APPENDIX B: BIG QI REPORT

Tulsa Health Department (THD)
QI Site Visit: Big QI Report
July 16, 2008

The Executive Management Team (EMT) convened at 8:00 AM in the Board Room. Gary Cox presented a high level overview of the recent Operational Definition metrics self-assessment. He reviewed areas of high performance and opportunities for improvement. EPHS 1 received the highest assessment at the public health system level. EPHS 9, evaluation, was an area selected for additional concentration through the recently received NACCHO Quality Improvement Demonstration Grant.

Public Health Foundation has been contracted with to assist the health department with its QI and evaluation, as part of the NACCHO grant. On behalf of PHF, Les Beitsch presented an overview of QI, dividing quality improvement into its two major constituent parts: Big QI (the enterprise-wide superstructure that supports QI across and within the entire Tulsa Health Department) and Little QI (the QI cycles that take place within each division and program to improve its performance).

Les Beitsch offered several definitions/models for Big QI (Baldrige, Turning Point, and Balanced Scorecard). Given the strong overlap among them, the structure was discussed employing the Baldrige framework as the reference. The 7 domains of Baldrige are as follows:

1. Leadership
2. Strategic Planning
3. Customer and market focus
4. The organization uses data and information systems to support key processes and manage performance
5. Human resource focus
6. The health department manages its processes
7. Business results (for public health this translates into improvements in performance and community health status

8. Alignment of the 7 domains (Les Beitsch subsequently recommended an 8th domain be added to represent the senior management responsibility for assuring that all the 7 domains are appropriately aligned to reflect agency priorities and the strategic plan). The remainder of the marathon meeting was directed at defining what a Big QI structure would look like for THD.

Big QI Oversight

Much of the discussion centered on what might be the best approach for THD. The following were among the thoughts shared:

- Leadership has to set the tone that they are committed
- there should be close association with the EMT in order not to build another new and separate silo
- input from field staff (those closest to the work) is critical for the QI system to function effectively
- senior management must establish and nurture both a top down and bottom up approach for a new QI culture to thrive
- this process offers an opportunity to model a well rounded leadership style
  - allow employees to experiment and make mistakes in a supportive atmosphere
  - develop leadership capacity of “new blood” and avoid possible inbreeding
as Little QI is developed it should feed into the goal system and strategic planning already in place
size of the Big QI oversight group is an important consideration
  o if the Director Advisory Committee (DAC) functions as the Quality Council, then it may be large and unwieldy with approximately 25 members
how we engage and communicate with the next level down within the organization will go a long way in determining the acceptance of a QI culture
  o even when information is shared, staff do not always “hear” it
sometimes our jobs get in the way-- we need to establish QI as a priority, and as part of our jobs

Options Discussed
- EMT also sits as the organization wide Quality Council
- at the other end of the continuum, EMT serves as the “boundary setters”
  o a subsidiary group guides Big QI and reports regularly to the EMT
  o this group is “deputized” by the EMT to serve as the Quality Council
    - it serves as a clearinghouse for new QI ideas and projects
  o another alternative recognizes roles for DAC and Employees Committee, a sort of trilogy
- vesting Big QI authority with a group selected for their knowledge of EPHS and accreditation
- there appeared to be general consensus that regardless of structure selected, ultimate responsibility for leadership falls to EMT
- Strategic Planning domain already set in place with a formal structure.
- How would various options be operationalized?
  o EMT sets the “what”
  o a new Quality Council determines the “how”
  o EMT establishes organizational QI priorities (what), then turns to Quality Council and asks them to formulate appropriate strategies (how)
  o membership could be representative from each Little QI project underway
  o membership could be DAC minus EMT plus QI team representatives
  o membership could alternatively be EMT plus another representative from each division
  o EMT could sit on a larger committee or council and serve in an ex officio capacity
  o boundaries also set by EMT
- once structure established, remaining domains and their alignment would be determined

Additional Recommendations
Les Beitsch made some additional recommendations for consideration by the EMT.
- Baldrige be strongly considered as the basis for the Big QI framework for THD
  o Baldrige is public domain, and materials, training, and technical assistance are available at moderate costs
  o Each state has its own Baldrige type process and so resources are available within the state
- If the Baldrige recommendation is accepted, consider undertaking the first level Baldrige recognition or challenge (Oklahoma version) approximately one year from now
- The Tulsa Board of Health undertake the use of the governance instrument of the National Public Health Performance Standards in order to compare results with the
other assessments recently completed and to enhance Board understanding of current standards, QI, and accreditation activities.


APPENDIX C: SMALL QI REPORTS

Family Planning—QI Project Name
Unsure of patient compliance regarding teaching to began prenatal care received at time of positive pregnancy test

QI Team Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Title, Department or Role</th>
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<tbody>
<tr>
<td>Tammy Goodman</td>
<td>RN</td>
</tr>
<tr>
<td>Sharon Barnes</td>
<td>Administrative assistant</td>
</tr>
<tr>
<td>Cherlyn Hiner</td>
<td>RN</td>
</tr>
<tr>
<td>Haydee Monet</td>
<td>Interpreter</td>
</tr>
<tr>
<td>Roxana Shea</td>
<td>Administrative assistant</td>
</tr>
<tr>
<td>Maria Munoz</td>
<td>Outreach worker</td>
</tr>
<tr>
<td>Anabel</td>
<td>Interpreter</td>
</tr>
<tr>
<td>Pat</td>
<td>Consumer protection</td>
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What were you trying to accomplish?
Determine if patients are following instructions provided by RN to schedule PNC within 2 weeks of receiving a positive pregnancy test and if they are taking PNV provided by RN on day of test.

1. PLAN: What was the state of affairs when you began?
We have started by collecting all charts for patients that have had positive pregnancy test since 09/01/08.

What change could be made that would result in improvement?
We do not have improvement theory because we do not know if anything needs to be improved as of yet.

2. DO: How was the test implemented?
2 weeks after clinic visit client will be contacted via phone to assess if they have appt for PNC and if they are taking PNV. If unable to be reached by phone outreach worker will attempt to contact patient by doing a home visit.

3. CHECK: Did it work?
The data collected so far looks like the clients are following instructions and are getting timely PNC

4. ACT: What are the next steps?
No new approach was implemented in our study. The numbers show that patients are following the instructions given by the nurse to start taking prenatal vitamins and to schedule prenatal care within two weeks of obtaining proof of pregnancy therefore no other tests are needed.

Include any specific tools, diagrams or processes used—fishbone, affinity, process mapping, logic models, 5W’s, etc.
QI Project Name—Planning and Epidemiology/Emergency Preparedness Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Title, Department or Role</th>
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<tbody>
<tr>
<td>Nicole Schlaefli</td>
<td>Epidemiologist</td>
</tr>
</tbody>
</table>
What were you trying to accomplish?
The group is trying to increase the availability of informational sources available to the public

1. PLAN: What was the state of affairs when you began?
Current methods for distribution of information mainly involve the public coming directly to us at the James Goodwin Health Center. When a concerned individual or group requires knowledge about a disease or preparedness, they currently can: call up the appropriate department and ask for information; request information be mailed to them; log on to the Tulsa City County Website; or the concerned member of the public can come to the front desk of the James Goodwin Health Department.

What change could be made that would result in improvement?
QI team staff will identify new distribution locations within the different Tulsa Health Department locations by visiting each site to determine the best location for the information to be placed. In addition, seasonal information will be provided throughout the year along with everyday information. Also, the seasonal information will be provided throughout the ear along with the everyday information.
The THD mascot (the kangaroo) will be utilized at one of the locations each month (rotating locations each month) to distribute information to individuals.

2. DO: How was the test implemented?
Team members scouted locations during the week of Sept 22-26, took pictures of all of the potential locations in which kiosks could be placed. During the week of Oct 6-10, work orders will be placed to install kiosks in needed locations and brochures are going to be edited and created if needed. Brochures orders are going to be placed to the printer so both the P&E dept and EPD divisions are ensured to have enough fliers to fill the kiosks.
See attached “Fliers per Site” for a list of what is being placed at each site and “Site Pictures” for the potential locations for each site kiosk.

3. CHECK: Did it work?
Kiosks will be filled during the week of Oct 13-17. Each brochure was numbered so the P&E dept and EPD could count how many of each brochure was taken.

4. ACT: What are the next steps?
After filling all the kiosks, monitoring which information was more utilized, and recounting to see how many brochures in all were taken, several issues were raised and corrected. The two main areas of improvement that are now being addressed are 1) providing information in accordance with the season (i.e. West Nile Virus in the summer and cold/flu information in the winter) and 2) providing information in Spanish (or other second language). Originally, no Spanish brochures were distributed at Central Regional Health Center and Expo Health Center. When a team member went back to refill the brochures and count them, several disease topics brochures that had been translated into Spanish were used in the refill of the kiosks.

Include any specific tools, diagrams or processes used—fishbone, affinity, process mapping, logic models, 5W’s, etc.

Process Mapping – Flow Charting:
- AS IS:
Customer questions answered?

- No
- Yes
- Stop

1. Public contacts P&E / EPD
   a. Internal & External clients
   b. Call back from someone previously contacted
   c. Request for presentations and health fairs
      i. Direct to appropriate website or mail appropriate information
      ii. Direct to lobby for printed literature

**Cause and Effect Diagrams:**

- Inadequate availability of information in public
  - Zero/limited access to website
  - No designated areas for information

- Lack of manpower
  - Hiring freeze
  - Budget constraints
    - Other obligations

- Preconceived Erroneous Knowledge
  - Handouts/literature in appropriate language
  - Cultural sensitivity
    - Age appropriate & Educational level materials

- Not aware of Health Dept. Resources

- Language/cultural problems
  - Increase Public Knowledge

**Kiosk Stands Internal**
- Place in all THD Clinics & satellite locations
  - Utilize 595-4EPD
  - EPD Newsletter

**Kiosk Stands External**
- Community Partners
  - Kangaroo Mascot – Story Time
  - EPD Newsletter

- Increase Availability of Information
### Gantt Chart:

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Week Ending</th>
<th>Assign To</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Visit THD Clinics/Satellite locations</td>
<td>9/18/08</td>
<td>Patrick Hilton/Brenda Dale</td>
</tr>
<tr>
<td>2. I.D. External Partners for newsletters</td>
<td>10/10/08</td>
<td>Kelly VanBuskirk</td>
</tr>
<tr>
<td>3. Translating Resources</td>
<td></td>
<td>Linda Muirheid</td>
</tr>
<tr>
<td>4. Transcribe QI training notes from 9/15/08</td>
<td>9/18/08</td>
<td>Joann Calloway</td>
</tr>
<tr>
<td>5. Literature Review</td>
<td>10/10/08</td>
<td>Chanteau Orr / Nicole Schlaefli</td>
</tr>
<tr>
<td>6. Complete PDCA1</td>
<td>10/3/08</td>
<td>Nicole Schlaefli</td>
</tr>
<tr>
<td>7. Complete PDCA2</td>
<td>10/17/08</td>
<td>Nicole Schlaefli</td>
</tr>
<tr>
<td>8. Final Report to NACCHO</td>
<td></td>
<td>10/24/08</td>
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QI Project Name: Human Resources Technology Applications

QI Team Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Title, Department or Role</th>
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<tbody>
<tr>
<td>John Gogets</td>
<td>Director, HR</td>
</tr>
<tr>
<td>Esther Fourkiller</td>
<td>Administrative Assistant, HR</td>
</tr>
<tr>
<td>Ingrid Alvarez</td>
<td>Administrative Aide, HR</td>
</tr>
<tr>
<td>Kathy Cooper</td>
<td>Accounts Supervisor, PHS</td>
</tr>
<tr>
<td>Rick Mysofski</td>
<td>Safety/Loss Prevention Coordinator, HR</td>
</tr>
</tbody>
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What were you trying to accomplish?
Reduce the time for Human Resources personnel to forward quality employment applications to the hiring manager with the use of technology.

1. PLAN: What was the state of affairs when you began?
   - Human Resources staff reported that existing services to hiring managers could be improved.
   - Human Resources formed a quality improvement team to improve existing services, research issues for clearer understanding and determine the scope of the project.
   - Team members attended quality process training facilitated by the Public Health Foundation.
   - Follow-up team meetings were scheduled. Team member roles and responsibilities were assigned. The team mission or focus was clarified. Current and future states of the problem were discussed. A problem statement was determined. The work process was discussed (see process flow chart for description).

What change could be made that would result in improvement
   - The improvement theory uses computer technologies such as document scanners and groupware software to provide fast, secure online delivery of employment applications to hiring managers.
   - Increases in Human Resources staff and hiring manager satisfaction verify process improvement.

2. DO: How was the test implemented?
   - The team analyzed the current work process (S-I-P-O-C) and used a flow chart to visually represent the work process.
   - The team used Force Field Analysis as well as Fishbone Cause and Effect/Solution Diagrams to define the problem, identify positive and negative influences.
   - The team identified and prioritized root causes of problems and solutions.
   - The team used the Plan-Do-Check-Act improvement cycle.
   - The test solution included: a) purchase of a document scanner; b) equipment installation and staff training by ITS personnel; c) use of new equipment to scan qualified employment applications; and d) distribution of applications to hiring managers via the THD Intranet.
   - No implementation obstacles were reported. A high level of inter-department cooperation was observed.

3. CHECK: Did it work?
   - Data collection was not necessary to implement the improvement strategy.
   - Observed results match expectations and include: a) less staff time required to distribute qualified employment applications due to operational efficiencies; b)
convenient access to employment applications by hiring managers; and c) available secure online tracking capabilities for distributed employment applications.

4. ACT: What are the next steps?
   o New approach adopted. Additional technology options to permit greater flexibility discussed.
   o Next steps for improvement include:
     • Standardize the application process.
     • Leverage benefits of future technology for advanced human resources applications.

Include any specific tools, diagrams or processes used—fishbone, affinity, process mapping, logic models, 5W's, etc.
QI Project Name: Community Health Services WIC WAITING ROOM

QI TEAM MEMBERS:

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
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<tbody>
<tr>
<td>Elaine Wyatt</td>
<td>WIC clerk</td>
</tr>
<tr>
<td>Anne Majsterek</td>
<td>WIC nutritionist</td>
</tr>
<tr>
<td>Cheryl Schendt</td>
<td>WIC manager</td>
</tr>
<tr>
<td>David Sellers</td>
<td>Manager, Maintenance and Operations</td>
</tr>
</tbody>
</table>

What were you trying to accomplish?
To make a plan to rearrange the WIC waiting room to provide more privacy at the WIC intake windows and a safer environment for clients.

1. PLAN: What was the state of affairs when you began?
CURRENT PROCESS: We completed the project and used the Gantt chart.

What change could be made that would result in improvement?
We used theory #1: Rearrange the room and dispose of tables, replacing them with chairs. An evaluation tool, a tally sheet, was made by Anne to record comments about the new waiting room arrangement. The tally sheet will be inner office mailed to QI Coordinator.

2. DO: How was the test implemented?
David and his staff moved the waiting room chairs and removed tables, replacing them with chairs. Anne made the evaluation tool, a tally sheet to document comments about the new chair arrangement.

Elaine and Anne recorded data on the evaluation tool. Cheryl and Elaine discussed the information on the evaluation tool. There were no obstacles to the QI process or the evaluation tool.

3. CHECK: Did it work?
Please see evaluation tool for data collected. The results were positive in meeting our goals of having a more private area around the WIC windows and a safer room for clients. We will continue to use the room as it is arranged presently, and an ongoing evaluation will be done. The results matched our expectations. The new arrangement is an improvement over the previous arrangement.

4. ACT: What are the next steps?
The new waiting room arrangement will continue, as it is working well. We will continue to monitor comments about the room from staff and clients. We may install a sign, which stands from a base on the floor to further direct clients to the WIC window. It would say “please wait here until called”, or some words similar to those.
Include any specific tools, diagrams or processes used—fishbone, affinity, process mapping, logic models, 5W's, etc
QI Project Name: Environmental Health Services—Reduce Inconsistency Mosquito Trapping

QI Team Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Scott Meador</td>
<td>Env. Specialist</td>
</tr>
<tr>
<td>John Zima</td>
<td>Supervisor</td>
</tr>
<tr>
<td>Bernard Dindny</td>
<td>Sr. Env. Specialist</td>
</tr>
<tr>
<td>Lois Swanson</td>
<td>Lab Supervisor</td>
</tr>
<tr>
<td>Vicki Silva</td>
<td>Administrative Assistant</td>
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<tr>
<td>John Baker</td>
<td>Manager</td>
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1. Plan: What was the state of affairs when you began?
We as a division had various (up to 6) different ways of site selection, setting up and collection of mosquito traps. We needed to have a uniform method of collection to ensure that number of mosquitoes per site was valued equally. The process has been unchecked since the inception of the program many years ago. Now that we are using more data to determine use of pesticides, more complete data is needed. The current approach was that each collector used the methods that best met their needs and physical abilities. Simply stated the current state of the program is in disarray. Improvement could be made in the areas where the mosquito traps are placed, the water used for the traps, and which types of batteries are used to capture the mosquitoes. We looked at every piece of the trap and all the elements of the trap to check which parts could be consolidated and/or made uniform.

2. DO: How was the test implemented?
Each collector was asked to list the things that they thought were important to maintain with the current procedure. Then they expressed any concerns they had with upcoming changes. This included any scientific differences they may have and any physical limitations they may have. Many differences were found with the amount of time that we were to use for the collections time. We did not implement any of the new ideas because the end of the mosquito season was near and any changes at that time would have been useless.

3. CHECK: Did it work?
We were unable to begin the process of checking if any of our new procedures would work. The time of the QI process was the same time as the end of our mosquito season. We were unable to continue because also there are no mosquitoes this time of year. The process will begin with the new trapping season that begins in April 2009.

4. ACT: What are the next steps?
The new procedure will be tested and most likely be implemented in the 2009 mosquito season. We are currently researching the data from the 2008 season. One of the inspectors used most of the methods that we are implementing in the future. The mosquitoes collected by that collector was the highest numbers, so the evidence is clear that this can work.

<table>
<thead>
<tr>
<th>Elements</th>
<th>Control</th>
<th>Implement</th>
<th>Involve &amp; Influence</th>
<th>Outside Our Control &amp; Influence</th>
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</thead>
<tbody>
<tr>
<td>Education</td>
<td>Within</td>
<td>Within</td>
<td>Within</td>
<td>In</td>
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<tr>
<td>Same water</td>
<td>Within</td>
<td>Within</td>
<td>Need influence</td>
<td>In</td>
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<tr>
<td>Batteries</td>
<td>Out</td>
<td>Within</td>
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<td>In</td>
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<td>1 night trapping</td>
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APPENDIX D: QI TRAINING AGENDA

PHF Quality Improvement Workshop
Tulsa Health Department
NACCHO Quality Improvement Initiative
September 15, 2008
8:00 AM:
- Welcome Remarks
- Introductions
- Overview of the NACCHO Process
- Why we are here?

8:30 AM
- Introduction QI Process
- Review Problem Statements with Teams
- Discuss process for team problem solving process

Plan:
- Review Current and Future State Problem Statement
- Force Field Analysis on problem statement
- Maximize opportunities, minimize barriers
- Understand the benefits
- Review team Outputs

10:00 AM
Break

10:20 AM

Do:
- Map the process - High level flow chart of the Current State
- Develop a Cause and Effect Diagram on selected areas of improvement

12 Noon
Lunch

1:00 PM

Do: (continued)
- Complete Cause and Effect Diagram
- Review team outputs
- Map the process - High level flow chart of the Future State
- Develop a Cause and Effect Diagram on selected areas of improvement

3:00 PM
Break

3:20 PM

Check:
- How will we know if we are successful?
- What are the indicators of success?

Act:
- Project planning for November, 2008
- Develop a Gantt Chart of activities and tasks

4:30 PM
What’s next?

5:00 PM
Adjourn