunities, enhance management, develop leadership, and strengthen collaborative partnerships within the community. By applying for accreditation, the department will continue its commitment to quality and performance improvement.

2.5. Customer Service

Most programs or service areas will evaluate customer service satisfaction. Providers and coalitions may also be evaluated to ensure the SCCPHD is meeting the customers' needs. Branch reports will include results from program and/or service satisfaction surveys, and the findings rolled up at the department level, to assure customer service standards are met. A core set of questions will be used by all customer service surveys.

An agency policy on customer service will be included in the agency policy book and updated regularly to ensure its effectiveness in guiding customer service satisfaction.

2.6. QI Training, Resources, and Recognition

QI principles, tools, and techniques will be provided to staff on a continual basis in an effort to build a quality-focused culture at SCCPHD. Trainings are promoted and training content provided in a training calendar on the intranet. Staff may access online articles and videos and request books through an online resource library to enhance their learnings from the trainings. A summary of QI training and participation will be provided to the QI Council quarterly.

1. All staff are required to complete an online module on basic PM/QI concepts, resources, and departmental PM/QI policy.
2. Staff responsible for providing leadership and hands-on support in QI across their Branch (QI training cohort) are required to: (1) attend a Just Culture training and two basic or advanced QI tools trainings, (2) apply at least two of the QI tools (either basic or advanced) independent of a QI project, (3)

develop a process map and logic model for their program area, (4) attend at least one each of a speaker series, data drop-in, and sharing forum, and (5) lead, facilitate, or participate in a QI project (either PDSA/PDCA or Six Sigma). QI Council members are also required to fulfill these training requirements. These training opportunities are open to all staff, regardless if they are a QI training cohort or QI Council member.

3. Staff responsible for entering data into the performance management system, updating performance measures, ensuring performance data collection and analysis occurs, identifying and addressing improvement opportunities, or communicating and coordinating performance measure changes with the PM/QI program and program managers are expected to attend regular trainings on developing, using, and/or reporting on performance measures.
4. Staff involved in QI projects are encouraged to attend just-in-time trainings on QI methods (i.e. PDSA/PDCA, Lean Six Sigma). These are offered through the Health and Hospital System Unit-based Team cohorts and through the SCCPHD.
5. A new employee orientation will be offered annually to include an overview of SCCPHD's QI initiative, its major components, and how these components support the goals of the Department.

Additional trainings will be provided as needed; for instance, staff training in the use of evidence-based and model practices at the request of QI team leads/sponsors.

The Staff Engagement Committee recommends opportunities for recognition of staff participating in QI efforts in the department. The committee should make concrete efforts to recognize and thank staff for participating in QI teams and using QI methods and tools in their daily work. Additionally, staff who complete the training program outlined above will receive a certificate of completion and will be invited to participate in a special celebration in early 2017.

2.7. Alignment of QI Plan with Other Initiatives

2.7.1. Employee Performance Evaluations

The Department's annual employee development performance review process includes evaluating management staff in their use of QI in their daily work. The following competency and criteria are assessed for all management staff:

- Demonstrates ability to use quality principles and tools: Uses quality principles, methods, and tools to analyze and improve work processes. Actively participates in quality teams, when applicable to their work. Participates in training opportunities to learn more about quality principles, methods, and tools. Uses data to better understand the effectiveness and efficiency of work.

2.7.2. Communications

The QI Council will work with the Communications team to develop and implement an internal and external communications strategy for QI, which may include creating QI posters and signs, gathering QI testimonials during regular trainings to post on the intranet, and conducting a QI roadshow showcasing successful QI projects. The QI plan will be posted on the Department's intranet site.

2.7.3. Just Culture

A *Just Culture* is a culture of trust, fairness, and environment that learns from its mistakes by reporting errors, and every employee is accountable for their actions. PM/QI provides the systems and procedures for *Just Culture*, which entails developing processes for accountability and articulating the mission and goals into meaningful metrics. The *Just Culture* trainings in the Department can help establish the

necessary staff and management behaviors for PM/QI, which involve being accountable, communicating clearly, and supporting efforts to improve.

2.7.4. Santa Clara Valley Health and Hospital System (HHS) Strategic Roadmap

HHS's strategic roadmap focuses on core objectives to improve the health and well-being of the residents and communities of Santa Clara County. These objectives are aligned with the six strategic plan priority areas:

- SCCPHD strategic priorities to engage partners and communities to improve community health, advance racial and health equity to eliminate health disparities, and strengthen prevention and response to current and emerging infectious diseases align with the HHS strategic roadmap objectives of increase healthy lifespan and decrease burden of disease; and
- SCCPHD strategic priorities to strengthen organizational capacity for accountability and transparency, successfully communicate the value of SCCPHD and public health, and promote a robust prevention-oriented countywide health systems align with the HHS strategic roadmap objectives of decrease redundancies, delays, and cost of care, improve customer experience and service, and invest in our workforce.

2.7.5. Center for Leadership and Transformation (CLT)

The CLT is a county effort to transform operations based on a 90-day plan for fast and effective change. CLT projects underway at SCCPHD use common QI principles and methods. The CLT is founded on the principles that lasting, organizational transformation can be achieved when Santa Clara County:

- Encourages employees and equips them with methods and processes to lead change from any part of the organization;
- Empowers employees to suggest and participate in innovative, actionable solutions and breakthrough ideas;
- Cultivates the power and expertise of cross-functional collaboration;
- Develops metrics that establish the findings and best practices from change efforts; and
- Fosters an environment necessary to transform business policies and practices.

2.7.6. Unit-Based Teams (UBTs)

A UBT is a labor/management work group of frontline staff, managers, and union representatives who work collaboratively to solve problems, improve performance, and enhance quality. UBTs utilize the Rapid Improvement Model (RIM), which is based on the Model for Improvement, which asks three fundamental questions for achieving improvement: (1) What are we trying to accomplish?, (2) How will we know that a change is an improvement?, and (3) What changes can we make that will result in improvement?. The Model for Improvement incorporates the PDSA cycle as a quick way to test change in a real work setting—plan it, try it, observe the results and act on what is learned. Santa Clara Valley Health and Hospital System (SCVHHS) is using UBTs to improve the care and service they provide at SCVHHS. To date, our Department's California Children's Services (CCS) program is the only program in the Department to organize a UBT through the HHS cohorts, although the UBT framework is being applied to all QI projects throughout SCCPHD.

2.8. Evaluation and Revision of the QI Plan

The QI Plan is revised and approved annually by the QI Council to reflect program enhancements and revisions. Activities listed in the annual QI work plan are developed based on the recommendations from the QI Council, as described earlier. The QI plan is evaluated against the strategic plan targets for quality

improvement and PHAB standards and measures (Standard 9.1: Use a performance management system to monitor achievement of organizational objectives, and Standard 9.2: Develop and implement quality improvement processes integrated into organizational practice, programs, processes, and interventions).

3. References

1. Sedwick County Health Department. 2011 Quality Improvement Plan.
2. Spokane Regional Health. 2011 Quality Improvement Plan.
3. Tacoma-Pierce County Health Department. 2012-13 Quality Improvement Plan.
4. Washington County Department of Public Health and Environment. 2012 Quality Improvement Plan.
5. Riley WJ, Moran JW, Corso LC, Beitsch LM, Bialek R, Cofsky A. Defining quality improvement in public health. *Journal of public health management and practice : JPHMP*. Jan-Feb 2010;16(1):5-7.
6. Santa Clara County Public Health Department. Roadmap to a Healthier Future: A Strategic Plan 2012-2015.
7. Jack Moran and Bill Riley. Building Blocks of a Quality Culture.
8. National Association of County and City Health Officials. 2010 National Profile of Local Health Departments. Retrieved from http://www.naccho.org/topics/infrastructure/profile/resources/2010report/upload/2010_profile_main_report-web.pdf.
9. National Performance Management Advisory Commission. Performance Management Framework.

Appendix A
Glossary of Key Quality & Performance Management Terms

Accreditation for public health departments is defined as:

1. The development and acceptance of a set of national public health department accreditation standards;
2. The development and acceptance of a standardized process to measure health department performance against those standards;
3. The periodic issuance of recognition for health departments that meet a specified set of national accreditation standards; and
4. The periodic review, refining, and updating of the national public health department accreditation standards and the process for measuring and awarding accreditation recognition. *(Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA. May 2011).*

Baseline is the quantitative starting point that is the basis for comparison with subsequently acquired data.

Community Health Improvement Plan
Community health improvement plan is a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done a timely way. *National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007 (Adapted from: United States Department of Health and Human Services. Healthy People 2010. Washington, DC: US Department of Health and Human Services; 2000.)*

Continuous quality improvement is an ongoing effort to increase an agency's approach to manage performance, motivate improvement, and capture lessons learned in areas throughout the agency. It is an ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities, outcomes. A variety of methods and tools (QI/QP/Lean, etc.) are utilized as part of a larger, on-going system of improvement. Performance measurement tells us what we need to work on; Performance management helps us to prioritize and organize what we work on; and CQI helps us to do the work.

Cultural competency: Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. *OMH, DHSS*

Customer satisfaction is a measure of how products and services supplied by an organization meet or surpass customer expectations. Customer satisfaction is the number of customers, or percentage of total customers, whose reported experience with an entity, its products, or its services (ratings) exceeds specified satisfaction goals. *Farris, Paul W.; Neil T. Bendle; Phillip E. Pfeiffer; David J. Reibstein (2010). Marketing Metrics: The Definitive Guide to Measuring Marketing Performance. Upper Saddle River, New Jersey: Pearson Education, Inc.*

Goals are general statements expressing an organization's (Dept., division, program) aspirations or intended effects, often stated without time limits. Goals may not necessarily be stated in quantitative terms though they should be associated with one or more measureable objectives.

Objectives are results of specific activities or outcomes to be achieved over a stated time. Objectives are specific, measurable, attributable, realistic, time-limited statements of intention (a.k.a., SMART). Objectives include a direction, target, measure, and timeframe. For example: "Increase the % of children under two in county registry who receive all recommended immunizations from current 85% to 95% by

January 2013." You cannot manage your progress toward strategic goals without objectives. People sometimes confuse objectives with performance measures, which is one component of a SMART objective (see definition of performance measures above).

Performance management is what you do with the information you learn and knowledge you gain from measuring performance. Performance management is an ongoing, systematic approach to improving results through evidence based decision-making, continuous organizational learning, and a focus on accountability. Performance managing means using performance information: for example, to review services and programs; assess and revise goals and objectives; assess progress against targets; conduct employee evaluations; and formulate and justify budgets. It is the use of performance information to help set agreed-upon performance goals, allocate and prioritize resources, inform managers to either confirm or change current policy or program directions to meet those goals, and report on the success in meeting those goals.

Performance measurement is the selection and use of quantitative measures of capacities, processes, and outcomes to develop information about critical aspects of activities, including their effect on the public. It is the regular collection and reporting of data to track work produced and results achieved. It is what we do to determine if we are making progress toward our objectives.

Performance measures are quantitative indicators of performance and can be used to show progress toward a goal or objective overtime. It is the specific number representation of a capacity, process, or outcome that is relevant to the assessment of performance. [Note: sometimes performance measures are confused with objectives. For our purposes, when we talk about performance measures, we are only referring to what is being measured (number + unit of measure), not the entire SMART objective (see definition of objectives below).]

> **Types of performance measures:**
> **Process measures** are the steps or activities in producing a product or service and provide feedback on how well you are performing a process.
> For example,
> - Number of days between a request for services and an actual meeting with a service provider.
>
> **Outcome measures** are the expected, desired, or actual results from the outputs of the activities of a service or agency and shows whether you made progress in reaching your ultimate goal.
> For example,
> - Percentage of children with age-appropriate immunization levels at age two.

PHAB Domains are groups of standards that pertain to a broad group of public health services. There are 12 domains; the first ten domains address the ten Essential Public Health Services. Domain 11 addresses management and administration, and Domain 12 addresses governance. (Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA, May 2011).

PHAB Standards are the required level of achievement that a health department is expected to meet. (Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA, May 2011).

PHAB Measures provide a way of evaluating if the standard is met. Required documentation is the documentation that is necessary to demonstrate that a health department conforms to a measure. (Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA, May 2011).

Program evaluation is defined as the systematic application of social **[**or scientific**]** research procedures for assessing the conceptualization, design, implementation, and utility of social **[**community**]** intervention programs. Rossi PH, Freeman HE, Lipsey MW. *Evaluation: A Systematic Approach*. 6th ed. Sage; 1999.

Program QI is the application of quality management tools and methods at a program level. Program QI typically includes an assessment of program purpose and goals, customer needs, and current quantitative performance in order to identify specific improvement opportunities. While programs may have focused projects or focused events, the work is not time-limited. Programs will take their key processes through repeated cycles of improvement.

Public Health Accreditation Board (PHAB) is the national accrediting organization for public health departments. A nonprofit organization, PHAB is dedicated to advancing the continuous quality improvement of Tribal, state, local, and territorial public health departments. PHAB is working to promote and protect the health of the public by advancing the quality and performance of all public health departments in the United States through national public health department accreditation. (Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA, May 2011).

Quality: The degree to which policies, programs, services and research for the population increase desired health outcomes and conditions in which the population can be healthy. U.S. Department of Health and Human Services. (2008). Consensus Statement on Quality in the Public Health System. [cited 2016 Mar 4]. Available from: URL: http://www.hhs.gov/ash/initiatives/quality/quality/phqf-consensus-statement.html#.

Quality Improvement: A deliberate and defined improvement process which is focused on activities that are responsive to community needs and improving population health. Riley WJ, Moran JW, Corso LC, Beitsch LM, Bialek R, and Cofsky A. Defining Quality Improvement in Public Health *J Public Health Management Practice*, 2010, 16(1), 5–7.

Quality Improvement (QI) Project: A time-limited effort to improve an existing process regarding a specific quantitatively defined problem such as error frequency, cycle-time, etc. A quality improvement project typically hands-off to operations for the control and on-going improvement of the process in question. QI is also known as process improvement, six-sigma, etc.

Strategic Plan: A strategic plan sets forth what an organization plans to achieve, how it will achieve it, and how it will know if it has achieved it. The strategic plan provides a guide for making decisions on allocating resources and on taking action to pursue strategies and priorities. A health department's strategic plan focuses on the entire health department. *PHAB*

Target: The quantifiable amount of improvement to be achieved. For example, "from 85% to 95% of children receive …"

Appendix B
Quality Improvement Council Charter and By-laws
Santa Clara County Public Health Department

1. Purpose

The purpose of the Quality Improvement (QI) Council is to support the creation, implementation, monitoring and evaluation of quality improvement efforts of Santa Clara County Public Health Department and to support the Executive Leadership Team in building a culture of continuous quality improvement throughout the organization. The QI Council is charged with providing oversight for Department QI efforts and activities, and accountability for monitoring for QI follow-through and documentation, which include: developing and evaluating an annual QI plan that is integrated with the Community Health Improvement Plan and Strategic Plan, preparing to meet standards relative to QI, developing and evaluating QI projects, planning and participating in QI training activities, becoming skilled in QI tools and methods, and supporting the development and implementation of the agency's performance management system.

2. Membership

The membership shall not exceed 20 members and consist of at a minimum six members:

2.1. Deputy Director
2.2. At least one Branch Director
2.3. At least one Program Manager or line staff from each of the Branches

3. Roles and Responsibilities

Everyone has a role in SCCPHD's quality improvement efforts.

3.1. Health Director, Deputy Director, and Branch Directors
- 3.1.1. Provides support for the QI program and QI Council
- 3.1.2. Responsible for setting the vision/direction of quality improvement and performance management efforts
- 3.1.3. Reports on QI activities to the HHS Deputy County Executive
- 3.1.4. Encourages program staff to incorporate QI concepts into daily work
- 3.1.5. Requests the review of specific program evaluation activities or the implementation of QI projects

3.2. Program Managers
- 3.2.1. Responsible for supporting the implementation of QI projects; identifies appropriate staff to participate in QI projects as needed
- 3.2.2. Reports to the QI Council on program evaluation activities
- 3.2.3. Determines appropriate messages to communicate selected QI activities and results to staff, the public, and other audiences
- 3.2.4. Encourages program staff to incorporate QI concepts into daily work.
- 3.2.5. Responsible for the implementation of ongoing program-level quality improvement/planning for his/her program(s)

3.2.6. Responsible for monitoring and reporting program, center/division, and department-level performance measures that fall within their program(s); report results to QI Council

3.3. All SCCPHD staff

3.3.1. Participate in QI projects and incorporate QI concepts into daily work, as requested by Branch Managers or program managers

3.3.2. Collect and report data for reporting of performance measures; use data to identify areas needing improvement

3.3.3. Encourage colleagues to incorporate QI concepts into daily work

3.3.4. Understand how performance measures related to their work affect the Department's strategic priorities

3.3.5. Participate in QI trainings

4. Steering Committee

4.1. Members

4.1.1. The Executive Leadership Team will serve as members of the steering committee.

4.2. Purpose

4.2.1. Guide implementation of the quality improvement plan developed by the Quality Improvement Council

4.2.2. Encourage program staff to incorporate QI concepts into daily work

4.2.3. Inform the development of the department-wide performance management system to improve the quality, efficiency and effectiveness of the Department

4.3. Vision

4.3.1. The Department demonstrates accountability, results and efficiency through the ongoing use of performance standards, measures and outcome reports that guide quality improvement efforts and decision-making for the ultimate purpose of improving and protecting the health of Santa Clara County residents.

4.4. Goal

4.4.1. Identify, create and implement changes that enable integration of standards, measures, reporting and quality improvement into the Department

4.5. Activities

4.5.1. Develop a common understanding of the components of performance management (objectives, measurement, monitoring and reporting, and quality improvement)

4.5.2. Review and approve performance measures for incorporation into the department-wide performance management system

4.5.3. Provide direction on the prioritization, selection and implementation of department-wide activities that support performance management, quality improvement, and accreditation preparation

4.5.4. Articulate the roadmap for and progress made towards managing the performance of the Department

4.5.5. Identify and select QI Council members

5. Administrative and Technical Support

5.1. The Performance Improvement Manager provides administrative and technical support to the QI Council. This support includes:
   - 5.1.1. Providing staff coordination for the quarterly QI Council meetings, including facilitating meetings and distributing the agenda
   - 5.1.2. Providing staff training in QI methods and tools
   - 5.1.3. Assisting program staff to track and trend their performance data
   - 5.1.4. Providing technical assistance for QI projects or ongoing program QI, which may include data collection/analysis and advice on QI methods/tools
   - 5.1.5. Developing the annual QI plan and QI program evaluation; ensure QI plan meets accreditation requirements
   - 5.1.6. Identifying, contracting, and coordinating training specialist and consultants to QI project teams and to the QI Council and Steering Committee as needed
   - 5.1.7. Integrating QI principles in Department policies/protocols (e.g. employee hiring; performance review; meeting minutes documentation; develop/review PM/QI policy)
   - 5.1.8. Maintaining all meeting minutes and sign-in sheet records
   - 5.1.9. Maintaining QI Council membership list

6. Chairs

The QI Council will select two co-chairs for a minimum of one year. The Chair(s) shall:

6.1. Facilitate meetings (clarify who presides in absence) and attend all meetings
6.2. Set the meeting agenda that gets shared electronically with all council members prior to each scheduled meeting

7. Membership

7.1. Members shall serve for a period of at least one year.
7.2. Less than half the QI Council should rotate off the council at any given time to maintain continuity.

8. Meetings

8.1. The QI Council will meet quarterly.
8.2. Additional meetings and cancellations may be made at the discretion of the chairs or by a majority of the representatives.
8.3. A meeting ***may*** be cancelled in the anticipated absence of a quorum, a quorum being defined as at least half of the total QI Council members in attendance.

9. Decision making

9.1. Decisions shall be made by consensus. In the event that consensus is not possible, a majority of the QI Council may decide that an issue shall be decided by majority vote.
9.2. Decisions may not be made in the absence of a quorum.

10. Attendance

10.1. Members who must miss a meeting may fulfill their attendance requirements by appointing a proxy or requesting an alternate.
10.2. Members are expected to be present for the entirety of the meeting.

11. Committees

11.1. Standing committees – In addition to QI Council members, general SCCPHD staff may serve on standing committees.

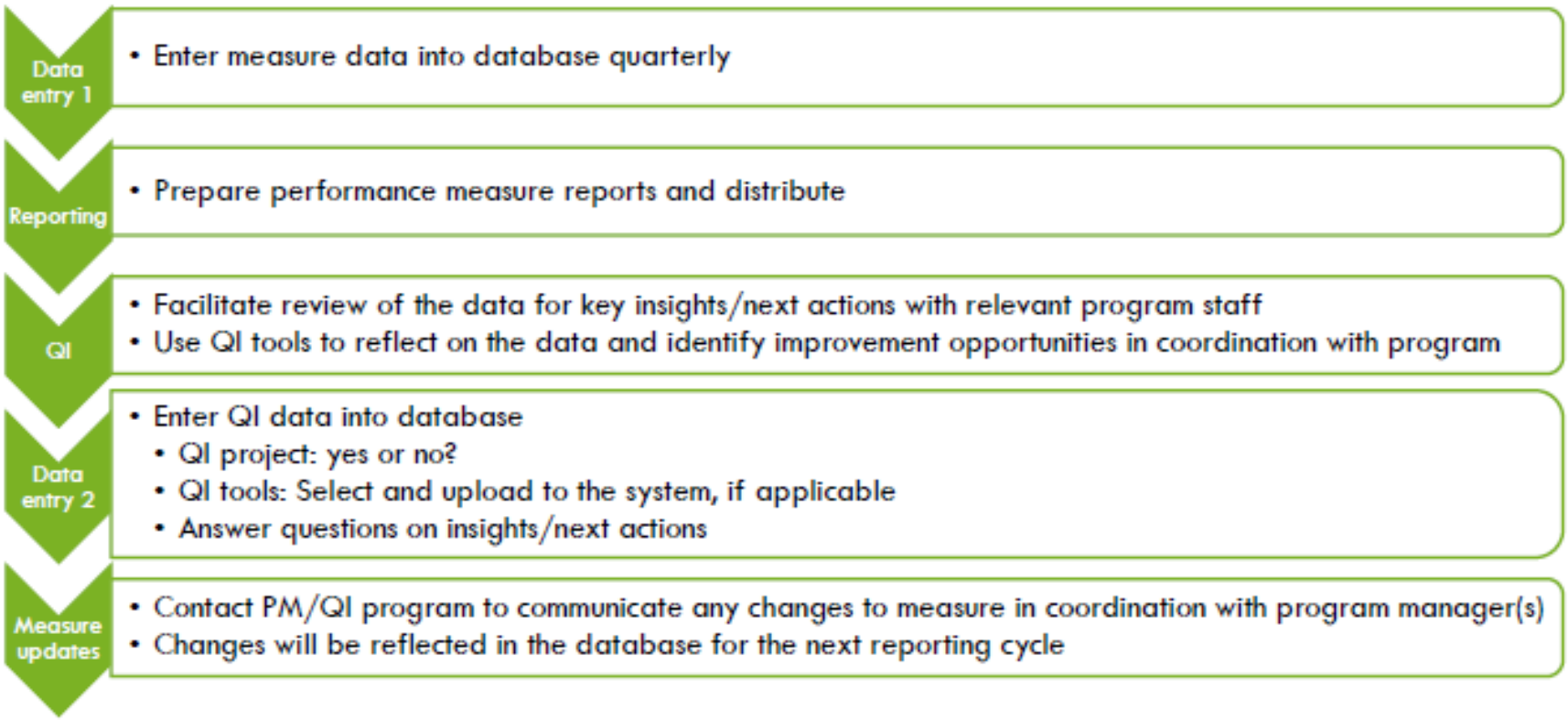
11.1.1. Staff Engagement Committee – Provides recognition of staff for quality improvement successes; communicates key messages regularly; and promotes forthcoming trainings and participation/engagement opportunities

11.1.2. Quality Improvement Training Cohort – Provides leadership and hands-on support for quality improvement within their respective Branch. Fulfills training requirements on an annual basis to improve their knowledge and skills in QI. QI Council members are expected to complete these training requirements.

Appendix C
Quality Improvement Council Workplan

	Accountable Staff	Completion Date	Review Date	Target Met?
QI Projects (see 2.1)				
Increase the number of changes to simplify the travel process to at least 3 changes by February 2016	Lead: Carol Melton Facilitator: Whitney Webber Sponsor: Rocio Luna	February 2016	June	Yes, 5 changes
Increase the Medical Eligibility determination within 5 business days to 90% by December 31, 2014	Leads: Janet Callaway, Tiffany Garcia Facilitator: Ann Nicolson Sponsor: Marilyn Cornier, Aimee Reedy	December 2014	June	Yes, 93% in 12/14; 99% in 4/16
Reduce the number of CCS clients who lose Medi-Cal by 50% by December 31, 2015	Leads: Gian Osorio, Raquel Gonzalez, Luz Gutierrez Facilitator: Ann Nicolson Sponsor: Marilyn Cornier, Laura Brunetto	December 2015	June	Yes, 13 Baseline: 40
Increase the compliance rate of CCS diabetic multidisciplinary team visits at SCVMC Pediatric Endocrine Clinic From 62% to 67% by April 2016	Leads: Emma Mendez, Karen Chen, Gabriel Sainz Facilitator: Joe Tansek Sponsor: Marilyn Cornier, Laura Brunetto	April 2016	June	Yes, 90% in 4/16
Increase the percent of families who keep their WIC appointments by 5% or more by May 2016	Lead: Evelyn Chu Facilitators: Judy Lee, Jaclyn Allardyce Sponsors: Laura Brunetto, Aimee Reedy	June 2016	June	No, but close 55.3% to 59.4%
Submit a 100% completed and county-approved CHDP & CCS Plan & Fiscal Year 2015-2016 Guidance to CDHS mailbox	Leads: Ali Ahmadieh Facilitator: Marilyn Cornier Sponsor: Marilyn Cornier, Rhoda Blankership	April 2016	June project workshops and sharing forum	Yes, 100% complete
Increase the average recognition score across the department from 6.1 to 7 by August 2016	Leads: Vanessa Merlano, Marcela Vasquez Facilitators: Whitney Webber, Maritza Rodriguez Sponsor: Aimee Reedy	August 2016	September	No, but there was an increase to 6.4
Increase the percent of Ryan White providers who implement value-based performance measures to 100% by July 2016	Lead: Supriya Rao Facilitator: Supriya Rao Sponsor: Lisa Hernandez, Jim McPherson	July 2016	September	Yes, 100%
Increase enrollment into Black Infant Health program group sessions from 27 women to 40 women by October 2016	Leads: Louise Hill, Rachelle Chavez Facilitator: Tiffany Garcia Sponsor: Laura Brunetto	October 2016	September	No, 4 new enrollments; goal was 13 new
Increase the number of providers from 0 to 1 that have identified service gaps in the Ryan White renewal/recertification process by September 2016	Leads: Mike Torres Facilitator: Mike Torres Sponsor: Lisa Hernandez, Jim McPherson	September 2016	November 15 Day Away	Yes, 1 provider

Increase the percent of documented CCS SOPs for high priority tasks in RFE and BIS units from 0% to 17% (9 out of 52 tasks) by December 31, 2016	Leads: Gian Osorio, Ali Ahmadieh Facilitator: Whitney Webber Sponsor: Laura Brunetto, Marilyn Cornier	December 2016	November 15 Day Away	Yes, 20%
Increase the percent of documented medical homes/primary care providers for children enrolled in the CCS program from 67% to 100% by December 31, 2016	Leads: Janet Callaway, Ali Ahmadieh, Emma Mendez Facilitator: Marilyn Cornier Sponsor: Laura Brunetto	December 2016	November 15 Day Away	100% not achievable, 99.3% at last follow-up
Decrease the percent of client refusals for Regional Public Health Nursing Services by 5% for Narvaez and 10% for North County from the same month from the previous year	Leads: Elinor Stetson, Anne Marie Santos Facilitator: Angela Huang, Frank Serrano Sponsor: Laura Brunetto	September 2016	December	Yes for North County (40.9% in 9/15 to 15.8% in 9/16) No for Narvaez, but there was a decrease (17.3% in 9/15 to 14.4% in 9/16)
Reduce the number of rejected too long in transit blood lead samples from 42 to 10 specimens (of a total of 5389 blood lead samples received in 2015) by October 2016	Leads: Patty Dadone, Bethany Montes Facilitator: Don Long Sponsor: Lisa Hernandez	October 2016	December	Yes, 10 specimens
Decrease the percent of late client and interim care plans from 30% to 15% by November 30, 2016	Leads: Charadine Dore, Grace Meregillano Facilitator: Tiffany Garcia Sponsor: Laura Brunetto	September 2016	December	No, 21%
	Accountable Staff	**Completion Date**	**QI Council Review Date**	
Standing Committees (see 2.2)	Whitney Webber	Updates	Quarterly	
SCCPHD Performance Measures (Teddy Daligga & Whitney Webber) (see 2.3)				
Strengths and opportunities for improvement and implications for QI projects by 12 strategic goals	Goal 1, 8: Rocio Goal 2: Nicole/Teddy/Sue Goal 3: Ali / Tammy / Judy / Jackie / Dina / Grace / Marilyn / Aida / Elaine Goals 4-6, 9, 11: Aimee Goal 7: Supriya / Beth Goal 9: Whitney Goal 10: Bianca Goal 12: Anne Marie / Nicole / Teddy / Sue	Jun, Sept, Dec	Jun for Jan-Mar Sept for Apr-Jun Dec for Jul-Sept	
ELG and HHC PM/QI program highlights	QI Council (All)	March, Jun, Sept	Quarterly	
Public Health Accreditation (see 2.4)	Whitney Webber	Annually	Annually	

Customer Service (see 2.5)	Aimee Reedy	Updates	Quarterly
QI Training and Resources (see 2.6)	QI Council (All)	Updates	Quarterly
Alignment (see 2.7)	Whitney Webber	Updates	Quarterly
Evaluation of 2015 QI Plan (see 2.8)	Whitney Webber	February	March
Approval of 2016 QI Plan	QI Council (All)	February	March

Appendix D
5-Step Process Flow Chart for Performance Monitoring